South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 30 April 2019 at 9.30am
Room 49/50, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.31**	**Declarations of interest**	Chair	**Verbal item**	1	To receive
3.	**9.32**	**Minutes and matters arising from previous Trust Board meeting held 26 March 2019**	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 Strategic overview of business and associated risks	Director of Strategy	**Paper**	10	To receive
		6.2 Board Assurance Framework (BAF)	Director of Finance & Resource	**Paper**	15	To receive
		6.3 Corporate / organisational risk register (ORR)	Director of Finance & Resource	**Paper**	15	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
7.	**10.40**	**Business developments**				
		7.1 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of Strategy	**Verbal**	10	To receive
		7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy	**Paper**	10	To receive
8.	**11.00**	**Performance reports**				
		8.1 Integrated performance report (IPR) Month 12 2018/19	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	45	To receive
	11.45-55	*Break*			*10*	
		8.2 Safer staffing report	Director of Nursing & Quality	**Paper**	10	To receive
		8.3 Guardian of safe working hours annual report	Medical Director and Guardian of Safe Working	**Paper**	10	To receive
9.	**12.15**	**Strategies**				
		9.1 Digital Strategy progress update	Director of Finance & Resources	**Paper**	10	To receive
		9.2 Update of the Risk Management Strategy including review of Risk Appetite Statement	Director of Finance & Resources	**Paper**	10	To approve
10.	**12.35**	**Governance items**				
		10.1 Audit Committee Annual Report 2018/19 including updated terms of reference for Trust Board committees	Director of Finance & Resources	**Paper**	10	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		10.2 Internal meeting governance framework	Director of Finance & Resources	**Paper**	5	To receive
		10.3 Draft Annual Governance Statement 2018/19	Director of Finance & Resources	**Paper**	10	To approve
		10.4 Compliance with NHS provider licence conditions and code of governance - self-certifications	Director of Finance & Resources	**Paper**	5	To approve
		10.5 Operational plan 2019/20	Director of Finance & Resources	**Paper**	5	To receive
		10.6 Update of the Scheme of Delegation	Director of Finance & Resources	**Paper**	5	To approve
		10.7 Going Concern	Director of Finance & Resources	**Paper**	5	To approve
11.	**13.10**	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive
12.	**13.15**	**Assurance and receipt of minutes from Trust Board committees** - Audit Committee 9 April 2019 - Clinical Governance & Clinical Safety Committee 2 April 2019 - Nominations Committee 9 April 2019	Chairs of committees	**Paper**	5	To receive
13.	**13.20**	**Trust Board work programme**	Chair	**Paper**	1	To note
14.	**13.21**	**Date of next meeting** The next Trust Board meeting held in public will be held on Tuesday 25 June 2019, Room 5/6, Laura Mitchell Health and Wellbeing Centre, Great Albion St, Halifax HX1 1YR	Chair	**Verbal**	4	To note

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
15.	**13.25**	**Questions from the public**	Chair	**Verbal**	10	To receive
	13.35	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 26 March 2019
Rooms 3 &4, Laura Mitchell, Halifax

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) (from 10.17am)	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 (author)
	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

TB/19/16 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies as above were noted. It was noted that Kate Quail would be arriving between 10.00 and 10.30am. At the commencement of the meeting there were three members of the public in attendance which included two governors. 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 members of the public preferred to raise their questions in that way and to enable a response to be provided outside of the meeting.

TB/19/17 Declarations of interest (agenda item 2)

The following declarations were considered by Trust Board:

Name	Declaration
Chair	
MONAGHAN, Angela Chair	Spouse - Strategic Director at Bradford Metropolitan District Council. Spouse - Non-Executive Director of the National Association for Neighbourhood Management.
Non-Executive Directors	
CAMPBELL, Laurence Non-Executive Director	Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council.
COURT, Rachel	Director and Chair, Leek United Building Society.

Name	Declaration
Non-Executive Director* (*term ends 31 March 2019)	Chair, Invesco Pensions Ltd. Director, Invesco UK Ltd. Director, Leek United Financial Services Ltd. Chair, PRISM. Governor, Calderdale College. Magistrate. Chair, NHS Pension Board.
DYSON, Charlotte Deputy Chair / Senior Independent Director	Independent Marketing Consultant, Beyondmc (including consultancy for Royal College of Surgeons of Edinburgh). Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional). Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee. Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.
MAHMOOD, Erfana Non-Executive Director	Non-Executive Director, Chorley and District Building Society. Non-Executive Director, Plexus/Omega Housing, part of Mears Group PLC. Sister - employee for Guide-Line telephone helpline for Mind in Bradford.
QUAIL, Kate Non-Executive Director	Owner / Director of The Lunniagh Partnership Ltd, Health and Care Consultancy.
YOUNG, Sam Non-Executive Director	Owner / Director, ISAY Consulting Limited. Non-Executive Director, Great Places Housing Group.
Chief Executive	
WEBSTER, Rob Chief Executive	Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England). Visiting Professor, Leeds Beckett University. Honorary Fellow, Queen's Nursing Institute. Honorary Fellow, Royal College of General Practitioners. Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System).
Executive Directors	
BREEDON, Tim Director of Nursing and Quality / Deputy Chief Executive	Son - works in the Trust's Occupational Health Service as a Registered Nurse.
BROOKS, Mark Director of Finance and Resources	No interests declared.
DAVIS, Alan Director Human Resources, Organisational Development and Estates	Spouse - Employed by Blackpool Teaching Hospitals NHS FT as the Managing Director for NHS North West Leadership Academy.
THIYAGESH, Dr Subha	No interests declared.

Name	Declaration
Medical Director	
Other Directors (non-voting)	
HARRIS, Carol Director of Operations	Spouse - Engineering Company has contracts with NHS providers including Mid Yorkshire Hospitals NHS Trust.
RAYNER, Sean Director of Provider Development	No interests declared.
YASMEEN, Salma Director of Strategy	Board member, PRISM charity in Bradford.

Note, Kate Henry, Director of Marketing, Communication and Engagement is on maternity leave until her contract ends in August 2019. No interests have been previously declared.

Laurence Campbell (LC) explained that there would be a change to his declaration from 2019/20 and this would be confirmed at the April 2019 Trust Board meeting.

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

TB/19/18 Minutes and matters arising from previous Trust Board meeting held 29 January 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 29 January 2019 as a true and accurate record. The following matters arising were discussed:

- A number of actions relating to the corporate risk register have been completed and will be presented at the April 2019 Board meeting when the risk register is next on the agenda.
- TB/19/15d – Initiative about future new optimal health care model for the Trust with the specific focus on prevention. Tim Breedon (TB) has a draft response to review and will circulate this week commencing 1 April 2019.
- All actions completed can be taken off the action log.

TB/19/19 Service User Story (agenda item 4)

The Trust Board heard a service user story in relation to the experience of Horatio Clare in the form of a recording of an interview with the BBC. Carol Harris (CH) felt that it provided a good insight into how it feels to go through our services. She also explained that use of the story had been discussed with Horatio and he would be pleased to have involvement with the Trust in the future to support our services. He did make some suggestions regarding information leaflets and how we explain things to service users such as the use of fobs.

AM felt that the compassion shown by our staff stood out from the story.

Charlotte Dyson (CD) stated that the story helped remind us of how alien inpatient wards are to people, particularly those entering our services for the first time.

Rachel Court (RC) asked if the Trust does enough to capture user experiences. CH explained that there are daily ward meetings and other formal meetings to do this, but we can always look to improve.

AM asked if a link to the interview could be put on our website. CH will investigate.

Alan Davis (AGD) stated that the observations on the environment were helpful and Dr. Subha Thiyagesh (SThi) agreed with this.

Rob Webster (RW) stated there were 4 key points from his perspective that can be considered from this story. They are 1) maintaining Safewards initiatives and effective communication 2) access to the outside world and provision of meaningful activity 3) training and induction 4) the fact Horatio is willing to work with us in the future

CH explained that the same story had been used recently at the West Yorkshire contract partnership board and the feedback was that it had an impact on all those who listened to it.

CD asked if there could in future be stories from a learning disability service user and a staff member.

The Board thanked the service user for sharing their story.

It was RESOLVED to NOTE the Service User Story and to consider how the story was used for effective communication and picking up further work with Mr Clare. [Salma and Carol to pick up]

TB/19/20 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- Members' Council election - uncontested seats in Barnsley (Keith Stuart-Clark), Calderdale (Phil Shire and Adam Jhugroo) and social care staff working in integrated teams (Paul Batty). Voting opened on 25 March 2019 and closes at 5pm on 18 April 2019.
- The meeting was Rachel Court's last meeting as a Non-Executive Director of the Trust Board. Her contribution and insight has been invaluable and will be missed. Rachel was thanked for all that she has done in her 4 years as a Non-Executive Director with the Trust.
- The Board will be discussing the following items in private session today, which are considered as commercial in confidence:
  - Those aspects of financial performance considered to be commercial in confidence.
  - Serious incidents under investigation.
  - Operational plan 2019/20, which includes the Trust's proposed control total.
  - Commercially confidential 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. His report provided additional information and he highlighted the following:

- The role played by the NHS Confederation and NHS Providers in terms of lobbying on behalf of social care
- The role of the Integrated Care Systems (ICS) is ramping up in respect of the 2019/20 operating plan. This has included involvement in contract mediation and management of risk, including with the Trust
- Care Quality Commission (CQC) has issued reports regarding the Mental Health Act and an update to learning from deaths that are relevant for the Board to consider
- A system wide conference is taking place in relation to safeguarding and will include representatives from a range of stakeholders. Focus needs to be placed on legal duties, remaining professionally curious, not following a general rule of optimism without firm evidence and always seeking evidence
- There is a separate more detailed report on SystmOne implementation. This has largely gone well with good engagement and a fairly smooth transition to the new system. There have recently been some issues with slow running of the system. The reasons for this are felt to be understood and the Trust is working with TPP to address as soon as practically possible.
- The Trust has won an award for most innovative campaign in relation to flu fighters

Sam Young (SYo) reinforced the comments made about SystmOne.

CD asked whether an update relating to learning from deaths will be taken to the Clinical Governance and Clinical Safety Committee. TB confirmed it would be.

CD asked where the report on the national workforce would go and if it covered the mental health workforce. RW stated a report is likely to be available by the end of April and will be included in a future Board paper. It was confirmed it does cover the mental health workforce. AM asked if we have responded to the consultation on this subject. RW explained that a response has been sent by the trust, by the mental health alliance and through the ICS on behalf of all organisations.

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

TB/19/21 Performance reports (agenda item 6)

TB/19T21a Integrated performance report M11 2018/19 (agenda item 6.1)

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

- The temporary placement of children and young people in adult inpatient wards continued in February. TB stressed safeguarding protocols are in place and that helpful conversations have taken place with commissioners.
- In respect of complaints, a new manager has been appointed and the quality of complaint reports is improving. The turnaround in performance is being impacted by available capacity. More time is being spent on local resolution of complaints.
- Medicines omissions improved in February. This needs to become a more sustainable performance.
- An increase in number of falls in February was associated with levels of acuity and complexity.
- Within safer staffing overall fill rates are good, but there are some local pressures.
- Work is taking place on CQC action planning. Our provider information request submission has been made to the CQC. The detailed report will be taken to the Clinical Governance and Clinical Safety Committee.

Erfana Mahmood (EM) asked in light of the high agency spend how often is it sense-checked with safer staffing numbers. TB explained that safer staffing numbers do not include medical staff and a sizeable proportion of our agency costs relates to medical

locums. He added that a formal establishment review was conducted in 18/19 Q3 that is being addressed through current workforce planning workshops. There is also a formal establishment review every six months to the Clinical Governance and Clinical Safety Committee and Trust Board. LC asked if six months was too long a period to wait to make changes. TB explained that professional guidance is used on a daily basis if there are any staffing issues that need to be addressed. The longer term solution is via the establishment review. AM asked how the professional tool had been developed. TB stated it had been developed internally with reference to approaches adopted in other mental health trusts. Changes in regulation and acuity are taken into account as part of the consideration in the establishment reviews.

From the recent internal audit on complaints, LC felt that the processes and use of Datix didn't quite mesh. TB stated that the new manager is reviewing this issue. TB also confirmed additional KPIs could be introduced for April.

LC asked about the detail of Information Governance incidents. MB explained that a deep-dive report is being taken to the April Audit Committee. He also added that additional assurance is being sought on actions taken following an incident by means of a formal letter to general managers and deputy directors.

RW emphasised the need to make the improvement in medicines omissions sustainable. TB stated this needs to be through operational discipline and capacity in the pharmacy team. ST highlighted the issue is an area of focus at the Drugs and Therapeutic Committee.

RW asked why the Friends & Family test results for December were not in the report. This will be followed up.

Action: Tim Breedon

Kate Quail (KQ) asked about the ages of children and young people being admitted to inpatient wards. CH stated they are typically 16 or 17 years olds. KQ also asked if emergency Care Education and Treatment Reviews (CETRs) are carried out with the aim of stopping an admission. TB said this approach would be taken forward via the new models of care team.

KQ asked how the Trust benchmarks with others in relation to incident reporting. TB stated that typically we are quite similar in respect of the proportion of green incidents, but a little lower in terms of total number of incidents reported. Awareness will continue to be raised.

CD asked how red-rated incidents are triangulated with other issues such as staffing numbers. TB explained that calibration is carried out at the risk panel and a regular report is taken to the Operational Management Group (OMG) and Executive Management Team (EMT). CD followed this up by asking how emerging issues are managed. CH explained there is a process of escalation to OMG.

KQ asked if, in respect of the work SSG have carried out on out of area beds, whether parents and carers have been involved. MB clarified that the purpose of the SSG work was to focus on internal processes and external demand factors with the aim of making improvements which would allow for a reduction in the use of out of area bed placements. RW stated that, in respect of children and younger people, there needs to be appropriate input from families and carers into the new model of care.

SYo noted there was a relatively low number of compliments received in the month, whilst acknowledging these need to be reviewed over a period of time. SYo also asked how often the profile and proportion of incident type was reviewed. TB explained that this is carried out quarterly for any trends to be meaningful.

SYo asked about the use of prone restraint for a period of over three minutes. TB explained that any such incident is reviewed by specialist advisors as part of the post incident review. Any learning from these reviews will be taken into account. CD noted these incidents were also reviewed at the Clinical Governance and Clinical Safety Committee. KQ asked if it could be made clear in the narrative that it is the Trust's aim to reduce restrictive practice. TB will include this in the narrative next time.

Mark Brooks (MB) highlighted the following in relation to National metrics:

- There are a small number of metrics not updated in February given the focus of the team on the SystmOne implementation
- Typically the Trust is meeting the thresholds set for nationally reported metrics

CH highlighted the following in relation to Locality:

- Contract negotiations for 19/20 are taking place
- Staff survey results are being assessed with local action plans being put in place
- Work is taking place on finalising a proposed stroke pathway in Barnsley
- Mobilisation of liaison & diversion services is taking place in readiness for these services transferring across to us in South Yorkshire on April 1st
- Anti-ligature work in the ward 18 garden area has been completed
- A recovery action plan is in place for services provided at the Young Offenders' Institute in Wetherby

Salma Yasmeen (SY) introduced the priority programme section and referred to a separate board paper on the implementation of SystmOne, work taking place on the stroke pathway in Barnsley and out of area beds.

EM asked if there were any quick wins on out of area beds. SY stated that criteria-led discharge is now in place across the Trust's geography, however more work was on going to embed this and ensure it is standardised through implementation. MB suggested that, based on the output from the SSG report, there are eight work streams that would collectively make a difference to the use of out of area bed placements as opposed to there being one or two single actions. RW highlighted the fact that work was initiated across the West Yorkshire Integrated Care System in relation to the bed base. SR felt this has not moved in line with initial expectations. A new programme director starts in June and this issue will be raised within the mental health collaborative

MB highlighted the following in relation to Finance:

It was noted there was a deficit of £244k in February with additional non-recurrent income of £400k received from the Kirklees CCGs to support the increased use of out of area bed placements. He also noted there were a number of one-off costs incurred in the month meaning the underlying deficit was £163k. The year-to-date position is a deficit of £325k and the full year target now looks to be very achievable. Issues remain with out of area beds with one service user historically costing circa £2k per night and these costs are set to more than double. Agency costs were similar to previous months' at £545k and are projected to be 23% over the cap by the year-end. Cost Improvement Projects will over achieve compared to plan largely because of the savings resulting from a revaluation in property.

RW emphasised that the Trust had been ahead of plan every month in the year, which was a result of good planning and actions taken during the year such as not filling some

vacancies, particularly in corporate areas. LC echoed this point. CD stated that how the financial position is communicated to staff is important.

AGD highlighted the following in relation to Workforce:

- Sickness fell slightly in February although challenges remain in some areas
- He felt the Trust needs to improve the quality of opportunity offered in some cases
- Actions continue in respect of staff turnover
- All mandatory training targets have been achieved

AM asked how training requirements for medics were captured. SThi explained these are calculated separately as they must achieve 100% in order to meet re-validation requirements

CD stressed the importance of the completion of supervision within policy.

RW highlighted the importance of remaining focused on those issues that are not being resolved quickly. These include the use of out of area beds, workforce issues in forensics and specialist BDUs, psychology waiting times and children and younger people. RC asked whether any external support is required. CH explained that an internal approach has been taken with the forensic and specialist BDUs. The Trust is working with NHS Improvement on recruitment and retention. MB highlighted that he and a group of senior managers are meeting with NHS Improvement's national support team in respect of agency staffing costs.

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

TB/19/21b Staff survey results (agenda item 6.2)

AGD reported that the staff survey results were published in a slightly different format this year, meaning there is less ability to drill down or compare with previous years. Overall the results suggest the Trust is fairly average with the results this year although there are a range of results across services and teams, some of which are positive and others less so. Discussions on the results have taken place within teams, at extended EMT and EMT. Local action plans are being put in place. AGD felt there are four key areas of focus which are:

- Staff engagement
- Quality of appraisals
- Staff wellbeing
- Prevention of harassment and bullying

EM asked if it was still a view that prevention of bullying and harassment would have a positive impact on other issues as well. AGD believes our aspiration on prevention of bullying and harassment is to be the best. EM also asked how the results of the survey calibrated with the work being carried out on equality and diversity. AGD stated one of the purposes of the networks is to challenge the organisation. AGD also stated that in terms of reporting of incidents of harassment and bullying the figure is quite low.

AM asked if the quality of appraisals for doctors is included in these data and how we monitor quality of doctor appraisals.

CD asked how leadership fits in to making improvements. AGD agreed this is an important point and we need to continually focus on how we develop leaders. RC also noted that some bullying is peer to peer and questioned how this is issue is addressed. AGD acknowledged this is an issue. RW re-iterated the importance of the Board and senior

leaders setting the right tone. There will be more focus on the staff survey results and ensuing actions at the Workforce and Remuneration Committee.

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

TB/19/21c Clinical Records System update (agenda item 6.3)
SY highlighted the following:

- The go-live on both inpatient units and community services took place as planned
- The delta cut has been taken
- The use of floor walkers continues and the role of super-users has been key
- There have been circa 2,000 calls to date with the majority dealt with and approximately 200 being worked on. Calls have typically related to four categories which are a) how to use the system b) rotas c) user acceptance issues particularly the medic care plan and d) e-discharge in pharmacy
- There is a current issue regarding the speed of the system which has impacted on the Trust since a national update was applied. The cause is felt to be understood and relates to the number of users allocated to individual units in order to complete the catch up data input from when the Trust was without a system. Plans are in place to address for all users by the end of the week
- The Trust will move quickly into system optimisation with plans being developed. RW explained there would be a financial pressure in the short term as a consequence.

EM praised the positive outcome and felt the approach taken had won the hearts and minds of staff. CD asked for an update on the issue with the care plan. SY stated this was on track for completion in May. RC asked if there had been any impact of the slow running on service users. SThi stated the issue of slowness was impacting the time taken to update records and had needed to apologise to service users for this. CD stated that the risks would continue to be reviewed at the Clinical Governance and Clinical Safety Committee. AM asked for an update on the status of staff training. SY noted that training was going very well with particular focus in increased super-user training at the moment.

It was RESOLVED to:

- **NOTE the CRS Go Live progress update and on-going management of key risks; and**
- **NOTE the key programme milestones.**

TB/19/21d Freedom to Speak Up Guardian update (agenda item 6.4)
AGD highlighted the following:

- The annual report by the guardians will be reviewed at the Clinical Governance and Clinical Safety Committee
- There has been some dedicated time committed to the role with Estelle Myers providing an additional one day a week to the role
- An advertisement is in place for a two-year secondment into a part-time position from 2019/20 onwards

RC asked if the vision for the role could be made clearer and simplified in the documentation. CD stressed the importance of closing the loop on issues raised ensuring we are seen to be taking appropriate action. Also a summary of key themes reported to Board would be helpful.

KQ asked how it would be ensured that staff who raise issues remain protected. AGD explained we work closely with the individual on this and agreed there is more that can be done to provide assurance on this matter.

LC asked that if an issue is raised and an individual is moved out of a service/team whether we check back to see if the issue has been resolved. AGD stressed any investigation is independently carried out and that he meets with the freedom to speak up guardians every six weeks.

EM asked what the process would be if a Non-Executive Director had an issue. AGD explained there is a leaflet on the intranet which highlights all the various routes that can be taken to raise an issue. The first point of call for a Non-Executive Director would be the Senior Independent Director.

AM asked what the optimal size for the guardian network is. AGD stated it is a minimum of four and that he is not certain on what the maximum size would be yet.

It was RESOLVED to NOTE the Freedom to Speak Up Guardian update and APPROVE the Vision and Strategy.

TB/19/22 Business developments (agenda item 7)

TB/19/22a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.1)

AGD introduced this paper.

RW stated the most notable issue as being the interim governance changes that are being put in place. AGD believes they are a sensible set of interim arrangements. RW suggested the Trust write formally to the SYBICS to support the interim governance arrangements and reinforce our commitment to being engaged in future arrangements, as well as the ongoing work of the mental health programme and the Barnsley work taking place.

Action: Alan Davis/Angela Monaghan

LC asked for confirmation of accuracy of some of the benchmarking data used in the indicators, particularly that of West Yorkshire. RW believes the information looks appropriate and highlighted that ICSs will all be targeted to deliver improvements in performance.

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

Erfana Mahmood left the meeting.

TB/19/22b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.2)

SY highlighted the following:

- Significant work is taking place in relation to the carers' programme
- The looking after your neighbours campaign has been well supported across West Yorkshire and Harrogate with over 300 organisations supporting the campaign

SR stated that, in respect of Transforming Care Partnerships, the aim is to move from three to one, with the one being a West Yorkshire and Barnsley footprint.

RW highlighted that Tom Jackson has presented nationally on work being carried out in relation to learning disabilities.

LC asked about the role of primary care networks and whether these are defined or evolving. RW explained that this varies by location and that there is a maturity matrix. In future, monies will flow through GP contracts for a number of specific services and to incentivise working in networks.

RW also highlighted that the partnership board has held a development session. It was identified that more public representation is required on the board and recruitment is taking place to co-opt four members of the public on to the board.

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**

Erfana Mahmood returned to the meeting.

TB/19/23 Strategies and policies (agenda item 8)

TB/19/23a Updates to Learning from Healthcare Deaths Policy (agenda item 8.1)

TB introduced the updated learning from healthcare deaths policy and explained the process the policy has been through. The main point to draw to the Board's attention is support for bereaved families. He also explained that the first meeting of the new clinical mortality review group (CMR) is taking place later this week.

LC requested that, for any future updated policies, the updates be shown in a different colour or by using track changes.

CD asked how the Board will have oversight. TB stated that key themes will be included in the integrated performance report and it will be an agenda item at the Clinical Governance and Clinical Safety Committee

AM asked whether we are doing enough to prevent deaths including listening to carers and families. CD followed this up by asking how we know if the culture is right. RW stated that there is always an investigation when there is an issue. RW suggested we need 1) fuller reporting 2) involvement from families, carers and service users to drive the culture 3) to follow the thematic review of the CQC at the newly formed CMR group.

TB reminded Board members that learning from deaths is already reported to Trust Board. RW asked whether there is enough focus on the learning from deaths at the Trust Board. CD stated that themes are regularly reviewed at the Clinical Governance and Clinical Safety Committee as part of the quarterly incident management reports.

AM asked about any conclusions from the equality impact assessment, noting that it did not reflect analysis by protected characteristic of deaths recorded since the policy came into effect. TB confirmed any differentials are reviewed. TB will confirm the key points from the equality impact assessment at the next board meeting.

RW asked if the policy had to be named as it currently is with the word 'healthcare' included as it suggests we only consider deaths that are caused by healthcare, rather than deaths where people were in receipt of healthcare. TB stated this was agreed within the northern alliance and he would check for the next meeting.

It was RESOLVED to RECEIVE and APPROVE the Healthcare Deaths policy and the NEXT STEPS identified.

TB/19/24 Governance matters (agenda item 9)

TB/19/24a Eliminating mixed sex accommodation (EMSA) declaration (agenda item 9.1)
TB introduced this paper.

LC noted on page 6 the number in the 'other' column for Wakefield seemed high. TB believed this related to inter-ward movements, and would confirm if this is the case.

Action: Tim Breedon

RW noted in section 5.4.2 there were some reds relating to psychiatric intensive care units (PICU) and asked if these could be explained, including how these affected compliance. TB stated that we are EMSA compliant and referred to the criteria at the front of the executive summary. Essential requirements are met and we are making progress with some desirable requirements.

It was RESOLVED to SUPPORT the compliance declaration that was approved by the Clinical Governance and Clinical Safety Committee on 12 February 2019.

TB/19/24b Data Security and Protection toolkit (agenda item 9.2)
MB highlighted the following:

- The Data Security and Protection (DSP) toolkit has replaced the Information Governance (IG) toolkit.
- MB has reviewed the evidence provided to date and noted that the recent internal audit will provide significant assurance. There are some minor improvements identified which the Trust will put into action. The detailed internal audit report will be reviewed at the Audit Committee.

MB will review the final submission and associated evidence with the Information Governance Manager before it is submitted before the end of the week. MB was comfortable in his role as Senior Information Risk Owner (SIRO) that following review of the evidence, the outcome of the internal audit and the return being in line with previous submissions that a compliant declaration on the submission was appropriate.

RW asked if a Non-Executive Director should review the submission with MB. AM stated she did not feel this was necessary.

It was RESOLVED to:

- **NOTE the work undertaken to date and that which is ongoing to ensure all mandatory standards are met by the deadline for submission by the 31st March 2019; and**
- **AGREE that the Trust submits a DSPT that is compliant with the standards.**

TB/19/24c Update on financial and business planning, integrated performance report, board assurance framework (agenda item 9.3)

MB highlighted the following:

- Progress is being made on the final operating plan for 2019/20. Papers are being taken to the private session of the Board in respect of the financial position and contract status. Once the Board has made an informed decision based on these papers the final templates and narrative will be completed in readiness for the final submission
- Feedback from NHS Improvement on the draft plan will also be incorporated in the final plan
- In respect of the integrated performance report for 2019/20, in recent years MB has circulated a paper following consultation with other directors about which metrics to include in the executive summary dashboard which help inform how well the Trust is doing in meeting its objectives. A separate paper on objectives and priority programmes is being taken to the private session of the Board and following agreement MB will liaise with EMT members and bring a proposal for the full Board to consider in April
- There are likely to be some additional nationally reported metrics for 2019/20 and these will also be highlighted to Trust Board members
- The outline for the Board Assurance Framework (BAF) will also be developed following the agreement of 2019/20 Trust objectives. The report provided to the April Trust Board will be the Q4 18/19 and will also include an outline of the strategic objectives and risks for 2019/20 for discussion and approval

It was RESOLVED to:

- **following agreement with regard to the financial plan for 2019/20, DELEGATE AUTHORITY to the Trust Chair, Chief Executive, and Chair of Audit to agree the final plan submission for the 4 April 2019;**
- **REQUEST a paper on potential updates to the integrated performance report for 2019/20 to Trust Board in April 2019; and**
- **depending on timescales for agreement and impact of year-end reporting on capacity, REQUEST an updated Board Assurance Framework to Trust Board in April 2019.**

TB/19/24d Brexit contingency plan (agenda item 9.4)

AGD provided a summary of the current position, highlighting that the Trust continues to follow national guidance. The Trust plan has been subject to external scrutiny which confirmed our alignment with the national requirements.

CD asked if the work required had incurred additional cost to the Trust with any possibility of reimbursement. AGD stated that we have been asked to maintain a record of costs incurred but no indication of reimbursement at this stage.

It was RESOLVED to NOTE and COMMENT on the content of the report.

TB/19/25 Receipt of public minutes of partnership boards (agenda item 11)

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

- Barnsley Health and Wellbeing Board 5 February 2019
- Calderdale Health and Wellbeing Board 21 February 2019
- Kirklees Health and Wellbeing Board 31 January 2019

- South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board 8 March 2019
- West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group 28 February 2019
- West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive 8 January 2019 and 5 February 2019

It was RESOLVED to RECEIVE the updates provided.

TB/19/26 Assurance and receipt of minutes from Trust Board Committees (agenda item 12)

Clinical Governance & Clinical Safety Committee 12 February 2019
CD highlighted the following:

- CQC action plan.
- Waiting lists.
- Patient experience internal audit.
- Forensic CAMHS.
- MAV.

Equality & Inclusion Forum 5 March 2019
AM highlighted the following:

- Recommendation to change the Forum to a Committee.
- Update on the dashboard development.
- Further work required regarding completion of EIAs.
- Update on EDS2 panels – all panels will have taken place by the time the Board meets on 26 March.
- Update on the staff network progres

Mental Health Act Committee 12 March 2019
KW highlighted the following:

- Monitoring & Management Information
  - Considered MHA in IPR & including items on organisational risk register.
  - Report of BDU performance to provide improved narrative and context.
  - New one page tracker for CQC recommendations.
- Committee Annual Report 2018 /2019 and & self-assessment (review of effectiveness). Terms of Reference and Annual Work Programme 2019/20.
- The Trust is fully prepared for upcoming legislation.
- Current performance (compliance with Act): Ongoing challenges re documentation (Section 17 leave). Action taken: new MHA Office process - return forms to ward if not completed. SystmOne should also resolve this.
- Partnership working:
  - Positive feedback from CHFT - strong, effective partnership working with SWYPFT services.
  - Variable attendance from Local Authorities. Action: new template for views/ experiences of partners to be fed into Committee.
- Staff Training: MCA/DOLs 92.71%; MHA 86.70%. Increase in both figures.
- Positive feedback from Chair Hospital Managers' Forum - excellent care at Poplars.

Workforce and Remuneration Committee 12 February 2019
RC highlighted the following:

- Organisational Development: Committee reviewed links between the OD Plan and oversight by Sub-Committees and Executive Groups. The Committee noted that the OD Strategy are due for renewal in 2019/20 and suggested this might be a focus of a strategic board session.
- Workforce Strategy Update: The Committee received an update on the Trust's approach to coaching and mentoring including the potential development of reciprocal mentoring.
- 2017/18 Pay Audits based on Gender, Ethnicity and Disability and Action Plan.
- Preventing Bullying and Harassment: Call to Action: The Committee received proposals for an engagement process to develop and organisational wide approach to prevent bullying and harassment in the workplace.
- HR Exception Report: The Committee received a focus report on sickness / absence including a deep dive into Forensic Services. The Committee also received an update on the recruitment and retention action plan.
- Annual review of Annual Report 2018/19 including self-assessment, Terms of Reference and Annual Work Programme 2019/20.

West Yorkshire Mental Health Collaborative Committees in Common 4 March 2019
AM highlighted the following:

- Relationships and communication – organisational check in (local issues, key risks, successes)
- Business and strategy
  - ICU update
  - Programme update delivery report
- Programme governance and infrastructure

TB/19/27 Use of Trust Seal

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

TB/19/28 Trust Board work programme 2018/19 and 2019/30

It was RESOLVED to NOTE the work programme for 2018/19 and CONFIRM the work programme for 2019/20.

TB/19/29 Date of next meeting (agenda item 14)

The next Trust Board meeting held in public will be held on Tuesday 30 April 2019, Room 49/50, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT.

TB/19/30 Questions from the public (agenda item 15)

TB/19/30a - Is possible to be more flexible with the transition age from CAMHS to Adult services.
CH commented that the new models of care approach does allow for this flexibility and includes CAMHS support from 18-24yrs.

TB/19/30b - Does the trust utilises both flat and fitted sheets.
CH confirmed that both are used across the Trust.

TB/19/30c - Is there a gap in Trust governor representation at ICS level.
RW explained the current arrangements and acknowledged that the linkage could improve.

<u>TB/19/30d</u> - Concern about the impact of the support messages and memorial tributes upon people in severe distress that are prominent on North Bridge. Is this being considered.
TB advised that this matter is subject to attention through our West Yorkshire suicide prevention work and acknowledged the need for sensitivity when approaching this matter. TB noted that our approach to suicide prevention is the subject of a Members' Council agenda item at the autumn session.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 26 MARCH 2019 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 26 March 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/21a Integrated performance report M11 2018/19	RW asked why the Friends & Family test results for December were not in the report. This will be followed up.	TB		
TB/19/22a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	RW stated the most notable issue as being the interim governance changes that are being put in place. AGD believes they are a sensible set of interim arrangements. RW suggested the Trust write formally to the SYBICS to support the interim governance arrangements and reinforce our commitment to being engaged in future arrangements, as well as the ongoing work of the mental health programme and the Barnsley work taking place.	AGD/AM		
TB/19/24a Eliminating mixed sex accommodation (EMSA) declaration	LC noted on page 6 the number in the 'other' column for Wakefield seemed high. TB believed this related to inter-ward movements, and would confirm if this is the case.	TB		

Outstanding actions from 29 January 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/06a Board Assurance Framework (BAF)	SYo commented, in relation to strategic risk 2.2, that it includes reference to the work taking place nationally on the NHS workforce as well as that taking place by the Trust, such as the quality improvement training addressing areas that lack capacity. CD commented that as well as the quality improvement reference, the work that the Trust is	AGD	April 2019	Updated BAF included on agenda for April 2019.

Min reference	Action	Lead	Timescale	Progress
	doing to be outstanding needs to be reflected.			
TB/19/06a Board Assurance Framework (BAF)	RC commented, in relation to strategic risk 3.1, that the work taking place on the NHS Long Term Plan, financial sustainability plan, and strategic plans needs to be captured. AGD commented that one of the limiting factors around the NHS Long Term Plan was workforce. It was important that the right number of people with the right skills and expertise were in place to deliver the ambitions.	MB	July 2019	A separate workforce objective is being considered. Once agreed the BAF will be updated to reflect this risk for 2019/20 which will be reported to the July meeting.
TB/19/06a Board Assurance Framework (BAF)	RC commented that it was helpful to show the RAG ratings over the year to track progress and suggested a comparison be made over a longer period of time to see what had changed.	MB	July 2019	To be considered for 2019/20 BAF which will be reported to the July meeting.
TB/19/06a Board Assurance Framework (BAF)	SYo commented, in relation to strategic risk 3.4 that, while it was RAG rated green overall, there were areas of concern under the surface. MB commented that that the RAG rating of that strategic risk was one of the ones most debated at EMT meetings. AM asked if the cover page of the report could reflect the discussion of EMT in future.	MB	April 2019	Updated BAF included on agenda for April 2019.
TB/19/06a Board Assurance Framework (BAF)	MB commented that it was important there was appropriate ownership of each strategic risk to ensure they are updated appropriately to provide assurance to Trust Board. RW commented that any gaps in assurance could be discussed as part of agenda setting. An area for specific consideration as part of the BAF in 2019/20 may be in relation to workforce.	AM/RW	July 2019	A separate workforce objective is being considered. Once agreed the BAF will be updated to reflect this risk for 2019/20 which will be reported to the July meeting.
TB/19/10 Governance items 10.3 Update to the Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)	SYo suggested that a reference be included in relation to the consideration of digitally-enabled care in the development and review of policies.	MB/EJ	July 2019	This will be considered in conjunction with the Director of Nursing & Quality to ensure it is introduced in an effective and meaningful way.

Min reference	Action	Lead	Timescale	Progress
TB/19/15b - *Will it be possible to celebrate Trust anniversary similar to 70 years NHS anniversary?*	Board Angela Monaghan (AM) commented that she was not aware of what has been considered to date. Alan Davis (AGD) commented that in 2002 the Trust became the South West Yorkshire NHS Mental Health Trust, in 2009 the South West Yorkshire Partnership NHS Foundation Trust, and in 2011 merged with Barnsley. Emma Jones (EJ) suggested that the 10 year anniversary of becoming a foundation trust could be incorporated into the Annual Members' Meeting (AMM) in September 2019. This was supported by the Trust.	AM	September 2019	This will be considered in the planning for the 2019 AMM.
TB/19/15d - *Initiative about future New Optimal Health Care Model for the Trust with the specific focus on Prevention:* • *Promoting Mandatory Health Science Literacy for the general public (information and education)* • *Increase role of patient in self-care and lifelong self-education.*	Tim Breedon (TB) took the question on notice for response.	TB	April 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	SY	April 2019	Update included on agenda for April 2019.

Min reference	Action	Lead	Timescale	Progress
	what would be done as a result of the analysis and any actions identified. ➢ Inclusion of the last review date within the report. ➢ 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.			

Outstanding actions from 25 September 2018

Min reference	Action	Lead	Timescale	Progress
TB/18/78 Chair and Chief Executive's remarks (Chief Executive's report)	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. *29 January 2019 update:* AGD commented that the policy would be updated and conversation was taking place with the local Police with an aim to agree by end of the financial year.	AGD	April 2019	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 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:	The Brief, provided monthly to all staff and cascaded through the Extended Executive Management Team (EEMT), delivers a summary of the Trust's context, performance and finances. This is attached. Since the publication of The Brief, we have seen the political landscape dominated by the Brexit and very little from the national bodies as we enter the new financial year. Issue to note: ➢ The CEO designate of NHSX – the new national body created to coordinate work across agencies on technology – has been appointed. Matthew Gould, the Director General for Digital and Media at the Department for Culture Media and Sport will have strategic responsibility for setting the national direction on technology across health and care organisations. The CEO will be accountable to the Health Secretary and chief executives of NHS England and NHS Improvement. ➢ NHS Providers have published the latest in their series of *Provider Voices.* This is entitled "Community Services, Our Time" and includes a range of pieces from leaders about how we ensure investment and reform in community services continues. It is the latest in a line of think pieces that is part of NHS Providers' thought leadership approach. Alongside their excellent briefings, used frequently by Board, and network meetings, such material is a benefit from our membership of NHS Providers. ➢ The Integrated Care Systems within which we operate have been active in the end of year position, planning, assurance and transformation agendas for each of the places in which we work. Our involvement in them continues to develop, with differences between the two systems and our roles understood. The development of a shared control total in West Yorkshire & Harrogate is a visible demonstration of this. Our strategy Board session in May will be a good place to take stock. ➢ The new South Yorkshire liaison and diversion service has gone live, with the Trust delivering care to all communities. The launch

	event was a positive session which brought staff and stakeholders together to discuss next steps. ➢ The annual priorities for the organisation are being cascaded throughout the Trust and include the move to a "quadruple aim" of improving health, improving care, improving resources and making the Trust a great place to work. This reflects the need to emphasise our continuing focus on our workforce. ➢ Our communications team continue to deliver good, effective campaigns that have impact. Much of this is down to the professional expertise of the team and leadership of the Head of Communications, Jude Tipper. I would like to wish Jude well and thank her for her time at the Trust as she moves to a secondment in a national role at NHS Digital. The workload during this period has been substantial for corporate and operational services. The Care Quality Commission inspections and well-led reviews are imminent; the need to deliver annual governance statements, arrangements, reports and accounts is upon us; the need to engage in planning and transformation in all places continues; and the need to deliver safe, high quality care everywhere within a tough financial envelope is a daily reality. The role of the Board at this time in the prioritisation of work and the focus of our governance is essential.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

28 March 2019

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

With **all of us** in mind.

Our mission and values

We exist to help people reach their potential and live well in their community

To achieve our mission we have a strong set of values:

- We put people first and in the centre and know that families and carers matter
- We're respectful, honest, open and transparent
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow

Our Wakefield College apprenticeship nominees and winners

With **all of us** in mind.

Safety and quality

In February we had:

- 1032 incidents - 903 rated green (no/low harm)
- 121 rated yellow or amber
- 8 rated as red
- 4 serious incidents – 3 of which were apparent suicides and one where cause of death is unknown/awaiting confirmation.

Fire risk assessments and environment audits are available to view on the K drive, via the intranet.

We held our second annual safeguarding conference on 25 March with over 80 attendees.

Are you professionally curious? Do you know how to spot the signs?

The Trust now has a Child Sexual Exploitation (CSE) framework, developed by our safeguarding team. Bespoke training and events have been developed.

Only 72.8% of staff are reporting that they are receiving supervision within policy guidance. Make sure you record your supervision. This needs to be a priority for improvement.

With **all of us** in mind.

NHS
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NHS Foundation Trust

Safety and quality:
Care Quality Commission (CQC)

Don't count the days until our CQC visit... make the days count

We have completed our PIR self assessment and rate ourselves as good. We need to prove it when the CQC visit.

Our CQC action plan shows what action we are taking in response to the findings of our last inspection. Know the plan and how you can help us to make improvements.

Next steps: At least one of our core services will be visited, possibly as early as late April 2019; and we'll have our annual well-led review within the next 6 months.

Service user, carer and staff focus groups were held throughout March across all our BDU areas. Keep an eye out for new information and sessions to help support you.

Thank you to everyone for your hard work so far.

We have a lot to be proud of and have made significant improvements.

Some important areas remain which we must address within agreed timescales.

With **all of us** in mind.

NHS
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NHS Foundation Trust

Safety and quality:
Focus on pharmacy and medicine optimisation

MEDICINE OPTIMISATION

Is a person centred approach to getting the most from medicines for both patients and the NHS, ensuring the safe and effective use of medicines to deliver the best outcomes. It covers the way medicines are chosen, bought, transported and stored through to how they are prescribed, ordered, dispensed, taken and destroyed.

OUR MEDICINE OPTIMISATION STRATEGY FOCUSES ON

Person first and in the centre
- Medicine choice and information for all
- Treatment tailored to individuals
- Supporting improved physical health through medicine use
- Reducing inappropriate prescribing and medicine side effects

Putting safety first always
- Developing smart storage solutions
- An effective medicines safety programme
- Promoting medicines education and training

Getting ready for tomorrow
- Managing formularies effectively
- Budgetary management
- Assurance and audit
- Reviewing our procurement approach
- Promote digital first

Supporting our staff and working in partnership
- Ensuring direct patient facing time
- Pharmacy staff professional development
- Extend roles and develop our service offer

WHAT THE TEAM DO

EQUATES TO

1 clinical pharmacist

FOR EVERY

17 doctors 200 nurses

Approximately **600 ward visits** and have **620 patient interventions** every month

The team includes **registered pharmacy technicians** and **pharmacy assistants**

Dispense **8,500** items every month

Each year we supply **£1.13m** antipsychotic injections

Find out more on the intranet

With **all of us** in mind.

Our performance in February

- **99.1%** follow ups within 7 days of discharge
- **96.6%** inpatients with a Cardiometabolic Assessment (CMA)
- **98%** of people recommend our community services
- **84%** recommend our mental health services
- **83%** of people dying in a place of their choosing
- **27%** of people in CAMHS receiving treatment within 18 weeks of referral
- **80.6%** of prone restraint lasted less than 3 minutes
- **96%** of staff have completed their information governance training

Thank you for working to improve our medicines omissions performance.

It is now at 13.9% having last month been 23.5%.

There were 13 confidentiality breaches. Please remember to always double check details and stay focussed. How would you want your personal information looked after?

With **all of us** in mind.

Staffing

NHS
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NHS Foundation Trust

Sickness absence was 5.2% in February – now 5.1% year to date. There's wellbeing support for #allofus

We're going to appoint a part-time freedom to speak up guardian lead. Watch out for more info.

We are currently hitting all our targets for mandatory training, thank you.

A Moving Forward leadership programme will be shared soon, specifically designed for BAME staff.

Work continues to prepare for all Brexit eventualities. Ask your manager if you need support.

Learning needs analysis is being collated. Thank you. Please ensure study leave is booked in line with policy.

Join our LGBT+ staff and allies get together. Friday April 5, 11.30-1pm, Fieldhead.

A new annual leave year begins for most staff on 1 April. Please plan your leave carefully. Leave can only be carried over in exceptional circumstances.

With **all of us** in mind.

#allofus – our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Values led appraisal

Your appraisal is a time to reflect on the past year. It's an opportunity for a supportive two-way conversation about:

- How you've performed
- Your personal development and training needs
- Your health and wellbeing
- Your job related objectives for the coming year

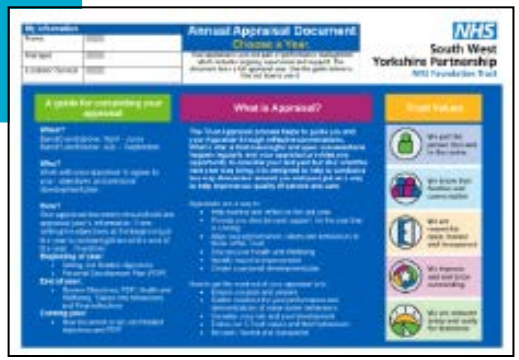
To get ready, you can attend appraisal training – choose your preferred date on the intranet and email the learning and development team with a completed study leave form.

Making our Trust a great place to work

Following the recent NHS Staff Survey, we want to make our Trust a great place to work.

We'll be holding events which everyone can contribute to, and we'll be visiting teams to get your views.

More information coming soon.



#allofus
our wellbeing at work

With **all of us** in mind.

Members' council elections

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Join our members' council!

The Trust belongs to staff and is accountable via the members' council.

Elected uncontested
Congratulations to Paul Batty who is the newly elected staff governor representing social care staff working in integrated teams. Three public governors were also elected uncontested - Keith Stuart-Clarke (Barnsley), Adam Jhugroo (Calderdale), Phil Shire (Calderdale).

Vote for your staff representative – Nursing support
Voting is now open for staff within this constituency.

Encourage someone you know to vote for the public seats
Encourage public members to vote for their representatives in Kirklees and Wakefield.

Details have been sent to those eligible to vote on 25 March 2019 by the Electoral Reform Services (ERS).

The role of the members' council is to make sure our board of directors are accountable to our local communities.

Voting closes
18 April

With **all of us** in mind.

Our finances explained

NHS
South West Yorkshire Partnership
NHS Foundation Trust

For the last financial year (April 2018 – March 2019), we're forecasting to spend £2million more than we've been given. This is in line with our approved plan, so we'll receive £2.7million of national funding for future investment in our estate and technology.

April is the beginning of the new financial year and the financial challenges we're facing are tougher than ever before.

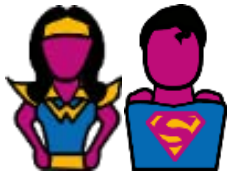
February update

We spent £244,000 more than we received.

This extra cost means we need to save money elsewhere.

We spent over £191,000 on beds outside our area because we didn't have enough for our service users.

What can you do?



Ask yourself:

Am I spending our money the best way I can?

How can I improve?

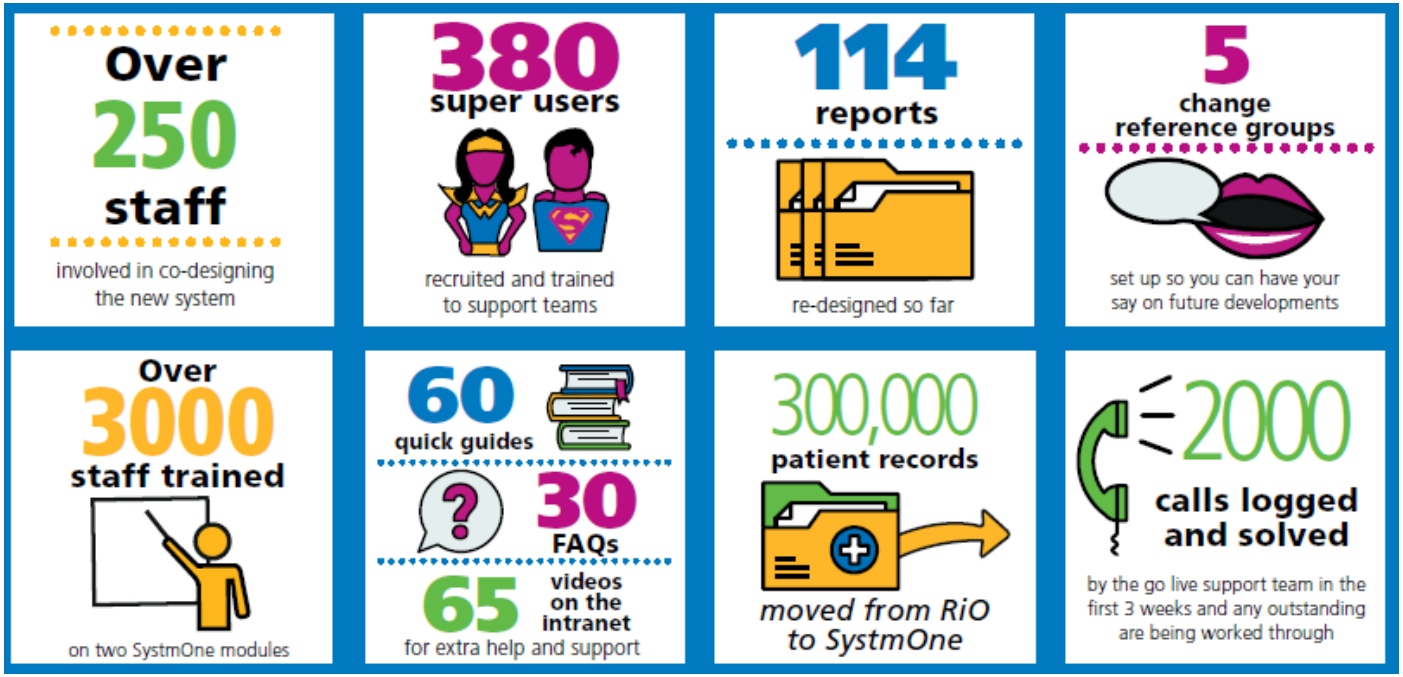
What can my service do differently to reduce inefficiency and waste?

What's happening internally

SystmOne for mental health

South West Yorkshire Partnership NHS Foundation Trust

Thank you to everyone for your hard work on go-live.
How we implement and use SystmOne is just as important as our go-live. We now need to build on our progress and resolve any issues as they come up.
The journey so far…



Improvements made from your go live feedback…

- Medical care plans and the e-discharge process have been refined
- Tailored changes have been made to suit individual teams e.g. IHBT teams now have bespoke progress notes

Coming soon…

- Top tips
- Data catch up
- Optimisation plan

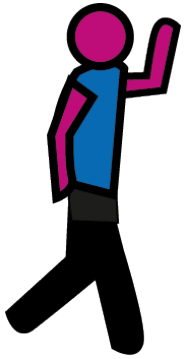
With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

What's happening internally

SystmOne for mental health – support is available

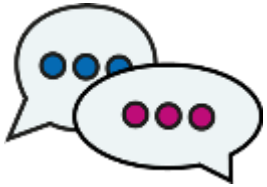
Latest updates, resources and support on our intranet



Floor walkers

Ask your super user

Online training videos to refresh your knowledge



FAQs available

Contact service desk if you need help

Online quick guides

With **all of us** in mind.

Search 'SystmOne for mental health' on the intranet

Service change

New management arrangements for inpatient areas
Sandra Keen has been appointed as the Trustwide general manager for adult acute inpatient services.

Her role will bring together the leadership of adult acute inpatient services across the Trust to improve service quality, promote improved joint working and encourage shared learning.

Work is continuing on our **out of area** project with detailed plans and resources being developed.

This is being aligned with the findings of the community mental health transformation review.

Katie Yockney is our new **advanced specialist practitioner** supporting palliative care patients in Barnsley care homes.

EyUp! now has a new fundraising manager. If you have an idea on how to raise money for our charity or would like to get more involved contact Jana Harris.

With **all of us** in mind.

#allofusimprove
and be outstanding

NHS
South West Yorkshire Partnership
NHS Foundation Trust

What do you think of the i-hub?
Tell us what you think by taking part in our short online and paper survey.

Our 2018-9 flu campaign won a national flu fighter award for most innovative communications campaign.

Police commendation in Barnsley
Our liaison and diversionary service team leader has received an award for outstanding contribution.

Apprentice awards
Wakefield College has named us as apprentice employer of the year, with 2 of our staff singled out for recognition.

It currently takes an average of 134 days to recruit a member of staff.
Help us to make our recruitment processes more streamlined and efficient.
All our vacancies are shared on social media - @NHSYorksJobs – give us a follow…

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Don't count the days until our CQC visit… make the days count. Be proud of what we have done so far, and don't lose sight of what we still need to do

Thanks for making the SystmOne for mental health go live a success so far. There's support available

We must keep our focus on quality and safety, regardless of what's going on around us

Help us reduce waste and manage our finances with our #allofusimprove resources

Get involved in our BAME and LGBT+ staff networks.

Be careful with people's information – confidentiality breaches can be avoided

Pledge your support for our 'look out for our neighbours' campaign

With **all of us** in mind.

28 March 2019

South West Yorkshire Partnership NHS Foundation Trust

The Brief

Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

Why not take a couple of minutes in your team to talk about a positive example of where an individual or team has demonstrated the values of our Trust?

Have you got a news story or an example of how you're living our values? Shout about it with the help of Comms..

Safety and quality

We put safety first, always.

Reporting of incidents remains within expected range – please keep reporting on Datix
In February we had:

- 1032 incidents - 903 rated green (no/low harm)
- 121 rated yellow or amber
- 8 rated as red
- 4 serious incidents – 3 of which were apparent suicides and one where cause of death is unknown/awaiting confirmation.

Thank you for your hard working in always ensuring quality and safety come first.

Only **72.8%** of staff are reporting that they are receiving supervision within policy guidance. Make sure you record your supervision. This needs to be a priority for improvement.

Fire risk assessments and the environment audits
These are available to view on the K drive. Find out more about our regulatory obligations to the CQC on the intranet where it explains how this helps to make sure our premises are clean, suitable for purpose, maintained and appropriately located. It also ensures that equipment that we use for care and treatment is clean, suitable for purpose, maintained, stored securely and used properly.

Strategic Child Sexual Exploitation (CSE) framework
Within our local authorities areas there has been recent media coverage of a number of reviews and criminal proceedings into child grooming and Child Sexual Exploitation

(CSE). Following this the safeguarding team have developed a CSE strategy, which aims to:

- To provide a framework for our strategic response to identify and reduce rates of child sexual exploitation.
- To ensure we contributes to effective multi-agency and partnership working to protect children and young people from this form of abuse at a national, regional and local level
- To ensure we are able to respond with appropriate interventions to the victims of this crime within the range of commissioned services.
- To ensure the framework aligns with the National Action Plan to tackle child sexual exploitation.

Training and events have been developed to target the services where a young person who has been harmed in this way may access. The message to practitioners includes questions such as, 'Are you professionally curious?' 'Are you confident you can spot the signs of CSE and act accordingly?' Support is available from our safeguarding team.

'Thriving beyond surviving' – safeguarding conference
On 25 March we held our second annual safeguarding conference, focused on child sexual exploitation, domestic abuse, looking after vulnerable children and the Truth project. For more information on the conference contact the safeguarding team. Support on safeguarding for adults and children can be found on the intranet.

Focus on: Care Quality Commission (CQC)

Don't count the days until our CQC visit……make the days count

We were last visited by the CQC in March 2018. As a learning organisation, we value our relationship with the CQC and we have kept doing the things they found to be 'Good' and 'Outstanding' whilst improving in areas that needed focus.

To help us do this we have a detailed CQC action plan. View a summary of action we are taking in response to the findings of our last inspection on the intranet.

We have conducted our self-assessment as part of the Provider Information Return. This assessment shows that we believe we are a good organisation – we need to prove it when the CQC visit.

We have a lot to be proud of in our Trust, alongside many areas where we have made significant improvements. Some important areas for improvement remain; we must ensure that they are addressed within the agreed timescales.

Provider Information Return (PIR)
At the start of February we received and responded to our PIR request from the CQC.

Service user, carer and staff focus groups
The CQC will be checking whether our services are safe, caring, effective, responsive and well led. To do this they spoke directly to service users, carers and staff at a number of sessions across Barnsley, Calderdale, Kirklees, Wakefield and in our forensic services.

Thank you to everyone who got involved.

Next steps
The PIR triggers a process that will lead to at least one of our core services being visited and our annual well-led review. Service visits could start as early as late April 2019 and our well-led review will take place within the next 6 months. We'll keep you updated as soon as we find out more.

Following a quick survey, a range of information and sessions for staff will be available shortly to provide support staff told us they would like before, during and after the inspection. Please keep an eye out for dates.

Thank you to all staff for your hard work and responsiveness in gathering data for the PIR, ensuring attendance at focus group and working on actions from the action plan.

Focus on: pharmacy and medicine optimisation

Medicines use can have significant impacts on health, well-being and patient safety.

The pharmacy and medicines optimisation team works collaboratively with all our services and service users to provide a high quality, person centred care.

Our new pharmacy and medicine optimisation strategy for 2018-2024 is now available on the intranet. The strategy sets out the vision and actions which will drive our approach to pharmacy and medicine use, ensuring that the way we prescribe, administer, order, transport and destroy medication is safe and effective.

Our pharmacy team equates to 1 clinical pharmacist for every 17 doctors and for every 200 nurses and includes registered pharmacy technicians and pharmacy assistants. They make 620 patient interventions and dispense 8,500 items a month. They make approximately 600 ward visits every month and supply £1.13m antipsychotic injections.

Medicines optimisation is everyone's business and staff should familiarise themselves with the strategy and how this links to their own workplace. The strategy is available on the intranet along with an infographic summarising the strategies main points. There are also pharmacy stories on the intranet where you can find out more information on what the team do.

For more information contact the pharmacy team.

Performance (February)

- **99.1%** follow ups within 7 days of discharge
- **96.6%** of inpatients with a Cardiometabolic Assessment (CMA)
- **98%** of people recommend our community services
- **84%** recommend our mental health services
- **83%** of people dying in a place of their choosing
- **27%** of people in CAMHS receiving treatment within 18 weeks of referral
- **80.6%** of prone restraint lasted less than 3 minutes
- **13.9%** medicines omissions

- **96%** of staff have completed their information governance training

Thank you to our clinical staff and pharmacy colleagues for working to improve our medicines omissions performance which is now at 13.9% having last month been at 23.5%.

There were 13 confidentiality breaches during February involving information disclosed in error, lost or stolen paperwork and patient healthcare record issues. These are frequently down to human error. Please remember to always double check address details and stay focussed on the task in hand when working with people's personal data and information. Think about how you would want your information looked after.

Staffing

- Sickness absence was **5.2%** in February. It's now standing at **5.1%** so far this year to date, above our target of **4.5%,** though this is slightly lower than this time last year**.** Remember there is wellbeing support available to #allofus.
- We are currently hitting all our targets for mandatory training, thank you to all staff. Please keep up with training when reminded to do so, rather than waiting for it to expire. We should always be meeting our training targets.
- Our Black Asian Minority Ethnic (BAME) network is sharing details of the Moving Forward programme, a leadership programme specifically targeted at BAME staff.
- We're appointing a part time freedom to speak up guardian lead on an internal secondment. Look out for the job ad via The Headlines or visit NHS Jobs.
- Although the dates may be changing we continue to make preparations so we are ready for all Brexit eventualities. We are ensuring that those who are likely to be affected are supported. You can find information on the EU settlement scheme and about professional registration on the intranet, along with other helpful advice and contacts. Please also ensure that service users can access support and information, including this question and answer resource about medicines, and the NHS.uk website which is kept up to date with patient facing information.
- On Friday 5 April, 11.30am-1pm, at Fieldhead learning and wellbeing centre, there's an LGBT+ get together for staff and allies. Contact Kate McNulty or Paul Brown with any queries.

Annual leave

Our new leave year begins on 1 April for most people. Please book your leave in in good time with your line manager following any local procedures.

Leave cannot be carried into the next leave year so please make sure you use it within year. You will only be able to carry unused leave in exceptional circumstances, as detailed in our annual leave policy.

If your leave year doesn't run from April to April please use this opportunity to plan your leave within your leave year. Carrying leave from one year to the next, regardless of the start date of your year, is for exceptional circumstances only. Please discuss this with your line manager / clinical lead if you have any queries.

We also offer staff the opportunity to buy up to two weeks additional annual leave, eligibility criteria applies. Find out more on the intranet.

Learning needs analysis

Learning needs analysis (LNA) has been/is being collated across all BDUs and corporate services. This informs where and how the Trust needs to deliver training, education, apprenticeships, and how to apply study leave. Thanks to everyone for your input. The delivery plan will be presented to executive management team and budget will be prioritised and allocated accordingly.

Study leave

All study leave applications for training or conferences must follow the Trust's study leave procedures by submitting applications with at least 20 days' notice for non-medical staff and 6 weeks' notice for doctors, and have study leave forms approved prior to training or conference places being booked. Where study leave applications require exceptional approval with less than the required notice, individuals must first contact Learning and Development or the Medical Education department before the booking is made.

The Trust continues to make significant investment in staff training and development, and adherence to the Trusts' study leave and procurement procedures ensures that this provides best value for money and consistency as well as equity for all staff.

#allofus – our wellbeing at work

Values led appraisal

As we enter a new financial year, it's also an important time to reflect on what went well, what could have gone better and how we've lived our values and behaviours over the past year. Your values led appraisal is an opportunity for a supportive two way conversation about: how you've performed, your personal development and training needs, your health and wellbeing, and your job related objectives for the coming year.

We listened to your feedback and have made improvements to the appraisal, including:

- Formatting changes on the appraisal form have made it easier to read what you've written and to print out
- Performance objectives have changed to job related objectives to make the connection to the work we do clearer
- Drop down menus have been introduced instead of signatures for ease of use
- Ratings have been removed to improve the quality of appraisal conversations
- The health and wellbeing review has been simplified so it's easier to complete
- New supporting documents have been created to help guide appraisal conversations

The changes to the form are designed to improve the quality of the appraisal by ensuring a focus on helping you to improve how you do your job, having clear objectives and feeling valued.

To get ready, you can attend appraisal training - choose your preferred date and email the

learning and development team with a completed study leave form to book your place.

If you're band 6 and above, please organise your appraisal with your manager by the end of June. If you're band 5 or below, please do this from July to September.

Making our Trust a great place to work
The NHS staff survey is an important way for you to share your views on what it feels like working for the Trust. We're only required to survey a select number of people, but we choose to ask all of you your views so that everyone has a chance to have their say. Following the results of the staff survey we want to make sure that our Trust is a great place to work. We want to make improvements around four key themes:

- Staff engagement
- Workplace health and wellbeing
- Bullying and harassment
- Quality of appraisals

We will be meeting with groups of staff to find out what staff think we do well in these areas, where they think we can improve and, most importantly, what more we need to do to be a great employer that delivers great services.

You can also email your thoughts to the great place to work email address. HR will also be holding events and visiting teams where you will be able to contribute your thoughts. Any response will be treated confidentially. More information about these are coming soon.

Members' council elections

The Trust belongs to staff and is accountable through the members' council. The role of the members' council is to make sure our board of directors are accountable to local communities.

Members' council elections are currently taking place. Congratulations to Paul Batty, who is the newly elected staff governor representing social care staff in integrated teams. Three public governors have also been elected uncontested, Keith Stuart-Clarke representing Barnsley, and Adam Jhugroo and Phil Shire for Calderdale.

Voting is now open for a staff representative from the nursing directorate; and for the public seat representatives in Kirklees and Wakefield. Voting is open until 18 April, please encourage people to vote.

Our finances explained

What's the current financial position?
We continue to forecast delivery of the Trust financial plan for 2018/19. This is a deficit of £2 million which means we will have spent more money than we received. This has been challenging but is achievable thanks to additional one off income we have received from commissioners and through the revaluation of Trust assets.

Overall achieving this will enable the Trust to access £2.7m of national funding which can be used to support future investment in our estate and technology.

South West Yorkshire Partnership NHS Foundation Trust

How did we do in February (Month 11)?
February 2019 followed the trend of previous months with costs £244k more than income. This continues to present a significant challenge which we all need to address; this position is not sustainable. As part of the annual planning process we are working with commissioners to secure additional income for the services we provide but we also need to reduce costs compared to what we are currently spending.

What were are key financial pressures?
We spent over £191k on beds outside our area because we didn't have enough for our service users - this equals 194 bed days. This is less than previous months but remains more than planned. Whilst commissioners have provided some additional funding to offset this during 2018/19 action plans continue to be implemented to move towards the Trust target of nil out of area usage.

The use of agency staff also remains a key pressure with £545k spent in February, bringing our year to date total to £5.8m. Overall, including bank and agency, we have spent £14.2m on staff who are on temporary or fixed term contracts (non-substantive staff).

What can you do?
To support our current position and the development of our next financial plan we must keep the focus on making sure we work as efficiently as possible. Keep asking, how can I improve? What can my service do differently to reduce inefficiency and waste? Are there areas where we can reduce our spend?

The Trust's financial position is directly linked to the decisions and actions we all make every day. All of us have a role to play in how we spend our money, get involved with #allofusimprove.

Infrastructure: SystmOne for mental health

Thank you to everyone for your hard work on go-live. How we implement and use SystmOne is just as important as our go-live. We now need to build on our progress and resolve any issues as they come up.

So much has been achieved on the journey so far, you can find out more in this infographic on the intranet.

Improvements made from your go live feedback…
- Medical care plans have been refined so they're easier to use and more fit for purpose
- The e-discharge process has been refined to improve communication with GPs
- Tailored changes to suit individual teams e.g. IHBT teams now have their own bespoke progress notes

What's next…
- Top tips coming soon – share yours on i-hub or with the team
- Catch up activities are now in progress – speak to your manager to get involved
- An optimisation plan is in development for future improvements

South West Yorkshire Partnership NHS Foundation Trust

Infrastructure: SystmOne for mental health support available

As we implement and use SystmOne there is still staff support available.

The 'SystmOne for mental health' intranet section is being used to post the latest news and developments. This includes status updates, information on any emerging issues and what is being done to resolve them. Training videos where you can refresh your knowledge, FAQs and quick guides are also available on the intranet.

Floor walkers are continuing for a limited period in light of the current issue with system performance.

If you can't find the answer to your question or want to raise an issue then speak to your local superuser or contact the IT service desk.

Remember, staff support is still available.

Service change

Mental health inpatient management changes
The Trust is currently developing a new operational management structure to ensure that services are well led, have strong clinical leadership with appropriate general management support. As part of this, Sandra Keen has been appointed as the Trustwide general manager for adult acute inpatient services.

Her role will bring together the leadership of adult acute inpatient services across the Trust in order for us to provide high quality care. Sandra will work across the Trust's inpatient services to unite them as one service, driving up quality and providing a more efficient way of working.

Sandra's role will reduce unnecessary clinical variation across the inpatient pathway, improve quality in service delivery, and promote improved joint working and shared learning. She will be working closely with colleagues in each BDU to ensure services are connected and responsive.

Out of area
Following our work with external consultants, work has now commenced on more detailed planning and resourcing of the identified work streams. These are being aligned with findings from the community mental health transformation review and change activity will be taken forward through spring of this year.

New specialist post to support care home residents
Katie Yockney has been appointed to a new advanced specialist practitioner post, funded by our Trust and Macmillan Cancer Support to support palliative care patients within care homes in Barnsley. Read more.

New fundraising manager for our EyUp! charity
Jana Harris has been appointed as our new fundraising manager for EyUp! – our charity that raises funds to improve the experiences of our service users and carers.

If you have an idea on how to raise funds for our wards and community teams, or just want

to get more involved in the work of the charity then contact Jana for more information.

#allofusimprove

What do you think about i-hub?
Do you love sharing your ideas or have you never heard of it? Do you check it every day or don't know how to access it? We want to know - tell us in our short survey. Paper copies are available from Kate Ledger for staff who don't routinely access a computer.

Flu Fighter award win
Our communications team have won a national Flu Fighter award for most innovative communications campaign. The award was for the posters which featured staff tending to vulnerable service users, replacing the message of 'comfort giver' with 'flu giver' to drive the message home. Congratulations to everyone who helped us to achieve a jab rate of 76.2%.

Superintendent's Commendation for liaison and diversion lead
The team leader of the liaison and diversion service in Barnsley has been presented with a Superintendent's Commendation by South Yorkshire Police for her outstanding contribution to the development of liaison and diversion services in the borough.

Congratulations to Emma Robinson who was nominated by South Yorkshire Police's Superintendent mental health lead Dan Thorpe after he worked with her at a national liaison and diversion conference in Leeds.

Trust named wins at the apprentice of the year awards
Wakefield College has named our Trust as apprentice employer of the year in their apprenticeship awards 2019. The awards took place on Monday 4 March and were presented in the company of the Mayor and Mayoress of Wakefield. We were nominated for our apprentice levy programme and the apprenticeship diplomas we fund and deliver through the college.

As well as our Trust nomination two of our employees were also nominated in the higher apprentice of the year category. Jan Spence, manager of Yorkshire Smokefree in Calderdale and Judith Megson, team manager in our Kirklees older people's services, were named as finalists in the annual awards, with Judith being chosen as a winner.

Recruitment process
We have been looking at how long it takes to recruit a member of staff, from the point a manager informs recruitment that they have a vacancy (the VRF form) to the day a candidate starts.

Currently it takes an average of 134 days. We are aiming to get this down to a maximum of 100 days – which is national best practice. We are putting a range of actions in place to make improvements – from shortlisting to DBS checks, internal processes, keeping touch with candidates and methods of advertising.

If you'd like to know more or have any suggestions for improvements, please contact Andrew Prince. And don't forget to follow 'NHS Yorkshire Jobs' on Facebook and @NHSYorksJobs on Twitter.

28 March 2019

South West Yorkshire Partnership NHS Foundation Trust

Pledge your support to the 'Looking out for our neighbours' campaign
This new campaign led by West Yorkshire and Harrogate Care Partnership, launched in March and aims to help prevent loneliness in our communities by encouraging people to look out for one another. Choose how to support the campaign - from displaying posters or handing out packs, to promoting the campaign on social media or directing people to the website. Find our more details about the campaign or pledge your support on the intranet.

Take home messages

1. *We'll be visited by the CQC. Don't count the days until our CQC visit… make the days count.*
2. *Thanks for making the SystmOne for mental health go live a success so far. There's support available.*
3. *We must always keep a focus on quality and safety, regardless of what is going on around us.*
4. *Be careful with people's information, double check and stay focussed on the task. Confidentiality breaches can be avoided.*
5. *Show your support for our BAME and LGBT+ colleagues by getting involved in our staff networks.*
6. *Get involved with #allofusimprove and help us reduce waste, manage our finances and improve clinical quality.*
7. *Please help a community group or organisation pledge support for our look out for our neighbours campaign.*

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 6.1

Title:	**Strategic overview of business and associated risks**
Paper prepared by:	Director of strategy
Purpose:	The purpose of this report is to: ➢ Support the Trust Board in reviewing the external environment in which the Trust operates. ➢ Evaluate the Trust's preparedness, responsiveness and strategic positioning in response to the internal/external environment. Provide assurance of the alignment between the Trust's strategy, BAF, priority programmes and risk management processes.
Mission/values:	The process of analysing the external environment and the Trust's own readiness and capability to respond to those external factors is a key aspect of strategy development, implementation and monitoring process for the Trust. The Trust's strategy supports the achievement of our mission to help people reach their potential and live well in their community. The way in which we develop strategy in an honest, open and transparent manner demonstrates how we live the values of the Trust.
Any background papers/ previously considered by:	This paper summarises the strategic overview of business and associated risks for the Trust Board in the PESTLE (Political, Economic, Social, Technological, Legal/Regulatory and Environmental) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis aligned with the Trust risk register, and the priority programmes where this is possible. The paper was previously discussed during October 2018 Trust Board.
Executive summary:	The report is presented depicting the links between SWOT, PESTLE, risk and priority programmes. **PESTLE** Key updates in the **PESTLE** summary report include: ➢ **The NHS Long Term Plan (LTP)** was introduced in January 2019. It builds on the vision and ambition set out in the five year forward view (5YFV) with greater emphasis on better access to mental health services to help achieve the government's commitment to parity of esteem between mental and physical health; better integration of health and social care so that care does not suffer when patients are moved between systems; greater emphasis on collaboration through Integrated Care Systems (ICS) place based intervention; greater role for primary care and community services focusing on the prevention of ill-health so people live longer,

	healthier lives; and with a strong focus on workforce and technology. ➢ **The long term plan (LTP) emphasises the stronger role of ICSs in system** oversight and regulation. Work continues to ensure strong links between SWYPFT, the WY&H ICS, South Yorkshire ICS, and local elected members and Health and Wellbeing Boards. ➢ The **planned increase in funding to support the LTP**, particularly with a 'guarantee' that investment in primary, community and mental health care will grow faster than the level of growing overall NHS budget, supports improvements to services ➢ The **first appointments to the new unified NHS Executive Group** will be in place from April 2019, although it is still not clear what the effects of this closer working arrangement between NHSE and NHSI will be. ➢ **Proposals for possible changes to legislation to support the implementation of the LTP**. The engagement documentation, NHS Legislation Survey issued by NHSE on 28th February 2019, proposes possible changes to primary legislation relating to the NHS. The legislation is designed to solve specific practical problems that the NHS faces and avoid creating operational distraction, with the intention of making the implementation of the NHS LTP easier and faster. These changes offer significant opportunity to further strengthen joint working across ICSs such as West Yorkshire and Harrogate and South Yorkshire. ➢ Ever uncertain future of **Brexit** agreements remains. Key updates in the **SWOT** summary report include: **Strengths** ➢ Recognition of our services through local, regional and national awards raises the profile of the Trust and celebrates outstanding achievements. In 2018/19 these included: Barnsley's intermediate care chosen as the winner in the 'Close Partnering and Collaboration Award' category of the 2019 Healthcare Financial Management Association (HFMA) Yorkshire and Humber awards, finalist in HSJ Value awards the 'Communication initiative' category for our #allofus campaign which supports staff wellbeing, Wakefield College named our Trust as apprentice employer of the year in their apprenticeship awards 2019. Adult ADHD project team nominated in the 'Psychiatric team of the year: working age adults' category at the Royal College of Psychiatrists Award 2018; Medical education team won a certificate of merit in the team category of the Clinical Teaching Excellence Awards. **Weaknesses** ➢ We need to better recruit and retain staff. In common with other trusts we experience difficulties in ensuring that we have the right

	workforce in some hot spots. E.g. staff grade doctors, ward based nursing staff, Psychological Wellbeing Practitioners in improving access to Psychological Therapies. ➢ A high number of people continue to be placed out of area with the potential to compromise quality of care. ➢ Continued long waits experienced for some services such as CAMHS, Psychology services impact on service responsiveness, quality and experience **<u>Opportunities</u>** ➢ We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional lead provider in forensics. ➢ Opportunity to consider how the investment from LTP can support the improvement of services. SWYPFT is in a strong position to influence this at a placed based level as project lead for Operational Delivery Network for LD & Autism Yorkshire & Humber. ➢ Collaborative partnership working by the Trust with third sector organisations such as 'Live Well Wakefield' strengthens the Trust's effectiveness as a local partner in emerging primary care networks. Including enhancing the offer through Creative Minds and Recovery Colleges. ➢ Opportunity to strengthen engagement with external stakeholders and maximise the Trusts role and 'offer' within newly forming primary care networks and enhanced primary/ community care services **<u>Threats</u>** ➢ Continuing high numbers of people being placed out of area leading to financial pressures for the Trust. ➢ Significant progress that has been made in response to the CQC action plan does not result in improved CQC ratings. ➢ Financial position – the Trust is currently operating with a deficit. Reductions in cash and regulator intervention could impact on our ability to improve services and meet our objectives This report suggests that the Trust strategy addresses the key points raised in it through the strong alignment between the Trust strategy, BAF, and priority programmes.
Recommendation:	**Trust Board is asked to NOTE the content of the report and ADVISE on any further developments required.**
Private session:	Not applicable.

Strategic Overview of Business and Associated Risks

Trust Board Agenda Item 6.1

30 April 2019

14th April 2019

Salma Yasmeen, Director of Strategy

With **all of us** in mind.

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1. Purpose of the Report

This report updates on the last report to the Trust Board dated 30 October 2018 based on a review of the PESTLE, SWOT, operational risk report, and the priority programmes on 25 March 2018.

2. Information and Analysis

There should be a natural and coherent alignment between and across the content of the Trusts SWOT and PESTLE analyses', risk register and the annual priority programmes. However, strict alignment and correlation of content across these factors is not practical, nor likely, due to the complex and non-linear nature of the external environment that our PESTLE analysis in particular aims to reflect, and is therefore not to be expected. Furthermore the emphasis on alignment with risks should not overshadow the ability of the PESTLE and SWOT to highlight positive and beneficial developments and opportunities for the Trust, as well as ensuring that negative influences are appropriately addressed.

Our PESTLE (political, economic, social, technological, legal, and environmental factors) and SWOT (strengths, weaknesses, opportunities and threats) registers are summarised in this report. The registers gather information including:

- **The date when the entry was first added to the register.**
  Where this date is greater than one year this is referenced to help indicate where long term issues may require additional and specific attention.
- **The date the record was last updated.**
  This is to ensure register currency and validity.
- **Cross-reference to the Trust organisational level risk register (ORR).**
  This is to indicate alignment between the Trust risk register and external environment and highlight which issues are being managed through risk management action plans and resulting mitigation measures in the ORR. Cross reference between entries in the register and matching of risks is to the Trust Operational Risk Register dated 4th April 2019 (updated 30th April with no changes to risk ratings).
- **For SWOT analysis 'weaknesses' and 'threats' entries are also cross referenced with the Trust priority programmes for 2018/19**

The entries in the PESTLE and SWOT registers have been assessed against the current Board Assurance Framework (BAF) and the updates to the registers have been found to be aligned and addressed in that BAF.

Updates and additions made since the last report to Trust Board are indicated in Blue text in this report and are indicated with a blue 'tick' (✓) in the relevant 'updated this time' field. Any entries in the record that are suggested to be no longer applicable are indicated with text crossed out to this effect.

3. PESTLE Analysis

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

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

The following summary relates to the PESTLE register from page 5 through page 14 in this report.

3.1 Frequency of Updating

- There are 59 current entries in the PESTLE record. This is an increase of 2 since the last update to Trust Board (with 2 removed as agreed).
- 4 of the 59 entries have been added this time.
- 33 of the total entries have been updated this time.
- 13 of the entries remain unchanged for more than a year.

Note: There is frequent review of all entries in the record and 13 records have been checked that they are still current and up to date.

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

3.2 Alignment to the Trust Risk Register

- 12 of the 59 entries are matched against current risks which are being managed on the Trust's organisational risk register. This matching indicates a degree of correlation between

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

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

4. SWOT Analysis

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

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

The following summary relates to the SWOT register from page 15 through page 28 in this report.

4.1 Frequency of Updating

- There are 79 current entries in the SWOT register.
- 9 of the 79 entries have been added this time.
- 27 of the total entries have been updated this time and 1 has been deleted.
- 3 have been marked for suggested deletion next time as no longer relevant.
- 17 of the 79 entries remain unchanged for more than 1 year.
  These 17 entries have however been checked that they are still current, valid and up to date.

4.2 Alignment to the Trust Risk Register

Risks from the ORR are matched against the opportunities in the SWOT to ensure the Trust is capitalising on these opportunities and there are enough resources in place. The opportunities have been assessed against existing risks and where a relationship is present these have been included in this update.

A comparison of 'weaknesses', 'opportunities' and 'threats' in the register indicates that 31 out of the 79 entries are matched against risks in the Trust operational risk register. This matching

includes 8 ‘weaknesses’, 7 ‘opportunities’, and 16 ‘threats’ that have been aligned. The report also shows that most risks are managed within the agreed risk tolerance.

4.3 Alignment to Priority Programmes

The report also highlights where ‘weaknesses’ and ‘threats’ are being addressed through the priority programmes in the Trust’s plan.

Generally there is strong alignment, and where there are gaps, these will be considered for inclusion in the Trust’s forward programme.

5. PESTLE Register

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

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Political	1.1	The NHS Long Term Plan (LTP) was introduced in January 2019. It builds on the vision and ambition set out in the five year forward view (5YFV) with greater emphasis on better access to mental health services to help achieve the government's commitment to parity of esteem between mental and physical health; better integration of health and social care so that care does not suffer when patients are moved between systems; greater emphasis on collaboration through Integrated Care Systems (ICS) place based intervention; greater role for primary care and community services focusing on the prevention of ill-health so people live longer, healthier lives; and with a strong focus on workforce and technology. SWYPFT has a strong position given SWYPFT CEO is a member of the Learning Disability and Autism working group and the lead for the West Yorkshire and Harrogate Health and Care Partnership as well as a member of the national NHS Assembly.	Mar-19	Mar-19	✓				
Political	1.2	Public debate regarding social care funding gap and resulting tensions between local and central government related to tax revenue raising powers. This has resulted in heightened debate around 'health and care' and increasing openness to challenge assumptions regarding future form and function of the NHS. Investment into social care re flow and delayed transfer of care has created opportunity as well as tension.	Jan-17	Aug-18					
Political	1.3	The public debate regarding yearly 'winter pressures' in urgent care and primary care has started to change expectations on targets, access and personal responsibility. This is further highlighted by ongoing political comments on A&E four-hour targets. Integrated care systems are working through emergency care boards sharing the responsibilities of winter pressures.	Jan-17	Aug-18					
Political	1.4	Nine integrated care systems (ICS's) were announced as the first wave and in May 2018 an additional number of ICS's were announced in the second wave of	Jan-17	Mar-19	✓	695			

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
		sustainability and transformation partnerships (STPs) to become ICSs. This included the West Yorkshire and Harrogate (WY&H) ICS. The long term plan (LTP) emphasises the stronger role of ICSs in system oversight and regulation. ICSs to be across the UK by April 2021. Work continues to ensure strong links between SWYPFT, the WY&H ICS, South Yorkshire ICS, and local elected members and Health and Wellbeing Boards.							
Political	1.5	Impact of continued austerity for local authorities coupled with perception of strong 'NHS' focus of integrated care system plans/partnerships guidance may make local political alliances with elected members more difficult which may manifest through Health and Wellbeing Boards and Overview and Scrutiny Committees.	Pre Apr 16	Mar-19	✓				
Political	1.6	Continued emphasis on collaborative place based approaches to improvement and associated changes in organisational form such as integrated care systems and partnerships indicate a subtle shift away from market based drivers of improvement. The Trust is playing a key role in each of the partnerships that are emerging and developing for the places in which we provide services.	Pre Apr 16	Apr-18		812			
Political	1.7	The continued uncertainty of the impact of the UK referendum decision on EU membership. Potential to alter previous assumptions regarding the quantum and focus of public spending, which underpin NHS budget projections. The potential to impact on workforce availability. Longer term potential to impact on public procurement and other public law. Initially has at least re-affirmed the importance of the NHS to the public but the continued uncertainty is a concern.	Pre Apr 16	Mar-19	✓				
Political	1.8	Increased Treasury influence over the style and emphasis of Department of Health and Social Care (DoH) and NHS England (NHSE) communications, also impacting on regulatory regime.	Oct-16	Mar-19	✓				
Political	1.9	The political stance on NHS employment contracts, e.g. Junior Doctors, emphasises the potential for continued discontent and disruption. Changes to IR35 and to NHSI expectations on limiting the use of agency highlight the changing political position and public affinity with healthcare professions acting as locums and agency workers.	Pre Apr 16	Mar-19	✓				
Political	1.10	The impact of Yorkshire devolution/mayor plans and devolvement of major powers to the region could move key decision making on Government funds to the region.	Apr-18	Apr-18					
Political	1.11	Continued regulatory and commissioner scrutiny on people who are placed out of area. We are working with partners and commissioners on a joint action plan in	Jul-18	Mar-19	✓	1319			

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
		relation to monitoring and management of out of area cessation plans.							
Political	1.12	The appointment of Matt Hancock MP as SoS for Health and Social Care in July 2018 with top priorities of: workforce, technology and prevention and his support for the NHS Long Term Plan (also called the 10 year plan).	Sep-18	Mar-19	✓				
Political	1.13	The future of agreements following Brexit, if it occurs, continue to be uncertain. If the UK does leave the EU and if a deal on the arrangements necessary post Brexit are made then the following will need to be included: • Legal and regulatory systems would carry on as they currently are until the end of the transition period (31 December 2020) • Eligible EU staff will be able to apply for settled status or work towards it in the UK If there is no deal made then: • EU medicines approvals would convert into UK approvals • Existing business continuity plans should include a reference to no deal • UK is expected to offer settled status unilaterally – but this is yet TBC	Sep-18	Mar-19	✓	1369			
Political	1.14	As part of implementing the key role of ICSs at place level in accordance with LTP ambitions, commissioning arrangements will be streamlined to leaner Clinical Commissioning Groups (CCGs). The aim is typically to have 1 CCG per ICS area.	Mar-19	Mar-19	✓				
Economic	2.1	Gap between ideal of Five Year Forward View (FYFV) funding shift (prevention, primary care, mental health etc.) and the reality of 2017–2019 contracts enabled debate with commissioning partners. Collaboration re mental health investment standard helping establish shared intent. Changes in funding outlined in the NHS Long Term Plan further supports collaboration and parity of esteem between Mental Health, Learning Disabilities, and Physical Health.	Jan-17	Mar-19	✓				
Economic	2.2	Increased impact on jobs, services and income related to public health prevention services. Pace of change increased significantly, linked to continued austerity in local authorities	Oct-16	Oct-17					
Economic	2.3	Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices. NHS Improvement and HMRC interventions continue to impact	Oct-16	Mar-19	✓				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Economic	2.4	The impact of NHS financial control measures on both commissioners and providers – particularly around control totals, agency caps, etc. There is stronger financial interdependence across health systems through integrated care systems-level control totals, as underlined in the FYFV and in the NHS long term plan.	Oct-16	Mar-19	✓	812			
Economic	2.5	Impact of current employment market for clinical and IT staff, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans and 'cap'.	Oct-16	Oct-17		905			
Economic	2.6	Major Cost Improvement Programme requirements of financially challenged NHS providers leading to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing	Jul-16	Oct-17		275			
Economic	2.7	The planned increase in funding to support the LTP, particularly with a 'guarantee' that investment in primary, community and mental health care will grow faster than the level of growing overall NHS budget. 2019/20 planning guidance includes independent assessment of CCG MH investment through ICS.	Jul-16	Mar-19	✓	522			
Economic	2.8	The Government has lifted the 1% pay cap and NHS chiefs and health unions in England have agreed a three-year pay deal pending membership agreement. The pay scales are set for 19/20 and beyond giving us certainty on the values so will not increase financial risk. It is yet to be seen if this will provide relief on the recruitment and retention of staff that has been experienced.	Sep-17	Mar-19	✓				
Economic	2.9	The strength, viability and maturity of the third sector to operate fully in the competitive market place impacts on the degree of flexibility that the Trust can partner to provide flexible and diverse services within health enabling us to reach into and benefiting communities.	Apr-18	Apr-18					
Economic	2.10	The Carter report published in May 2018 leading to increased discussions on unwarranted variations and productivity in mental health services and community health services. This provides increasing opportunities to address the issues raised in the report along with increased focus on efficiencies.	Jul-18	Mar-19	✓				
Economic	2.11	The long-term funding of adult social care continues to be unclear with the publication of the Green Paper on social care for adults being further delayed.	Aug-18	Mar-19	✓				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Economic	2.12	An increase in funding over the next 5 years to support the LTP (with a new guarantee that investment in primary, community and mental health care will grow faster than the level of growing overall NHS budget), builds on the progress of the Five year forward view for mental health.	Aug-18	Mar-19	✓				
Economic	2.13	At present, demand and capacity issues across West Yorkshire and nationally have meant that children and young people requiring a CAMHs bed are temporarily located in a bed assigned for adults. Development of a new CAMHs inpatient facility in Leeds for West Yorkshire is scheduled for completion in 2020. Planned investment outlined in the Long Term Plan can support improvements to services.	Mar-19	Mar-19	✓	1368			
Socio-Cultural	3.1	High profile campaigns, celebrity endorsement, local action and the aspirations of the NHS long term plan are all impacting on societal attitudes towards mental health increasing recognition of widespread prevalence and relevance in the lives of all and potentially removing the societal stigma of mental health conditions. Together with the NHS long term plan for services for young people, the likely uptake and demand for MH services and the whole system response has the potential to increase the likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention.	Jan-17	Mar-19	✓				
Socio-Cultural	3.2	Migration trends into the UK show increasingly diverse countries of origin, increasing complexity in service provision, and enriching local communities. Future impact of Brexit on European migration trends not yet fully understood.	Jan-17	Jan-17					
Socio-Cultural	3.3	Impact of demographic change on the demand for services and also on workforce age profiles.	Pre Apr 16	Mar-19	✓				
Socio-Cultural	3.4	Changing expectations of services. Public expect greater personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention all supported by the NHS long term plan.	Pre Apr 16	Mar-19	✓				
Socio-Cultural	3.5	Changing expectations of services, greater expectation of personalisation, higher standards of customer service and responsiveness, greater level of co-production etc. drive changed workforce requirements with new skills, new roles and new psychological contracts at work necessary.	Pre Apr 16	Mar-19	✓	1151			

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Socio-Cultural	3.6	The national shortages of clinical staff is affecting the Trusts ability to recruit suitably qualified clinical staff which may have an effect on: the safety and quality of our services and the effective delivery of the Trust strategy, particularly in the ability for future development in services and increases our expenditure on bank and agency staff to fill the shortage gap.	Feb-18	Mar-19	✓				
Socio-Cultural	3.7	The provision of effective health and wellbeing services are a significant contribution to the political ideology of social solidarity, initially proposed by Nye Bevan, which allows people to cope with life situations, have more choices, cope better with anxiety and depression and therefore improve confidence, motivation and wellbeing and sustain engagement in life of those people beyond the boundaries of illness.	Apr-18	Apr-18					
Socio-Cultural	3.8	The benefits of new health approaches - social prescribing, self-management, co-production, asset based approaches (placing people's skills, networks and community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community's health.	Apr-18	Apr-18					
Technological	4.1	Increased threat from cyber-crime impacting on NHS bodies – resulting in additional cost of defence and prevention, and heightened risk of disruption to service provision (mitigated by business continuity plans).	Jan-17	Jan-17		1080			
Technological	4.2	Digital technologies, and the continued direction of travel in public service towards "digital by default" are a key enabler for and driver of change within the Trust and externally. In addition, "political will", individuals and communities drive demand for health and care providers to keep pace with their use of technology as in other aspects of their lives. This has been adopted by the Trust and is central to the digital strategy that has now been approved and initiatives like the ORCHA pilot in CAMHS are enabling that very strategy. The Trust has developed considerable infrastructure to support agile working. The use of NHS apps and digital technology is emphasised in the NHS LTP.	Pre Apr 16	Mar-19	✓				
Technological	4.3	Inequalities in technology access, competence, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. In some ways technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to deliver the Trust mission and objectives.	Jul-16	Jul-16					

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Technological	4.4	Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable – e.g. Patient opinion. Supports choice agenda, potentially links to commissioner decision making.	Pre Apr 16	Jul-16					
Technological	4.5	Technology enables improved access and use of data – telehealth monitoring of vital signs, self-reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, self-care, and movement towards coaching approaches. As supported in the LTP	Pre Apr 16	Mar-19	✓				
Technological	4.6	Interoperability of clinical systems, and enhanced analytical functions (data warehouses, big data etc.) support evidence based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. Progress lags behind the vision. The LTP accelerates opportunities to integrate and standardise health care information across care systems.	Pre Apr 16	Mar-19	✓				
Technological	4.7	Platform technology potentially allows Trust's to widen the range of offers available to service users e.g. mobile apps, enables more peer to peer support, promotes innovation and provides data on choice. Also platforms have potential to disrupt traditional 'supply chain' based markets – e.g. Uber, Airbnb, eBay etc.	Jul-16	Jul-16					
Technological	4.8	Increased use of communications technology for consultation – engagement of carers/ Multi-Disciplinary Teams etc.	Pre Apr 16	Jul-16					
Technological	4.9	Technology opens up wider possibilities in terms of 'remote working', operating over a larger geography, and different option for provision of support services including more self-service, more collaboration and traded services between NHS partners and integrated care organisations.	Pre Apr 16	Mar-18					
Technological	4.10	The provision of agile working (using communications and information technologies to enable staff to work in ways which best suit their needs) offers the capacity to help the Trust become a more responsive, efficient and effective organisation, ultimately improving performance.	Apr-18	Apr-18					
Legal/ Regulatory	5.1	Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions (e.g. Integrated Care System, Multi-specialty Community Provider), and for service line specific collaboration (e.g.	Jan-17	Mar-18					

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
		mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place based care provision							
Legal/ Regulatory	5.2	The effects of the changing landscape of health regulation is developing with NHSE and NHSI establishing new working arrangements delivered through integrated teams with the devolution duties of financial oversight, provider configuration, regulation and special measures moved to these new regional directorates. The first appointments to the new unified NHS Executive Group will be in place from April 2019 and although it is still not yet clear what the effects of this closer working arrangement between NHSE and NHSI will be it will bring together a new CQC inspection and framework; NHS Improvement's Single Oversight Framework and alignment with Care Quality Commission; diminished emphasis on previous markers of independence such as Foundation Trust status and more focus on system-wide view of finance, quality and governance.	Pre Apr 16	Mar-19	✓				
Legal/ Regulatory	5.3	Care Quality Commission visit and subsequent publication of ratings of Trust services confirm regulatory position of the Trust overall and in relation to specific factors – this shapes future regulatory framework and frequency of review for the Trust.	Jul-16	Jul-16					
Legal/ Regulatory	5.4	Some signals of changing commissioner alignment and relationships. In terms of commissioner to commissioner relationships, and also breaking down aspects of purchaser/ provider split. Committees in common in West Yorkshire and South Yorkshire, and provider to provider alliances starting to take shape.	Oct-16	Oct-16					
Legal/ Regulatory	5.5	Mergers and Acquisitions regulation and guidance – legal and regulatory framework unchanged but the anticipated approach to the practical application of this regulatory framework is uncertain in light of shift towards system based solutions. Implementing the NHS Long Term Plan - Proposals for possible changes to legislation. The engagement documentation, NHS Legislation Survey issued by NHSE on 28th Feb 2019, proposes possible changes to primary legislation relating to the NHS. The legislation is designed to solve specific practical problems that the NHS faces and avoid creating operational distraction, with the intention of making the implementation of the NHS LTP easier and faster. These changes offer significant opportunity to further strengthen joint working across ICSs such as West Yorkshire and Harrogate and South Yorkshire.	Pre Apr 16	Mar-19	✓				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Legal/ Regulatory	5.6	~~Choice agenda in health remains within NHS plans and policy, but pace of implementation has slowed, with far less prominence than previously.~~ The NHS LTP places greater emphasis on choice and parity of esteem between mental health and physical health.	Pre Apr 16	Mar-19	✓				
Legal/ Regulatory	5.7	The review of the Mental Health Act 1983 (2007), commenced in May 2017, is likely to brings changes to legislation to change the way that care to people under the Act is delivered. Sir Simon Wessley has now completed and published the findings of the review. The recommendations, if approved, will have implications for staff training and practice. There will also be increased scrutiny by the Tribunal service re decision making in certain areas.	Mar-18	Mar-19	✓				
Legal/ Regulatory	5.8	A draft bill following review of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) could potentially impact on Trust resources and the way in which we work with regards to administration of DoLS. Introduction of the draft bill could likely increase the Trusts resources required to implement and monitor the scheme, re-train the workforce, make changes to policies and procedures as well as incur additional costs for best interest assessors.	Mar-18	Mar-18					
Legal/ Regulatory	5.9	The review to develop a new NHS estates strategy to achieve best value from NHS estate; target the sale of surplus or inefficiently used NHS property; release land to build new homes on NHS land; support the realisation of the FYFV and enable clinical transformation to deliver world class care will brings changes to the Trusts estate strategy.	Apr-18	Apr-18					
Legal/ Regulatory	5.10	Changes in law to data protection legislation with the introduction of the EU General Data Protection Regulation (GDPR) from 25th May 2018 will affect how the Trust governs the management and use of patient data and may attract financial penalties if these measures are not met.	Apr-18	Apr-18		1216			
Legal/ Regulatory	5.11	There is a legal regulatory framework provided through health and safety legislation for employers to provide employees with a safe and secure workplace in which to work. The legal remedies to provide appropriate management specifically on aggression and violence and on manual handling for the Trust are considerable.	Mar-19	Mar-19	✓				
Environmental	6.1	Local Economic Partnership areas developing plans linked to local authority housebuilding. Likely to increase density of population in some areas and potential increase in demand and pressure on existing services.	Jan-17	Mar-19	✓				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated this time?	Cross Ref with ORR	Current Risk Level	Risk Appetite	Link to Strategic Priorities
Environmental	6.2	Change in travel patterns as part of new service models and technological change – e.g. more home based care but fewer trips back to base. More support staff using video conferencing	Pre Apr 16	2 yrs +					
Environmental	6.3	Opportunities around renewable energy are emerging	Pre Apr 16	2 yrs +					

6. SWOT Register

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

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
Strength	1.1	Compelling model for alternative capacity – Creative Minds, Recovery Colleges and Altogether Better is well aligned to LTP direction and offers opportunities for partnership in local place-based solutions such as ICS	Pre Apr 16	Mar-19	✓						
Strength	1.2	Clarity of approach to management of partnerships and contractual relationships with other providers, and track record of integrated teams and multi-agency joint-delivery, is a strength in formation of integrated care systems.	Jul-16	Mar-18							
Strength	1.3	Partnership track record and place based delivery structure underpinned by clear FT governance arrangements including plans to fully engage and mobilise an active public membership – all key for system leadership in emerging ICS's and place based integrated care partnerships.	Oct-16	Mar-19	✓						
Strength	1.4	Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of ICS aims.	Oct-16	Mar-19	✓						
~~**Strength**~~	~~1.5~~	~~Devolved Business Delivery Unit structures offer tried and tested approach to operating as a multi-'place based' provider – increasingly relevant in development of integrated care systems~~ Remove this	~~Pre Apr 16~~	~~Jan-17~~	✓						

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
		point as it has been superseded by the work of ICS's and place based integrated care partnerships.									
Strength	1.6	'Centres of excellence' within services recognised internally and externally – e.g. Adult ADHD project team nominated in the 'Psychiatric team of the year: working age adults' category at the Royal College of Psychiatrists Award 2018; Equipment Store recycling rates; Medical education team won a certificate of merit in the team category of the Clinical Teaching Excellence Awards; Forensic services taking a lead role in developing a new model of care through the WY&H ICS; leading implementation of suicide prevention strategy for WY&H ICS; and leading on partnerships, e.g. Wakefield MH Alliance and the Kirklees MH and Wellbeing Alliance.	Jan-17	Mar-19	✓						
Strength	1.7	Clear commitment to the Trusts mission, good values base, and increased understanding and alignment around strategic priorities within all parts of the Trust.	Jul-17	Jul-17							
Strength	1.8	Integrated approach to quality improvement ensures quality drives everything we do. The Trusts integrated change framework supports innovation, change and improvement and programmes to develop capability and capacity are in place with 'allofusimprove' IHI Open School.	Jul-17	Mar-19	✓						
Strength	1.9	What the Care Quality Commission report confirmed about how staff treat people with kindness, care and compassion, and that we are respectful and warm was further confirmed when the Trust was chosen as the winner of the organisation category at the 2017 Kate Granger awards for compassionate care. A local example of this is our Calderdale memory	Jul-16	Mar-19	✓						

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
		assessment service being accredited by the Royal College of Psychiatrists for the care they provide to local people with memory problems or dementia and their families.									
Strength	1.10	Our Care Quality Commission report (2016) highlights the outstanding features of end of life care services provided by the Trust. It also highlights consistent good ratings in most services.	Jul-16	Oct-18							
Strength	1.11	Our Care Quality Commission report highlights that more than 85% of the individual ratings are good or outstanding and 11 of our 14 core services are rated Good with all services rated as Good or Outstanding for being caring.	Jul-16	Oct-18							
Strength	1.12	Our culture of supporting those with which we work, Trust's commitment to staff health and wellbeing, our work with and supporting service users and carers and the activities of 'allofusimprove' makes us different to many other Trusts. This is seen as a major organisational strength and it inspires staff and offers potential for building external relationships and engaging with commissioners more effectively.	Jul-16	Mar-19	✓						
Strength	1.13	Our partnership relationships and the way in which we conduct ourselves when working collaboratively and co-producing with others demonstrates a real focus on the needs of the people who use our services.	Jul-16	Mar-18							
Strength	1.14	The additional external responsibilities taken on by our Chief Executive in relation to leadership roles in ICS's and on national bodies ensure we have high level connections and influence at a strategic level.	Jul-16	Mar-19	✓						
Strength	1.15	Our stakeholder survey indicates partners consider the Trust to be well led with an important role to play	Jan-17	Jan-17							

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
		in the formation and delivery of local place based plans.									
Strength	1.16	Recognition of our services through local, regional and national awards raises the profile of the trust and celebrates outstanding achievements. In 2018/19 these included: Barnsley's intermediate care chosen as the winner in the 'Close Partnering and Collaboration Award' category of the 2019 Healthcare Financial Management Association (HFMA) Yorkshire and Humber awards, finalist in HSJ Value awards the 'Communication initiative' category for our #allofus campaign which supports staff wellbeing, Wakefield College named our Trust as apprentice employer of the year in their apprenticeship awards 2019, and the long-standing collaborative relationship between Interserve and the Trust has been recognised by Constructing Excellence at its annual awards ceremony.	May-18	Mar-19	✓						
~~**Strength**~~	~~1.17~~	~~SWYPFT were featured as one of seven improved mental health providers in a CQC good practice guide 2018~~ Remove this point as it is out of date and has been previously reported (Apr 2019) and subsequent CQC inspection and rating impacts on this	~~May-18~~	~~May-18~~	✓						-
Strength	1.18.	Partnership working by the Trust with the 3rd sector (voluntary and community sector) plays a significant role in strategic partnership working and in creating and maintaining local care network model. For example, partnership working with Nova and Living Well Service in Wakefield.	Jan-19	Jan-19	✓						
Weakness	2.1	Some elements of data quality undersell the true quality and contribution made by the Trust. But	Pre Apr 16	Oct-18						Clinical Record System	

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
		examples of poor use of data that undermine stakeholder confidence and therefore impacts on Trust reputation and sustainability.									
Weakness	2.2	There are some Trust services where access to help can be too slow and needs to improve. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity.	Pre Apr 16	Apr-18		1078				West Yorkshire work – Tier 4 CAMHS Improving Autism and ADHD	
Weakness	2.3	We need to better recruit, and retain staff. In common with other Trusts we experience difficulties in ensuring that we have the right workforce in some hot spots. e.g. staff grade doctors, ward based nursing staff, Psychological Wellbeing Practitioners in Improving Access to Psychological Therapies. Opportunity to re-think models of care and roles.	Pre Apr 16	Oct-18		905				Workforce Productivity	
Weakness	2.4	Our IT systems don't always support the desired agile style of working, particularly for those working in community services and non-SWYPFT locations, where connectivity or access to systems is not effective.	Pre Apr 16	Oct-17						Clinical Record System Digital infrastructure	
Weakness	2.5	Our most recent CQC Report from April 2018 highlights that there is a requirement to improve our adult acute inpatient and PICU services, CAMHS and Community mental health services for adults service. And overall we need to improve our 'Safety' and 'Responsiveness'.	Jul-16	Oct-18						Quality Improvements	
Weakness	2.6	Sometimes we act in silos, with particular need to address gaps between operations and corporate support, and between strong local identities.	Jul-16	Sep-17						Quality Improvements	

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes
Weakness	2.7	There is a gap between our brand and offer as we would like it to be – 'integrated holistic care' and the perceptions of many of our stakeholders, who often see us as focused on mental health alone	Oct-16	Jan-17						Integrated Care Partnerships
Weakness	2.8	Sometimes our approach is too bureaucratic, and colleagues and partners would like us to be faster in making decisions	Jul-16	Aug-17						Quality Improvements
Weakness	2.9	Our approach to change takes too long, and is not always as engaging as it needs to be	Jul-16	Oct-18		695				Quality Improvements
Weakness	2.10	We have made improvements but we continue to make unnecessary and avoidable Information Governance breaches which undermine service user, commissioner, and regulator confidence and trust.	Jul-16	Sep-17		852				Quality Improvements
Weakness	2.11	In our place based/integrated care system discussions with partners our broad geography can be portrayed as a lack of 'belonging' to each specific place and community	Apr-17	Mar-18						Integrated Care Partnerships
Weakness	2.12	Our previous clinical record system (RiO) had not been reliable, resilient nor robust since November 2015, due in most part to how the system has been developed by the vendor, which impacts on effectiveness and the morale of staff using the system. The Trust selected a provider of a new CRS system (SystmOne) which has successfully gone live and is in the latter stages of implementation across inpatient and community MH and LD services.	Oct-17	Mar-19	✓					Clinical Record System
Weakness	2.13	The sustainability of the Trust relies on the level of contracted 'business' and the loss of any business could affect financial, operational and clinical sustainability	Feb-18	Feb-18		1077				

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
Weakness	2.14	A lack of engagement with external stakeholders and the resulting potential misalignment to commissioning intentions may result in non-achievement of the Trust's strategic ambition as set out in the Trust strategy	Feb-18	Feb-18		773				Integrated Care Partnerships	
Weakness	2.15	CQC overall rating reduced from good to requires improvement	Jul-18	Jul-18							
Weakness	2.16	High number of people continue to be placed out of area with the potential to compromise quality of care	Jul-18	Oct-18		1319				Out of Area Beds	
Weakness	2.17	Significant waits experienced by people referred to CAMHS and for psychology services that impact on service responsiveness, quality and experience	Apr-19	Apr-19	✓	1078				West Yorkshire work – Tier 4 CAMHS Improving Autism and ADHD	
Opportunity	3.2	Through the development of integrated care partnerships we have opportunities to provide integrated joined up care and engage local populations in their health. Integrated care developments in Barnsley, Alliance developments in Wakefield and Calderdale Cares have the opportunity to demonstrate this.	Jul-16	Mar-18						Integrated Care Partnerships	
Opportunity	3.3	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional lead provider in forensics.	Jan-17	Mar-19	✓					West Yorkshire projects - Forensics	
Opportunity	3.4	The integrated nature of our organisation, with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature.	Pre Apr 16	Sep-17						Integrated Care Partnerships	

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
Opportunity	3.5	We can forge stronger collaboration and promote the delivery and growth of innovation through our connectivity to integrated care partnerships. In particular we have an opportunity to make a bigger contribution to the South Yorkshire ICS/ e.g. in the mental health workstream, to secure sustainable pathways and West Yorkshire and Harrogate Health and Care Partnership developments in new models of care.	Jul-16	Oct-18		1114				Integrated Care Partnerships	
Opportunity	3.6	By fully rolling out our devolved approach to leadership we can empower and inspire more people and continue becoming an employer of choice and delivering great results in partnership with our service users.	Jan-17	Mar-19	✓	1151				Leadership and management development	
Opportunity	3.7	We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place based care systems.	Jan-17	Mar-18		1214				Integrated Care Partnerships	
Opportunity	3.8	We can use our skills in health and wellbeing and health coaching to support our revised workforce strategy with a focus on retention and wellbeing	Jan-17	Mar-18		1151				Workforce Productivity	
Opportunity	3.9	We can use the replacement of our clinical records IT system for mental health as an opportunity to improve quality, safety, and efficiency; and to create a system fit for the integrated place based systems of care envisaged in our integrated care partnerships and integrated care system plans.	Jan-17	Mar-18						Digital Infrastructure	
Opportunity	3.10	We have an opportunity to transform the approach to the delivery of our services through innovation that makes greater use of our unique approaches e.g. creative minds, recovery colleges and altogether	Jan-17	Aug-17							

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes
		better								
Opportunity	3.11	Additional investment in social care to address flow and reduce delayed transfers of care (DTOC) offers an opportunity for innovative collaboration with partners, taking a system view using the Better Care Fund mechanism.	Apr-17	Apr-17						
Opportunity	3.12	The result of our Care Quality Commission inspection provides opportunities to improve from 'requires improvement' to 'good' and outstanding.	Apr-17	Oct-18						Quality Improvements
Opportunity	3.13	We can use our strategic aim of co-production to explore arts and health, sports, and health and wellbeing tender and bid opportunities.	Mar-18	Mar-18						
Opportunity	3.14	There is an opportunity for the Trust to contribute to the NHS long term plan for the future of the NHS and help shape the ambitions for improvement in the NHS to meet the requirements of the five years of funding settlement from 2018 and the Trusts Chief Executive has a key role in the working party for the Learning Disability and Autism clinical priority.	Aug-18	Mar-19	✓					
Opportunity	3.15	Collaborative partnership working by the Trust with 3rd sector organisations such as 'Live Well Wakefield' strengthens the Trusts effectiveness as a local partner in emerging primary care networks	Jan-19	Mar-19	✓					
Opportunity	3.16	Opportunity to consider how the investment from LTP can support the improvement of services such as Dementia and CAMHS. SWYPFT in strong position to influence this at a placed based level as project lead for Operational Delivery Network for LD & Autism Yorkshire & Humber.	Mar-19	Mar-19	✓	1078				West Yorkshire work – Tier 4 CAMHS Improving Autism and ADHD

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
Opportunity	3.17	Opportunity to strengthen engagement with external stakeholders and maximise the Trusts role and 'offer' within newly forming primary care networks and enhanced primary/ community care services.	Mar-19	Mar-19	✓	773				Integrated Care Partnerships	
Opportunity	3.18	Opportunity to build capability to enhance capacity for change within the organisation to meet strategic objectives through programmes such as IHI open school	Mar-19	Mar-19	✓	1217				Quality Improvements	
Threat	4.1	Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, and diversion of effort away from progressive activities.	Jan-17	Jan-17		812				Financial sustainability	
Threat	4.2	If place based 'integrated care' systems are developed which result in significant loss of contracts for the Trust this would be a de-stabilising factor requiring a step change reduction in organisational cost base, and therefore a threat to viability.	Jan-17	Mar-18						Integrated Care Partnerships	
Threat	4.3	~~NHS sustainability agenda focuses primarily on the highly visible challenges to the viability of acute hospital model, which may marginalise the needs of community, learning disability, and mental health services in terms of funding and support.~~ Remove this point as it has now been superseded by the work of the NHS LTP and no longer applicable (Apr 2019)	Pre Apr 16	Sep-17	✓						
Threat	4.4	Focus on one or two particular issues could be a distraction to ensuring that all key performance metrics are given sufficient and appropriate focus and time.	Oct-16	Oct-17							
Threat	4.5	It is possible that well-developed infrastructure around service delivery and gaps between corporate support and operations may lead to a lack of agility to respond	Pre Apr 16	Sep-17		1432				Leadership and management development	

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes
		to changing priorities quickly enough.								
Threat	4.6	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g. as a result of benefit restrictions).	Pre Apr 16	Oct-18		275				Integrated Care Partnerships
Threat	4.7	Threat of decommissioning of services may result in loss of services and financial income.	Jan-17	Apr-18						Integrated Care Partnerships
Threat	4.8	Data quality and information governance issues may lead to regulatory action and reputational damage.	Pre Apr 16	Sep-17		852				Digital Infrastructure
Threat	4.9.	Threat that the Trusts current financial position reduces funding available for investment in required capital schemes including IM&T	Jan-17	Apr-19	✓	1076				Financial sustainability
Threat	4.10	Threat that the under-delivery of cost improvements impacts negatively on cash flow, necessitating undesirable urgent cost control measures, and negatively impacting on key operating measures that trigger regulatory action	Apr-17	Oct-17		1114				Financial sustainability
Threat	4.11	Threat of cyber-attack impacting on operational continuity and stakeholder confidence	Apr-17	Sep-17		1080				Digital Infrastructure
Threat	4.12	The development of an integrated care system for South Yorkshire (SY&B ICS) may lead to the Trust sharing accountability for achievement of a system wide control total and performance. Need to clarify the Trusts role within the SY&B ICS.	Apr-17	Jan-19	✓	812				Integrated Care Partnerships
Threat	4.13	There is a threat of a sub-optimal implementation of the clinical record system (SystmOne), selected to replace our existing RiO system.	Oct-16	Oct-17		1213				Clinical Record System
Threat	4.14	There is a threat that the Trusts reputation could be	Feb-18	Feb-18		1132				Workforce Productivity

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
		adversely affected by long waiting lists delaying treatment and recovery									
Threat	4.15	Threat that the local tendering of services could increase, impacting on Trust financial viability.	Feb-18	Feb-18		1214				Integrated Care Partnerships	
Threat	4.16	Threat likely to the safety and quality of current services, ability for future development in services, and the effective delivery of the Trust strategy due to national shortages in clinical staff affecting ability to recruit suitably qualified clinical staff.	Feb-18	Feb-18		1151				Workforce Productivity	
Threat	4.17	The constant level of tendering activity, natural in the provider sector, can have a negative impact on the moral of staff working in the 'tendered' services which could lead to sub-optimal performance and increased staff turnover.	Feb-18	Oct-18		1212				Integrated Care Partnerships	
Threat	4.18	Non, or late, submission of statutory returns could result in non-compliance with constitution and licence	Feb-18	Oct-18						Integrated Care Partnerships	
Threat	4.19	The ageing workforce who are able to retire in the next five years brings a potential loss of knowledge, skills and experience	Mar-18	Mar-18		1153				Leadership and management development	
Threat	4.20	The impact of universal credit and its roll out has the potential for some groups to lose out financially due to reduced benefits income or delays in claims for benefits may have an increased negative affect on people's mental health and therefore an increased pressure on Trust resources. This places greater emphasis on the need to continue to work with partners and Health and Wellbeing Boards to address the wider determinants of health and social care.	Mar-18	Mar-19	✓					Integrated Care Partnerships	

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
Threat	4.21	Cuts to Citizens Advice (CAB) funding is reducing the numbers of people that CAB can help with problems such as debt, benefits, housing and employment worries therefore potentially increasing people's mental health problems, the knock on affect to mental health services.	Mar-18	Mar-18						Integrated Care Partnerships	
Threat	4.22	Cuts in local authority budgets, and social care budgets specifically, could adversely affecting health services, particularly in delays in discharges from hospital, due to problems accessing social care services.	Mar-18	Mar-18						Integrated Care Partnerships	
Threat	4.23	Barnsley CCG ~~have indicated their intention to go through a process to appoint a single provider in Barnsley.~~ and provider partners are working together to develop integrated care and services and the CCG are leading on the development of Primary Care Networks aligned to neighbourhoods. Greater importance needs to be placed on clarifying and strengthening the Trusts role within primary care networks.	Jul-18	Apr-19	✓					Integrated Care Partnerships	
Threat	4.24	Continuing high numbers of people being placed out of area leading to financial pressures for the Trust	Jul-18	Dec-18		1335				Out of Area Beds	
Threat	4.25	No replacement intranet platform being implemented by the time MS SharePoint license support is removed in October 2020 will have an adverse impact on: internal communications that are vital for agile workers; productivity concerns where employees will find it harder to find information; collaboration across different or disparate teams; a standard repository for	Jan-19	Jan-19	✓						

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes	
		Trust policies, procedures and guidance.									
Threat	4.26	Significant progress that has been made in response to the CQC action plan does not result in improved CQC ratings	Apr-19	Apr-19	✓					Quality Improvements	
Threat	4.27	Financial position – the Trust is currently operating with a deficit. Reductions in cash and regulator intervention could impact on our ability to improve services and meet our objectives	Apr-19	Apr-19	✓	1076				Financial sustainability	

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 6.2

Title:	**Board Assurance Framework (BAF) Quarter 4 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. This report provides the updated 2018/19 BAF for review and discussion at the Trust Board. This report provides the recommended strategic risks to be incorporated in the 2019/20 BAF following discussion at the February Board Strategy meeting and agreement of 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 have been put in place during the year in relation to 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	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	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	Y
	1.3 Differences in the services may result in inequitable services offers across the Trust	10	Y	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	Y
	2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	15	Y	Y	Y	Y	Y
	2.3 Failure to create learning environment leading to repeat incidents	18	Y	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	Y
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	Y
	3.2 Failure to develop commissioner relationships to develop services	26	A	Y	Y	Y	Y
	3.3 Failure to deliver efficiency improvements / CIPs	28	A	A	A	A	A
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	30	Y	G	G	G	G

The following changes have been made to the BAF since the last Board report in January 2019:

Strategic objective	Areas updated
Improving health Working in partnership	Strategic risk RAG ratings reviewed and remain unchanged.
	Rationale for current assurance level updated.
	Strategic risk 1.1 – Assurance outputs, gaps in assurance, completion dates updated and narrative included.
	Strategic risk 1.2 – Assurance outputs, gaps in assurance, completion dates updated and narrative included.
	Strategic risk 1.3 - Assurance outputs, gaps in assurance, completion dates updated and narrative included.
Improving care Safety first, quality counts and supporting our staff	Strategic risk RAG ratings reviewed and updated
	Rationale for current assurance level updated.
	Strategic risk 2.1 - Gaps in controls and assurances, completion dates updated and narrative included.
	Strategic risk 2.2 - Gaps in assurance updated
	Strategic risk 2.3 - Gaps in controls and assurances, completion dates updated and narrative included.
	Strategic risk 2.4 - Gaps in controls and assurances, completion dates updated and narrative included. Risk rating changed to yellow
Improving resources Ready for tomorrow: Operational excellence	Strategic risk RAG ratings reviewed and updated
	Rationale for current assurance level updated.
	Strategic risk 3.1 - Gaps in controls and assurances, completion dates updated and narrative included. Risk rating changed to yellow
	Strategic risk 3.2 - – Assurance outputs, gaps in assurance, completion dates updated and narrative included.
	Strategic risk 3.3 - Assurance outputs, gaps in assurance, completion dates updated and narrative included
	Strategic risk 3.3 - Assurance outputs, gaps in assurance, completion dates updated and narrative included

The most notable changes relates to a) strategic risk 2.4 - increased demand for and acuity of service users leads to a negative impact on quality of care where the rating has changed from amber to yellow following the completion of a number of actions taken and the most recent self-assessment in advance of the CQC inspection and b) strategic risk 3.1 Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme which has also moved from amber to yellow given the achievement of the 18/19 financial control total.

Appendix 2 shows the strategic risks aligned to Trust objectives for 2018/19 and the proposed strategic risks aligned to objectives for 2019/20. The proposed changes for 2019/20 are based on the discussions that took place between Board members at the February 2019 Trust Board strategy session.

Recommendation:	**Trust Board is asked to:** ➢ **NOTE and the controls and assurances against the Trust's strategic objectives for Quarter 4 2018/19;** ➢ **AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified; and** ➢ **AGREE to the updated strategic risks to be included in the Board assurance Framework for 2019/20.**
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	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	Y
	1.3 Differences in the services may result in inequitable services offers across the Trust	10	Y	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	Y
	2.2 Inability to recruit and retain skilled workforce leading to poor service user experience	15	Y	Y	Y	Y	Y
	2.3 Failure to create learning environment leading to repeat incidents	18	Y	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	Y
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	Y
	3.2 Failure to develop commissioner relationships to develop services	26	A	Y	Y	Y	Y
	3.3 Failure to deliver efficiency improvements / CIPs	28	A	A	A	A	A
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	30	Y	G	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	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 and 18/19 report included in 19/20 work plan. (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 and 18/19 report included in 19/20 workplan. (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. Operational plan for 2019/20 approved at Trust Board March 2019 (P, N) (I).	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Annual reports of Trust Board Committees to Audit Committee,	Audit Committee and Trust Board – April 2018. (P) (I)	A14	DFR	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**
attendance by Chairs of Committees and Director leads to provide assurance against annual plan	Audit Committee and Trust Board – April 2019 (P) (I)			
Rolling programme of staff, stakeholder and service user/carer engagement and consultation events	Communication, engagement and involvement strategy 2016-2019 (approved October 2016). Weekly and monthly engagement with staff (huddles, the Headlines, the View and the Brief) plus staff listening events June 2018, monthly engagement with stakeholders (the Focus), various 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)	A15	DHR, DS	1.1, 1.3, 2.4
Commissioning intentions for 2019/20 have been factored into our operating plans	Mutual agreement between provider and commissioner of investment priorities (P) (I)	A23	DFR, DO	1.1, 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. (Linked to ORR Risk ID 812). (completed during 2019/20 contracting round)	Jan 2019 *Complete*
Assessment of place based plans in each Integrated Care System (ICS). (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).Reviewing all place based plans with further engagement with key stakeholders in light of long term plan publication and development of 5 year ICS plans*	Jun 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 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 and 18/19 report included in 19/20 work plan. (I)	A06	DNQ	1.1, 1.2, 1.3
Strategic priorities and programmes	Monthly update provided to Trust Board	A07	DS	1.1, 1.2,

Assurance (Strategic Risk 1.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR	via the IPR (reviewed monthly by EMT). (P) (I)			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 (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 and 18/19 report included in 19/20 workplan (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. Operational plan for 2019/20 approved at Trust Board March 2019(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) and Workforce & Remuneration Committee, deviations identified and remedial plans requested	Update reports into EMT and Workforce & Remuneration Committee (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 OMG, 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	Benchmarking reports are received by	A20	DFR	1.2, 3.1,

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**
plans in place to address variation	Executive Management Team (EMT) and any action required identified. (P, N) (I, E)			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
Commissioning intentions for 2019/20 have been factored into our operating plans	Mutual agreement between provider and commissioner of investment priorities (P) (I)	A23	DFR, DO	1.1, 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. (Linked to ORR Risk ID 812). (completed during 2019/20 contracting round)	Jan 2019 *Complete*
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 and 18/19 report included in 19/20 work plan.(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	Monthly update provided to Trust Board	A09	EMT	1.1, 1.2,

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**
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	via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)			1.3, 2.4, 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 2019 (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
Commissioning intentions for 2019/20 have been factored into our operating plans	Mutual agreement between provider and commissioner of investment priorities (P) (I)	A23	DFR, DO	1.1, 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. (Linked to ORR Risk ID 812). (completed during 2019/20 contracting round)	Jan 2019 *Complete*
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**	**Y**

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

Ref	Description	RAG Rating
2.1	**Lack of suitable and robust, performance and clinical information systems leading to lack of timely high quality management and clinical information to enable improved decision-making**	**Y**
2.2	**Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience**	**Y**
2.3	**Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation**	**Y**
2.4	**Increased demand for and acuity of service users leads to a negative impact on quality of care**	**Y**

Rationale for current assurance level (Strategic Objective 2)

- Monitor well-led review undertaken by independent reviewer demonstrated through stakeholder engagement that the Trust's mission and values were clearly embedded through the organisation.
- Staff 'living the values' as evidenced through values into excellence awards.
- In the main, positive Friends and Family Test feedback from service users and staff with the exception of CAMHs (being addressed through joint action plan with commissioners).
- Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery.
- Strong and robust partnership working with local partners, such as Locala to deliver the Care Close to Home contract and establishment of Programme Board.
- Care Quality Commission (CQC) revisit overall rating of requires improvement, number of areas rated good or outstanding, action plan to address improvement recommendations.
- Internal audit reports – Risk management, Information Governance, Data Quality, Staff Engagement, Mental health Act Governance, Quality Governance – significant assurance.
- CQUIN targets largely achieved.
- Regular analysis and reporting of incidents.
- Data warehouse implementation taking place, but at slower pace than originally planned to ensure alignment with SystmOne implementation.
- Focused information provided for out of area bed review to support findings and recommendations
- Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 11 shows: Friends & Family Test MH amber, F&F Test Community green, 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. *Second internal audit report provided significant assurance and all actions completed prior to go live*	Quarter 4 *Complete*
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	Contracting risks, bids & tenders update	A10	DS	1.1, 1.2,

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**
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. (P, N) (I)			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
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. *Updates provided.*	Quarter 3 *Complete*
Implementation of actions identified in internal audit report on SystmOne implementation governance arrangements. *Focus in Q3 & Q4 was on ensuring clinical record data for fit for migration to SystmOne for mental health services*	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). *Recommended for approval at April Audit Committee. Board agenda item April 2019*	Quarter 4
Data input for SystomOne implementation catch up is not yet complete	June 2019

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 trust-wide 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

Regular meetings established with Sheffield and Huddersfield University to discuss undergraduate and post graduate programmes	C47	DHR	2.2

Gaps in control - what do we need to do to address these and by when?	**Date**
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 Further work required on response rates Complete - New arrangements in place and response rate significantly increased.	*Sept 2018 Complete June 2019*
Support needed for a tailored medical leadership / talent development programme. Currently capacity issues exist to support this.	June 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 Jun 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)*	June 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 via IPR and annual report, scheduled in 19/20 work plan (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 six monthly report to Trust Board (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. *Reviewing & streamlining current processes which causes delay to meeting original plan*	Jun 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 uncertain. *Brexit coordination group established and Trust*	

meeting national guidance. *Timescale changed to be in line with latest withdrawal date*	Oct 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 OMG, 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. Will be embedded during 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	OMG, 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 via IPR and annual report scheduled in 19/20 work plan. (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) *IG training achieved the target. Deep-dive conducted for Audit Committee. Updated comms plan taking effect from April following SysmOne go-live*	Jan 2019 *Largely complete*
Impact of learning lessons process on all relevant practitioners	Sep 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
Process to manage the CQC action plan	C57	DNQ	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 and 18/19 report included in 19/20 work plan. (E)	A12	DNQ	1.1, 1.2, 2.4
Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees	Audit Committee and Trust Board – April 2018. (P) (I) Audit Committee and Trust Board – April	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**
and Director leads to provide assurance against annual plan	2019 (P) (I)			
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 OMG, 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
CQC self-assessment process	Reviewed by EMT as part of preparation for CQC inspection process	A43	DNQ	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 upon patients and families of out of area placements. (Linked to ORR 1319) *Independent SSG report completed and recommendations being implemented during 19/20*	Mar 2019
Outcome of community mental health transformation programme review. *Initial findings presented to EMT in February. Some further points of clarification requested*	May 2019
Impact of waiting list in CAMHS services. *Working as part of all place-based systems to identify how improvements can be made. Some additional investments made for 2019/20 and focus applied on recruitment and retention.*	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	Y

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**	Y
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 delivery higher than plan in 2018/19
- Recurrent CIP delivery 75% of total in 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). *Total CIP delivery in excess of plan in 2018/19 with 75% recurrent*	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). *Contractual growth for 2019/20 in line with mental health investment standard, recognises demographic growth and some specific service pressures*	Ongoing
All financial risk for out of area bed costs currently sits with the Trust (Linked to ORR Risk ID 1335). *Non-recurrent support provided by commissioners in 2018/19. Recognition of demographic growth in 2019/20- contracts and recognising priority for in year funding if required and available*	March 2019 *Complete for 18/19 and 19/20 contract*
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	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	A01	DFR	All

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**
to be taken				
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 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. Scheme of delegation. Reports to Audit Committee. (P, N) (I)	A10	DS DFR	1.1, 1.2, 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. Operational plan for 2019/20 approved at Trust Board March 2019.(P, N) (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) Draft Annual Governance Statement 2018/19 reviewed by Audit Committee and Trust Board in April 2019	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	A46	DFR	3.1

Assurance (Strategic Risk 3.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
	to Scheme of Delegation reviewed by Audit Committee on April 2017 prior to approval by Trust Board and Members' Council. Updates to Scheme of Delegation taken to Audit Committee and Trust Board in April 2019(P) (I)			
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. *Updates to Scheme of Delegation taken to Audit Committee and Trust Board in April 2019*	Quarter 4
CIP delivery is currently behind plan and not fully identified. Ongoing review of potential upsides and mitigations. *(CIP delivery for 18/19 was ultimately ahead of plan with 75% considered recurrent*	March 2019 *Complete for 18/19*
Internal audit reports with partial assurance management actions agreed by lead Director. Review of high and medium priority recommendations to be undertaken quarterly. *Completion of internal audit recommendations is largely in line with original timescales (92% implemented as at 31/3/19)*	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. *Non-recurrent support provided in 2018/19*	March 2019
Cash position is largely dependent on us delivering a surplus.	Ongoing
Balanced financial plan for 2018/19 not yet in place. *The Trust ultimately achieved its financial targets for 18/19.* Development of a financial sustainability plan. *(Note, expected completion date changed from Quarter 3 to March 2019. Work on the financial sustainability plan has commenced with an initial paper taken to December Trust Board. Further work scheduled for quarter 4.). Financial sustainability plan is on the agenda at the April Trust Board. Delivery 18/19 control total achieved*	April 2019
Recurrent position is a deficit in excess of £4m	

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). Specific action to develop a prospectus and stakeholder engagement plans within each place to be complete by June 2019*	June 2019

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
2019/20 contracts reflect growth in line with mental health investment standard as well as some specific service pressures	Contracts in place for 2019/20 (P) (I,E)	A50	DFR	1.1, 1.2, 1.3, 3.1, 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)Completed during planning process and contract negotiations*	Jan 2019 *Complete*
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) reviewing all place based plans with further engagement with key stakeholders in light of LTP publication*	Jun 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. (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
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.. Final plan for 2019/20approved by Trust Board in March 2019 and submitted in April 2019 (P, N) (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 –	Monthly bids and tenders report to	A21	DFR	1.2, 3.1,

covers bids and tenders activity, contract risks, and proactive business development activity	Executive Management Team (EMT) and twice yearly to Trust Board (P) (I)			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
Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG)	Standing agenda item 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**
CIP delivery is currently behind plan and not fully identified. Ongoing review of potential upsides and mitigations. *(CIP delivery for 18/19 was ultimately ahead of plan with 75% considered recurrent*	March 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) Financial sustainability plan is on the agenda at the April Trust Board. Delivery 18/19 control total achieved*	March 2019
Insufficient CIPs identified to date to delivery 2019/20 control total	June 2020

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. 19/20 operating plan approved by Trust Board in March 2019 and submitted to NHSI in April 2019(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. *Reviewed regularly and reported to board. Further review of all place based plans following publication of long term plan*	Jun 2019

South West Yorkshire Partnership NHS Foundation Trust

Appendix 2

Board Assurance Framework – 2019/20

Proposed Strategic Risks

Objective	Current strategic risks	Proposed strategic risks
Improving health	Differences in published local priorities could lead to service inequalities across the footprint.	Differences in published local priorities could lead to service inequalities across the footprint.
Improving health	Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans	Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans
Improving health	Differences in the services provided due to unnecessary internal variation in practice, may result in inequitable service offers across the whole Trust.	Differences in the services provided due to unnecessary internal variation in practice, may result in inequitable service offers across the whole Trust.
Improving health		Impact of the Trust no having a robust and compelling value proposition leading to under-investment in services
Improving care	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	Lack of suitable and robust, performance and clinical information systems backed by strong analysis leading to lack of timely high quality management and clinical information to enable improved decision-making
Improving care	Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience	
Improving care	Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation	Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation
Improving care	Increased demand for and acuity of service users leads to a negative impact on quality of care	Increased demand for and acuity of service users leads to a negative impact on quality of care
Improving resources	Deterioration in financial performance leading to unsustainable organisation and insufficient cash to deliver capital programme	Deterioration in financial performance leading to an unsustainable organisation and insufficient cash to provide services effectively
Improving resources	Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being lost, reduction in income	Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being lost, reduction in income
Improving resources	Failure to deliver efficiency improvements/CIPs	Failure to identify and deliver efficiency improvements/CIPs
Improving resources	Capacity and resources not prioritised leading to failure to meet strategic objectives	Capacity and resources not prioritised leading to failure to meet strategic objectives
Making SWYPFT a great place to work		Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 6.3

Title:	**Corporate/Organisational Risk Register Quarter 4 2018/19**
Paper prepared by:	Director of Finance and Resources
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives.
Mission / values:	The risk register is part of the Trust's governance arrangements and integral elements of the Trust's system of internal control, supporting the Trust in meeting its mission and adhere to its values.
Any background papers / previously considered by:	Previous quarterly reports to Trust Board. Standing agenda item at each sub-committee meeting. Triangulation of risk performance and governance report to Audit Committee in April 2019
Executive summary:	**Corporate/Organisational Risk Register** The Corporate/Organisational Risk Register (ORR) records high level risks in the organisation and the controls in place to manage and mitigate the risks. The organisational level risks are aligned to the Trust's strategic priorities and to one of the sub-committees for the Trust Board for review and to ensure that the committee is assured the current risk level is appropriate.

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

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**:

	Risk ID	Description
	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.
	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.

The following changes have been made to the ORR since the last Board report in January 2019:

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.	Controls and actions updated	Reviewed by lead Director and EMT. An additional control added. Actions updated, including further actions identified.
	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. A complete action and moved to controls. A further action identified.

Risks below 15 (outside risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	275	Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding.	Controls and actions updated	Reviewed by lead Director and EMT. A complete action and moved to controls. A further action identified.
	905	Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications	Controls and actions updated	Reviewed by lead Director and EMT. A complete action and moved to controls. A new action identified.
	1078	Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.	Actions updated	Reviewed by lead Director and EMT. Complete action removed and a further action identified.
	1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	Actions updated	Reviewed by lead Director and EMT. Complete action removed and two further actions identified.
	1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls.
	1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: ➢ Inpatient ligature risks ➢ Learning from deaths & complaints ➢ Clinical risk assessment	New organisational level risk	New risk added to the organisational level risk register.

		➢ Suicide prevention		
	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. Action completion dates updated due to requirement to completion 2019/20 financial plan first. This will be an agenda item for Trust Board in April 2019. The engagement action has been updated to align with the Board Assurance Framework (BAF).
	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.	Actions updated	Reviewed by lead Director and EMT. Action completion dates updated due to requirement to completion 2019/20 financial plan first. This will be an agenda item for Trust Board in April 2019.
	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.	Controls and actions updated	Reviewed by lead Director and EMT. Completed action moved to controls. Action completion dates updated due to delayed in funding.
	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.	Actions updated	Reviewed by lead Director and EMT. Action completion dates updated as workforce plans cannot be completed until the annual plan has been signed off.
	1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and DES.	Controls and actions updated	Reviewed by lead Director and EMT. Completed actions moved to controls. Further action identified.
	1158	Risk of over reliance on agency staff which could impact on quality and finances.	Actions updated	Reviewed by lead Director and EMT. Action completion dates 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.	Actions updated	Reviewed by lead Director and EMT. Completed actions removed. Seven further actions identified.
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	Actions updated.	Reviewed by lead Director and EMT. Completed action removed.

	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. Action completion dates updated due to focus on and resource required for the SystmOne implementation.
	1319	Risk that quality of care will be compromised if people continue to be sent out of area.	Controls and actions updated	Reviewed by lead Director and EMT. Two actions complete and moved into controls.

Risks below 15 (managed within risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	Actions updated	Reviewed by lead Director and EMT. Dates changed for some actions and a new action identified.
	1362	Risk the Trust is unable to fully implement the falsified medicines directive 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.	Controls updated	Reviewed by lead Director and EMT. Two further controls identified.
	1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	Controls and actions updated	Reviewed by lead Director and EMT. Completed actions moved to controls.
	1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	Controls and actions updated	Reviewed by lead Director and EMT. Completed action moved to control. Dates changed for some actions.
	1432	Risk of problems with succession planning / talent management.	New organisational level risk	New risk added to the organisational level risk register.

Risks recommended for closure:

	Risk ID	Description	Status	Update (what changed, why, assurance)
	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.	Recommended for closure	Risk recommended for closure from the organisational level risk register. Management systems now in place for the safe disposal of Clinical waste following change in

				provider.
	1004	Risk that a decentralised model for health records results in inconsistent application of standards and / or loss of health records.	Recommended for closure	Risk recommended for closure from the organisational level risk register. Good controls in place with actions completed. Risk score has been maintained within risk appetite.

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 were considered for inclusion:

- Inpatient safety, ligatures, and other actions following CQC report - EMT noted that ligature risks were on the BDU risk registers and ligature reported to Clinical Governance & Clinical Safety Committee. EMT agreed that an organisational level risk should be included in relation to patient safety.

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 ORR:

- 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 the risk in relation patient safety.
- 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.

A new organisational level risk in relation to patient safety has been included (Risk ID 1424) which covers inpatient ligature risks, learning from deaths and complaints, and clinical risk assessments which has been review by the Clinical Governance & Clinical Safety Committee.

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,**
- **DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review; and**

	➢ **AGREE the two risks recommended for closure.**
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) - 30 April 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). (awaiting national confirmation) ➢ The implementation of year 3 of the data centre infrastructure plan focusing on improvements to: (DFR) (31 March 2020) ➢ Replacement of core equipment ➢ Application availability *(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 – April 2019

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		➢ 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. ➢ Annual cyber exercise					➢ Implement recommendations from NHS IT health check report (DFR) (30 Sept 2019) ➢ Implement Forcepoint email filtering solution (DFR) (March 2020) ➢ Strengthen user password requirements (DFR) (August 2019) ➢ Implement windows defender advanced threat protection (DFR) (March 2020) ➢ Work towards full cyber essentials certification (DFR) Dec 2020)						Internal assurance report for the Trust controls and mechanisms in relation to the WannaCry Ransomware cyber-attack produced and all actions complete. Actions identified for 2018/19 are complete with any further improvements identified included in the 19/20 plan	
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. ➢ Meetings led by NHSE took place. The system is better informed of the challenges with agreement to working together to best meet the needs of children and young people.	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) ➢ Consider how the planned investment outlined in the long term plan can support improvements to services (MB/CH) (by June 2019) ➢ Recruitment into all age liaison/home treatment teams from local CCG investments in 2019/20 in order to increase opportunities for alternatives to admission (by June 2019)	DO	Ongoing risk given external influenc e outside our control	EMT (monthly) CG&CS (regular) Trust Board (each meeting through integrated performanc e report)	4 Yellow /Moder ate (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 – April 2019

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

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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. ➢ New organisational change policy to include further support for the transfer and redeployment of staff.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Joint working in Calderdale is captured in the Calderdale Cares document and delivery is overseen through the Health and Wellbeing Board. Updates are provided to EMT and to Board via the Health and Wellbeing Board minutes. (DNQ) ➢ 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) ➢ Partners in development of integrated care partnerships in each place (DS/DPD)	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 – April 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. ➢ Additional funding requested from commissioners through contract negotiations where applicable. ➢ Monthly safer staffing reports Board and OMG with appropriate escalation arrangements in place 6/12 safer staffing report to Board and Commissioners	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) ➢ Temporary staffing is monitored through OMG / DO) ➢ Safer staffing group meets on a monthly basis. (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 – April 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	4 Major	3 Possib le	12 Amber / High risk (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ A commitment has been made to an improvement plan by key agencies, SWYPFT, Mid Yorkshire Hospitals NHS Trust, Wakefield CCG and Wakefield 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	DO	Review every three months	Performanc e reporting to EMT - monthly Assurance report to Clinical Governanc e Committee	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	Every three months prior to business and risk Trust Board – April 2019

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		supporting local teams with the action plans. ➢ CAMHS performance dashboard for each district. ➢ Work has taken place to implement care pathways and consistent recording of activity and outcome data. ➢ Kirklees has a new ASD pathway in place. ➢ System wide work was undertaken in Wakefield to improve access to assessment for ASD. ➢ There is ongoing dialogue with people on the waiting list to keep in touch and to carry out well-being checks. ➢ Active participation in STP CAMHS initiative. ➢ Jointly agreed neuro-developmental pathway implemented in Kirklees. ➢ Additional funding requested from commissioners through contract negotiations where applicable.					diagnostic assessment pathway and is currently considering options for investment in a waiting list initiative. (DO) (Date to be confirmed by CCG). ➢ Fulfil requirements of the NHS Long Term Plan. (DO) ➢ Work has taken place with each of the commissioners to agree additional investments in all age liaison / extended home treatment and waiting lists initiatives for ASC. (The details of each investment are provided in the CAMHS report to CGCS). Recruitment is underway (June 2019)			Individual district performanc e reports reviewed by BDU			to support reduction of the ASC waiting list. 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 secured waiting list initiatives as part of the 2019/20 contract negotiations 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. (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 has taken place with commissioners to agree additional capacity in specific services. /(DO) ➢ Review of impact and ongoing risk to be presented to CGCS committee (June 2019) ➢ Detailed evidence of demand growth in neighbourhood nursing and MSK being developed for discussion with commissioner (DO/DFR) (May 2019)	DO	July 2019	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 Som	Every three months prior to business and risk Trust Board – April 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 for 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	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 including the trial period for the use of e-cigarettes. (DO) ➢ New inpatient builds and major developments fitted with sprinklers. (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	Every three months prior to business and risk Trust Board – April 2019

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		➢ Trust smoking policies with the use of e-cigarettes agreed for a trial period ➢ 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; 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. ➢ Use of sprinklers across all Trust buildings reviewed as part of the capital programme.											policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings.	
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) ➢	MD	Ongoing	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 – April 2019
1424 NEW RISK	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: ➢ Inpatient ligature risks ➢ Learning from	➢Clear policy & procedure in place providing framework for the identification and mitigation of risks in respect of ➢Ligature assessment ➢Blue light alerts and learning library introduced Immediate lessons learnt are shared and prompt action taken to prevent recurrence of incidents (DNQ)	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Our Learning Journey report disseminated across all teams and discussed at team level (DNQ) (2017/18 report complete, 2018/19 report by Q3 2019/20) ➢ Rollout of “Safety Huddles” programme (DNQ) (Q3 2019/20) ➢ “All of us improve” campaign relating to patient safety (DNQ) (Q3 2019/20) ➢ Mental health safety improvement partners in place	DNQ MD	On going	Performanc e & monitoring via EMT, OMG & TB reports e.g. quarterly Patient	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board

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	deaths & complaints ➢ Clinical risk assessment ➢ Suicide prevention	➢Learning from deaths ➢Complaints ➢Clinical risk assessment ➢Suicide prevention ➢Weekly risk scan of all red and amber patient safety incidents for immediate action ➢Monthly clinical risk report to OMG for action and dissemination. ➢Monthly IPR performance monitoring report includes complaints response times and risk assessment training level compliance ➢Patient safety strategy in place to reduce harm and improve patient experience. ➢Patient safety strategy identifies key metrics for harm reduction which are reported to EMT & TB ➢Suicide prevention strategy in place to reduce to reduce risk of suicide. ➢Monthly complaints review meeting with CEO / DNQ / MD / DO to scan and act on themes ➢Introduction of "Manchester scale" to improve reliability & validity of ligature assessment process and to prioritise remedial action. ➢New AMD for patient safety appointed to revised JD.					with NHSI/CQC to improvement patient safety (DNQ) (Q3 2019/20) ➢ Alignment of WY&H ICS suicide prevention strategy with SWYPT plans (DNQ) (Q2 2019/20) ➢ CQC action plans performance managed through Clinical Governance Group with escalation arrangements in place where action behind schedule (DNQ) ➢ Suicide prevention strategy action plan (DNQ) ➢ Quality improvement network focus on patient safety improvement (DNQ) ➢ Clinical risk assessment training programme to meet mandatory compliance target. (DNQ) ➢ Updated clinical risk report that captures a wider range of risk information for OMG (DNQ)			Safety report & incident report				April 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)	➢2019/20 planning guidance includes independent assessment of CCG mental health investment (DFR) (April 2019) ➢The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) ➢Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – April 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	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 / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – April 2019

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		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.												
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.	➢Financial planning process includes detailed two year projection of cash flows. ➢Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately. ➢Capital prioritisation process to ensure capital is funded where the organisation most needs it. ➢Stated aim of development of financial plans that achieve at least a small surplus position. ➢Estates strategy with the intent of selling surplus buildings. ➢CIP identification and review process. ➢Treasury Management policy.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Trust bidding to improve 2018/19 outturn position in order to generate additional provider sustainability funding (PSF) (DFR) (April 2019) ➢ 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 training. (DFR) ➢ Collaborative working within West Yorkshire STP. (DFR / CEO / DPD)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO3	Every three months prior to business and risk Trust Board – April 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) (April 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 2019) ➢ 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 – April 2019

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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 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of longer term financial sustainability plan. (DFR) (April 2019) ➢ 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 /Moderate (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 – April 2019
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. ➢ Working in partnership across W Yorks on international recruitment.	3 Moderate	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) (June 2019) ➢ Marketing of the Trust as an employer of choice. (DHR) (June 2019) ➢ Develop new roles e.g. Advanced Nurse Practitioner. (DNQ / DHR / MD) ➢ Safer staffing reviewing establishment levels. (DNQ) ➢ Development of Physician Associate role. (DHR / MD)	DHR	Ongoing given external influence outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performance report)	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to business and risk Trust Board – April 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 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Refresh of workforce plans. (DHR) (June 2019)	DHR	Ongoing	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moderate (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 – April 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
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 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Wellbeing plan to be established in each BDU. (ALL)	DHR	31/08/19	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moderate (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 – April 2019
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. ➢ Establishment of staff disability network and LGBT network. ➢ Links with Universities on widening access.	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of action plan to tackle harassment and bullying from services users and families. (DoN) (Q2 2019/20)	DHR	Ongoing	EMT (quarterly) E&I Forum (quarterly)	6 Yellow / moderate (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 – April 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 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Introduction of new roles e.g. Advanced Clinical Nurse Practitioners to be included in 2019/20 workforce planning meeting to reduce the need for medical locum. (DNQ / DH) (May 2019) ➢ Recruitment to Consultant Roles (DHR / MD).	DHR	May 2019	EMT (monthly) Board (monthly)	6 Yellow / moderate (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 – April 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	➢Information is available daily at HCP, team, BDU and Trust level. ➢A regular summary is reviewed at Operational Management Group (OMG) to track progress	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – 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 – April 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
	clinical risk and poor outcomes for service users.													
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. ➢ Established a credible implementation plan which is accepted and supported by the organisation. ➢ Detailed cutover plan and resources in place for Go Live. ➢ Additional resources agreed to support staff on the group up to 31 August 2019 to cover full data catch up period, provide additional training where required and implement early optimisation plans. ➢ Weekly status reports by programme lead to EMT. ➢ Communications and engagement plans in place. ➢ Current CRS to continue and be accessible until June 2019.	4 Major	3 Possible	12 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Learning from other mental health SystmOne implementations (DS) (May 2019) ➢ Ensure training is transitioned to Business as usual and on-going training available (DS) (June 2019) ➢ Monitor system implementation post go live ➢ Continue to provide support through helpdesk, floor walkers and super users ➢ Monitor catch up of data and data completeness and quality (DS) (May 2019) ➢ Post implementation Review (DS) (May 2019) ➢ Develop optimisation plan and phase two of programme (DS) (May 2019) ➢ End of phase 1 project report (DS) (June 2019) ➢ Regular reports to EMT and Trust Board (DS). ➢ Risk management oversight through Audit Committee (DS) ➢ Ongoing monitoring of resources (DS) ➢ 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)	DS	31 May 2019	Monthly reports to PSG, Transformation Board, and Trust Board. Weekly status reports to EMT. Weekly cutover meetings with operational leads. Quarterly reports to CG&CS Committee and Audit Committee	6 Yellow / moderate (4-6)	AC	Risk appetite: Strategic risk 8 – 12 Links to BAF, SO3	Every three months prior to business and risk Trust Board – April 2019
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 – Cauti-ous / moder-ate (1 – 6)	➢The Trust leadership is developing productive partnerships with other organisations to develop joint bids and shared services in preparation for integration of services. (DFR / DS / 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 – April 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
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 – Cauti-ous / moder-ate (1 – 6)	➢Centralisation of Subject Access Requests staffing and consistent process. (DFR/DO) (June 2019) ➢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) ➢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 This has been delayed given the impact of the SystmOne implementation on capacity	Every three months prior to business and risk Trust Board – April 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. ➢Agreed governance structure, with meetings in place, with commissioners in relation to the monitoring and management out of area cessation plans.	3 Moderate	4 Likely	12 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢Implementation of pathway for supporting people with Emotionally Unstable Personality Disorder. This will be led by the newly appointed lead with a review in October 2019 (DO) ➢Engagement of SSG to work with internal leads to deliver the actions that arose from the independent assessment of plans and improvement opportunities (DO) (June 2019) ➢Development and implementation of local plans of change activity to reduce admissions and plans to reduce length of stay. (DO) ➢Development and implementation of local plans of change activity to reduce PICU bed usage. (DO) ➢Working with STP partners to review bed management across West Yorkshire. (DO) ➢Implementation of actions identified through independent review of our bed management processes (DO)	DO	October 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 – April 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)	➢Ongoing review with commissioners.to prioritise areas of expenditure (DFR) ➢Implementation of actions identified through independent review of our bed management processes (DO)	DO / DFR	Ongoing	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 – April 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)
1362	Risk the Trust is unable to fully implement the falsified medicines directive 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.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	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)
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)
1432 NEW RISK	Risk of problems with succession planning / talent management.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Yellow / Moderate (4-6)

Risks recommended for closure

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
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)	12 Amber / high (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 performanc e report)	4 Yellow /Moder ate (1-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6	N/A Recom -mend -ed for closure
1004	Risk that a decentralised model for health records results in inconsistent application of standards and / or loss of health records.	➢ Guidance issued through weekly comms not to destroy paper. ➢ IG and records staff supporting teams when asked. ➢ Guidance on document upload, paperlight, scanning, records retention and transporting records issued. ➢ Policies and procedures in place. ➢ Guide on "how to move records securely"	4 Major	1 Rare	4 Yellow / moder ate (4-6)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Data scanning implementation (ongoing programme) ➢ Data Quality Improvement Programme (ongoing)	DFR		ICIG EMT (monthly)	4 Yellow / moder ate (4-6)	AC	Risk appetite: Clinical risk risk target 1 – 6 Links to BAF, SO3	N/A Recom -mend -ed for closure (super-seded by BDU level risk ID 1149

Risk profile (risks outside the risk appetite) **– Trust Board 30 April 2019**

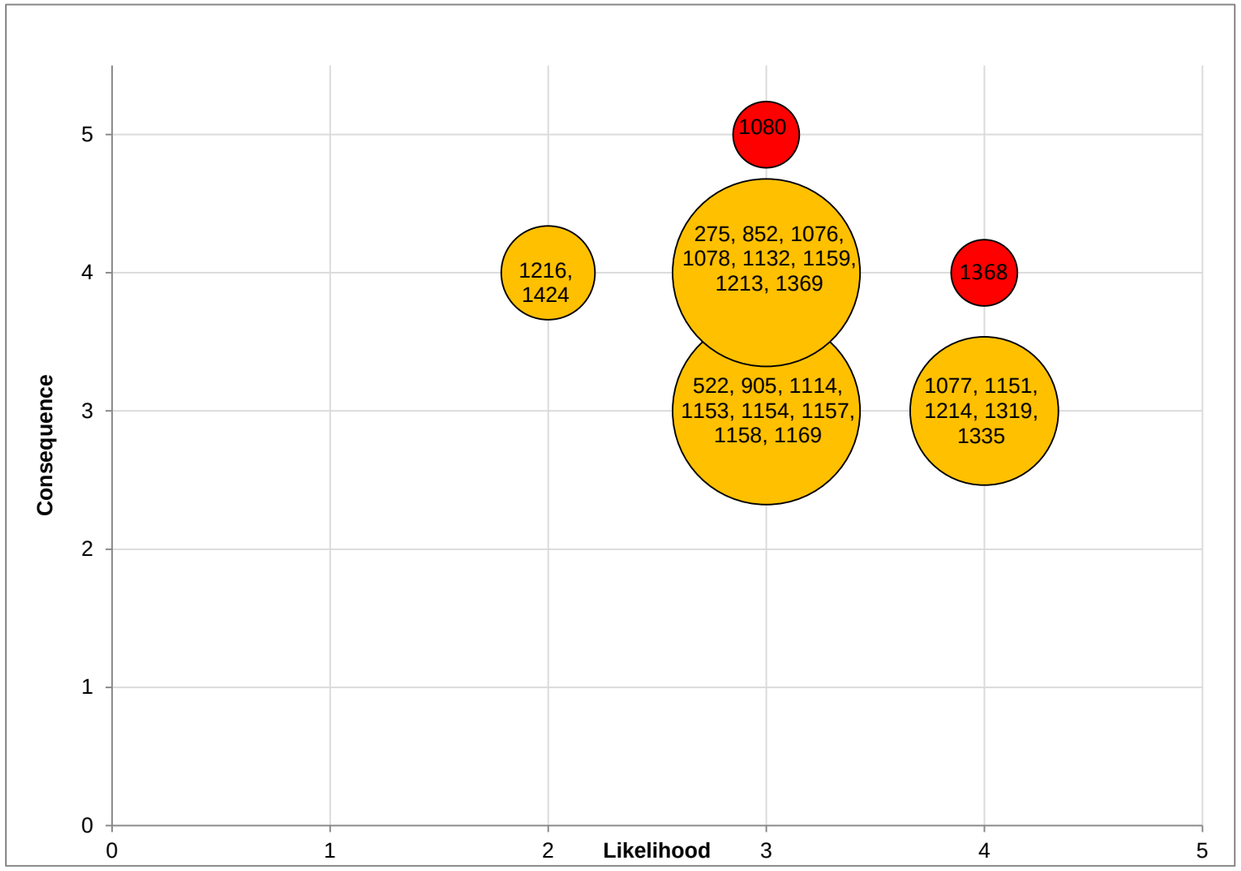
South West Yorkshire Partnership NHS Foundation Trust

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 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 serious harm occurring from known patient safety. risks (1424)	= 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 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 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), (1368), (1369), (1424)		
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		

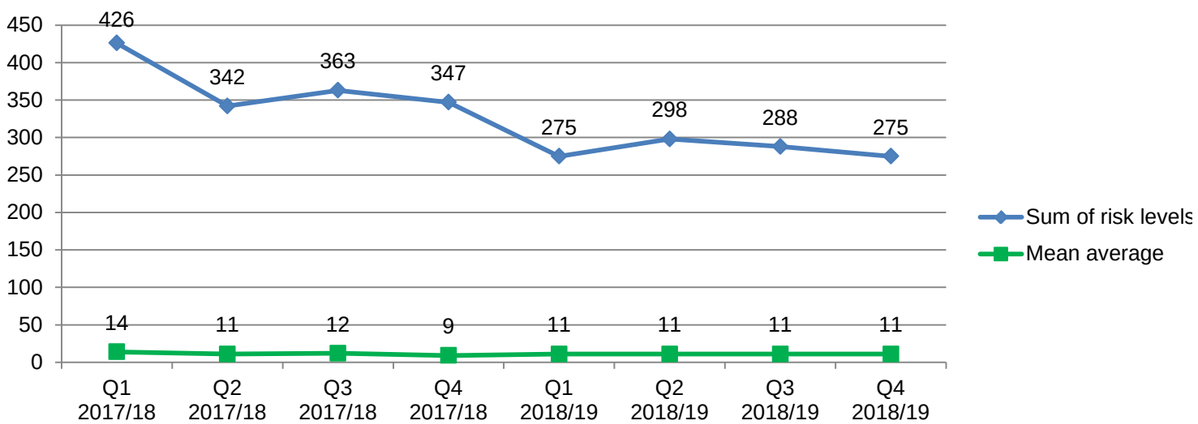
With **all of us** in mind.

Risk profile (risks outside risk appetite) **– Trust Board 30 April 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.
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.
8	1424	Risk of serious harm occurring from known patient safety. risks.

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)	**Q4** (25 risks)
14	**11**	**12**	**9**	**11**	**11**	**11**	**11**



Recording Risks: guidance on using the risk grading matrix

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Risk grading matrix

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possible y frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes.

4 Calculate the risk score, multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 7.2

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 March 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 (WY&H HCP). 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.

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

Trust Board 30 April 2019

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 also includes 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. The Partnerships priorities, ambitions and progress is set out in the 'Our Next Steps to Better Health and Care for Everyone' document.

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.

3. Update – Progress West Yorkshire and Harrogate Health and Care Partnership

3.1 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 March meeting include the following:

- The WY&H partnership provided a collective response to the letter from Baroness Harding and Julian Hartley regarding the national workforce strategy. The ICS is well placed and has responded to the forthcoming workforce strategy as significant

progress has already been made (*and was shared with Trust Board members at the last meeting)*

- Work to develop a draft 5-year ICS strategy is underway.
- Following the recent publication outlining proposals for legislative changes the Core Team are in the process of co-ordinating a response on behalf of the ICS. (*This will have been submitted by the time of the Board meeting and will be shared with Board members)*
- The new operating model for NHSI/E will become functional in April. The positive support that regulators continue to give to the partnership was acknowledged and it was hoped that this would continue.

3.2 Key updates from the ICS Programmes was received at the March SOAG meeting including:

- ***Mental Health***
  - A new Programme Director, Keir Shillaker, has been appointed and will commence in post in June 2019. Sara Munro CEO lead for the programme confirmed that the programme board will be reviewing CCG plans for compliance with the Mental Health Investment Standards. (*The review is now complete and the Trust is compliant)*
  - It was agreed that SOAG will also have a detailed look at the issue of shared system responsibility for suicide prevention. *(The Trust is leading on the suicide prevention programme.)*
- ***Primary and Community Care***
  - The ICS place visits have concluded and the programme team are reviewing the feedback and priorities in line with the NHS Long Term Plan (LTP). It was agreed that the check and confirm sessions would be a useful mechanism in understanding what needed to be undertaken at place. It was agreed that, in order to support the development of the WY&H primary care strategy it will be important to understand the impact of work going on in each place, and to establish a clear baseline of the number and scope of primary care networks that are being implemented. (*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 programme is looking at a broader set of objectives which will incorporate population health and health inequalities. The programme continues to make good progress particularly on reducing smoking rates, alcohol related admissions and on meeting trajectories for the diabetes prevention programme. *(The Trust provides Yorkshire Smoke Free Services and contributes to the system wide outcomes.)*
- ***Workforce***
  - The Local Workforce Action Board (LWAB) has agreed to invest in the development of a "Workforce Hub" which will provide greater support and dedicated project management.
  - Health Education England has further invested £1million to the WY&H LWAB to spend on transformation programmes. The LWAB are deciding on key system-wide strategic priorities and local place based priorities.

3.3 Review of System Performance and Delivery at the March SOAG Meeting

The financial position in respect of WY&H NHS organisations at M10 was acknowledged with no material change noted from the previous forecast at M9. Progress with financial planning for 2019/20 was discussed, including details of organisations which had not accepted their control totals and those which may require contract mediation. Subsequently all organisations have now accepted their control total except the Harrogate system that is receiving support from the ICS.

3.4 Performance Dashboard

The system dashboard has undergone significant development. It was agreed that it will be useful to focus on issues which show the greatest variation, and on a small number of 'obsessions' for both places and programmes. The partnership will need to consider how to resolve key obstacles to more effective use of data, the need for data sharing agreements, gaps in the availability of information, and business intelligence capacity.

3.5 NHS Long Term Plan and Partnership Plan Developments

An editorial group for the development of the Partnership's five year plan has met. This has been further discussed through the new Partnership Board. There is an expectation that all Integrated Care Systems will produce a five year plan by autumn 2019. There is really strong alignment between the Long Term Plan and the Partnership's regional ambitions, as set out in the 'Next Steps to Better Health and Care for Everyone' document (February 2018).

The WY&H Partnership Board will be involved in setting the parameters for and signing off the 5 year strategy. The five-year planning horizon will provide an opportunity to think more creatively about the future shape of services in WY&H, for example to:

- 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.
- 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.
- provide a clearer articulation of how the partnership will develop integrated health and care services for communities of 30-50,000 people, including primary care networks and population health management capability - and the benefits this will offer.
- think radically about some of the key enablers for change over a longer time horizon - including the workforce, digital technology and innovation.
- set out the end-state on structural changes, including integrated care partnerships, acute physical and mental health service collaboration, partnership commissioning at place and WY&H level, and oversight and mutual accountability (as set out in the partnership MoU).

The draft plan will be shared with Partners, the Partnership Board and stakeholders, such as HWB chairs and governing boards for their views ahead of publication in the autumn 2019.

3.5.1 *WY&H HCP Priority Programmes Refresh and 'Check and Confirm' Sessions*

The process of refreshing priority work programmes through Programme Board arrangements has commenced. These Programme Boards bring together relevant place and sector leads,

and will help ensure that there is a strong place and sector voice in the development of new ambitions. Programme Boards will return a first cut of the refreshed plans by 3 May 2019. These plans will be reviewed in 'check and confirm' sessions which will run between 14-28 May. The check and confirm sessions provide an opportunity for colleagues to discuss the ambitions of the partnership programmes and refresh them in response to the Long Term Plan and ensure that the right capacity, support and working arrangements are in place to deliver them.

Additional priorities will include a focus on children and young people and a broader scope for the prevention programme that includes a focus on health inequalities. *(The Trust is a key partner in the Mental Health, Autism and Learning Disabilities Programme and is leading on a number of programmes including suicide prevention, Forensics and Learning Disabilities New Models of Care. Feedback from the review will be received by the West Yorkshire Mental Health Services Collaborative Committees in Common that is now chaired by the Trust Chair Angela Monaghan)*

3.5.2 Engagement- Partnership 5 Year Plan Development

The Partnerships 5-year strategy will build on the extensive engagement that has been undertaken at place and WY&H level over recent years. As part of the process, NHS England has commissioned each local Healthwatch to undertake a piece of specific engagement work on the NHS Long Term plan, particularly focusing on "hearing the voices of the seldom heard". This will feed into the development of the Partnership's 5-year strategy. There are two questionnaires that people can fill in. One is a survey designed by local Healthwatch and the Partnership; the second has been produced by Healthwatch England and is aimed at people with long term health conditions. People can complete the surveys until 3 May 2019 via their local Healthwatch. *We will be promoting this through social media and our usual communications channels.*

A series of focus groups are also being planned in local areas. The focus of the discussions will be around digitisation, personalisation and relevant local long-term plan priorities. These will also be completed by 3 May. The intention is for Healthwatch to complete a report in June to share with Healthwatch England and the Partnership. This will continue the strong role of Healthwatch in the Partnership.

3.5.3 *NHSE/I Framework*

NHS England and NHS Improvement are working on an 'implementation framework' which will describe in more detail the requirements for 5-year strategies. The Partnership core team are feeding into national discussions about the design of this. Our understanding is that it will be an enabling framework and an accelerant of ICS working rather than a more prescriptive set of asks for each system. The framework will not be produced until after Easter. In line with the ambitions set out in the Long Term Plan ICSs will be more prominent and play a stronger role in regulation and oversight of system performance and development and will oversee and approve the partnership plan.

3.6 Supporting People with Learning Disabilities

The Leadership Group took part in a workshop on Tuesday 2 April 2019 that focused on supporting good health services for people with learning disabilities. This was coordinated by Change, a national human rights organisation led by disabled people, based in Leeds. They

employ people with learning disabilities as part of their core staff team. The session was led by people with learning disabilities. There has been a recent review of deaths of people with learning disabilities carried out by Public Health England and the Norah Fry Research Centre. They found that the life expectancy of people with learning disabilities is 19.7 years lower than those who do not have a learning disability. There was a consensus amongst leaders present that this is unacceptable and personal pledges were made to ensure that we work individually and collectively to address this inequality.

Following this workshop the ICS communications and engagement team are supporting the development of an approach and a proposal for an organisation to develop a cohort of health champions across West Yorkshire and Harrogate who can help shape improvements and change across organisations and programmes. (*The Trust has expressed interest in supporting this proposal and engaging with the selected organisation to support co-production of service improvements and engage with the work of the Learning Disability Operational Delivery Network that we are leading across the region)*

3.7 Looking out for our Neighbours Campaign

The first West Yorkshire and Harrogate Health and Care Partnership 'Looking out for our neighbours' campaign was launched on 15 March 2019. This campaign covers Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The campaign aims to tackle the impact of loneliness. The campaign has received significant publicity and support from diverse organisations across West Yorkshire and currently has the support of around 300 plus organisations including the Trust. Over 30, 000 campaign packs have been distributed across the region. Phase 2 of the campaign will be launched on 13 May 2019 'promoting positive experience', this will include collecting stories and sharing them and distributing campaign related materials across the region. There has been significant interest in the campaign from other Integrated Care Systems and places.

3.8 ICS Financial Framework 2019-20

The WY&H HCP CEO lead Rob Webster has written to all System Leaders to outline the details of the ICS financial framework including the system PSF scheme, transformation funding and ICS oversight. Integrated care systems are expected to take greater responsibilities for the collective improvement, performance and finances of the local health and care system. In return, we expect greater freedoms, financial flexibilities and up front resources. The Partnership CEO lead has been part of a group of ICS leaders working with the national team to develop the ICS financial framework for 2019/20.

The framework includes a package of proposals that are consistent with the ambitions of the ICS:

- A proposition whereby if the Integrated Care System agrees to link a proportion (minimum 15%) of Provider Sustainability Funding (PSF) to delivery of a system control total, they will receive a pot of local transformation funding. This is expected to be at the same level as 2018/19, £8.75m.
- Greater local control of the national transformation funding that we expect to receive in 2019/20. It is estimated that around £100m of funding earmarked for specific programmes will be available for Integrated Care Systems. Based on our population size as one of the largest, we would expect a significant share in the region of £15-£20m.

- An automatic right to PSF for all organisations if the overall control total is achieved each quarter, without recourse to the regulators to agree variances.
- Automatic right to access any incentive schemes that become available, although these are not anticipated in 2019/20.
- Further movement towards the next stage as a fully mature ICS.

Directors of finance have been working through the framework, and have provided a recommendation for the Partnership to consider. *The Trust has agreed to the proposition via Chair's action due to the deadlines involved. Details of any risks and benefits for the Trust are included in the finance report. The commercial nature of these means the detail is covered in the private section of the Board for members to consider.*

3.9 West Yorkshire & Harrogate Mental health 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 and the new Long Term Plan. The Committee is attended by chairs and chief executives and has oversight of the programmes and work delivered through the mental health, learning disabilities and autism programme board. The Minutes from the most recent meeting are available for Trust Board members (Assurance from Trust Board Committees section). The Trust Chair Angela Monaghan will formally be chairing the committee moving forward.

3.9.1 Mental Health Learning Disabilities and Autism Programme update

Progress is being made against all programmes as reported through the Trust Integrated Performance Report (IPR) and through the Committee in Common for Mental Health Providers. Key developments to note include:

3.9.2 Individual Placement Support (IPS)

The expansion of IPS services to support people with mental health issues to find and retain employment is part of NHS England's objective to double access to IPS by 2020/21. The Trust's business development team coordinated the bid for wave 2 funding on behalf of the ICS. Areas included in the bid were Calderdale, Harrogate and Leeds. Kirklees and Wakefield commissioners did not express and interest in being part of the ICS bid due to existing employment provision in these areas. The bid was successful and the Calderdale Vocational team will benefit from an additional IPS post (£208k funding over 2 years)

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 at 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 have completed the formal training and developing insights to better understand the challenges to increasing activity with a wide range of residents across Calderdale. 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 and Mental Health Alliance

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. The Mental Health Alliance has worked together to agree the priorities for 2019/20 in line with the MH investment standard, and agreed significant investment for example in CAMHS, crisis pathways and all age psychiatric liaison services, all of which are also priorities for the Trust.

Wakefield Primary Care Networks - The Trust's Director of Provider Development is the SRO for this programme (on behalf of the NMoC Board). There will be seven PCHs in Wakefield. The Trust's service offer in Wakefield is being aligned to the primary care networks, and the lessons from this work (plus the equivalent work in Barnsley) will help shape the Trust's place based service configuration going forward.

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 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 Executive Partnership Group and have been supported. Further engagement has taken place with key strategic leads across the system to clarify and develop the engagement plan, governance arrangements and scope that should include a focus on prevention and links to Primary Care Networks as they develop. As the proposals for an Alliance are developed and co-produced with partners in Kirklees 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**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 8.1

Title:	**Integrated Performance Report Month 12 2018-19**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for March 2019.
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** ➢ Positive CQUIN performance in the year with circa 98% achieved ➢ Excellent performance on friends & family test with mental health scoring 95% and community services 99%. ➢ Safer staffing fill rate of 118% but significant staffing challenges remain in response to increased acuity. ➢ Total number of reported incidents remains in line with recent trend and the expected range. ➢ An increase in the number of falls has been reported given service user acuity and complexity. Increased observations and staffing being put in place. **NHSI Indicators** ➢ Limited national metric data currently available for March given the impact of SystmOne implementation. Most data expected to be available by early May. ➢ 4 days occupied by 1 young person in adult wards. ➢ All IAPT targets have been met. **Locality** ➢ Focus being applied to the use of un-commissioned neuro rehab beds with a marketing day planned for May. ➢ The Barnsley inpatient advocacy forum has supported a project run by the European court of human rights aiming to develop an information booklet on mental health rights for all patients on acute wards. Barnsley was the only unit nationwide to support the project to come to an inpatient facility and to facilitate engagement with the inpatient user group in this way. Service users gave their opinion on how the information could be made bolder, clearer and simpler, and have been told how this information will be used in moving forward with the development of the booklet. Service users provided positive feedback on this initiative.

	➢ Ward 18 garden area reviewed for overall safety and new anti-ligature, anti-climbing and netting. Further anti ligature work is being undertaken. ➢ Regional forensic child and adolescent mental health service underwent a service review as part of programmed reviews of all pilot sites. ➢ Adult community medical vacancies and gaps continue to be a pressure in Wakefield leading to financial and clinical continuity challenges. ➢ A review of the CAMHS service has recently taken place by the national intensive support team (IST). Feedback is expected on 29 April. ➢ Flu campaign won a national flu fighter award for the most innovative comms. **Priority Programmes** ➢ Work has commenced on implementing the work streams agreed as part of the recommendations made in the independent SSG report in relation to improving the out of area beds position. ➢ The use of SystmOne for mental health is becoming more embedded in daily operations. Focus remains on data catch up and support to users. ➢ Work continues on developing the stroke pathway with Barnsley hospital and the CCG, with particular focus on the model, activity and finances. **Finance** ➢ Pre Provider Sustainability Funding (PSF) deficit in for 2018/19 of £1.6m compared to the revised plan of £2.0m. ➢ Since the finance report was produced correspondence has been shared by NHS Improvement indicating the draft value of provider sustainability funding for 2018/19 is £4.7m, which is £2m higher than the previous forecast and £1.6m higher than expected. ➢ Included in the February position it non-recurrent income of £0.35m for out of area bed usage from Calderdale CCG. ➢ The cumulative position is £0.5m favourable to plan and includes a significant saving in capital charges (£1.4m) from a revised calculation for asset valuations, as well as one-off asset disposal gains of £0.5m and non-recurrent income support of £1.3m. ➢ Expenditure on out of area beds of £355k takes the cumulative spend to £3.9m. ➢ Cumulatively net savings on pay amount to £0.2m. Inpatient ward costs are overspent by £2.4m for the full year. ➢ Agency staffing costs were £0.6m in month, and £6.5m for the full year, which is £1.2m higher than our cap and £0.7m above last year. ➢ CIP delivery of £10.6m is £0.9m above plan with performance

	boosted by the reduction in capital charges. ➢ The cash balance remains in relative health at £27.8m. **Workforce** ➢ Sickness absence reduced to 4.6% in March and to 5.0% for the full year. This compares favourably to 2017/18 when the full year rate was 5.2%. ➢ All mandatory training targets have been achieved. ➢ Staff turnover reduced year on year from 12.6% to 11.9%.
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

March 2019

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for March 2019. 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 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. Further review has taken place in readiness for 2019/20 and these updates will be reflected in the report covering April 2019.

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.

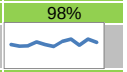
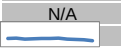
The Trust's three strategic objectives are:
• Improving health
• Improving care
• Improving resources
•The report for 2019/20 will be updated to reflect the addition of a fourth objective - 'making SWYPFT a great place to work'

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• 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.

The Trust went live successfully with SystmOne for mental health during February and March. This has resulted in delays to some information being available and there is increased requirement for data quality checking. As such a number of metrics are not included in this report for March. It is currently expected that the majority of infomation will be available early May.

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	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Year End Position
Single Oversight Framework metric	2	2	2	2	2	2	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Improve people's health and reduce inequalities	**Target**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Year End Forecast**
Total number of children & young people in adult inpatient wards [5]	0	1	0	3	3	1	2	2	3	1	1	1	1	1
% service users followed up within 7 days of discharge	95%	94.3%	99.2%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100%	99.2%	Due May 19	4
% clients in settled accommodation	*60%*	78.9%	78.5%	79.1%	78.7%	78.8%	79.0%	78.5%	78.2%	78.5%	*78.0%*	*78.2%*	Due May 19	4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]	95%		86.7%			84.6%			84.2%			82.8%		95%
Out of area beds [2]	Q1 940, Q2 846, Q3 752, Q4 658	531	282	368	436	589	384	165	360	317	343	184	164	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%	83.3%	83.2%	Due May 19	4
Inpatient [9]			89.1%	90.6%	93.3%	91.2%	90.1%	91.0%	92.5%	95.3%	97.4%	96.6%	90.2%	4
Smoking Cessation - 4 week quit rate [8]	tbc		63%			65%			63%			Due July 19		N/A
Improve the quality and experience of care	**Target**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Year End Position**
Friends and Family Test - Mental Health	85%	86%	75%	82%	88%	91%	88%	89%	86%	90%	87%	84%	95%	85%
Friends and Family Test - Community	98%	97%	100%	98%	99%	97%	98%	100%	97%	99%	97%	98%	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	23	19	20	30	23	18	31	37	21	37	29	36	
Safer staff fill rates	90%	118%	120%	118%	118%	117%	116%	116%	119%	118%	119%	119%	118%	100%
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	8	11	14	16	14	15	14	20	11	10	13	9	
% people dying in a place of their choosing	80%	82.8%	88.5%	92.9%	85.7%	90.0%	89.2%	90.9%	83.3%	87.9%	80.0%	92.0%	82.6%	N/A
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic [7]	trend monitor		15.1%			14.1%			13.0%			Due May 19		N/A
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [3]	trend monitor	38.1%	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	Due May 19	
Improve the use of resources	**Target**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Year End Position**
Projected CQUIN Shortfall	£4.2m	-	£160k	£252k	£379k	£379k	£261k	£204k	£204k	£204k	£204k	£204k	£134k	£134k
Surplus/(Deficit)	In line with Plan	(£292k)	(£204k)	(£464k)	(£125k)	(£139k)	£424k	(£73k)	(£80k)	£158k	£714k	(£244k)	(£1240k)	(£15644k)
Agency spend	In line with Plan	£444k	£538k	£484k	£526k	£575k	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£6.5m
CIP delivery	£1074k	£619k	£1308k	£1981k	£2737k	£3615k	£4452k	£5234k	£6015k	£6779k	£8764k	£9669k	£10574k	£10.6m
Sickness absence	4.5%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	5.0%
Aggression Management training	>=80%	79.3%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	81.7%	81.7%
Moving and Handling training	>=80%	85.2%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	90.5%	90.5%
Staff Turnover [6]	10%	9.7%	8.5%	11.6%	12.4%	13.0%	12.8%	12.5%	12.3%	12.0%	12.0%	12.0%	11.9%	11.9%

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
• Positive CQUIN performance in the year with circa 98% achieved
• Excellent performance on friends & family test with mental health scoring 95% and community services 99%
• Safer staffing fill rate of 118% but significant staffing challenges remain in response to increased acuity
• Total number of reported incidents remains in line with recent trend and the expected range
• An increase in the number of falls has been reported given service user acuity and complexity. Increased observations and staffing being put in place

NHSI Indicators
• Limited national metric data currently available for March given the impact of SystmOne implementation. Most data expected to be available by early May
• 4 dayas occupied by 1 young person in adult wards
• All IAPT targets have been met

Locality
• Focus being applied to the use of un-commissioned neuro rehab beds with a marketing day planned for May
• The Barnsley inpatient advocacy forum has supported a project run by the European court of human rights aiming to develop an information booklet on mental health rights for all patients on acute wards. Barnsley was the only unit nationwide to support the project to come to an inpatient facility and to facilitate engagement with the inpatient user group in this way. Service users gave their opinion on how the information could be made bolder, clearer and simpler, and have been told how this information will be used in moving forward with the development of the booklet. Service users provided positive feedback on this initiative
• Ward 18 garden area reviewed for overall safety and new anti-ligature, anti-climbing and netting. Further anti ligature work is being undertaken.
• Regional forensic child and adolescent mental health service underwent a service review as part of programmed reviews of all pilot sites.
• Adult community medical vacancies and gaps continue to be a pressure in Wakefield leading to financial and clinical continuity challenges.
• A review of the CAMHS service has recently taken place by the national intensive support team (IST). Feedback is expected on April 29th.
• Flu campaign won a national flu fighter awards for the most innovative comms

Priority Programmes
• Work has commenced on implementing the work streams agreed as part of the recommendations made in the independent SSG report in relation to improving the out of area beds position
• The use of SystmOne for mental health is becoming more embedded in daily operations. Focus remains on data catch up and support to users
• Work continues on developing the stroke pathway with Barnsley hospital and the CCG, with particular focus on the model, activity and finances

Finance
• Pre Provider Sustainability Funding (PSF) deficit in for 2018/19 of £1.6m compared to the revised plan of £2.0m.
• Since the finance report was produced correspondence has been shared by NHS Improvement indicating the draft value of provider sustainability funding for 2018/19 is £4.7m, which is £2m higher than the previous forecast and £1.6m higher than expected.
• Included in the February position it non-recurrent income of £0.35m for out of area bed usage from Calderdale CCG.
• The cumulative position is £0.5m favourable to plan and includes a significant saving in capital charges (£1.4) from a revised calculation for asset valuations, as well as one-off asset disposal gains of £0.5m and non-recurrent income support of £1.3m
• Expenditure on out of area beds of £355k takes the cumulative spend to £3.9m
• Cumulatively net savings on pay amount to £0.2m. Inpatient ward costs are overspent by £2.4m for the full year
• Agency staffing costs were £0.6m in month, and £6.5m for the full year, which is £1.2m higher than our cap and £0.7m above last year
• CIP delivery of £10.6m is £0.9m above plan with performance boosted by the reduction in capital charges.
• The cash balance remains in relative health at £27.8m
• Contracts for 19/20 with CCGs agreed and signed. Contract with specialist commissioning agreed and will be signed

Workforce
• Sickness absence reduced to 4.6% in March and to 5.0% for the full year. This compares favourably to 2017/18 when the full year rate was 5.2%
• All mandatory training targets have been achieved

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 2018-19.

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	Jan-19	Feb-19	Mar-19	Year End Position
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	Reporting commenced April 18				38.1%	39.8%	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	Due May 19	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	22% 2/9	25% 3/12	Due May 19	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	25% 3/12	10% 1/10	Due May 19	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%	87%	84%	95%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	98%	98%	98%	97%	100%	98%	99%	97%	98%	100%	97%	99%	97%	98%	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	N/A	75%	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	N/A	65%	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	49	10	Due May 19	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	20	25	*57*	Due May 19	N/A
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	N/A	26				0	1	*1*	*1*	2	*2*	*1*	1	2	0	*0*		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	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%	*87.5%*	Due May 19	Due May 19	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%	2.3%	2.4%	Due May 19	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	10	13	9	
	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%	1.8%	1.6%	1.6%	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%	89.3%	*84.6%* **	Data avail May 19	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%	92.9%	*76.4%* **		N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	2849	3065	2962	3441	1074	1090	1039	1168	1004	862	1085	1108	986	1099	1042	1079	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	21	13	15	22	21	13	21	28	18	25	20	25	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	5	1	1	1	4	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	5	4	4	2	2	5	4	2	11	8	7	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%	23.5%	13.9%	17.7%	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%	119%	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%	98.7%	97.5%	96.5%	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	30	30	44	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	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	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%	82.4%	80.6%	88.0%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	139	139	150	181	40	40	44	43	37	52	40	41	49	39	48	59	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	165	168	207	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	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	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%	87.6%	82.8%			83.7%			82.5%			84.9%			4

Quality Headlines

** See key included in glossary*
Figures in italics are not finalised
*** - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystmOne implementation impacting on reported performance.*

1 - Attributable - A pressure ulcer (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 eg 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.

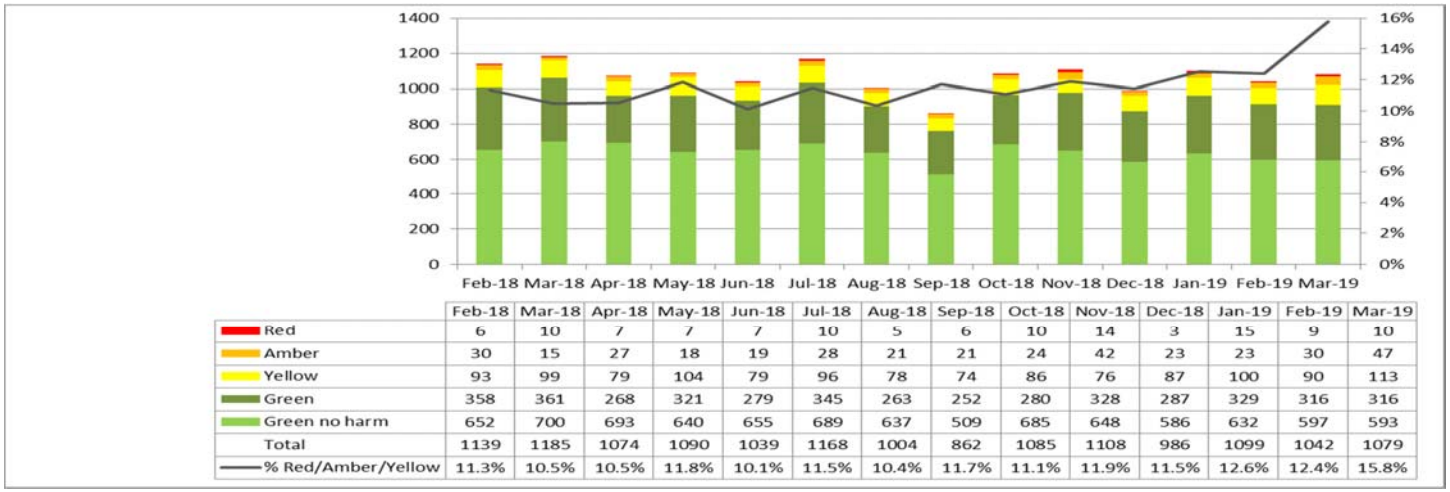
Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

- Number of restraint incidents - the number of restraint incidents during March has increased compared to previous months, please see below headline related to reducing restrictive physical intervention, which gives more detail.
- NHS Safety Thermometer - medicines omissions – performance continues to be sustained in March compared to previous months and stands at 17.7% for March. This 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 and overall there has been a reduction of 9%. However, the mental health safety thermometer's national data has shown that the Trust has been an outlier when benchmarked. Over the last month, there has been a focus for improvement on medicines omissions at all levels of the organisation. Wards and pharmacy teams have been working closely together on the causes and solutions to include in everyday practice. Some wards have included medicines omissions in safety crosses and others are reviewing each day. A "medicines refused? Refer to pharmacy" campaign was started during February. Ward breakdowns have also been provided giving more information to operational services. As we have previously reported, long-term plans include the procurement of Electronic Prescribing & Medicines Administration (EPMA) system which will prevent omissions.
- Number of falls (inpatients) - March has seen a further increase in fall incidents during the month compared to previous months; this was attributed to increases in Wakefield, Barnsley and Kirklees and was predominantly due to an increase in service users with high acuity high and as such increased levels of observations being put into place to mitigate the risk. Staffing has been increased as a result of the acuity and falls risks which is reflective of the current service user group awaiting longer term placements.
- % 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



	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Red	6	10	7	7	7	10	5	6	10	14	3	15	9	10
Amber	30	15	27	18	19	28	21	21	24	42	23	23	30	47
Yellow	93	99	79	104	79	96	78	74	86	76	87	100	90	113
Green	358	361	268	321	279	345	263	252	280	328	287	329	316	316
Green no harm	652	700	693	640	655	689	637	509	685	648	586	632	597	593
Total	1139	1185	1074	1090	1039	1168	1004	862	1085	1108	986	1099	1042	1079
% Red/Amber/Yellow	11.3%	10.5%	10.5%	11.8%	10.1%	11.5%	10.4%	11.7%	11.1%	11.9%	11.5%	12.6%	12.4%	15.8%

** 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 2018/19

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Death - cause of death unknown/ unexplained/ awaiting confirmation	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Informal patient absent without leave	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Information disclosed in error	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	1
Lost or stolen hardware	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Lost or stolen paperwork	0	0	1	1	0	0	0	0	0	0	0	1	0	1	0	0	2
Self harm (actual harm) with suicidal intent	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1
Suicide (incl apparent) - community team care - current episode	12	4	3	4	6	3	3	1	3	0	2	1	0	2	1	1	23
Suicide (incl apparent) - community team care - discharged	2	2	1	0	2	0	0	0	0	2	0	1	0	0	0	0	5
Suicide (incl apparent) - inpatient care - current episode	1	0	0	1	0	0	1	0	0	0	0	0	0	1	0	0	2
Unwell/Illness	0	0	1	1	0	0	0	0	0	0	0	1	0	0	0	1	2
Physical violence (contact made) against staff by patient	0	1	0	1	0	0	0	0	0	1	0	0	0	1	0	0	2
Pressure Ulcer - Category 3	2	1	1	0	0	0	2	0	0	1	1	0	0	0	0	0	4
Total	18	8	9	10	8	4	6	1	3	4	5	4	0	6	2	2	45

• 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 Mar 2019
• Patient safety alerts not completed by deadline of Mar 2019 - None

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
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.

Mortality
A new clinical mortality review group was held on 29/3/19 which focussed on learning and action from outcomes from learning from deaths reviews, including serious incidents, structured judgement reviews and other investigations. A further group will be held in June to continue this work.
Regional work: A meeting took place 5 April 2019 with the Northern Alliance. Looked at themes, and deaths from choking were discussed. Further work to be carried out internally and regionally. Next meeting July.
Training: Further Structured Judgement Reviewer (STR) training is being arranged for July and December.
Reporting: The Trust's Learning from Healthcare Deaths information is 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

Safer Staffing

Overall Fill Rates: 118%
Registered fill rate: (day + night) 96.5%
Non Registered fill rate: (day + night) 138.5%

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

BDU Fill rates - January 19 - March 19

Overall Fill Rate	Month-Year		
Unit	Jan-19	Feb-19	Mar-19
Specialist Services	180%	156%	103%
Barnsley	121%	123%	122%
C & K	109%	109%	108%
Forensic	116%	114%	115%
Wakefield	130%	135%	140%
Overall Shift Fill Rate	**119%**	**119%**	**118%**

The figures (%) for March 2019:
Registered Staff: Days 89.4% (an increase of 0.2% on the previous month); Nights 103.6% (a decrease of 2.3% on the previous month)
Registered average fill rate: Days and nights 96.5% (a decrease of 1% on the previous month)
Non Registered Staff: Days 135.1% (a decrease of 4.4 on the previous month); Nights 142.0% (an increase of 0.6% on the previous month)
Non Registered average fill rate: Days and nights 138.5% (a decrease of 1.9% on the previous month)
Overall average fill rate all staff: 118.1% (a decrease of 1.1% on the previous month)
Overall fill rates for staff for the all inpatient areas remain at 90% or above apart from Enfield Down (88.7%) which is at the end of a process to alter their establishment template.

Summary
One ward has fallen below the 90% overall fill rate. Enfield Down is currently completing a roster template change process which will give a more realistic picture going forward. Of the 31 inpatient areas 26, an increase of two on the previous month, (83.2%) achieved greater than 100%. Indeed of these 26 areas, 10 achieved greater than 120% fill rate. This was three less than the previous month.
Registered On Days (Trust Total 89.4%)
The number of wards that have failed to achieve 80% remained consistent at five (16%) on the previous month. All five wards were within the Forensic BDU (Chippendale, Priestley, Hepworth, Appleton and Johnson). There were various factors sited including vacancies, sickness and supporting acuity across the BDU.
Registered On Nights (Trust Total 103.6%)
Only one ward has fallen below the 80% threshold. This was Sandal ward within the Forensic BDU (79.4%). The number of wards who are achieving 100% and above fill rate on nights remained at 20 wards (64%) from the previous month.
Average fill rates for most areas were relatively stable. Barnsley BDU decreased by 1% to 122%. Calderdale and Kirklees BDU decreased by 1% to 108%. Forensic BDU were 115% a decrease of 1%. Wakefield BDU increased by 5% to 140%. Specialist services were 103% a decrease of 53% which was in line with an adjustment to their establishment template due to the care packages that were being delivered. 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

A decrease in the number of confidentiality related information governance breaches was seen during March 19 with 9 breaches reported. This is just above the Trust's local threshold of 8 but is an improvement on previous months reported during 18/19. The breakdown of the nature of the incidents is as follows:

6 counts of information disclosed in error, 2 incidents relating to patient healthcare record issues, 1 incident relating to data/information lost in transit.

No incidents were reported to the information commissioner's office.

Commissioning for Quality and Innovation (CQUIN)

Services continue to work towards the requirements for 18/19 and are now completing the final year end requirements which are due to be submitted to the commissioner at the end of April.

All CQUINs for 2018/19 have a RAG rating of green with the exception of:

• Cardio metabolic assessment and treatment for patients with psychoses - The early intervention in psychosis (EIP) element of this indicator had been rated as amber based on the 17/18 results. The Trust have their local results of the audit now and this does show some under performance against the BMI reduction element for the EIP indicator.
Other indicators that were identified as areas of risk were as follows, however, we are now forecasting these to be achieved:
• NHS staff health and wellbeing – risk in achievement was 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 and these have been successfully achieved at year end..
• Flu vaccinations - the Trust exceeded the 75% threshold and therefore achieved all income associated with this indicator.
• 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 Trusts recent forecast as part of a review of the quarter 4 submissions shows a risk in acheivement of £134k for the full year. The final position will be confirmed once commissioners have reviewed our quarter 4 submissions.

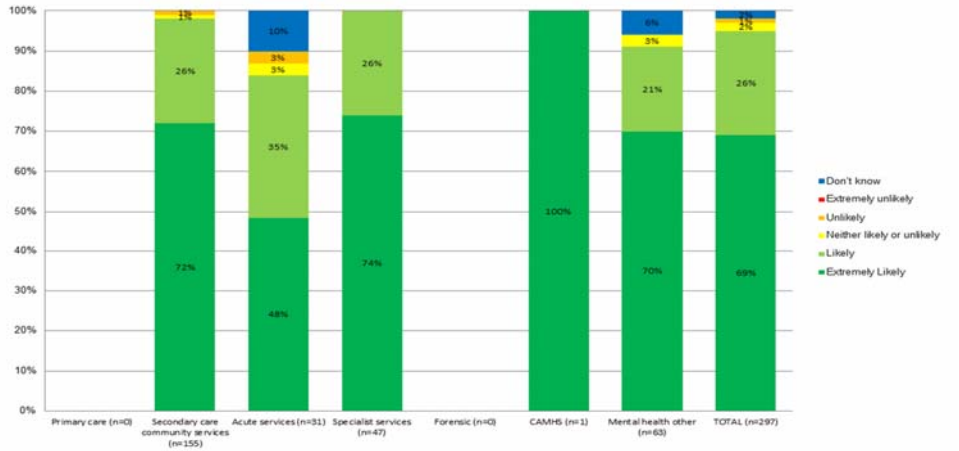
The 19/20 national CQUIN schemes have been recently published, the Trust is working with its commissioners to agree the applicable indicators for each contract. The rules state there must be a maximum of 5 indicators per contract, overall value of the scheme as reduced to 1.25% of contract value.

Patient Experience

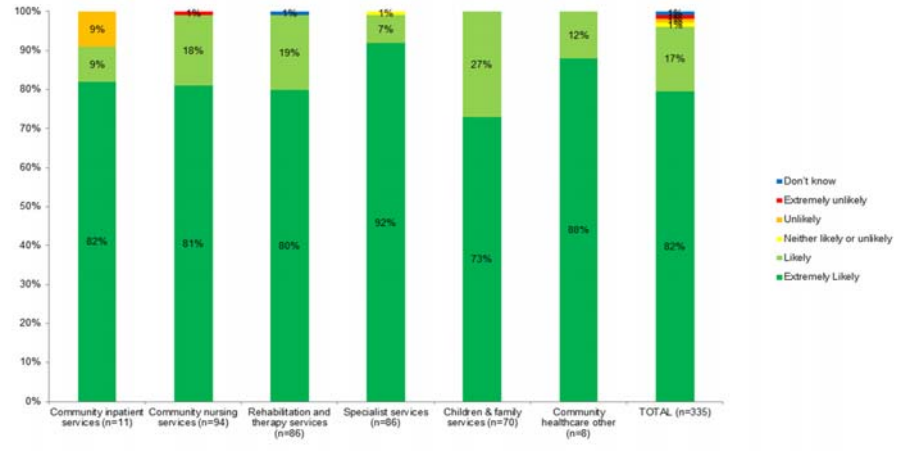
Friends and family test shows

- Community Services – 99% would recommend community services.
- Mental Health Services – 95% would recommend mental health services.
- Significant variance across the services in the numbers extremely likely to recommend the Trust – between 48% in acute services and 100% in child and adolescent mental health services
- Small numbers stating they were extremely unlikely to recommend.

Mental Health Services



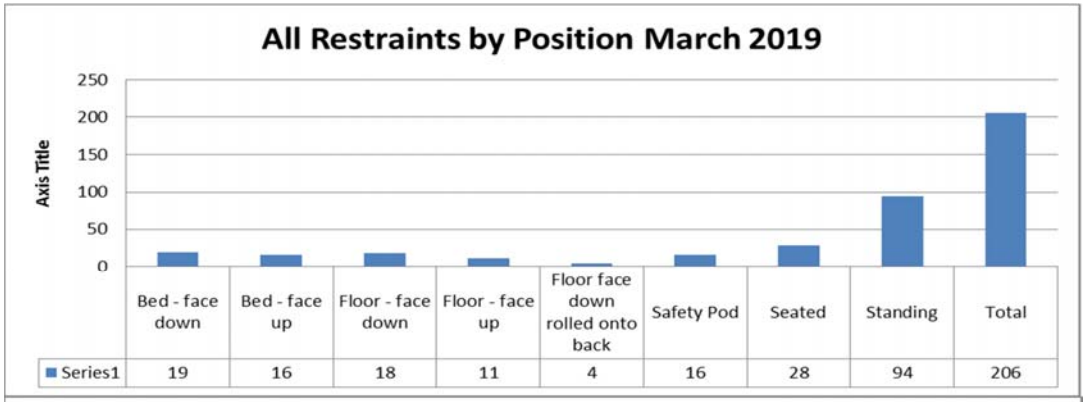
Community Services

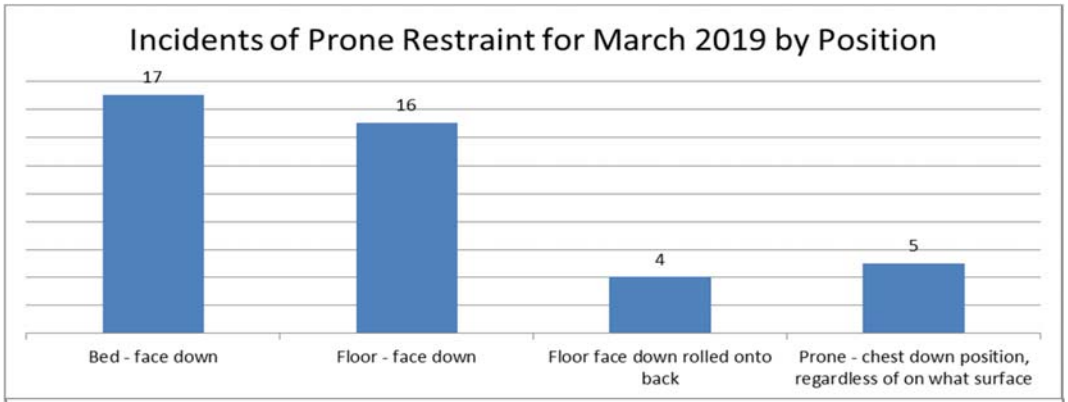


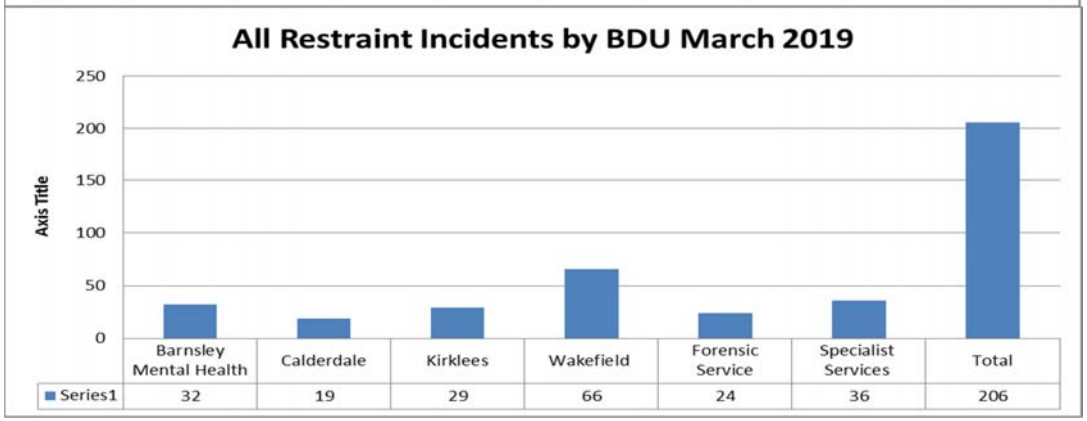
Returns from secondary care community services and CAMHS were low in March due to the Appointment Reminder / FFT text messaging service being offline as part of the transition from RiO to SystmOne. The system is due to recommence in April 2019.

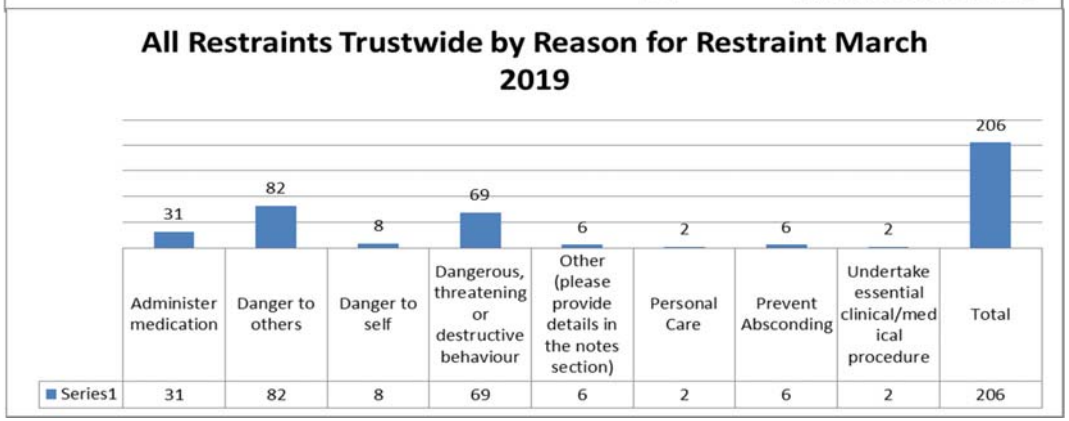
Reducing Restrictive Physical Intervention

There were 207 restraints reported in March this being a 23% increase on the February figures that stood at 168. The highest proportion of all restraints again was in the standing position 94 which equates to 45.5% of all incidents of restraint. Seated restraints stood at 28 that equates to 13.5% of all incidents of restraint. In relation to incidents of that would be deemed prone restraint, there was a 35% increase of prone restraint use in March (42) as opposed to February (31). There was an 80% increase in restraints face down on floor from February (10) to March (18). The use of prone restraint on beds saw a 35. 5% increase from February (14) as opposed to March (19).
The 42 incidents of prone restraint involved 35 individual service users. Of these 42 incidents reasons given for this positions use were 10 to facilitate a safe seclusion exit, 18 to facilitate the administration of I.M medication, 7 due to the level of aggression displayed, 5 were rolled out of the prone position asap, 1 to facilitate a search of person and 1 no reason given.
The reducing restrictive physical intervention team as always continue during training to place all the emphasis on non-physical interventions 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 90% of prone restraints being under 3 minutes is discussed at length and the importance of striving to maintain this is strongly emphasised. In March 88% of Prone Restraints lasted under 3 minutes









During March Wakefield BDU had the highest number for all types of incidents of restraint Trustwide and also had the highest number of all incidents of what would be identified as prone restraints Trustwide. Within the Wakefield BDU the highest incidents occurred on Walton which being a PICU one would expect high acuity.

Care Quality Commission (CQC)

CQC Inspection
The CQC have announced dates for our 2019 inspection. They have informed the Trust that they intend to undertake our well led assessment on 11th & 12th June and a desk top review of incidents, safeguarding and customer service processes on 8th & 9th May along with several focus groups.
Core service visits are expected imminently. Preparation events are planned across the Trust and intranet pages updated with a toolkit of resources.

CQC action plan update
An event was held in March 2019 to review outstanding actions from the CQC action plan. At the time of the meeting a number of actions were identified as amber/red. Following the meeting, specific focus has been targeted on these areas and the number of actions rated as red/amber has reduced.

Through discussions at the event it was acknowledged that some of the actions required proved a challenge due to the complex nature of the task. Although some of the actions have not been completed within the 2018/19 financial year, we are focussed on completing the remaining actions within one year of the CQC report; 30th June 2019.

Updates received for March 19 are included in the table below.

	Progress at 31.3.19	
	MUST (n =18)	SHOULD (n=47)
Blue	8 (44%)	38 (81%)
Green	8 (44%)	6 (13%)
Green Amber	0 (0%)	0 (0%)
Amber Red	2 (11%)	3 (6%)
Red	0 (0%)	0 (0%)
Total	18	47

Blue – Action completed. Green – On-target to deliver actions within agreed timeframes. Green /Amber – 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

The actions that remain off track are:
Must do:
CAMHS : The Trust MUST ensure that all community environments are assessed, reviewed and secured so that they provide the appropriate level of security for the service being delivered
CAMHS: The Trust MUST ensure that staffing issues around the out of hours on call service are monitored, reviewed and resolved

Should do:
CAMHS: The Trust SHOULD ensure that the lone working policy clearly identifies how staff are to keep themselves safe when lone working. Where lone working devices are used, the Trust should ensure that action is taken to monitor and improve compliance. Where staff have no device robust local measures should be implemented
CAMHS: The Trust SHOULD ensure that effective governance processes are implemented to monitor, review and improve systems and processes within the service
Acute wards & PICU: The Trust SHOULD ensure that discharge planning meets the requirements of the Trusts policy and evidences the involvement of the patient, their carer's and other professionals.

CAMHS service have been requested to provide a deep dive into their actions and advise which areas of the plan and which locality, require intensive intervention prior to the pending CQC visit.

In summary:
71% of all actions are complete, 22% are making good progress and 7% are not making the progress we would have expected but will be complete within one year of CQC report. For those actions that have been completed, it needs to be acknowledged that due to the timing of the impending inspection, some actions may not be fully embedded in practice and the benefits might not be fully realised.

Safeguarding

Safeguarding children's activity March 2019
- Named nurse safeguarding children attended learning event in Cumbria to represent SWYPFT as part of a Child Safeguarding Practice review (CSPR)
- Named nurse safeguarding children attended Rapid review response to the suicide of two young people
- The safeguarding team hosted a safeguarding conference, with external speakers; the conference was attended by SWYPFT staff and representatives from partner agencies.
- Safeguarding team facilitated the SWYPFT Safeguarding link practitioner's forum.
- Safeguarding children nurse advisor has participated in the development if an information sharing pathway between SWYPFT and Locala (school nursing and health visiting)
- Named nurse safeguarding children attended the Kirklees safeguarding adults board development day on behalf of the safeguarding adults specialist advisor.

Safeguarding adult activity March 2019
- Bespoke training was delivered on site to the workforce of the equipment / aids and adaptations service, this was positively received
- The specialist safeguarding advisor supported the safeguarding link forum; the named nurse for safeguarding children delivered a presentation on sexual safety and the specialist adviser updated on relevant policies and sexual safety leaflet
- The safeguarding team are in the process of updating the domestic abuse strategy
- The safe to go home project was promoted on the safeguarding stall at the Trust safeguarding conference and will go wider for invite to a task and finish project / pilot
- The safeguarding adults advisor post had been advertised, positive response and interviewing on the 10th April

Infection Prevention Control (IPC)

• Infection prevention and control annual programme 2018-19 has been completed, all objectives achieved, annual plan 2019-20, which includes the annual audits was approved at infection prevention and control task and finish group.
• Surveillance: there has been no MRSA bacteraemia, cIostridium difficile, or any other alert organisms, trust wide.
• Q4 - Wakefield - 5, Barnsley (mental health and community) - 4, Forensics - 2, Calderdale/Kirklees – 6, Specialist Services - 0 and Corporate Support Services - 0.
• Incident breakdown – 4 sharp related incidents, 1 sharp related not needle stick, 2 disposal of sharp, 2 inappropriate disposal of clinical waste, 2 outbreak/outbreak restrictions in place, 2 faeces, 3 ward cleanliness and 1 spit.
• Severity rating – 13 incidents were risk rated green and 4 yellow.
• Mandatory training figures are healthy:
Hand Hygiene-Trust wide total – 92%; Infection Prevention and Control- Trust wide total – 89%
• Policies and procedures are up to date.

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.
• Due to the requirements of staff to support the SystmOne go live, not all performance data is available this month at the time of report submission.

NHS Improvement - Single Oversight Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1 18/19	Q2 18/19	Q3 18/19	Year End Position	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	97.1%	97.3%	97.2%	97.1%	96.2%	97.2%	98.0%	99.0%	99.3%	99.8%	98.2%	99.4%	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%	97.9%	98.9%	100%	100%	100%	100%	98.6%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	*95.5%*	98.3%	98.8%	98.9%	97.5%	97.0%	99.0%	98.8%	97.6%	95.5%	97.4%	Data avail May 19	97.6%	97.9%	98.9%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	94.3%	99.2%	100%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100%	99.2%	Data avail May 19	97.7%	97.1%	97.1%	4	
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	98.3%	98.2%	98.2%	98.2%	98.2%	98.2%	98.3%	98.2%	98.1%	*98.1%*	*98.1%*	Data avail May 19	98.2%	96.8%	98.1%	4	
Out of area bed days [5]	Improving Care	Responsive	CH	Q1 940, Q2 846, Q3 752, Q4 658	531	282	368	436	589	384	165	360	317	343	184	164	1181	1409	842	1	
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	52.9%	57.2%	53.2%	54.0%	52.1%	47.1%	50.8%	50.1%	57.8%	55.0%	54.9%	56.5%	54.4%	51.1%	*52.8%*	3	
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	91.6%	88.0%	93.9%	93.9%	94.8%	94.0%	94.6%	96.9%	91.1%	92.3%	87.0%	85.7%	91.3%	94.3%	*94.4%*	4	
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	100%	98.7%	100%	99.7%	99.5%	99.6%	99.7%	99.7%	99.4%	99.3%	99.0%	99.4%	99.4%	99.6%	*99.6%*	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	53%	93.5%	81.0%	70.0%	92.0%	91.4%	90.3%	94.2%	94.7%	88.6%	85.1%	85.3%	Data avail May 19	81.7%	90.3%	92.6%	4	
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	78.9%	78.5%	79.1%	78.7%	78.8%	79.0%	78.5%	78.2%	78.5%	*78.0%*	*78.2%*		79.1%	78.8%	*78.2%*	4	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	9.0%	8.7%	8.6%	8.5%	9.5%	8.9%	8.6%	9.0%	9.3%	9.2%	*9.2%*		8.6%	8.8%	9.3%	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	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1 18/19	Q2 18/19	Q3 18/19	Year End Position	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	2	0	14	22	1	22	8	29	2	4	15	4	16	45	39	2	
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	1	0	3	3	1	2	2	3	1	1	1	1	4	6	6	2	
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	212			192			184			*Due May 19*			212	192	184	N/A	
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	15.1%			14.1%			13.0%			*Due May 19*			15.1%	14.1%	13.0%	N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Q1 18/19	Q2 18/19	Q3 18/19	Year End 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%	97.4%	97.7%	97.5%	98.8%	98.5%	99.1%	98.9%	97.0%	98.7%	98.8%	99.3%	*97.6%*	97.8%	98.8%	98.1%	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%	99.9%	99.9%	99.9%	100.0%	99.9%	100.0%	99.9%	99.9%	99.9%	*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%	90.7%	90.5%	90.8%	90.5%	95.5%	95.1%	91.0%	90.9%	90.8%	90.4%	*90.7%*	Data avail May 19	90.8%	91.1%	90.9%	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:

• A number of metrics have not been finalised at the time of the report. Some of this relates to the impact of transition to a new mental health clinical record system, as a result some data quality issues are being experienced and we are working to resolve these as far as possible. We have informed our regulators and commissioners of the position and will keep them updated on progress and impact.

• The Trust continues to perform well against the majority of NHS Improvement metrics

• The proportion of people completing treatment who move to recovery within Improving Access to Psychological Therapies (IAPT) is above threshold for March. This is provisional data and the final data will be reported in next month's report.

• During March 2019, the number of service users aged under 18 years placed in an adult inpatient ward remained at 1 - this related to the admission of a 17 year old that turned 18 during their stay but attributed 4 days under 18 year old. The admissions continue to relate to factors 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 during the year. 8 workstreams have been established following the independant review of our bed management process with the aim of reducing out of area bed placements.

• % 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

General community services

Key Issues
• Epilepsy – work commenced on service demand and capacity in line with performance data. Initial information shows activity is 46% higher than plan.
• Parkinsons Service – activity level currently at +60% and continuing to rise due to demand – we are reviewing care pathway and service delivery.
• Neuro rehabilitation unit (NRU) internal work continues in relation to bed usage. NRU open day arranged for 21 May 2019

Strengths
• Health integration team (HIT) in Urban House have been shortlisted for the RCNi Nurse Awards 2019 Finals
• Paediatric therapy services - additional resources has been allocated by the commissioner for 2019/20
• Neurological rehabilitation unit – internal quality monitoring visit included 4 commissioners took place on 11 April. No areas of concern were highlighted.
• EPaCCS (Electronic Palliative Care Coordination System) – roll out to GP practices

Challenges
• Yorkshire smoke free Barnsley service out for tender in April/ May 2019
• Child health information system (CHIS) – issues with regard to data sharing under discussion.

Areas of Focus
• Stroke services – work continues in partnership with clinical commissioning group and Barnsley hospital foundation trust in line with hyper acute stroke units (HASU) and remodelling the pathway.
• Neighbourhood nursing service - Work ongoing to demonstrate activity trends and adherence to agreed model.
• Musculoskeletal service – remains challenging. Internal work underway regarding pathway/contract targets and diagnostics.

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 remains a challenge in community services, particularly in the enhanced pathways. Action plans and data improvement plans are in place and there is support with staff wellbeing. Good progress is being made with partnership approaches and effective communication between the council and SWYPFT.
• Extensive work is underway across new teams and with new SWYPFT colleagues in Sheffield, Doncaster and Barnsley to implement the South Yorkshire wide model for liaison and diversion services following a successful and well-attended launch event on 8 April 2019.

Strengths

• Management of patient flow.
• The Barnsley inpatient advocacy forum has supported a project run by the European court of human rights aiming to develop an information booklet on mental health rights for all patients on acute wards. Barnsley was the only unit nationwide to support the project to come to an inpatient facility and to facilitate engagement with the inpatient user group in this way. Service users gave their opinion on how the information could be made bolder, clearer and simpler, and have been told how this information will be used in moving forward with the development of the booklet. Feedback from our service users about this opportunity to make a difference was really positive.
• Our early intervention in psychosis service lead a national 'at risk mental state' (ARMS) webinar this month for NHS England.

Challenges

• Demand and capacity in community services.
• Action plan continues to improve data quality and in particular performance around care programme approach 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.
• Monthly sickness rates are in excess of trust target with a hotspot in acute services. General managers are working with human resource business partners to review all cases and to ensure robust process and appropriate support is in place. This is monitored through team managers meetings and reported through to deputy director, for review at BDU level meetings.

Areas of Focus

• Admissions and discharges and patient flow in acute adults.
• Continue to improve performance and concordance in service area hotspots tracked team by team by general managers
• Demand and capacity work in single point of access and the enhanced pathway.
• Reduction of agency and bank spend in acute services.
• Work continues with partners on integrated care networks, working with the neighbourhoods already in place. SWYFT staff are represented at local and network level both developmentally and operationally.
• Local action planning in response to staff survey.
• Sickness management.

Calderdale & Kirklees BDU:

Key Issues

• Continued pressure for admissions, particularly female, however a number of beds have been internally available for males. Occupancy and acuity remains high on all female adult wards and across the business delivery unit.
• Kirklees clinical commissioning groups have agreed to commission a second personality disorder advanced practitioner post.

Strengths

• High performance on mandatory training.
• Appraisal completion over 99% across all bands.
• Sickness absence is well managed across BDU with 4.5% achieved overall for the BDU at year end.

Challenges

• Adult occupancy levels are high in inpatients and with intensive home based treatment teams.
• Caseload pressures have built up in some adult community teams. Recruitment is being reviewed in order to look at widening opportunities to replace leavers.

Areas of Focus

• Ward 18 garden area reviewed for overall safety and new anti ligature, anti climbing and netting is in place. Further anti ligature work is being undertaken.
• Improvements to access and egress from the dales to increase security is taking longer, due to increased complexity of monitoring controls. It is anticipated that the physical works will have been completed by the end of April.
• Additional fencing work at the dales garden has been commissioned due to recent absent without leaves (AWOLs). The fence height is to be increased. The work is due to be commenced in May.

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
• Work is taking place with the commissioner to repurpose 8 forensic learning disability beds.
• Service review/business case as lead provider continues to progress. Following the two successful workshops collaboration with partners continues. The partnership is hopeful that an opportunity to develop a forensic community service across West Yorkshire will progress.
• Learning disability forensic outreach service recruitment to initial service continues. Team leader and key clinicians appointed on a fixed term/secondment basis. Confirmation has now been received that £1.8m will be released by clinical commissioning groups to fund the original proposal. Recruitment to the consultant psychiatrist post may be a challenge with no applicants at the first advert. Service is offering advice and consultation since 1.4.19.
• Work on the recovery plan for the secure estate is on-going.
• Occupancy levels in both medium and low secure will be scrutinised closely throughout 19/20.
• Regional forensic child and adolescent mental health service underwent a service review as part of programmed reviews of all pilot sites. Some positive verbal feedback. Official response has not yet been received.

Strengths
• Strong performance on mandatory training.
• Good track record delivering 'commissioning for quality and innovation' CQUIN.
• Progress being made on CQC action plans. Only action waiting to be addressed is the call system which is waiting a Trust wide response.

Challenges
• Delivering the recovery plan for the secure estate.
• Recruitment of band 5 nurses (23 vacancies across the business delivery unit).
• High turnover.
• Reducing sickness.
• Delivery of service improvement with a view to removing the performance notice.

Areas of Focus
• Forensic CAMHs performance notice.
• The BDU will undertake a piece of work supported by human resources and will focus on the following areas:

*Leadership
*Sickness/absence
*Turnover
*well-being
*Bullying and harassment

Specialist BDU:

Key Issues
• Consultant recruitment across CAMHS and learning disability remains a significant challenge – resulting in high agency use
• Waiting times from referral to treatment in Wakefield and Barnsley CAMHS remain a concern. New investment has been secured in Wakefield to target a waiting list initiative and an ADHD-related business case is under consideration in Barnsley. Efforts to address the position in Wakefield are being supported by a CAMHS Oversight and Assurance Forum.
• Learning disability staff vacancies remain relatively high and this creates some challenges re waiting times for specialist interventions – most notably psychology (Barnsley/Wakefield). However, in the vast majority of cases those waiting are receiving support from another member of the multi-disciplinary team. The number of 18 week breaches in March was 1 (Barnsley) and 3 (Wakefield). Recruitment efforts are being supplemented by use of bank and temporary staff - plus agency(where dictated by clinical risk)
• The recent staff survey identified significant challenges in CAMHS – most notably in the Barnsley and Wakefield teams. Locality-based workshops – supported by HR - are being arranged to discuss the detail and action plan.
• A review of the CAMHS service has recently taken place in Barnsley by the national intensive support team (IST). Feedback is expected on April 29th.

Strengths
• Learning disability community teams have strong multi-disciplinary teams in place which ensure referrals can be effectively prioritised and allocated. The team also regularly review waiting lists (weekly) with their discipline teams to ensure 18 week breaches are minimised.
• Calderdale and Kirklees CCG's have committed to further ASC waiting list initiative investment in 2019/20.
• All CCG's have prioritised 2019/20 investment in development of an all-age liaison model.

Areas for focus
• Proactively addressing vacancy levels in learning disability services and consultant posts in learning disabilities and CAMHS
• Development and implementation of the all-age service model and waiting list initiatives in CAMHS
• Ongoing focus across specialist services on staff engagement, appraisal, prevention of bullying/harassment and health and wellbeing.

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 to explore all possible alternatives at the point of admission.
• 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 community service lines leading to continued expenditure on agency medical staffing. Action plans are in place lead by clinical leads to address this post by post.

Strengths
• Management of patient flow and for Wakefield nil out of area bed usage.
• Human resource workforce performance strong across all domains other than food safety where an action plan is in place
• The Wakefield serious incident group were joined at their latest monthly meeting by commissioners wishing to review governance and process around how security incidents are managed within the BDU. Commissioners gave very positive verbal feedback to the staff present stating that they had received assurance that all necessary steps and actions were embedded and that they had been impressed with how the meeting had worked to demonstrate reflection, connections and learning.

Challenges
• Adult community medical 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.
• Wakefield BDU sickness rates are in excess of trust target. General managers are working with human resource business partners to review all cases and to ensure robust process and appropriate support is in place. This is monitored through team managers meetings and reported through to deputy director, for review at BDU level meetings.

Communications, Engagement and Involvement

• Flu campaign won a national flu fighter award for most innovative comms.
• #allofus shortlisted for national HSJ value award under 'best communications initiative'.
• Internal comms survey analysis: increased staff satisfaction with 88% saying they feel kept up to date (31% increase in 3 years) and 80% satisfied with how they are communicated with (35% increase in 3 years). Action plan for further improvements developed.
• SystmOne for mental health – targeted go live messages, with regular updates and support sources
• Financial sustainability key messages launched, information governance comms plans developed.
• Promotion of members' council elections
• Supported launch of the forensic outreach liaison service
• Support to the 'Thriving after surviving' safeguarding conference and promotion of national safeguarding campaigns.
• Launch of the pharmacy and medicine optimisation strategy, including a summary infographic
• Gender pay gap reporting infographic
• Promotion and support to West Yorkshire and Harrogate health and care partnership 'our neighbours' campaign
• Week long trustwide photo shoot to support development of recruitment marketing materials

This is the April 2019 priority programme update for the integrated performance report for progress on the 2018/2019 Trust priorities. A summary of key updates for activity conducted in March includes:
Out of area:
• Bed pressures remain in the system and out of areas placements continue, though the levels fluctuate. Recent placements continue to be from the Calderdale/Kirklees locality.
• Work has taken place to establish a priority programme based on the work streams identified by SSG Health and activity highlight in the transformation review. Resources to support changes are being put in place. This includes delivery leads, clinical leads and project leads.
• A new partnership governance structure is being established to support the change programme and meetings are scheduled for April 2019 and new reporting structures will commence from May 2019.
• Project task and finish groups are being set up and will commence meeting through April and May to develop detailed plans and continue change activity.
• The new personality disorder pathway lead will be in post from mid May and recruitment of bed manager post to support inpatient changes is planned for April 2019.

Clinical record system:
The SystmOne programme team are continuing to work with services in implementing the new clinical record system and have already started to work on co-creating and delivering improvements based on the feedback received during go live such as refinement of medical care plans, the e-discharge process, tailored changes to suit individual teams - for example, Intensive home based treatment teams, and delegation of tasks such as outcoming patient appointments. Other activities include:
• Slow running issues have now been resolved following fix by TPP 210319.
• Data migration activities, scheduled for February and March, have been successfully completed.
• 96% of all Trust staff requiring SystmOne training have now completed that training. The programme team continue to monitor system implementation post go live, meeting weekly with service representatives. Provision of support to staff continues through the information, management and technology helpdesk, floor walkers and super users.
• The programme team are also supporting 'catch up' activities in preparation for the cessation of RiO access in June.
• An optimisation plan is in development for future improvements and continuation of working with teams to help each other get to grips with the new system and discover new ways of working.

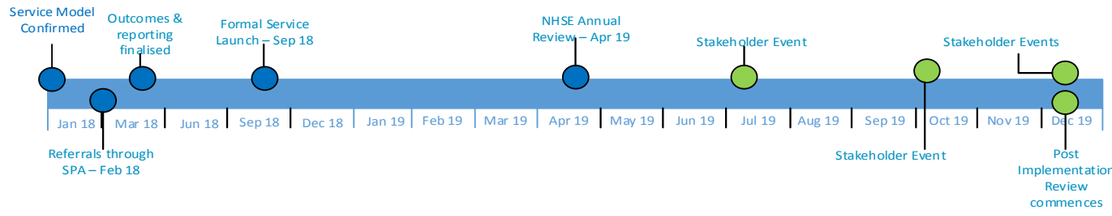
Stroke services review:
•A third senior executive level meeting re: stroke pathway costings took place on 15 March 2019. Barnsley clinical commissioning group (CCG) went away to consider proposals for service model/finances against their initial referral assumptions.
• Barnsley CCG have now remodelled the pathway based on their revision of referral assumptions against actuals. This has resulted in potential changes in demand which may impact on the staffing, finance and also inpatient bed modelling. Next steps are for SWYPFT and Barnsley hospitals NHS foundation trust to receive and review evidence and consider potential effect. This additional work may impact on timescales and financial planning
• Plan is for new model developments to be presented to members council (timing to be confirmed following agreement of remodelling)

Learning disabilities operational delivery 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 the March period includes:
• Following expressions of interest to co-lead the three community infrastructure work-streams, the adult learning disability (LD) and non-LD autism groups now have joint leadership in place.
• Task and finish groups have now been established with leads (apart from the positive risk taking group that will be reallocated to a lead).
• Following a workshop that was held on 25th January 2019 to launch the main work-stream (community infrastructure) with an objective to commence scoping of key areas of focus and prioritisation, the project group are now supporting the ODN to generate some questions to use to facilitate co-production with service users/carers
• Quarterly north region ODN meetings have met and shared information/papers as relevant. Following a recent joint meeting to plan a joint forensic event, ODNs will run events to identify best practice across the patch as well as developing a proposed model of the West Yorkshire ODN support people with complex needs and how we build that local resilience.
• Rehab utilisation work is now completed with a presentation to the NHS England (NHSE) executive strategy group on 1st March.
• Community Infrastructure work-streams have met for the first time in mid-March.
• The out of area agreement has been drafted and will be presented to NHSE executive strategy group for comment on 5th April.
• Annual review is due to take place on 12th April 2019.

The Trust is reviewing this section of the integrated performance report (IPR) and will commence reporting against the 19/20 priorities next month.

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 integrated care system (ICS) work on the hyper-acute stroke unit (HASU) provision and the wider hospital services review SWYPFT and Barnsley Hospital NHS Foundation Trust (BHNFT) were asked to work together by clinical commissioning group (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 MDT working across both organisations to reduce the impact of pathway handovers on patient care and improve system wide patient flow. • 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	• A third senior/exec level meeting re stroke pathway costings meeting took place in March 2019. Proposals are being considered and the model and activity assumptions reviewed in further depth. • An independent assessment of the model and associated costs is being planned. • Plan is for new model developments to be presented to members council (timing to be confirmed following agreement of remodelling) Single TIA pathway (TIA): • Ongoing monitoring and review of new process via task and finish group (TAG). Stroke early support discharge (ESD): • Financial projection was discussed in more detail at the additional stocktake meeting in March. • The CCG have undertaken a review of the modelling and their findings need to be considered as a next step • An additional steering group has been arranged for mid-May – with a view to changing focus once model agreed and implementation can commence. • An external critique is also to be undertaken to peer review and benchmark the proposal against other areas. Multidisciplinary teams (MDT): • SWYPFT and BHNFT colleagues continue to meet to discuss patient flow. • Proposal for project support to develop integrated dashboard reporting system to share real time information to support MDT working and decision making • Continue to seek resolution for interoperability between clinical systems	Progress Against Plan	
		Initial areas of risk include: • Finances/contracting - potential increasing risk following remodelling from CCG (including transition /double running costs) • Recruitment and retention - recruitment could be a challenge through 2019 if additional staffing is required to establish the new pathway. Also retaining current staff in the new model is a growing challenge. • Contracting arrangements • Hyper-acute stroke unit (HASU) timeline - our ability to implement in line with HASU go live could be at risk depending on when the new model is agreed. • Social care not yet fully included in scope of stroke developments although they have been invited to future steering groups. • Requirement for shared information technology (IT) systems	Management of Risk	

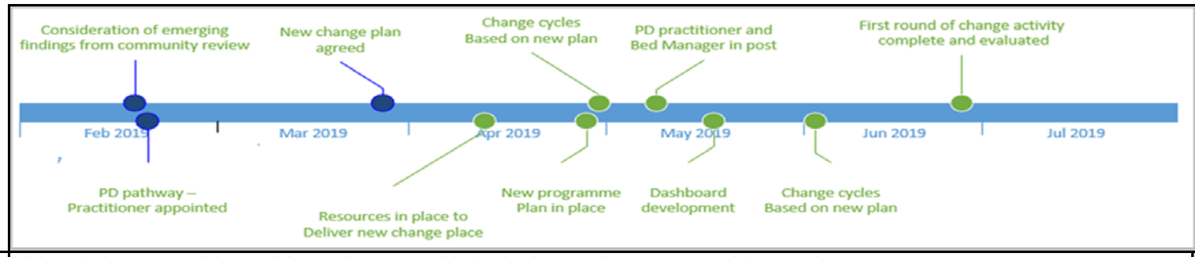
		High level milestones: ESD - financial projections in place (Dec / Jan) ESD - senior meeting to be organised for January 2019 ESD - service model agreement - February 2019 ESD costing meeting February 2019 ESD further modelling breakdown - 15 March 2019 Review of CCG modelling (new action – Apr/May 2019) ESD - implementation process - timing TBC following agreement of the model New model presented to members council - timing TBC		
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 unit (NRU) Barnsley CCG are has reduced the number of beds they commission in the NRU from 12 to 8. NRU has always had some out of area bed usage but in light of this change we want to raise the awareness of our unit amongst out of area clinicians and commissioners, encouraging them to commission beds and/or choose our service for future referrals. We also want to raise awareness of the unit across the Trust.	Barnsley CCG are reducing the number of beds they commission in the next financial year for NRU from 12 to 8. NRU bed base remains at 12 with 4 beds available for out of area usage. The service aim to raise the awareness of this availability internally across the Trust and amongst out of area clinicians and commissioners, encouraging them to commission beds and/or choose the NRU service for future referrals. An update on activity during the period February and March is as follows: 1) The ward manager for NRU has now left the Trust and the post is currently at advert. Cover is provided by our senior nurses with oversight from the matron 2) Planning continues in relation to the NRU open day on Tuesday 21st May; this event is to market the available beds • Banner stands have been designed and ordered through procurement. • Invites for the open day are being sent out; to the same distribution as the booklets. • Presentation is being pulled together for the open day 3) Planning continues in relation to the families and carers open day on Thursday 23rd May 2019. 4) Two consultants are due to commence in post in April 2019.	Progress Against Plan	
		Since October 2018 the decommissioning of 4 NRU beds from 12 to 8 presents a financial risk to SWYPFT in securing additional income for 4 beds from alternative commissioners.	Management of Risk	
		Implementation Plan is 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 attention deficit hyperactivity disorder (ADHD)	This priority reports bi-monthly on the IPR. This is the latest update completed in March 2019: • Early discussions still are taking place on developing a formal plan to take this priority forward. • However, this plan will include lessons learned from the current West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) priority for improving autism and attention deficit hyperactivity disorder (ADHD).	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.	A business case for a new care model for forensic services, with SWYPFT as lead provider continues to progress through the West Yorkshire forensic provider group with the intention that this is completed in May 2019. The group are also hopeful of an opportunity to bid to develop a forensic community trail site across West Yorkshire. We await the invitation to express our interest in this opportunity.	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	

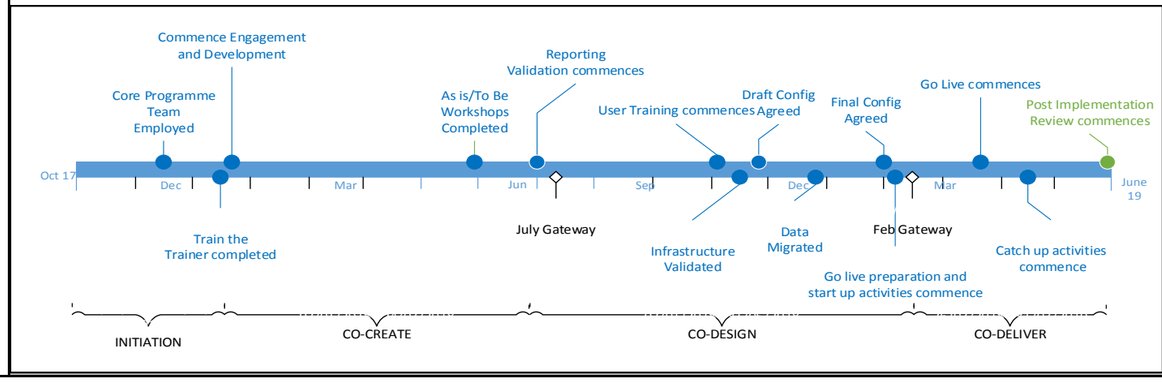
West Yorkshire Projects: Community Forensics CAMHS	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Community Forensic child and adolescent mental health services (CAMHs)	This priority reports bi-monthly on the IPR. This is the last update completed in March 2019: • Paula Phillips will now oversee the Yorkshire and Humber (Y&H) regional forensic child and adolescent mental health service (FCAMHs) following the move of the previous manager to the secure estate work. • Referrals continue into the service at a positive rate. Referrals declined over Christmas and new year, as anticipated, however are slowly increasing to normal levels. • Band 6 mental health practitioner is now in post, commencing 25 February 2019. • Y&H team representatives have met with East Midlands FCAMHs to discuss the Bassetlaw area and cases along the border of the two regions – East Midlands are really keen to work closely with us and we have agreed to meet regularly for peer support / shared training events etc. • The team attended a PREVENT event, put on by North West FCAMHS in January – this was a really informative day • NHS England have requested an annual review now that the service has been running for a year. A date for this is set for end March/early April 2019. A full audit of the first year of the service will be compiled in preparation for this meeting. • The next national clinical network meeting will be held on 22 March 2019 in Reading and Yorkshire and Humber will be represented at this event. • The project is scheduled for closure in May 2019 incorporating the NHSE annual review and project audit, with a post implementation review scheduled for December 2019.	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. Providers of trial sites were required to meet the following requirements: • Overall rated as 'Good' or 'Outstanding' by the CQC and in all safety domains (including a 'Good' or 'Outstanding' rating in all of the forensic and adult services domains) • Rating 1 or 2 in the NHS Improvement single oversight framework • Currently provide medium secure, low secure and community forensic teams. A bid was duly prepared for this opportunity and submitted. However, the bid was not successful. Following feedback on the bid, the forensic services team have continued to engage in a national network involving the successful sites, in order that learning from this can be used to inform a wave 2 bid. wave 2 was expected to be published by end of March 2019 but is yet to be published by NHSE. It is expected that wave 2 will request applications from integrated care systems (ICS) areas, rather than individual trusts.	Progress Against Plan	N/A
		Not applicable	Management of Risk	N/A
		Not applicable		

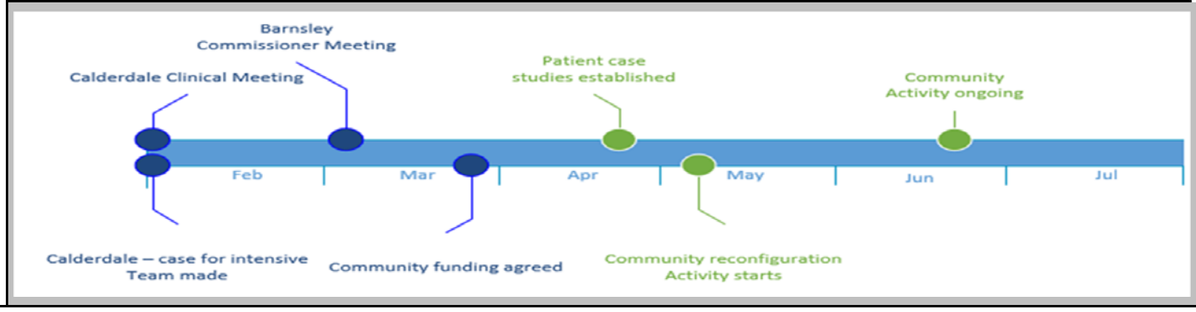
West Yorkshire Projects: Forensic Community LD	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) to deliver shared objectives with our partners in the area of: • Forensic community learning disability (LD)	• SWYPFT submitted a proposal to NHSE for provision of a community forensic learning disability service to support individuals with a learning disability (LD) 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. • SWYPFT are awaiting confirmation of funding	Progress Against Plan	N/A
		No known risks identified at this time.	Management of Risk	N/A
		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: • Reducing waiting times for ASC/ADHD assessment/diagnosis. Initially focusing on sharing evidence based improvements and learning and where possible embedding consistency of approach/ standardisation of practice. • Explore opportunities about future models.	There are separate workstreams under the WY&H HCP MH Programme Board for both adults and childrens adults autistic spectrum condition (ASD)/attention-deficit/hyperactivity disorder (ADHD). • 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 is a clear link to the adult project that needs to be maintained, and to that end it has the same key objectives as the children's. Children's ASC ADHD: • Children and young people (CYP) sharing continues between services – Mid Yorkshire sharing learning with BTHFT • CYP autism raised as area to be looked at in relation to new care models – paper going to April 2019 programme board prior to proposal being presented to NHSE on 24 April • Planning to reform with smaller group to refocus Adults ASC ADHD: • Bradford adult waiting list in much better position – hopefully to be cleared by Summer 2019 • First ODN Adult Autism meeting – to focus on access to mainstream mental health services and emergency/crisis support. Region wide survey developed with VCS colleagues working with adults with autism to find out what specific challenges to keeping psychologically well are from our autistic population	Progress Against Plan	
		<u>Children's ASC ADHD high level risk:</u> • Current active risk exists 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 specification in light of this. • The Autism overlap with Learning Disability Transforming Care Partnership (TCP) work needs to be managed. A new West Yorkshire TCP Board being established in April – clarification whether Autism will be included in this agenda is being sought.	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: • Following expressions of interest to co-lead the three community infrastructure work-streams, the Adult LD and Non-LD Autism groups now have joint leadership in place. • Task and finish groups have now been established with leads (apart from the positive risk taking group that will be reallocated to a lead). • Following a workshop that was held on 25th January 2019 to launch the main work-stream (community infrastructure) with an objective to commence scoping of key areas of focus and prioritisation, we are now supporting the ODN to generate some questions to use to facilitate co-production with service users/carers • Quarterly north region ODN meetings have met and shared information/papers as relevant. Following a recent joint meeting to plan a joint forensic event, ODN's will run events to identify best practice across the patch as well as developing a proposed model of how we support people with complex needs and how we build that local resilience. • Rehab utilisation work is now completed with a presentation to executive strategy group (ESG) on 1st March. • Community Infrastructure work-streams have met for the first time in mid-March. • The out of area agreement has been drafted and will be presented to ESG for comment on 5th April. • Annual review is due to take place on 12th April 2019.	Progress Against Plan	
		No specific risks identified at this point although a potential area to be mindful of is the level of engagement and commitment to ODN related work which is required of all members - ODN, wider network, work-stream leads and work-stream group members – for the ODN to be successful and productive. Whilst not having a clinical lead in post yet, the ODN have mitigated for this without affecting the programme progressing.	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. This is the last update completed in March 2019: • 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	This priority reports bi-monthly on the IPR. This is the last update completed in March 2019: • '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 sustainability and transformation partnership. [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 as there may be financial risk for the Trust. • 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.	Out of Area (OOA) • Bed pressures remain in the system and out of areas placements continue, though the levels fluctuate. Recent placements continue to be from the Calderdale/Kirklees locality. • Work has taken place to establish a priority programme based on the work streams identified by SSG Health and activity highlight in the transformation review. Resources to support changes are being put in place. This includes delivery leads, clinical leads and project leads. • A new partnership governance structure is being established to support the change programme and meetings are scheduled for April 2019 and new reporting structures will commence from May 2019. • Project task and finish groups are being set up and will commence meeting through April and May to develop detailed plans and continue change activity. • The new PD pathway lead will be in post from mid May and recruitment of bed manager post to support inpatient changes is planned for April 2019.	Progress Against Plan	
		Current high 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. A wider risk register for programme level risks is in development and will be reported from May onwards.	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.	This priority reports bi-monthly on the IPR. This is the last update competed in March 2019: • Recruitment and retention steering group is work on several themes which include: - Development of career pathways in professions. Plan to develop more visual progress opportunity for staff both within intranet and at job application, job advert/NHS Jobs e.g . fully utilising NHS Yorkshire jobs Facebook feed and development of a bespoke webpage for apprenticeships - Procurement of Trusts bespoke on boarding process microsite ongoing. - Staff ending employment procedure re-designed and in place with greater focus on feedback. Trust wide report to capture ALL staff feedback is in development. - Capture of exit interview feedback from internal movement of staff has been rolled out. - New retirement interview procedure is in place to focus on furthering employment within the Trust. - Secured operational management group £10k funding to improve branding and awareness including SWYPFT representation at the mental health (MH) nursing recruitment fayre in Edinburgh in May 2019. - Brexit retention. Work completed to identify staff in Trust liable for settlement status. No issues envisaged with retention of these staff. - Recruitment process has been evaluated and review is in progress as target set to achieve 100 day turnaround currently being not achieved. A number of interventions have been put in place to improve timescales. This will be reevaluated in 4 months • Development of trainee nursing associates (TNA) and nursing apprenticeships ongoing. Workforce plans by BDU to be signed off in readiness for April 2019. • Trusts clinical support workforce plan to be updated for 2019-2021 and published by April 2019 following BDU workforce plans being signed off and complete. • Collaborative workforce planning ongoing across both SY&B and WY&HHCP being led by SWYPFT colleagues with the aim to be lead in production of West Yorkshire strategic workforce plans. • Clinical support workforce strategy refresh will focus on further strengthening the apprenticeship model, developing clearer band 2, 3 to 4 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.	Progress Against Plan	
		• Despite ongoing work around nursing strategy and recruitment/retention, we are still seeing sustained nurse vacancies across the whole Trust (currently 53 whole time equivalents within mental health inpatient areas only). To achieve 100% nursing establishment approx. 180 additional whole-time equivalent (WTE) would be required over the next 12 months. Nurse vacancies are not reducing but not increasing either in general terms. Mitigating plans are being planned against which include greater emphasis on improving our nurse bank and increase/over recruitment into clinical support roles, alternative roles to recruitment to fill current workforce gaps in nursing including pharmacy technicians, allied health professional (AHP) roles and AHP support roles. • Agency spend across Trust in excess of cap (projected £879k) above cap of £5.5m. Work within annual planning assumptions on workforce being conducted to identify ward establishment review requirements for skill mix of staff to identify reduction in agency spend.	Management of Risk	

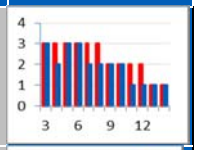
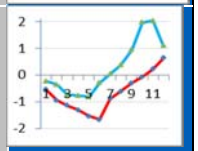
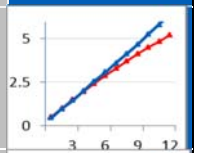
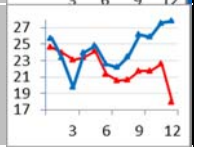
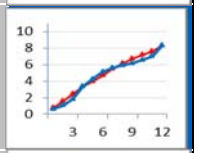
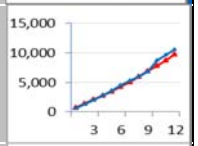
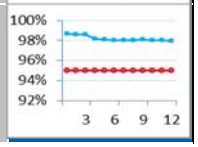
		Milestones from the implementation plan for this priority: • Initial recruitment/retention steering group set up July • Analysis and focus groups in high turnover areas – July • Wellbeing survey deep dive done - August • West Yorkshire collaborative activity to commence - September • Professions workforce planning workshop underway – Jan/Feb 2019 • Workforce planning cycle starts - February 2019 following workforce workshops conclusion • Strategic workforce plan update and clinical workforce support strategy refresh – Two-year plan to be developed from April 2019.		
Clinical record system	Plan and deliver a new clinical record system which supports high quality care	The SystmOne team are continuing to work with services in implementing the new clinical record system and have already started to work on co-creating and delivering improvements based on the feedback received during go live such as refinement of medical care plans, the e-discharge process, tailored changes to suit individual teams - for example, intensive home based treatment teams, and delegation of tasks such as outcoming patient appointments. Other activities include: • Slow running issues have now been resolved following fix by TPP 210319. • Data migration activities, scheduled for February and March, have been successfully completed. • 96% of all Trust staff have now completed their SystmOne Training. The team continue to monitor system implementation post go live, meeting weekly with service representatives. The service continues to provide support through helpdesk, floor walkers and super users. • The team are also supporting 'catch up' activities in preparation for the cessation of RiO access in June. • An optimisation plan is in development for future improvements and continuation of working with teams to help each other get to grips with the new system and discover new ways of working.	Progress Against Plan	
		No new risks were identified in the Risk register	Management of Risk	
				

Older peoples services transformation	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.	• This project is now moving forward on the basis of seeking to make improvements to community services in advance of any proposed in patient changes. • Further conversations have been held with commissioners and these have helped shape the local change programme. • Local plans will be established before local community improvements are taken forward through 2019. These changes will take place as part of local partnership governance programmes as appropriate.	Progress Against Plan	
		• 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 appropriately resourced.	Management of Risk	
				

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	1	The financial sustainability risk rating at the end of 2018/19 is rated 1, this is the best rating possible and is in line with plan. All metrics are in line with our revised plan with the exception of agency, the breach of the agency cap by 24% has resulted in a rating of 2 compared to a planned rating of 1.	
2	Normalised Deficit (excl PSF)	(£1.6m)	(£2.0m)	A final position of £1.6m deficit has been recorded for 2018/19. This is £0.5m better than plan and will mean that Provider Sustainability Funding (PSF) of at least £2.7m will be received. The potential for further PSF will be confirmed by NHS Improvement in late April 2019; the value of this is not yet known.	
3	Agency Cap	£6.5m	£5.2m	Agency expenditure for the year of £6.5m exceeds the agency cap by £1.3m (24%).	
4	Cash	£27.8m	£18.0m	Cash remains ahead of plan primarily due to one off benefits such as asset sales, additional commissioner income and low levels of outstanding debtors.	
5	Capital	£8.3m	£8.3m	Total capital expenditure is in line with plan at £8.3m. This is an increase from the original £8.1m plan due to £0.2m additional national funding secured. The major schemes undertaken in year, non secure wards and clinical record system will both formally be completed in Q1 19/20.	
6	Delivery of CIP	£10.6m	£9.7m	The Trust has exceeded the CIP target for 2018/19 given higher capital charge savings. Of this £2.7m is identified as non recurrent.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value. Overall the Trust have maintained excellent performance against this metric and ensured that suppliers are paid in a timely manner.	

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

Plan
Actual
Forecast

Contracting - Trust Board

Contracting Issues - General

The Trust has agreed and signed 2019/20 contracts with all main CCGs Barnsley, Wakefield, Calderdale, Greater Huddersfield and North Kirklees. The contract with NHSE for secure services is being has been agreed and will be signed shortly.

CQUIN

The national CQUIN schemes for 19/20 contracts applicable to contracts has been agreed.

Contracting Issues - Barnsley

The main and alliance contracts for 2019/20 have been agreed and signed with Barnsley CCG. Growth in funding is in line with programme requirements for the Mental Health Investment Standard. Work is taking place to finalise the detail of the investment plan by the end of April across the range of identified priorities including all age liaison psychiatry, expansion of crisis resolution services for children and young people, diagnosis and treatment of ADHD in children and young people and further development of improving access to psychological therapies for long terms conditions in adults young people. Further review will take place during 2019/20 in relation to neighbourhood nursing , musculoskeletal and dementia services. The expansion plan to address pressures within children's therapy services is underway following the additional investment made in the service.

Contracting Issues - Calderdale

The 2019/20 contract has been agreed and signed. The 2019/20 contract will see growth in mental health services in line with the Mental Health Investment Standard including investment for intensive home based treatment, early intervention in psychosis, mainstreaming of investment for perinatal mental health services and children's and young people's mental health services. Further work will take place in year in relation to the transformation of mental health services for older people to support provision of care closer to home through community based provision.

Contracting Issues - Kirklees

The 2019/20 contract has been agreed and signed. The contract continues to see significant growth in mental health services in line with the Mental Health Investment Standard including investment for improving access to psychological therapies for adults covering both core and long term conditions services, early intervention in psychosis and core mental health liaison. This also includes the mainstreaming of investment for perinatal mental health services. The CCGs are also investing in the transformation of mental health services for older people to support provision of care closer to home through community based provision.

Contracting Issues - Wakefield

The 2019/20 contract has been agreed and signed. The contract, in line with the local Mental Health Alliance agreed priorities, will see growth in mental health services in line with the Mental Health Investment Standard including the mainstreaming of investment for perinatal mental health services, development of all age liaison psychiatry and the expansion of crisis services and support for addressing waiting lists for children and young people with a mental health need. Additional priority areas for investment identified are the expansion of adult crisis and intensive home based treatment services including a safe space to reduce the need for treatment out of area, the personality disorder and chaotic lifestyles pathway and suicide prevention. The Mental Health Alliance aims to review and agree the investment plans across these areas by the end of April 2019.

Contracting Issues - Forensics

The 2019/20 contract offer with NHS England for secure services has been agreed and will be signed shortly. The key priority work stream for 2019/20 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.

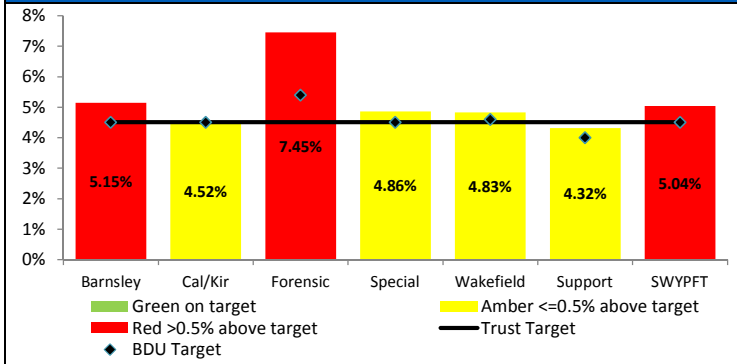
Contracting Issues - Other

The new contract for the provision of liaison and diversion services across South Yorkshire covering Barnsley, Rotherham, Doncaster and Sheffield commenced on 1 April 2019.

Workforce

Human Resources Performance Dashboard - February 2019

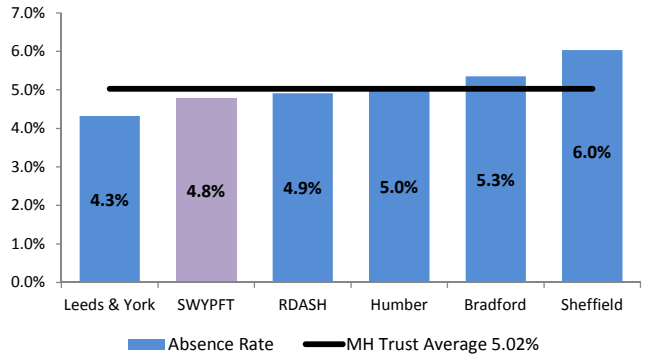
Sickness Absence



Current Absence Position and Change from Previous Month - Mar 2019

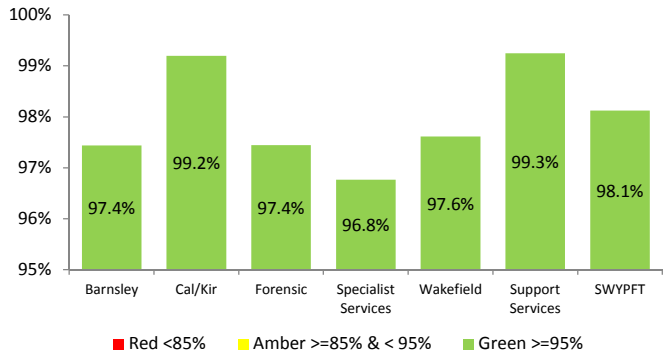
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	0.05364	4.24%	5.58%	2.98%	4.68%	4.27%	4.63%
Change	↓	↓	↓	↓	↓	↓	↓

The Trust YTD absence levels in March 2019 (chart above) were above the target at 5.04%.
The YTD cost of sickness absence is £6,053,273. If the Trust had met its target this would have been £5,404,708, saving £648,565.



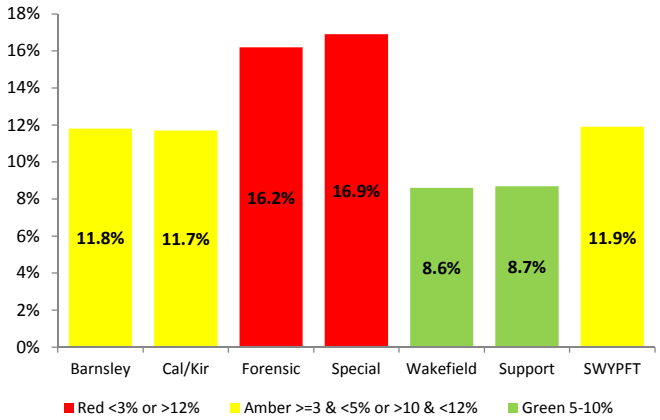
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2018 to October 2018.
During this time the Trust's absence rate was 4.78% which is below the regional average of 5.02%.

Appraisals - All Staff

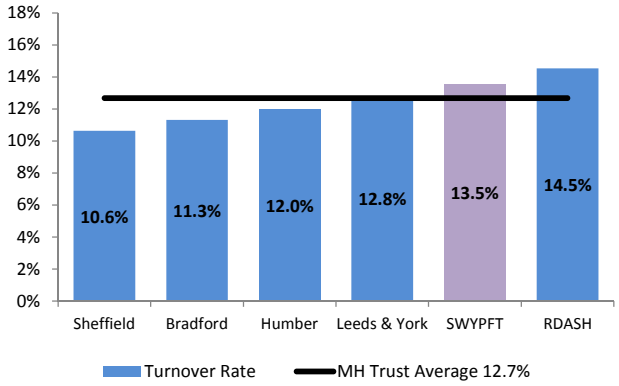


The above chart shows the appraisal rates for the Trust to the end of March 2019.
From September 2018 all staff have been included in the figures.
All areas have improved, month on month, and are now well above the target of 95%.

Turnover and Stability Rate Benchmark

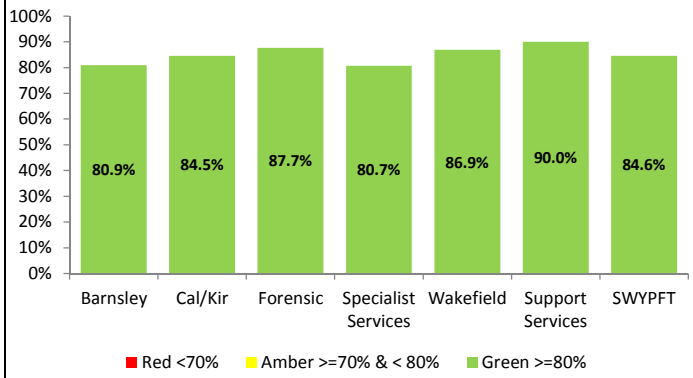


This chart shows the YTD turnover levels up to the end of March 2019.
*The turnover data excludes recently TUPE'd services



This chart shows turnover rates in MH Trusts in the region for the 12 months ending in November 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 Lecture Training



The chart shows the 12 month rolling year figure for fire lectures to the end of March 2019. The Trust continues to achieve the 80% target across all BDUs.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	5.3%	4.4%	4.4%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.9%	4.4%	4.4%	4.4%	4.7%	4.8%	5.1%	5.7%	5.8%	5.8%	6.0%	5.2%	4.6%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	97.8%	7.3%	26.1%	72.2%	87.7%	92.8%	95.0%	95.8%	98.1%	98.2%	99.1%	99.1%	99.1%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	96.0%	0.8%	2.8%	9.4%	21.6%	48.1%	78.6%	87.2%	94.3%	95.0%	96.5%	97.5%	97.5%
Aggression Management	Improving Care	Well Led	AD	>=80%	79.3%	79.3%	81.7%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	81.7%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	81.4%	82.3%	84.0%	84.5%	84.8%	83.3%	81.6%	80.1%	80.2%	81.2%	82.1%	81.4%	80.7%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	85.1%	85.6%	85.5%	85.8%	85.9%	86.0%	85.8%	85.8%	86.1%	87.4%	87.8%	88.7%	88.4%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	88.5%	89.0%	89.8%	89.7%	89.8%	90.1%	89.8%	90.2%	90.7%	91.3%	90.9%	91.0%	90.3%
Fire Safety	Improving Care	Well Led	AD	>=80%	85.4%	85.3%	86.8%	86.6%	86.6%	87.4%	86.3%	86.8%	86.7%	88.1%	85.2%	84.9%	84.6%
Food Safety	Improving Care	Well Led	AD	>=80%	77.2%	76.2%	77.2%	77.5%	80.8%	81.9%	81.7%	81.9%	84.1%	82.2%	82.3%	83.7%	83.4%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	86.8%	87.0%	87.3%	87.3%	87.8%	88.5%	89.1%	89.3%	89.1%	89.7%	89.5%	90.4%	89.9%
Information Governance	Improving Care	Well Led	AD	>=95%	96.5%	92.4%	92.7%	92.1%	91.9%	92.2%	92.1%	92.3%	90.2%	90.8%	96.1%	97.6%	98.5%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	85.5%	85.2%	85.9%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	90.5%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	90.7%	91.1%	91.4%	91.3%	92.2%	91.7%	90.9%	91.4%	92.6%	92.3%	92.7%	92.5%	91.7%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	84.7%	85.7%	86.8%	86.5%	88.1%	87.3%	85.9%	85.8%	87.7%	86.7%	86.7%	86.4%	84.5%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	87.6%	82.8%			83.7%			82.5%			84.9%		
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	89.9%	90.0%	91.0%	91.3%	91.7%	91.7%	91.5%	92.1%	93.0%	93.7%	93.2%	93.4%	91.1%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	87.8%	88.4%	88.6%	89.4%	90.1%	90.4%	90.0%	90.4%	89.4%	91.4%	91.3%	90.9%	92.9%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	93.4%	94.4%	95.1%	94.9%	95.8%	95.2%	94.6%	94.6%	94.1%	94.5%	93.9%	94.5%	94.9%
Bank Cost	Improving Resources	Well Led	AD	-	£907k	£557k	£603k	£768k	£646k	£730k	£845k	£615k	£674k	£678k	£752k	£1048k	£772k
Agency Cost	Improving Resources	Effective	AD	-	£555k	£444k	£538k	£484k	£526k	£566k	£522k	£537k	£536k	£530k	£596k	£545k	£634k
Overtime Costs	Improving Resources	Effective	AD	-	£6k	£8k	£13k	£5k	£11k	£5k	£8k	£4k	£5k	£7k	£7k	£8k	£48k
Additional Hours Costs	Improving Resources	Effective	AD	-	£23k	£29k	£15k	£23k	£31k	£32k	£29k	£30k	£31k	£24k	£26k	£27k	£40k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£483k	£430k	£449k	£420k	£461k	£471k	£507k	£586k	£580k	£580k	£612k	£476k	£482k
Business Miles	Improving Resources	Effective	AD	-	230k	274k	264k	259k	291k	269k	279k	267k	299k	279k	286k	270k	289k

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont…

Mandatory Training
• The Trust is above 80% compliance for each of the 14 mandatory training programmes with 6 being above 90%

Appraisals
• The appraisal rates continues to be above the 95% target and at the end of March remains at 97.5%, which is slightly above the rate for the same period last year (96.7%)

Sickness Absence:
• The sickness rate in March of 4.6% which is in line with the Trust projections and the year end position for sickness absence is 5.0%, whilst higher than the target this represents a 0.2% improvement compared to last year.
• Forensic services absence increaded from 6.8% to 7.4%. A targeted action plan is being agreed as part of a programme to improve staff wellbeing.
• The Trust compared to other MH/LD Trust in Yorkshire has a below average sickness rate and is the second lowest of the 6 organisations.
• Wakefield, Calderdale and Kirklees specialist services and support services sickness rate decreased with Barnsley remaining the same.

Turnover:
• Turnover continues to be an area of focus and the recruitment and retention task group have developed an action which is monitored through the workforce and remuneration committee.
• Staff turnover reduced year on year from 12.6% to 11.9%

Guardian of Safe Working Report - Q4 (Jan-Mar 2019)

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. There was a GPVTS vacancy in the rotation up to January but the situation in Barnsley has improved from February.

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 none during this period.

Fines

There have been none within this reporting period.

Work schedule reviews

There were no reviews required.

Gaps by rota January/February/March '19

Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	3 (2%)	0	0	3 (100%)	0
Calderdale 1st	45 (25%)	43 (96%)	0	0	2 (4%)
Kirklees 1st	15 (17%)	15 (100%)	0	0	0
Wakefield 1st	6 (3%)	6 (100%)	0	0	0
Total 1st	69 (11%)	64 (93%)	0	3 (4%)	2 (3%)
Wakefield 2nd	4 (4%)	0	0	4 (100%)	0

Costs of Rota Cover January/February/March '19

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	0*	0	0	0	
Calderdale	43 (374)	£13187.25	0	0	£13187.25+
Kirklees	15 (112)	£7700.00	0	0	£7700.00
Wakefield	6 (73.5)	£2572.50	0	0	£2572.50
Total	64 (559.5)	£23459.75	0	0	£34806.75+

• 2 shifts in Calderdale were covered by senior doctors stepping down who were paid according to their individual terms and conditions. *The vacant shifts in Barnsley were covered by other trust staff paid according to their own terms and conditions.
• There continue to be a number of trainee vacancies across the trust which in turn places greater pressure on those in post. As a result of these vacancies there are numerous gaps on the rota and the lack of staff means that the remaining Trainees cannot be expected to do all the extra shifts. The tables detail rota gaps by area and how these have been covered. As discussed, the areas with the most vacancies have the most gaps. 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 2 shifts unfilled, both in Calderdale and senior staff were required to act down.

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 further such trainees will be allocated to the trust. Unfortunately there were no new core trainees appointed to the Calderdale in Kirklees scheme to start in February and initial figures suggest that while other rotations have largely been filled, there are still likely to be a number of vacancies for Calderdale and Kirklees in 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, there have still been 2 shifts that were un-covered and senior staff were required to act down.
• 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 or the AMD for Medical Education.
• Education and support – The Guardian will continue to work closely with the AMD for Postgraduate Medical Education to improve trainees experience and to support clinical supervisors. The Guardian will continue to encourage trainees to use Exception Reporting, both at induction sessions and through the Junior Doctors' Forum.
• 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.

Department of Health and Social Care

Overseas visitor charging: guidance for NHS service providers on updates to regulations
This guidance sets out how changes to charging regulations will affect how NHS organisations recover costs from overseas visitors and migrants if the UK leaves the European Union with no deal.
Click here for link to guidance

NHS England

NHS Workforce Disability Equality Standard: technical guidance
The NHS Workforce Disability Equality Standard is designed to improve the workplace experience and career opportunities for disabled people working, or seeking employment, in the NHS. Organisations will be encouraged to introduce new measures and practices that positively support disability equality in the workplace and further the involvement and engagement of disabled communities more widely in the work and aims of the NHS. This technical guidance provides detailed information and advice to support the Standard which will apply to all NHS trusts and foundation trusts from 1 April 2019.
Click here for guidance

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

Learning disability services monthly provisional statistics (assuring transformation: March 2019, mental health statistics data set: January 2019, final)

Direct access audiology waiting times: February 2019

Out of area placements in mental health services: January 2019

Provisional monthly hospital episode statistics for admitted patient care, outpatient and accident and emergency data: April 2018 –February 2019

Psychological therapies: reports on the use of Improving Access to Psychological Therapies (IAPT) services, England January 2019 final including reports on the IAPT pilots

Community services statistics: December 2018

Diagnostics waiting times and activity: February 2019

Referral to treatment waiting times statistics for consultant-led elective care: February 2019

Delayed transfers of care: February 2019

Early intervention in psychosis: February 2019

Monthly hospital activity data: February 2019

Publication Summary

Cover of vaccination evaluated rapidly (COVER) programme 2018 to 2019: quarterly data

Weekly national flu reports: 2018 to 2019 season

Mixed sex accommodation breaches: February 2019

NHS Improvement provider bulletin: 17 April 2019:

- New reference price for adalimumab
- Opportunity for views to be submitted related to the 2019/20 national tariff consultation process
- Reducing inappropriate polypharmacy
- Financial planning workbooks
- Midlands and East of England: safeguarding — gangs and county lines

NHS Improvement provider bulletin: 3 April 2019:

- Extension of pause on the use of vaginal mesh
- New ambulances to be purchased in line with the standard ambulance vehicle specification from 1 April
- Changes to self-certification communications
- NHS England and NHS Improvement funding and resource publication
- NHS Assembly membership
- 2017/18 reference cost benchmarking tool now available
- Developing workforce safeguards
- NHS optical voucher values/hospital eye service maximum charge from 1 April
- Gender pay gap report
- Updates from NHSI partners

NHS Improvement provider bulletin: 27 March 2019:

- Change to venous thromboembolism (VTE) data collection
- Workforce deployment software supplier contracts — renewal guidance
- 2019/20 national tariff published
- Official statistics on patient safety incident reporting and latest patient safety review and response report
- Updates from NHSI partners

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

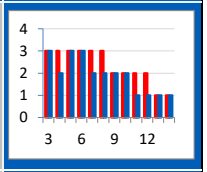
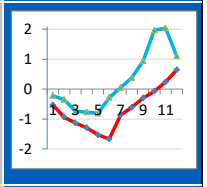
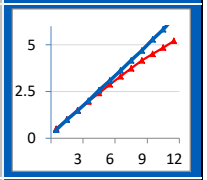
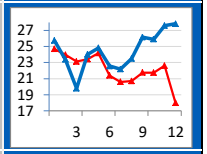
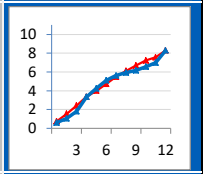
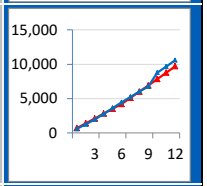
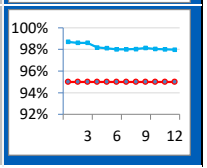
Month 12
(2018 / 19)
Appendix 1

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

Performance Indicator		Year End Position	Year End Plan	Narrative	Trend
1	NHS Improvement Finance Rating	1	1	The financial sustainability risk rating at the end of 2018/19 is rated 1, this is the best rating possible and is in line with plan. All metrics are in line with our revised plan with the exception of agency, the breach of the agency cap by 24% has resulted in a rating of 2 compared to a planned rating of 1.	
2	Normalised Deficit (excl PSF)	(£1.6m)	(£2.0m)	A final position of £1.6m deficit has been recorded for 2018/19. This is £0.5m better than plan and will mean that Provider Sustainability Funding (PSF) of at least £2.7m will be received. The potential for further PSF will be confirmed by NHS Improvement in late April 2019; the value of this is not yet known.	
3	Agency Cap	£6.5m	£5.2m	Agency expenditure for the year of £6.5m exceeds the agency cap by £1.3m (24%).	
4	Cash	£27.8m	£18.0m	Cash remains ahead of plan primarily due to one off benefits such as asset sales, additional commissioner income and low levels of outstanding debtors.	
5	Capital	£8.3m	£8.3m	Total capital expenditure is in line with plan at £8.3m. This is an increase from the original £8.1m plan due to £0.2m additional national funding secured. The major schemes undertaken in year, non secure wards and clinical record system will both formally be completed in Q1 19/20.	
6	Delivery of CIP	£10.6m	£9.7m	The Trust has exceeded the CIP target for 2018/19 given higher capital charge savings. Of this £2.7m is identified as non recurrent.	
7	Better Payment	98%		This performance is based upon a combined NHS / Non NHS value. Overall the Trust have maintained excellent performance against this metric and ensured that suppliers are paid in a timely manner.	

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels	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		Revised Plan - Month 12	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	2.7	1	2.5	1
	20%	Liquidity (Days)	21.1	1	17.2	1
Financial Efficiency	20%	I & E Margin	0.5%	2	0.3%	2
Financial Controls	20%	Distance from Financial Plan	0.2%	1	0.0%	1
	20%	Agency Spend	24.0%	2	-0.1%	1
Weighted Average - Financial Sustainability Risk Rating				1		1

Impact

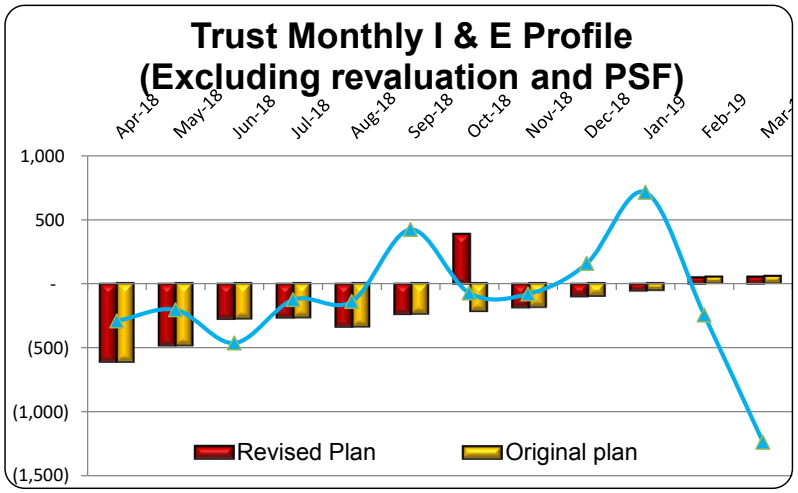
The Trust has achieved a financial sustainability risk rating of 1, the highest rating available. The overall risk rating is based on a weighted average, the capital service capacity, liquidity and distance from plan metrics all scored level 1. The I & E margin score was under a 1% surplus and as such achieved level 2, agency spend also achieved level 2. It should be noted the original plan was to achieve a financial risk rating of 2. This improved to 1 when the revised control total of £2m deficit was accepted.

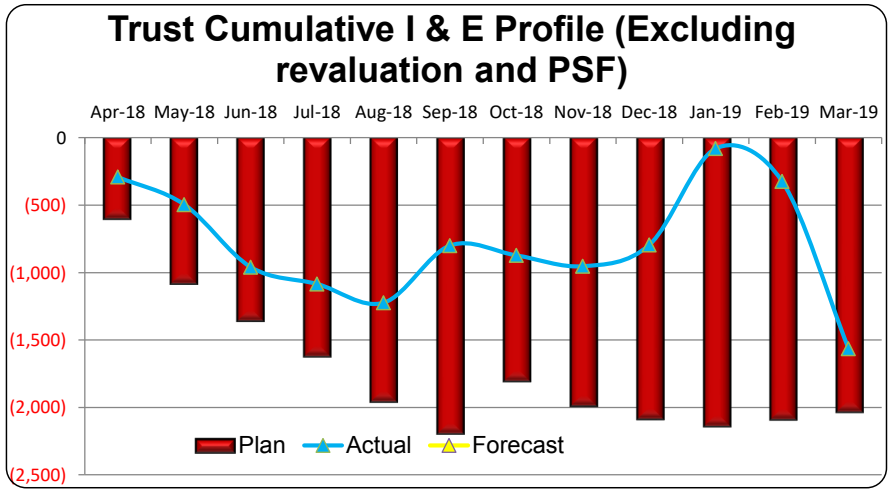
Definitions

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 End Budget	Year End Actual	Year End Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**
				16,881	17,506	625	Clinical Revenue	201,471	202,942	1,471
				16,881	**17,506**	**625**	**Total Clinical Revenue**	**201,471**	**202,942**	**1,471**
				1,518	1,419	(99)	Other Operating Revenue	13,971	14,457	486
				18,399	**18,925**	**526**	**Total Revenue**	**215,442**	**217,399**	**1,957**
4,108	4,112	4	0.1%	(14,251)	(15,304)	(1,053)	Pay Costs	(168,709)	(168,476)	233
				(3,815)	(5,321)	(1,507)	Non Pay Costs	(42,610)	(44,959)	(2,349)
				499	1,130	631	Provisions	2,602	1,708	(894)
				0	(26)	(26)	Gain / (loss) on disposal	600	500	(100)
4,108	**4,112**	**4**	**-0.1%**	**(17,566)**	**(19,521)**	**(1,954)**	**Total Operating Expenses**	**(208,117)**	**(211,227)**	**(3,111)**
4,108	**4,112**	**4**	**-0.1%**	**833**	**(596)**	**(1,428)**	**EBITDA**	**7,326**	**6,172**	**(1,154)**
				(470)	(456)	14	Depreciation	(5,671)	(4,741)	930
				(310)	(204)	106	PDC Paid	(3,726)	(3,156)	570
				4	16	13	Interest Received	45	161	116
4,108	**4,112**	**4**	**-0.1%**	**56**	**(1,240)**	**(1,295)**	**Normalised Surplus / (Deficit) Excl PSF**	**(2,026)**	**(1,564)**	**462**
				310	310	0	PSF (Provider Sustainability Fund)	2,670	2,670	0
4,108	**4,112**	**4**	**-0.1%**	**366**	**(930)**	**(1,295)**	**Normalised Surplus / (Deficit) Incl PSF**	**644**	**1,106**	**462**
				0	(775)	(775)	Revaluation of Assets	0	(11,856)	(11,856)
4,108	**4,112**	**4**	**-0.1%**	**366**	**(1,705)**	**(2,071)**	**Surplus / (Deficit)**	**644**	**(10,750)**	**(11,394)**





Income & Expenditure Position 2018 / 2019

The Trust has delivered its financial target for 2018/19. Significant financial pressures, arising from demand, have been offset by one off savings and actions.

Update to plan

The plan position was updated in October 2018 as agreed by Trust board to reflect the one-off gain on the disposal of Trust properties. The Trust has agreed a revised control total of £2.0m deficit (pre PSF) for 2018/19 and a surplus of £644k including PSF.

Month 12

The March position is a pre PSF deficit of £1.2m and a post PSF deficit of £0.9m. The normalised full year position is a pre PSF deficit of £1.6m, which whilst £0.5m favourable to plan, has only been made possible by a number of non-recurrent measures. The underlying position remains adverse to this.

The key pressures remain as previous months and are outlined below; workforce pressures and out of area bed usage continue to be the most significant although these are partially mitigated through savings elsewhere within the Trust, and receipt of non-recurrent income.

Income

At month 12 income is £0.6m higher than plan. A full breakdown of income is shown on page 7.

An estimate of current CQUIN risk has been included in this position. This will be fully agreed with commissioners once actual performance is confirmed.

Pay Expenditure

The full year pay saving was £0.2m. Spend in March was higher than the standard profile as all costs incurred but not yet paid e.g. bank shifts, enhancements etc. are estimated and included in the position. The standard run rate, which continues to flag pressures in inpatient service requirements, is being reviewed as part of the overall recruitment and retention action plan. Additional analysis is included within the pay information report to highlight the different expenditure levels across the services.

March agency costs are 77% higher than the month's plan with full year expenditure of £6.5m exceeding the NHSI agency cap of £5.2m by £1.3m. Bank costs also continue to increase. The amount spent on temporary staffing this year totals £15.8m 9.4% of the total workforce expenditure. Additional information is provided in the pay and agency section.

Inpatient wards across the Trust continue reporting significant pressures. Across all inpatient wards (excluding Forensic BDU) the average overspend each month is £235k, due to high occupancy, high acuity levels, vacancies and sickness.

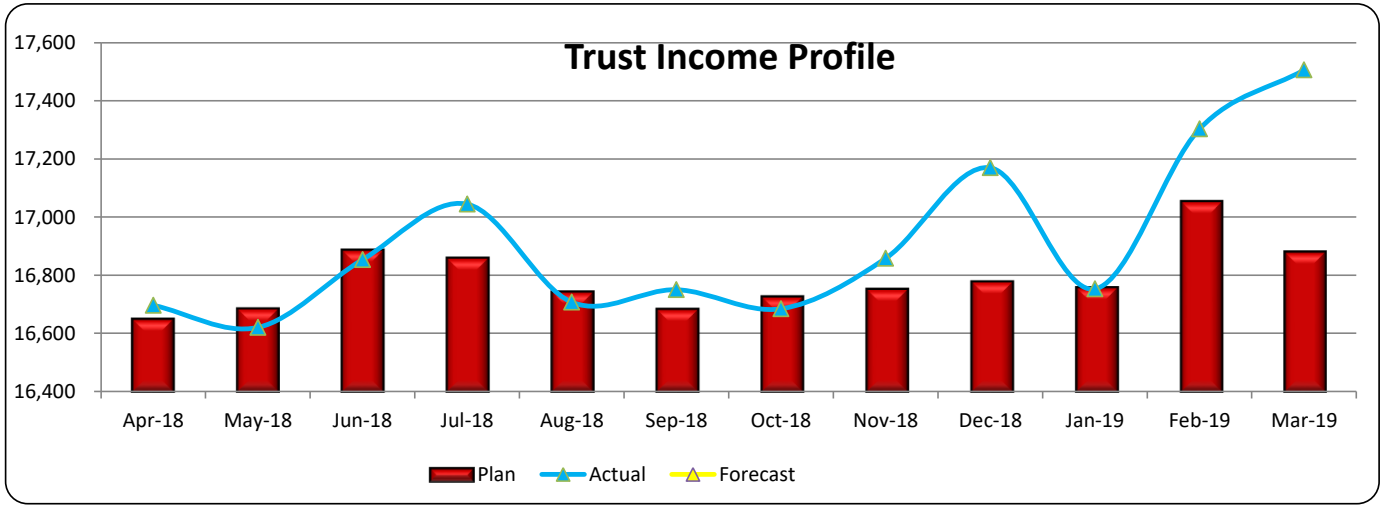
Non Pay Expenditure

Non pay overspent by £2.3m in 2018/19. Excluding out of area beds and drugs costs this reduces to £0.2m. Out of area bed spend is £355k in-month and £3.9m cumulatively. 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.

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	12,429	12,663	**146,036**	**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	1,290	1,288	1,324	**14,596**	**11,478**
Local Authority	430	413	422	438	426	426	416	437	437	437	375	416	**5,074**	**4,851**
Partnerships	577	577	577	585	655	595	561	612	611	559	605	659	**7,172**	**6,838**
Other	558	567	543	543	560	579	542	542	604	516	660	497	**6,709**	**6,981**
Total	**16,696**	**16,620**	**16,853**	**17,044**	**16,707**	**16,750**	**16,684**	**16,858**	**17,169**	**16,752**	**17,303**	**17,506**	**202,942**	**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**	



Year end income positions have been agreed with the main CCG commissioners. This includes an agreed estimate of CQUIN performance; which will be confirmed in early 19/20.

Income is higher than plan in month due to:

Additional commissioner investment to support costs incurred to deliver in year activity. This includes both inpatient activity over the course of the year and also additional investment in areas such as CAMHS waiting lists to deliver increased levels of activity.

Contracts, with the main commissioners, have been agreed for 2019/20.

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 80% 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.

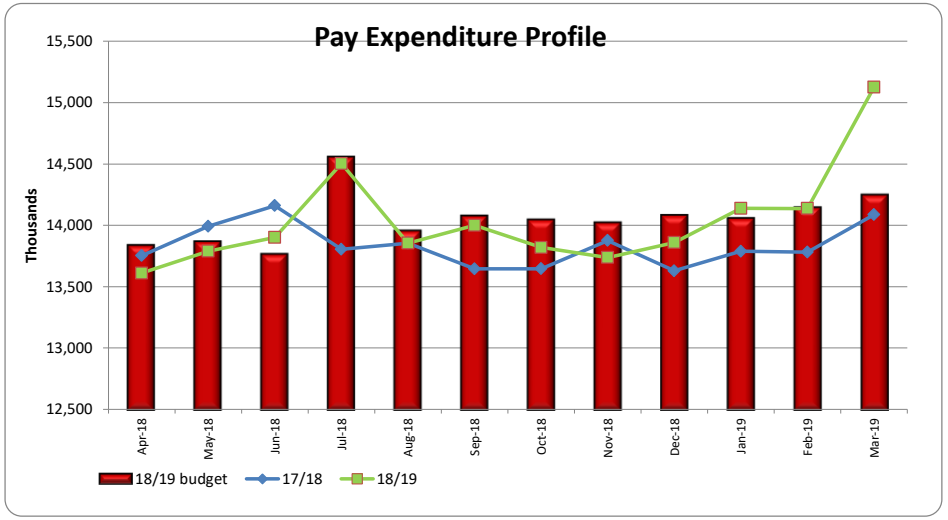
	Apr-18 £k	May-18 £k	Jun-18 £k	Jul-18 £k	Aug-18 £k	Sep-18 £k	Oct-18 £k	Nov-18 £k	Dec-18 £k	Jan-19 £k	Feb-19 £k	Mar-19 £k	Total £k
Substantive	12,595	12,598	12,578	13,290	12,529	12,600	12,647	12,498	12,605	12,755	12,478	13,486	**152,658**
Bank & Locum	571	652	839	687	749	878	635	704	726	787	1,114	1,006	**9,349**
Agency	444	538	484	526	575	522	537	536	530	596	545	634	**6,468**
Total	**13,610**	**13,789**	**13,901**	**14,503**	**13,854**	**14,000**	**13,819**	**13,738**	**13,861**	**14,138**	**14,137**	**15,126**	**168,476**
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%	5.6%	7.9%	6.6%	5.5%
Agency as %	3.3%	3.9%	3.5%	3.6%	4.2%	3.7%	3.9%	3.9%	3.8%	4.2%	3.9%	4.2%	3.8%

Year to Date Budget v Actuals - by staff group

	Budget £k	Substantive £k	Temp £k	Agency £k	Total £k	Variance £k
Medical	22,161	18,141	484	3,580	22,206	(45)
Nursing Registered	60,584	52,753	3,069	599	56,421	4,163
Nursing	17,985	17,275	4,608	1,408	23,290	(5,305)
Other	40,039	39,594	504	857	40,955	(916)
Corporate Admin	15,225	14,069	175	0	14,244	981
BDU Admin	12,715	10,826	508	25	11,359	1,356
Total	**168,709**	**152,658**	**9,349**	**6,468**	**168,476**	**233**

Year to date Budget v Actuals - by service

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	71,971	63,743	1,796	4,225	69,764	2,207
Inpatient	42,909	37,846	6,546	1,953	46,345	(3,436)
BDU Support	7,002	6,351	168	2	6,521	480
Community	20,366	19,403	355	199	19,957	409
Corporate	26,462	25,315	484	90	25,889	573
Total	**168,709**	**152,658**	**9,349**	**6,469**	**168,476**	**233**



Key Messages

In absolute terms pay expenditure has increased from £166.3m to £168.5m year on year (1.3%). As a proportion of Trust healthcare income this is a reduction from 84% to 83%.

The annual overspend on inpatient services (excluding forensics) is £2.4m. In March this equates to an additional 150 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 (£2.2m).

Full year bank expenditure is £9.3m , £1.9m (25%) higher than the same period in 2017/18 and agency expenditure is £640k (11%) higher than 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.

Across the year medical staffing is underspent by £45k, and is running with circa 47 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 is £5.2m

The year end position exceeds the cap by £1.2m

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 increased again this year 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 profile reduces from £500k per month in April 2018 to £359k per month in March 2019. The year end position exceeds cap by £1.2m (24%).

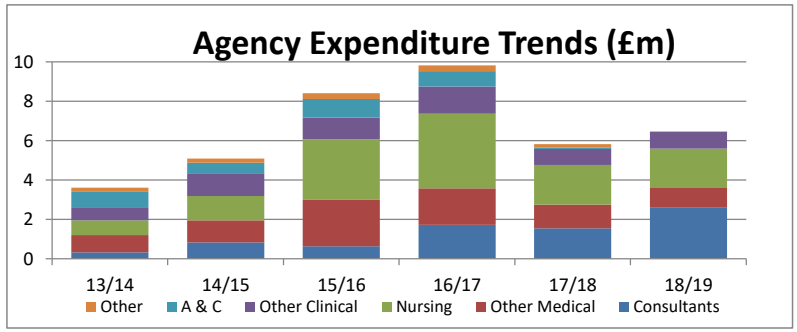
At month 12 agency spend is £634k, which is the highest monthly expenditure of the year.

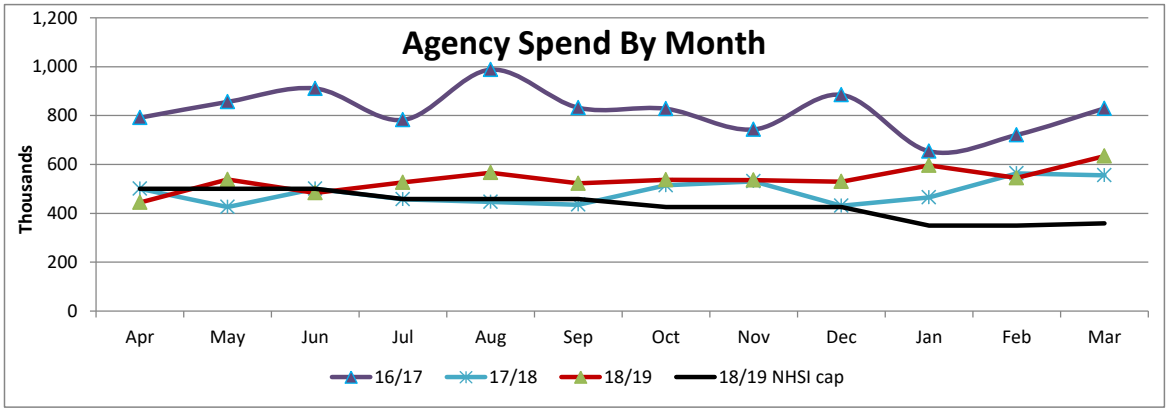
Agency expenditure for the full year totals £6.5m, £640k higher than expenditure in 2017/18. Consultant agency spend increased by £1.1m (69%) compared to 2017/18, Other medical decreased by £0.2m, nursing and other clinical remained at similar levels, whilst admin and clerical and other reduced signifiantly.

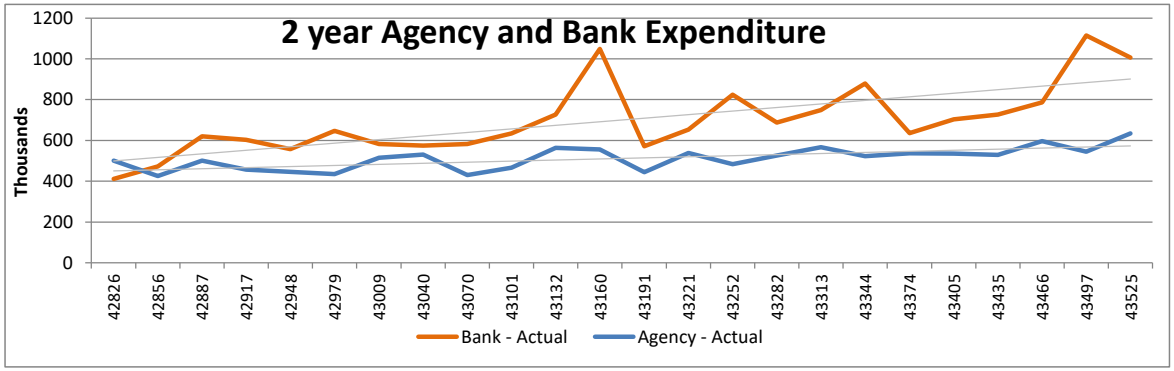
Agency expenditure is subject to detailed scrutiny at all levels within the Trust. Plans continue to be progressed to reduce this level of expenditure. The Trust continues to report agency usage to NHS Improvement on a weekly basis.

Bank expenditure in March is £1.0m. The increase is not restricted to one BDU and mainly results from high acuity, high sickness and on-call cover.

In 2018/19, 82% of bank expenditure has been on nursing staff, of which 83% is across the Trust's 30 wards. Bank nursing expenditure on 4 wards, Johnson, Sandal, Nostell and Walton accounts for 27% of total ward bank nursing expenditure.





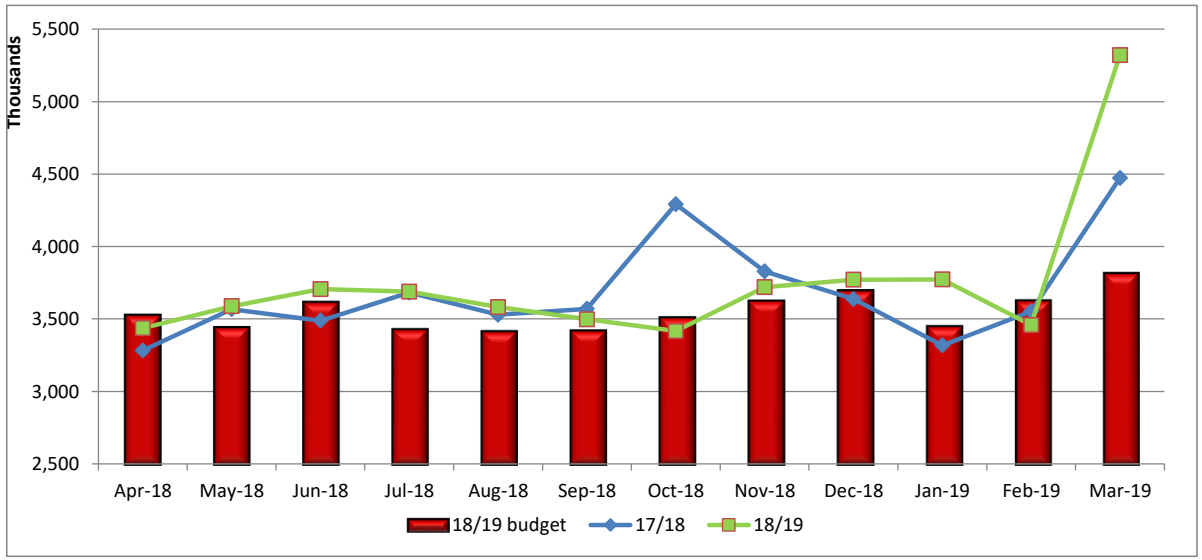


2.1 Non Pay Expenditure

Whilst pay expenditure represents over 80% 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	3,773	3,458	5,321	**44,959**
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 Year End £k	Actual Year End £k	Variance £k
Clinical Supplies	2,717	3,161	(444)
Drugs	2,940	3,371	(430)
Healthcare subcontracting	4,617	6,355	(1,738)
Hotel Services	1,862	1,887	(24)
Office Supplies	5,311	5,138	173
Other Costs	5,113	5,191	(78)
Property Costs	6,528	6,883	(354)
Service Level Agreements	6,153	6,042	110
Training & Education	971	650	321
Travel & Subsistence	3,758	3,474	284
Utilities	1,321	1,395	(74)
Vehicle Costs	1,317	1,414	(96)
Total	**42,610**	**44,959**	**(2,349)**
Total Excl OOA and Drugs	**35,052**	**35,234**	**(181)**



Key Messages

Healthcare subcontracting relates to the purchase of all non-Trust bed capacity and is overspending by £1.7m. As a constant and significant pressure the out of area focus provides further details on this.

Drugs expenditure is £430k overspent against budget, the Pharmacy team continue to review prescribing practices, standardise drugs and ensure that price changes are proactively managed. Property costs is overspent by £354k, this includes small overspends on rates, materials and repairs.Clinical supplies is £444k overspent mainly due to overspends against budget for disibility living aids and general clinical supplies.

Excluding these specific issues good non-pay expenditure control has occured across the majority of areas throughout the year. The largest favourable variances to budget are within travel and subsistence, training & education and office supplies.

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 (£)

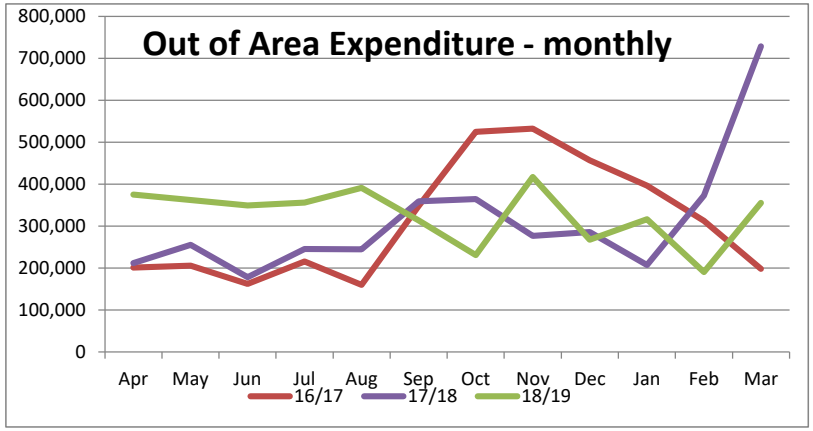
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
16/17	202	206	162	216	160	349	525	533	457	397	313	198	**3,718**
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**

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	329	358	197	220	**4,904**

Bed Day Information 2018 / 2019 (by category)

PICU	316	207	142	91	76	30	48	41	31	31	28	55	**1,096**
Acute	278	157	258	348	542	401	127	396	278	288	129	124	**3,326**
Gender	13	10	12	62	62	42	70	71	20	39	40	41	**482**
Total	607	374	412	501	680	473	245	508	329	358	197	220	**4,904**

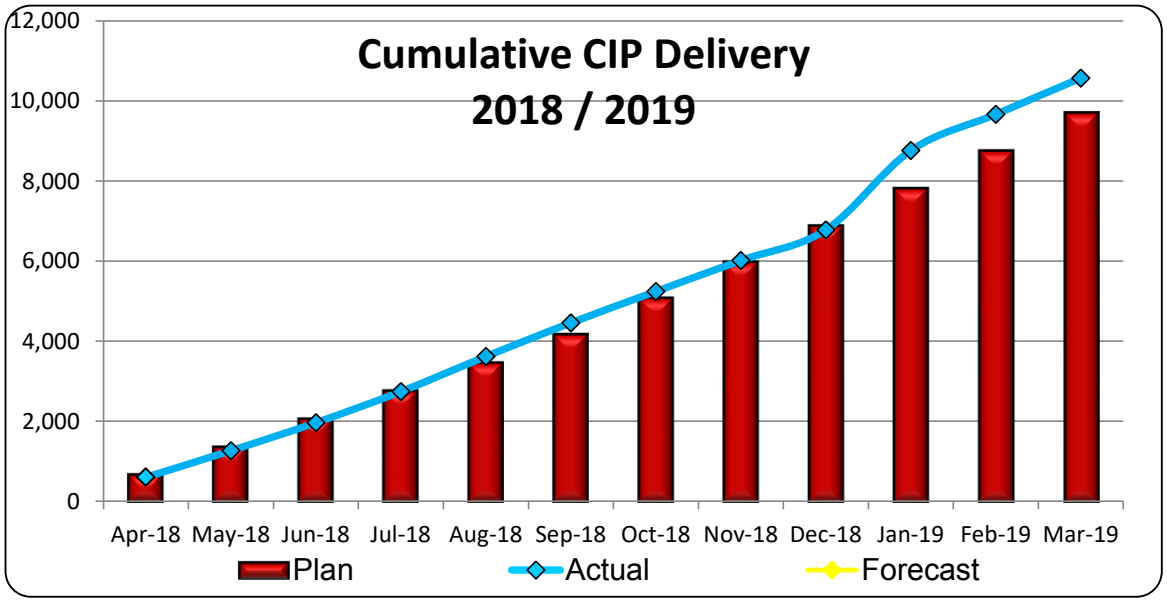


Due to the increasing levels of high demand from January to March 2018 the out of area budget has been weighted to account for higher spend at the start of the year reducing significantly across the year as actions from the project board are implemented.

In March acute activity reduced over the course of the month to 3 female patients out of area. PICU activity steadily increased over the same period, 5 male patients were placed out of area at the end of March, 3 of these were placed in gender specific environments, 1 of them is a patient awaiting a forensic placement and is high cost. Action plans continue to be implemented, with one general manager now responsibile for the adult wards plus out of area placements across the Trust. Workstreams are being set up to implement other plans.

2.1 Cost Improvement Programme 2018 / 2019

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
	£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	9,701
Delivery as originally planned	555	1,136	1,699	2,259	2,827	3,394	3,975	4,560	5,139	5,739	6,342	6,945	6,945
Mitigations - Recurrent & Non-Recurrent	39	124	260	478	788	1,061	1,264	1,455	1,640	3,025	3,327	3,628	3,628
Mitigations - Upside schemes													0
Total Delivery	**595**	**1,260**	**1,959**	**2,737**	**3,615**	**4,455**	**5,240**	**6,015**	**6,779**	**8,764**	**9,669**	**10,574**	**10,574**
Variance	(96)	(122)	(132)	(61)	114	251	139	17	(116)	941	907	873	873



The Trust had set a challenging CIP target for 2018/19 of £9.7m which included £1.6m of unidentified savings at the beginning of the year.

A number of upsides, including the positive impact from the asset revaluation exercise, identified against this target have materialised in year which has resulted in savings of £10.6m, £0.9m more than plan, being identified. This has helped to support the overall delivery of the 2018/19 control total.

Of this value £2.7m (25%) had been identified as non-recurrent. This has been reviewed as part of the annual planning process and an indicative £0.2m will be converted into recurrent savings in 2019/20.

3.0 Balance Sheet 2018 / 2019

	2017 / 2018 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	123,810	126,239	100,006	1
Current Assets				
Inventories & Work in Progress	232	232	259	
NHS Trade Receivables (Debtors)	1,388	2,907	3,012	
Non NHS Trade Receivables (Debtors)	1,913	3,177	1,074	2
Other Receivables (Debtors)	1,219	1,000	1,513	3
Accrued Income	3,660	4,650	3,067	4
Cash and Cash Equivalents	26,559	17,974	27,824	5
Total Current Assets	**34,971**	**29,940**	**36,749**	
Current Liabilities				
Trade Payables (Creditors)	(4,158)	(4,440)	(4,800)	6
Capital Payables (Creditors)	(1,142)	(792)	(1,070)	6
Tax, NI, Pension Payables	(5,782)	(6,000)	(5,880)	
Accruals	(5,799)	(6,000)	(8,020)	7
Deferred Income	(670)	(670)	(276)	
Total Current Liabilities	**(17,552)**	**(17,902)**	**(20,045)**	
Net Current Assets/Liabilities	**17,419**	**12,038**	**16,703**	
Total Assets less Current Liabilities	**141,229**	**138,277**	**116,709**	
Provisions for Liabilities	(6,490)	(4,740)	(7,221)	
Total Net Assets/(Liabilities)	**134,739**	**133,537**	**109,489**	
Taxpayers' Equity				
Public Dividend Capital	44,015	44,015	44,221	
Revaluation Reserve	24,938	24,938	9,453	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	60,566	59,364	50,595	8
Total Taxpayers' Equity	**134,739**	**133,537**	**109,489**	

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

1. Capital expenditure is detailed on page 14. The full programme has been spent with the reduction in asset value due to the impact of the asset revaluation exercise in January 2019.

2. Non-NHS debtors, and debtors generally continue to be lower than plan. Work continues to ensure that this positive position is maintained.

3. Other debtors variance, including prepayments, is due to payment timing for licences and the lease car insurance.

4. Accrued income is lower than planned with as many invoices as possible raised prior to year end.

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.

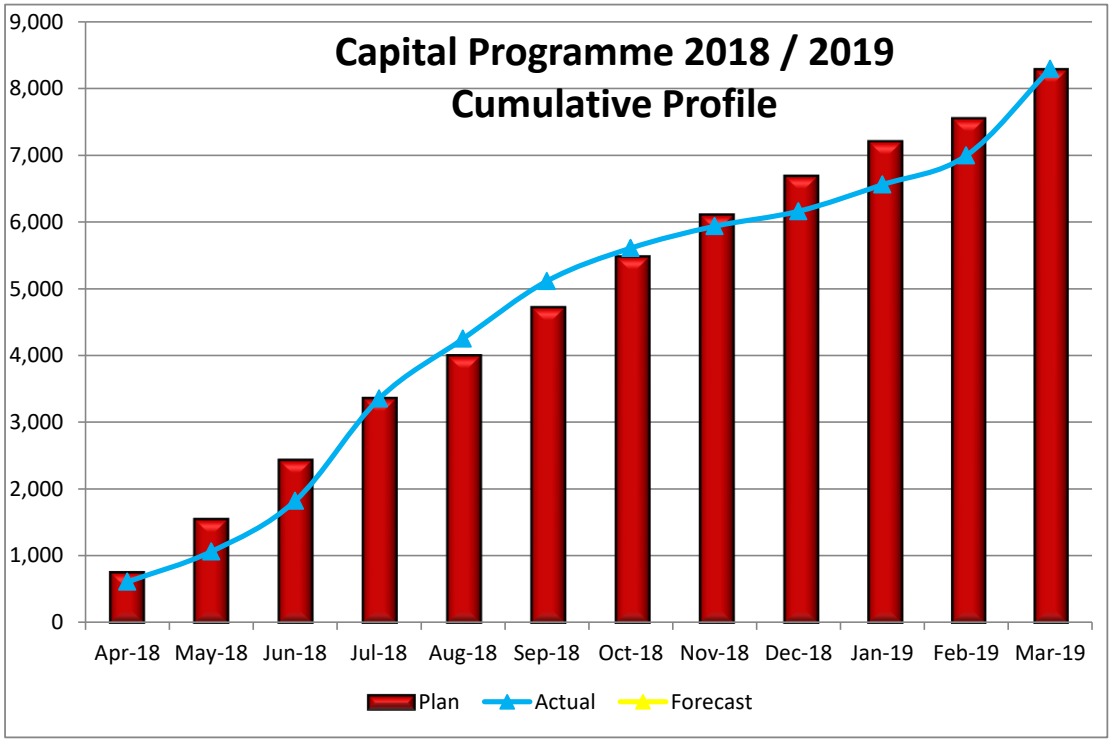
7. Accruals are higher than plan as some invoices have not yet been received.

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

3.1 Capital Programme 2018 / 2019

	Annual Budget £k	Year End Actual £k	Year End Variance £k	Note
Maintenance (Minor) Capital				
Facilities & Small Schemes	1,628	1,576	(52)	3
Equipment Replacement	0	64	64	
IM&T	1,610	1,343	(267)	
Major Capital Schemes				
Fieldhead Non Secure	4,229	4,452	223	
Clinical Record System	828	917	88	
VAT Refunds	0	(56)	(56)	4
TOTALS	**8,295**	**8,295**	**0**	1, 2

The capital programme for 2018/19 has been fully utilised.



Capital Expenditure 2018 / 2019

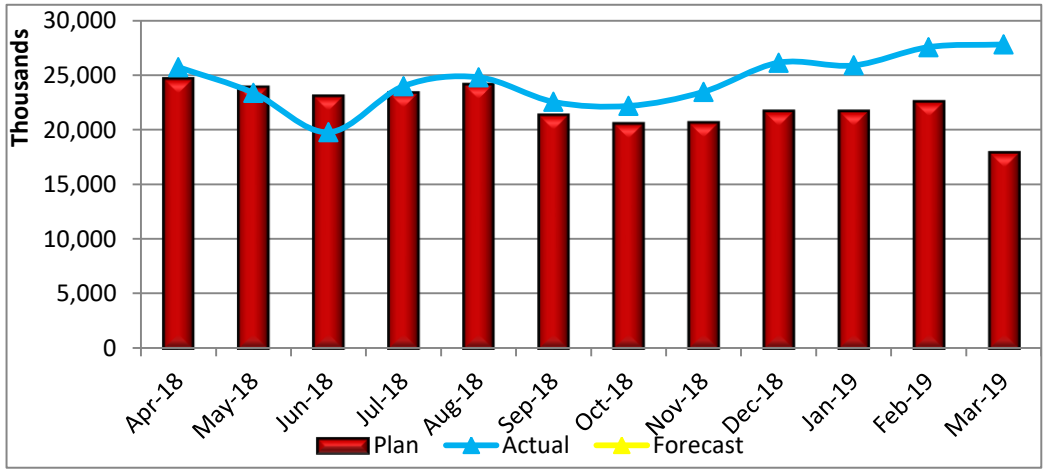
1. The originally agreed capital plan for 2018 / 19 was £8.1m and schemes are guided by the current estates and digital strategy. A further £195k was secured throughout 2018/19 from national funding.

2. All schemes have completed with the exception of the continuation of the main schemes for non secure ward environments and the mental health clinical record system.
These are due to complete in Q1 2019/20.

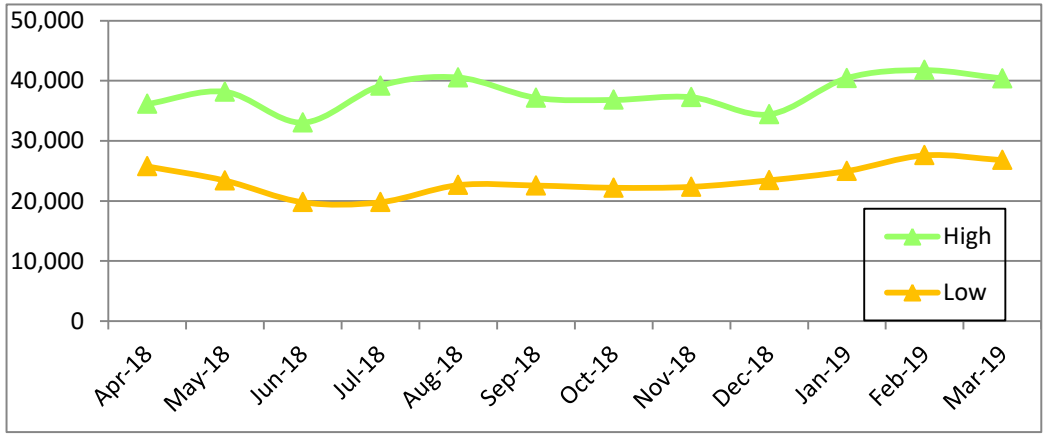
3. An extensive and changing minor capital programme was delivered which continues to help underpin the Trust's activities and ensure we have a safe, effective and pleasant environment for all who come into contact with the Trust.

4. VAT claims for capital programmes are being chased. These will be added back into the capital programme as and when confirmed.

3.2 Cash Flow & Cash Flow Forecast 2018 / 2019



	Plan £k	Actual £k	Variance £k
Opening Balance	26,559	26,559	
Closing Balance	17,974	27,824	9,850



Effective cash management remains a key financial objective. Continued effort has helped to secure a healthy year end cash balance.

Overall cash remains higher than plan due to one off benefits in previous months such as asset sales, additional commissioner income and continued low debtor levels.

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

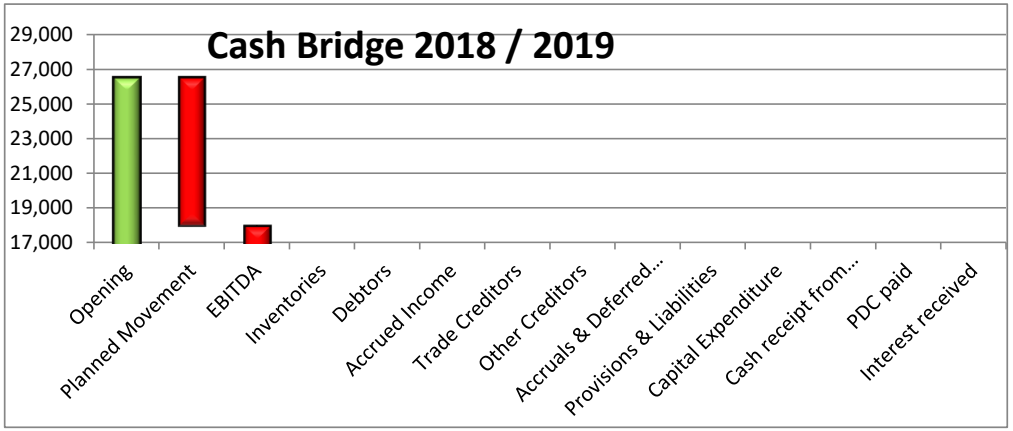
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £40.4m
The lowest balance is: £26.8m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**26,559**	**26,559**	0	
Surplus / Deficit (Exc. non-cash items & revaluation)	8,196	#VALUE!	#VALUE!	1
Movement in working capital:				
Inventories & Work in Progress	0	(27)	(27)	
Receivables (Debtors)	(3,600)	(834)	2,766	2
Accrued Income / Prepayments	0	348	348	5
Trade Payables (Creditors)	350	788	438	
Other Payables (Creditors)	0	207	207	
Accruals & Deferred income	(1,750)	1,827	3,577	3
Provisions & Liabilities	0	730	730	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(8,100)	(8,368)	(268)	6
Cash receipts from asset sales	0	1,295	1,295	4
PDC Dividends paid	(3,726)	(3,205)	521	
PDC Dividends received			0	
Interest (paid)/ received	45	161	116	
Closing Balances	**17,974**	**#VALUE!**	**#VALUE!**	



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

Factors which increase the cash positon against plan:

1. The overall I & E position is better than plan. This does not include the lower than plan depreciation costs which is a non cash item.

2. Debtors are lower than plan and have been a key part of the teams approach to maximising cash. This has been reflected in a revised plan for 2019/20.

3. 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.

4. Cash receipts from the sale of Trust assets

5. Accrued income is lower than planned with as many invoices raised prior to year end as possible. Prepayments are also lower than plan with some agreements expiring as at 31st March 2019 and the new year invoices have not yet been received.

Factors which decrease the cash position against plan:

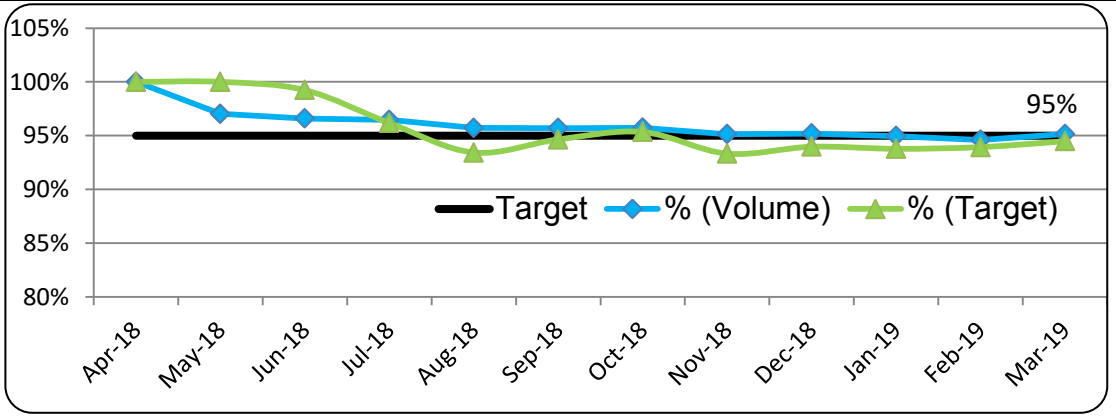
6. Creditors, and capital creditors, are higher than planned. Invoices are paid in line with the Trust Better Payment Practice Code and any aged creditors are reviewed and action plans for resolution agreed.

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

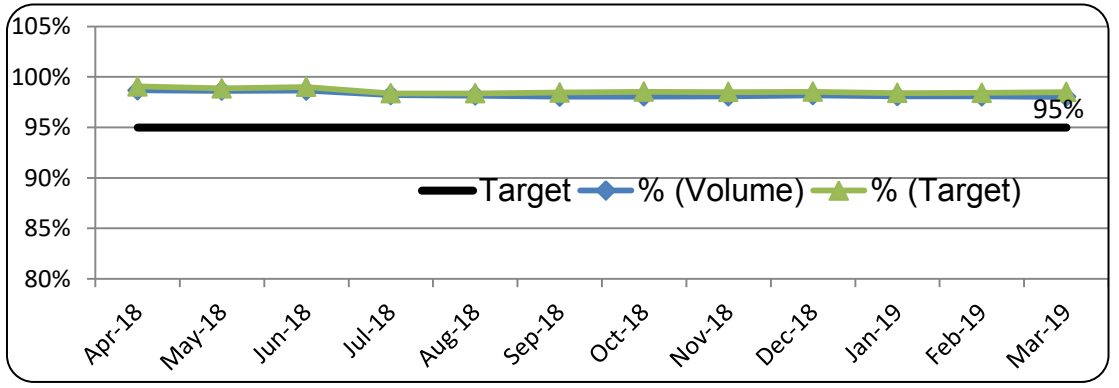
4.0 Better Payment Practice Code

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 February 2019	95%	94%
Year to March 2019	95%	94%



Non NHS	Number %	Value %
Year to February 2019	98%	98%
Year to March 2019	98%	98%



4.1 Transparency Disclosure

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

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

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
18-Mar-19	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3100943	121,808.39
04-Mar-19	Property Rental	Kirklees	Bradbury Investments Ltd	3099159	118,518.12
21-Feb-19	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3099273	105,625.09
22-Feb-19	IT Services	Trustwide	Softcat Ltd	3098252	101,878.80
06-Mar-19	IT Services	Trustwide	Daisy Corporate Services Trading Ltd	3099663	93,125.00
20-Feb-19	Property Rental	Wakefield	Assura HC Ltd	3099712	90,000.00
25-Mar-19	Project Support	Trustwide	Fischer Associates	3101560	69,830.00
19-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3101021	52,440.00
29-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3102055	52,440.00
05-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3099477	47,304.60
05-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3099484	47,304.60
19-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3101064	47,196.00
22-Mar-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3101425	44,122.11
05-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3099477	43,700.00
05-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3099484	43,700.00
25-Feb-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3098344	41,544.32
14-Mar-19	Purchase of Healthcare	Forensics	Sheffield Children´s NHS Foundation Trust	3100602	37,086.75
29-Jan-19	Staff recharge	Trustwide	Leeds and York Partnership NHS FT	3095755	36,658.70
07-Mar-19	Staff recharge	Trustwide	Leeds and York Partnership NHS FT	3099760	35,636.02
08-Mar-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3099817	35,351.47
28-Mar-19	Staff recharge	Trustwide	Leeds and York Partnership NHS FT	3102192	34,882.40
21-Mar-19	Staff recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	3101372	34,812.44
28-Feb-19	IT Equipment	Trustwide	Dell Corporation Ltd	3098901	34,731.36
04-Mar-19	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3099226	34,425.51
21-Mar-19	Property Rental	Kirklees	Mid Yorkshire Hospitals NHS Trust	3101320	34,425.51
12-Feb-19	Staff recharge	Trustwide	Greater Manchester Mental Health NHS Foundation Trust (GMMH	3097209	31,542.67
01-Mar-19	Purchase of Healthcare	Forensics	Cloverleaf Advocacy 2000 Ltd	3099000	31,415.92
06-Mar-19	Property Rental	Barnsley	Community Health Partnerships	3099585	31,178.18
21-Mar-19	Property Rental	Barnsley	Community Health Partnerships	3101311	31,066.10
01-Feb-19	Staff recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	3096065	29,452.53
05-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3099472	29,160.00
01-Mar-19	Electricity	Trustwide	EDF Energy	3098968	29,058.25
21-Mar-19	Staff recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	3101318	27,736.98
05-Mar-19	IT Equipment	Trustwide	Dell Corporation Ltd	3099467	27,456.00
01-Feb-19	Staff recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	3096064	27,390.46
04-Mar-19	Property Rental	Kirklees	Bradbury Investments Ltd	3099163	27,107.82
11-Mar-19	Purchase of Healthcare	Forensics	Humber NHS Foundation Trust	3100056	27,014.50
28-Feb-19	Communications	Trustwide	Virgin Media Payments Ltd	3098875	25,806.44
19-Mar-19	Communications	Trustwide	Vodafone Corporate Ltd	3101016	25,745.23
06-Mar-19	Electricity	Trustwide	EDF Energy	3099611	25,332.84
06-Mar-19	Property Rental	Barnsley	Community Health Partnerships	3099587	25,050.61

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	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.5%	4.8%	5.0%	5.1%	5.1%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.6%	6.7%	6.2%	6.1%	5.7%	5.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	90.2%	96.2%	96.7%	98.7%	98.7%	98.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	77.7%	90.9%	91.7%	94.1%	96.7%	96.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.5%	82.4%	81.1%	81.9%	83.6%	82.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.5%	80.4%	82.5%	82.8%	82.8%	82.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	87.3%	88.2%	88.9%	88.9%	86.5%	84.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.5%	92.0%	92.6%	91.8%	90.9%	89.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.9%	86.6%	87.5%	81.7%	82.4%	80.9%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	74.1%	77.0%	75.0%	77.8%	77.2%	81.7%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	89.8%	90.0%	89.7%	88.8%	90.4%	90.0%
Information Governance	Resources	Well Led	AD	>=95%	90.9%	89.3%	88.6%	94.1%	96.2%	97.6%
Moving and Handling	Resources	Well Led	AD	>=80%	83.5%	85.2%	86.7%	85.4%	87.3%	87.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	87.5%	89.0%	89.1%	90.0%	88.8%	87.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	81.1%	85.0%	84.0%	83.2%	84.7%	78.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	89.1%	90.7%	90.9%	90.6%	90.0%	89.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.4%	89.4%	89.9%	89.1%	88.8%	89.1%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.2%	95.4%	95.8%	95.8%	95.8%	96.2%
Agency Cost	Resources	Effective	AD		£90k	£73k	£68k	£46k	£30k	£37k
Overtime Costs	Resources	Effective	AD		£1k	£0k	£3k	£3k	£1k	£2k
Additional Hours Costs	Resources	Effective	AD		£15k	£17k	£10k	£9k	£13k	£10k
Sickness Cost (Monthly)	Resources	Effective	AD		£185k	£183k	£172k	£177k	£146k	£165k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		77.74	84.42	85.79	73.4	73.85	79.37
Business Miles	Resources	Effective	AD		105k	107k	100k	104k	97k	97k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.4%	4.4%	4.5%	4.5%	4.5%	4.5%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.4%	4.5%	4.9%	5.1%	4.7%	4.2%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.4%	99.7%	99.7%	100.0%	100.0%	100.0%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	92.8%	95.4%	97.1%	97.8%	98.5%	98.5%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	79.2%	80.6%	82.2%	82.4%	82.4%	81.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.2%	79.5%	78.4%	81.6%	79.1%	77.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	87.7%	87.7%	88.0%	88.0%	89.3%	89.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.9%	90.4%	91.3%	90.5%	91.8%	90.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.7%	87.7%	88.8%	85.1%	83.6%	84.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	84.1%	88.1%	87.8%	84.6%	84.3%	83.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	88.1%	87.6%	89.9%	89.8%	90.2%	88.4%
Information Governance	Resources	Well Led	AD	>=95%	94.9%	92.7%	91.2%	97.5%	97.8%	98.8%
Moving and Handling	Resources	Well Led	AD	>=80%	88.5%	89.0%	88.8%	87.8%	88.9%	89.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.9%	91.4%	91.1%	91.9%	92.5%	91.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.6%	89.7%	89.1%	88.6%	87.5%	86.4%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.4%	93.6%	94.6%	93.9%	92.7%	91.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.4%	86.2%	89.9%	88.9%	88.0%	88.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.7%	95.2%	95.2%	94.9%	95.9%	95.9%
Agency Cost	Resources	Effective	AD		£103k	£114k	£105k	£101k	£102k	£135k
Overtime Costs	Resources	Effective	AD		£1k	£4k	£2k	£2k	£1k	£1k
Additional Hours Costs	Resources	Effective	AD		£0k	£1k	£1k	£0k	£1k	£4k
Sickness Cost (Monthly)	Resources	Effective	AD		£109k	£105k	£121k	£127k	£109k	£109k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		78.65	79.51	74.99	68.26	70.03	68.72
Business Miles	Resources	Effective	AD		54k	77k	57k	69k	64k	82k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.5%	7.6%	7.6%	7.7%	7.6%	7.5%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	8.1%	7.6%	8.3%	8.4%	6.5%	5.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.7%	93.3%	93.4%	94.6%	94.4%	94.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	89.7%	96.9%	97.2%	98.4%	98.3%	98.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.6%	86.8%	86.1%	85.1%	87.6%	87.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	85.0%	85.3%	84.7%	84.2%	86.2%	85.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	82.4%	82.2%	85.2%	86.4%	89.3%	89.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.4%	95.0%	95.6%	95.3%	95.4%	94.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.6%	84.6%	87.7%	87.6%	89.5%	87.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	86.1%	86.1%	84.1%	84.3%	87.4%	83.6%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.2%	90.3%	90.4%	90.6%	90.6%	90.4%
Information Governance	Resources	Well Led	AD	>=95%	91.2%	89.8%	93.1%	95.4%	97.2%	98.5%
Moving and Handling	Resources	Well Led	AD	>=80%	91.4%	91.8%	91.4%	90.6%	92.7%	94.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	89.2%	91.3%	90.0%	89.6%	89.5%	89.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	80.6%	85.4%	83.6%	83.3%	83.2%	81.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.6%	93.5%	95.3%	96.0%	96.5%	96.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.5%	87.6%	91.4%	93.3%	94.2%	93.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.5%	82.8%	88.7%	93.3%	93.1%	92.9%
Agency Cost	Resources	Effective	AD		£44k	£62k	£76k	£69k	£31k	£69k
Overtime Costs	Resources	Effective	AD		£0k		£0k	£2k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£3k	£2k	£1k	£2k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£76k	£69k	£80k	£88k	£56k	£55k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		63.16	63.48	57.24	48.97	62.2	64.52
Business Miles	Resources	Effective	AD		5k	4k	9k	8k	7k	9k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.8%	5.0%	5.1%	5.1%	5.0%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.6%	6.3%	5.6%	5.0%	4.6%	3.0%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	98.8%	98.4%	98.4%	99.5%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	77.3%	90.5%	90.5%	91.8%	92.7%	92.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.6%	77.7%	83.7%	85.5%	81.8%	80.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.7%	79.0%	78.3%	78.2%	77.4%	76.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.9%	92.4%	93.2%	92.7%	94.0%	93.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	88.3%	89.2%	90.2%	89.4%	88.5%	88.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.1%	82.0%	83.1%	81.0%	80.4%	80.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	70.0%	73.3%	73.3%	72.4%	72.4%	71.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	89.5%	89.4%	89.3%	89.1%	91.2%	90.7%
Information Governance	Resources	Well Led	AD	>=95%	92.1%	87.4%	87.7%	95.5%	98.2%	98.7%
Moving and Handling	Resources	Well Led	AD	>=80%	89.3%	89.2%	89.0%	87.7%	90.5%	90.2%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.7%	95.1%	94.4%	93.8%	93.9%	93.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.4%	88.7%	86.9%	87.8%	87.6%	86.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.4%	93.6%	93.9%	92.8%	93.3%	93.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.5%	92.1%	93.4%	92.8%	91.2%	91.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.0%	92.3%	92.8%	91.4%	91.9%	92.3%
Agency Cost	Resources	Effective	AD		£221k	£202k	£202k	£264k	£276k	£275k
Overtime Costs	Resources	Effective	AD		£0k	£0k	£0k	£1k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£0k	£2k	£1k	£1k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£82k	£73k	£66k	£59k	£46k	£32k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		63.85	57.17	57.68	56.77	64.46	61.42
Business Miles	Resources	Effective	AD		37k	44k	43k	38k	39k	35k

Appendix 2 - Workforce - Performance Wall cont….

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.0%	4.1%	4.2%	4.3%	4.3%	4.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.2%	5.0%	4.8%	5.4%	4.6%	4.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.5%	99.5%	99.5%	99.5%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	99.0%	98.3%	98.3%	99.2%	99.2%	99.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	79.6%	77.3%	74.0%	76.7%	73.2%	68.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.8%	75.0%	85.2%	84.0%	84.0%	84.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	25.0%	0.0%	100.0%	100.0%	100.0%	100.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	86.0%	87.2%	87.5%	87.6%	88.1%	88.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.7%	89.1%	91.4%	90.0%	89.4%	90.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	94.4%	96.5%	95.9%	97.2%	97.2%	97.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.1%	87.2%	88.3%	88.7%	88.1%	90.3%
Information Governance	Resources	Well Led	AD	>=95%	91.8%	90.4%	94.4%	97.5%	98.7%	98.2%
Moving and Handling	Resources	Well Led	AD	>=80%	89.0%	91.6%	91.4%	89.3%	86.6%	92.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.0%	99.2%	99.2%	99.0%	99.3%	99.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	82.6%	85.7%	87.5%	95.2%	95.2%	95.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.3%	95.1%	96.2%	94.5%	97.5%	97.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.2%	94.2%	95.6%	96.1%	96.8%	96.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Agency Cost	Resources	Effective	AD		£5k	£16k	£8k	£26k	£22k	£12k
Overtime Costs	Resources	Effective	AD		£1k	£1k	£1k	£0k	£4k	£45k
Additional Hours Costs	Resources	Effective	AD		£12k	£9k	£7k	£10k	£7k	£17k
Sickness Cost (Monthly)	Resources	Effective	AD		£71k	£81k	£74k	£83k	£66k	£63k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		42.92	41.1	46.27	50.42	52.74	49.57
Business Miles	Resources	Effective	AD		32k	28k	32k	24k	23k	29k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.7%	4.8%	4.8%	4.9%	4.8%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.9%	5.1%	4.9%	5.6%	4.7%	4.7%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	97.4%	96.9%	96.9%	99.5%	99.5%	99.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	89.9%	93.4%	93.9%	95.8%	95.8%	95.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.8%	83.1%	85.5%	86.3%	85.8%	86.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.2%	78.3%	83.0%	82.9%	81.6%	80.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	78.2%	78.4%	80.9%	82.6%	84.2%	83.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.2%	90.8%	91.3%	92.2%	91.9%	91.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.9%	87.0%	89.2%	88.0%	89.1%	89.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	70.9%	69.7%	67.4%	68.7%	73.6%	74.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	91.1%	91.2%	91.3%	90.9%	92.1%	90.5%
Information Governance	Resources	Well Led	AD	>=95%	92.7%	90.0%	90.5%	97.6%	98.5%	98.9%
Moving and Handling	Resources	Well Led	AD	>=80%	87.1%	89.7%	89.2%	89.5%	92.3%	92.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.5%	92.5%	92.2%	93.1%	92.5%	91.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.7%	87.6%	87.2%	87.6%	86.9%	85.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.5%	93.6%	93.6%	94.3%	94.4%	95.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.0%	87.1%	89.8%	90.0%	89.4%	90.1%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	92.3%	93.3%	94.2%	91.9%	92.7%	94.1%
Agency Cost	Resources	Effective	AD		£73k	£68k	£70k	£90k	£82k	£107k
Overtime Costs	Resources	Effective	AD		£0k		£1k		£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£2k	£1k	£5k	£3k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£62k	£61k	£59k	£68k	£53k	£58k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		42.47	45.36	45	45.52	41.04	39.69
Business Miles	Resources	Effective	AD		34k	39k	38k	43k	40k	37k

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 8.2

Title:	**Safer staffing report**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This paper builds upon the previous six-monthly safer staffing papers submitted since July 2014. It outlines the work being done to ensure ward areas provide staffing levels that are safe and effective.
Mission/values:	Honest, open and transparent, person first and in the centre and improve and be outstanding.
Any background papers/ previously considered by:	Monthly safer staffing exception reports are submitted to the Trust Safer Staffing Group, Executive Management Team and Deputy District Directors. Business case August 2015 and updated paper May 2016 both presented to Executive Management Team.
Executive summary:	The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda. An acuity and establishment review tool for mental health/LD wards has been developed and we await its publication. 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. This results in use of existing staff doing additional hours, bank and agency staff. Staff survey and Datix reports suggest concerns remain regarding safer staffing on wards but action throughout 2017 and 2018 has resulted in increased staffing fill rates, successful recruitment of registered and non-registered staff, significant reduction in agency use and initiatives to respond quickly to areas of need. The CQC published their latest inspection report in July 2018 following a comprehensive re-inspection of SWYPFT services between November 2017 and April 2018. In relation to safer staffing, the CQC identified that in working age adult and forensic mental health wards, we do not always meet our planned 'appropriate' staffing fill rates. However, they accepted that this was above a 'minimum' staffing fill rate. They also highlighted that the trust has taken significant steps in dealing with the challenge of a national shortage of registered staff. They have recommenced their inspection of SWYT services. Key points to note: ➢ The inpatient wards in SWYPT required a 17% uplift on establishment and planned staffing.

	➢ As part of a new NHS Improvement initiative, SWYPT has developed a staff recruitment and retention strategy ➢ Introducing the safer staffing agenda into the community has proven challenging for a variety of reasons but the terms of reference meeting and further monthly meetings have been scheduled from April 2019. ➢ Care Hours Per Patient Day has been published on NHS Choices and a teleconference with NHSi took place on 27th March 2019 to discuss care hours in our PICUs. Plans going forward for 2019/20 include: ➢ SWYPT involvement in the development of a national acuity and staffing resource for community teams, to ensure the trust is at the forefront of any developments ➢ Continue to review the Medical Bank capability ➢ Publish the new staff bank procedure and hold engagement events with bank only staff ➢ Continue expanding the bank to support other areas including AHPs and community teams ➢ Interpret and act upon NHSi Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from January 2019 ➢ Support the introduction of the acuity staffing management tool, Safe Care ➢ Work with OMG to review how we capitalise on the establishment review and opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners) ➢ Contribute to implementation of SWYPT Recruitment & Retention Strategy ➢ Review and improve Preceptorship for newly qualified nurses **The report was considered by the Clinical Governance & Clinical Safety Committee held on the 2nd April 2019. The Committee commented as follows:-** ➢ The report provides a comprehensive review of activity relating to the Safer Staffing agenda. ➢ The positive work around staff retention through the workforce strategy has contributed to the current position. ➢ The regular system of exception reporting of planned vs actual fill rates remains an important part of the routine assurance, through the IPR. ➢ The establishment review is an important part of maintaining assurance and will be addressed during workforce planning this year. ➢ The report provided assurance that the Safer Staffing agenda is being addressed appropriately throughout the organisation. ➢ Challenges in recruitment and retention of registered nurses and concerns about increased rate of 25% of newly qualified nurses leaving within one year **Risk Appetite** Failing to maintain safer staffing within the clinical, operational and support services within the Trust is likely to result in risks to service users, staff and other stakeholders. There are also significant reputational risks. The Trust

	has invested in a safer staffing project to mitigate the risk to supplement existing environmental, procedural and relational solutions and policies and procedures. Capacity and demand are monitored closely and escalation processes in place to maintain safe staffing levels.
Recommendation:	**Trust Board are asked to NOTE the report.**
Private session:	Not applicable**.**

South West Yorkshire Partnership NHS Foundation Trust

Safer Staffing Report

Trust Board 30th April 2019

Reviewed by Clinical Governance and Clinical Safety Committee and amended for Trust Board
2nd April 2019

Specialist Advisor for Safer Staffing
22nd March 2019

Supported by
Deputy Director of Nursing and Quality
Associate Director of Nursing and Quality

PURPOSE OF THE PAPER

This paper provides an update and overview of work undertaken by SWYPFT in response to the safer staffing challenge. The paper outlines the work we have undertaken and what our future plans are to ensure that our clinical areas remain appropriately staffed so that they can run safely and effectively. This is an updated version of the safer staffing paper which went to our Trust Board in November 2018. The paper will be submitted to the April Trust Board, informed by Clinical Governance Clinical Safety committee review.

1.0 INTRODUCTION

At a national level, there continues to be some key changes around the delivery of the safer staffing agenda. Interest in safer staffing arose from concerns nationally regarding acute inpatient staffing levels. The Trust is expected to publicly declare staffing fill rates for inpatient settings and the focus of much of the work to date has been on ensuring safer staffing levels on inpatient wards. However, there will continue to be an engagement process with all our community teams providing mental health, learning disability and physical health care to scope what safer staffing means to them and what support can be provided following transformation processes.

National Health Service Improvement (NHSI) has continued work on providing Safe and Sustainable resource for Mental Health and Learning Disability services through the National Quality Board (NQB). One of the major conclusions is that there needs to be more research carried out in this area. They advise on what areas need to be looked at including the right staff at the right time and in the right place. NHSI have led a working group on an evidence based acuity dependency tool which is awaiting publication. Given this we will be adopting the Safer Care software utilising the indicators of acuity contained within the original Keith Hurst tool for calculating staffing levels.

We have also completed an establishment review for all inpatient areas, which has been integrated into recent Workforce Planning for 2019/20.

The Trust continues to maintain accurate and up-to-date information of “composite indicators“ on the electronic staff record system (ESR) in relation to the proposed Safer Staffing Indicators as follows:

1. Staff sickness rate, taken from the ESR at the end of February 2019;

- Inpatient areas – 6.6% compared to the Trust average of 5.1%

2. The proportion of mandatory training completed at the end of February 2019;

- Inpatient areas: - 98.3% compared to the Trust figure of 98.1%

3. Completion of appraisals at the end of February 2019;

- Inpatient areas – 89.3% compared to the Trust figure of 89.7%

- Staff views on staffing and resources about average based on the 2018 National Staff Survey measure

I have adequate materials, supplies and equipment to do my work:
SWYPFT 56.6% v Average 58%

There are enough staff at this organisation for me to do my job properly:
SWYPFT 31.2% v Average 32.3%

Based on these indicators, positive findings are evident but we continue to be faced with ongoing challenges. Within SWYPFT, significant financial investments have already been made since 2014 to develop interventions around the Safer Staffing agenda including increasing some ward establishments following an establishment review, establishing a peripatetic workforce and centralising the Trust staff bank.

The Trust made the decision to combine the function of the Trust staff bank manager with that of the Specialist Advisor for Safer Staffing and this has helped to ensure a consistent and co-ordinated approach to Safer Staffing.

2.0 SUMMARY OF PREVIOUS REPORT AND ACTIONS

In previous safer staffing assurance reports, we identified a need for the following:

1. Continue to build upon and improve data in exception reports

Action: Monthly exception reports continue to highlight areas where staffing levels fall below 90% overall and below 80% for Registered-qualified staff. Ward Managers in areas that do not achieve targets are asked to provide updates to help improve our understanding of why we have shortfalls (see fill rates below). Monthly Exception Reports have allowed us to develop an enhanced picture of the inpatient ward areas regarding Safer Staffing. We will continue to analyse why areas go above 120% fill rates and the team managers will be asked to provide an exception report for this.

2. Extend and maximise functionality within current e-rostering system as part of the centralisation programme for the Trust staff bank

Action: A report will continue to be sent weekly to the inpatient area Managers and General Managers providing an analysis of each ward's use of the e-roster system. This enables Managers to anticipate and plan for where they could make better use of their available resources and enables them to reflect on the previous week. This provides an understanding of areas that may require support to alleviate staffing shortages and will continue following recent changes to operational structure.

3. Continue to provide effective and efficient support to meet establishment templates

Action: As well as having established a robust process to look at the appropriateness of the establishment resource for inpatient areas, we completed an establishment review in July 2018. This looked at Care Hours per Patient Day (CHPPD), fill rates and other indicators. This work has informed discussions within this round of workforce planning.

4. Project Manager to work closely with 'hotspot' wards where there is pressure on meeting staffing numbers

Action: Where wards are experiencing staffing shortfalls for any reason, support is offered through the Specialist Advisor. This has allowed for temporary contracts to be offered through the staff bank as well as the effective deployment of Peripatetic Workers (PWs). This has been particularly effective when dealing with short term anomalies or bespoke care packages. Localised escalation plans are activated where areas require additional support. This includes clinicians in non-clinical roles supporting the area, initially on a 9 – 5 basis, and is implemented as required and reviewed by the safer staffing group.

5. Involvement in the National Performance Advisory Group

Action: Continued representation within the National Performance Advisory Group for Safer Temporary Staffing, which ensures we are kept abreast and involved in national developments around Safer Staffing. We have recently begun to collaborate with Northern NHS Trusts to get a consensus on reporting and managing safer staffing.

6. Continue to develop, manage and deploy the peripatetic workforce

Action: As well as maintaining a small central resource, which can be deployed across all areas of the trust when required, in the BDUs, staff are being used in a peripatetic way to provide a flexible resource as part of the over establishment strategy. This continues to have a positive effect on the agency spend within the last financial year as well as the waiting time to recruit health care assistants.

7. Enhance the availability of resources within the trust staff bank

Action: There has been a concentrated recruitment drive through the staff bank office with support from the BDUs to recruit medics, Allied Health Professionals, AHP support workers, Admin staff and various other disciplines. This continues to date and we now have 533 staff on the non-substantive bank (see 6.1 below) compared to 353 for the same time in 2018, with 249 staff recruited to the bank in 2018 and 68 so far in 2019.

As the use of bank staff has increased, the use of agency has remained stable (see acuity and additional duties below), 7.7% of workforce were bank v 3.9% in February 2019, compared with 4.5% bank and 3.9% agency in October 2018.

The Trust is currently exploring the option of the organisation NHS Professionals offering independent staff bank services. We are currently undertaking the financial due diligence and developing the business case for the EMT for end of May 2018. If EMT agree the business case the quality due diligence will be completed.

8. Production of a new Staff Bank Procedure

Action: With the support of Human Resources and other support disciplines the new bank procedure has been produced will be published on the staff bank webpage on 23rd April and an email will be sent to all bank staff. This will give clarity in resource availability, utilisation and management and will be reviewed in August 2019.

9. Monitor any NHS Improvement guidance for safer staffing and impact on the trust

Action: As this guidance has been developed, the trust has been a well-placed participant allowing us to help shape this advice and position ourselves accordingly. We are awaiting the publication and licensing of this evidence based tool. This was expected in November 2018 but there are delays due to licensing issues.

10. Align Safer Staffing initiatives with Trust Workforce Strategy

Action: Close co-ordination with the recruitment team has informed the numbers of peripatetic and bank staff needed in the non-registered workforce to support clinical acuity. BDU workforce plans have been informed by an establishment review.

11. Establishment review

Action: A comprehensive establishment review of all 31 inpatient areas was completed, discussed at OMG and approved by EMT.

Findings from the establishment review informed the annual round of workforce planning workshops in 2018/19. The findings from the review were used in negotiations with CCGs and BDUs conducted a capacity and skill mix review of registered staff on wards and considered relative merits of nursing associates and non- registered staff.

As a result of workforce planning process, 75 new trainee nursing associate posts will be recruited to in 2019/20 with a significant investment of over £2million in these substantive staff for our clinical services. These costs will be at least partially offset by savings in bank and agency staff and long-term vacancies.

12. Interpretation of NHS Improvement Care Hours Per Patient Day (CHPPD)

Action: We will review CHPPD data monthly in safer staffing group and this will be escalated to OMG as required. First review of our data compared to Yorkshire and Humber (Y&H) average is summarised in Table 1 below.

The green figures are where we are above the Y&H average, red below and blue about the same. As a Trust overall, we have 2.5 hours more nurse CHPPD than the Y&H average and 1.8 hours more HCA time. We are lower than Y&H average for adult mental illness and rehabilitation wards and higher for PICU and LD wards. Older person wards are higher for nurses but lower for HCAs, whereas forensic wards are slightly lower for nurses and HCAs. Medium and Low Secure units will normally manage their staffing establishment as whole across all 11 wards so shortfalls on one ward will be covered by additional staff in other wards.

There is a wide variation in CHPPD between Barnsley adult mental illness wards and other mental illness wards in the Trust. A previous review of possible reasons for this conducted by a sub-group of OMG concluded that this was due to the different wards sizes; 14 beds in Barnsley, 24 beds in Halifax, 23 on ward 18 in Dewsbury and 22 beds in Wakefield.

The figures have been discussed in OMG and work is underway to address staffing shortfalls and variation across the Trust. This includes recruitment of the additional staff required CHPPD as identified by the recent establishment review, and work to review out of area placements and patient flow across all adult mental illness wards.

On 27th March 2019, SWYPFT had a conference call with NHSI. They queried our relatively high CHPPD rates in Bronte, Walton and Melton wards. They were assured when we informed them that these were high resource-low volume PICUs. Further calls planned with NHSI later in 2019, dates to be confirmed.

Still early days in use of CHPPD data although NHSI have asked if we would be interested in participating in a pilot ‘Case Study’ approach to improve productivity, where higher than average CHPPD are reduced. Conversely, from a CQC perspective the emphasis is likely to be on lower than average CHPPD and a focus on variation across the same core service type.

Table 1: Care Hours Per Patient Day: Comparison between SWYPFT wards and Yorkshire & Humber average based on November 2018 data

Speciality	Ward Name	Trust Nurse	Trust HCA	Y&H nurse	Y&H HCA	Nurse Diff	HCA Diff
Rehabilitation	Neuro Rehab Unit	2.4	5.6	3.5	6.4	-1.1	-0.8
	Stroke Rehab Unit	3.7	5.0	3.5	6.4	0.3	-1.4
Rehabilitation Total		3.1	5.3	3.5	6.4	-0.4	-1.1
Learning Disability Total	Horizon	7.6	19.7	7.6	17.3	0.0	2.4
Adult Mental Illness	Ashdale	2.6	2.9	3.5	4.9	-0.9	-2.0
	Beamshaw	4.9	4.7	3.5	4.9	1.5	-0.2
	Clark	4.4	4.0	3.5	4.9	0.9	-0.9
	Elmdale	2.5	2.9	3.5	4.9	-0.9	-2.0
	Enfield Down	2.9	4.1	3.5	4.9	-0.6	-0.9
	Lyndhurst	2.7	5.1	3.5	4.9	-0.8	0.2
	Nostell	2.7	5.7	3.5	4.9	-0.7	0.7
	Stanley	3.3	3.2	3.5	4.9	-0.2	-1.7
	Ward 18	2.5	3.3	3.5	4.9	-0.9	-1.6
Adult Mental Illness Total		3.3	4.6	3.5	4.9	-0.1	-0.3
Adult Mental Illness PICU	Melton Suite PICU	10.5	20.4	6.0	14.1	4.5	6.3
	Walton PICU	6.6	12.0	6.0	14.1	0.6	-2.1
Adult Mental Illness PICU Total		8.6	16.2	6.0	14.1	2.5	2.1
Forensic Psychiatry	Appleton	6.8	16.9	4.6	7.8	2.2	9.2
	Bronte	8.7	13.6	4.6	7.8	4.1	5.8
	Chippendale	4.0	5.5	4.6	7.8	-0.6	-2.2
	Hepworth	3.4	4.4	4.6	7.8	-1.2	-3.4
	Johnson	3.3	8.4	4.6	7.8	-1.3	0.7
	Newhaven	4.1	6.1	4.6	7.8	-0.5	-1.7
	Priestley	2.4	3.0	4.6	7.8	-2.2	-4.8
	Ryburn	6.9	5.7	4.6	7.8	2.3	-2.1
	Sandal	4.0	9.8	4.6	7.8	-0.6	2.0
	Thornhill	3.4	4.7	4.6	7.8	-1.2	-3.1
	Waterton	2.7	4.4	4.6	7.8	-1.9	-3.4
Forensic Psychiatry Total		4.5	7.5	4.6	7.8	-0.1	-0.3
Old Age Psychiatry	Beechdale	3.4	4.8	3.0	7.0	0.4	-2.2
	Chantry Unit	3.2	6.5	3.0	7.0	0.2	-0.5
	Poplars	3.5	9.1	3.0	7.0	0.5	2.1
	Ward 19 - Female	4.1	5.3	3.0	7.0	1.1	-1.7
	Ward 19 - Male	3.7	4.7	3.0	7.0	0.7	-2.3
	Willow Ward	4.8	10.3	3.5	4.9	1.3	5.4
Old Age Psychiatry Total		3.6	6.1	3.0	7.0	0.6	-0.9
Total						2.5	1.8

3.0 ANALYSIS OF FILL RATES December 2018 – February 2019

The Deputy District Directors and EMT receive monthly exception reports on fill rates (figures 1 and 2) within our inpatient areas with particular emphasis on areas where fill rate overall (registered nurses and health care assistants) is below 90%, and where registered nurses on days or nights falls below 80%. Managers are asked to provide exception reports on why fill rates are not achieved, how it was managed and actions to prevent recurrence.

Figure 1. **Overall Day Registered Nurse Fill Rate Inpatient Areas per BDU**

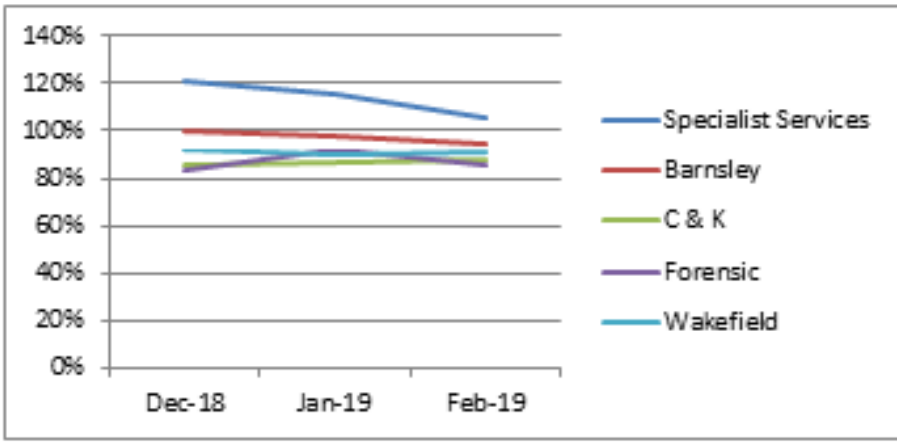


Figure 2. **Overall Night Registered Nurse Fill Rate Inpatient Areas per BDU**

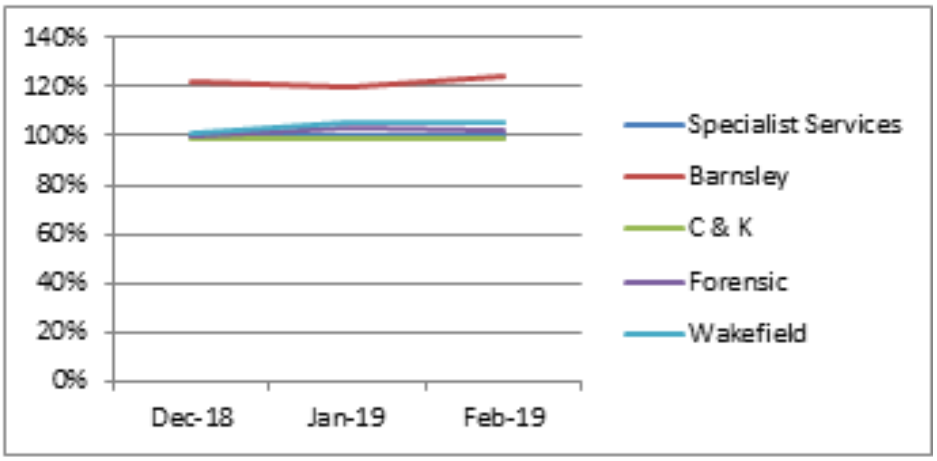
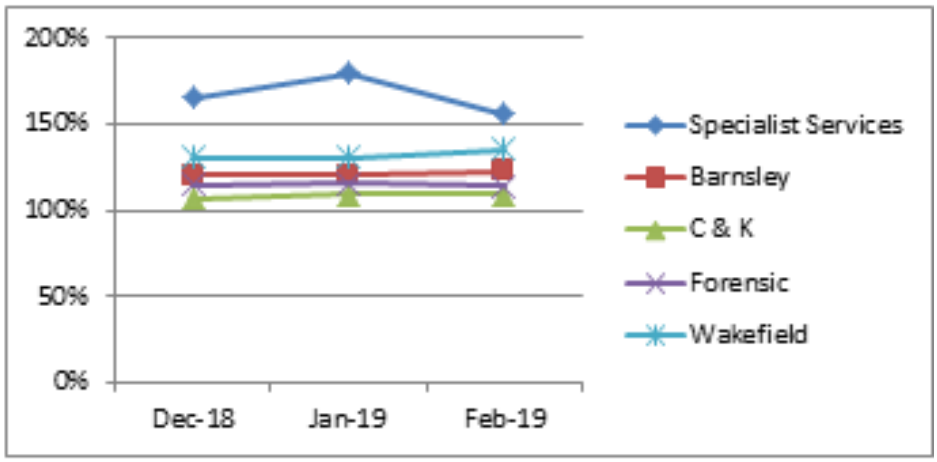


Figure 3. **Overall Fill Rate Inpatient Areas per BDU**



Summary of fill rates

Based on the above graphs, overall combined fill rates remain above the 100% level and they have remained consistent for both registered and non-registered staff with December showing a slight decrease which is in line with our annual leave expectations. This trend shows a fluctuation in overall fill rate for registered nurses particularly on days. This is often compensated through the deployment of our non-registered workforce, which explains why we have high HCA bank and agency usage even though we have very few vacancies.

The majority of wards have experienced challenges in regularly achieving the thresholds in all areas above. This has been due to various reasons including vacancies, sickness and supporting other wards within their BDU.

To be able to provide a balanced understanding of why some wards are not achieving fill rates, we are looking at introducing the ability for ward areas to cancel a shift as opposed to showing it as an unfilled shift. This would only be an exceptional intervention based on the clinical needs of the ward (e.g. when number of inpatients reduces) and ensuring that there is no negative impact on the service users within that area.

We feel this will be supported with the introduction of the SafeCare module which will give a real time reflection of acuity, staffing and “hot spots”.

Many of the areas continue to achieve the overall fill rate through the use of health care assistants to cover temporary vacancies. Recruitment assessment centres for bands 2 and 5 continue in line with our recruitment and retention strategy.

There is also a pattern of a higher fill rate of registered nurses on nights in comparison to days and this is explained in the exception reports as being reflective of a sustained increase in acuity on nights and the need for covering a time span out with the working patterns of other disciplines and senior clinical staff who can offer support.

Acuity and additional duties

There continues to be an upward trend in acuity, which is resulting in the need for more temporary staff. Recent analysis of additional duties has shown a sustained significant demand placed on wards over and above usual staffing establishments. These additional duties were for clinical reasons only and requested in response to increased clinical acuity and demands on staff. Additional duties included special observations of service users (e.g.

staff: service user obs; 1-1, 2-1, 3-1), escorting inside and outside of ward, seclusion, special needs and enhanced care packages.

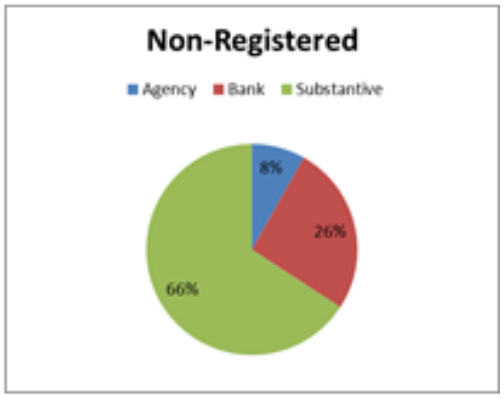
The available figures are for 2018 and in summary, the review of additional duties found;

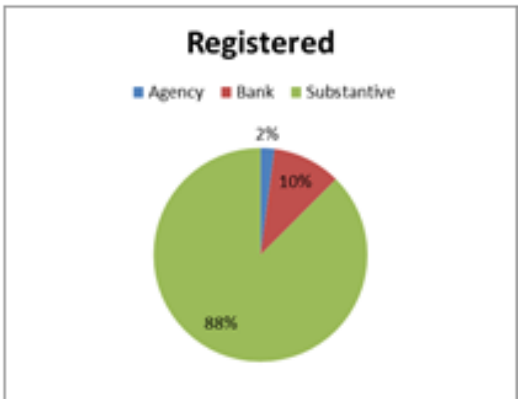
- The inpatient wards in SWYPFT required a 17% uplift on establishment and planned staffing. This does not include the shifts that couldn't be filled.
- Inpatient areas are working above bed occupancy expectations by at least 3% overall.
- Additional duties required during this time in response to clinical acuity equate to over 115.8 HCAs and 8.5 registered nurses giving a total of 124.3 whole time equivalents.

The costs of agency and bank in total for year to date equates to over £7.89 million and is broken up as part of our total spend in the graphs below. Use of agency and bank additional duties includes cover for vacancies as well as increased acuity.

Non-Registered	
Agency	1,391,827
Bank	4,417,231
Substantive	11,184,344
Total	**16,993,401**

Registered	
Agency	352,999
Bank	1,735,386
Substantive	14,650,271
Total	**16,738,655**





As part of our ongoing approach to ensuring that we are utilising our staffing resource optimally, the trust has invested in the safe care acuity tool. This is an attachment to the allocate e-roster package, which allows the inpatient areas to describe their acuity at multiple times during the day and dictates how many staff are needed to manage this at that given moment in time. We are due to begin the roll out process following work with our suppliers and on our infrastructure.

4.0 ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING

In the 12 months leading up to the 28th February 2019, there were 191 Datix incident reports highlighting staffing issues. Although this is a decrease from the previous report there are also a further 143 reported incidents where staffing is listed as a contributory factor. This increase is largely due to a better understanding amongst staff following discussion at the safer staffing meetings.

We continue to monitor and learn lessons including the need for proactive monitoring of staffing levels based on weekly e-rostering 'past and future' staffing levels and using escalation plans sooner. Plans for the future include roster 'check and challenge' events and introduction of Safecare acuity tool

5.0 CQC INSPECTION AND REPORT ON SAFER STAFFING

The CQC published their latest inspection report in July 2018 following a comprehensive re-inspection of SWYPFT services between November 2017 and April 2018. In relation to safer staffing, the CQC identified that in working age adult and forensic mental health wards, we do not always meet our planned 'appropriate' staffing fill rates. However, they accepted that this was above a 'minimum' staffing fill rate. They also highlighted that the trust has taken significant steps in dealing with the challenge of a national shortage of registered staff.

We have commenced the CQC inspection cycle once again following submission of provider information in February 2019. The well-led review is planned for 11th and 12th June 2019 and we can expect our core services to be inspected from May 2019.

5.1 Recruitment since last CQC visit

The Trust has continued a centralised recruitment process for both registered and non-registered nursing staff within inpatient areas. Since September 2016 the Trust has held monthly assessment centres to recruit Band 5 nurses. These have allowed us to remain relatively constant with our band 5 vacancies. There has been continued recruitment of band 2 staff as well as registered and non-registered staff onto the staff bank.

We have also had an increase in the non-substantive bank resources of all disciplines over the last 12 months, with nursing and HCAs in particular from 239 (96 nurses) in March 2018 to 358 (116 nurses) in February 2019 (see below).

Staffing on the bank as of 28th February 2019

Staff Group	Bank Only
Add Prof Scientific and Technic	12
Additional Clinical Services	242
Administrative and Clerical	87
Allied Health Professionals	10
Estates and Ancillary	11
Medical and Dental	55
Nursing and Midwifery Registered	116
Grand Total	**533**

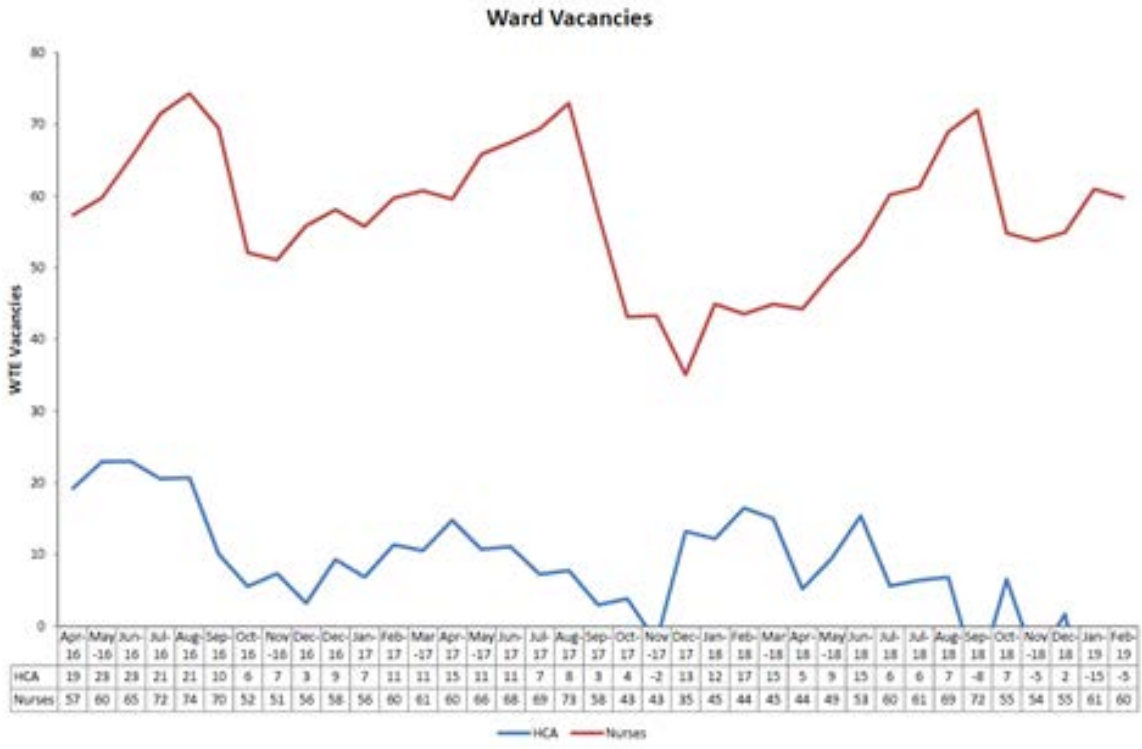
5.2 Retention strategy

As part of a new NHS Improvement initiative, SWYPFT has developed a staff retention strategy aimed at improving retention of staff and reducing our turnover rate to 10% from 10.68% by April 2019. This has been shared with and commended by NHSI workforce team and will be shared at safer staffing meetings as part of implementation plan.

5.3 Vacancies

As with most mental health inpatient wards across the country, SWYPFT experienced a sharp rise in registered nurse vacancies from June to August 2016 and again in 2018. This coincides with the timing of students qualifying and taking up post (Figure 4). Please note that where registered nurses are unavailable for bank or agency duties then often ward teams will cover with HCAs.

Figure 4. Inpatient vacancies



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
HCA	19	23	23	21	21	10	6	7	3	9	7	11	11	15	11	11	7	8	3	4	-2	13	12	17	15	5	9	15	6	6	7	-8	7	-5	2	-15	-5
Nurses	57	60	65	72	74	70	52	51	56	58	56	60	61	60	66	68	69	73	58	43	43	35	45	44	45	44	49	53	60	61	69	72	55	54	55	61	60

NB - This chart shows the difference between the budgeted establishment and staff on Health Roster at the end of each month. Staff on maternity leave and long-term sick are not excluded from the staff numbers but those on secondment (e.g. full-time nurse training) are included.

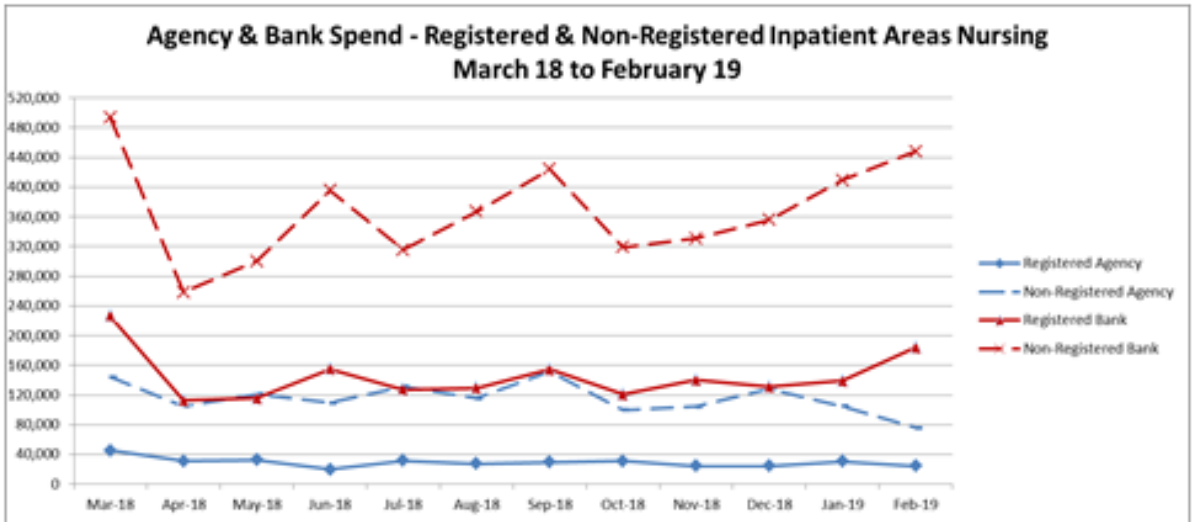
Our centralised band 5 recruitment process allows us to maintain our level of vacancies with fluctuations in line with recruitment from universities. On our inpatient wards, 85 staff including 50 nurses left in 2018/19. At the same time we recruited 84 staff but only 28 nurses.

Registered nursing vacancies are a national problem with the figure expected to rise above 50000 across the UK in 2019. There are various national initiatives looking at staffing and supporting the profession. This includes Nursing Associates as well as apprenticeships for registered nurse training. We plan to recruit 75 trainee nursing associates across the Trust in 2019/20, which will enhance the skill mix at a time of shortages in registered nurses.

A worrying trend is the 25% of newly qualified registered nurses leaving within 12 months of starting in SWYPFT. We have already enhanced the Preceptorship period for newly qualified nurses with reflective practice sessions, training and senior mentors and a meeting is being held on the 2nd May 2019 to consider how we can reinvigorate the Preceptorship plus offer with guaranteed skills training, career progression and improved support and supervision.

Figures 5 shows the positive impact that the recruitment drives, new agency vendor, the centralisation and expansion of the bank office and peripatetic workforce has had on the trust agency spend. Agency spend on inpatient wards in February 2019 was at its lowest since 2016.

Figure 5. Inpatient Registered and Non-registered Agency Spend



5.4 Safer Staffing in the community

Introducing the safer staffing agenda into the community has proven challenging for a variety of reasons. These include the volume of teams and variety of roles, the transformation projects they have been going through for some time and also the lack of a nationally directed and recognised staffing tool. This leads to challenges with benchmarking our teams, resources and outcomes. However, work is in progress to ensure safer staffing within individual teams and caseloads were recently reviewed as part of transformation agenda.

So far, in 2018/19:

- There have been several pieces of bespoke work with various teams including district nurses in Barnsley and CAMHs. This has looked at staffing models and support in service delivery.
- Attendance at several team meetings to introduce the themes and understand what safer staffing means for the community teams.
- Workshop involving the Wakefield and Calderdale & Kirklees areas in June 2018.
- Ongoing involvement in the early stages of developing a staffing tool with NHSI.

A meeting was held with key managers and Deputy Directors on 5th April 2019 and terms of reference for community safer staffing group have been drafted. Given the number of community teams, a roaming safer staffing meeting will be planned starting in May 2019.
This will entail a monthly meeting taking place in rotation with C&K, Wakefield and Barnsley. Initially the team's general managers will be invited to the meetings to restrict the disruption to the local teams. Meetings have been set to begin in April. There will also be an acuity tool

testing phase carried out with a selection of four teams to try and inform on consistency across our teams.

6.0 SUMMARY AND NEXT STEPS

The national commitment to safer staffing is ongoing and SWYPFT need to maintain the progress already made in delivering safer staffing as well as being engaged in the national development of the mental health safer staffing tool and related initiatives.

The Trust currently meets its safer staffing requirement overall, although there is regularly a shortfall in registered nurses and in some areas difficulty in sustaining sufficient numbers in times of increased demands. This has resulted in the use of existing staff, bank and agency staff.

Agency usage in inpatient areas continues to fall as bank usage continues to increase. This is largely due to increased clinical acuity on the wards.

Planned inpatient staffing numbers rostered onto shifts meet or exceed the requirements for planned, appropriate staffing and measures are in place to manage demand and capacity to ensure our wards are safe. The concept of a more peripatetic workforce supported by an enhanced centralised bank staff management system is now established.

Medical staffing bank established and has 65 doctors, as of February 2019, registered on our bank.

Following the drive to produce and publish Care Hours Per Patient Day through NHSI, CHPPD figures for the Trust have been published on NHS Choices from January 2019. This has led to a conference call being set up with NHSI to look at the differences in our attainment figures across our services.

We will continue:

- Building upon and improve data in exception reports including;
    a. Triangulation of DATIX, exception reporting and HR information
    b. Extend the narrative and analysis of the information
    c. Weekly roster analysis including unfilled shifts, acuity and bed occupancy
    d. Understanding any significant increase in staffing fill rates
- Extending and maximise functionality within current e-rostering system as part of the centralisation programme for the trust staff bank
- Providing effective and efficient support to meet establishment templates
- Working closely with ‘hotspot’ wards where there is pressure on meeting staffing numbers
- Supporting the development of the NHSI led acuity tool within community teams
- Developing, managing and deploying the peripatetic workforce
- The Safer Staffing Group, and monitor the action plan and new initiatives
- Working with Quality Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time
- Recruitment onto staff bank
- Aligning Safer Staffing initiatives with new Trust Workforce Strategy
- Making effective use of the awarded agency master vendor contract for both Nursing and AHP

New plans for Quarters 1 and 2 2019 include:

- Involvement in the development of a national acuity and staffing resource for community teams, to ensure the trust is at the forefront of any developments
- Review the Medical Bank capability and assist in registering everyone on e-roster
- Publish the new staff bank procedure and hold a bank engagement event in each main area
- Continue expanding the bank to support other areas including AHPs and community teams
- Collaborate closely with NHSI and OMG to interpret and act upon Care Hours Per Patient Day (CHPPD) statistics as they are reported monthly from January 2019
- Support the introduction of the acuity staffing management tool, *Safe Care,* and develop pilot project plan
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPFT Recruitment & Retention Strategy

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 8.3

Title:	**Annual report on Safe Working Hours Doctors in Training (April 2018– March 2019)**
Paper prepared by:	Guardian of Safe Working
Purpose:	To provide assurance to the Board that we are meeting our responsibilities in relation to the monitoring of safe working hours within the new Doctors in Training contract. Trust Board is asked to note the report.
Mission/values:	The Trust is meeting its duties on safe working hours and requirement to have a Guardian of Safe Working. Caring for the wellbeing of our staff and provision of safe clinical care is essential to support the Trust's mission in helping people to reach their potential and live well in their communities. The training of the next generation of substantive GPs and psychiatrists is of strategic importance for not only the Trust's succession planning but to ensure provision of a highly trained medical workforce within the wider health and care system.
Any background papers/ previously considered by:	Briefing paper presented to Trust Board on 25 April 2017 2017 Quarterly reports presented to Trust Board 27 June 2017, 31 October 2017, 30 January 2017 and 24 April 2018 (within Integrated Performance Report) 2018/19 Annual report presented to Trust Board 24 April 2018 2018 Quarterly reports within Integrated Performance Reports
Executive summary:	The introduction of the 2016 contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. In order to protect the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training, the role of Guardian of Safe Working was established. The Guardian ensures that issues of compliance with safe working hours are addressed as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board that doctors' working hours are safe. The Trust appointed Guardian of Safe Working is Dr Richard Marriott. The 2018/9 Annual Report highlights the following: ➢ The number of exception reports has remained low (3) during 2018/19, which is in line with the majority of trusts providing mental health services. ➢ All concerns were closed. ➢ Concerns about work pressure continue in Calderdale. ➢ How the role of the Guardian of Safe Working is communicated to

	the trainees has been improved with more time given to this at all induction sessions throughout the year. ➢ Although there continues to be a major concern around the number of vacancies on the on-call rotas, improvements have been made around the consistency across the Trust as to how the gaps are managed. ➢ The development of the Trust Medical Bank appears to be assisting in reducing the number of shifts needing to be covered by agency staff, with doctors from the Trust's Medical Bank covered 78% of the 1st on-call rota gaps during the period. ➢ Work to develop a system for monitoring the impact of vacancies from a financial point of view is on-going with more data available than in the previous year.
Recommendation:	**Trust Board is asked to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

ANNUAL REPORT ON SAFWORKING HOURS:
DOCTORS IN TRAINING (April 2018 - March 2019)

Introduction

The 2016 junior doctors' contract has introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The Guardian is independent of Trust management and the Guardian's main roles are to:

- Champion adherence to safe working hours
- Oversee safety-related exception reports and monitor compliance with the system
- Escalate issues for action where not addressed locally
- Request work schedule reviews to be undertaken where necessary
- Intervene as required to mitigate safety risks
- Intervene where issues are not being resolved satisfactorily
- Provide assurances on safe working and compliance with TCS
- Submit a quarterly and an annual report to the Trust Board on the functioning of the contract and exception reporting.

This report outlines:

- Challenges
- The Junior Doctors' Forum
- The number and distribution of doctors in training across the Trust
- A summary of exception reports (ERs) submitted by doctors in training
- Fines
- Work schedule reviews
- Rota gaps and cover arrangements
- Locum Work carried out by Trainees
- Medical Bank
- Issues of concern
- Actions taken
- Summary

High level data

Number of doctors in training (total):	57
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

Challenges

1) **IT System**: The Trust has now been using the IT system Allocate for 12 months. This is used to both develop the rota patterns for junior doctors and manage Exception Reports (ERs). After initial teething problems with emails being caught up in trust filters, this seems to be working smoothly now.

2) **Cost/Salary Implications**: The contract has been largely cost neutral for the trust at this stage but has resulted in considerable changes in salary for certain grades of doctor. There is a large increase in salary between CT2 and CT3 (£10,000+; trainees in other specialties would often be ST3/registrar at this stage). Higher trainees without pay protection will be worse off with no further increment on reaching higher training. On-call pay is based on intensity of work and so higher trainees may choose to work at other trusts where they can earn more on their busier rotas. This may have implications for recruitment in future as doctors who work with the trust as trainees are more likely to apply for consultant posts in trusts with which they are familiar.

3) **Trainee and Clinical Supervisor Engagement**: There are varied levels of understanding about the contract amongst all grades of doctors, many of whom have expressed confusion regarding its implications. To introduce the Guardian role and Exception Reporting System, presentations have been undertaken at the Induction Programme for each cohort of new junior doctors. As well as the Junior Doctors' Forum, I attend the Medical Education Trust Action Group, which has oversight of all issues to do with Medical Education within the Trust.

4) **Trainee concerns**: Trainees Surveys I have carried out suggest that trainees remain reluctant to complete ERsand continue to express uncertainty and anxiety about the exception reporting process. A number of Foundation trainees report that ERs completed in acute trust have not been dealt with, reducing their faith in the system.

5) **Interaction with other Trusts**: a number of the Trust's Trainees are employed by partner organisations, who may have different systems for Exception Reporting. All Trainees have been asked to use the SWYPFT reporting system whilst in a SWYPFT post. As an example of potential effects, one trainee requested Time off in lieu during a SWYPFT rotation in relation to an ER in another trust.

Junior Doctors' Forum

The setting up of a Junior Doctors' Forum is a key requirement of the new contract. The forum meets quarterly. The role of the forum is to advise the Guardian in all aspects of the role.

All junior doctors within the Trust are invited to the forum but particular efforts have been made to ensure that representatives of all the BDUs and rotas are able to attend. The other key attendees are the Associate Medical Director for Postgraduate Medical Education, Local Negotiating Committee Chair or representative and the Human Resources Business Partner. The local British Medical Association representative has also attended periodically.

Few of the issues raised at the forum have related to hours of working. Where hours are raised, the main area of discussion tends to be non-resident on-call (NROC) rotas. Due to the variability of this work, it is hard to specify the workload. Clearly there will be busy nights and trainees have been encouraged repeatedly to complete ERs if they work beyond their contracted hours. Whilst there have been anecdotal reports that these rotas are becoming busier, there have been no related ERs.

Most of the other concerns raised relate to training and issues encountered when on-call. The AMD for Medical Education attends these meetings and is able to pick up on concerns about training. Other on-call issues raised mainly by Calderdale and Kirklees trainees have been raised with the relevant clinical leads to try to address.

Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives Trainees from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the Trainees are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by junior doctors. These are trainees from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme, although Barnsley's 1st on-call rota also includes non-training Specialty

Doctors. The 2nd on-call rotas for each locality are staffed partly by Higher Trainees and partly by non-training Specialty Doctors, the latter whose contracts are subject to different terms and conditions.

Tables shown in the appendix demonstrate the breakdown of the different grades of Trainees in each locality, also noting the areas where there are vacancies. Recruitment to the Foundation and GP training programmes have been good and almost all posts have been filled. Poor recruitment to core training posts in Psychiatry has led to a number of gaps with 1 out of the 7 Wakefield posts vacant, 3 out of 10 posts on the Calderdale and Kirklees Core Training Scheme but none of the 4 posts in Barnsley. Things are looking better for this August in most parts of Yorkshire but this is not the case for Calderdale and Kirklees or Hull (although the second round of interviews may change this).

Exception reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20for%20guardians%20August%202016%20v2.pdf.

Each Trainee receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a Trainee is required to work beyond those hours, or if work commitments prevent them from attending required training, the Trainee is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the Trainee's clinical supervisor. If the clinical supervisor agrees the ER, the options are for the Trainee to be given time off in lieu or to be paid for the extra time.

There have only been a few ERs completed in SWYPFT since the introduction of the new contract. This is to some extent reassuring, although there does appear to be a degree of reluctance amongst trainees to complete ERs. Most trainees state that this is because there had been nothing for them to report. However, others report various concerns; these include uncertainty as to how to complete the report or what would constitute and exception. Others were concerned that exception reporting would not achieve anything and might lead to them being seen as causing trouble. The Guardian has longer sessions with new trainees at induction and has produced more detailed information about exception reporting in their induction pack.

Exception Reports By Area				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	1	1	0
Calderdale	0	1	1	0
Kirklees	0	1	1	0
Wakefield	0	0	0	0
Forensic	0	0	0	0
Total	0	3	3	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
GPVTS	0	0	0	0
CT1-3	0	2	2	0
ST4-6	0	1	1	0
Total	0	3	3	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	0	0
GPVTS	0	0	0	0
CT1-3	0	0	2	0
ST4-6	0	0	1	0
Total	0	0	3	0

For the exceptions noted in the tables above, the actions were:

1) Extra payment was made for 1 exception when a higher trainee was asked to act down to cover a gap in the junior trainee rota.
2) Time off in lieu was granted for the other 2 exceptions.

There were issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. Also, it appears that notifications from Allocate were being caught by the Trust Spam-filter. This has been resolved

after liaison with the Trust's IT department to white-list Allocate emails. All clinical supervisors have addressed the ERs once prompted.

Some higher trainees, employed before 2017, remain on the old 2002 junior doctors' contract. Historically, the response rate for rota monitoring exercises under the old contract has been poor. It has therefore been decided not to attempt to monitor these doctors' working hours separately. They have all been given access to the Allocate system and have been encouraged to complete ERs if they have concerns about their working patterns or hours, although they would not be eligible for payments in the same way as trainees on the new contract.

Fines

Should certain of the hours and rest rules under the new contract be broken, a fine will be incurred, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to use to improve training within the Trust. None of the ERs received so far have resulted in a fine. Despite no fines being levied at this stage, a decision has been made to identify an account and a member of finance personnel to support audit of any funds, should fines be levied.

Work schedule reviews

The new contract requires that generic work schedules detailing work patterns and pay be sent to trainees prior to commencement of the post and this was achieved. Following commencement of the post, the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post. The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period.

Rota gaps and cover arrangements

There continue to be a number of trainee vacancies across the trust which in turn places greater pressure on those in post. As a result of these vacancies there are numerous gaps on the rota and the lack of staff means that the remaining Trainees cannot be expected to do all the extra shifts. The following table details rota gaps by area and how these have been covered. As discussed, the areas with the most vacancies have the most gaps. Due to the number of gaps, it has been necessary to use agency or external staff on a number of occasions. In addition, there were 3 shifts where it was not possible to obtain junior doctor cover.

Gaps by rota April 2018 – March 2019					
Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	124 (17%)	67 (54%)	6 (5%)	51 (41%)	0
Calderdale 1st	180 (25%)	151 (84%)	17 (9%)	9 (5%)	3 (2%)
Kirklees 1st	80 (22%)	80 (100%)	0	0	0
Wakefield 1st	15 (2%)	15 (100%)	0	0	0
Total 1st	399 (16%)	313 (78%)	23 (6%)	60 (15%)	3 (1%)
Wakefield 2nd	14 (4%)	0	0	14 (100%)	0

Colleagues in Postgraduate Administration have been able to capture some information about the financial cost to the Trust of covering rota gaps. This will be offset by vacancies.

Costs of Gaps by rota April 2018 – March 2019				
1st On-Call Rotas	Shifts (Hours) Covered by Bank	Cost (£) of Shifts Covered by Bank	Shifts (Hours) Covered by Agency	Cost (£) of Shifts Covered by Agency
Barnsley	67 (587.75)	20,606.25	6 (52*)	2,598.40*
Calderdale	151 (937.25*)	46,987.25	17(148.25)	6,518.92
Kirklees	80 (1223)	47,305	0	0
Wakefield	15 (159.25)	5,573.75	0	0
Total	313 (2907.25)	120,472.25	15 (151)	9,117.32

Over 40% of shifts in Barnsley and a few in Calderdale were covered by Specialty Doctors who were paid according to their individual terms and conditions. *Some of the hours' data for Barnsley and Calderdale were unavailable.

Locum work carried out by Trainees

The Trust is largely reliant on the current Trainees to do locum shifts to fill the gaps on the rota. However, the number of gaps that have been required to be filled has left staff stretched. Agency staff have been used in Calderdale and to a lesser extent, Barnsley, to fill gaps.

Postgraduate administrators and the Medical Bank staff ensure that Trainees doing locum shifts, sign the European Working Time Directive (EWTD)

waiver. This allows trainees to work up to an average of 56 hours a week instead of the usual 48 hours a week. Postgraduate administrators then monitor to ensure that individual doctors are not taking on excessive additional hours / shifts.

Medical Bank

A Trust Bank that all Trainees are able to join on commencement of work with the Trust is now up and running. It does appear that following this, a greater number of shifts have been covered without the need to employ agency / external staff (23 shifts in 18/19 versus 110 in 2017). This should be safer for patients as well as being slightly cheaper for the trust, given the higher hourly rate charged by agencies.

There have been discussions at HEE and with the other Trusts in West Yorkshire aimed at setting up a county wide bank, to increase the pool of doctors that can cover vacant shifts but this is not likely to be available in the near future.

Issues of Concern

1) **Recruitment:** The biggest current challenge is recruitment to training posts, particularly core training posts in Psychiatry. It is of concern that whilst recruitment to other rotations in Yorkshire has improved, this is not yet the case for the Calderdale and Kirklees Scheme. Staff managing the rotas need to maintain a safe service to our patients while ensuring high quality training and safe working patterns for our Trainees. Initiatives such as the Royal College MTI scheme (Medical Training Initiative – specific to Psychiatrists) and HEE's WAST scheme (Widening Access to Specialty Training – offering 6 months on Psychiatry and 6 months in other settings), both attracting doctors from overseas, may go some way to reducing the number of gaps. However, it is likely to be the quality of the experience we offer to medical students and Foundation doctors that is most likely to lead to trainees choosing to train in Psychiatry in this trust. The appointment of a high quality tutor for Calderdale and Kirklees College Tutor, to develop training further in this part of the trust is underway as a priority.

2) **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 now experienced and used to processes to manage gaps. However, the trust is likely to need to continue to need support from agency locums in the short to medium term.

Actions taken to resolve issues

There have been no significant actions arising out of trainees' working hours. All 3 ERs were dealt with appropriately and none required there to be fines or work schedule reviews.

Most of the other issues raised at the Junior Doctors forum have related to issues arising out of on-call duties. These have been raised with the relevant clinical lead to address. One issue, related to access to training experience in the assessment of patients presenting with self-harm, is under consideration by the AMD for Medical Education to look at the best way to deliver this.

Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract.

The Postgraduate Medical Education Coordinator has implemented processes trust-wide to ensure that trainees doing extra shifts have signed the EWTD waiver and that the number of shifts they do remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff.

The main concerns continue to arise out of vacancies and the management of gaps on the rota. There have been improvements in the consistency across the trust as to how gaps on the on-call rotas are managed. The development of the Trust Medical Bank has improved this with a reduction in the number of shifts needing to be covered by agency staff.

As described above, there have been very few ERs generated. This is not unusual compared to other Trusts providing mental health services. However, the issue of vacancies in Calderdale and Kirklees will continue to put pressure on trainees here, which appears, in turn, to be affecting recruitment. It is concerning that initial recruitment figures suggest that we may have even fewer trainees from August. Without other solutions the employment of locum doctors is likely to be required for some time.

Questions for consideration

Trust Board is asked to note this report. There remain concerns about work pressures, mainly caused by vacancies, especially in Calderdale. The trust has signed up to national initiatives to offer trainees posts to doctors from overseas, which may go some way to fill some of the vacancies. Any unresolved issues will be included in the next quarterly report.

Appendix

Distribution of Trainees by Locality

Barnsley

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	3	0*	Sheffield Health and Social Care Trust
GP Trainee	1	1	Barnsley Hospital NHS Foundation Trust
CT1-3	4	4	Sheffield Health and Social Care Trust
FY2 FY1	1 1	1 1	Barnsley Hospital NHS Foundation Trust

*1 on Maternity Leave and 1 Acting Up in Consultant Role

Calderdale

Grade of Trainee	**Number Expected**	**Number in Post (WTE)**	**Employer**
ST4-6	1	1	South West Yorkshire Partnership NHS FT
GP Trainee	2	2.8	South West Yorkshire Partnership NHS FT
CT1-3	4	1*	South West Yorkshire Partnership NHS FT
LAS (covering Training gaps)	N/A	0.8	South West Yorkshire Partnership NHS FT
MTI WAST		1	South West Yorkshire Partnership NHS FT
FY2 FY1	3 1	3 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

*1 on Maternity Leave

Kirklees

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	1	2	South West Yorkshire Partnership NHS FT
GP Trainee	3	2	South West Yorkshire Partnership NHS FT
CT1-3	6	4.5*	South West Yorkshire Partnership NHS FT
LAS (covering Training gaps)	N/A	1	South West Yorkshire Partnership NHS FT
MTI WAST		 1	South West Yorkshire Partnership NHS FT
FY2 FY1	1 1	1 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

*+1 (60%WTE) on Maternity Leave

Wakefield

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	4	5.4*	South West Yorkshire Partnership NHS FT
GP Trainee	4	4.1	Mid Yorkshire NHS Trust
CT1-3	7	6	Leeds and York Partnership NHS FT
LAS (covering training gaps)	N/A	0	South West Yorkshire Partnership NHS FT
FY2 FY1	2 3	2 3	Mid Yorkshire NHS Trust Mid Yorkshire NHS Trust

1 currently on OOPE with HEE but still doing on-call with the trust

Forensic: Newton Lodge /Bretton /Newhaven

Grade of Trainee	Number	Employer
ST4-6	4	South West Yorkshire Partnership NHS FT
ST4-6	1	Sheffield Health and Social Trust

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 9.1

Title:	**Digital Strategy Progress Update**
Paper prepared by:	Director of Finance Director of Strategy
Purpose:	To provide an update of the progress being made against the 2018/19 activities included in the Digital Strategy
Mission/values:	Supports all Trust objectives
Any background papers/ previously considered by:	Updated Digital Strategy approved by the Trust Board in January 2018 Trust Board is provided with a twice yearly update of progress being made against the strategy.
Executive summary:	➢ Progress against the activities agreed for 2018/19, in particular the final six months of the year, is identified in this report. Key achievements include: ➢ Successful go-live of SystmOne for mental health clinical record system ➢ Completion of year 2 of the 3 year capital investment plan improving IT infrastructure, business continuity and cyber security ➢ Gaining non-recurrent funding to support paper free and recruitment to the associated positions ➢ The procurement and re-tendering for the continued provision of a clinical information system that supports the requirements of the Improving Access to Psychological Therapies (IAPT) services was completed ahead of the end of March 2019 deadline ➢ The cyber security governance audit conducted in July/August 2019 provided a significant assurance rating and all recommendations have been completed. ➢ A clinical coding audit was undertaken which demonstrated an improvement on last year's performance and also confirmed that 100% finished consultant episodes were coded within the 6 weeks target, maintained throughout year. ➢ The scanning bureau has improved the average number of scanned records per month and as at the end of March 2019, 27,736 paper records (6,606,423 pages) had been scanned since the programme of work commenced in April 2017. ➢ For all areas where guidance has been published, the Trust achieved full compliance for General Data Protection Regulations (GDPR) as at 31 October 2018. ➢ The Data Protection & Security Toolkit (IG Toolkit) audit was completed in March 2019 with the outcome being significant assurance opinion received and the assessment status achieved for 'standards met'. ➢ A number of services are actively using ORCHA and promoting apps through their services, the services specifically utilising the platform are Yorkshire Smoke Free, Wakefield Recovery College, Health and Well-being service, Wakefield CAMHs, Calderdale/Kirklees CAMHs and Early Intervention in

	Psychosis. ➢ Establishment of a Trust Digital strategy group which will oversee and co-ordinate initiatives which explore new and emerging digital opportunities to bring about further digital evolution across the organisation. **Risk appetite** This paper needs to be considered in line with the Trust risk appetite statement which aims for clinical risk of 1-6 (subject to Board approval).
Recommendation:	**The Trust Board is asked to NOTE and COMMENT on the update of progress made against the Trust's Digital Strategy.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Digital Strategy

Progress Report

Head of IT Services & Systems Development

April 2019

With **all of us** in mind.

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Purpose of Report
The purpose of this report is to inform the Board of the progress and developments made during the last 6 months in respect of the Trust's Digital Strategy.

Executive Summary
This report focuses on the progress made during the second half of 2018/19 with regard to the priority areas in support of delivery against the aims and objectives of the Digital Strategy. Within the report there are a number of new and emerging themes which will continue to develop during the course of 2019/20 and beyond.

To support the delivery of the Digital Strategy, a milestone delivery plan has been developed which includes 8 cross-cutting domains. These domains map to the 6 key aims of the digital strategy. The cross-cutting delivery domains are: -

1. ***Fit for Purpose IM&T Infrastructure***
   To ensure that the Trust has a strategically aligned, resilient and robust IT infrastructure (network/end user computing hardware and software) which enhances business continuity, disaster recovery capabilities and potential cyber security safeguards for wider organisational assurance. The primary focus during 2018/19, which is year 2 of the 3 year infrastructure modernisation programme of works, was to build on the progress made during 2017/18. Overall good progress has been made within the schemes in this domain with all planned activities being completed by 31 March 2019.

2. ***Integrated Electronic Care Record System***
   Use technology and information innovatively to make the most effective and efficient use of resources and as an enabler in redesigning services which supports making better use of clinical information systems and integration capabilities. This domain is focused on developing the Trust's electronic care record systems and the drive towards seamless integration and enhanced interoperability that supports the electronic exchange of information and messaging capabilities. Work to date has focused upon the migration from RiO to SystmOne for the mental health clinical records system (CRS). Now that SystmOne is operational across the Trust, work will continue in order to optimise the system to further support the provision of clinical care and delivery of business intelligence data.

3. ***Digitisation & Information Sharing with our Partners***
   The focal point for this domain is to make inroads into the reduction of the paper estate and to increase the Trust's digital footprint as a result, thus enabling improved information sharing opportunities with our partners and key stakeholders. This supports the Trust in moving towards becoming paper free by 2020. The Trust has been successful in gaining some non-recurrent funding enabling a project team to be recruited in order to deliver this programme of work, including a review and prioritisation of the delivery of paper digitisation.

4. ***Business Intelligence Systems***
   This domain is concerned with the advancement of the Trust's reporting capabilities through the development of business intelligence and improving data quality which in turn aids organisational and service line performance. Whilst information governance (IG) falls under this domain, IG spans all domains to ensure robust practice, principles and compliance is maintained in support of digital strategy delivery.

   The use of business intelligence tools helps to deliver information in a more standardised and user-friendly way e.g. via dashboards. Such developments increase the use of forecasting, benchmarking and statistical techniques to deliver information rather than data and wider sharing information capabilities. They also support the delivery of care, improve data quality and information accuracy and ensure relevant information is shared in a timely and automated way. The associated activities for this domain are key components within the CRS implementation and ongoing optimisation plans so continued emphasis has been prioritised around this.

5. ***A Skilled & Digitally Enabled Workforce***
   This domain focuses on the development of digital skills and working practices across the Trust's workforce. Equipping Trust staff with the requisite digital skills is critical in the utilisation of digital technologies, systems and information. By improving capabilities within services, with all staff having access to or being provided with the appropriate digital skills to use current and future technologies serves to meet the changing demands of the organisation and the services we provide. This remains a developing domain.

6. ***Engaging and Learning from Digital Best Practice***
   This domain focuses on exploiting opportunities for digitisation through wider awareness of the use and application of new and emerging digital capabilities. Central to this will be sharing and spreading our own digital best practice, learning from what others do nationally and internationally, working with our partners and adopting digital tools that have been tried and tested elsewhere. This is also a developing domain.

7. ***Championing Digital Inclusion for People Accessing our Services***
   This is an emerging domain and enhancements within other domains will aid the Trust's overall digital maturity and support opportunities to improve the digital offer and experience for our patients, service users, carers and families. This will be delivered through setting up peer-to-peer projects to help people learn digital skills, putting in place Wi-Fi access for service users, rolling out text message appointment reminders and using digital channels to engage with people more effectively.

8. ***Embedding Digital in our Culture***
   This is also a developing domain and enhancements elsewhere in support of delivering against this strategy will aid the Trust's overall digital maturity and opportunities to nurture and

embed digital by default in everything that we do. This will be supported through hosting digital events, launching digital challenges on iHub to gather ideas, adopting a digital-by-design approach to service re-design and tenders, and piloting the use of digital innovations e.g. apps in clinical practice.

Digital Strategy Progress

Detailed within this report is a summary of the activities and progress to date, particularly over the last six months, in respect of the agreed 2018/19 milestones. Below is a summary of the main achievements and items to note in this reporting period.

- SystmOne was implemented as planned, delivering access to more than 3,500 users across mental health services. This programme of work was a major undertaking for the organisation and its relative success is down to the engagement and active participation by staff across all areas of the Trust.

- General community services have been supported in service redesign activities during the reporting period and also all bar one of the therapy services have deployed full clinical functionality available within SystmOne. This remaining service will be completed during 2019/20.

- The procurement and re-tendering for the continued provision of a clinical information system that supports the requirements of the Improving Access to Psychological Therapies (IAPT) services was completed ahead of the end of March 2019 deadline.

- The Trust successfully submitted a bit for funding via the Health Service Led Investment in Provider Digitisation scheme to aid the acceleration of paper digitisation (paperlight & paperless) via the West Yorkshire & Harrogate (WY&H) and South Yorkshire & Bassetlaw (SY&B) ICSs.

- Further significant enhancements have been made to the Trust's core IT network infrastructure which serves to improve resilience, cyber security and disaster recovery capabilities. The work completed lays the foundations from which to further increase application availability and more comprehensive disaster recovery arrangements planned in 19/20.

- The cyber security governance audit conducted in July/August 2019 provided a significant assurance rating and all recommendations have been completed.

- A clinical coding audit was undertaken which demonstrated an improvement on last year's performance and also confirmed that 100% finished consultant episodes were coded within the 6 weeks target, maintained throughout year.

- The scanning bureau has improved the average of scanned records per month and as at the end of March 2019, 27,736 paper records (6,606,423 pages) had been scanned since the programme of work commenced in April 2017.

- For all areas where guidance has been published, the Trust achieved full compliance for General Data Protection Regulations (GDPR) as at 31 October 2018.

- Information Governance Training: The 95% target was achieved during prior to the 31 March 2019 deadline.

- The Data Protection & Security Toolkit (IG Toolkit) audit was completed in March 2019 with the outcome being significant assurance opinion received and the assessment status achieved for 'standards met'.

- A number of services are actively using ORCHA and promoting apps through their services, the services specifically utilising the platform are Yorkshire Smoke Free, Wakefield Recovery College, Health and Well-being service, Wakefield CAMHs, Calderdale/Kirklees CAMHs and Early Intervention in Psychosis.

- Establishment of a Trust Digital strategy group which will oversee and co-ordinate initiatives which explore new and emerging digital opportunities to bring about further digital evolution across the organisation.

Risks

The priorities set out as summarised in this report continue to reduce the likelihood of risk of system failure. This includes the work activities which remain focused on: -

- Continuation of the infrastructure modernisation programme covering both the data centre enhancement and improvements to disaster recovery so as to improve resilience and application/systems availability. This programme of work also incorporates cyber security enhancements to establish further controls and measures to reduce the risk and likelihood associated with the threat of cyber-attacks.

- Delivery of paper digitisation changes that introduce new working practices and ways of working across clinical services. This will require time and support from clinicians and administrative staff in order to deliver this efficiency agenda successfully. Changes to clinical and administrative processes will need to be agreed at both local and regional levels in order to reduce paper generation and consumption.

The persistent ability to deliver on all of the 2019/20 priorities in line with the timescales identified later in this report is very much dependent on availability of suitable resources and continuous balancing of competing priorities.

A particular point to note is the ever-increasing growing demand on digital technologies and solutions within available resources. This will require careful management of expectations of Trust staff. Horizon scanning and exploring opportunities to source and secure other avenues for external funding will be key to supporting wider organisational aspirations in line with digital strategy objectives. The Digital Strategy group will play a fundamental role in supporting this requirement.

The provision of digitally enabled services is vital in enabling Trust staff to deliver safe care. As such the risk appetite remains to be considered low with a target score of 1-6.

Summary

The information included in this update report clearly articulates the breadth and scale of the 2018/19 Digital Strategy work which has been completed and which continues during 2019/20. A considerable amount of time has been afforded in the planning of activities to support progress being made, which has also taken account of the annual planning processes. This has meant timescales for delivery of the initiatives in this document remain realistic and achievable, subject to allocated/available resources. Any associated risks being managed with mitigating actions put in place where required.

As this update report demonstrates, good progress has been made against 2018/19 priorities in support of the Digital Strategy, with the majority of the key initiatives across the domains being on track as depicted in the summary dashboard on the page below and in the individual summaries provided for each initiative. Therefore, the March 2019 position has been rated as **GREEN** overall.

The Board is asked to note the progress in respect of the delivery against the 2018/19 milestones. The Board will continue to be updated in respect of progress against Digital Strategy delivery twice a year with the next update to be provided in October 2019.

Digital Strategy Summary Dashboard (March 2019)

Domain 1: Fit for purpose IM&T infrastructure	RAG Status	Progress Indicator
Infrastructure Modernisation Programme	G	↗
Microsoft Licensing	G	↗
N3 Replacement	G	↗
Cyber Security & Threat Monitoring	G	↗
Migration to Windows 10	G	↗
Email Platform Review	G	↗
Telephony Services Review	P	→
Domain 2: Integrated Electronic Care Record System	**RAG Status**	**Progress Indicator**
Community Services Clinical Record Systems	G	↗
Mental Health Services Clinical Record System	G	↗
Improving Access to Psychological Therapies	C	✓
Clinical Portal Development	G	↗
eCorrespondence	G	↗
Mental Health Services – RiO Legacy System	G	↗
Domain 3: Digitisation & Information Sharing with Partners	**RAG Status**	**Progress Indicator**
ICS/STP Digital Work Streams	G	↗
Records Management	G	↗
Paperlight/Paperless NHS	G	↗
Multi-Function Device (MFD) Procurement	P	→
eConsultation	P	→

Domain 4: Business Intelligence Systems	RAG Status	Progress Indicator
Business Intelligence / Data Warehouse	P	→
Information Governance	G	↗
National Data Opt-Out Programme	P	→
Domain 5: A Skilled & Digitally Enabled Workforce	**RAG Status**	**Progress Indicator**
Intranet Development	P	→
Social Media Access for Staff	G	↗
Succession & Workforce Planning (IM&T Staff)	G	↗
Development of Staff Training (IT/Digital Skills)	G	→
Domain 6: Engaging and Learning from Digital Best Practice	**RAG Status**	**Progress Indicator**
Digital Strategy Group	G	↗
Domain 7: Championing Digital Inclusion for People Accessing our Services	**RAG Status**	**Progress Indicator**
Patient Reminder System	G	↗
Reporting Health Outcomes	P	→
Service User (Patient) Portal Development	P	→
Domain 8: Embedding Digital in our Culture	**RAG Status**	**Progress Indicator**
Apps for Service Users and Carers	G	↗
i-Hub Digital Challenge	G	↗

Key

C	**Completed**	G	**On track**	A	**Off track but in control**
R	**Off track requires attention**	P	**Planned for the future**	↗	**Improving position**
→	**No progress**	↘	**Deteriorating position**	↘	
✓	**Completed activities**	➢	**Ongoing activities**		

Financial Investment

In order to meet the priorities outlined in this report, a capital allocation of £2.4m was made available during 2018/19. A capital allocation of £2.495m has been approved to support the priorities in 2019/20. The table below provides a summary of the associated expenditure for 2018/19 as at 31 March 2019 and the planned capital allocation for 2019/20.

Scheme		18/19 (£k)			19/20 (£k)
		Allocation	Expenditure	Variance	Allocation
IT Infrastructure	Data Centre/Disaster Recovery	400	398	2	400
	Infrastructure/WAN	250	200	50	250
	Server Hardware Refresh	200	200	0	150
	Network Switch Upgrades	300	287	14	300
	Cyber Security	25	28	(3)	200
	Mid Yorks Site connectivity	55	48	7	
	HSCN	75	74	1	
	Wireless Remediation	15	14	1	
	Email Upgrade				25
	WiFi (Corporate) Refresh				100
Clinical Systems Development	Mental Health Clinical Records System	828	917	(89)	0
	Integration & Portals (Inc Interoperability)				150
	Electronic Prescribing & Medicines Administration				165
Business Intelligence	Business Intelligence, Data Warehousing and Reporting*	180	0	180	55
Corporate Development	Finance Ledger System				300
	PLICS System (Finance)**	0	10	(10)	
	Database System (Finance)**	0	18	(18)	
	Multifunction Device Contract Replacement				50
Digital Innovation	Paper Digitisation (Paperlight/Paperless NHS)***	104	106	(2)	250
	Digital Innovation Opportunities (Digital Strategy Group)				100
Overall Capital Total		**2,432**	**2,298**	134	**2,495**

*£100k from the business intelligence scheme was re-allocated to offset against the new reporting environment as part of the mental health clinical records system programme. £80k was re-allocated to other capital schemes within the Trust plan.

**The PLICS and database Systems schemes that were brought forward into 18/19 capital plan due to opportunities within the overall capital programme

***Originally £100k was allocated for paper digitisation in 18/19 but £104k external funding secured meant this allocation was re-provisioned within other planned capital schemes within the Trust during 18/19.

COMPLETED MILESTONES FOR 2018/19 SCHEMES (April 2019 position):

Domain 1: Fit for Purpose IM&T Infrastructure	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability***

Status	**Infrastructure Modernisation Programme** **Phase 3: Data Centre Improvements (Year 2 of 3)**
C	

Summary update	***Milestone***	***Achieved***
Purpose: This is a 3-year programme of work that focuses on the review and modernisation of the Trust's core IT infrastructure and the two existing data centres located at Fieldhead and Kendray. The purpose is to provide a strategic, robust and secure IT environment, removing single points of failure, which therefore provides the Trust with the necessary assurances, business resilience and disaster recovery capabilities to support the digital future. The business case for this programme was approved in July 2017.		
Key Activities: ✓ ***Year 2 (2018/19) Plan:*** Completion of the year 2 capital investments for data centre modernisation, improved disaster recovery capabilities, enhancements to the core Trust network infrastructure/wide area network (WAN), upgrading/replacement of IT network hardware capital schemes. All works and activities were completed by 31 March 2019 as planned and within the agreed capital budget allocations.	**Mar 2019**	**Mar 2019**
Expected Outcomes: • Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g. from Fieldhead to Kendray).		

• No requirement for short term investment in event of a disaster. • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licensing (potentially reducing costs). • Proven disaster recovery position with confirmed recovery points and associated timelines. • Enhanced cyber security position would bring about improved resilience and greatly reduce the risk from cyber-attack, malicious or otherwise.		

Status C	**Health & Social Care Network (HSCN) Implementation (N3 Replacement)**		
Summary update		***Milestone***	***Achieved***
Purpose: Focuses on the replacement of the existing N3 (NHS-wide national network) with the new Health & Social Care Network (HSCN). **Key Activities:** ✓ ***Legacy Network Connections:*** The Trust received formal notification of Point of Presence (POP) network connection closure dates utilised by the Folly Hall site. This was originally earmarked for September 2018 but was subsequently confirmed by NHS Digital that this date had been put back to July 2019. The planned migration to HSCN connectivity for this site has addressed this, further site migrations are planned ahead of the remaining POP closure dates. **Expected Outcomes:** • Continuity of wide area network (WAN) connections that essentially provide inter-connectivity between Trust sites and the wider NHS/Social Care infrastructure. • Improved resilience of core IT infrastructure.		**Jun 2019**	**Feb 2019**

Status C	**Cyber Security & Threat Monitoring**		
Summary update		***Milestone***	***Achieved***
Purpose: The potential threat of cyber-attack is on the increase as witnessed by the WannaCry incident in May 2017, where a number of public sector/NHS and private sector organisations' business operations			

were impacted. The Trust continues to take such threats extremely seriously and has established a number of steps to safeguard against such threats. **Key Activities:** ✓ ***Cyber Security Governance Audit:*** The audit findings identified 4 recommendations (1 medium and 3 low) and the necessary actions with agreed timescales are being taken to address these items. The 1 medium and 2 low recommendations were completed as planned by the 30 September 2018 deadline. The remaining 1 low recommendation, which had a deadline of 31 December 2018, has now been completed.	**Dec 2018**	**Jan 2019**
✓ ***Board-level Cyber Training:*** The Trust took up a service offer from NHS Digital for board-level cyber security training which was provided for members of the Audit Committee and other board members, and undertaken in January 2019.	**Jan 2019**	**Jan 2019**
✓ ***ATP (Advanced Threat Protection):*** The rollout of ATP has been completed across all end user computing devices to comply with our licencing arrangements. This is a new tool that is available as part of the centralised Windows 10 licensing agreement and is also compatible with Windows 7.	**Jan 2019**	**Jan 2019**
✓ ***On-site Cyber Assessment:*** The Trust undertook an NHS Digital assured on-site cyber assessment that was being offered to a number of trusts across the country. This was scheduled and completed in January 2019 and the findings will inform a Trust action plan which is to be completed during 2019/20.	**Jan 2019**	**Jan 2019**
Expected Outcomes: • Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats. • Adoption of industry standard best practices, as appropriate. • Improve the defence against a cyber-attack.		

Status	**Email Platform Review**		
C			
Summary update		***Milestone***	***Achieved***

Purpose: To put controls and measures in place to prepare the Trust and all staff for the impending replacement and future provision of its corporate email platform during 2019/20. **Key Activities:** ✓ ***Mailbox Account Limits:*** From 1 October 2018 a limit of 4.5GB was imposed on all email accounts. Individual staff whose mailbox size reaches 3.5GB will receive daily alerts to advise them to reduce the size of their mailbox. Once their mailbox size reaches 4GB, they will still be able to receive emails but will not be able to send emails until mailbox size is reduced to within agreed levels. If their account subsequently exceeds 4.5GB, they will not be able to send or receiving emails until mailbox size is reduced to within agreed levels. Only a small number of users remain in an exception group and currently exceed these limits. **Expected Outcomes:** • Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources.	**Oct 2018**	**Oct 2018**

Domain 2: Integrated Electronic Care Record System	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***3. To foster integration, partnership and working together*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status C	**Community Services Clinical Records System (SystmOne)**		
Summary update		***Milestone***	***Achieved***
Purpose: Development of SystmOne to support physical health community services development priorities, service re-design and new models of care agendas. **Key Activities:** ✓ ***Intermediate Care (Barnsley):*** Work to support the development of the new integrated model of		**Sep 2018**	**Sep 2018**

care for intermediate care services in collaboration with partners across the district is now complete. Reporting is well established for the current service model and a flow of data between Barnsley Hospital NHS Foundation Trust (BHNFT) and SWYPFT is in place which facilitates SWYPFT to flow all contractual reporting requirements for the service to the commissioner.		
✓ ***Stroke/Neuro-Rehabilitation unit (NRU) (Barnsley):*** Work to migrate bed management system activities from RiO to SystmOne was complete in advance of the CRS go live. Reporting is in place to meet the needs of the SRU/NRU wards from SystmOne. This includes the in-house build of a commissioner data set (CDS) submission which is a national mandatory submission. A local solution was built following the inbuilt system extract not being fit for purpose.	**Dec 2018**	**Dec 2018**
✓ ***Therapy services (Barnsley):*** Work has been completed with domiciliary physiotherapy & falls, dietetics, occupational therapy and adult SALT therapy service teams in the deployment of full SystmOne clinical functionality.	**Jan 2019**	**Jan 2019**
✓ ***Mental Health Liaison & Diversion (South Yorkshire):*** This newly commissioned service went live on SystmOne as planned on 1 April 2019 in readiness for 1 April 2019 service commencement.	**Mar 2019**	**Mar 2019**
Expected Outcomes: • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. • To support the development of new integrated models of care. • To ensure that all community services are fully optimised in their use of SystmOne.		

Status C	**Clinical Portal Development (PORTIA)**	
Summary update	***Milestone***	***Achieved***
Purpose: Enables the Trust to bring together information from different clinical information systems into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need. **Key Activities:**		

✓ Changes have been made to the Trust clinical portal (PORTIA) so that data sourced from RiO for mental health services has been re-designed to source data from SystmOne following the successful migration from RiO to SystmOne. **Expected Outcomes:** • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems.	**Mar 2019**	**Mar 2019**

Status C	**Improving Access to Psychological Therapies (IAPT)**	
Summary update	***Milestone***	***Achieved***
Purpose: Development of the PC-MIS specialist clinical information system in support of IAPT services priorities, service re-design and new models of care agendas. **Key Activities:** ✓ ***IAPT Clinical Information System:*** The procurement and tendering process for the continued provision of a clinical information system that supports the requirements of the IAPT services was completed ahead of the end of March 2019 timeframe. The outcome of the tender exercise was to continue with the existing clinical information system PC-MIS. A subset of PC-MIS data is also presented in the PORTIA solution for wider access outside IAPT services. **Expected Outcomes:** • To ensure that this specialist clinical information system is developed to meet service needs and support the commissioner reporting requirements. • To explore opportunities for standardisation and joint working across place based specialist services.	**Mar 2019**	**Mar 2019**

Domain 3: Digitisation & Information Sharing with our Partners	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***2. To enable prevention, wellbeing and recovery***

	3. To foster integration, partnership and working together ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status		**Integrated Care System (ICS)/Sustainability Transformation Partnerships (STPs) Digital Work Streams**		
C				
Summary update			***Milestone***	***Achieved***
Purpose: Across the ICS/STP regions (West Yorkshire & Harrogate and South Yorkshire & Bassetlaw) in which SWYPFT is a key stakeholder, work has been progressing on a variety of digital interventions through the work of place-based initiatives in support of wider digital maturity. **Key Activities:** ✓ ***Health Service Led Investment in Provider Digitisation (HSLI):*** The Trust successfully submitted a bid for funding to aid the acceleration of paper digitisation (paperlight/paperless) via the West Yorkshire & Harrogate (WY&H) and South Yorkshire & Bassetlaw (SY&B) ICSs. Funding for 18/19 has been agreed (£104k). **Expected Outcomes:** • The vision will lead to an integrated digital infrastructure across ICS regions, making more effective use of the technical expertise available and allowing our collective digital capabilities to develop in parallel with technological advancement. • Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Local systems will support digital pilots and wider delivery and the scaling up of successful interventions will be coordinated by digital work streams and the supporting key interventions.			**Nov 2018**	**Feb 2019**

Status	**Records Management (Scanning – Archive/Paper Records)**

C			
Summary update		***Milestone***	***Achieved***
Purpose: Continue to develop the onsite scanning bureau and work towards meeting the 2020 paper free target. **Key Activities:**			
✓	***Destruction of Paper Records:*** Approval to commence the destruction of paper records was provided at the Improving Clinical Information Group (ICIG) in October 2018. Final audit actions have been completed on the first records scanned and confidence level for the checks performed has confirmed 100% accuracy. The destruction of paper records which have been scanned commenced in January 2019 and will continue during 2019/20.	**Oct 2018**	**Oct 2018**
✓	**Clinical Coding Audit:** A clinical coding audit was undertaken in January 2019 and initial findings are 100% accuracy against a target of 85% for primary diagnoses. For secondary diagnoses 96.3% has been achieved against a target of 75%. These are an improvement on last year when the results were 97% for primary diagnoses and 93.6% for secondary diagnoses. Therefore the audit was achieved with 100% finished consultant episodes coded within the 6 weeks target, which was maintained throughout year.	**Jan 2019**	**Jan 2019**
✓	***Scanning Bureau Activity:*** The scanning bureau has improved the average of scanned records per month, increasing from 1,250 to 1,280 records every month as at March 2019, which includes performing quality assurance checks on every sheet.	**Mar 2019**	**Mar 2019**
✓	***Scanning Bureau Activity:*** At the end of March 2019, 27,736 paper records (6,606,423 pages) had been scanned since the programme of work commenced in April 2017.	**Mar 2019**	**Mar 2019**
Expected Outcomes: • Reduced reliance on off-site storage (avoidance of increased costs). • Improved governance through having easy, electronic access to all records related to a Trust client, supporting the digitisation and paperless NHS agendas.			

Status	**Paperlight/Paperless NHS**

C			
Summary update		***Milestone***	***Achieved***
Purpose: Paperlight forms part of the wider care record digitisation agenda and aims for all clinical services (predominantly those services that currently use SystmOne as their main clinical information system) to work towards achieving paperlight accreditation. **Key Activities:** ✓ ***Calderdale & Kirklees Paperlight:*** Calderdale is now paperlight and approximately 1/3 of records from Dewsbury have been scanned. **Expected Outcomes:** • Reduce/remove the creation of paper records/case files for new service users which has been achieved for Calderdale. • Support the Trust's drive towards achieving paperless services by 2020 as part of the wider national paperless agenda.		**Mar 2019**	**Mar 2019**

Domain 4: Business Intelligence Systems	***Supports Digital Strategy Aims*** ***3. To foster integration, partnership and working together*** ***5. To maximise efficiency and sustainability***

Status C	**Information Governance**		
Summary update		***Milestone***	***Achieved***
Purpose: To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations. General Data Protection Regulations (GDPR) is the new legal framework in the EU that took effect from			

25 May 2018, irrespective of the UK's decision to leave the EU. The regulations enhance data subjects' rights, introducing new rules that govern how data is collected, processed, shared and retained. Organisations will have significantly more legal liability if they are responsible for a breach with fines increased substantially compared to those currently in operation. **Key Activities:** ✓ ***General Data Protection Regulations (GDPR):*** Subject to areas where guidance has not yet been published, the Trust achieved full compliance by 31 October 2018. ✓ ***Information Governance Training:*** The 95% target was achieved during prior to the 31 March 2019 deadline. ✓ ***Data Protection & Security Toolkit (DSP Toolkit):*** The toolkit audit was completed in March 2019 with the outcome being significant assurance opinion received. The final submission maintaining compliance achieved against the 2018/19 toolkit. The assessment outcome no longer has scores, so the revised status is 'standards met'. **Expected Outcomes:** • Mandatory information governance training target is achieved. • DSP toolkit target of meeting the standards is maintained. • Preparedness for the GDPR is assured and processes established to ensure ongoing compliance.	**Oct 2018** **Mar 2019** **Mar 2019**	**Oct 2018** **Mar 2019** **Mar 2019**

Domain 5: A Skilled & Digitally Enabled Workforce	***Supports Digital Strategy Aims*** ***4. To develop an effective and digitally empowered workforce***

Status C		**Succession & Workforce Planning (IM&T Staff)**	
Summary update		***Milestone***	***Achieved***
Purpose: To ensure that the IM&T Service has a suitability skilled workforce, including the required skills-mix balance and the requisite resources from which to deliver effective and efficient services to the			

organisation. This includes meeting both current and future needs of the organisation and will establish foundations for a robust succession plan which informs and supports wider staff development opportunities. **Key Activities:** ✓ ***IM&T Teams Development:*** Time-outs to support IM&T service development facilitated by Learning & Development were held in October 2018 and a programme of work to aid continuous development and service improvements has been established following these initial timeout sessions. **Expected Outcomes:** • Improve access and availability of training and development opportunities in support of identified needs. • Improves service resilience and delivery.	**Oct 2018**	**Oct 2018**

Domain 8: Embedding Digital in our Culture	***Supports Digital Strategy Aims:*** ***1. To enhance quality of care and patient safety*** ***2. To enable prevention, wellbeing and recovery*** ***3. To foster integration, partnership and working together*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status C	**Apps for Service Users and Carers**	
Summary update	***Milestone***	***Achieved***
Purpose: As part of the wider digitisation agenda, the Trust is exploring opportunities from which to make information and services more accessible to our patients, service users and carers. **Key Activities:** ✓ ***ORCHA Usage:*** The services below are using ORCHA and promoting through their services:- ▪ Yorkshire smoke free	**Dec 2018**	**Dec 2018**

▪ Wakefield Recovery College ▪ Health and Well-being service ▪ Wakefield CAMHs ▪ Early Intervention in Psychosis ▪ Kirklees/Calderdale CAMHs **Expected Outcomes:** • Improves the overall patient experience. • Improves access to services, supportive information users and is part of the wider digitisation of the NHS, further supporting the Local Digital Roadmaps(LDR) plans and aspirations of ICS/STPs.		

ONGOING MILESTONES FOR 2019/20 & BEYOND (March 2019 position):

Domain 1: Fit for Purpose IM&T Infrastructure	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability***

G	↗	**Infrastructure Modernisation Programme** **Phase 3: Data Centre Improvements (Year 3 of 3)**

Summary update	***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ ***Year 2 (2018/19) Review:*** An end of period review report covering 1 April 2018 to 31 March 2019 is being prepared that will provide a summary position of what progress has been made during year 2 of this 3 year programme and what this work has achieved/delivered in line with the business case previously approved.	**May 2019**	
➢ ***Year 3 (2019/20) Plan:*** The detailed technical schedule of works for 2019/20 is currently being drawn up and finalised, with technical plans being established for the required activities throughout the financial year that are in line with the IM&T capital programme.	**May 2019**	
➢ ***Year 3 (2019/20) Programme:*** This work will focus on: - ▪ Further enhancements to the Trust data centres & disaster recovery capabilities. ▪ Core network infrastructure and Wide Area Network (WAN) enhancements. ▪ Rolling programme of IT network hardware and server hardware upgrading, replacement and	**Mar 2020**	

refresh. ▪ Health & Social Care Network (HSCN) replacement of N3. ▪ Enhancements to cyber security solutions and capabilities ▪ Improved application availability **Expected Outcomes:** • Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g. from Fieldhead to Kendray). • No requirement for short term investment in event of a disaster. • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licensing (potentially reducing costs). • Proven disaster recovery position with confirmed recovery points and associated timelines. • Enhanced cyber security position would bring about improved resilience and greatly reduce the risk from cyber-attack, malicious or otherwise.		

Status	*Direction*	**Microsoft Licensing Trust Wide Agreement (2017-19)**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: To conduct a review of the Trust's requirements for Microsoft products based on usage with a view to reducing/rationalising existing Trust licence quantities where possible. This will also explore the most appropriate and cost effective way forward for continued provision and access to Microsoft products as used by the Trust. This follows on from the commencement of the Trust's 3-year enterprise wide agreement (EWA) with Microsoft for software licenses established on 1 July 2017. **Key Activities:** ➢ ***Microsoft License Costs:*** The Trust is continuing to explore making further inroads to reduce the existing end-user computing (desktops/laptops) estate, especially where staff has access to more than one device e.g. a desktop and a laptop. A meeting with Microsoft has been arranged in April 2019 to consider the options and associated costing models. A briefing paper will be produced outlining the proposed approach and Trust position ahead of the June 2019 license renewal point and in support of this, this report will be presented to OMG for consideration ahead of subsequent EMT			**May 2019**	

and Trust Board approval. ➢ ***NHS Digital Negotiations with Microsoft:*** NHS Digital remains in negotiation with Microsoft regarding wider centralised licensing opportunities. There is a cost risk depending on eventual outcome. **Expected Outcomes:** • Supports the infrastructure modernisation programme which will add resilience, improve performance for end-users, and build in contingency in the event of network failure. • Potential for a NHS-wide agreement for Windows 10 software licensing to reduce Trust direct annual costs associated with Microsoft licensing arrangements.	**Jun 2018** **Jun 2019**	

Status	***Direction***	**Health & Social Care Network (HSCN) Implementation (N3 Replacement)**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ ***HSCN Connectivity Options Appraisal:*** The Trust IT Service has evaluated the options and associated costs for HSCN connectivity to replace existing N3 wide area network (WAN) connections. Pricing schedules from Redcentric (Yorkshire & Humber Public Sector Network (YHPSN) framework preferred supplier) and the incumbent provider Virgin Media have been reviewed in order to inform the Trust's strategic direction of travel. A paper is being readied for EMT approval. ➢ ***Replacement of Point of Presence (POP) Network Connections:*** The planned migration of the wide area network (point of presence) connections at Kendray Hospital, Laura Mitchell and Airedale Health Centre sites to new HSCN connections are scheduled for completion during April/May/June 2019 ahead of the 20 July 2019 closure date. ➢ ***Implementation of HSCN Circuits to replace N3:*** The replacement of N3 and implementation of HSCN circuits is anticipated to take approximately 2 years to complete commencing during quarter 1			**May 2019** **May 2018** **2019/20 & 2020/21**	

2019/20. **Expected Outcomes:** • Continuity of wide area network (WAN) connections that essentially provide inter-connectivity between Trust sites and the wider NHS/Social Care infrastructure. • Improved resilience of core IT infrastructure.		

Status	***Direction***	**Cyber Security & Threat Monitoring**	
G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ ***Cyber Security Survey:*** Conduct an annual cyber security survey to further gauge staff awareness and understanding and identify if this is improving. ➢ ***Cyber Essentials:*** The findings and recommendations from the review conducted during 2017/18 have informed strategic IT infrastructure roadmap planning and prioritisation of the detailed IT programme of works. This incorporates additional cyber capabilities through enhanced threat protection and detection which provides more proactive technologies and safeguards. ➢ ***Simulated Phishing Exercise:*** The Trust has registered an expression of interest to participate in conducting a simulated phishing training tool developed by NHS Digital. ➢ ***Next Generation Firewall (NGFW) Pilot:*** The Trust successfully bid to be a pilot site (one of five nationally) for the Next Generation Firewall (NGFW) initiative as part of NHS Digital's Cyber Security Operations Centre (CSOC) developments. This resulted in an NHS Digital NGFW being installed at the Trust during October 2018 which has provided in-depth monitoring reports against potential threats. No critical issues have been identified from this analysis to date and the outputs from this technical report will inform Trust plans to prioritise future investment in the cyber security and IT infrastructure as part of year 3 programme of works. The findings from this pilot will also be used by NHS Digital to inform future areas for prioritisation across the NHS.	**May 2019** **Ongoing** **Awaiting timescale** **Sep 2019**	

➢ ***Cyber Table Top Exercise:*** Following a recommendation from the cyber security audit conducted during 18/19, it is planned to conduct an annual table top exercise to be scheduled between the Trust's IT Service and Daisy to ensure that processes, roles and responsibilities are clear in support of mobilising against a cyber-attack. This follows the exercise conducted in January 2019.	**Jan 2020**	
➢ ***Cyber Threat Monitoring:*** The monitoring against the potential threat of a cyber-attack continues to be an integral item of business for monthly service performance and review meetings with Daisy IT services. The Trust routinely reviews the actions taken or required to be taken to mitigate and establish safeguards against the threat of cyber-attacks.	**Ongoing**	
➢ ***Staff Awareness:*** Staff vigilance remains an integral defence, regular communications are issued to staff and staff are advised to raise any questions or concerns with the IT service desk in the first instance at the earliest opportunity.	**Ongoing**	
Expected Outcomes: • Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats • Adoption of industry standard best practices, as appropriate. • Improve the defences against a cyber attack		

Status	***Direction***	**Migration to Microsoft Windows 10**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: To initiate a programme of work during 2018/19 to bring about the upgrade/migration of the Trust's end user computing estate (desktops and laptops) from the existing Microsoft Windows 7 platform to Microsoft Windows 10 operating system ahead of the 14 January 2020 deadline. This work will also include the planned end user computing replacement programme across the Trust as part of this work. **Key Activities:** ➢ The deployment of Windows 10 will focus on the replacement of existing old desktops/laptops that are not capable of running the Windows 10 operating system as part of the centralised end user			**Dec 2019**	

computing replacement programme and the aim is to complete this replacement programme by 31 December 2019. ➢ At present this is being conducted as a 'business as usual' operational activity so that additional project/professional service costs are not incurred. However, following planned discussions with Microsoft regarding future licensing requirements, it may be necessary to mobilise a project to accelerate the replacement of Windows 7 across the Trust end user computing estate. A cost pressure has been put forward to support the migration activities for this project but this would also be subject to funds being made available to replace all remaining devices that are not capable of supporting Windows 10. **Expected Outcomes:** • Enables the Trust to provision new and replacement end user computing devices in a strategic and planned manner, making better use of available resources. • Centralised control of all end user computing assets, therefore optimising use across the Trust. • Improves end user experience. • Provides greater assurance and controls from which to minimise the risk of cyber threats through continuous availability to software security updates.		

Status	*Direction*	**Email Platform Review**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: To conduct a review of the options open to the Trust for the future provision of its corporate email platform (NHS Mail v Microsoft Exchange/Outlook) so as to inform the development of a business case for consideration and approval **Key Activities:** ➢ Conduct an options appraisal of future strategic corporate email platforms (NHS Mail v Microsoft Office365/Exchange) to inform a business case for consideration during quarter 1 2019/20. This work has been aligned into the future software licensing negotiations with Microsoft. ➢ Detailed plans and activities to be established following Trust approval of the proposed recommendations			**Was Dec 2018 now May 2019** **Dec 2019**	

detailed within the business case, and for implementation activities to commence during 2019/20 ahead of the 14 January 2020 deadline, when the current version of Microsoft Exchange/Outlook expires. A cost pressure has been identified during 2019/20 to support the necessary migration activities. **Expected Outcomes:** • Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources. • Potential for wider STP region standardisation of email platforms and closer partnership/collaborative working opportunities.		

Status	***Direction***	**Telephony Services Review**	
P	→		
Summary update		***Milestone***	***Achieved***
Purpose: To conduct a review of the options and to explore the potential to consolidate both desk and mobile telephony contracts and to integrate service provision. **Key Activities:** ➢ Conduct an options appraisal for the future provision of both desk and mobile telephony services. The outcomes to inform a proposal/business case during Q3 2019/20. ➢ Detailed implementation/transition plans and activities to be established following Trust approval of the proposed recommendations detailed within the business case. **Expected Outcomes:** • Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources. • Potential for wider STP region standardisation of email platforms and closer partnership/collaborative working opportunities.		**Oct 2019**	

Domain 2: Integrated Electronic Care Record System	***Supports Digital Strategy Aims***

	1. To enhance quality of care and patient safety ***3. To foster integration, partnership and working together*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status	***Direction***	**Community Services Clinical Records System (SystmOne)**		
G	↗	***Summary update***	***Milestone***	***Achieved***
		Purpose: Please see previous section. **Key Activities:** ➢ ***Intermediate care/Rightcare (Barnsley) service re-design:*** A further programme of work is being established in support of service re-design and enhancements to support new models of care/integrated service models. This will incorporate independent sector bed management and also service developments within Rightcare Barnsley in collaboration with partners across the district. It is anticipated that this is a significant piece of work that will take approximately 6 months to complete given the complex service model and inter-dependencies. ➢ ***Therapy services (Barnsley):*** Work to complete the last remaining services left to deploy full SystmOne clinical functionality which are Paediatric Audiology and Rapid Access. **Expected Outcomes:** • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. • To support the development of new integrated models of care. • To ensure that all community services are fully optimised in their usage of SystmOne.	**Under review** **Jun 2019**	

Status	***Direction***	**Mental Health Services Clinical Record System (CRS) (SystmOne)**		
G	↗	***Summary update***	***Milestone***	***Achieved***

Purpose: Implementation of the new mental health CRS (SystmOne) that replaces RiO. This is a major change initiative being driven by staff from all areas of the organisation. **Key Activities:**		
✓ ***Data migration:*** Data migration activities have been completed as planned to support go live and a subsequent delta cut of data extracted from RiO to further reduce manual data input for operational staff was uploaded to SystmOne successfully.	**Mar 2019**	**Mar 2019**
✓ ***Infrastructure:*** A new reporting server environment has been procured and installed to support the reporting work stream in developing the necessary report. An assessment of the Trust IT infrastructure has been conducted as part of the implementation plan to ensure both the current and future requirements are appropriately met. A number of technical enhancements to the Trust's infrastructure were identified in order to meet the requirements stated within the supplier's (TPP) technical documentation. All infrastructure work was completed prior to go live as planned.	**Feb 2019**	**Feb 2019**
✓ ***Slow System Performance Issue:*** Following a scheduled update to SystmOne on 14 March 2019 (2-3 weeks after go live) by TPP (system supplier), Trust staff experienced SystmOne running extremely slowly. This was escalated to TPP and the cause identified and resolved following a subsequent fix that was applied to the system by TPP on 21 March 2019. This issue only impacted the Trust mental health services during this time. System performance continues to be monitored by the Trust systems team and since the fix was made by TPP, SystmOne continues to operate in terms of system speed as expected with no issues reported since.	**Mar 2019**	**Mar 2019**
➢ ***End User Training:*** 95.5% of all required Trust staff have now completed their SystmOne Training. Trainers are continuing to provide additional post go live floor-walking support to staff until 12 April 2019. A new junior doctors' intake will complete training during the first week in April 2019 and additional teaching videos are in development. It is planned that the ongoing 'business as usual' training programme will commence from 15 April 2019.	**Apr 2019**	
➢ ***End User Support:*** Following the recent system performance issues, a backlog of support calls have built up that the systems team are now focused on resolving as part of the transition to business as usual operations. The systems management team are meeting weekly to monitor progress of reducing the call backlog and to ensure calls are prioritised accordingly. The SystmOne support desk that was established for go live has been decommissioned and activities seamlessly transferred to the	**May 2019**	

Trust service desk. ➢ ***System Configuration:*** Further amendments to e-discharge form have been made with more fields being made mandatory to support better communications with GPs. Operational configuration changes are continuing as part of business as usual activities. ➢ ***Reporting:*** The majority of all reports are now built and good progress being made on validation. MHSDS and CDS have been generated and submitted. Activity levels for March 2019 are below expected levels and this may be due to the recent performance issues that staff experienced. Additional support and training tools are being made available to staff. ➢ ***Change Management:*** An outline approach to optimisation has been produced and communications are being planned to inform change reference groups of future plans/activities, subject to EMT approval. ➢ ***Optimisation:*** An optimisation options paper was submitted to the programme steering group in March 2019 and a revised paper with preferred option was submitted to EMT in April 2019 for consideration and approval. ➢ ***Communications:*** Key messages and availability of training materials (user guides and videos) continue to be circulated to staff through various communication channels. ➢ ***Data Catch-up:*** Work to catch up on the inputting of all activity conducted during the cut-over period between staff stopping inputting into RiO and starting to use SystmOne has commenced. Additional facilitated sessions over weekends in April/May 2019 are being setup to further support operational services with the catch-up activities. ➢ ***Financial Management:*** It is predicted that the total spend for the project will be £87k below the original budget forecast. There will be more costs to be incurred in April and May 2019 for start-up and catch-up work completed, but overall this is a positive position. **Expected Outcomes:** • Transition services from RiO to SystmOne for mental health, by successfully moving the electronic clinical records and providing adequate training to colleagues for go-live.	**Ongoing** **Apr 2019** **May 2019**	

• Work with clinical and administrative colleagues to co-produce a system that suits the Trust's needs. This includes key clinical documentation e.g. care plans to make the system fit for purpose. • Deliver a new system that gives the Trust the opportunity to improve how we work now and in the future. • to better support the development of new integrated models of care. • the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs, further demonstrating our commitment in meeting commissioner intentions. • improve service user care through more timely receipt and management of referral to services via electronic capabilities.		

Status	***Direction***	**Clinical Portal Development (PORTIA)**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ ***PORTIA Roll-out:*** The focus during 2019/20 remains on continuing the rollout of the Trust clinical portal (PORTIA) and promotion of its usage. As at 31 March 2019 over 850 Trust staff have been provided with access to PORTIA. ➢ ***PORTIA Usage:*** To date approximately 14,000 patient record searches have been conducted. **Expected Outcomes:** • Provision of a single integrated holistic patient record view. • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner.			**Ongoing** **Ongoing**	

Status	***Direction***	**eCorrespondence**

G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: Enables the Trust to reduce the reliance and flow of paper both internally and with our partners in respect of delivering patient care. This also supports the digitisation agenda and the drive towards a paperlight/paperless NHS by 2020. **Key Activities:** ➢ ***eDischarge Summaries:*** Changes have been made to the inpatient discharge summary letter following the implementation of SystmOne to replace RiO and usage is under review. ➢ ***eDischarge Volumetrics:*** Over 1,586 eDischarge messages have been successfully sent to and received by GP practices to date as at the end of March 2019. **Expected Outcomes:** • Supports the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs. • Potential to improve ongoing client care through the provision of discharge information to GPs in a much improved timeframe. • Ability to send discharge letters etc. electronically rather than traditional printing/posting channels.		**Apr 2019** **Ongoing**	

Status	***Direction***	**Mental Health Services Legacy Clinical Record System Decommissioning (RiO)**	
G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: To plan and prepare for the decommissioning of the RiO clinical information system following its replacement by SystmOne. RiO accessibility was extended to 30 June 2019 and it is planned to decommission this system following this date. **Key Activities:** ➢ ***RiO Decommissioning:*** The Trust systems team are to work with Servelec to plan and co-ordinate the activities required to decommission the RiO clinical information system, retrieval of the Trust		**Jul 2019**	

owned server hardware environment for secure disposal and repatriation of the Trust data held within the system. **Expected Outcomes:** • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. • To support the development of new integrated models of care.		

Domain 3: Digitisation & Information Sharing with our Partners	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***2. To enable prevention, wellbeing and recovery*** ***3. To foster integration, partnership and working together*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status	***Direction***	**Integrated Care System (ICS)/Sustainability Transformation Partnerships (STPs) Digital Work Streams**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ ***WY&H and SY&B ICSs:*** Trust continues to participate in a number of external groups/forums in support of the ICS digital work stream initiatives in collaboration with health and social care partners. ➢ ***LHCRE:*** The Trust is engaged in the developments to support the local health and care integrated records exemplar (LHCRE) initiative. ➢ ***Kirklees Digital Transformation Board:*** A Digital transformation board has recently been established and SWYPFT is an active member.			**Ongoing** **Ongoing** **Ongoing**	

➢ ***Barnsley Shared Care Record:*** A group is being established to consider the potential for development of a Barnsley 'place' shared care record solution across all partners.	**Ongoing**	
➢ ***ePrescribing/EPMA:*** The Trust submitted a bid for external funding to support the implementation of ePrescribing and electronic prescription management administration (EPMA). This is a pharmacy led initiative which is being supported by IM&T and will be subject to wider governance/approval/support prior to bid submission for wave 2. Implementation during 2019/20 is being considered as there is a dependency on the mental health clinical records system deployment. A business case was presented to EMT on 24 January 2019 and approved, prior to the bid being submitted by 31 January 2019 deadline. The outcome from the bid is awaited.	**TBD**	
➢ ***SystmOne record sharing:*** The Trust has initiated discussions with its partners who utilise SystmOne across the West Yorkshire and in South Yorkshire (Barnsley) with regards to establishing and agreeing a common approach to SystmOne record sharing.	**Ongoing**	
Expected Outcomes: • The vision will lead to an integrated digital infrastructure across ICS regions, making more effective use of the technical expertise available and allowing our collective digital capabilities to develop in parallel with technological advancement. • Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Local systems will support digital pilots and wider delivery and the scaling up of successful interventions will be coordinated by digital work streams and the supporting key interventions.		

Status	***Direction***	**Records Management (Scanning – Archive/Paper Records)**	
G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: Please see previous section.			

Key Activities: ➢ The scanning bureau is focusing on reducing offsite storage costs through destruction of records past retention date, ad-hoc retrieval of records not being returned to offsite storage as well as 'business as usual' bureau work to scan records both on/offsite storage, once Calderdale & Kirklees paper light work transfers to Paper Digitisation Project.	**May 2019**	
➢ Development of the Key Performance Indicators (KPIs) has been subject to delays due to some further changes required by the system supplier Ideagen, so has resulted in a timescale slippage. A revised plan is being developed to consider the quality/quantity KPIs that can be used to monitor and track performance and progress against reducing paper records and off-site storage costs.	**Jun 2019**	
➢ Subject access requests (SARs) volumes continue to be high and Trust wide 76% of requests were responded to within the required timescales. A revised process has been implemented to improve this position and work is ongoing operationally to enhance procedures further.	**Mar 2020**	
➢ The clinical coders continue to meet their 100% target for finished consultant episodes within 6 weeks of discharge or transfer. However, the transition to SystmOne is impacting the ability to code all episodes within the six-week target and this is being investigated further with TPP.	**Ongoing**	
Expected Outcomes: • Reduced reliance on off-site storage (avoidance of increased costs). • Improved governance through having easy, electronic access to all records related to a Trust client, supporting the digitisation and paperless NHS agendas.		

Status	***Direction***	**Paperlight/Paperless NHS**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section.				

Key Activities: ➢ **Paper Digitisation Project Team:** The paper digitisation project team recruitment activities are nearing completion. The project manager, change & benefits manager and two project support officers commenced in post during March 2019. The two remaining project support officers have been appointed and commencement dates are being agreed subject to the necessary completion of recruitment checks. ➢ ***BDU Paper Digitisation Areas for Prioritisation:*** The project team are meeting with BDU representatives to discuss BDU requirements, priority service areas for BDU and to outline the approach and scope. These activities will inform the development of the project plan. ➢ ***Project Governance:*** This project will report into the Trust's Transformation Board as part of project governance. **Expected Outcomes:** • Reduce/remove the creation of paper records/case files for new service users. • Reduce/remove the usage/reliance on fax machines in use across the Trust in line with the national directive for decommissioning of fax machines by 31 March 2020 • Reduce the demand for paper records storage and space in the future. • Support the Trust's drive towards achieving paperless services by 2020 as part of the wider national paperless agenda.	**May 2019** **May 2019** **Ongoing**	

Status	***Direction***	**Multi-Function Device (MFD) Procurement**		
P	➔			
Summary update			***Milestone***	***Achieved***
Purpose: To undertake a re-procurement exercise in respect of the Trust's multi-function device fully managed service provided by Xerox. This provides an opportunity to review the Trust's current and future requirements and to explore the prospects of securing service efficiencies, cost savings and improving the existing quality of service. **Key Activities:** ➢ This procurement exercise is set to commence and this work will need to incorporate a revised			**May 2019**	

specification of requirements to account for compliance with records scanning standards. ➢ Implementation of the preferred solution to be completed by January 2020. **Expected Outcomes:** • Improve the patient experience. • Improve access to services, engaging information users and further supporting the digitisation agendas in line with wider ICS/STP digital aspirations.	**Dec 2019**	

Status	*Direction*	**eConsultation**		
P	➔			
Summary update			***Milestone***	***Achieved***
Purpose: eConsultations are electronic means of establishing consultative communications between clinician-to-clinician at a provider-to-provider level or in collaboration with patients/service users/carers via an electronic health record (EHR) or web-based platform. eConsultations offer the potential to improve access to specialty expertise for patients and providers without the need for a face-to-face visit. **Key Activities:** ➢ To consider and explore the opportunities for use of Microsoft Skype for Business in support of eConsultation capabilities (clinician to clinician and/or clinician to patient tele-conferencing). Potential pilot project opportunity for consideration by the Trust Digital Strategy Group and also a potential area for wider ICS collaboration during 2019/20 which the Trust has expressed interest in **Expected Outcomes:** • Improve the patient experience. • Improve access to services, engaging information users and further supporting the digitisation agendas in line with wider ICS/STP digital aspirations.			**TBD**	

Domain 4: Business Intelligence Systems	***Supports Digital Strategy Aims*** ***3. To foster integration, partnership and working together***

	5. To maximise efficiency and sustainability

Status	***Direction***	**Business Intelligence/Data Warehouse (information hub & dashboards)**		
P	→			
Summary update			***Milestone***	***Achieved***
Purpose: The development of a business intelligence/data warehouse that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service improvements and delivery. **Key Activities:** ➢ Work is underway to scope out future business intelligence development priorities. The development programme will support Trust priorities including SystmOne optimisation and reduction in out of area beds. **Expected Outcomes:** • Continue to improve and make available the use of real time information to support operational services and transformation agendas.			**TBD**	

Status	***Direction***	**Information Governance**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ **General Data Protection Regulations (GDPR):** Monitoring audits will be conducted during 2019/20 and appropriate action will be taken as and when new GDPR guidance is available. ➢ **Information Governance training:** Ensure that the mandated annual information governance			**Ongoing** **Ongoing**	

training update is maintained and that classroom based IG training continues to be rolled out for staff groups who do not have ready access to a computer. ➢ **Data Protection & Security Toolkit (IG Toolkit):** Gather evidence and ensure compliance against the 2019/20 toolkit. **Expected Outcomes:** • Mandatory IG training target is achieved. • The Data Protection & Security toolkit target of meeting all mandatory standards is maintained. • Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.	**Ongoing**	

Status	*Direction*	**National Data Opt-Out Programme**	
P	➔		
Summary update		***Milestone***	***Achieved***
Purpose: The national data opt-out programme is a new service that allows individuals to opt out of their confidential patient data being used for research and planning. **Key Activities:** ➢ NHS Digital has been implementing this since May 2018 but all other organisations that use health and care information must comply by March 2020. Trust plans are in early stage of development to support this. **Expected Outcomes:** • Preparedness for the national data opt-out is assured and processes established to ensure compliance within prescribed timescales.		**TBD – Mar 2020**	

Domain 5: A Skilled & Digitally Enabled Workforce	***Supports Digital Strategy Aims*** ***4. To develop an effective and digitally empowered workforce***

Status	*Direction*	**Intranet Development**

P	→	

Summary update	*Milestone*	*Achieved*
Purpose: To ensure that the Trust corporate intranet is developed, maintained and services/information is accessible across the workforce. This is being led by the marketing, communications & engagement team. **Key Activities:** ➢ Define and scope out requirements for the re-design/re-development of the Trust intranet to inform the production of a business case for Trust approval. ➢ Initiate procurement activities, subject to Trust approval, for the re-provisioning of the Trust intranet based on the agreed requirements. **Expected Outcomes:** • To improve access to corporate systems and information in a timely and responsive manner.	**Deferred 2019/20** **Q1-Q2 2020/21**	

Status	*Direction*	**Social Media Access for Staff**
G	↗	

Summary update	*Milestone*	*Achieved*
Purpose: To enable more staff to access information online and join online networks/discussions forums. **Key Activities:** ➢ **Social media guidance updates:** Collaborate with staff side, IT HR and IG for comments. ➢ **Social media savvy guides:** Bitesized do's and don'ts guides for staff, working with staff side to review content. ➢ **Social media drop-ins:** Open workshops for troubleshooting, suggestions, hints and tips. ➢ **Social media webinars:** Themed webinars on how to get the most out of corporate webinars – using	**TBD** **TBD** **Dec 2019** **Mar 2020**	

skype for business. **Expected Outcomes:** • Improve staff access to social media to enhance digital capabilities.		

Status	*Direction*	**Succession & Workforce Planning (IM&T Staff)**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ A programme of work to aid continuous development and service improvements is being initiated from the timeout workshop outcomes and key themes identified. This is supported by Learning & Development. An internal steering group to consider service improvement opportunities has been established to drive this agenda forward with activities based on outputs from the time-out sessions held during October 2018 and the staff survey findings. ➢ A workforce plan has been drafted in support of annual planning activities and this will also incorporate the develop succession plans. ➢ Working with Learning & Development to consider opportunities for wider eLearning training provision. **Expected Outcomes:** • Improve staff retention. • Improve access and availability of training and development opportunities in support of identified needs. • Improves service resilience and delivery. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities.			**Ongoing** **Ongoing** **Ongoing**	

Status	*Direction*	**Development of Staff Training (IT & Digital Skills)**

G	➔		
Summary update		***Milestone***	***Achieved***
Purpose: To explore opportunities from which to support staff development (capacity/capability) in the use of IT/digital technologies and solutions in the workplace. Individual need will be based on employee capability on using new systems as well as general IT/digital skills in using applications such as Microsoft Office etc. **Key Activities:** ➢ Discussions are ongoing between Learning & Development and IM&T regarding opportunities for the provision of IT/digital training across the Trust. ➢ Calderdale College is looking to including digital in their existing curriculum for students entering the health & care sector. Potential to explore opportunities to tailor their external offer to NHS providers in developing education packages in the same area for existing staff, which might align with the wider digitisation agendas. ➢ The Digital Strategy Group will help support the development of a wider digital culture and digital champions within the workforce. **Expected Outcomes:** • Improve staff retention. • Improve access and availability of training and development opportunities in support of identified needs. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities.		**Ongoing** **Ongoing** **Ongoing**	

Domain 6: Engaging and Learning from Digital Best Practice	***Supports Digital Strategy Aims:*** ***1. To enhance quality of care and patient safety*** ***2. To enable prevention, wellbeing and recovery*** ***3. To foster integration, partnership and working together*** ***4. To develop an effective and digitally empowered workforce***

	5. To maximise efficiency and sustainability ***6. To support people and communities***

Status	***Direction***	**Digital Strategy Group**
G	↗	

Summary update	***Milestone***	***Achieved***
Purpose: A Trust-wide group has been established to oversee and co-ordinate the initiatives and programmes of work included in the Trust's Digital Strategy. Focus will be on exploring new and emerging digital opportunities and solutions from which to bring about further digital evolution across the organisation and its constituent services, with a focus on clinical application and utilisation. This will also consider wider collaborative opportunities that will aid closer working across a variety of sectors including digital technology solution providers and partners and will act as a conduit for expansive Integrated Care System alignment.		
Key Activities: ➢ The inaugural meeting of the digital strategy group was held on 8 February 2019 and a schedule of quarterly meetings scheduled throughout 2019/20 commencing in April 2019.	**Ongoing**	
➢ Potential digital solution providers will be invited to the Digital Strategy Group to present their service offerings for the group to consider applicability to Trust services.	**Ongoing**	
Expected Outcomes: • To develop and maintain a register of digital innovation opportunities to support external bids for funding streams and also internal annual planning prioritisation. • To oversee and drive an effective digitisation of the Trust workforce plan and training programmes. • To demonstrate and evidence improvements through effective benefits identification, measurement, management and realisation. Accounting for return on investment in both financial and qualitative terms from approved pilot projects. • To explore wider learning opportunities, approaches and experiences externally. • To approve and advise on policies and standard operating procedures as required.		

Domain 7: Championing Digital Inclusion for People Accessing our Services	Supports Digital Strategy Aims: 1. To enhance quality of care and patient safety 2. To enable prevention, wellbeing and recovery 3. To foster integration, partnership and working together 4. To develop an effective and digitally empowered workforce 5. To maximise efficiency and sustainability 6. To support people and communities

Status	Direction	Patient Reminder System		
G	↗			
Summary update			**Milestone**	**Achieved**
Purpose: We have a patient appointment reminder system in operation which aims to reduce "did not attend" (DNA) levels across the Trust services. **Key Activities:** ➢ Due to the transition from RiO to SystmOne the appointment reminder service was temporarily suspended to allow clinicians to start using HCP/clinic rotas, with the appointment location and contact telephone number details updated. This work is nearing completion and extracts are running in shadow form to testing the output. When final testing of the extract by Healthcare Communications has been completed the patient appointment reminder service will recommence. It is anticipated this will be from Monday 15 April 2019. Also from this date, patient appointment reminders will recommence from CAMHS services (who were previously using the service). ➢ On recommencing the service, patient appointment reminders will be sent for all clinic appointments. This means use will increase from around 200 clinic appointment reminders to approximately 400 per day. ➢ From the beginning of May 2019, it is planned to introduce interactive voice messaging reminders for service users without a mobile telephone recorded, and an agent call patient reminder for any person over 75 years old or with a learning disability appointment where there is no mobile telephone number recorded.			**Apr 2019** **May 2019**	

➢ We intend to start sending reminders for appointments from the HCP rota for core teams as soon as possible, and also to recommence using the service to collect friends and family feedback. **Expected Outcomes:** • Reduce DNAs, increase re-use of appointment slots ('fast-track' patients in need of urgent appointment) and in turn reduce costs and waiting times. The pilot teams have been able to demonstrate a 30% reduction in DNA rates. • Improve efficiency of services. • Improve quality of services. • Improve patient experience.	**TDB**	

Status	***Direction***	**Collecting and Reporting Health Outcomes**	
P	➔		
Summary update		***Milestone***	***Achieved***
Purpose: Outcomes are changes in health that result from an intervention/procedure. The measurement of these outcomes provides insight into not just whether the treatment has been successful but also into the patient experience as a whole. Clinical outcomes can be measured by data such as hospital re-admission rates, or by the 5 domains set out in The NHS Outcomes Framework Indicators: ▪ Preventing people from dying prematurely ▪ Enhancing quality of life for people with long-term conditions ▪ Helping people to recover from episodes of ill health or following injury ▪ Ensuring that people have a positive experience of care ▪ Treating and caring for people in a safe environment and protecting them from avoidable harm **Key Activities:** ➢ The Trust is exploring digital solutions to collection and reporting outcomes. Some services such as IAPT, CAMHS and early intervention are required to routinely collect outcome measures. However in other services there is no consistent approach to outcome measure collection. The manual collection and re-inputting into the electronic clinical record of patient reported outcome measures (PROMs) is		

also time consuming which adds to existing clinical burden, and there is little feedback to either clinician or service user as to the outcomes of intervention. ➢ A digital solution would allow a quick way of sending out and collecting the volume and diversity of PROM data required, without increasing the clinical burden. It would generate fast, measurable and significant benefits through: - ▪ Self-reporting of outcomes where the patient completes health outcomes via the internet or smart phone at home, or at a clinic appointment before, during or after treatment. ▪ Staff time preserved that allow for replacement of paper questionnaires with a streamlined electronic process, requiring no collation or management of questionnaires or re-inputting of data required. ▪ Integration of data available via a single reporting dashboard would allow integration with other patient feedback and audit data. ▪ Support future move to future outcomes based payment systems. **Expected Outcomes:** • Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient. • Improved timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment. • Automatic analysis, scoring and reporting in real time at clinical, service and organisational level. • Better understanding of clinical need and effectiveness of services.		

Status	***Direction***	**Service User (Patient) Portal Development**		
P	➔			
Summary update			***Milestone***	***Achieved***
Purpose: Development of a SWYPFT patient portal solution that allows Trust service users and carers with access to their electronic care record information, provide opportunities to self-manage and engage more readily in the delivery of their care and that provides alternative means from which to engage with care professionals offering greater flexibility.				

Key Activities: ➢ ***Patient Portal scoping & design:*** To formulate a plan and establish a project from which to scope out the design and development of a SWYPFT patient portal. **Expected Outcomes:** • Provision of a single integrated holistic patient record view that facilitates a patient's access to their own electronic care record. • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner.	**Mar 2020**	

Domain 8: Embedding Digital in our Culture	***Supports Digital Strategy Aims:*** ***1. To enhance quality of care and patient safety*** ***2. To enable prevention, wellbeing and recovery*** ***3. To foster integration, partnership and working together*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status	***Direction***	**Apps for Service Users and Carers**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: As part of the wider digitisation agenda, the Trust is exploring opportunities from which to make information and services more accessible to our patients, service users and carers. **Key activities:** ➢ A capital bid has been submitted as part of the capital planning to secure further funding for ORCHA into 2019/20 and 2020/21. ➢ Marketing, communications and engagement are assisting the services where necessary through			**Apr 2019** **Ongoing**	

regular social media, as well as regular updates in the internal communications routes to help promote ORCHA within the services.		
➢ The integrated change team, with support from ORCHA, has met individually with services via team meetings/phone calls to provide any support needed to take this project forward.	**Ongoing**	
➢ As part of the project ORCHA continue to provide us with some hard data such as, site visits, numbers and details of apps searched for and downloaded by our patients and populations, search terms, numbers and details of apps searched for and apps recommended by your professionals and conversion rate post recommended app.	**Ongoing**	
➢ As part of the Digital Innovation we will be re-launching our work with ORCHA with the current services with a view to roll out to more services across the Trust within the next 12 months.	**Ongoing**	
➢ As part of the re-launch we have asked for an ORHCA champion from each service who will be the regular point of contact for ORCHA.	**Ongoing**	
Expected Outcomes: • Improves the overall patient experience. • Improves access to services, supportive information users and is part of the wider digitisation of the NHS, further supporting the LDR plans and aspirations of ICS/STPs.		

Status	***Direction***	**i-Hub Digital Challenge**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: i-Hub is a social innovation platform where the aim is to crowdsource ideas and experiences, to help develop and realise identified organisation priorities. i-Hub is centred around a number of 'challenges' that pose a key question, opportunity or area of development to engage our workforce about (including volunteers). **Key Activities:** ➢ In 6 months' time, the i-Hub platform should operate as a network for engagement with			**Ongoing**	

frontline staff around ideas innovation and collaboration. With this in mind, the aim is to work towards a re-launch to include: - ▪ Clarifying content – easier/quicker to understand ▪ i-Hub will form part of the #allofusimprove initiative ▪ Clearly stating incentives to engage ▪ Coherent message and branding ▪ A platform that has transparency and a clear intent ▪ Director/top-down support ➢ During year 3, three main challenges will be focused on, Your Fab Stuff, My Idea and a rolling director sponsored challenge that will reflect our strategic priorities. **Expected Outcomes:** • This online tool helps the Trust connect, share, discuss, develop and spread ideas. • Support staff to continuously innovate, improve and transform. • Improve efficiency of services. • Improve quality of services. • Improve patient experience.	**Ongoing**	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 9.2

Title:	**Update of the Risk Management Strategy including review of Risk Appetite Statement**
Paper prepared by:	Director of Finance and Resources Company Secretary
Purpose:	The Trust's Risk Management Strategy ensures there are appropriate and adequate risk management processes in place within the Trust to manage and mitigate risk and is a key Strategy to support the Accounting Officer's Annual Governance Statement.
Mission/values:	The Risk Management Strategy provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management.
Any background papers/ previously considered by:	The Risk Management Strategy was last approved by Trust Board in January 2017. The updated Strategy has been considered by the Executive Management Team (EMT) on 7 March 2019 and Audit Committee on 9 April 2019 who recommend its approval by the Board.
Executive summary:	The Risk Management Strategy enables the Trust to identify key risks in the external environment and in its forward plans. Planned actions to mitigate risks are described in the Board Assurance Framework (BAF) and Corporate/Organisational Risk Register (ORR), which are reviewed by Trust Board on a quarterly basis. A detailed review of the Risk Management Strategy was last completed and approved by Trust Board in 2017. The Strategy is now due for review and has been updated to reflect changes in the internal and external environment in relation to risk to ensure it is fit for purpose for a further three years and against best practice. Amendments include an update to the Risk Appetite Statement as approved by Trust Board in April 2018 (appendix 3) and a reduction in appendices which were duplicated in the Risk Management Procedure which underpins the Strategy. The Procedure has also been updated and reviewed by EMT for final approval by the Director of Finance and Resources as the lead Director. **Risk Appetite** Annually in April, the Trust Board is required to review the Risk Appetite Statement. This was last reviewed in and updated by Trust Board in April 2018 and no further changes have been recommended. The delivery of the Risk Management Strategy supports the Trust in providing safe, high quality and equitable services within available resources through an integrated approach to managing risk, 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 Risk Management Strategy.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Risk management strategy

Version v9

April 2019 – April 2022

Document name:	**Risk Management Strategy**
Document type:	**Trust-wide Strategy**
What does this policy replace?	**Update of previous strategy (requirement for annual review by Trust Board)**
Staff group to whom it applies:	**All staff within the Trust**
Distribution:	**The whole of the Trust**
How to access:	**Intranet and internet**
Issue date:	V1 issued December 2008 V2 issued October 2010 V3 issued December 2011 V4 issued October 2012 V5 issued December 2013 V6 issued January 2015 V7 issued January 2016 V8 issued January 2017
Revised date:	**Revised April 2019**
Next review:	**April 2022**
Approved by:	Trust Board 20 December 2011 Trust Board 30 October 2012 Trust Board 17 December 2013 Trust Board 27January 2015 Trust Board 29 January 2016 Trust Board 31 January 2017 To be approved by Trust Board 30 April 2019
Developed by:	**Company Secretary** **Corporate Governance Manager**
Director leads:	**Director of Finance and Resource**
Contact for advice:	**Company Secretary** **Corporate Governance Manager**

Contents

1. Introduction

1.1. Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We put the person first and in the centre
- We know that families and carers matter
- We are respectful, honest, open and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

In 2018/19, our strategic objectives were:

- Improving health – a priority for joined-up care
- Improving care – a priority for safety first, quality counts
- Improving resources – a priority for operational excellence

In 2019/20, our draft strategic objectives have been amended to include and additional objective:

- A great place to work – a priority for ensuring we have high quality workforce

This risk management strategy will support the achievement of the organisation's mission and objectives. Every aspect of the strategy will be delivered in line with our values.

1.2. Purpose and scope

The Trust is committed to ensuring the safety of the people who use its services, its staff and the public through an integrated approach to managing risk regardless of whether the risk is strategic, clinical, financial or commercial or relates to compliance. The Trust recognises the importance of effective integrated risk management arrangements to underpin the safe and effective delivery of its services, its reputation and its organisational viability and sustainability. As a foundation trust, the Trust must have the skills and systems in place to manage its own business. Trust Board must be assured of the safety and effectiveness of services and the financial sustainability of the organisation and is responsible for developing the appetite of the Trust to take risks and the ability of the Trust to manage risk. In turn, Trust Board must be able to provide assurance to its regulators. This includes registration with the Care Quality Commission (CQC) to be a provider of NHS commissioned services and adherence to Monitor (NHS Improvement) licensing conditions.

The purpose of the strategy is to set out the Trust's strategic approach to the anticipation, prevention, mitigation and management of risk, linked to the Trust's Business Plan (Operational Plan). The strategy describes the systems the Trust has in place at a strategic, corporate and operational level to ensure that assurance is provided to Trust Board through its governance arrangements and to external bodies that risk is being effectively managed within the Trust. It also sets out the framework through which Trust Board drives a culture of proactive risk management.

2. Context

2.1. Definition of risk and risk exposure

The Trust is a large and complex organisation, operating in a changing environment, which remains competitive and contestable in each health economy facing service, political and

financial challenges. The Trust is also subject to public scrutiny. In this context, risk cannot be completely eliminated and the Trust's approach is to have in place systems and processes that enable it to:

- anticipate where risks might occur
- make sound decisions based on information and intelligence
- minimise the likelihood or impact of potential risks.

Trust Board takes a prudent and pragmatic attitude to risk, adopting a flexible approach and the determination of its response as the need arises. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time. The organisations risk appetite is set out in Appendix 3. Where risks cannot be managed within the risk appetite of the Trust, they will be subject to further scrutiny by the relevant sub-committee as identified within the committee's Terms of Reference.

Risks can be broadly defined as follows:

Clinical risks

Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.

Commercial risks

Risks which might affect the sustainability of the Trust, or its ability to achieve its plans, such as inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact om commissioners' decisions to place contracts with the organisation.

Compliance risks

Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.

Financial risks

Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.

Strategic risks

Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.

2.2. Risk reporting and procedures

The Trust uses Datixweb to support the recording, management and review of risks and production of risk registers across the Trust to ensure consistency of recording. Datix allows control measures to be recorded and actions to be scheduled, with a full audit trail of changes to risk assessment. Information feeds through levels of risk register from 'ward to Board'. The system has the ability to report at different levels, look at themes across the organisation and risk areas, such as information governance, or health and safety, and record and manage actions. The Trust has a "Risk Management Procedure" for staff which sets out the processes for this system and this can be found on the Trust's intranet.

2.3. Risk management processes

Risk management is recognised as integral to good management practice and is the business of everyone in the organisation. Risk management processes are designed to support better decision-making by contributing to a greater understanding of risks and their potential impact.

The principal tools used by Trust Board to gain assurance are described in the Chief Executive's **Annual Governance Statement**. It shows that the Trust understands its risks, is taking reasonable action to manage those risks and has action plans in place. Systems of internal control are designed to manage risk to a reasonable level rather than to eliminate all risk. Controls include the continuous assessment of the internal and external environment to identify risks to the achievement of the Trust's objectives, ensuring mitigating action is in place and prioritising risk management through assessment of the likelihood and impact of identified risks if they materialise.

Effective management of risk relies on the following processes and systems.

As part of its **Licence** (issued by Monitor), the Trust is required to have a Constitution in place which is compliant with legislation. The Licence also requires that the organisation is financially viable and sustainable, well governed, and that it can continue to provide commissioner requested services.

The **Constitution** of the Trust sets out the legal framework in which the Trust operates. The Constitution is based on the model core constitution and defines the powers of both Trust Board and the Members' Council. The **Standing Orders** of Trust Board and Members' Council form part of the Constitution.

As part of its Standing Orders, Trust Board has approved **Standing Financial Instructions** (SFIs) and a **Scheme of Delegation** which provide the framework within which responsibility for financial decision making takes place throughout the organisation, and is designed to ensure Trust Board has appropriate levels of control over financial decisions and is alerted to financial risks.

Trust Board assurance that risks around its strategic objectives are being managed is summarised and evidenced in the **Board Assurance Framework (BAF).** Where there are gaps in control or Trust Board has received insufficient assurance, these are reflected on the risk register. The BAF is reported to Trust Board on a quarterly basis and provides evidence of actions taken to manage risks.

The BAF and risk register are reviewed during the year to ensure the process, which is scrutinised by the Audit Committee on an annual basis, and format continue to provide an effective tool for summarising and monitoring assurance and risk management at Board level. The advice of internal audit is sought as part of this review.

The **Risk Register** links closely to the BAF and enables Trust Board to closely monitor any risks identified in the BAF where there are gaps in control (i.e. where there are external factors which the Trust cannot control or where the measures being taken by the Trust are unable to eliminate the risk). Risk registers are held at all levels of the Trust, including corporate / organisational level (Trust Board), BDU level, and team level. The risk registers held by BDUs are reviewed regularly and any risk which could have an impact across the Trust is reported to the Executive Management Team (EMT) monthly to ensure risks which may have a Trust-wide impact are recorded on the Trust's corporate / organisational level risk register. Individual directors are responsible for ensuring there is a process for identifying risks relating to support services and for adding items to the corporate / organisational level risk register (see section 9). All risk registers are designed to be 'live' working documents which support the organisation to identify, assess and manage risks.

The Trust is required by its Regulator to produce an annual **Business Plan** (Operational Plan) for organisational and service development. The plan describes the key risks to delivery of the plan and how these would be mitigated. It maps the direction of travel, and so supports Trust Board and service managers to identify where it may be deviating from target and take remedial action.

Annual plans are developed within each directorate and co-ordinated into a Trust plan. Annual plans are agreed with commissioners and support the delivery of the Business Plan. The plans identify service developments and changes, and the financial and workforce implications of those plans, including any required cost improvements (CIPs). Undertaken by the Director of Nursing & Quality, the Medical Director and the Director of Human Resources, Organisational Development & Estates, each cost improvement is subject to a **Quality Impact Assessment (QIA)**. The assessment covers three aspects of quality person-centred, safe, effective and efficient. The assessment tool provides a quality impact rating on RAG rated scale (Blue: Improves quality; Green: Neutral impact on quality; Amber: Potential impact on quality; Red: Likely impact on quality). The assessment is based on the Care Quality Commission's (CQC) five key domains: safe, effective, caring, responsive, and well-led. Where risks are considered to be substantive, plans may be changed or mitigating action put in place to manage the risk.

Reporting of performance against plan enables Trust Board to assess the impact and opportunities of financial decisions on clinical services and the impact of service changes on the financial position of the Trust. The reports also support Trust Board in the early identification of any risks to its strategic position, financial viability or public reputation. High level performance reports (Integrated Performance Report) are circulated to Trust Board on a monthly basis and each quarter the Board agenda is dedicated to consideration of strategic and business risks, which includes review of performance against plan and compliance.

A range of **strategies, policies and procedures** are in place to support the effective management of risk throughout the organisation and these are located on the Trust's intranet.

The Trust aims to have a whole system approach to risk management where all staff are encouraged to take responsibility for assessing and managing risk within their own sphere of responsibility and the Trust, through its management structure, and all staff have a shared responsibility for ensuring the requisite skills are in place to identify and manage risks.

A risk management process based on the Australian / New Zealand Standard is used within the Trust. The Risk Management Procedure document which underpins this Strategy sets out the risk management overview and process and the steps included. The whole system approach is continuously monitored by Trust Board and through the leadership and management framework to support learning and improvement. The aim of the approach is to support an organisational culture based on prudent ambition in relation to service development and learning from experience to minimise the likelihood of risks manifesting themselves and to enable the Trust to respond positively to mitigate the impact of unavoidable risks and maximise opportunities of doing so.

Challenges in the external environment, combined with both service and structural transformation, offer opportunities to develop services but expose the organisation to a degree of risk. The Trust continues to develop its risk systems in line with the changes to its structure and leadership and management arrangements, and put in place robust plans for managing risk through a period of political and financial instability, and externally and internally driven change.

3. Risk management strategy objectives

The risk management strategy is designed to ensure a systematic and focused approach to clinical and non-clinical risk assessment and management is in place to support the Trust in meeting the needs of decision-makers throughout the organisation and to meet all external compliance and legislative requirements, including those set by regulators. Robust risk management systems, supported by effective training, need to be in place throughout the organisation and to be routinely used to support planning and delivery of services.

The risk management strategy is a key strategy for the organisation and its objectives are to:

- provide a framework for risk management that assures Trust Board that the Trust is delivering against the strategy set out in its plan
- clarify responsibility and accountability for management of risk throughout the organisation from Trust Board to the point of delivery (from 'Board to ward') and support greater devolution of decision-making as close to the user of Trust services as possible
- define the processes, systems and policies throughout the Trust which are in place to support effective risk management and ensure these are integral to activities in the Trust
- promote a culture of performance monitoring and improvement which informs the implementation of the Business Plan and ensure risks to the delivery of the Trust's plans and market position are identified and addressed
- ensure staff are appropriately trained to manage risks within their own work setting and clear processes are in place for managing, analysing and learning from experience, including incidents and complaints
- ensure approaches to individual risk assessment and management balance the rights of individuals to be treated fairly, the rights of staff to be treated reasonably and the rights of the public in relation to public protection
- support Trust Board in being able to receive and provide assurance that the Trust is meeting all external compliance targets and legislative responsibilities, including standards of clinical quality, Monitor compliance requirements and the Trust's licence
- enable Trust Board to define the appetite for risk and ensure this is understood and acted upon at all levels in the organisation.

4. Delivery and outcome measures

Trust Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the agreed direction, ensuring corrective action is in place where necessary. Trust Board must be confident that systems and processes are in place to support corporate, individual and team decision-making and accountability for the delivery of safe and effective, person-centred care within agreed resources.

The agenda and focus of Trust Board meetings is continuously reviewed to ensure attention is given to both strategy and implementation. Each quarter, there is a business and risk meeting which is forward looking and risk-based, a performance and monitoring meeting which provides a detailed retrospective review of performance, and a strategic meeting which also informs Trust Board development.

There are currently four 'risk' **committees of Trust Board**:

- Audit Committee
- Clinical Governance & Clinical Safety Committee
- Mental Health Act Committee
- Workforce & Remuneration Committee.

Each of these committees has clearly defined **Terms of Reference** which set out the functions that the committee carries out on behalf of the Trust Board including the specific risks they are responsible for reviewing assurance in line with the Trust Risk Appetite Framework. All committees are chaired by a Non-Executive Director. Minutes are formally presented to Trust Board one approved and assurance is provided to Trust Board by the committee chairs. The Audit Committee chair does not routinely attend any other committees to ensure objectivity; however, the Audit Committee chair has the opportunity to attend each committee once a year as part of providing assurance to Trust Board on effectiveness of other risk committees.

Membership of committees is organised to ensure good linkages through Non-Executive and executive Directors.

The **Audit Committee** is responsible for assessing the adequacy of systems, controls assurance and governance in the organisation as described in the Annual Governance Statement and that the systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring there is independent verification of the systems in place for risk management. Responsibility for monitoring financial performance is held by Trust Board but the Audit Committee scrutinises the financial management systems through its links to internal and external audit.

The **Clinical Governance & Clinical Safety Committee** provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice, and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. The Clinical Governance & Clinical Safety Committee has a particular focus on ensuring standards of clinical care are improved or maintained in a climate of cost control and efficiency savings.

The **Mental Health Act Committee** is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act (2005), as amended by the 2015 Act, and with reference to the guiding principles set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty Standards.

The **Workforce & Remuneration Committee** has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and executive Directors and a local pay framework for senior managers that actively contribute to the achievement of the Trust's aims and objectives. The Workforce & Remuneration Committee also has delegated authority to approve any termination payments for the Chief Executive and executive Directors and is also responsible for approving Clinical Excellence awards for Consultant Medical staff. The Committee also supports the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues.

Trust Board and its committees are reviewed on an ongoing basis to ensure that Trust Board adds value to the organisation in terms of setting strategy, monitoring performance and managing risk. This includes:

- a development programme based on continuous review of the combined skills and competencies of the Trust Board
- ongoing review of the format of Trust Board meetings to ensure best use of time and appropriate balance between strategy development and retrospective performance monitoring
- an annual review of the committee structure, membership and Terms of Reference and value added to ensure clarity of role and optimise their effectiveness.

The **Members' Council** plays a key role in the Trust's governance arrangements. It provides a bridge to the community, supporting the Trust to engage with its membership and acting in an advisory role in the development of strategy and plans. The Members' Council primary duty is to hold Non-Executive Directors to account for the performance of Trust Board. Its work programme is specifically designed to reflect this duty.

Some Staff Governors have been appointed as Freedom to Speak Up Guardians. Specific risks identified through this role will be escalated to the lead Director as appropriate, to be dealt with in accordance with the Risk Management Strategy and procedure.

The Members' Council is also responsible for monitoring the effectiveness of Trust Board including the appraisal of the Chair and appointment and removal of Non-Executive Directors. The Members' Council has a **Nominations Committee** to support this role.

Ongoing development of the Members' Council focuses on:

- development of the interface between the Trust Board and Members' Council
- public and staff elections to attract people who represent the diversity of the community served by the Trust and effective induction of new members
- development of individual and collective skills of the whole Members' Council
- development of the interface between the Members' Council and the wider membership to optimise the Members' Council's role.

The **Chief Executive** is the Accounting Officer of the Trust and has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding its resources. The Accounting Officer's approach is set out in the Annual Governance Statement, which describes the system of internal control within the organisation. This is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The Chief Executive provides leadership to the **Executive Management Team** (EMT). The EMT is made up of executive, clinical and operational Directors and is responsible for ensuring implementation of the strategy agreed by Trust Board.

The EMT reviews the risk register and scans clinical risks including incidents, claims and complaints to ensure they are being effectively managed and action is being taken to minimise the risk of recurrence. The EMT also reviews the strategic position of the Trust and any potential threats to income or achievement of its plans.

The **Extended EMT** meets monthly. The Extended EMT provides an opportunity to engage all first line report staff in transformation, delivery and focus on potential risks. It comprises of the Chief Executive, all executive Directors, and senior staff including deputy directors, clinical, general management and practice governance leads from BDUs.

Business Delivery Units (BDUs) are responsible for delivering safe and effective services within agreed resources within geographical or specialist service areas, within a framework of devolved responsibility to ensure effective delivery of the Trust's Business Plan and providing an effective performance framework for delivery.

The executive functions of the organisation have been reviewed to support the ongoing development of BDUs and devolution of decision-making to service lines. The EMT has reviewed the way that it works to ensure effective matrix working between the BDUs and the support directorates through a "Quality Academy" approach designed to ensure capacity in the organisation is prioritised towards delivering high quality, sustainable services.

Each BDU has a deputy district director to support executive Directors to deliver services. They also manage the working relationship of the 'trio'-based approach at senior level, encompassing clinical, general management and practice governance to ensure excellence in service quality and delivery in terms of effective clinical engagement and prioritisation, appropriate deployment of resources and effective clinical governance.

The Director of Operations is responsible for determining the configuration of service lines within the BDUs to optimise quality and efficiency.

The role of the "**Quality Academy**" is to:

- combine the work of the voting executive directors, with support from the Director of Strategy

- ensure key linkages and synergies between all portfolios to provide optimal support to delivery of services in BDUs
- ensure ongoing quality improvement and associated compliance with regulatory requirements
- ensure linkage across key domains of the “Quality Academy”.

Trust-wide action groups (TAGs) focus on specific issues and ensure these are being properly addressed through the BDUs. Executive Directors establish TAGs to support them to discharge their accountability.

Professional leadership arrangements are in place within the Trust for nursing, allied health professionals, medicine and pharmacy, psychological therapies and social care staff working in integrated teams to support the delivery of safe clinical services through development of the knowledge and skills of staff. This is led by the Director of Nursing and Quality and the Medical Director.

The Trust has a dedicated **Contracting Team** to manage the relationship with commissioners ensuring there are sound systems in place to respond to issues which might affect future commissioning intentions and provide a forum for exploring opportunities for service development. These are supported by Director-level Contracting and Quality Boards in each district. Identification of risks to income, opportunities for expansion, and risks to achieving targets and key performance indicators are reported and considered through EMT meetings where appropriate action is agreed.

Effective management of the Trust’s relationships with commissioners is reviewed by the EMT on a regular basis to ensure it reflects the changing arrangements for commissioning set by the Government and NHS England. The Trust is actively involved in Integrated Care Systems in West Yorkshire & Harrogate and South Yorkshire & Bassetlaw. These increasingly impact on our relationship with commissioners.

5. Risks

Risks identified in the delivery of this strategy include:

- Procedures, processes and systems not embedded throughout the Trust to support effective risk management.
- A lack of collective commitment internally in promoting a culture of effective risk management.
- A lack of personal responsibility for individually identifying, assessing and managing risk within their own area of responsibility.

Key risks will be mitigated in line with this strategy and risk appetite. An implementation plan for the Strategy is outlined at Appendix 6 and monitoring and compliance with the strategy is outlined at Appendix 1.

6. Resourcing, staffing and technology related issues

Risk management needs to be an integral part of our work right across the organisation. The strategy has been designed not to create additional activity, but to align resources and efforts based on Trust priorities. It is, therefore, vital the implementation plan is incorporated into the annual planning process rather than viewed as separate activities.

The Trust’s approach to risk management training in respect of Trust Board and the Extended EMT is outlined in Appendix 6 and set out in the Risk Management Procedure.

7. Next steps and governance arrangements

This strategy is reserved for agreement at Trust Board and will be delivered through our EMT. The Director of Finance & Resource is accountable for delivery. Implementation of the strategy will see involvement from teams across the organisation. An implementation plan for the Strategy is set out in Appendix 6.

Directors are responsible for the identification, assessment and management of risk within their own area of responsibility. **Trust Board**, as a whole, provides leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed. Trust Board is required to approve an annual self-certification confirming that risk management systems are effective and fit for purpose.

The **Chief Executive** has overall responsibility for risk management across the Trust and delegates general risk management responsibilities to all Executive and Operational Directors. Individual directors have lead responsibility for specific areas of risk management, which are detailed in Appendix 5.

Managers are responsible for the management of day-to-day risks of all types within their remit and budget allocation. They are charged with ensuring that risk assessments are undertaken within their own service area on a proactive basis, ensuring risks identified are appropriately managed and controlled, and that risks which cannot be controlled or prevented are recorded on the appropriate risk register at the appropriate level. Individual managers should:

- ensure adherence to Trust policies and procedures to support effective risk management
- raise staff awareness of the key objectives in the risk management strategy
- foster a supportive environment to facilitate the reporting of risks and incidents
- manage clinical and non-clinical risks in their area, including risks to the Trust's reputation
- manage communications, including adherence to Trust policy
- ensure staff are aware (including sub-contractors) of risks in the working environment
- ensure staff training needs are identified and addressed
- ensure adherence to standing orders, standing financial instructions and scheme of delegation.

All staff have responsibility for managing risk within their own sphere of responsibility, including:

- awareness of organisational and health and safety risk assessments and of any measures (such as, policies and procedures) that are in place to mitigate risks
- identifying and reporting hazards and risks arising out of work-related activities
- awareness of the requirement to report risks and how this is done within the Trust
- working within their area of competence and identify their own training needs
- following Trust policies and procedures
- contributing to identification of risks and follow up actions in the risk register.

8. Evaluation and review

This strategy covers a period of three years and will be evaluated and reviewed in April 2022.

Monitoring of risk and the effectiveness of the Risk Management Strategy is undertaken through:

- review of the Strategy by Trust Board every three years
- scrutiny of Trust Board committee Minutes as a standing item on the Trust Board agenda

- internal and external audit activity
- scrutiny of the assurance framework and risk register by Trust Board quarterly and by the Executive Management Team monthly
- areas of underachievement and potential risk highlighted through the Integrated Performance Report to Trust Board monthly
- Directors' reviews with the Chief Executive
- the Chief Executive's reviews with the Chair.

Compliance with the strategy will be monitored through established risk processes already in place within the organisation. These are outlined in Appendix 1.

9. Quality and equality impact assessment

From a quality perspective, in approving this strategy our Executive Management Team has confirmed that it:

- Will help improve service user experience
- Will help reduce harm
- Will help us to be more effective
- Is aligned to our mission and values
- Is aligned to our system intentions
- Is ambitious.

An equality impact assessment has been undertaken, and can be found in Appendix 10.

10. Appendices

10.1. Appendix 1 – Monitoring compliance with the strategy

Risk process	Purpose	Frequency	Lead	Outcome
Review of the Risk Management Strategy	To ensure it is appropriate for the Trust, reflects current priorities and the external environment, and is fit for purpose.	Every three years	Company Secretary	To ensure Trust Board fulfils its overall accountability and responsibility for risk management in the organisation and that the Trust's approach to risk fits with the Trust's strategic direction.
Annual Governance Statement	Sets out the Trust's systems and processes of internal control	Annual	Chief Executive	Presented to and supported by Trust Board. Included in the Trust's annual report and accounts. Scrutinised by the Audit Committee, Trust Board and Monitor.
Trust Board Committees review of their effectiveness	To ensure Trust Board committees are meeting their terms of reference and providing assurance to Trust Board of their effectiveness in scrutinising risk in the organisation.	Annual	Committee Chairs and lead Directors	Annual report presented to each Committee by Committee Chair and lead Director. Committee undertakes a review of its terms of reference to ensure relevance and appropriateness, approves its annual work programme and undertakes a self-assessment. The annual report is then presented to the Audit Committee to provide assurance to Trust Board.
Audit Committee review of the effectiveness of risk committees	To ensure Trust Board committees are meeting their terms of reference and providing assurance to Trust Board of their effectiveness in scrutinising risk in the organisation.	Annual	Chair of Audit Committee	Presented to the Audit Committee, which provides assurance to Trust Board.
Ongoing work of risk committees	Scrutiny of risk and its management	Committees meet a minimum of four times per year	Non-Executive Chairs / Lead Directors / Director of Finance and Resource / Company Secretary	Feedback to Trust Board and annual reports to the Audit Committee and, through the Committee, to Trust Board.

Risk process	Purpose	Frequency	Lead	Outcome
Internal audit programme	This takes a risk-based approach to provide assurance that the Trust's key internal controls are robust, appropriate and fit for purpose. The programme forms the basis of the Head of Internal Audit Opinion and the Accounting Officer's Annual Governance Statement.	Annual work programme	Director of Finance and Resource	Presentation of reports to the Audit Committee. Head of Internal Audit Opinion forms a key part of the Trust's annual reporting statements. Supported by independent review of Trust annual report, accounts and Quality Accounts.
Internal audit of risk management processes	To provide assurance that the Trust's processes are robust, appropriate (fit for purpose) and are followed.	Annual	Internal audit / Director of Finance and Resource	Presentation of report to Audit Committee.
Review of the Trust's appetite for risk.	To ensure that the Trust's strategic direction, objectives and annual plan reflect its appetite for risk and is consistent with the Trust's mission, vision and values.	Annual (as part of annual planning)	Chair and Chief Executive	Agreement of the Trust's strategic direction and annual plan to ensure the Trust meets its objectives and manages risk in an effective way at a level appropriate to the Trust.
Risk management training	To ensure that the Trust's approach to risk management is embedded at the highest level within the organisation.	Annually	Director of Finance and Resource	Trust Board and members of the Extended Executive Management Team undertake mandatory risk management training annually via information booklet available on the intranet. To be rolled out to other staff as appropriate.
Triangulation of risk, performance and governance	To triangulate performance, risk and governance to demonstrate that all key strategic risks are captured by the risk management process; risks are appropriately highlighted and managed through the governance committees and operational meetings; and there is a clear link between risk management and identifying areas of poor performance by cross referencing the content of the performance report to the risk register.	Quarterly	Director of Finance and Resource / Company Secretary	Presentation of report to Audit Committee.

10.2. Appendix 2 – Risk registers: guidance on use of the risk grading matrix

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

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

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood score (L)
What is the likelihood of the consequence occurring?
The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes.

4 Calculate the risk score, multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

10.3. Appendix 3 – Risk appetite statement

Risk Appetite, definition and purpose
Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. It goes to the heart of how an organisation does business and how it wishes to be perceived by its key stakeholders. The amount of risk an organisation is willing to accept will depend on the business it is in, its systems and policies and the internal and external environment it is facing.

A risk appetite enables Trust Board to formally communicate to the organisation the level and type of risks it is willing to accept to achieve the Trust's mission, strategic objectives and organisational priorities. It will assist decision-makers in understanding the degree of risk to which they are permitted to expose the Trust whilst encouraging enterprise and innovation. The Public Accounts Committee (PAC) supports well managed risk taking recognising that innovation and opportunities to improve public services often requires risk taking providing the organisation has the ability, skills, knowledge and training to manage those risks well. The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust will review its risk appetite at least annually as part of the review of its Risk Management Strategy.

Process
It is recognised that the Trust may have limited influence on external factors that can impact on the Trust's ability to manage a risk down to the risk target. The risk target is just that: a target the Trust is trying to manage down to; however, on occasions the Trust may have to revise that target to the least worst option. The Executive Management Team, through its monthly review of the organisational and directorates risk registers, will consider if there is a likelihood of a risk not being managed down to the right level. A risk exception report will go to the relevant sub-committee or forum of Trust Board (as set out in their Terms of Reference) setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Through EMT, a scan across Directorate registers of both risks scoring below 15 and above 15 (before mitigation) will allow any themes / hot spots to be identified, mitigating actions agreed and referral to the appropriate sub-committee / forum of the Board as applicable.

Trust Board will review its activities at the quarterly Business and Risk meeting, ensuring any risks, emerging risks, changes in activities or key risk indicators are reviewed in accordance with the risk appetite of Trust Board. This may involve taking considered risks into account where the long-term benefits outweigh any short term losses. The impact of these risks will be reflected through the Board Assurance Framework.

The Trust's Risk Management Strategy sets out the Trust's risk scoring approach, which is based on the likelihood of an event happening multiplied by the consequence of the action.

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

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

Good Governance Institute matrix	**Risk appetite Level**	**Risk target score (range)**
Avoid: Avoidance of risk and uncertainty is a key organisational objective	**None**	**Nil**

Good Governance Institute matrix	Risk appetite Level	Risk target score (range)
Minimal: (ALARP: As low as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM)	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Application

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

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

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

Compliance risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	**Risk appetite Minimal/low-Cautious/moderate**	**Risk target 1-6**
• Risk of failing to comply with Monitor requirements impacting on license • 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 risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	**Risk appetite Minimal/low-Cautious/moderate**	**Risk target 1-6**
• Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment • Risk of breakdown in financial controls, loss of assets with significant financial value.		

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

Reviewed and approved by Trust Board: 24 April 2018

10.4. Appendix 4 – Board risk assurance and risk escalation framework

Introduction

South West Yorkshire Partnership NHS Foundation Trust (the Trust) has developed a range of policies, systems and processes which when drawn together comprise a robust framework for the assurance of quality and escalation of risk within the Trust.

This document describes the assurance and risk escalation framework and demonstrates how the Trust's risk systems and learning from events is monitored and escalated where necessary by an effective governance and committee structure.

A robust governance framework is essential for the organisation as it provides assurance to the Trust Board, the Members' Council, senior managers and clinicians that the essential standards of quality and safety are being met by the Trust. It also provides assurance that the governance processes are embedded throughout the organisation.

This framework describes the responsibility and accountability for the Trust's governance structures and systems, through which Trust Board receives assurance or escalates concerns and risks related to quality of services, performance targets, service delivery and achievement of strategic objectives. It also addresses under-performance and ensures that potential performance problems are identified early, and action plans developed to rectify or mitigate the issues.

Culture

The Trust has an open, honest and learning culture, which is set out in its mission and values and underpinned in its Being Open policy. The Trust encourages the reporting of all adverse incidents by its staff and the reporting of complaints and concerns by service users, their carers and relatives, supported through an independent advocacy process if required.

Staff Involvement

The Trust has an overarching Communication, Engagement and Involvement Strategy and a number of policies and mechanisms which encourage staff at all levels to be involved in performance monitoring and to raise concerns about any risk issues. Examples include Raising Concerns (Whistleblowing) Policy, Freedom to Speak up Guardians, Being Open Policy, Risk Management Strategy, Incident Reporting and Management Policy, Customer Services Policy, safeguarding policies and procedures, staff surveys and through the Staff Partnership Forum.

Service user / carer / public involvement

The Trust encourages service users, their carers and the public to make comments and / or raise concerns both formally and informally via a number of mechanisms, such as customer services, patient experience surveys, friends and family test, service line specific service user and carer groups, Patient Led Assessments of the Care Environment (PLACE), 'CQC type' walk rounds and service user led 15 steps visits. The Trust has been independently accredited to Customer Service Excellence, a nationally recognised standard of customer focused service delivery.

Internal and external sources of assessment and assurance

The Trust has a number of internal and external sources of assessment and assurance, including the following:

<u>Internal</u>

- Board and committee assurance reports
- Trust Action Group (TAG) reports

- Integrated Performance Report (IPR)
- Minutes (of key meetings)
- Internal Audit reports
- Local Counter Fraud reports
- Staff Survey Results
- Serious Incident (SIs) Reports
- Annual Governance Statement
- Information Governance (IG) Toolkit
- Quality Impact Assessments (QIAs)
- Members' Council Quality Group

External
- External visits / inspection reports such as CQC visits
- Independent reviews (such as Ombudsman Reports)
- External accreditations such as Customer Services Excellence, IIP, Clinical Network Reviews
- Quality Account and its independent audit
- Annual Audit letter
- National staff surveys
- National Patient Satisfaction Surveys (Friends and Family Test)
- Patient Led Assessment of the Clinical Environment (PLACE) Inspection reports
- Healthwatch reports
- External Audit reports

The Trust also commissions additional external reviews of activities, services and events where a need for independent assessment and assurance has been identified.

Commissioners and Regulators
In addition to the internal routes for raising concerns and escalating risk, there are formal mechanisms which can be used by key stakeholders, such as commissioners and regulators to raise concerns such as contract and performance review meetings with Clinical Commissioning Groups (CCGs), specialty commissioning meetings, board-to-board meetings with other NHS providers / commissioners, work undertaken within Integrated Care Systems, CCGs Quality Board, NHS Improvement Quarterly Review Meetings (QRMs) with the EMT.

Trust's internal quality and performance monitoring
The Trust has a number of fora where quality and performance is discussed. The key performance meetings are the Operational Management Group (weekly) and EMT performance and monitoring meeting (monthly). Trust Board committees provide assurance following each meeting including approved committee Minutes.

Performance is managed at a local level through monthly BDU performance and governance meetings. Each BDU considers its performance against key performance targets and reviews the performance of individual service lines within the BDU against these indicators. Where performance issues are identified, actions plans are developed and implemented to address the issues.

Reporting of key issues adversely affecting performance is done on an exception basis at the OMG and any key risks or areas of performance requiring escalation are elevated to the EMT to be managed accordingly.

The Clinical Governance & Clinical Safety Committee receives performance information and intelligence relating to all aspects of quality, safety, risk and regulation, and patient experience; likewise the Mental Health Act Committee has a specific focus on aspects relating to the Trust's implementation of the Mental Health Act. Any significant risks or issues are reported through to the Trust Board through the monthly committee assurance report and the Board Assurance Framework (BAF), which is submitted quarterly to the Board.

Trust Board receives an Integrated Performance Report (IPR) each month. It details a range of indicators with the most recent month's performance against target on a RAG rated basis. Any areas of adverse performance are reported to Trust Board via more detailed exception report as requested by the Trust Board.

A 'ward-to-Board' dashboard is in operation which gives specific information on key performance indicators on a service line basis, ensuring through the trio partnership of clinician, general manager and practice governance coach, all areas are providing safe, effective care and a positive patient experience.

Cost Improvement Plans (CIPs)
The Trust has in place a process for the development, evaluation and monitoring of Cost Improvement Plans (CIPs) which includes a robust Quality Impact Assessment (QIA) for each individual scheme, that sets out an independent assessment of the quality and risk to services of implementing the project. Projects evaluated as high risk require further work on mitigation of risks or substitution of alternative schemes.

Quality Strategy and Quality Account
The Trust has in place a Quality Strategy, which sets out the Trusts key priorities for quality improvement, which are aligned to the CQC domains. The delivery of the continuous quality improvement described by the strategy and plan is underpinned by the Trust's seven step Quality Improvement Framework.

The Trust's annual Quality Account, which is prepared in line with the requirements of the NHS Act 2009, Health and Social Care Bill 2012 and our regulator NHS Improvement, provides a report to the public about the quality of services the Trust provides and the progress against its strategic and annual quality objectives. It provides an opportunity for scrutiny on how the Trust performs in relation to quality and sets out the focussed areas for quality improvement for the forthcoming year. Independent assurance is obtained on the Trust's Quality Account from commissioners, other external stakeholders and the Trust's external auditors.

Compliance with Regulators
Care Quality Commission (CQC)
As a provider of health services the Trust is registered with the CQC and has systems in place to ensure compliance with its fundamental standards. This includes internal inspections based on five key questions in relation to whether services are safe, effective, caring, responsive and well led. A self-assessment tool kit is available for teams to benchmark against each of the fundamental standards.

The Clinical Governance & Clinical Safety Committee receives exception reports on any areas of noncompliance or with compliance concerns. Exception reports also provide assurance against the steps being taken to ensure compliance is achieved.

The CQC also undertakes a mixture of announced and unannounced inspections, leading to ratings of individual services and the provider overall.

NHS Improvement / Monitor

Trust Board confirms compliance with NHS Improvement (NHSI) regarding the conditions of Monitor's provider Licence in relation to all targets and national core standards, on an annual basis as part of the Annual Business Plan (Operating Plan) submission and through the submission of other requested statements to NHSI as requested. NHSI holds a Quarterly Review Meeting (QRM) with the EMT to review performance.

Risk escalation framework

Risks are assessed using the methodology described in the Risk Management Strategy. Risk assessments are entered onto the Datix risk management system to inform the organisation's risk registers.

The Corporate / Organisational Risk Register is reviewed and updated by the EMT on a cyclic basis, and reviewed on a quarterly basis by the Trust Board in conjunction with the Trust's Board Assurance Framework (BAF) and Risk Appetite Statement.

Board Assurance Framework (BAF)

The Board Assurance Framework (BAF) underpins the delivery of its strategic objectives and incorporates the highest risks faced by the organisation. Italigns the Trust's principal risks with key controls and assurances for each of the Trust's strategic objectives. Where gaps in assurance are identified, mitigating actions are developed to reduce the risk of non-delivery of these key objectives.

The BAF is reviewed on a cyclic basis by the EMT and a quarterly basis by Trust Board. Strategic risks are identified by the Trust Board and reviewed quarterly on receipt of the BAF and annually against the Trust's strategic objectives. The BAF provides a vehicle for Trust Board to be assured that the systems, policies and people in place are operating in a way that is effective and focussed on the key risks which might prevent the Trust's objectives being achieved.

Assuring board effectiveness

There are a number of ways in which Trust Board assures itself that it is fulfilling its duties effectively. These include:

- Committee annual self-assessments and Annual Reports.
- External effectiveness reviews including the CQC's well-led review.
- Annual assessment against the Annual Governance Statement, completed in accordance with NHS Improvement's Annual Reporting manual.
- Board strategic and development sessions.
- Scrutiny of Trust Board and committee Minutes, robust monitoring and follow up of the Trust Board's action points and work programme.
- Trust Board director induction and appraisal.
- Assurance reports from the committees to Trust Board.

Learning Lessons

The Trust is committed to learning lessons in an open and transparent way. It does this through the examination of complaints, serious incidents, staff feedback, service user and carer feedback, internal reports, external reviews, assessments, inspections and the review of national reports and reviews.

Conclusion

The strategic risks within the Board Assurance Framework (BAF) are reviewed annually to ensure they reflect the current position of the Trust and format reviewed to ensure it is effectively utilised. Trust Board committees will retain oversight of its implementation through their work programme, review of escalated issues, and through the review of risk registers by EMT. The Audit Committee will also ensure the BAF remains fit for purpose by reviewing, as appropriate, the systems and processes contained within it.

10.5. Appendix 5 – Director's responsibilities

Trust Board has overall responsibility for setting the strategic direction of the organisation, ensuring the Trust meets all external compliance duties and promoting a culture of effective risk and performance management. Individual Directors have specific responsibilities in relation to risk management.

Chief Executive	As Accounting Officer, has overall accountability for risk within the organisation, in particular, internal control systems and organisational governance, Risk Management Strategy and Business Plan.
Director of Finance and Resource	Executive Director with accountability for strategic financial planning and management, demonstrating probity, including counter fraud, and value for money. Responsibility for performance management and information management and technology, information governance and corporate governance. Holds the role of Senior Information Risk Officer and lead Director for co-ordination of the risk agenda.
Medical Director	Executive Director with accountability for medical leadership, including professional development and practice effectiveness, medicines management, public health, research and development, professional leadership (with the Director of Nursing and Quality), and shared accountability for clinical quality with the Director of Nursing and Quality.
Director of HR, OD and estates	Executive Director with accountability for strategic Human Resource management, workforce development, facilities and estates maintenance, catering and food hygiene, environmental management, fire safety, health and safety, security management, and waste management. Director lead for the strategic approach to the Trust's estate. Also lead director for emergency and business continuity planning.
Director of Nursing and Quality	Executive director with accountability for clinical governance and clinical safety, and compliance, including safeguarding children and vulnerable adults, system for reporting, managing, analysing and learning from incidents, including serious incidents, managing violence and aggression, infection prevention and control, medical devices, clinical records management, professional leadership for non-medical clinical staff, and the Mental Health Act. Has shared accountability for clinical quality with the Medical Director. Holds the role of Caldicott Guardian.
Director of Strategy	Lead Director with overall responsibility for coordination of the transformation programme to re-design services, including implementation of SystmOne. Also holds director lead for business and commercial planning, including securing a strong market position for the organisation. Responsible for integrated business and annual planning processes, and service level agreements and contracting.
Director of Operations and Director of Provider Development	Directors with strategic and operational accountability for service delivery across Barnsley and Wakefield, Calderdale, Kirklees and Specialist Services, and Forensic services.

There are also a number of statutory and regulatory responsibilities across the Trust relating to risk as follows.

Function	**Lead**
Accounting Officer	Chief Executive
Caldicott Guardian	Director of Nursing and Quality
Company Secretary	Company Secretary
Controlled Drugs	Chief Pharmacist
Counter Fraud	Director of Finance and Resource
Director for security	Director of HR, OD and estates
Emergency planning	Director of HR, OD and estates
Fire	Director of HR, OD and estates
Health and Safety	Director of HR, OD and estates
Income from overseas	Director of Operations
Lead Governor	Public Governor of the Members' Council
Registration Authority Manager	Director of Finance and Resource
Senior Independent Director	Non-Executive Director
Senior Information Risk Officer	Director of Finance and Resource
Whistleblowing (Non-Exec)	Deputy Chair / Senior Independent Director

10.6. Appendix 6 – Implementation plan

Action required	Action plan	Review date	Lead	Training implications
Review Board meeting cycle, agenda setting process and committee functions to ensure focus of each meeting is clear and ensure adequate focus on strategy, risk and performance.	Review agenda setting to ensure balance of focus on strategy and retrospective performance monitoring. Review terms of reference and membership of committees to ensure clarity of function and effective Board assurance.	Annually	Chair, Chief Executive and Company Secretary	Board development sessions and strategy sessions built into cycle
Continue to develop improved performance reporting to Trust Board to ensure information is well integrated, timely and accessible.	Review Board approach to performance monitoring to ensure the information meets Board requirements.	Ongoing	Director of Finance and Resource and Director of Nursing and Quality	Individual and whole Board development to support effective governance
Each committee to undertake an annual self-assessment exercise and produce an annual report to Trust Board demonstrating how it has met its terms of reference.	Self-assessment exercise to be undertaken by each committee to review performance against annual plan and interface with other committees and reported to Trust Board by the Audit Committee	Annually (April)	Chair of Audit Committee, other Committee Chairs and lead director for each committee	None
Work programmes to be developed annually and reviewed regularly for each Committee to ensure efforts are focused on management and monitoring of risks identified in the assurance framework, risk register and annual plan.	Annual work programme to be developed for each committee and reported to Trust Board. Work programmes to be amended in the light of changes to risk register	Annually (February to April) Ongoing	Committee chair and lead director	To be identified as part of work programme
Assessment of effectiveness of Board and individual directors	External facilitated assessment of Trust Board effectiveness as part of the well-led review. Chair's appraisal. Chair's quarterly reviews with Non-Executive Directors. Chief Executive's quarterly reviews with Directors. Assessment of skills and experience of Trust	Every 3 years Annually Quarterly Quarterly As part of role of	Chair / CE led SID with Members' Council Chair Chief Executive Chair	None None None None Access to training as

Action required	Action plan	Review date	Lead	Training implications
	Board to ensure remains fit for purpose as a Foundation Trust Board.	Nominations Committee		appropriate
Assessment of effectiveness of Members' Council and individual governors	Annual evaluation session Individual reviews with Chair Individual induction meetings with the Chair Trust responsibility to ensure development and maintenance of skills and knowledge of governors	Annually (February) Annually (Jan/Feb/Mar) On appointment Ongoing	Chair Chair Chair Chair	Review of training arrangements for governors underway
Assurance provided by Committees specifically reported to Trust Board	Chairs of committees provide specific assurance to each Board meeting where they have responsibility for scrutiny of an issue – risks are aligned to relevant committees to provide additional assurance to Board	Ongoing	Chairs and lead directors	None
Ensure effectiveness and accessibility of approaches used by Trust Board to monitor risks and receive assurance	Continued embedding of risk register management through Datix and assurance framework to support the overall system of internal control.	Ongoing	Chair of Audit Committee, Chief Executive	
Develop internal control systems to support effective risk management in the context of devolved decision making	Develop and implement internal governance arrangements to support service line management and to support the introduction of payment by results.	Ongoing	Chief Executive, Deputy Chief Executive	
	Review Standing Orders, Standing Financial Instructions and Scheme of Delegation.	Biennially	Chief Executive, Director of Corporate Development and Director of Finance and Resource Audit Committee and Trust Board	

Action required	Action plan	Review date	Lead	Training implications
Risk management training relevant to individual roles to be undertaken	Trust Board to receive training in risk analysis and risk management relating to the role of a corporate board as part of Board development programme. Extended EMT to receive training on risk management. Training booklet to be made available on the Trust intranet.	Biennially Biennially	Director of Finance and Resource Director of Finance and Resource	
Key policies and procedures on the intranet to be brought up-to-date to enable document store to support information governance requirements in relation to non-clinical records.	Complete work to update the document store.	Ongoing	Director of Finance and Resource	Training relevant to roll out of individual policies as and when they are revised.

10.7. Appendix 7 – Risk related Trust documents – policies, procedures, protocols and guidelines

All Trust policies and procedures have a role in proactively managing risk by putting in place systems and processes to effectively control and reduce identified risks.

A full list of current Trust policies, procedures and guidelines is available on the Trust intranet system. This is a constantly changing list as policies, procedures and related documents are developed and updated to ensure that they reflect current legislation, guidelines, good practice and learning.

The following documents are key to risk management.

- Trust Constitution (including Standing Orders)
- Standing Financial Instructions (SFIs)
- Scheme of Delegation
- Trust Board committees' Terms of Reference
- Business Plan (Operating Plan)
- Annual Planning Guidance
- Integrated Performance Report
- Emergency planning and business continuity policy
- Serious Incident management Procedures
- Incident Management Policy and Procedures
- Being Open – Policy and Guidelines
- Complaints policy and procedure (Customer Services Policy)
- Claims policy and procedure
- Communication, engagement and involvement strategy
- Media policy
- Care Programme Approach (CPA) Policy
- Clinical risk policy
- Health and Safety - Policies and Procedures
- Human Resources – various related policies, procedures, protocols and guidelines
- Infection Control Policies and Procedures
- Information Governance
- Medicines Management - related policies, procedures, protocols and guidelines
- Clinical and operational policies including Mental Health Act, Consent, Safeguarding Children, Vulnerable Adults and other related policies, procedures, protocols and guidelines

10.8 Appendix 8 – Checklist for review and approval

Date: 7 March 2019

	Risk Management Strategy	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?	N/A	
	Are people involved in the development identified?	N/A	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	N/A	
	Is there evidence of consultation with stakeholders and users?	Trust Board	
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?	N/A	
	Are supporting documents referenced?	YES	

6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
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	

10.9 Appendix 9 – Version control sheet

Version	Date	Author	Status	Comment / changes
1	December 2008	Integrated Governance Manager	Final	Final version approved by Trust Board
2	October 2010	Integrated Governance Manager		Changes made to reflect transfer of services from NHS Barnsley. Approved by Trust Board
3	December 2011	Integrated Governance Manager	Final	Annual review approved by Trust Board
4	October 2012	Integrated Governance Manager	Final	Inclusion of Datix processes approved by Trust Board
5	December 2013	Integrated Governance Manager	Final	Annual review approved by Trust Board
6	January 2015	Integrated Governance Manager	Final	Annual review approved by Trust Board
7	January 2016	Integrated Governance Manager	Final	Annual review approved by Trust Board
8	January 2017	Integrated Governance Manager	Final	Annual review approved by Trust Board
9	January 2019	Company Secretary Corporate Governance Manager	Final	Reviewed for approval by Trust Board

10.10 Appendix 10 – Equality Impact Assessment tool

Date of Assessment: 7 March 2019

	Equality Impact Assessment Questions:		**Evidence based Answers & Actions:**
1	**Name of the document that you are Equality Impact Assessing**		Risk Management Strategy
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 risk management All staff
3	**Who is the overall lead for this assessment?**		Director of Finance and 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?**		The Audit Committee Chair and Executive Management Team were consulted on the update of the strategy. Trust Board is responsible for approving the Strategy. N/A
6	**What equality data have you used to inform this equality impact assessment?**		This policy impacts on everyone therefore no equality data is 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:**	**No**	The strategy aims to reduce risk to all service users, carers, staff and members of the public from the nine protected characteristics.
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:-**		N/A
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		N/A
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		N/A
9c	**Promotes good relations between different equality groups;**		N/A
9d	**Public Sector Equality Duty – "Due Regard"**		N/A
10	**Have you developed an Action Plan arising from this assessment?**		No
11	**Assessment/Action Plan approved by**		**Signed: Mark Brooks Date: 7 March 2019** **Title: Director of Finance & Resources**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 10.1

Title:	**Audit Committee Annual Report 2018/19 including updated Terms of Reference for Trust Board committees**
Paper prepared by:	Company Secretary on behalf of the Chair of Audit Committee
Purpose:	The purpose of this paper is: ➢ To provide assurance to Trust Board that its committees operate effectively and meet the requirements of their terms of reference. ➢ Make suggested improvement to Board and sub-committee arrangements. ➢ Support the Annual Governance Statement of the Trust.
Mission/values:	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation.
Any background papers/ previously considered by:	The annual reports of each committee were considered at the following meetings: ➢ Audit Committee 9 April 2019. ➢ Clinical Governance and Clinical Safety Committee 12 February 2019 ➢ Mental Health Act Committee 12 March 2019 ➢ Workforce and Remuneration Committee 12 February 2019 ➢ Equality & Inclusion Forum 5 March 2019 The final annual reports of each committee were considered by the Audit Committee on 9 April 2019.
Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that: ➢ risk is effectively managed and mitigated within the organisation; ➢ Committees are fulfilling their terms of reference; and ➢ integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board committees are required to produce an annual report and an annual work programme, undertake an annual self-

	assessment, and review their terms of reference for relevance and appropriateness. As part of the process in 2018, the Trust Board requested that the Equality & Inclusion Forum be included in the process in 2019. The Audit Committee received the annual report, work programme, and updated Terms of Reference approved by each committee (Note, the Terms of Reference and work programme for the Clinical Governance and Clinical Safety Committee were reviewed and updated after the Audit Committee meeting). The reports were supported by each committee Chair and lead Director to provide assurance to in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees. A summary is contained within the Audit Committee annual report to Trust Board. Updated committee Terms of Reference are provided for the final approval of Trust Board. A question was raised as to whether the Trust would benefit from having a separate finance and performance committee. This will be discussed at the Trust Board. **Risk Appetite** The review of committees' effectiveness and integration to provide assurance to Trust Board that risk is effectively managed and mitigated within the organisation; committees are fulfilling their terms of reference; and integration between committees avoids duplication.
Recommendation:	**Trust Board is asked to:** ➢ **RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:** • **committees meeting the requirements of their Terms of Reference;** • **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and** • **committees can demonstrate added value to the organisation.** ➢ **APPROVE the recommendation that the Equality and Inclusion Forum now becomes a formal committee of the Trust Board;** ➢ **APPROVE the update to the Terms of Reference for the:** ➢ **Audit Committee;** ➢ **Mental Health Act Committee;** ➢ **Clinical Governance and Clinical Safety Committee;** ➢ **Workforce and Remuneration Committee;** ➢ **Equality and Inclusion Committee; and** ➢ **CONSIDER whether the Trust requires a separate finance and**

	performance committee.
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019

Audit Committee Annual Report 2018/19

1. Purpose of report

The purpose of the report is to provide a summary of the Audit Committee's activities during the financial year 2018/19 to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

2. Terms of Reference and Audit Committee duties

The Audit Committee is a formal Committee of Trust Board, which provides the Board with assurance that the Trust is discharging its responsibilities in relation to the following.

- The establishment and maintenance of effective systems and processes that provide internal control within the organisation, particularly, review of all risk and control related disclosure statements, such as the Annual Governance Statement and value for money audit opinion.
- The effectiveness of the governance arrangements that cover evidence of achievement of corporate objectives and the adequacy of the assurance framework.
- The effectiveness of policies and processes to ensure compliance with regulatory frameworks, including Monitor's (now NHS Improvement's) risk assessment framework.
- The effectiveness of systems of internal control for the management of risk including the risk strategy, risk management systems and the risk register.
- The effectiveness of policies and procedures to prevent and manage fraud and compliance with regulatory requirements monitored through the Counter Fraud and Security Management Service.
- Overview of the work of other Committees to provide Trust Board with assurance in relation to the overall effectiveness of governance arrangements through the committee structure.

Changes to Terms of Reference

In 2019, some minor updating has been incorporated within the Committee TOR to be approved by the Committee on 9 April 2019. These include an update to member's names and further areas recommended by the Internal Auditors. Final formal approval of the changes will be given by Trust Board on 30 April 2019.

Reporting to Trust Board

Under its terms of reference, the Audit Committee is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Committee's Minutes are presented to the Trust Board once ratified.

Membership

The Committee is made up of Non-Executive Directors and members from 1 April 2018 to 31 March 2019 were as follows.

Name/role	Attendance 2018/19
Laurence Campbell, Non-Executive Director - Committee chair	5 / 5
Rachel Court, Non-Executive Director	4 / 5
Chris Jones, Non-Executive Director* (member to 31 July 2018)	2 / 3
Erfana Mahmood, Non-Executive Director* (*member from 25 September 2018)	1 / 2
Sam Young, Non-Executive Director* (*member from 25 September 2018)	2 / 2

The Director of Finance and Resources attends as lead Director.

3. Review of Audit Committee activities

The Audit Committee's activities during the year have been cross referenced to its Terms of Reference.

3.1 Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation.

	Progress
Review all risk and control related disclosures, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances.	As part of its consideration of the annual report, accounts and Quality Accounts, the Committee received and recommended for approval the Chief Executive's Annual Governance Statement for 2017/18. The Committee also received the statement from external audit for those with responsibility for governance in relation to 2017/18 and the Head of Internal Audit opinion.
Review underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principle risks and the appropriateness of the disclosure statements (above), including the fitness for purpose of the assurance framework.	The Committee was presented with the external audit plan in October 2018. Significant audit risks were outlined as follows. - Understatement of the provisions balance - Accounting for Property valuations - Management override of controls These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk. The Committee receives an annual report on the process to develop the Board Assurance Framework (BAF), which is presented quarterly to Trust Board.
Review policies and processes for ensuring compliance with relevant regulatory, legal or code of conduct requirements, including the Monitor	The Committee reviewed the Treasury Management Policy and Strategy in January 2018 and supported its approval by Trust Board.

	Progress
risk assessment framework.	An update is provided at each Committee meeting. The Committee last reviewed the Trust Constitution, Scheme of Delegation, and Risk Management Strategy in January 2017 and supported their approval by Trust Board. They will next be due for review in 2019.
Review the systems for internal control, including the risk management strategy, risk management systems and the risk register.	*Approval of the Trust's Risk Management Strategy is a matter reserved for Trust Board. It is next due for review in 2019*. The Committee receives a report at each meeting on the triangulation of risk, performance and governance, which provides assurance that all key strategic risks are captured by the risk management process, that risks are appropriately highlighted and managed through governance committees and operational meetings, and there is a clear link between risk management and identifying areas of poor performance by the cross-reference of performance reporting to the risk register. The Committee finds this report particularly helpful in supporting scrutiny of performance and risk through Trust Board. The corporate / organisational risk register is reviewed quarterly by Trust Board and risks aligned to the Committee are reviewed at each meeting.
Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.	See section 3.3.
Review the work of other Committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.	See section 4.2.
Review the arrangements that allow Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.	*Updates in relation to 'whistleblowing' arrangements and Freedom to Speak Up Guardians are provided to the Clinical Governance and Clinical Safety Committee.*

3.2 Internal Audit

The Committee shall consider the appointment of the internal auditor (for approval by Trust Board) and ensure that there is an effective internal audit function, established by management, that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chair, Chief Executive and Trust Board.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	Through a procurement framework and tender process, 360Assurance was appointed as the Trust's internal auditor from 1 July 2017. Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the

	Progress
	requirements of both Professional Internal Auditing Standards and 360Assurance's own Internal Audit Manual.
Review and approval of the Internal Audit strategy and programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	The Internal Audit Annual Plan for 2018/19 was presented to and approved by the Committee in April 2018. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by internal audit. Regular meetings are held with the Director of Finance to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2017/18. This provided significant assurance. The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. In 2018/19, 7 internal audit reports were presented to the Committee. Of these, there were: - 5 'significant assurance' reports; - 2 'limited assurance' reports (New Clinical Information System, Patient Experience - Complaints). Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by 360Assurance. In the main, there are no significant outstanding actions. Further internal audit reports relating to 2018/19 were presented to the first Committee meeting in 2019/20 on 9 April 2019.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year.
An annual review of the effectiveness of internal audit.	Performance is reported to the Committee through the internal audit progress report at each meeting and a summary included in the internal audit annual report. The Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit.

3.3 Counter Fraud

The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. The Committee shall also review the work and findings of the Local Counter Fraud Specialist as set out in the Standards for NHS Providers and as required by NHS Counter Fraud Authority.

	Progress
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal.	Through a procurement framework and tender process, Audit Yorkshire was appointed as the Trust's Local Counter Fraud Specialist from 1 July 2017.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	Audit Yorkshire presented a programme of work to the Committee in April 2018 and May 2018, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action.
Receive and review the annual report prepared by the Local Counter Fraud Specialist.	The Committee received an annual report for 2017/18 in July 2018.
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Following a re-procurement exercise during 2015, the Members' Council approved a proposal to re-appoint Deloitte as the Trust's external auditor from 1 October 2015 for a period of three years. The Lead Governor for the Members' Council was involved in the tender process. In April 2018, the Members' Council confirmed that the contract with Deloitte for provision of external audit services continues for a further two years, therefore until 30 September 2020.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee has received and approved the Annual Audit Plan in October 2018. Progress against the plan is monitored at each meeting.
Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The fee for Deloitte was approved as part of the re-appointment process in 2015. A formal audit plan was presented to and approved by the Committee in October 2018. This included an evaluation of risk, which is summarised under section 3.1 above.
Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: - the statement for those with responsibility for governance in relation to 2017/18 accounts; - final reports and recommendations as scheduled in the annual plan.
Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit	Deloitte has not been engaged to provide any non-audit services during 2018/19

	Progress
and non-audit services.	

3.5 Financial reporting

	Progress
The Committee has responsibility for approving accounting policies.	The Committee considered and approved minor changes to accounting policies at its meeting in January 2019. These changes were supported by the Trust's external auditor.
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission.	The Committee recommended to the Trust Board for approval the annual report, accounts and Quality Account for 2017/18 at its meeting in May 2018 prior to submission to NHS Improvement (Monitor). As part of the consideration of the auditor's report, the Committee received and reviewed the Use of Resources Assessment for 2017/18. The Committee also reviewed the external audit report on the production of the Quality Account for 2017/18. *(It should be noted that the scrutiny of the preparation, development and final content of the Quality Accounts is the responsibility of the Clinical Governance and Clinical Safety Committee.)* The Committee also recommended for approval the stand-alone annual report and accounts for charitable funds in October 2018.
The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided.	The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board, including any review of the adequacy of reporting. The Committee reviewed the Treasury Management Policy and Strategy in January 2018 and supported its approval by Trust Board. An update is provided at each Committee meeting. The Committee also receives a detailed report on procurement activity at each meeting, which monitors non-pay spend and progress on tenders, the use of single tender waivers, and progress against the Procurement Strategy and associated cost improvement programme. The Committee's agenda includes a standing item to review progress towards implementation of service line reporting (private item). The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission. The Committee received and reviewed the Use of Resources Assessment for 2017/18.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation;	The Committee last reviewed the Standing Financial Instructions in October 2016 and supported their approval by Trust Board in October 2016. Changes to the Trust's Constitution (including the Standing Orders) and Scheme of Delegation were considered by the Committee in January 2017 and approved by the

	Progress
	Trust Board in January 2017 and Members' Council in February 2017. They will next be due for review in 2019.
- examines circumstances associated with each occasion Standing Orders are waived;	There were no occasions when Standing Orders were waived in 2018/19.
- reviews the schedules of losses and compensations on behalf of Trust Board.	The losses and special payments report is received by the Committee at each meeting.

4. Review of Audit Committee administrative arrangements

The Audit Committee meet the minimum requirement for the number of meetings in the year and has been quorate at each meeting.

The requirement to send papers out six clear days in advance of the meeting has been met throughout the year. There have been some instances where individual papers have, with agreement, been sent out after this requirement.

5. Audit Committee self-assessment

In line with the Terms of Reference, the Audit Committee has an agreed self-assessment process. The proforma used is that recommended by the Audit Committee Handbook. The self-assessment has eight sections:

- composition, establishment and duties;
- compliance with the law and regulations governing the NHS;
- internal control and risk management;
- Internal Audit;
- External Audit;
- Annual Accounts;
- administrative arrangements
- other issues

The Committee reviewed the positive outcome of the self-assessment at its meeting on 9 April 2019 with two areas discussed in relation to succession planning for a committee member with a financial background to be discussed further by the Nomination Committee and division of activity between the Clinical Governance and Clinical Safety Committee and Mental Health Act Committee with a joint agenda setting and review of work programmes taking place. No further actions were identified.

6. Governance assurance

6.1 Review of committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining achievements against objectives and compliance with Terms of Reference. The annual reports, work programmes and updated terms of reference were provided to the Audit Committee to provide assurance to Trust Board.

6.2 Audit Committee review of the effectiveness of Trust Board committees

In April 2010, the Audit Committee agreed an approach and process to fulfilling its role to provide oversight and assurance to Trust Board on the effectiveness of the other sub-committees of the Board.

The committees assumed within scope of the Audit Committee review are:

- Clinical Governance and Clinical Safety Committee;
- Mental Health Act Committee; and
- Workforce and Remuneration Committee (previously the Remuneration and Terms of Service Committee).

In 2018, the Trust Board agreed that the Equality and Inclusion Forum should be included in the process for 2019.

The draft annual report, annual work programme and the outcome of self-assessments for these committees and the Forum were provided to the Audit Committee on 9 April 2019 for 2018/19. The purpose of the review was for the Audit Committee to provide assurance to Trust Board that:

- each meets the requirements of its Terms of Reference;
- each work programme is aligned to the risks and objectives of the organisation, which are in the scope of its remit; and
- each can demonstrate added value to the organisation.

The review was undertaken as part of formal Audit Committee business with committee chairs and lead Directors invited to present to provide assurance to the Audit Committee on the assurance each committee and the Forum has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees and the Forum.

<u>Audit Committee</u>
Chair – Laurence Campbell; Lead Director – Mark Brooks

Key areas highlighted for 2018/19 were:

- The focus on the triangulation of risk across the four areas: Organisational Risk Register (ORR), Board Assurance Framework (BAF), strategic overview of risks, and Integrated Performance Report (IPR)
- Review of other committees' effectiveness
- Focus on key risks, particularly the CRS implementation and the direction of Internal Audit activity.
- Review of external audit process.

<u>Clinical Governance and Clinical Safety Committee</u>
Chair – Charlotte Dyson; Lead Director – Tim Breedon

Key areas highlighted for 2018/19 were:

- Approval of relevant strategies including the Patient Safety Strategy and an update of the Healthcare Deaths Policy.
- Performance management of the Care Quality Commission (CQC) Action Plan.
- Review of the Transformation programmes from a clinical perspective including the review of the Community Mental Health Transformation.
- Ongoing scrutiny of Children's and Adolescent Mental Health Services.
- Ongoing review of Waiting Lists.
- Regular updates on the FSUG network.
- Ongoing focus on Serious Incident reporting and learning lessons.

<u>Mental Health Act Committee</u>
Chair – Kate Quail*;* Lead Director – Dr Subha Thiyagesh

Workforce and Remuneration Committee (previously the Remuneration and Terms of Service Committee)
Chair – Sam Young (from1 April 2019); Lead Director – Alan Davis

Key areas highlighted for 2018/19 were:

- Review and monitoring the Workforce Strategy Action Plan
- Review and monitoring of the Organisational Development Strategy Action Plan
- Review and monitoring of the Recruitment and Retention Action Plan
- Review of remuneration arrangements for Directors
- Receive exception reports on Sickness, Turnover and Agency Spend
- Received updates on Employment Tribunals as appropriate
- Ratified the Clinical Excellence Awards for Consultants
- Received regular updates on Directors objectives and performance
- Consider the implications for new Director Structure
- Approved any senior managers redundancy business case in line with national arrangements
- Reviewed Workforce risk register
- Received pay gap audits for gender, ethnicity and disability and agreed action in response to the findings

Equality & Inclusion Forum
Chair – Angela Monaghan; Lead Director – Tim Breedon

Key areas highlighted for 2018/19 were:

- The Forum met quarterly during 2018/19 and met all its key duties as set out in its terms of reference. In all respects bar name, it has operated as a Board committee throughout the year.
- In addition to the Forum members, who comprise three non-executive directors, four executive directors, and a governor, the Forum was attended by representatives from staff side and, latterly, the staff equality networks. Technical support is provided by human resources managers and equality and engagement development managers, who also attend.
- At each of its meetings, the Forum considered reports in relation to: corporate risks aligned to the Forum by the Board; feedback from our staff equality networks; the Trust's progress against the Workforce Race Equality Standards (WRES) and Disability Equality Standards (DES); the status of equality impact assessments (EIAs) across the Trust; the Trust's performance against the NHS Equality Delivery System (EDS2); updates on our inclusive leadership and development programme; and updates on any relevant national issues and policies.
- During the year, the Forum also received reports on the Trust equality, inclusion and engagement review and learning from the NHS staff survey and wellbeing at work survey; reviewed the Trust Equality and Diversity Annual Report prior to its submission to the Board; and reviewed progress against the Trust's Equality Strategy action plan – this strategy is next due for review in 2020.
- The Forum reviewed its terms of reference and is recommending that the Forum becomes a formal Board committee from 2019/20.

The Audit Committee reviewed the documents and areas discussed and considered it was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that committees and Forum:

- had met the requirements of their Terms of Reference;

- had followed a workplan aligned to the risks and objectives of the organisation, within the scope of each committee and the Forum's remit; and
- could demonstrate added value to the organisation.

6.3 Consideration of Trust financial performance

A question was raised with regard to whether the Trust needs a separate finance, and performance committee. It was noted that the Trust has had a detailed financial review once a month at EMT for over a year, which Non-Executive Directors are invited to. This is believed to be working well, but there is an increasing level of financial challenge given the Trust is planning a deficit for the second consecutive year and there will need to be high level of focus and scrutiny in order to deliver financial improvements. This issue will be raised with the Trust Board.

6.4 Independent review of the Trust's governance arrangements

In 2014, Monitor (now NHS Improvement) stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years. Monitor issued guidance to support Trusts in ensuring they are 'well-led,' which supported the NHS response to the Francis Report and was aligned with the assessment the Care Quality Commission (CQC) makes on whether a foundation trust was well-led as part of its revised inspection regime. In 2015/16, Deloitte undertook an independent in line with the framework which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff. There were no 'material governance concerns' arising from the review, with a number of developmental areas recommended further work and an action plan developed. In 2016, an internal audit review of the action implementation as part of an audit on corporate governance arrangements received 'significant assurance'. In 2017, NHS Improvement aligned its well-led review to the CQC well-led key lines of enquiry. In April 2018, the CQC undertook a well-led review of the Trust which with the well-led domain rated as 'GOOD'. The CQC are due to conduct a further inspection of the Trust in 2019.

In 2018/19, an internal audit review of governance was conducted to provide independent assurance of the robustness and effectiveness of the governance arrangements in place at Trust Board committee level; and undertake a deep dive of the Clinical Governance and Clinical Safety Committee and received 'significant assurance'.

7. Conclusion

In summary, the Annual Report of the Audit Committee will be used as evidence the Committee has discharged its responsibilities in relation to its statutory obligations and Terms of Reference. This includes providing the Trust Board with assurance on the effectiveness of other committees and the Forum which is part of the Audit Committee role in supporting integrated Governance.

South West Yorkshire Partnership NHS Foundation Trust

AUDIT COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2019

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
Taking guidance from Monitor and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

Membership as at 1 April 2019
Chair – Non-Executive Director - Laurence Campbell
Non-Executive Director - Erfana Mahmood;
Non-Executive Director - Sam Young.

Attendance
The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit are also invited and expected to attend. The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Finance and Resources.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. There will also be an additional meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

<u>Governance, risk management and internal control</u>

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board;
- the underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework including risk appetite and providing assurance that action plans are in place to address significant control issues;
- the policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the Monitor risk assessment framework;
- the systems for internal control including the risk management strategy, risk management systems and the risk register;

- the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service;
- the work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action;
- ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively;
- such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed; and
- these processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

Internal Audit

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal;
- review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources;
- ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit;

- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy;
- discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses;
- Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Protect Standards for Providers and as required by NHS Protect. In particular:

- consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- receive and review the annual report prepared by the Local Counter Fraud Specialist;
- receive update reports on any investigations that are being undertaken.

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to Monitor, Trust Board and the Members' Council. In particular, the Committee shall focus on:

- changes in, and compliance with, accounting policies and practices;
- major judgemental areas; and
- significant adjustments arising from the annual audit.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- examines the circumstances associated with each occasion Standing Orders are waived;
- reviews schedules of losses and compensations on behalf of Trust Board.

Relationship with the Members' Council

To reflect best practice and Monitor's Code of Governance, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

To be approved by Trust Board: 30 April 2019
Next review due: April 2020

South West Yorkshire Partnership NHS Foundation Trust

CLINICAL GOVERNANCE AND CLINICAL SAFETY COMMITTEE
Terms of Reference
For approval by Trust Board 30 April 2019

All Trust Board Committees are responsible for scrutinising and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. On behalf of the Trust Board, it will have an oversight of clinical risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Clinical Governance and Clinical Safety Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors (NED) also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 1 April 2019:
Chair - Non-Executive Director - Charlotte Dyson (Deputy Chair / Senior Independent Director)
Non-Executive Director - Angela Monaghan (Chair of the Trust)
Non-Executive Director - Kate Quail
Lead Director - Director of Nursing and Quality – Tim Breedon
Medical Director - Dr Subha Thiyagesh
Director of Human Resources, Organisational Development and Estates - Alan Davis

Attendance
The Director of Operations and the Deputy Director of Nursing and Quality are in attendance at each meeting. Clinical representatives and relevant Trust officers are invited to meetings as appropriate to ensure the remit of the Committee is adequately covered. The Chief Executive, other Directors, and relevant officers attend the Clinical Governance and Clinical Safety Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Nursing and Quality.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of six times per year.

It is the responsibility of the lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Health and Safety;
- Drugs and Therapeutics (Medicines Management);
- Safeguarding (vulnerable adults and children);
- Infection Prevention and Control;
- Managing Aggression and Violence;
- Quality Network Improvement Group;
- Patient Safety Strategy Group; and
- Improving Clinical Information Group.

Duties

The Committee provides assurance to Trust Board on service quality, practice effectiveness and the application of controls assurance in relation to clinical services and ensures the Trust is discharging its responsibilities with regard to clinical governance and clinical safety.

<u>Strategy and policy</u>

1. To approve relevant strategies and policies on behalf of the Trust Board
2. To monitor implementation of strategic objectives relevant to clinical governance, care delivery and practice effectiveness, such as implementation of care management processes and clinical information management, providing assurance to Trust Board that these are appropriately managed and resourced.

Clinical governance

3. To provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharge their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.
4. To provide assurance to Trust Board that the Trust is meeting national requirements for clinical governance and clinical safety.
5. To assure Trust Board that the Executive Management Team and Business Delivery Units have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

6. To monitor, scrutinise and provide assurance to Trust Board on the Trust's compliance with national standards, including the Care Quality Commission, the quality elements relating to NHS Improvement (NHSI) and NICE guidance.
7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation.
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management, and the safety elements covered by the Health and Safety TAG.

Clinical safety management

9. To provide assurance to the Trust Board that environmental risks, including those identified as a result of PLACE inspections or environmental audit, are addressed and monitor appropriate action plans to mitigate these risks.
10. To provide assurance to the Trust Board that robust arrangements are in place for the proactive management of complaints, adverse events and incidents, including scrutiny of quarterly and annual reports on incidents and complaints and implementation of action plans.
11. To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
12. As delegated by Trust Board, to monitor implementation of action plans relating to reviews of complaints by the Health Service Ombudsman and of action plans identified through independent inquiry reports relating to the Trust.

Public and service user experience

13. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users and carers, and clinicians to shape service delivery.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting wherever practical. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

To be approved by Trust Board: 30 April 2019
Next review due: April 2020

NHS
South West Yorkshire Partnership
NHS Foundation Trust

MENTAL HEALTH ACT COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2019

All Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. It is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Mental Health Act Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 1 April 2019
Chair – Non-Executive Director - Kate Quail;
Non-Executive Director - Laurence Campbell;
Non-Executive Director - Erfana Mahmood;
Lead Director - Medical Director - Dr Subha Thiyagesh;
Director of Nursing and Quality - Tim Breedon;
Director of Strategy - Salma Yasmeen.

Attendance
Representatives of the four local authorities, a representative of the three acute trusts covering the Trust's geography, and one Associate Hospital Manager (as nominated by the Hospital Managers' Forum) are invited to attend meetings. The Committee also has scope to invite other external individuals on an ad-hoc basis where it is felt expertise or specialist advice is required. The Director of Operations; Assistant Director, Legal Services; and Clinical Legislation Manager are in attendance at meetings.

The Chief Executive, other Directors, and relevant officers attend the Mental Health Act Committee by invitation. Administrative support is provided by the Personal Assistant to the Medical Director.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect availability of quarterly reports.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Hospital Managers Forum.

Duties

1. To monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983 and the Mental Capacity Act 2005, within the Trust taking into account best practice.
2. To consider the implication of any changes to legislation and regulations within a local context.
3. To receive reports from Associate 'Hospital Managers' in their role of hearing appeals and to scrutinise the processes for and outcome of appeals and tribunals.
4. To ensure there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role.

5. To monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary.
6. To receive reports following Care Quality Commission (CQC) visits for information and comment and ensure appropriate action is agreed and implemented within the organisation.
7. To scrutinise delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board.
8. To approve policies in relation to the Mental Health Act and Mental Capacity Act across the Trust and scrutinise the application of these policies throughout the Trust in relation to both Acts.
9. To address training issues in terms of delegation of responsibilities under the Mental Health Act 1983.
10. To address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983.
11. To manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.
12. To request specific reports relevant to the application of the Mental Health Act.
13. To undertake duties relevant to the Committee set out in the 'Duties of Hospital Managers' Policy.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

To be approved by Trust Board: 30 April 2019
Next review due: April 2020

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

WORKFORCE AND REMUNERATION COMMITTEE
Terms of Reference
For approval Trust Board 30 April 2019

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Workforce and Remuneration Committee (formerly known as Remuneration and Terms of Service Committee) was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Workforce and Remuneration Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate that actively contribute to the achievement of the Trust's aims and objectives. The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

Membership
Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

Membership as at 1 April 2019
Chair – Non-Executive Director - Sam Young;
Non-Executive Director - Angela Monaghan (Chair of the Trust);
Non-Executive Director - Charlotte Dyson (Deputy Chair of the Trust / Senior Independent Director);
Chief Executive (non-voting Committee member) - Rob Webster.

Attendance

The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Director of Human Resources, Organisational Development and Estates is also in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Director of Human Resources, Organisational Development and Estates.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of the Chief Executive, the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend as a non-voting member.

Frequency of meetings

The Committee will meet no less than four times per year.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

Duties

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:
   a) determine the remuneration and terms of service for the Chief Executive;
   b) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
   c) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;

d) to ratify remuneration arrangements for senior management posts;
e) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;
f) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
g) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.

2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
4. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
5. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
6. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
7. To consider future national developments which could impact on the Trust's strategic workforce objectives.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the private session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

To be approved by Trust Board: 30 April 2019
Next review due: April 2020

South West Yorkshire Partnership NHS Foundation Trust

EQUALITY AND INCLUSION COMMITTEE
Terms of Reference
To be approved by Trust Board 30 April 2019

The Equality and Inclusion Forum was initially set up by Trust Board in May 2015 for a twelve-month period, subject to review. In 2018, the Forum became and standing Forum and in 2019 it was recommended that the Forum became a formal committee of the Board. The Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Equality and Inclusion Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity. The Committee will develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities.

Membership
The Equality and Inclusion Committee is chaired by a Non-Executive Director. At least one other Non-Executive Director also sits on the Forum as well as relevant Directors of the Trust and a Governor.

Membership as at 1 April 2019
Chair - Chair of the Trust - Angela Monaghan;
Non-Executive Director - Erfana Mahmood
Non-Executive Director - Sam Young
Chief Executive - Rob Webster;
Lead Director - Director of Nursing and Quality - Tim Breedon;
Director of Human Resources, Organisational Development and Estates - Alan Davis;
Director of Provider Development - Sean Rayner.

Attendance
Technical support is provided by Human Resources Managers and Equality and Engagement Development Managers, who are in attendance. A Governor, the staff side representative with lead for equality and diversity, and a representative from each of the staff networks is also invited to attend meetings. Other directors, and relevant officers attend the Committee by invitation. Administrative support is provided by the Corporate Governance team.

Quorum

The quorum will be half of the membership which must include one Non-Executive Director and one Director; however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year and be reviewed every twelve months.

Duties

- To promote the values of inclusivity, mainstreaming equality, diversity and inclusion across the Trust.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust has a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers, staff and Members' Council.
- To monitor and provide assurance to Trust Board that the Trust is embedding diversity and inclusion in all its activities and functions.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust is compliant with legal and national guidance, including Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES).
- To agree an annual work plan that link to the Trust's strategic direction, workforce plan and the wider priority programmes and to monitor progress.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work (see above).

All Trust Board committees have a responsibility to ensure they foster and maintain relationships and links between the Forums/Committees and Trust Board. Each committee also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

To be approved by Trust Board: 30 April 2019
Next review due: April 2020

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 10.2

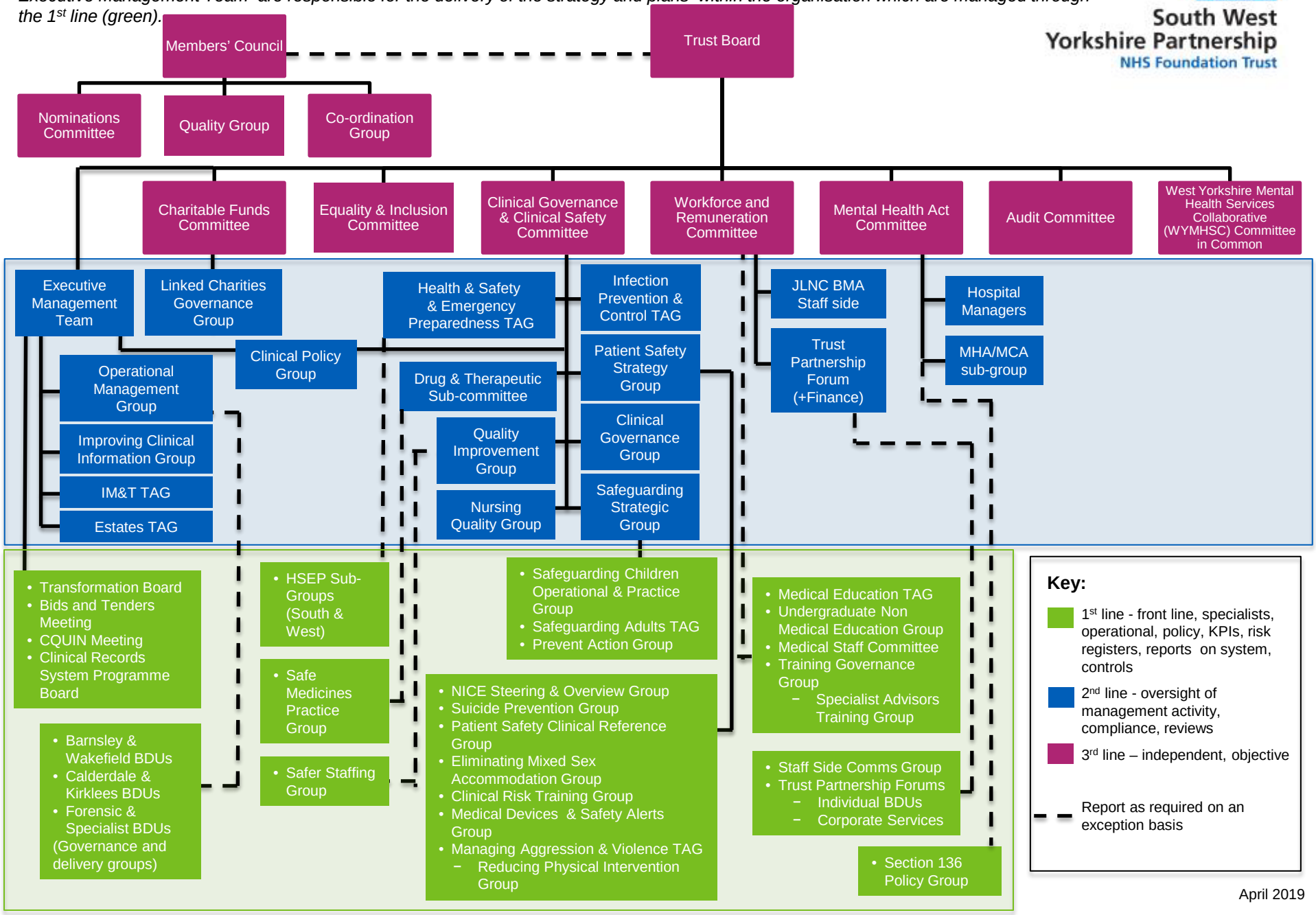
Title:	**Internal meetings' governance framework update**
Paper prepared by:	Director of Finance Company Secretary
Purpose:	To review the Trust's internal meeting governance structures to ensure they support the delivery of the Trust's mission and values, strategic objectives and legal requirements and provide the Trust Board and committees of the Board with the required levels of assurance.
Mission/values:	Good internal meeting governance provides a framework for the continuous development of systems and processes to support assurance, compliance and risk management in support of the delivery of the Trust's mission and strategic objectives.
Any background papers/ previously considered by:	Previous version received by Trust Board 30 January 2018. Draft update was considered by the Executive Management Team (EMT) and comments included as applicable.
Executive summary:	Trust meeting structures should enable the Board to: ➢ Meet its statutory duties. ➢ Aid good decision making. ➢ Ensure timely escalation of issues. ➢ Share learning. ➢ Provide assurance on delivery and compliance with legislation. In 2017, the Executive Management Team (EMT) conducted a review of formal internal meetings to ensure clarity of purpose and outputs from the range of committees/meetings in place. The review highlighted some inconsistencies in reporting of committees and how they supported the assurance structures of the organisation. EMT supported a rationalisation of 1st and 2nd line assurance reporting into the formal sub-committees of the Board with a report into Trust Board January 2017. Further work took place to align the committee terms of reference which were updated and approved by Trust Board in April 2017. The terms of reference for each committee continue to be reviewed annually as part of the Audit Committee Annual Report to Trust Board. The internal meetings' governance framework has now been updated to reflect changes that have taken place in the last year, including reflecting the disbanding of the Workforce Development Trust Action Group (TAG) with increased reporting now going to the Workforce & Remuneration Committee (previously Remuneration & Terms of Service Committee), and the addition of the West Yorkshire Mental Health Services Collaborate (WYMHSC) Committee in Common which

	meets quarterly as Committees in Common with three other trusts in West Yorkshire. There is a separate paper on the agenda for the Audit Committee Annual Report which provides assurance that the sub-committees of the Trust Board are meeting their terms of reference following their individual annual reports to the Audit Committee on 9 April 2019. Part of this process also included the annual report from the Equality & Inclusion Forum which recommended that the Forum now become a formal sub-committee. **Risk Appetite** The delivery of the internal meetings' governance framework supports the Trust in providing safe, high quality and equitable services within available resources through an integrated approach to delivery, management of risk and the provision of assurance at the right level. Improving the Trust's efficiency and effectiveness in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to RECEIVE the update to the internal meetings' governance framework.**
Private session:	Not applicable.

Internal governance structures – 3 lines of assurance

Board are required to ensure appropriate risk management processes are in place.
Executive Management Team are responsible for the delivery of the strategy and plans within the organisation which are managed through the 1st line (green).

NHS South West Yorkshire Partnership NHS Foundation Trust



April 2019

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 10.3

Title:	**Draft Annual Governance Statement**
Paper prepared by:	Director of Finance and Resources Company Secretary
Purpose:	To enable the Trust Board to review and comment on the draft annual governance statement.
Mission/values:	➢ Respectful, honest, open and transparent. ➢ Relevant today and ready for tomorrow.
Any background papers/ previously considered by:	➢ Draft annual governance statement has been reviewed and commented on at both the Executive Management Team (EMT) and the Audit Committee. ➢ Considered and approved by the EMT, Audit Committee and Trust Board annually.
Executive summary:	As part of the annual accounting and reporting requirements the accounting officer (Chief Executive) is required to provide an annual governance statement (AGS), which needs to be approved in line with other annual reporting requirements. All NHS organisations are required to have risk management, control and review processes in place, appropriate to their circumstances and business. All Foundation Trusts have to produce an Annual Governance Statement (AGS), which is included in the organisation's Annual Report and accounts and is externally audited, covering: ➢ scope of responsibility; ➢ the purpose of the system of internal control; ➢ capacity to handle risk; ➢ the risk and control framework; ➢ review of economy, efficiency and effectiveness of the use of resources; ➢ annual Quality Report; ➢ review of effectiveness; ➢ conclusion. Foundation Trusts are required to make disclosures or qualifications in the AGS about their risk management and review processes being in place for the full year, and gaps in assurance frameworks. The AGS must contain statements on compliance with and assessment against specified requirements and significant control issues for 2018/19.

	Organisations should ensure that they have evidence which they deem sufficient to demonstrate that they have implemented processes appropriate to their circumstances under each of the high level elements to support their AGS for 2018/19. The AGS has been produced in accordance with current guidance from NHS Improvement. The outline of the requirements of the AGS is provided in annual guidance by the regulator (Monitor/NHS Improvement). ➢ Certain elements of the wording are prescriptive and in other sections there is clear guidance on what to include. ➢ At this stage it is a draft statement with elements of the wording only available on completion of the year-end and/or confirmation from Board committees or the Board itself. This narrative is in red in the main document. ➢ This report enables Trust Board members to have an early oversight of the AGS and provide any feedback. ➢ It should be noted that the requirements of the AGS have been carefully reviewed by the Company Secretary and Director of Finance to ensure the Trust's AGS complies with those requirements. ➢ Wording highlighted in grey is a mandatory requirement.
Recommendation:	**The Trust Board is asked to REVIEW the draft annual governance statement and COMMENT accordingly.**
Private session:	Not applicable.

DRAFT Annual Governance Statement 2018/19

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

This Annual Governance Statement reflects the challenging context within which I deliver my responsibilities and demonstrates the complexity and diversity of the services the Trust provides across a broad geographical area.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability for monitoring the organisation's performance against the Trust's strategy and objectives, ensuring corrective action is in place where necessary. The Trust Board's attitude to risk is based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Strategy and Risk Appetite Statement.

The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has matured in its role of holding Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust and on the Trust's future strategy. Training and development ensures governors have the skills and experience required to fulfil their duties.

The Board includes an Executive team with the day to day responsibility for managing risk. Over the last year, we have had continuity in the Executive Director team. There have been some changes in posts, with a reduction in the number of Business Delivery Unit (BDU) directors to consolidate all operational matters under a single Director of Operations. A Director of Provider Development has been created to support the substantial changes

occurring across West Yorkshire & Harrogate. These changes reflect the fact that director portfolios are continually reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust.

The Members' Council, Board and Executive team are operating in an environment of change and system pressure where risk is constant and at a heightened level.

The Trust operates within a strategic framework that includes a Vision, Mission and Values, supported by three Strategic Objectives and a number of Priority Programmes. This approach is agreed and set by the Board and provides an effective underpinning of the Chief Executive objectives and the objectives of the Executive team determined in line with director accountabilities. I review these objectives on an on-going basis with individual directors with progress, issues and risks reflected in the Board Assurance Framework and corporate/organisational risk register.

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate Scheme of Delegation and Standing Financial Instructions.

The Trust works in partnership with health economies in Calderdale, Kirklees, Wakefield, Barnsley and the Sustainability and Transformation Partnerships of South Yorkshire and West Yorkshire & Harrogate. We identify and manage risk at those levels as well as at Trust level, as reflected in the roles and responsibilities of the Board, of Executives and staff within the Trust. This is evident from the Board Assurance Framework and Trust risk registers.

The Trust continued to operate a strengthened risk management arrangement during 2018/19 with regular reviews of risk at Executive Management team meetings, and the Trust Board, alongside the forums of the Board and its sub-committees. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk.

Risk management training for the Trust Board is undertaken bi-annually. The training needs of staff are assessed through a formal training needs analysis and staff receive training appropriate to their authority and duties. The role of individual staff in managing risk is supported by a framework of policies and procedures that promote learning from experience and sharing of good practice. The Risk Management Strategy was updated and approved by Trust Board on 31 January 2017 and is due to be reviewed again in April 2019.

Alongside this capacity, the Trust has effective Internal Audit arrangements, with a work plan that helps to manage strategic and business risk within the Trust.

The risk and control framework

The risk and control framework flows from the principles of good governance. It uses effective Board and committee structures, supported by the Trust's Constitution (including Standing Orders) and Scheme of Delegation. The Risk Management Strategy describes in detail how risk is applied within this framework.

The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures through a cycle of audit, self-assessment and annual review. The latest annual review was received by the Board on 30 April 2019.

The Audit Committee assessment was supported by the Trust internal auditors conducted a survey of Trust Board members for the second consecutive year in relation to risk management which again supports this assessment.

The cycle of Trust Board meetings continues to ensure that the Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there is one monthly meeting with a forward-looking focus centred on business risk and future performance, one meeting focusing on performance and monitoring, and one strategic development session. The Trust Board meetings relating to business risk and future performance, and performance and monitoring are held in public and the Chair encourages governors to attend each meeting.

The Board has recognised the development of stronger partnerships across the geography in which we operate. Formal partnership Boards and committees have reports and Minutes received by the Board and are reflected in our risks.

The Trust's Risk Management Strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of risk. The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was approved by Trust Board in July 2016 for implementation from September 2016. It was further refined during 2018. The Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its specific boundaries and risk tolerance thresholds under four categories (strategic, clinical, financial or commercial, and compliance risks), and supports delivery of the Trust's Risk Management Strategy and procedures. Risks that are significant are monitored by the appropriate committee. Over 2018/19, further work has continued to review risk registers where organisational risks not considered significant (level 15 and above) fall outside the Risk Appetite.

Risk exception reports are used at the relevant committees or fora of the Board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Work continues to take place to further develop risk tolerance and this is a regular item of discussion at Trust Board meetings.

The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust. The BAF is aligned to the three strategic objectives of the Trust. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its sub-committees. At the February strategy meeting of the Board the structure of the BAF was reviewed to assess whether it was sufficiently capturing strategic risks. Some revisions were suggested which will strengthen the focus on strategic workforce risks particularly. The Board will approve the outline of the updated BAF in April 2019.

As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity and performance management. In 2018/19, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director.

In support of the BAF, the Trust also has a corporate/organisational risk register in place which outlines the key strategic risks for the organisation and action identified to mitigate these risks. This is reviewed on a monthly basis by the Executive Management Team and quarterly by Trust Board, providing leadership for the risk management process.

Risk registers are also developed at service delivery level within BDUs and within the corporate directorates. These are reviewed regularly at the Operational Management Group.

The Trust's main risks at the end of 2018/19, can be summarised as follows:

Area of focus	Sample of actions underway
Workforce pressures	Workforce plan being implemented following revised strategy. Focusing on wellbeing and engagement, recruitment and retention, development of new roles and establishment reviews Development of staff networks
Acuity and demand pressures	Successfully implemented waiting list initiatives, with more underway. Extra focus on hotspots such as CAMHS and inpatient wards. System-wide reviews Continued focus on serious incident reporting, investigations & learning. Greater partnership working with local partners. Ongoing review with commissioners
Financial sustainability in a changing environment	Financial sustainability plan being developed Maintaining focus on quality improvement. Engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw integrated care systems
Out of area placements	High level of internal focus Engagement of independent support and implementation of recommendations Working closely with commissioners to identify system wide solutions
Cyber-crime	Anti-virus software in place, including additional email security and data loss prevention and security patching regime covering all servers, client machines and key network devices. Annual infrastructure, server and client penetration testing. 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. Implementation of three year (data centre) infrastructure plan, including security and firewall rules for key network and computer devices, and IT services business continuity and disaster recovery. Increased training for information asset owners and managers.
Tenders and operating environment	Engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw integrated care systems Engagement in all places the Trust operates in Stakeholder engagement plans

Given the strategic context within which we operate, the risks outlined above will continue into 2019/20 with mitigating actions in place. The creation of Integrated Care Systems (ICS) across West Yorkshire & Harrogate and South Yorkshire & Bassetlaw will provide a further mechanism for managing some risks across organisations. As the lead Chief Executive for the ICS in West Yorkshire & Harrogate, I am able to ensure we are closely engaged in the leadership and delivery of these plans. The Director of Provider Development role means we have senior capacity working on the programmes that relate to the Trust. In parallel, as an engaged member of the leadership team of the South Yorkshire & Bassetlaw ICS, I will ensure that the risks inherent in the move to an Integrated Care System are understood and mitigated.

Our Licence

The Trust was awarded a Licence by Monitor on 1 April 2013 with no conditions. There are currently no risks to compliance with the Licence conditions that apply to the Trust, including NHS Foundation Trust condition 4, which applies to Foundation Trusts only.

The Trust operates under the Single Oversight Framework issues by NHS Improvement which assists the Trust in compliance with the Monitor Licence. Our rating under this framework is 2 – targeted support. The Trust will record a deficit in 2018/19 prior to the provision of provider sustainability funding. Achievement of our underlying deficit plan will result in provider sustainability funding being achieved and as such a net surplus will be recorded.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements through an internal regulatory compliance review process and by learning from a regular programme of quality monitoring visits. Following the CQC visit in March 2016 the Trust developed a new internal visit programme, which initially targeted those services rated as 'requires improvement'. Feedback reports are received and reviewed by BDU management trios, BDU deputy directors and team managers, who develop an action plan to address areas for improvement that are monitored through BDU governance functions. Feedback, lessons learned and good practice from the process are shared with the Clinical Governance and Clinical Safety Committee and used to inform changes to the next planned visit programme.

The Trust is rated 'Requires Improvement' overall by the CQC. This includes ratings of Good for, Caring, Effectiveness and for being Well-Led. Eleven out of fourteen core service lines are rated 'Good' overall with community based mental health services for adult of working age, specialist community mental health services for children and young people, and acute wards for adults of working age & psychiatric intensive care units being rated as 'Requires Improvement'.

Our ratings chart shows that 86% of the ratings within our service lines were found to be 'Good' or 'Outstanding'. The CQC found that our staff were caring and compassionate as well as respectful and warm towards patients. This reflects a values based culture within the Trust.

The Trust assesses itself annually against the NHS Constitution. A report was presented to Trust Board in December 2018 which set out how the Trust meets the rights and pledges of the NHS Constitution.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Value Based Culture

The Trust works hard to provide the highest standards of healthcare to all its service users. The promotion of a culture of openness is a prerequisite to improving business resilience, patient safety and the quality of healthcare systems. Good governance and a risk aware culture is emphasised in the Values of the Trust and reinforced through values based

recruitment, appraisal and induction. This has been further strengthened in 2018/19 with changes to the appraisal system to focus on objectives and values more explicitly.

Learning from incidents and the impact on risk management is critical. The Trust uses an e-based reporting system, DATIX, at directorate and service line level to capture incidents and risks, which can be input at source and data can be interrogated through ward, team and locality processes. This encourages local ownership and accountability for incident and risk management. Data is interrogated regularly to ensure that any risks are identified and escalated at the appropriate level. Staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes, ensuring risks are reduced. In 2018/19, 12,640 incidents were reported, of which 88% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based culture.

The Trust works closely with safety teams in NHS Improvement and uses Root Cause Analysis (RCA) as a tool to undertake structured investigation into serious incidents. Our aim is to identify the true cause of what happened, to identify the actions necessary to prevent recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident and mitigate future risk. Following the latest Well Led Review by the CQC, the Trust joined the inaugural Mental Health Safety improvement Partnership between the CQC and NHS Improvement. This work looks at balancing the requirements of our regulators on quality and finance with the need to improve services and true value.

The provision of mental health, learning disability and community services carries a significant inherent risk. Unfortunately, serious incidents do occur which require robust and well governed organisational controls. During 2018/19, there were 45 serious incidents across the Trust compared to 71 in 2017/18. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Where harm has taken place, the Trust ensures that communication with staff, service users and families is open, honest and occurs as soon as possible following any patient safety event. Our Duty of Candour is taken extremely seriously and staff understand their role in relation to Duty of Candour; they have the support required to comply with the duty and to raise concerns; the Duty of Candour is met through meaningful and sensitive engagement with relevant people; and all staff understand the consequences of non-compliance. This is monitored through a regular report to the Operational Management Group, the Executive Management Team and reported through the governance structures to Board.

The Clinical Governance and Clinical Safety Committee has a leading role to play. It scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports. In the last year, this has included the Trust's action plan in response to the CQC. This includes a review of arrangements for managing waiting lists Child and Adolescent Mental Health Services (CAMHS), and a recent report on improving the quality of the mortality review process. The Committee routinely monitors infection, prevention and control management of violence, safeguarding, patient safety, health and safety, quality impact assessments and issues identified at the drugs and therapeutic committee. The Committee oversees all work until actions have been completed and closed and it is satisfied that risks have been moderated.

The Clinical Risk Scan, chaired by the Director of Nursing and Quality, provides an organisational overview of the incident review, action planning and learning processes to improve patient safety and provide assurance on the performance management of the review process, associated learning, and subsequent impact within the organisation.

The key elements of the Trust's quality governance arrangements are as follows:

- The Trust's approach to quality reinforces its commitment to quality care that is safe, person-centred, efficient and effective. The Quality Strategy outlines the responsibilities held by individuals, BDUs, the Executive Management Team and Trust Board. The Trust Board approved an updated Quality Strategy on 27 March 2018.
- The Clinical Governance and Clinical Safety Committee is the lead committee for quality governance.
- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey, to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents.
- Monthly compliance reporting against quality indicators within the Integrated Performance report. Trust Board also receives a quarterly report on complaints.
- CQC regulation leads, monitor performance against CQC regulations and the Trust undertakes regular self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment for example, accreditation of electroconvulsive therapy (ECT), Psychiatric Intensive Care Unit (PICU) and Memory Services, CQC Mental Health Act Visits, national surveys (staff and service user).
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as Serious Incidents, Infection Prevention and Control, Information Governance, Reducing Restrictive Practice Group, Drugs and Therapeutics and policy development.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing & Quality approval required before a scheme can proceed.
- Measures are implemented and maintained to ensure practice and services are reviewed and improvements identified and delivered, such as the Trust's prioritised clinical audit and practice evaluation programme.
- The annual validation of the Trust's corporate governance statements as required under NHS foundation trust conditions. The Board certified that it was satisfied with the risks and mitigating actions against each area of the required areas within the statement.
- The Freedom to Speak Up Guardians ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. The staff has four Guardians, drawn from the staff governors and a representative of the BAME network. The arrangements surrounding the Guardians have been strengthened, with a slot at new staff induction, better administrative support, protected time allocated and clearer guidance available.

The Trust continues to build on its existing service user insight framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback. A number of initiatives have been established to strengthen customer insight arrangements, including the following:

- Systematising the collection of service user and carer feedback, with a consistent approach to action planning and communication of the responses, including assessment against the Department of Health's Friends and Family Test.
- Insight events for members and the public.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's transformation programme. The new mental health clinical record system implementation approach ensured that staff were fully engaged during both design and delivery phases.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken.
- The principle of co-production being embedded throughout the Trust, such as co-production of training in Recovery Colleges.
- Accreditation against the Cabinet Office's Customer Service Excellence award with an improved rating in the accreditation process for this year.

This approach has resulted in an increase in the number of issues raised and in the number of compliments received, which is a positive development in the context of the encouragement the Trust gives to people to offer feedback in all its forms.

The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental and social care in a modern health and care system, developing service change programmes and associated structures to transform the way it delivers services. The priority programmes are focused on ensuring the Trust continues to deliver services that meet local need, offer the best care and better outcomes, and provide value for money whilst ensuring the Trust remains sustainable and viable. The Trust has six priorities with a number of programmes that provide the framework for driving improvements. These include:

- *Joined up care - working with our local system partners in each of the places that we provide services including the two integrated systems that we are part of across South Yorkshire & Bassetlaw and West Yorkshire & Harrogate.*
- *Quality counts, safety first - is a key priority that focuses on programmes to develop and deliver safe, effective and high quality services, including the implementation of our patient safety strategy and the development of an integrated approach to quality improvement that equips our staff to make improvements for the benefits of our service users and carers..*
- *Operational excellence - focuses on improving patient flow through our systems and making the best use of all our resources including the use of technology to improve clinical care and our productivity through agile working and the implementation of the new clinical record system.*

This is underpinned by our values based culture and our approach to Leadership and a culture of improvement and inclusive change that is co-produced. Each programme has a Director sponsor and clinical lead, and is supported by robust project and change management arrangements through the integrated change team.

The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers. This is through initiatives such as Creative Minds and the development of a recovery approach and recovery colleges across our districts, as well as continuing to host Altogether Better, a national initiative which supports development of community champions.

The Trust continues its commitment towards carbon reduction. South West Yorkshire Partnership NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with and the value of diverse thinking and staffing is secured. This is achieved through Trust policies, training and audit processes. Early in 2015, Trust Board established an Equality and Inclusion Forum to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does.

The Forum develops and oversees the Equality Strategy to improve access, experience and outcomes for people from all backgrounds and communities including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities.

Staff networks are a significant part of our approach. The BAME staff network was established to empower and support BAME staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives. The Network had its second celebration event, which showcased some of their achievements, in October 2018. The Trust has established a disability staff equality network and a Lesbian, Gay, Bisexual, Transgender, Queer plus network using the same principles of self-determination and support. The networks play an active role in a number of elements of Trust business, including recruitment to senior positions and the development of Freedom to Speak Up Guardians.

The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on BAME Staff. The clinical network was established as in the NHS Staff Survey BAME staff reported the highest level of bullying and harassment from services users and carers.

Over the last year, the Board has continued to become more diverse. Appointments at director and non-executive director level have meant a better gender, age and ethnic balance across the Board.

In 2018/19, the Forum received reports on the following:

- *Barnsley pilot for service users into employment.*
- *Initiatives to encourage engagement with young people.*
- *Dementia awareness.*
- *Wellbeing survey results.*
- *Workforce Race Equality Standard (WRES) report and action plan*

The Trust has improved in 3 of the 4 Workforce Race Equality Standard indicators published in the NHS Staff Survey.

During the year, the Trust published its gender pay gap audit as required by law, and in addition produced pay gap audits for ethnicity and disability. These showed there is a pay gap on both gender and ethnicity but not disability. An action plan has been agreed and published on the Trust's internet.

During 2016/17, we worked with our Members' Council to develop our Membership Strategy which was approved by the Members' Council in April 2017. The key objectives of the strategy, underpinned by a detailed action plan, are:

1. We will build and maintain membership numbers to meet our annual plan targets, ensuring membership is representative of the population the Trust serves.
2. We will communicate effectively and engage with our public members and our staff members, maintaining a two-way dialogue and encouraging more active involvement.
3. We will develop an effective and inclusive approach to give our public members and our staff members a voice and opportunities to contribute to the organisation, our services, and plans for the future.

The Trust has adopted the National Equality Delivery System 2 (EDS2) Framework and focussed on improving the following areas, working closely with service users, public and commissioners:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well supported staff
4. Inclusive leadership at all levels

The Trust Board approved a Workforce Strategy in March 2017 which includes objectives, linked to the EDS2 Framework and the NHS Workforce Race Equality Standards (WRES), to support a representative workforce. The Trust has a joint EDS2 and WRES action plan.

We ensure Equality Impact Assessments (EIA) are undertaken and published for all new and revised policies and services. This ensures that equality; diversity and human rights issues and service user involvement are systematically considered and delivered, through core Trust business.

Review of economy, efficiency and effectiveness of the use of resources

The governance framework of the Trust is determined by the Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its committees, including the Nominations Committee, which is a sub-group of the Members' Council. The Trust complies with Monitor's (now NHS Improvement) Code of Governance and further information is included in the Trust's annual report.

The Executive Management Team has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, through Executive Management Team meetings, The Operational Management Group (OMG), BDU management teams and at various operational team meetings. To strengthen financial oversight and challenge Non-Executive Directors are invited to the financial review at Executive Management Team meetings. The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics

to review specific areas of service in an attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives and quality priorities whilst aligning Trust plans with commissioning intentions and local health and wellbeing plans. Increasingly we are ensuring that Sustainability and Transformation Plans (and their successor Integrated Care Systems) inform our work. These annual plans detail the workforce and financial resources required to deliver service objectives and include the identification of cost savings. The achievement of the Trust's financial plan is dependent upon the delivery of these savings.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee. Quality Impact Assessments (QIA) take an objective view of the impact of cost improvements on the quality of services in relation to the CQC five domains of safe, caring, effective, responsive, and well led. The Assessments are led by the Director of Nursing and Quality and the Medical Director with the Director of Operations, BDU Deputy Directors and senior BDU staff, particularly clinicians.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

The Trust delivered against its revised financial control total of £(2.0)m by achieving £(1.6)m. This entitled us to receive Provider Sustainability Funding (PSF) of £2.7m. In total, £10.6m cost savings were delivered against a target of £9.7m (109% delivery). Of the £10.6m, £7.9m was delivered recurrently and a further £2.7m non-recurrently.

Information Governance

Information governance compliance is assured through a number of control measures to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust Senior Information Risk Owner (SIRO). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust achieved the target of *95% of staff completing training on information governance by 31 March 2018.*

Information governance has had continued focus through 2018/19 through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended Executive Management Team, and offering advice and increasing availability of training for staff.

Incidents and risks are reviewed by the Improving Clinical Information Group which informs policy changes and reminders to staff.

In November 2016, the Information Commissioner's Office (ICO) undertook a consensual data protection audit. The final report, which provided reasonable assurance, was issued to the Trust in February 2017 and the executive summary was published on the ICO's webpage and the Trust's website. The Audit Committee reviewed progress against all

actions; the vast majority of which were completed in 2017/18 with final completion of outstanding actions taking place in early 2018/19. A deep dive of causes of confidentiality breaches was undertaken and reviewed at the Audit Committee in April 2019.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office (ICO). There have been 2 such incidents reported in 2018/19. This is a reduction compared to the nine reported incidents in 2016/17 and four incidents in 2017/18. They are summarised below together with the actions taken:

- A laptop and diary containing sensitive personal data was stolen from a staff member's car
- Hand written bed management information including patient details was stolen from a ward by a service user

Good information governance will continue to be a feature of the Trust in 2019/20. The Data Security and Protection Toolkit was submitted that is compliant with the standards.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Report which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

We have fully compiled our Annual Report with the guidance issued, with our Quality Account being published alongside our Financial Accounts to ensure there is a balanced picture of the value delivered by the Trust. Our public and staff members are represented by the Members' Council Quality Group who are fully involved in agreeing the indicators within the Quality Account. Public facing and easy read versions of the Quality Report will be made available and the full report will be accessible on the Trust's website.

The following steps have been put in place to assure the Trust Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

Governance and leadership of quality reporting

- Quality metrics are reviewed monthly by Trust Board and the Executive Management Team, alongside the performance reviews undertaken by BDUs as part of their governance structures.
- The integrated performance report covers substantial quality information and is reported to the Board and Executive Management team. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.
- The Clinical Governance and Clinical Safety Committee oversee the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance, supported by the Director of Nursing and Quality.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.

- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- During the move to a new clinical record system, staff have been fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system has been managed with input from ICIG and with significant governance via the programme board, Executive Management Team and Board. A named non-executive director has provided constructive challenge to the process.
- The Director of Nursing and Quality and Director of Finance co-chair the Trust-wide Improving Clinical Information and Information Governance Meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance and Clinical Safety Committees.

Role of policies and plans in ensuring quality of care provided

- Good clinical record keeping is part of good clinical practice and provision of quality care to the people who use our services.
- There is comprehensive guidance for staff on data quality, collection, recording, analysis and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies.
- There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the Improving Clinical Information and Information Governance Meeting with reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

Systems and processes

- There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant and complete through system documentation, guides, policies and training.
- During the move to a new clinical record system, staff have been fully involved in the development and delivery of templates to ensure quality data is captured and reported. The transition to the new system has been managed with with significant governance via the programme board, Executive Management Team and Board. A named non-executive director has provided constructive challenge to the process.
- Corporate security and recovery arrangements are in place with regular tests of business critical systems. These systems and processes are replicated Trust-wide.

People and skills

- Behaviours and skills are an essential part of good data quality, recording and reporting and compliance with policy.
- Roles and responsibilities in relation to data quality are clearly defined and documented.
- There is a clear training plan for Information Governance and the Trust's clinical information systems (RiO, SystmOne and a small number of additional systems) with the provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.
- During the move to a new clinical record system, staff training has been a key consideration of readiness for movement to the next implementation phase of the system. Training in the use of SystmOne for mental health reached levels of 89%

registered staff, 88% front line staff and 80% all staff prior to going live and in line with requirements set by the Trust.

Data use and reporting

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through Executive Management Team meeting and Trust Board, with key performance indicators set at both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the Improving Clinical Information Group and, where data quality standards are identified as a risk factor, these are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

The Trust's external auditor, Deloitte, provides external assurance on the Quality Report and the findings are presented to the Audit Committee, Clinical Governance and Clinical Safety Committee, Trust Board and the Members' Council. Internal Audit conducted two reviews of the governance and programme management arrangements of the implementation of the clinical record system. Any recommendations were taken account of and factored into our implementation plans.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Clinical Governance and Clinical Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework (BAF) provides evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The BAF is approved by Trust Board on an annual basis and reviewed and updated on a quarterly basis throughout the year. There were no significant gaps identified in the BAF.

Directors' appraisals are conducted by the Chief Executive with objectives reviewed and prioritised on a quarterly basis. This has provided a strong discipline and focus for Director performance. Non-Executive Director appraisals are undertaken by the Chair of the Trust. The Non-Executives' performance is collectively reviewed by the Council of Governors. The appraisal of the Chair is led by the Senior Independent Director and reports to the Council of Governors on the outcome.

The Trust has refined its values-based appraisal system for staff with a target for all staff in Bands 6 and above to have an appraisal in the first quarter of the year and the remainder of

staff by the end of the second quarter. The Trust also uses values-based recruitment and selection. During 2018/19, approximately 98% of staff had an appraisal.

All committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. The committees have met regularly throughout the year and their minutes and annual reports are received by the Board. Further information on Trust Board committees is contained in the annual report and in the Trust's Risk Management Strategy.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme. This was reported through its Annual Report to the Board. The Audit Committee was able to provide assurance that, in terms of the effectiveness and integration of risk committees, risk was effectively managed and mitigated. Assurance was provided that committees met the requirements of their Terms of Reference, that committee work programmes were aligned to the risks and objectives of the organisation, in the scope of their remit, and that Committees could demonstrate added value to the organisation.

The role of internal audit at the Trust is to provide an independent and objective opinion to the Trust, its managers and Trust Board on the system of control. It provides a Head of Internal Audit opinion each year. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust for 2018/19 was provided by 360Assurance.

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the Executive Management Team. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the Executive Management Team focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

In respect of the internal audit plan for 2018/19, 11 internal audit reviews were presented to the Audit Committee. Of these, there were 9 significant assurance opinions and 2 limited assurance opinions in relation to complaints management and phase 1 of the programme management arrangements relating to the implementation of the clinical record system. It should be noted phase 2 of this audit conducted closer to go-live provided significant assurance.

The fieldwork for the three remaining reports from the 2018/19 plan relating to Cost Improvement Projects & transformation, Data Quality framework and Compliance with legislation are in progress with the assurance ratings subject to discussion with management.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no' assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no' assurance' reports, a follow up audit is undertaken within twelve months.

The Head of Internal Audit's overall opinion for 2018/19 provided '**significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust, its Board and members of the leadership and management structure are alert to their accountabilities in respect of internal control. Throughout the year, the Trust has had processes in place to identify and manage risk.

The review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. A small number of internal control issues outlined in this statement are not considered significant. I can confirm that those control issues have been or are being addressed.

Over the past year, the Trust has delivered its business in a context of significant change. During this time, the system of internal control has remained robust and enabled change and risk to be managed effectively.

Rob Webster
Chief Executive Date: TBC

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 10.4

Title:	**Trust Board self-certification (G6/CoS7) – compliance with NHS provider licence conditions**
Paper prepared by:	Director of Finance and Resources Company Secretary
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license.
Mission/values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Any background papers/ previously considered by:	Trust Board received and approved the draft operational plan for 2019/20 on 11 February 2019 and final operational plan on 26 March 2019, and delegated the agreement of the final plan submission to the Trust Chair, Chief Executive and Chair of Audit to meet the 4 April 2019 deadline. The Trust reviewed compliance with NHS Constitution on 18 December 2019. The attached document has been reviewed by the Executive Management Team. A further self-certification will come to Trust Board on 25 June 2019.
Executive summary:	**Background** NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. As part of the annual planning arrangements, NHS Improvement requires the Trust to make a number of governance declarations. Trust Board is required to make self-certifications (G6/CoS7) by 31 May 2019 in relation to: ➢ The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions); and ➢ If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence) (appendix 1 –

NHS provider licence conditions).

A further self-certification (FT4) is required by 30 June 2019 and will come to the Trust Board meeting on 25 June 2019:

- The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence); and
- The training of Governors (as required by s151(5) of the Health and Social Care Act 2012).

Self-certification - part one (G6/CoS7)

Trust compliance with its Licence

The Licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which NHS Improvement/Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all foundation trusts were automatically issued with a licence as the Health and Social Care Act 2012 specified that foundation trusts were to be treated as having met all the licence criteria.

In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached paper (appendix 1) provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk. From the assurance provided, Trust Board is asked to certify that "***the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution***".

Providing commissioner requested services (CRS)

CRS designation is not simply a standard contract with a commissioner to provide services. CRS are services that commissioners consider should continue to be provided locally, even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable.

The attached paper (appendix 1) sets out the way the Trust complies with the continuity of services conditions in the NHS provider licence. From the assurance provided, Trust Board is asked to certify that *"**the Directors of the Licensee have a reasonable expectation that the***

	Licensee will have the Required Resources available to it after taking into account distributions which might reasonably be expected to be declared or paid for the period of 12 months*".*
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019

NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its Licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note.

The provider licence is split into six sections, which apply to different types of providers.

1. **General conditions (G)** – general requirements applying to all licensed providers.
2. Obligations about **pricing (F)** – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around **choice and competition (C)** – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable **integrated care (IC)** – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support **continuity of services (CoS)** – allows Monitor/NHS Improvement to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.
6. Governance licence **conditions for Foundation Trusts (FT)** – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
Section 1 - General conditions (G)		
G1: Provision of information	Obligation to provide Monitor with any information it requires for its licensing functions.	The Trust is currently obliged to provide Monitor/NHS Improvement with any information it requires and, within reasonable parameters, to publish any information Monitor/NHS Improvement requires it to. We have systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust although the Conditions are so broad the obligation could become overly burdensome.
G2: Publication of information	Obligation to publish such information as Monitor may require.	

Condition	Provision	Comments
G3: Payment of fees to Monitor	Gives Monitor the ability to charge fees and for licence holders to pay them.	There are currently no plans to charge a fee to Licence holders. Trust Board should note that there is, currently, no provision in the budget for additional fees and this would, therefore, become a cost pressure.
G4: Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission (CQC) published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make a declaration against the requirements on an annual basis to the Trust Board and has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Trust Board declaration and register of fit and proper persons, interests and independence policy was last reviewed and approved by Trust Board on 27 March 2018. The declarations are published on the Trust's website. All governors of the Members' Council are required to make a declaration of interest on commencement and on an annual basis which is reported to the Members' Council. The Members' Council declaration and register of interests, gifts and hospitality policy was last reviewed and approved by Members' Council on 27 April 2018. The declarations are published on the Trust's website. All governors of the Members' Council are required to sign a Code of Conduct for Governors on commencement.
G5: Monitor guidance	Requires licensees to have regard to Monitor guidance.	The Trust responds to guidance issued by Monitor/NHS Improvement. Submissions and information provided to Monitor/NHS Improvement are approved through relevant and appropriate authorisation processes.
G6: Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-

Condition	Provision	Comments
		ordinated by the Director of Finance.
G7: Registration with the Care Quality Commission	Requires providers to be registered with the CQC and to notify Monitor if their registration is cancelled.	The Trust is registered with the CQC.
G8: Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	The Trust's website sets out the service directories for each Business Delivery Unit (BDU) and the relevant access criteria for the services.
G9: Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS). See CoS1.
Section 2 - Pricing conditions (P)		
P1: Recording of information	Obligation of licensees to record information, particularly about costs.	The Trust responds to guidance and requests from Monitor/NHS Improvement. Information provided is approved through the relevant and appropriate authorisation processes. The Trusts' accounting systems and processes ensure appropriate recording of cost information. The Trust's accounts are subject to both internal and external audit each year.
P2: Provision of information	Obligation to submit the above to Monitor.	
P3: Assurance report on submissions to Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	
P4: Compliance with the National Tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance.
P5: Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to Monitor/NHS Improvement for a modification.	See P4.
Section 3 - Choice and competition (C)		
C1: Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	The Trust has in place a service directory setting out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.
C2: Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of	Trust Board has reviewed its position and considers that it has no arrangements that could

Condition	Provision	Comments
	preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board and Members' Council decide to consider any structural changes, such mergers or joint ventures.
Section 4 - Integrated care condition (IC)		
IC1: Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in several pilots aimed at developing new ways of working and new models of delivery. A number of services provided are done so through partnership working with other local stakeholders. The Trust plays an active role in Integrated Care Systems in West Yorkshire & Harrogate and South Yorkshire & Bassetlaw, and signatory to a Memorandum of Understanding with both.
Section 5 - Continuity of service (CoS)		
CoS1: Continuing provision of commissioner requested services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	As part of contract negotiations, the Trust has agreed CRS with commissioners, with the exception of Barnsley, that all mental health services will be considered as CRS. Barnsley Clinical Commissioning Group has reviewed the guidance and has determined that services provided under their contract will not be designated as Essential or CRS.
CoS2: Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek Monitor/NHS Improvement's consent before disposing of these assets if Monitor has concerns about the licensee continuing as a going concern.	As the majority of services the Trust provides are classed as CRS, all assets associated with these services are classed as restricted and these can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place.

Condition	Provision	Comments
		The Trust is only required to seek Monitor/NHS Improvement's consent for disposal of assets if Monitor/NHS Improvement is concerned about its ability to continue as a going concern.
CoS3: Standards of corporate governance and financial management (Monitor/NHS Improvement risk rating)	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place. These are subject to both internal and external audit annually. All audit plans are agreed by the Audit Committee and similarly all audit reports are received and reviewed at the Audit Committee
CoS4: Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
CoS5: Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for vital services if a provider fails).	There is currently no risk pool levy in place.
CoS6: Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with Monitor.	The Trust is aware it would need to co-operate with Monitor/NHS Improvement in such circumstances. The Trust submits periodic financial returns to NHS Improvement, participates in a Quarterly Review Meeting (QRM) with NHS Improvement and liaises extensively on financial matters.
CoS7: Availability of resources	Requires licenses to act in a way that secures resources to operate commissioner requested services (CRS).	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver CRS.
Section 6 - Foundation Trust conditions (FT)		
FT1: Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to Monitor.	See G1. The Trust is currently obliged to provide Monitor/NHS Improvement with any information it requires, including information to update its entry on the register of NHS foundation trusts and has processes in place to ensure it complies with such requirements
FT2: Payment to Monitor in respect of registration	The Trust would be required to pay any fees set by	Monitor/NHS Improvement has undertaken not to

Condition	Provision	Comments
and related costs	Monitor.	levy any registration fees on foundation trusts without further consultation.
FT3: Provision of information to advisory panel	Monitor has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The independent advisory panel was established by Monitor in April 2013 and the Trust provided a briefing on the Panel to the Members' Council. This Panel has since been disbanded by Monitor/NHS Improvement.
FT4: NHS Foundation Trust governance arrangements	Gives Monitor continued oversight of the governance of foundation trusts.	The Trust has sound governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This was also evidenced in the outcome of the well-led review of the Trust's governance arrangements in 2015/16 and by subsequent CQC reviews

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 10.5

Title:	**Operating Plan - 2019/20**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide board members with the final version of the operating plan which will be placed on the Trust's website
Mission/values:	All Trust values
Any background papers/ previously considered by:	The Trust Board received a presentation at the November Board strategy meeting. The Trust Board received papers at the December and January Trust Board meetings. The Trust Board received papers at the February Trust Board meeting The Trust Board has received regular correspondence on the development of the plan narrative and financial position. The Board received an update at the march Trust Board meeting and delegated final approval of the plan to the Trust Chair, Chief Executive and Chair of Audit Committee.
Executive summary:	➢ The Trust submitted its draft annual plan for 2019/20 in February. ➢ A final draft was presented to the Trust Board in March. ➢ The final plan submission was made in line with the NHS Improvement deadline of 4 April and in line with delegated powers was approved by the Trust Chair, Chief Executive and Chair of Audit Committee. ➢ Trust risk appetite statement which aims for financial risk of 4-6. Any implications on clinical risk must also be taken into account.
Recommendations	**It is recommended that Trust Board NOTES the final version of the 2019/20 operating plan which will be made available on the Trust's website.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Operational Plan – 2019/20

1. Activity Planning

1.1 Approach to activity planning

Our approach to activity planning is based on a practical understanding of service pathways and the journey taken by service users. We deliver across a broad portfolio of services and communities. In each, we seek to optimise the experience of care; ensure that resources are deployed effectively by matching capacity to demand; and where necessary highlighting development requirements arising from our partnerships with commissioners and providers.

The Trust has strong values and a clearly defined vision and strategy which is refreshed on a regular basis to take account of any changes in the operating environment. Our strategy is closely aligned to the NHS Long Term Plan and any further refinement will be considered by our Board. Plans are developed for all the service lines we provide and places in which we operate. We place considerable emphasis on our values, and input from our service users, patients, staff, members and carers as we develop our plans.

The Trust has four clearly identified strategic ambitions which the Board has agreed:

- ***Regional centre of excellence*** for specialist and forensic mental health and learning disability services.
- ***A strong partner in mental health service provision*** across West Yorkshire and South Yorkshire integrated care systems.
- ***A host or partner in four local integrated care partnerships*** - Barnsley, Calderdale, Kirklees and Wakefield.
- ***An innovative organisation with coproduction at its heart***, building on Creative Minds, Spirit in Mind, Recovery Colleges, Mental Health Museum and Altogether Better.

1.2 Demand and capacity modelling

The Trust utilises a demand and capacity modelling tool, enabling us to undertake scenario planning and predict the impact of variances in demand on activity and consequential changes in the workforce. We apply this to tenders and service reviews and also to inform our contract negotiations with commissioners, supporting a far better mutual understanding of capacity and demand requirements between provider and commissioners. Our approach to demand and capacity in ward-based services is informed by our safer staffing programme ensuring all inpatient clinical services are staffed appropriately so that they can run safely and effectively.

1.3 Key activity planning assumptions

Our plan assumes that demographic growth and other population changes impacting on acuity and demand are in line with contract settlements for 2019/20. Over the past three years there has been a significant increase in demand for inpatient beds, particularly in adult acute and psychiatric intensive care unit (PICU) services. Numbers of referrals for admissions to beds in adult acute wards has continued to increase annually. Demand has been met by a combination of internal efficiency improvement and the use of out of area bed placements. We have recently conducted a piece of work, alongside our commissioners, to better understand the drivers of this demand to enable contract assumptions to be aligned and to support our work to reduce out of area bed placements. This independent review has identified internal efficiency opportunities alongside the impact of increased demand. A trajectory for improvement has been agreed between the Trust and its commissioners.

We continue to experience demand-led growth in activity and acuity in areas such as CAMHS, intensive home based treatment, psychology, crisis, speech and language therapy, and neighbourhood nursing. We have reviewed our activity, workforce and financial data to ensure these triangulate such that we have appropriate resources in place to deliver effective services. It also takes into account national guidance and deliverables identified in the planning guidance and local demographic and population needs as identified through place-based commissioning intentions. Our analysis indicates that our ability to absorb demand through improvements in productivity has largely been expended, but with improved system benchmarking data becoming available, we aim to achieve more in future years. We have been able to agree with our commissioners further investment in services with long waits. In 2018/19, the Trust secured additional investment to support clearance of psychology waiting lists in Barnsley, with trajectory to clear waits by mid-2020.

Changes to our service portfolio through tendering activity and managed system care pathway change have resulted in movements in activity in different services both up and down. We anticipate further impacts on activity from the development of integrated pathways and alliance contracts aligned to emergent integrated care models.

1.4 Impact of system resilience planning

The 2019/20 activity plan is based on 2018/19 outturn and average over the last 3 full years' activity. Review of the last full 12 months' data has also been undertaken to ensure that additional activity related to winter resilience is considered. The staff bank has developed well over the past 18 months and it is anticipated that winter pressure staffing requirements can be sufficiently flexed by use of temporary staffing with a focus on our bank staff.

1.5 Achieving key operational standards

Activity plans will continue to support achievement of the key operational standards we are required to meet both nationally and locally. Typically the Trust has a strong record in achieving both national and local targets and where there are issues plans are rapidly deployed to address. Additional investment has been made in IAPT in Kirklees this year which has supported improved access, treatment and recovery.

We are a Trust that provides prevention, wellbeing and community healthcare as well as learning disability and mental health services. As such there are many operational standards that are important to us in addition to those that are reported on nationally. These are reviewed locally in our business delivery units and by our senior operational management group. Successful tenders have tended to require efficiency and productivity improvements along with expected levels in annual tariff changes, in services such as stop smoking, MSK and IAPT. Our plan considers the impact of ensuring adherence to the Mental Health Investment Standard and improved integration of community health and primary care services and assumes investment will be in line with national guidance.

Whilst on an improving trajectory, there are some services where the waiting times to access assessment and treatment remain too long. These are systemic problems and we have secured additional funding in 2019/20 for such services as ADHD and ASD assessments, CAMHS, and psychology waiting times. There will also be further investment in intensive home based treatment teams as we manage demand for inpatient beds for acute and PICU service users to tackle out of area placement in mental health services. We will continue to have a focus on transforming care for people with learning disabilities.

2. Quality Planning

2.1 Our approach to quality improvement, leadership and governance

Our executive lead for quality improvement is the Director of Nursing and Quality. Our Trust-wide improvement approach is clearly reflected in our updated Quality Strategy, which starts with our mission and values. These embed the drive to 'improve and be outstanding' enshrined in our values.

Within our strategy we describe an integrated approach to the delivery of change based on recognised best practice. Through this we aim to ensure that quality improvement occurs as near to people who use our services as possible, and we support the delivery of change initiatives to ensure quality improvements are successfully implemented.

In 2019/20 we will continue our focus on the development of skills for improvement throughout our Trust, working with our local Academic Health Science Network (AHSN), NHSI and others to build capacity and capability for change. Our innovation hub will mature to support every member of the team to identify improvement opportunities and act upon them, gaining support from colleagues where needed.

We have developed a quality assurance and improvement 'self-governing' assessment model, which provides a philosophy, process, and a set of tools for improving results for clinical teams. As a philosophy and process, the model provides a context for a dialogue on self-governance and self-evaluation. As a series of methods and tools, it helps map the relationships between quality assurance and quality improvement and will be a continual source of evidence for teams to inform them how well they are performing (in relation to quality).

The aim is to foster each team's sense of responsibility for its own quality outcomes and engender optimism that the quality of service delivery can continually be improved. As part of this initiative we have developed an accreditation scheme that will be underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts.

To guide our development, we report on over 20 different quality indicators in our integrated performance report (IPR), including friends and family test results, infection prevention, serious incidents, safer staffing, pressure ulcers, CQUIN performance and complaints. Each of these has a specific 'stretch' target that reflects improvement in quality, and can be viewed by team, service and Trust-wide. The report is considered at the Executive Management Team (EMT), the Board and its committees. This enables us to evidence the return on our investment in quality.

We learn through a robust clinical audit programme and we participate in research and development with links to universities and AHSN. We also contribute to and learn from external benchmarking and reporting initiatives, including the national confidential enquiry into homicide and suicide, mental health benchmarking and workforce capacity and demand. There is also an active programme of quality monitoring visits to all our operational areas, from which we derive significant learning and quality assurance, in addition to a Members' Council Quality Group.

We are engaged in a cycle of delivering against our improvement plans following CQC inspections, which is focused upon actions that are already underway and actions arising from new insights the CQC brings. We remain committed to ensuring that compliance is achieved through a focus on improvement.

We acknowledge that our drive for quality improvement can be put at risk if routine quality assurance measures are not in place. Therefore we have enhanced our current system to include a Clinical Governance Group focused on the delivery of our CQC action plan, demonstrating commitment to achieving a good or outstanding CQC rating across the Trust. This group, supplemented by our own internal inspection programme, provides a key monitoring and escalation route for action to maintain and improve quality.

Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC). This is a committee of the Trust Board. Reporting in to the CGCSC is the Trust's Quality Improvement Group. The purpose of the group is to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Strategy. The functions of the group are: horizon and risk scanning; interpretation and reporting of national/local quality and safety directives; critical consideration of organisational quality and safety improvements; information sharing; planning and monitoring delivery against plan. We also have a Members' Council Quality Group to support the Trust in its approach to quality.

2.2 Summary of Quality Improvement Plan (including compliance with national quality priorities)

Our quality priorities use the CQC 5 key domains as our framework for developing quality approaches in the Trust. Under each domain we have identified a set of key performance indicators to monitor the quality of care. Our quality priorities reflect the needs of our service users and learning from our quality improvement systems. During 2017/18 we refreshed our Quality Strategy and revised our quality priorities. These were updated in 2018/19. Our quality improvement priorities for 2019/20 are described below. Our priorities are aligned to national drivers and the Integrated Care System plans for West Yorkshire & Harrogate and South Yorkshire & Bassetlaw.

Domain	Priority
SAFE	Implementation of patient safety initiatives as outlined in our Patient Safety Strategy (e.g. prone restraint reduction, reduction of avoidable and attributable pressure ulcers) Implementation of suicide prevention strategy with a zero suicide philosophy Improve safer staffing fill rates Improved integration of physical and mental health On-going development of mortality reviews and Incident investigation system
EFFECTIVE	Timely assessments and reviews of care and treatment- IAPT and EIP transitions of care Effective transitions between CAMHS and adult services Development and implementation of outcome measures Recruitment and retention initiative within workforce planning
CARING	Improve quality of clinical record keeping Patient experience – refresh of system for capturing and acting on feedback Staff health and wellbeing – improved Staff Friends & Family Test and internal survey results Scale up our volunteer programme
RESPONSIVE	Improve waiting times Complaint closure and resolution times Zero approach to out of area beds working with partners to reduce utilisation and eliminating unwarranted variations in practice which contribute to the issue
WELL- LED	Implement quality assurance and improvement 'self-governing' assessment and accreditation model Friends & Family Test and service user feedback on co-production and access to peer support Learning lessons –further development of systems to improve how we learn lessons from patient experience, serious incidents, audits, safeguarding reviews and share learning

The top 3 risks to quality and mitigating actions are detailed below.

Description of risk to quality	**Impact**	**Mitigating actions**
Difficulties in recruiting qualified clinical staff due to national shortages.	Difficulties in ensuring optimal and safe staffing levels on mental health wards Lack of learning disability (LD) nurses, in particular newly qualified availability leading to extended vacancies in LD and CAMH services.	Established strong links with the universities' undergraduate and masters programmes for nursing Introduction of nursing associate and associate practitioners Think Ahead programme for social workers in mental health Trust-wide retention plan Recruitment programme for newly qualified RMNs Enhanced payments for RMNs working on bank Relocation package for out of area nurse recruitment Engagement with current consultants on developing new service models and introducing new roles Flexibility in special interests for new consultant posts to make them more attractive Attractive reward packages in line with national terms and conditions Exploring potential for overseas recruitment
Increased activity and demand impacting on capacity and workforce.	Increased use of out of area placements Waiting times for psychological therapy and CAMHS outside of desired level	Out of area project established with commissioner support to improve flow, discharge and community-based support offer, thus reducing demand for out of area placements. Protocol established to risk scan patients on waiting list and offer appropriate support. Close working with commissioners to review demand and capacity position leading to revised investment plans in order to reduce waiting times across services. West Yorkshire and Harrogate level work on managing capacity across the

Description of risk to quality	Impact	Mitigating actions
		system for mental health, CAMHS and LD.
Sub-optimal transition to new mental health clinical record system.	Unfamiliar system leads to reduction in productivity beyond transition phase	Clinical records system project board established to govern system transition and optimisation programme. Data migration testing took place prior to “go live” Internal audit review conducted at key stages in implementation programme. Staff training plan developed and implemented prior to “go live” with KPIs for required training levels. Super users trained to support staff at local level, video clip and written guidance available via intranet. Routine project reporting into Board, Audit Committee and Clinical Governance and Clinical Safety Committee.

The Trust is committed to ensuring learning from national investigations is implemented, including the Gosport Independent Panel. The Learning from Healthcare Deaths policy lays out the Trust’s process for reporting deaths and describes responsibilities, including those of the Trust Board who are accountable for ensuring compliance with the 2017 NQB guidance on Learning from Deaths.

Work continues to develop support materials for bereaved families. A task and finish group has met to develop our plans for implementing the National Quality Board guidance on 'Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers to align with the principles set out in the policy.

All deaths in the Trust are reported in line with the policy and reported via weekly risk panel and monthly mortality review groups. Our first Clinical Mortality Review Group was held in March 2019 with its purpose being to review and examine themes arising from reviews. Work continues in conjunction with both the Northern Alliance of mental health trusts and the Improvement Academy Regional Mortality Group to develop work on outcomes from the reviews/investigations and consider how to work together on themes and trends.

We are committed to the ambitious target announced by Public Health England (PHE) and NHS Improvement to reduce healthcare associated gram-negative bacteraemia by 50% with an associated reduction in antibiotic prescribing by 50% by 2021. Due to the Trust footprint, we have signed up to two separate health economy multifaceted, collaborative reduction plans; West Yorkshire Health Economy and Barnsley Health Economy.

The plans cover, by financial year, the period from 2017 – 2021 and are evidence based on national guidance, contractual guidance and best practice. Review occurs twice per year by the Infection Prevention and Control leads of all involved organisations in an inclusive and collaborative manner.

Local delivery of the plans within the Trust has consisted of implementation of interventions including antimicrobial prescribing data from the Refine electronic system, annual antimicrobial prescribing events aimed at promoting antimicrobial guardians, catheterisation audits and surveillance/monitoring of CAUTI, sepsis awareness promotion, hydration awareness promotion, re-launch of catheter passport, introduction of standardised catheter formulary, and education of urinary microbiological investigations (this list is not exhaustive). Plans are well established and considerably progressing, the West Yorkshire plan now consisting of 51 ongoing objectives whilst the Barnsley plan is RAG rated with all of the objectives being rated as amber or green.

2.2 Summary of quality impact assessment process

Efficiency opportunities and service improvements are identified through Trust-wide transformation initiatives, new service developments and through annual service line planning exercises. This is supported by internal and external benchmarking and market analysis. Schemes are documented on a simple standard template to aid clarity. At the time of scheme identification, service line teams undertake a self-assessed Quality Impact Assessment (QIA). This follows key lines of enquiry aligned to the CQC domains. The Quality Impact Assessment process also involves consideration of feasibility and achievability as well as impact on quality, and on staff, to facilitate early sight of scheme impact on quality and safety.

A series of QIA panels review all CIP proposals using key lines of enquiry in discussion with leads for each service line. This allows self-assessed QIAs to be peer reviewed, and potential risks to be considered, with support from clinical governance and safety experts. Panels are chaired by the Assistant Director for Nursing and Quality. RAG ratings for finance, deliverability and quality impact are brought together into an agreed overall rating, plus any mitigating actions required. Consideration is given at this stage to key metrics which will be used to measure impact and quality.

All QIAs of efficiency opportunities are specifically reviewed by the Medical Director and Director of Nursing and Quality, alongside the Director of Workforce OD and Estates, including a review of cumulative impact of CIPs in each service. Board assurance is achieved via the Executive Management Team (EMT) and CGCSC scrutiny and then direct Trust Board approval of the plan.

Throughout the year the Trust maintains a focus on quality, including the impact of change, through the weekly Operational Management Group (OMG) meeting attended by all operational directors, which receives reports on key operational and quality performance from all Business Delivery Units, and ensures action is taken. This includes review of CIP progress ensuring QIAs remain valid. Any new or substitute schemes are subject to the same QIA process. The ongoing progress in achieving CIPs and impact on quality and safety are measured against the Key Lines of Enquiry (KLOE) monthly via the OMG and EMT and progress reports are a standing item at each Clinical Governance and Clinical Safety Committee. Once delivered all high-risk CIPs are subject to post-implementation reviews to ensure there have been no unintended consequences from the schemes. OMG escalates issues to the EMT where required and an Integrated Performance Report is reviewed by EMT each month and presented to our Trust Board meetings.

Where there have been system-wide service changes through new models of care, a QIA process has been applied across that health system. QIAs also take place at key gateway points during major service transformations and priority programmes, and at the post-implementation review point.

2.3 Summary of triangulation of quality with workforce and finance

This plan forms the basis of our integrated performance approach – a report that can be used at all levels and covers quality, performance, workforce and finance. This supports our approach to triangulation of the data that takes place at Trust Board, EMT, locality and service line levels. Our IPR will continue to directly reflect the measures in this plan. These will be finalised at the April Board, following conclusion of contracting negotiations. A cross functional approach is used to develop the plan and test the assumptions being made, which enables the triangulation of financial, activity and workforce data to be considered robust.

During 2019/20 we will build on the trust-wide and place-based scorecards to implement an individual service level balanced scorecard to ensure that quality and performance measures are understood and used meaningfully at all levels. This will be reviewed extensively by the EMT and also discussed in public at Trust Board meetings.

The metrics used in the IPR, which aid triangulation, are multiple and include operational KPIs that also signify quality, such as referral to treatment times, plus indicators of quality and effective use of workforce, such as safer staffing fill rates in ward-based services, and indicators of quality and financial success such as use of out of area placements and use of agency staff. A further focus on key workforce metrics supports an understanding of current and future capacity and effectiveness, such as rates of attendance, appraisal and engagement. The IPR also draws together the feedback we receive through complaints and the Friends and Family Test describing how we are learning from feedback and sharing our learning. The Board receives the IPR on a monthly basis. It uses this information to track trends and to make specific enquiries into actions undertaken around hot-spots.

Alongside the operational issues, transformation programmes such as our recovery focused work in mental health, and the reduction of out of area placements for general acute mental health in-patient needs, are reported through the integrated approach. This process is informed by the full QIA process.

Throughout the year we continue to monitor the impacts on quality of our drive to always ensure safe levels of staffing, while also acting to reduce our use of agency staffing and to maximise local bed capacity to reduce use of out of area placements. Our approach is based on our belief that good quality services attract and retain excellent staff, and this will maximise benefits for service users.

3. Workforce Planning

3.1 Workforce planning

The Trust Board agreed a 3 year Workforce Strategy in 2017 which recognises that a key requirement to delivering safe and sustainable services within agreed resources is a fit for purpose workforce. The Workforce Strategy is consistent with the workforce issues identified in the NHS Long Term Plan and has 3 key strands, underpinned by equality and diversity and values-based human resources management:

- *Workforce Development*: Ensuring we have robust plans for the development and effective deployment of the workforce
- *Staff Wellbeing and Engagement*: Ensuring we have a fit and well engaged workforce.
- *Leadership and Management Development*: Developing current and future clinical and professional leaders and managers able to deliver safe and high quality services within agreed resources.

The Trust has a Board agreed annual Workforce Strategy action plan governed by the Workforce Remuneration Committee (WaRC) of the Board. Workforce planning is an integral part of the Trust's service line and financial planning process and is developed through a robust engagement process with clinical, operational, professional staff and staff side. The workforce plan is refreshed annually through a series of service-based workforce planning workshops aimed at:

- Understanding the key challenges faced by the services regarding workforce, including vacancy gaps, hard to recruit posts and roles, short to medium-term retirement potential, bank and agency staffing requirements and plans to reduce/remove, safer staffing requirements and the impact of a no-deal Brexit on current workforce eligibility.
- Current and future workforce state - skills mix of teams required to deliver safe and effective services.
- New and emerging role implementation/potential including alternatives to historic nurse recruitment such as trainee nursing assistants, advanced clinical practitioners, pharmacy associates, allied health professional support roles etc.
- Understanding of external and internal drivers for change regarding workforce delivery such as financial constraints, CIP requirements, commissioning intentions, Local Workforce Action Board (LWAB) priorities and direction in the NHS Long Term Plan.
- Learning need analyses (LNAs) to develop an ability to formulate cohesive workforce plan and LNAs which is within available resource and cost including maximisation of the apprenticeship levy.
- Ensuring we have a workforce representative of the communities we serve.
- Staff health and wellbeing including reducing absence rates and bullying and harassment.

The workforce plans are agreed and monitored by the EMT and the WaRC; a committee of the Trust Board. The Trust is part of a West Yorkshire integrated care system mental health workforce group to ensure partnership working and strong links to the LWAB. In addition we are part of the South Yorkshire and Bassetlaw workforce group.

Equality and diversity underpins all that we do in the management and development of the workforce. The Trust has established three equality networks for BAME staff, staff with a disability and LGBTQ+ staff. A fourth network is being supported for staff who are carers. Staff equality networks have had significant involvement in the development of our plan, particularly measures to ensure we comply with the Workforce Race Equality Standard, Workforce Disability Equality Standard and to improve diversity.

3.2 Workforce strategy

As recognised in the NHS Long Term Plan the supply of qualified staff remains one of the greatest workforce challenges. The top four supply challenges are shown below.

Description of Workforce Challenges	Impact on the Workforce	Initiatives in Place
Shortage of RMNs at Band 5 in Mental Health (MH) inpatient areas	Difficulties in ensuring optimal and safe staffing levels, on mental health wards, leading to increased agency and bank spend and a negative impact on staff wellbeing. Lack of learning disability (LD) nurses, in particular newly qualified availability leading to extended vacancies in LD and CAMH services. Despite a nursing recruitment programme in constant motion the Trust is still losing approx. 80wte nurses per year.	Established strong links with the universities undergraduate and masters programmes for nursing Introduction of nursing associate and associate practitioners Think Ahead programme for social workers in MH Trust-wide retention plan Recruitment programme for newly qualified RMNs Enhanced payments for RMNs working on bank Relocation package for out of area nurse recruitment Wellbeing plan with enhanced occupational health support
Shortage of Specialty Doctors in MH	Difficulties in recruiting SAS doctors has led to increased locum costs and pressures on on-call rotas.	Commitment to SAS charter Developing potential career paths for SAS doctors Business plan for GMC sponsorship to recruit doctors from overseas New roles introduced including development of associate specialist Medical workforce strategy
Shortage of CAMHS Consultants	National shortage of CAMHS consultants leading to service delays, increased locum spend, local trusts offering enhanced payments	Engagement with current consultants on developing new service models and introducing new roles Flexibility in special interests for new consultant posts to make them more attractive Attractive reward packages in line with national terms and conditions Exploring potential for overseas recruitment
Staff retention in hard to fill posts	Greater competition for staff across all health sector providers leading to aggressive financial incentives to 'entice' staff into vacancies leading to difficulties retaining staff, particularly in higher banded, speciality roles and medical posts where AFC not relevant.	Retention strategy in place aimed at internal retention priorities including career development opportunities, internal marketing of the Trust, benefits package realisation CPD opportunities Ease of staff movement internally for role change, career opportunity Improved work life balance opportunity, flexible working, health & wellbeing initiatives

3.3 Workforce efficiency and transformation

In support of the organisational risk register there is a dedicated workforce risk register which is regularly reviewed in detail through the WRC. The top 3 risks with the Trust's mitigating actions are detailed below.

Description of Workforce Risk	Impact of Risk (high, medium or low)	Risk Response Strategy	Timescales and progress to date
Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to	Medium	Monitoring turnover rates monthly. Exit interview improvements. Flexible working arrangements Investment in health and well-being services.	Annual workforce planning workshops took place in January/February 2019 Strategic workforce plan update in April 2019 to reflect intelligence and direction. Business plan developed for potential partnership with NHS

Description of Workforce Risk	Impact of Risk (high, medium or low)	Risk Response Strategy	Timescales and progress to date
retire in the next five years.		Retire and return options. Apprenticeship scheme Recruitment and Retention strategy Detailed annual workforce plans	Professionals - June 2019
Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand	Medium	Absence management policy. Occupational Health service. Trust Board reporting. Annual 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	Wellbeing groups established in service areas Annual Wellbeing and Engagement survey - March 2020 Wellbeing champions appointed for each BDU Annual workforce planning workshops including mitigating plans for hotspot areas Strategic workforce plan update – May 2019
Risk of over reliance on agency staff which could impact on quality and finances	Medium	Board self-assessment. Reporting through IPR. Safer staffing reports. Agency guidance Authorisation levels for approval of agency staff Restrictions on administration and clerical agency staff. Extension of the staff bank and development of medical bank OMG overview. Retention plan and R&R steering group in place	Business plan developed for potential partnership with NHS Professionals - June 2019 GMC sponsorship to support overseas recruitment - April 2019 Targeted recruitment for hotspot areas - April 2019 Business case for on-boarding system - April 2019 Review of ideal ward staffing requirements and establishment review Investment in band 4 TNA roles within inpatient areas as new roles & internal development of staff (approx. 74wte through 2019-20).

Our workforce strategy recognises that significant change in the workforce is required over the next 2-5 years to meet increasing service demands and acuity levels, through maximising productivity and new ways of working. This will be driven by our operational workforce plans, transformation programmes, financial resources and local and national investment priorities. Transformation will be supported through an established Recruitment and Retention Task Group, which includes senior staff, professional leads, staff side and HR, Operational Management Group (OMG) and WRC to ensure sufficient management resource and oversight. In addition, the Trust has a dedicated Integrated Change Team which supports significant transformation.

Outline of the Trust's long term vacancies is given below.

Description of long term vacancy	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Consultant CAMHS	2	None-covered by long- term agency locums	Engagement with existing CAMHs consultants on job redesign and remuneration arrangements. This has enabled a more flexible approach to advertising roles including supporting special interests. These arrangements have already had an impact with serious interest in 2 vacancies (timescale 3 months)
Learning Disability	1	None- covered by agency locums	Trust has been actively recruiting and an appointment to a Trust locum position with the potential for a substantive

Description of long term vacancy	Whole-time equivalent (WTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Consultant			appointment has been made. (timescale 6 months)
Working Age Adults Consultants	2	None-covered by agency locums	Acting arrangements in place to replace agency locums from experienced associate specialist and speciality doctor with opportunity to gain CCT. Will advertise later in the year. (timescale 12 months)
Speciality Doctors	4	None-mixture of cover arrangements in place including agency locum	Exploring the potential to replace some of the specialty doctor posts with advanced clinical practitioners. Also international recruitment will focus on the specialty doctor roles. Looking at the potential of physician associate (timescale 6 to 12 months)

Achievement of recruitment targets will be support through:

- Significant work with CAMHs consultants on the redesign of roles to make them more attractive, which has already started to have some impact on both staff retention and recruitment to long standing vacancies.
- The Trust's business case to become a GMC sponsor for international recruitment of Specialty doctors.
- Development of new roles particularly advanced clinical practitioners, with the potential to replace certain hard to fill specialty doctor roles.
- Physician associates roles being developed.
- Initiatives to recruit and retain newly qualified nurses - strong links have been established with both Sheffield and Huddersfield Universities to increase number of students for the 2019 intake.
- The Nursing Associate role, which is being introduced into inpatient areas to support safer staffing and skill mix
- Contract agreed with Thinking Ahead to introduce social workers as part of a broader skill mix.

The Trust plans to convert agency staff to substantive posts in 2019/20, thereby reducing agency spend from £6.4 million to £5.9 million. We recognise this exceeds the agency cap, but feel this reduction is realistic based on our detailed workforce strategy. We have identified 20 nurse posts, and 2 consultant posts which can be converted from agency to substantive, thereby also supporting our recruitment targets.

The focus of the Trust's workforce plan enhances both quality and productivity and includes:

- A focused medical workforce plan that will enable a continued reduction in use of agency staff through redesign of posts including more consultant-led services and the introduction of other professional roles, such as advanced clinical practitioners and physician associates.
- Reducing management costs through streamlining processes and devolved decision making. In addition the Trust will continue to develop strategic partnerships for collaboration across both South and West Yorkshire ICS areas
- The Trust's nursing strategy recognises the need for potential alternative delivery of newly qualified nurses following changes to nurse bursary arrangements.
- The Trust's *Recruitment and Retention plan* continues to be a major driver in workforce efficiency, identifying our need to improve the both the recruitment and retention of our staff through, for example, improvements in our "on-boarding", marketing and communications, health and wellbeing initiatives, freedom of staff movement and improved career progression. This work has several key workforce drivers and which include
  - Plans to address our rising allied health professional & psychology vacancy levels and retention rates which have both almost doubled in the past 12 months due to staff competition.
  - Difficulty in filling hard to recruit posts in both community mental health vacancies and in particular CAMHS and LD nursing posts.
- Improved staff engagement including a commitment to tackle harassment and bullying.

- A focus on the development of supporting roles to meet the Trust's revised establishment review and safer staffing modelling. This includes expansion and exploration of trainee nurse assistants, AHP support roles, social service integrated posts, pre-registration student placements, return to practice staff and our well established apprenticeship programme.
- Investment in band 4 trainee nurse associate (TNA) roles within inpatient areas as new roles and internal development of staff (approx. 74wte through 2019-20).
- Ongoing workforce transformation of our older peoples' mental health services.
- Community nursing services workforce redesign.
- Increases in our volunteer workforce with workforce plans to double our current volunteer workforce, currently around 200.
- Workforce implications of a system-wide review of assisted living services
- Improvements to adult autism and ADHD pathways and waiting times, including collaborative working across trusts to relieve pressure, and exploration of future models for assessment and diagnosis of ASC and ADHD in children.
- Implementation of new business from April 2019, notably LD forensic outreach liaison services and liaison and diversion.
- Implementation of new business from mid-term in this plan to incorporate Future In Mind (FIM) CAMHS service, EIP, IHBTT and IAPT service development. Detailed workforce requirements to be determined with spec. This is a £1.7m total cost.
- Movement toward NHS Professionals within bank provision arrangements.
- Workforce review of our acute care pathway to reduce the number of people in acute mental beds out of area and on-going development of the Wakefield mental health provider alliance as an example of innovative multi-agency partnership working.
- Opportunities for improved productivity identified in the Carter review such as use of NHSI mental health/community e-rostering improvement collaborative learning to improve inpatient rostering, roll out of Safecare module on Health Roster on inpatient wards, continuing to ensure recruitment processes are being streamlined in line with regional and national initiatives.

The Trust has been working in collaboration with other mental health trusts across South and West Yorkshire to co-ordinate a collaborative mental health workforce group. This is being established within West Yorkshire with HEE support with links to the LWAB and will be developing a joint workforce plan for West Yorkshire for 19/20. The three West Yorkshire mental health trusts will develop a partnership approach to delivering leadership and management development programmes. This is also replicated and further embedded within the South Yorkshire & Bassetlaw ICS footprint. Further collaboration is planned on a staff bank and HR streamlining.

4. Financial Planning

4.1 Financial forecasts and modelling

This section identifies how the financial plan has been developed and what our plans are to ensure it is delivered. It also clearly articulates the assumptions made when generating the plan and risks of achievement as currently identified. Following discussion with NHS Improvement the financial control total for 2018/19 was agreed at a £2.6m deficit (pre Provider Sustainability Funding). This is the first time the Trust has had a deficit plan and is a very much a reflection of a reduction in income, particularly higher margin community services, and operational pressures caused by increasing demand for inpatient beds and patient acuity. These pressures manifest themselves in increased use of out of area bed placements and staffing costs.

Within the current financial year there have been a number of variances to plan which at a high level include adverse positions on out of area bed placements, inpatient staffing costs and further reductions in income. These have been compensated for financially by pay savings in other areas, gains on asset disposals and non-recurrent income. As such, the Trust has been able to agree to a revised outturn position of £2m deficit, enabling it to access a further £1.2m of PSF monies if achieved, in addition to the £1.5m that will be provided if the initial £2.6m deficit control total is achieved. It must be emphasised that achievement of this year-end position is heavily underpinned by a number of non-recurrent measures.

Whilst the Trust is forecasting achievement of its full year control total, the underlying position is a deficit in excess of £4m. CIP delivery in 2018/19 is projected to be £10.6m (5.0%), of which £7.9m represents recurrent savings with the remaining £2.7m non-recurrent. This is considered a positive performance, particularly for a Trust in a block contract environment with declining income and reference costs of 99 for mental health service provision.

There have been a number of changes to the Trust's service provision in recent years which has resulted in on-going income reductions over the past five years. These income reductions have placed significant pressure on margins resulting in the current deficit position. As such, work has taken place on developing a financial sustainability plan using two different scenarios. This plan will be completed before the end of April and a number of themes identified in it are included in the efficiency savings for 2019/20 with further savings delivered through to 2021/22.

The step change in agency spend from a high in 2016/17 of c£10m has continued. However, there has been some pressure on agency spend against the cap this year, with the year-end spend on agency staff forecast to be £6.4m, which is £0.6m higher than last year and £1.2m (23%) above the agency cap. Use of medical locums is the main driver. It is also worth noting that further tendering of services has taken place during 2018/19 leading to a further reduction in contribution of £2.6m in 2019/20.

In generating this plan the impact of activity and acuity changes has been included. The impact of this is notably seen in the cost pressures which have arisen over the past twelve months in the form of additional staff required to ensure safe services on inpatient wards, particularly adult acute and PICU.

The Trust has worked constructively with its commissioners on contracts for 2019/20 to ensure that demographic changes, demand pressures and investments to improve mental health services are made.

In terms of clarifying the understanding of the financial position a bridge between 2018/19 and the 2019/20 has been developed and used. The most significant movements relate to income reductions, net changes to income tariff, pay inflation, non-repetition of non-recurrent measures, cost efficiency improvements and net benefits to contribution gained by incremental investment in mental health and community health services.

A full review of all assumptions has been made in developing the refreshed financial plan for 2019/20. In addition there continues to be work taking place in both the Integrated Care Systems in which we operate, which may have an impact on the Trust and the services it provides.

The Trust Board recognises the importance of achieving its control total and becoming financially sustainable, whilst maintaining service safety and quality. The scale of financial challenge in order to achieve a control total of £0.24m deficit is substantial at close to £14m of contribution, cost avoidance and cost improvement (6.5%). To deliver such a sum requires considerable thought and work to ensure quality and safety can be maintained. The scale of challenge is exacerbated by the impact of previous efficiency improvements, and the loss of income over the past two years largely through tendering and de-commissioning. The positive impact of income growth in 2019/20 combined with cost efficiency improvements results in £12.7m of this sum being identified to date leaving a further £1.3m currently unidentified. Based on our planning assumptions a further £2.5m of assumed benefits has a level of risk attached to it. Identification of mitigations continues and will be based largely on non-recurrent measures and review of service provision.

The Trust Board has accepted the control total based on the improved position since the draft plan submission, which has arisen through finalisation of contracts, more certainty relating to some of the cost improvement opportunities and additional savings being identified. Achievement remains challenging and the Trust will continue to work with its commissioners, other partners in the ICS and internally to identify other opportunities for improvement to support delivery of the plan.

In terms of financial assumptions these are shown in table 1:

Table 1			
	Key Assumptions		**Key Assumptions**
Funded cost inflation	3.8%	Pay inflation	2.1%
Efficiency factor	1.1%	Non consolidated pay inflation	0.5%
CQUIN income	1.25%	afc increments	0.1%
Drugs costs	2.0%	Apprenticeship levy	0.5%
CNST costs	-1.0%		

Based on activity and costs over the past three years there remains a risk that out of area bed placements do not reduce in line with our plans. As part of our contract negotiations we have secured some demographic growth which can be applied to existing demand pressures. The Trust and its commissioners have worked closely with independent advisors regarding bed management processes and have an agreed action plan in place based on the recommendations made following that review.

Elsewhere in this plan narrative there is reference to work being undertaken in both the West Yorkshire & Harrogate Partnership ICS and South Yorkshire & Bassetlaw ICS. The Trust is fully engaged with both ICSs. For the purpose of this plan, we have dealt only in known changes until agreement has been reached and reflected in any contracts and it is therefore assumed that there is no change to service provision in 2019/20.

As part of our financial improvement income assumed in the plan reflects the level of growth agreed during the contract negotiations and approved by the Trust Board. In the vast majority of cases the exact nature of growth to meet the mental health investment standard has been agreed by service. In some cases prioritisation of schemes needs to be confirmed between commissioner and the Trust and income for this will follow during the first quarter.

Table 2 below shows a summary of key financial headlines. This table excludes the impact of PSF monies achieved which equated to £2.9m in 2017/18 and are assumed to be £2.7m in 2018/19. Achievement of the pre PSF surplus in 2019/20 would enable access to £1.8m of PSF.

Table 2				
Key Financial Headlines	**2017/18 Actual**	**2018/19 Plan**	**2018/19 F'cast**	**2019/20 Plan**
	£m	**£m**	**£m**	**£m**
Operating income	219.9	213.5	222.5	225.3
Employee expenses	(166.4)	(165.3)	(167.5)	(171.7)
Other operating expenses	(48.6)	(45.6)	(51.3)	(49.5)
Impairments	(0.9)		(11.1)	
Operating surplus/(deficit)	4.0	2.5	(7.4)	4.2
Finance income/(costs)	0.1	0.0	0.2	0.1
Other costs	(3.0)	(3.7)	(3.2)	(2.7)
Surplus/(deficit) for the year	1.1	(1.2)	(10.4)	1.5
Adjusted surplus excl impairments	2.6		0.6	
Adjusted surplus excl PSF & impairments	1.1	(2.6)	(2.0)	(0.2)

The main movements in relation to income are the previously identified re-tendering of services, tariff uplift and other services gained. Pay costs have moved through a combination of pay inflation, service changes and cost efficiencies. As part of the development of the plan likely cost pressures are identified. For 2019/20 they cover such items as out of area bed use, inpatient staffing, migration to windows 10, dual running costs for our clinical record system implementation, and non-capitalisable anti-ligature works.

The Trust has strengthened its financial governance over the past year by holding a monthly focused finance meeting which all board members are invited to attend. Additionally, following review of national learning and best practice, enhanced communication and staff engagement plans are being put in place.

In generating the financial plan, a review of current run rates and budgets, identified cost pressures and initial cost improvement schemes has been undertaken. As previously highlighted, including the outcome of

contract negotiations, we have identified £12.7m of potential savings and improvements to date. Excluding contribution from contract growth this equates to £10.7m of CIP. A number of these are ambitious, remain subject to quality impact assessments being completed and require robust implementation plans. Further opportunities continue to be assessed.

The Trust Board and senior management is committed to putting plans in place to deliver its CIP and financial plans, identifying further savings opportunities and mitigating risk. In doing so, we think it is only prudent to recognise that we are managing risks that have been stated and articulated.

4.2 Efficiency savings for 2019/20

The Trust has a structure based on Business Delivery Units (BDUs) – Kirklees & Calderdale, Barnsley, Wakefield, Forensic and Specialist services that are supported by corporate services. The BDUs and corporate services are accountable for their own financial performance and identify specific cost improvement schemes. These are augmented by trust-wide schemes which are not necessarily specific to one particular service or corporate team. The Trust has a very clear principle of operating with a safety first approach. Quality Impact Assessments (QIAs) are therefore carried out on all proposed cost improvement schemes (see section 2)

For 2019/20 there are a number of key areas of focus which will help drive financial improvement. The risk relating to out of area bed usage has already been highlighted. A number of actions have been put in place to mitigate, but the pressure on our bed capacity has continued, despite some improvement in Wakefield and continued performance in Barnsley. This has been a combination of cost and volume. Through commissioner support and internal pathway re-design we have assumed this element of our financial challenge can be halved compared to current year.

The Trust has been developing a financial sustainability plan since the third quarter of 2018/19. The detailed plan will be approved by the Trust Board in May. The Board has discussed and agreed a number of themes that will support cost and efficiency improvements. Examples include improvements to bank management, , reducing agency costs, focus on actions to address loss-making services, further non-pay opportunities including drugs costs, operational management structure and capital charges. Work also continues on ensuring the skills mix for our workforce meets operational requirements.

Wherever headcount reduction is required the Trust will utilise vacancies to reduce staffing, to minimise disruption and redundancy costs. For some posts there are unlikely to be redeployment opportunities which may result in redundancy costs being incurred, which will impact upon the cash position.

There is an appreciation that more effective productivity and benchmarking data will support the identification of further options for efficiency and this is an area for improvement. Some initial productivity data is being gathered internally and we are using the mental health benchmarking information to more closely compare performance with neighbouring similar trusts. Use of the model hospital data in mental health providers is in its infancy, but arrangements are being made to better utilise the information in it to improve our own services and cost performance.

The Trust has a history of delivering CIPs, including 5.0% in 2018/19. This is over a period of time where it has become more difficult to identify and deliver them given the cumulative consequences of increased demand and acuity, income reduction, and increases in unavoidable cost pressures. Our historic CIP achievement includes a balance of recurrent and some non-recurrent CIPs. Strong governance regarding CIP management is in place including a regular in-depth review at weekly operational management meetings, regular service meetings with the Director of Finance and non-executive attendance on a monthly basis at an EMT financial review meeting.

A summary of CIP savings delivered in recent years and those required for the plan is shown in table 3. It is notable that CIP requirement and delivery has consistently been well above the efficiency factor applied to our contracts and the figures are as follows:

Table 3				
Cost Improvement	**2017/18 Actual £m**	**2018/19 Plan £m**	**2018/19 F'cast £m**	**2019/20 Plan £m**
Recurrent	5.9	8.1	7.9	7.4
Non-Recurrent	1.6	1.6	2.7	3.3
Total	7.5	9.7	10.6	10.7
% of operating cost	3.4%	4.6%	5.0%	4.9%

Table 4 below provides an indication of how the £10.7m CIP saving identified to date will be delivered.

Table 4	
Cost Improvement Delivery Breakdown	**£m**
Contribution from additional income	0.7
Out of area bed efficiencies	1.2
Procurement & Non-Pay	1.8
Temporary Staffing	0.9
Workforce	2.6
Non-recurrent pay	1.2
Non-recurrent non-pay	1.0
Other savings	0.1
Unidentified	1.2
Total	10.7

4.3 Agency Rules

Whilst expenditure on agency staff has reduced considerably, this will remain an area of clear focus as costs have increased in 2018/19. Costs reduced from £9.8m in 2016/17 to £5.8m in 2017/18. The projected outturn this year is £6.4m with a number of year on year reductions visible, but higher medic locum numbers and costs have more than offset savings elsewhere. With a revised cap of £5.3m in 2019/20 the aim is to continue the reduction in agency expenditure.

Use of agency is primarily due to vacancies in community teams and medical workforce. It can also be required due to short-term increases in inpatient acuity and short-term requirements that cannot be covered by the Trust's internal bank. We will review all vacant posts and consider an alternative workforce solution to those that are more difficult to recruit to. We anticipate that the move to all age psychiatric liaison services will support recruitment to substantive CAMHS consultant roles and reduce agency spend to cover rota gaps. There is continued commitment to training nursing associates, and opportunities to use non-medical prescribers and advanced practitioners will be explored further as an alternative to medical-locum use. Risks remain where an alternative is not appropriate and medical on call demands the use of a locum. Short term acuity demands will predominantly be met by the increased number of Trust bank staff and a more flexible approach to deployment of the workforce by the revised leadership structure for inpatient services.

To ensure tight control is retained over agency staffing spend the Trust is reinforcing and continuing to tighten management controls, redeploy existing resources and increasing the internal bank through the use of a temporary enhanced payment for ward bank staff.

4.4 Capital Planning

As previously highlighted the Trust has made significant and wise investments in its estate over the course of the past 6 years which includes upgrades to our forensic and adult acute inpatient wards as well as provision of community hubs in Halifax, Huddersfield, Wakefield, Barnsley and Pontefract. In developing our 2019/20 capital plan a full prioritisation process has taken place. There is a need to complete our Fieldhead re-development work and also our SystmOne for mental health implementation.

Other requirements for 2019/20 include IT infrastructure to boost our protection against cyber-crime as well as ensuring we have strong and robust system reliability. A minor capital programme is centred on high priority works including urgent replacement, nurse call system, anti-ligature and health & safety requirements.

Where schemes have not been included in the current financial plan a full risk assessment is taking place and mitigating actions will be identified if required. A summary of capital expenditure plans is shown in table 5 below:

Table 5

Capital Expenditure Plans	2017/18 Actual £m	2018/19 Plan £m	2018/19 F'cast £m	2019/20 F'cast £m
Fieldhead Re-development	7.0	4.2	4.2	0.6
Other buildings works	1.4	1.4	1.9	2.9
Nurse call system				0.6
Mental Health Clinical Record System	0.6	0.8	0.8	0.2
IT	1.6	1.6	1.3	2.5
Contingency	0.2	0.2		0.2
Total	10.8	8.2	8.2	7.0

The Trust will be using its own internal cash reserves to fund this expenditure. One building disposal could complete over the course of the next twelve months, but receipts have not been included in the financial plan given lack of certainty regarding exact timescales. Cash is projected to reach £22.6m at the end of 2018/19 and based on current assumptions will reduce to £19.0m by the end of 2019/20. Phasing of the capital programme is geared towards the second half of the year to ensure that cash balances are maintained if there are any issues with achievement of the control total.

4.5 Summary

The Trust Board takes its financial responsibilities very seriously, evidenced by a consistent and credible approach to planning and the regular achievement and bettering of financial plans. The financial challenge for 2019/20 remains high following further loss of income and known cost pressures. Following the conclusion of contract negotiations, identification of further savings opportunities and increased robustness of schemes previously identified the Trust Board has agreed to accept its control total for 2019/20. In order to achieve this, even stronger financial governance will be put in place and the Trust will continue to work internally, with its commissioners and both ICSs to identify further system improvements.

5. Link to the local sustainability and transformation plan

5.1 Vision and our role

The communities we serve are largely located in South Yorkshire (Barnsley) and in West Yorkshire (Calderdale, Kirklees and Wakefield) with additional services in Wetherby, Sheffield, Rotherham and Doncaster. In addition we serve the wider Yorkshire and Humber population in respect of our forensic service provision as well as place-based work across a range of geographies in Yorkshire. We are actively engaged in the West Yorkshire and Harrogate Health and Care Partnership Integrated Care System (ICS) and the South Yorkshire and Bassetlaw ICS.

We are also fully engaged in the development of local place-based plans in both ICSs which are the building blocks of our partnerships. The place-based plans cover each of the local authority areas within our two regional partnership footprints. We achieve this through our relationships with Health and Wellbeing Boards, Overview and Scrutiny Committees, Partnership Boards and a variety of developing integrated

care forums. Over the past year there has been further development of new models of care and integrated care pathways, such as Primary Care Home and Connecting Care in Wakefield and the development of the neighbourhood model in Barnsley.

The development of integrated care systems potentially have a significant impact on the future of the Trust clinically, operational and financially. Therefore strong engagement in all local place developments is a continued feature of our plan for 2019/20.

In terms of key programmes of work we are involved in with each ICS and which have an impact on the Trust these are summarised as follows:

- Optimisation and best use of the mental health bed base across West Yorkshire.
- An active partner in the ongoing development of CAMHS across West Yorkshire following the successful capital bid to develop a new 22-bedded inpatient unit in Leeds.
- Development and implementation of a new model of care for eating disorders services across West Yorkshire.
- Development of a zero suicide approach across West Yorkshire.
- Improving access to ADHD and ASD assessments in both West Yorkshire and South Yorkshire.
- Developing a plan to consider how learning disability services are best provided across West Yorkshire including the number of assessment and treatment units required.
- A new model of care is being developed across West Yorkshire for forensic services
- Plans are being developed with regard to mental health rehabilitation and high cost placements for locked rehab
- Work is underway in relation to "harnessing the power of communities" including support for unpaid carers, use of social media and digital, and making best use of community assets.
- Within Barnsley we are a key partner in the development of integrated care and are involved in future models of care for stroke services
- We are working with partners across South Yorkshire to provide support for those bereaved by suicide and to prevent suicide, develop Individual Placement Support services, improve support for young people and reduce waiting times for CAMHS, deliver on key targets related to IAPT services and reduce out of area bed usage.

Where we are able to the impact of the above is included in our operating plan and if not then potential financial upsides and risks are identified.

The Trust operates principally in four places and our role in each one is similarly summarised:

Barnsley – as a provider of mental health, learning disability and community health services we play a key role in the Integrated Care Partnership as new service models are developed. We are working with partners to improve integrated care through the development of primary care networks in neighbourhoods with enhanced multi-disciplinary teams.

Calderdale – a single plan for Calderdale that sets out a vision to improve health, social and economic outcomes has been developed. The focus of the "Calderdale Cares" proposal is to develop and deliver integrated care through localities including the development of primary care networks and primary care home. One area of focus is the development of arts and health approaches and with our Creative Minds approach the Trust is a key partner in this.

Kirklees – a focus in 2019/20 is to initiate the development of an alliance for mental health and wellbeing using our learning from a similar approach in Wakefield. Other areas of focus include working with partners to deliver more joined up 0-19 and older peoples' services and to improve service for people living with autism and ADHD.

Wakefield – the Wakefield Integrated Care Partnership has established a mental health alliance in order to progress the development of integrated care for the people of Wakefield. The focus of work for 2019/20 is to fully establish the alliance, how it operates, how additional funding for mental health is prioritised with the aim of improving outcomes. The mental health offer into Primary Care Homes will be developed.

6. Membership and Elections

6.1 Our Members' Council

Our Members' Council (council of governors) is made up of elected representatives of our public members and staff, and also appointed members nominated from key local partner organisations such as local NHS trusts, local authorities, staff side organisations and the University of Huddersfield. There are places for 34 governors, consisting of 18 public (reflecting our geography in proportion to the population of each area), 7 staff, and 9 appointed.

6.2 Governor elections

The Trust holds elections each year to reflect the vacancies on its Members' Council in accordance with the Trust's Constitution. The elections are managed for the Trust by the Electoral Reform Services (ERS) to ensure that the elections are managed impartially and fairly and that the process is independent and transparent. The most recent election was held in April 2018 for public seats Calderdale (1), Kirklees (1), Wakefield (2), and the Rest of South & West Yorkshire (1), and five staff seats, with candidates elected for a three year term commencing on 1 May 2018. The 2019 elections are currently underway for public governor vacancies in Barnsley (1), Calderdale (2), Kirklees (4) and Wakefield (1) plus two staff governor vacancies. The Barnsley, Calderdale and one of the staff seats have been filled unopposed, and voting for all the remaining seats closes on 18 April 2019. A representative has also been appointed to the previously vacant seat for Barnsley Hospital NHS Foundation Trust, which means that from 1 May 2019, all 34 seats will be filled.

6.3 Governor recruitment, training, development and engagement

The Trust works with Electoral Reform Services (ERS) to publicise its elections and to encourage members to stand for election. The Members' Council Co-ordination Group oversees governor recruitment, development and training. The Trust has an induction programme in place for new governors and its approach to the training and development of governors is updated regularly to reflect governor feedback from the annual evaluation of the Members' Council effectiveness and annual review meetings with the Chair. There are a number of activities to facilitate engagement between governors, members and the public, including the Annual Members' Meeting. Our Members' Council also helps us shape future strategy and is directly engaged in the development of the annual plan. Governors also play an important role in issues such as quality with the Members' Council Quality Group directly engaged in the development of our Quality Accounts.

6.4 Membership strategy and supporting diversity

The Trust's approach to membership and engagement is set out in our Membership Strategy. Its objectives cover our ambition to have a diverse range of members which are representative of the population the Trust serves, encourage more active involvement, and communicate and engage effectively to allow public and staff members to contribute to our organisation, services, and plans for the future. The Trust evaluates progress in membership recruitment through comparison of membership with local population demographics, which allows a focus on areas of under representation.

Key areas of focus for the next 12 months relate to delivering the membership strategy supporting governors to deliver the objectives of the Members' Council.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item 10.6

Title:	**Update of the Scheme of Delegation**
Paper prepared by:	Director of Finance and Resources Company Secretary
Purpose:	Update to the Trust Scheme of Delegation
Mission/values:	➢ Respectful, honest, open and transparent ➢ Relevant today and ready for tomorrow
Any background papers/ previously considered by:	➢ Considered and recommended for approval by the Executive Management Team (EMT) on 4 April 2019. ➢ Considered and recommended for approval by the Audit Committee on 9 April 2019.
Executive summary:	➢ Under the Standing Orders for the practice and procedure of the Trust Board within the Trust's Constitution, Standing Order 3.14 provides that, subject to directions given by the Secretary of State for Health or NHS Improvement, Trust Board may make arrangements for any of its functions to be carried out on its behalf by a Committee or sub-committee or by the Chair or by a director or any officer of the Trust, in each case subject to restrictions and conditions determined by Trust Board. ➢ The Scheme of Delegation (SoD) or "reservation of powers to trust Board and delegation of powers" is a key document used in the governance of the Trust. ➢ This report provides an update to the SoD based on any improvements identified, clarification of roles and general updates. ➢ The full SoD is attached and the recommended changes are highlighted using track changes. Where appropriate explanatory comments are provided to explain the rationale. ➢ It is noted that within the constitution for the Members' Council they have responsibility for appointing the deputy chair and senior independent director and as such this is removed from decisions reserved for the board ➢ A review of Trust strategies has taken place and recommended updates to strategy approvals are highlighted. ➢ The formalising of approval for final estate disposals is highlighted ➢ Updates to titles of roles, names of committees etc. are highlighted ➢ Updates to requisition purchase order and invoice approval levels are listed. These have been agreed with the Operational Management Group (OMG) and EMT.
Recommendation:	**Trust Board is asked to REVIEW the proposed changes to the Scheme of Delegation and COMMENT accordingly including which strategies need to be approved by the Trust Board and**

	which can be delegated to a committee of the Board. **Trust Board is asked to APPROVE the updated Scheme of Delegation and to RECOMMEND the final approval to the Members' Council.**
Private session:	Not applicable.

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Reservation of Powers to Trust Board and Delegation of Powers

Under the Standing Orders for the practice and procedure of the Trust Board within the Trust's Constitution, Standing Order 3.14 provides that, subject to directions given by the Secretary of State for Health or NHS Improvement, Trust Board may make arrangements for any of its functions to be carried out on its behalf by a Committee or sub-committee or by the Chair or by a director or any officer of the Trust, in each case subject to restrictions and conditions determined by Trust Board.

The purpose of this document is to describe those powers that are reserved to Trust Board (generally those matters for which the Trust is accountable to the Secretary of State or to NHS Improvement) whilst at the same time delegating the detailed application of Trust policies and procedures to the appropriate level. Trust Board remains accountable for all its functions, even those delegated to the Chair, individual directors or officers, and will put in place arrangements to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

- Part 1 – Reservation of powers to the Trust Board and Scheme of Delegation general provisions
- Part 2 – Decisions/duties delegated by the Trust Board to Committees
- Part 3 – Scheme of Delegation derived from the Accounting Officer's Memorandum
- Part 4 – Delegation of duties relating to Corporate Governance
- Part 5 – Scheme of Delegation from the Trust's Constitution Standing Orders
- Part 5 – Scheme of Delegation from the Trust's Standing Financial Instructions

Role of the Chief Executive

All powers of the Trust that have not been retained by Trust Board or delegated to a Committee will be exercised on behalf of Trust Board by the Chief Executive. The Chief Executive will prepare a scheme of delegation identifying the functions he/she will perform personally and those which will be delegated to other directors or officers. All powers delegated by the Chief Executive can be reassumed by him/her at any time. The Chief Eexecutive is the Accounting Officer for the Trust and is accountable to Parliament for the efficient and effective use of the Trust's resources.

Caution over the use of delegated powers

Powers are delegated to directors and officers on the understanding that they be exercised responsibly.

Directors' ability to delegate their own delegated powers

The Scheme of Delegation shows the delegation from Trust Board to Committees and Executive Directors. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust (Standing Financial Instructions) and any further scheme of delegation developed to support arrangements within Business Delivery Units and to support Service Line Management.

Absence of directors to whom powers have been delegated

In the absence of a director or officer to whom powers have been delegated those powers will be exercised by the director or officer's designated deputy unless alternative arrangements have been approved by Trust Board.

Matters reserved for Trust Board and those matters that are delegated by Trust Board to Committees or Executive Directors are detailed in the attached Scheme of Delegation schedule.

RESERVATION OF POWERS TO THE TRUST BOARD AND SCHEME OF DELEGATION GENERAL PROVISIONS

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
	Trust Board	**General Enabling Provision** Trust Board may make decisions on any matter for which it has delegated or statutory authority, in full session within its statutory powers.
	Trust Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive. 5. Approve a Scheme of Delegation of powers from Trust Board to committees. (Decisions taken by Committees within their delegated powers will be regarded as having been taken by Trust Board). 6. Establish terms of reference and reporting arrangements of all Committees and sub-committees that are established by Trust Board. 7. Grant delegated authority to the Chair or other directors to approve actions on its behalf, subject to ratification at a future meeting of Trust Board. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications to them. 9. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 10. Require and receive the declaration of interests for staff that may conflict with those of the Trust. 11. Approve arrangements for dealing with complaints. 12. Authorise use of the seal (delegated to Chief Executive / Executive Director). 13. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 6.6. 14. Discipline members of the Board or employees who are in breach of statutory requirements or SOs. 15. Receive reports from committees including those that the Trust is required to establish and to take appropriate action on. 16. Confirm the recommendations of the Trust's Committees where the committees do not have

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		executive powers. 17. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 18. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.
	Trust Board	**Appointments/dismissals**<br~~Appoint the Deputy Chair of the Board.~~<br~~Appoint the senior independent director.~~ 1. Appoint and dismiss committees (and individual directors) that are directly accountable to Trust Board. 2. Approve proposals regarding the Chief Executive, directors, senior employees ~~and those of staff not covered by the Remuneration and Terms of Service~~Workforce and Remuneration (delegated to Workforce and Remuneration Committee)~~Committee~~. 3. Appoint, discipline and dismiss Executive Directors (subject to SO 3.9). 4. Confirm appointment of members of any committee of the Trust as representatives on outside bodies where they are a voting member. 5. ~~Appoint, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders).~~ Appoint, discipline and dismiss the Secretary (delegated to Workforce and Remuneration Committee)
	Trust Board	**Strategy, Plans and Budgets** 1. Define and set the Trust's strategy, the strategic aims and objectives. 2. Approve the ~~five year Integrated~~ Business Plan or equivalent as required by NHS Improvement. 3. Approve the Trust's annual ~~budget~~ financial plan. 4. Receive and approve the Trust's Annual Report and Annual Accounts. ~~4.~~5. Receive and approve the Trust's Annual Quality Accounts ~~5.~~6. Approve the Trust's Communication, Engagement and Involvement Strategy. ~~6.~~7. Agree the Trust's Counter Fraud ~~Communications~~ Strategy (delegated to the Audit Committee). ~~7.~~8. Agree the Trust's Creative Minds Strategy (delegated to the Charitable Funds Committee). ~~8.~~9. Agree the Trust's Equality First Strategy (delegated to the Equality and Inclusion Forum and Executive Management Team) ~~9.~~10. Agree the Trust's Food and Drink Strategy (delegated to the Executive Management Team). ~~10.~~11. Approve the Trust's Digital~~IM&T~~ Strategy.

Comment [BM1]: Members' Council make this appointment

Comment [BM2]: Members' Council make this appointment

Comment [BM3]: Could be a conflict of interest, therefore delegated to the Workforce and Remuneration Committee

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		~~11.~~12. Agree the Medicines Management Strategy (delegated to the Executive Management Team). ~~12.~~13. Approve the Trust's Organisational Development Strategy. ~~13.~~14. Agree the Trust's Procurement Strategy (delegated to the Audit Committee). ~~14.~~15. Approve the Trust's Quality Improvement Strategy. 16. Approve the Trust's Risk Management Strategy. 17. Approve the Trust's Workforce Strategy 18. Approve the Trust's Estates & Environment Strategy ~~15.~~19. Approve the Trust's Innovation & Change Strategy ~~16.~~20. Agree other Trust strategies (delegated to the Executive Management Team). ~~17.~~21. Approve an annual plan for each Committee of Trust Board. ~~18.~~22. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. ~~19.~~23. Approve arrangements for agreeing action on litigation against or on behalf of the Trust. ~~20.~~24. Approve outline and final Business Cases for capital investment above £500,000 or a series of projects for which the combined value would exceed £1 million. 25. Ratify proposals for acquisition, disposal and final sale ~~or change of use~~ of land and/or buildings ~~above £500,000 or a series of acquisitions or disposals for which the combined value would exceed £1 million.~~ ~~21.~~26. Ratify proposals for change of use of land and/or buildings where that land and/or building has a value above £500,000 ~~22.~~27. Approve PFI proposals. ~~23.~~28. Approve the opening of bank accounts (on recommendation of the Audit Committee)~~.~~ ~~24.~~29. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 3 year period or the period of the contract if longer. ~~25.~~30. Review use of NHSLA risk pooling schemes. ~~26.~~31. Approve individual compensation payments not covered by the NHS LA risk pooling scheme above £5,000 (delegated to the Audit Committee, unless in relation to employment which is delegated to the Remuneration and Terms of Service Committee).
	Trust Board	**Policy Determination** 1. Approve the process for approval, dissemination and implementation of policies and procedures. 2. Approve the arrangements for dealing with complaints. 3. Approve Human Resources policies relating to the arrangements for the appointment, removal and

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		remuneration of staff not covered by the ~~Terms~~ Workforce and Remuneration Committee. 4. Approve the Treasury Management Policy.(on recommendation of the Audit Committee) 5. Approve Procurement policies (delegated to the Audit Committee), including tendering and quotation procedures that form part of the Standing Financial Instructions. 6. Approve policies relating to people's detention under the Mental Health Act (delegated to the Mental Health Act Committee). 7. Approve policies relating to statutory compliance. 8. Approve the policy and procedures for dealing with serious untoward incidents. 9. Approve policies relating to the management of clinical risk and clinical safety (delegated to the Clinical Governance and Clinical Safety Committee). 10. Approve the Standards of Business Conduct in Public Service Policy.
	Trust Board	**Audit** 1. Receive the ISA260 (or equivalent) received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
	Trust Board	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and ~~Annual A~~accounts including the Quality Account. 2. Receive and approve the Annual Report and a~~A~~ccounts for charitable funds held on trust as the Corporate Trustee. ~~2.~~3. ~~Receive and approve the Trust's Annual Quality Accounts~~
	Trust Board	**Monitoring** 1. Receive such reports as Trust Board sees fit from committees in respect of their exercise of delegated powers, including an annual report of activities undertaken by the committee. 2. Continuous appraisal of the affairs of the Trust by means of the provision to Trust Board as Trust Board may require from Directors, committees, and officers of the Trust as set out in management policy statements. 3. Receive performance reports on performance against annual and five year plans (or equivalent) and key performance indicators as agreed by Trust Board. 4. Receive and approve key reports as required including reports to and from NHS Improvement,

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		reports on compliance with the NHS Improvement Single Oversight Framework (or equivalent), the terms of the Trust's Licence, and Care Quality Commission.

DECISIONS/DUTIES DELEGATED BY THE TRUST BOARD TO COMMITTEES

(Committee Terms of Reference: http://www.southwestyorkshire.nhs.uk/about-us/how-we-are-run/trust-board/trust-board-committees/)

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
Standing Order (SO) 5.8.1 Standing Financial Instructions (SFI) 4.1	Audit Committee	The terms of reference of the Audit Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.4	Workforce and Remuneration ~~and Terms of Service~~ Committee	The terms of reference of the Workforce and Remuneration ~~and Terms of Service~~ Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.2	Clinical Governance and Clinical Safety Committee	The terms of reference of the Clinical Governance and Clinical Safety Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.3	Mental Health Act Committee	The terms of reference of the Mental Health Act Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.6 SFI 21	Charitable Funds Committee	The terms of reference of the Charitable Funds Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.5	Nominations Committee	The terms of reference of the Nominations Committee describe the functions that have been delegated to the Committee by ~~Trust Board.~~the Members' Council Refer to the current Terms of Reference on the Trust's website.
TBC	West Yorkshire Mental Health Services	The terms of reference of the West Yorkshire Mental Health Services Collaborative Committees in Common describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
	Collaborative Committees in Common	

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER'S MEMORANDUM

(Accounting Officer's Memorandum: https://www.gov.uk/government/publications/nhs-foundation-trusts-accounting-officers-responsibilities)

REF	DELEGATED TO	ACCOUNTING OFFICER'S MEMORANDUM DUTIES DELEGATED
Accounting Officer's Memorandum (AOM) 1	Chief Executive (CE)	The National Health Service Act 2006 (the Act) designates the chief executive of an NHS foundation trust as the accounting officer.
AOM 7	CE	The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that: • there is a high standard of financial management in the NHS foundation trust as a whole • the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation • financial considerations are fully taken into account in decisions by the NHS foundation trust.
AOM 8	CE	The essence of the accounting officer's role is a personal responsibility for: • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts • prudent and economical administration in line with the principles set out in m~~M~~anaging public money. • the avoidance of waste and extravagance • the efficient and effective use of all the resources in their charge.
	CE	Refer to Accounting Officer's Memorandum for full details of the Accounting Officer's responsibilities.

DELEGATION OF DUTIES RELATING TO CORPORATE GOVERNANCE

(Code of Governance: https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance)

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
	Trust Board	Ensure the organisation is compliant with the Terms of Authorisation and is financially viable, legally constituted, well governed and that the organisation complies with the constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.
Code of Governance (COG) A.1.a & b main principals	Trust Board	Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust. The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.
COG A.3.a main principals	Chair	The chairperson is responsible for leadership of the board of directors and the Members' Ccouncil ~~of governors~~, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.
COG A.4.a main principals	Non-Executive Directors	As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non- executive directors should also promote the functioning of the board as a unitary board.
COG A.5.a, b, c main principals	Governors	The Members' Ccouncil ~~of governors~~ has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust. The council of governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
		Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.
COG		Refer to the Code of Governance for full details of the responsibilities.
	All directors	Constructively challenge the decisions of Trust Board, monitor the performance of the organisation and make decisions objectively in the interests of the Trust.
	Non-Executive Directors	Non-Executive Directors are appointed by the Members' Council to bring independent judgement to bear on issues of strategy and performance.
Standing Order (SO) 8.3	Trust Board	Approve the Standards of Business Conduct in Public Service Policy.
	Trust Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
SO 8	Chair and Directors	Declaration of conflict of interests.
	Trust Board	Trust Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM SOUTH WEST YORKSHIRE PARTNERSHIPS NHS FOUNDATION TRUST CONSTITUTION STANDING ORDERS

(Trust Constitution including Standing Orders: http://www.southwestyorkshire.nhs.uk/about-us/how-we-are-run/trust-board/constitution-self-certification/)

REF	DELEGATED TO	STANDING ORDERS AUTHORITIES/DUTIES DELEGATED
Standing Order (SO) 4.9	Chair	Final authority in interpretation of Standing Orders (SOs).
SO 3.10	Members' Council	Appointment of Deputy Chair.
SO 4.1.2	Chair	Call meetings.
SO 3.2	Chair	Chair all Board meetings and all meetings of the Members' Council.
SO 4.9	Chair	Give final ruling in questions of order, relevancy and regularity of meetings.
SO 4.11.2	Chair	Having a second or casting vote.
SO 4.13	Trust Board	Suspension of Standing Orders.
SO 4.13.4	Audit Committee	Audit Committee will review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).
SO 4.14	Trust Board	Variation or amendment of Standing Orders.
SO 5	Trust Board	Formal delegation of powers to sub committees or joint committees and approval of their terms of reference.
SO 6.2	Chair & Chief Executive (CE)	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
SO 6.4.2	CE	The Chief Executive shall prepare a Scheme of Delegation identifying decision making rights and

REF	DELEGATED TO	STANDING ORDERS AUTHORITIES/DUTIES DELEGATED
		accountability.
SO 6.6	All	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
SO 8.1	Trust Board	Declare relevant and material interests.
SO 8.2	CE	Maintain Register(s) of Interests.
SO 8.3	All staff	Comply with national guidance contained in circular HSG 1993/5 "Standards of Business Conduct for NHS Staff".
SO 8.3.3	All	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
SO 10	CE	Keep seal in safe place and maintain a register of sealing.
SO 10.4	CE / Executive Directors	Approve and sign all documents which will be necessary in legal proceedings unless any enactment other requires or authorises.

Comment [BM4]: Is this still the most up-to-date guidance?

SCHEME OF DELEGATION FROM SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST STANDING FINANCIAL INSTRUCTIONS

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
Standing Financial Instructions (SFI) 1	Director of Finance (DoF)	Advice on interpretation or application of SFIs.
SFI 1	All members of the Trust Board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
SFI 3.2	Chief Executive (CE)	Responsible as the Accounting Officer to ensure the effective and efficient use of resources and for the overall ~~for the~~ System of Internal Control, which must be reviewed annually.
SFI 3.2	CE & DoF	Accountable for financial control and for putting in place appropriate arrangements for delegation of financial management.
SFI 3.2	CE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
SFI 3.3	DoF	Responsible for: a) implementing the Trust's financial policies and coordinating corrective action; b) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) design and supervision of systems of internal financial control; d) ensuring that sufficient records are maintained to explain Trust's transactions and financial position; e) providing financial advice to members of Board and staff; f) preparation and maintenance of accounts, certificates etc as are required for the Trust to carry out its statutory duties; g) lead the development of the Trust's financial strategy
SFI 3.4	All members of the Trust	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
	Board and employees	resources and conforming to Standing Orders, Financial Instructions and financial procedures.
SFI 3.4	CE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
SFI 4.1	Audit Committee	Provide independent and objective view on internal control and probity.
SFI 4.1	Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
SFI 4.2	DoF	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. This will be after discussion with ~~NHS Protect~~the NHS Counter Fraud Authority where appropriate. In cases of fraud and corruption DoF must inform the relevant Local Counter Fraud Specialists (LCFS) and NHS Counter Fraud Authority~~and Security Management Service (CFSMS) Regional Team~~ in line with SOs directions.
SFI 4.2	DoF	Notify LCFS~~CFSMS~~ and External Audit of all frauds.
SFI 4.4	DoF	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
SFI 4.3	DoF	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
SFI 4.5	Internal Auditor	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
SFI 4.6	Audit Committee	Ensure the External Auditors' work presents value for money.
SFI 4.2	CE & DoF	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 5.1	CE	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
SFI 5.1	DoF	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
SFI 5.1	DoF	Ensure adequate training is delivered on an on going basis to budget holders.
SFI 5.2	CE	Delegate budget to budget holders.
SFI 5.2	CE & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
SFI 5.3	DoF	Devise and maintain systems of budgetary control.
SFI 5.3	CE or nominated officers	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without ~~prior~~ consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources
SFI 5.3	CE	Identify and implement cost improvements and income generation activities in line with the Annual Plan
SFI 6	DoF	Preparation of annual accounts and reports.
SFI 7	DoF	Managing the banking arrangements, which have been approved by Trust Board, including: a) bank accounts and Government Banking Service (GBS) accounts; b) establishing separate bank accounts for the Trust's non-exchequer funds; c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 8	DoF	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
SFI 8.2	All employees	Duty to inform DoF of money due from transactions which they initiate/deal with.
SFI 8.2	Trust Board	Approval of income generating activities attracting an income of £500,000 or above.
SFI 9	CE	Negotiating contracts for the provision of healthcare services in accordance with the business plan, and for establishing the arrangements for extra-contractual services.
SFI 10.1	Trust Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Workforce and Remuneration Committee.
SFI 10.4	Director of HR	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions
SFI 10.4	Director of HR	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
SFI 10.5	Director of HR	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation and deal with variations to, or termination of, contracts of employment.
SFI 11.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
SFI 11.1	Trust Board	Agreeing the Trust's the Procurement Strategy(delegated to Audit Committee).

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REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 11.2	Trust Board	Approve any procurement arrangement that commits the Trust to expenditure above £500,000 over three or less years.
	DoF	To manage procurement of goods and services in accordance with the strategy and policies approved by Trust Board.
SFI 11.2	DoF	Responsible for the prompt payment of accounts and claims.
SFI 11.2	Appropriate Executive Director	Make a written case to support the need for a prepayment.
SFI 11.2	DoF	Approve proposed prepayment arrangements.
SFI 11.2	DoF	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
SFI 12	DoF	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. b) Prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds. c) Be responsible for the prompt payment of all properly authorised accounts and claims. d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment. f) Instructions to employees regarding the handling and payment of accounts within the Finance Department. g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
SFI 12	CE	Tendering and contract procedure.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 12.5	DoF	Responsible for the receipt, endorsement and safe custody of tenders received.
SFI 12.5	DoF	Shall maintain a register to show each set of competitive tender invitations despatched.
SFI 12.5	CE and DoF	Where one tender is received will assess for value for money and fair price.
SFI 12.7	CE or DoF	Waive formal tendering procedures.
SFI 12.7	DoF	Report waivers of tendering procedures to the next formal meeting of the Audit Committee.
SFI 12.7	DoF	Where a supplier is chosen that is not on the approved list the reason ~~shall~~ should be recorded in writing to the CE.
SFI 12.11	Trust Board	Approval of partnerships for the delivery of services or for obtaining goods and services where there is no exchange of monies or where the terms and conditions are negotiated by another body, and the value of the goods or services exceeds £250,000, including setting the timescale for its review and renewal.
SFI 13.1	DoF	The DoF will advise the Board on the Trust's ability to pay interest and repay and will report, periodically, any external borrowing
SFI 13.1	DoF	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
SFI 14	Trust Board	Approve treasury management policy (as recommended by Audit Committee)
SFI 14	DoF	Prepare detailed procedural instructions on the operation of investments held.
SFI 15	DoF	Ensure that the Trust Board are aware of the prevailing instructions and guidance of the Independent Regulatory, and any statutory or regulatory requirements, regarding the financial management and financial duties of the Trust.
SFI 16.1	Trust Board	Approval of all decisions relating to capital investment above £500,000.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 16.1	CE	a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and c) shall ensure that the capital investment is not undertaken without full consideration of the impact on the Trust's cash and working capital position and Risk Rating.
SFI 16.1	DoF	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
SFI 16.1	CE	Issue procedures for management of contracts involving stage payments.
SFI 16.1	DoF	Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
SFI 16.1	CE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
SFI 16.1	DoF	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
SFI 16.2	CE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
SFI 16.2	Trust Board	The Trust Board will approve all PFI proposals or proposals to enter into a contract that commits the Foundation trust to long term (15 years or more) arrangements for capital assets with a lifetime value in excess of £500,000.
SFI 16.2	Trust Board	Any individual capital development that forms part of an arrangement under PFI or a partnership described above.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
	CE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
	CE	Must ensure the Trust enters into suitable contracts with commissioners for the provision of NHS services
	CE	Ensure that regular reports are provided to the Board detailing actual and forecast income from contracts
SFI 16.2	DoF	Demonstrate that the use of private finance is fully assessed against alternative routes and follows with prevailing guidance.
SFI 16.3	CE	Overall responsibility for fixed assets and maintenance of asset registers (on advice from DoF).
SFI 16.3	DoF	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
SFI 17.1	CE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
SFI 18.1	DoF	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
SFI 18.1	Trust Board	Approval of disposal of assets with a Net Book Value in excess of £50,000.
SFI 18.2	DoF	Prepare procedures for recording and accounting for losses, special payments and informing counter fraud and police in cases of suspected arson or theft.
SFI 18.2	DoF	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
SFI 18.2	DoF	Consider whether any insurance claim can be made.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 18.2	DoF	Maintain losses and special payments register.
SFI 18.2	Audit Committee	Approve write off of losses (within limits delegated by the Department of Health).
SFI 19	DoF	Responsible for accuracy and security of computerised financial data.
SFI 19	DoF	Satisfy himself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
SFI 19	DoF	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
SFI 19	DoF	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
SFI 20	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
SFI 20	DoF	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
SFI 21	DoF	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 22	CE	Retention of document procedures in accordance with the Trust Non-Clinical Records Management Policy
SFI 23	CE	Implementation of the Risk management strategy
SFI 23	Trust Board	Approve and monitor risk management strategy
SFI 23	Trust Board	Decide whether the Trust will use the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
SFI 23	DoF	Where the Board decides to use the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by ~~the~~ NHS ~~Litigation Authority~~ Resolutionfor any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
SFI 23	DoF	Ensure documented procedures cover management of claims and payments below the deductible amount.

Financial approvals hierarchy

The following limits are applied for both requisitioning and approving of invoices. .A system of conscious delegation will operate for each cost centre with approvals agreed by the appropriate Deputy Director and Deputy Director of Finance

DELEGATED TO	LIMIT
2 Directors (normally the relevant Director and Director of Finance)	Greater than £75,000
Director	£75,000
Deputy Director	£540,000
~~Service Line Manager (Band 7 and above as approved Directors annually)~~Typically General Manager	£510,000
Budget holder (as approved by Directors annually)	£500~~,000~~
Senior Requestioner	£1~~5~~00

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019
Agenda item

Title:	**Going Concern Basis**
Paper prepared by:	Director of Finance and Resources
Purpose:	To enable the Board to make a decision that the 2018/19 accounts and financial statements are prepared on a going concern basis.
Mission/values:	Use of resources
Any background papers/ previously considered by:	Regular Finance report provided at each Board meeting.
Executive summary:	➢ There is a requirement for the directors of an organisation to confirm whether or not it is appropriate for the accounts of an organisation to be prepared on a "going concern" basis. ➢ The auditors of the Trust will require evidence with respect to how that conclusion has been derived. ➢ Principles to be followed are outlined in the paper. ➢ Good financial track record. ➢ Financial plan is targeting a deficit of £0.2m in 2019/20. £10.7m CIPs and other improvements identified to date with a further £1.3m required. £2.5m additional risk identified at this stage. ➢ Healthy cash (£27.8m) and net current assets position (£16.7m) at the 2018/19 year-end. ➢ Risks and potential mitigations regularly assessed and discussed at Board.
Recommendation:	**Trust Board is asked to APPROVE the preparation of the 2018/19 annual accounts and financial statements on a going concern basis.**
Private session:	Commercial in confidence.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Going Concern Basis

Introduction

There is a requirement for the directors of an organisation to confirm whether or not it is appropriate for the accounts of an organisation to be prepared on a "going concern" basis. The auditors of the Trust will require evidence with respect to how that conclusion has been derived. The principles directors need to follow are outlined below:

- Directors should make and document a rigorous assessment of whether the company is a going concern when preparing annual and half-yearly financial statements. The process carried out by the directors should be proportionate in nature and depth depending upon the size, level of financial risk and complexity of the company and its operations;
- Directors should consider all available information about the future when concluding whether the company is a going concern at the date they approve the financial statements. Their review should usually cover a period of at least twelve months from the date of approval of annual and half-yearly financial statements;
- Directors should make balanced, proportionate and clear disclosures about going concern for the financial statements to give a true and fair view.
- Directors should disclose if the period that they have reviewed is less than twelve months from the date of approval of annual and half-yearly financial statements and explain their justification for limiting their review.

It should be noted that financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without transfer of services to another entity, or has no realistic alternative but to do so. The anticipated continuation of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.

Context

The draft financial plan submission for 2019/20 was made to NHS Improvement in February 2019, with the final submission completed on 4 April 2019. This shows the Trust is planning to incur a deficit of £0.2m, whilst retaining a positive cash position. It is worth noting that within the draft submission the Trust did not accept its control total of £0.2m deficit and submitted a £3.7m deficit plan. In the final submission the control total was accepted which enables access to provide sustainability funding (PSF) of £1.8m.

A number of considerations and assumptions were made when developing the plan. These are summarised as follows:

- Income assumptions are based on agreed contracts, and other expected and agreed changes.
- Pay and non-pay inflation assumptions have been made based on national guidance

- Cost Improvement Project (CIP) shortfall and non-recurrent CIPs from 2018/19 have been factored into the financial plans.
- CIP schemes and other improvements of £10.7m have been identified for 2019/20, with a further £1.3m to be found/finalised.
- In addition to the unidentified CIPs risks to achieving the plan of £2.5m have been identified.
- Potential mitigations of less than £1m have been identified to date
- In addition to the above the following can be noted:
- The Trust has a positive cash position (£27.8m at the 18/19 year-end) which is projected to reduce to £19m by March 2020. Given additional PSF and improved outturn for 2018/19 this position could improve.
- The Trust has over-achieved against its financial targets for 2018/19, albeit with significant non-recurrent support, and has a track record of good financial performance. This will result in additional PSF of at least £0.5m being provided as cash to the Trust.
- Each division and corporate service has agreed its budget for the new financial year
- The Trust currently has a net current assets position of £16.7m.
- A draft financial sustainability plan has been presented to the Trust Board in December 2018 with an updated plan on the Board agenda for April 2019.

Recommendation

Given the above it is considered appropriate the Trust continues to report on a going concern basis

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 April 2019

Agenda item 11 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	9 April 2019
Member	Chief Executive / Director of Strategy
Items discussed	➢ Draft Terms of Reference. ➢ Integrated Care Outcome Framework. ➢ Alcohol Plan. ➢ Director of Public Health Annual Report. ➢ Barnsley Safeguarding Children Partnership Arrangements: Working Together 2018 Implementation. ➢ Joint Strategic Needs Assessment update.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	21 February 2019
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	➢ NHS Long Term Plan ➢ Calderdale Cares update ➢ Domestic Abuse pledge ➢ Hospital and Community Services reconfiguration - West Yorkshire Joint Health Overview and Scrutiny Committee Briefing
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=25859

Kirklees Health and Wellbeing Board

Date	28 March 2019
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	➢ Supplementary statement to the Pharmaceutical Needs Assessment. ➢ Kirklees Economic Strategy. ➢ Primary Care Network Development. ➢ Kirklees Health and Wellbeing Plan and local partnership planning arrangements. ➢ Proposed revisions to the Terms of Reference.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListDocuments.aspx?CId=15

	9&Mld=5635

Wakefield Health and Wellbeing Board

Date	21 March 2019
Member	Chief Executive / Director of Provider Development
Items discussed	➢ Maternity. ➢ Workforce Wellbeing Evaluation. ➢ Mid Yorkshire Hospitals Trust Update. ➢ West Yorkshire & Harrogate Health and Care Partnership Update. ➢ Health and Care Planning.
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	Next meeting scheduled for 10 May 2019
Member	Chief Executive
Items discussed	➢ To be confirmed.
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group

Date	24 April 2019
Member	Chief Executive
Items discussed	➢ To be confirmed
Further information:	Further information about the work of the System Oversight and Assurance Group is available at: https://www.wyhpartnership.co.uk/blog

Date	19 March 2019
Member	Chief Executive
Items discussed	➢ Programme updates • Mental Health • Primary and Community Care • Prevention at Scale • Workforce • Harnessing the Power of Communities ➢ Review of System Performance and Delivery ➢ Wider system risks and issues • Elective care waiting times deep dive revisited • Update on EU Exit Preparations
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	2 April 2019
Member	Chief Executive
Items discussed	➢ Operational Planning for 2019/20 Update and Next Steps ➢ Primary Care Transformation Update
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 30 April 2019

Agenda item 12 – Assurance from Trust Board committees

Audit Committee

Date	9 April 2019
Presented by	Laurence Campbell, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ Risk committee effectiveness: Inconsistent approach to voting membership; workload levels; role in key programmes for 2019/20; do we need a Finance Committee? ➢ Internal Audit plan approved for 2019/20; ➢ Information Governance deep dive; ➢ Patient Level Costing in 2019/20 and impact on Trust priorities; ➢ Head of Internal Audit opinion: Significant Assurance subject to finalising outstanding reviews.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 8 January 2019 (attached).

Clinical Governance & Clinical Safety Committee

Date	2 April 2019
Presented by	Charlotte Dyson, Deputy Chair / Senior Independent Director (Chair of Committee)
Key items to raise at Trust Board	➢ Care Quality Commission (CQC) action plan. ➢ CQC letter. ➢ Wetherby YOI report. ➢ Whistleblowing Freedom to Speak up Guardians. ➢ Bullying & Harassment – workforce remuneration
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meeting held on 12 February 2019 (attached).

Nominations Committee

Date	9 April 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Nominations' committee annual report and revised terms of reference. ➢ Review of skills and expertise required on the Board. ➢ Lead Governor appointment process. ➢ Committee work plan for 2019/20.
Approved Minutes of previous meeting/s for receiving	➢ Approved Minutes of the Committee meetings held on 16 July 2018 and 28 September 2018 (attached).

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Audit Committee held on 8 January 2019

Present:	Laurence Campbell	Non-Executive Director (Chair of the Committee)
	Sam Young	Non-Executive Director
	Erfana Mahmood	Non-Executive Director
	Members	
Apologies:	Rachel Court	Non-Executive Director
	Other	
	Leanne Hawkes	Deputy Director, 360 Assurance
In attendance:	Rob Adamson	Deputy Director of Finance
	Tim Breedon	Director of Nursing and Quality [item 16]
	Mark Brooks	Director of Finance (lead Director)
	Tony Cooper	Head of Procurement
	Caroline Jamieson	Assistant Director, Deloitte
	Emma Jones	Company Secretary
	Olivia Townend	Assistant Anti-Crime Manager, Audit Yorkshire
	Julie Williams	Interim Senior IM&T Manager (item 16)
	Jane Wilson	PA to the Director of Finance (author)

AC/19/01 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. The apologies, as above, were noted.

AC/19/02 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/19/03 Minutes from the meeting held on 16 October 2018 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meetings held on 16 October 2018 as a true and accurate record. Jane Wilson (JW) noted that going forward Sam Young's initials will be recorded in the minutes as SYo.

AC/19/04 Matters arising from the meeting held on 16 October 2018 (agenda item 4)

AC/18/56a Action log (agenda item 4.1)

The action log was noted. The following actions were discussed:

AC18/98 External audit update

Tim Breedon (TB) confirmed the quality account report preparation process and metrics would be taken to Members Council on 1 February 2019 for consideration. TB to ensure Karen Batty (KB) is aware of the updates required in the Quality Report for 2018/19 as per the external audit update report. Caroline Jamieson (CJa) to forward latest Q2 benchmarking report to Mark Brooks (MB) for onward circulation.

ACTION: Tim Breedon/Caroline Jamieson

AC/18/86 Approval of Charitable Funds annual reports and accounts
Rob Adamson (RA) confirmed these would be finalised before the end of January 2019.

ACTION: Rob Adamson

AC/18/61 Declaration of interests for staff – risk assessment
The Committee agreed that this item should be incorporated into the annual work plan and removed from outstanding actions.

ACTION: Jane Wilson

AC/17/63a Internal audit progress report
The Committee agreed that this item should be incorporated into the annual work plan and removed from outstanding actions.

ACTION: Jane Wilson

AC/19/05 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 of any changes/updates since the Audit Committee meeting on 16 October 2018. Emma Jones (EJ) stated that the version used for these papers is the report presented to the Trust Board on 30 October 2018.

There was one potential risk that has been assessed as relevant to the work of the Audit Committee and was currently exceeding the risk appetite of the Trust.

- LC - Cyber risk. MB suggested this be added to the work plan and updated twice yearly. The first update would take place at the April 2019 meeting. LC asked that the report included focus on the points raised in the Board cyber training sessions which preceded the Audit Committee meeting.

- LC (adequate staffing – wards). Is there an additional risk in relation to staffing in community teams. It was suggested this potential quality risk be discussed at both EMT and the Clinical Governance and Clinical Safety Committee meeting.

ACTION: Tim Breedon

- LC raised the question of whether risk targets were always same as risk appetite. MB stated it was expected that the two should be similar.

- Risk 1216 LC, noted there were no action updates or additional updates since October. MB stated that as this was the version used in the October Board any updates would be presented in the version being taken to the January Board.

- Risk 852 MB confirmed there continues to be a number of confidentiality breaches on a monthly report, which are reported into the Trust Board as part of the Integrated Performance Report. A discussion on this issue ensued and the following summary points and questions were noted and raised.

- The organisation does looks at means of escalation to raise awareness. This has included anonymising real incidents and these being communicated to Extended EMT for further dissemination by the Chief Executive.
- Erfana Mahmood (EM) asked if the Audit Committee should have increased visibility of the numbers and types of incidents. LC suggested management be asked to provide a deep-dive report for the next meeting including actions being taken to reduce the number of recorded incidents and whether a zero tolerance approach should be taken. MB felt any move to a zero tolerance approach would need discussion and consideration by the full Trust Board.
- EM asked about the types of incidents recorded. MB explained there was no single theme. Typically recent incidents have included people being overheard, issue with incorrect addresses, and email addresses.
- Sam Young (SYo) raised the question of whether the likelihood of an incident is probable rather than possible. MB explained this is regularly discussed at EMT and the view is that there are only a small number of data breaches from the many communications that regularly take place so a breach is not a likely scenario.
- LC explained the request for a deep-dive and focused review would be reported back to the Trust Board.

ACTION: Mark Brooks

- Risk 1212 – it was suggested this risk be transferred to the Workforce Remuneration Committee (WRC).

- SYo questioned whether risk 1076 had enough in initial mitigation. MB stated there was no immediate problem, confirming this year's cash balance was circa £20m. MB explained the risk is more likely to be a 2 year risk with declining cash balances and the Trust now in a deficit position. He felt it is an important corporate risk that needs on-going management and visibility.

ACTION: Mark Brooks/Emma Jones/Jane Wilson

It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee.

AC/19/06 Triangulation of risk, performance and governance (agenda item 6)

EJ confirmed the report used the version of the ORR submitted to the Business and Risk meeting of Trust Board on 30 October 2018. The report also considered the six monthly strategic overview of business and associated risks reported to Trust Board in October 2018. LC stated he felt this is a very useful report. EJ highlighted there were three areas for consideration from the review which would be highlighted at EMT. These relate to medicine omissions, complaints and percentage of service users in employment. MB explained that the national metric in relation to service users in employment does not cover all services users, only those on CPA. LC asked if there were any gaps in control in the Board Assurance Framework identified through this review. EJ stated there were not.

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.

ACTION: Emma Jones

AC/19/07 Agreement of draft final accounts timetable and plans (agenda item 7)

RA confirmed this was a standard timetable; no changes from previous years and timescales remain the same. CJa/ MB confirmed that delegation would be required from the Board to allow sign off of accounts at Audit Committee and prior to formal Board approval.

ACTION: Mark Brooks

It was RESOLVED to NOTE the update

AC/19/08 Annual Audit Committee report for Trust Board, including self-assessment of committees effectiveness (agenda item 8)

EJ explained this was an annual exercise and she would be taking this process forward for all committees. EJ to make the arrangements for the self-assessment of Audit Committee effectiveness. The Audit Committee will receive all reports and review prior to going to Trust Board. LC suggested adding a couple of extra questions which could go to all Committees.

ACTION: Emma Jones

It was RESOLVED to NOTE the update

AC/19/09 Review of accounting policies (agenda item 9)

RA confirmed this version was an update of previous policy updates as discussed and approved through audit committee. RA stated that External Audit had reviewed an early draft and that their comments had been incorporated into the document. RA confirmed any further changes in national guidance would be reflected in future versions.

ACTION: Rob Adamson

It was RESOLVED to NOTE the update

AC/19/10 Counter fraud policy update (agenda item 10)

Olivia Townend (OT) stated that the policy had been updated and approved last year and that no further changes were currently required.

It was RESOLVED to NOTE the report

AC/19/11 Declaration of Interests for staff (agenda item 11)

EJ provided an update of the processes in place in relation to staff declarations of interest as assurance that the Trust is meeting the requirements of NHS England guidance and that there are no identified current staff conflicts that present a risk to the Trust. EJ confirmed targeted emails had been sent to staff in a position to influence decisions including senior managers, budget holders and procurement staff. EJ confirmed over 300 declarations have been received and recorded on an electronic register in 2018.

MB explained that the Trust does need to put further details of declarations of interest on its website and needs to agree which staff this will cover. It is likely this will focus on the more senior staff in the organisation. Currently publicised details primarily relate to directors. He noted that the Trust Chair did receive a letter from an MP checking our compliance with the requirements, which we were able to respond to.

EJ stated she has reviewed what other trusts are publishing and to date there is limited information on trust websites. SYo said she felt the approach the Trust is taking is positive and moving in the right direction.

It was RESOLVED to NOTE the processes in place in relation to declarations of interest.

AC/19/12 Reference costs (agenda item 12)

RA provided an update on the reference costs reported in respect of the results of the national reference cost exercise for 2017/18 activity and costs. He explained that reference costs did increase for the Trust as a whole which was not surprising given the reduction in income in the year. LC stated there was a real difference between MH Community and MH other. MB confirmed he would provide a list of what is behind each heading and circulate to the Committee. He also noted that not all services were included in the reference cost exercise, including out of area beds. Erfana Mahmood (EM) queried whether their inclusion would have made our reference cost index worse. MB responded by saying it would be dependent on how it performed compared to other Trusts.

ACTION: Mark Brook/Rob Adamson

It was RESOLVED to NOTE the update

AC/19/13 GDPR update (agenda item 13)

MB presented the GDPR update confirming there would be an internal audit in 2019/20 to support assurance that we are compliant with the requirements of GDPR. There are areas where additional guidance may be provided nationally, which would be incorporated in Trust policies and procedures as appropriate.

ACTION: Mark Brooks

It was RESOLVED to NOTE the update.

AC/19/14 Accounting standards (agenda item 14)

RA confirmed that any changes would be brought to future committees.

ACTION: Rob Adamson

It was RESOLVED to NOTE the update

AC/19/15 Procurement report (agenda item 15)

Tony Cooper (TC) presented the procurement update. Three major contracts were let with a value of £188k including the external support to review and improve bed management/out of area bed processes, anti-ligature windows and e-cigarette vending machines. Eight major contracts are currently in progress including the provision of taxi services, a clinical record system for improving access to Psychological Therapies (IAPT) and various estates improvement works. £81k CIP (Cost Improvement Plan) savings have been identified to date in 18/19 with a further £85k cost avoidance. It was confirmed 81 Service Line Agreements (SLAs) have currently been signed, with 11 in negotiation, and 10 at the sign off stage.

TC informed the meeting that the Trust's multifunctional devices (photocopier) contract has been extended for twelve months and will now expire on 31 December 2019. The decision to extend was made due to IM&T's involvement in the SystmOne Clinical Information System

implementation. The procurement department has secured a £60k reduction in copier lease costs over the 2019 calendar year period. TC updated the meeting on the work that has been taken both nationally and locally in terms of procurement in readiness for Brexit. NHS Supply Chain have been tasked with ensuring continued supply of their catalogue lines, with other product areas being centrally managed by the Department of Health and Social Security (DHSC). This includes; licensed medicines and vaccines, medical devices and consumables, food, nutritional feeds and laundry services. All Trusts were requested to carry out an internal self-assessment of key suppliers/contracts and submit a return to the DHSC by 30 November 2018 for national collation and further action. The return identified thirteen Trust suppliers who were not on the centrally managed lists and all thirteen suppliers were asked by the Trust to complete and return a Brexit questionnaire. The Trust has received six responses from the thirteen suppliers identified through the self-assessment exercise and whilst the majority of suppliers listed were deemed as a low risk to the Trust all responses have been returned with a positive reply to any subsequent Brexit outcome. LC raised the question as to whether any supplier was causing concern TC said not as it currently stands as together with the national work the Trust has an internal Brexit group which includes representatives from pharmacy, catering and hotel services, estates and facilities, and procurement who will continue to meet up to and post Brexit to address any issues.

LC asked if the cost avoidance and CIP targets would be met, TC said that the cost avoidance target would be met but the CIP target may fall short of the figure. The reasons for the shortfall are timing issues where CIPs will cross into the next financial year given slow take up of awarded contracts. LC asked if the medical locums/Brookson contract was an issue as the uptake on the Direct Engagement (DE) model was only 67%, TC said that he had a meeting with the Medical Director and Brooksons on Friday 11 January to discuss their contract and one with the Medical Director, clinical leads and ID Medical on Friday 18 January to formally launch their contract which will hopefully drive the DE percentage to 80%. MB mentioned that there was a perception that Brookson were not providing a good service but pointed out that some of the issues previously identified were caused by our own internal processes. These issues are going to be discussed in the meeting on the 12 January. TC mentioned that he also has to complete a 2019-20 CIP target return for NHS Improvement (NHSI) by 31 January 2019, RA stated that this is in line with a similar financial return and would be used by NHSI to determine if there would be any national tender opportunities.

LC stated that there had been good progress on the SLAs, he also mentioned that the number of SLAs had significantly increased from the original sum. MB said that this was due to the Trusts partnership working going well but may have cost the Trust more money. LC said that the additional money would probably be offset through a reduction in financial challenges/disputes by our SLA partners.

ACTION: Tony Cooper

It was RESOLVED to NOTE the update

AC/19/16 SystmOne implementation risks and milestones (agenda item 16)

Tim Breedon (TB) presented the update in Salma Yasmeen's (SYa) absence. TB confirmed Ed Reid (ER) Programme Director, CRS was leaving the Trust at the end of January and that Julie Williams (JW) Interim Senior IM&T Manager would be taking over as programme lead. JW confirmed that following the testing phase as of today data migration was green. JW stated they were not anticipating any changes and confirmed that SystmOne would be developing a mental health care plan to be live within 6 months of go live, confirmation of this is part of the Go Live Authority to Proceed (ATP) criteria.

JW stated that training was still a concern, and currently only 50% of staff had been trained, the target is 85%, an option appraisal is being undertaken to be presented to EMT 18 Janauary

2019. There are still some key "business" decisions to be made for example changes to risk assessment process and documentation and these are the subject of a meeting being chaired by Mike Doyle (MD) on the 14 January 2019. Following this the system build will be finalised for Go Live and all the associated Change Management and support guides produced. JW stressed the importance of keeping staff engaged throughout the next seven weeks and TB confirmed the biggest issue was managing expectations and giving a positive message about the benefits of the system. LC asked if end-users are happy with the configuration. TB stated that practice governance coaches are a key link and that they are fully on board. He also highlighted that much of the system, circa 90%, will appear very similar to RiO. LC asked if we could take learning from other Trusts. JW confirmed they have worked closely with Central & North West London who are going live on 28 January, and that there had been shared learning on both sides. LC stated that good progress had been made. JW confirmed an updated report would go to EMT on 23 January, and then Trust Board on 29 January proposing go live decision based on the project status at that point and requesting delegated authority for executive directors to make the final go/no go decisions on the 24 February (inpatient) and the 4 of March (community). MB suggested a minimum of 3-4 directors on the call, JW agreed and stated that at least one of which needed to be Clinical.

LC asked if the remaining Go Live critical issues had been addressed, JW stated that they had been fully resolved or mitigated with clinically agreed "work-arounds" for Go Live, and confirmed that SystmOne would be developing a mental health care plan to be live within 6 months of go live, and development of the MHSDS report within the same time period. Confirmation of these is part of the Go Live Authority to Proceed (ATP) criteria for the final Go/No Go call.

ACTION: Julie Williams

AC/19/17 Treasury management update (agenda item 17)

RA confirmed that all funds remain within the Governance Banking Service (GBS) unless invested with the National Loan Fund. 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 £91k (April to November 2018). The total received for 2017/18 was £65k.

LC stated good progress had been made on cash management.

It was RESOLVED to RECEIVE the update.

AC/19/18 Internal audit progress report (agenda item 18)

MB presented the progress report in Leanne Hawkes (LH) absence.

Complaints report – which provided limited assurance
LC commented that this was a very detailed report but it highlighted issues with the Datix system. His sense is that we don't currently have a system that does the job required.

LC reported that the Committee and wider Board did not seem sighted on all KPIs associated with complaints and stated this was crucial, he raised the question of where these should be made visible. SYo concurred with this.

LC - asked if we had benchmarked ourselves with other trusts and identified areas we could learn from to improve.

SYo asked if the internal target we have set is genuinely achievable?

MB highlighted that this report has not yet been discussed at EMT and before any management response is made to Audit Committee regarding the points raised it is important that part of the process is completed. He would provide the comments made by Audit Committee members to TB such that they are fully considered.

In relation to SytmOne MB informed the Committee that 2 internal audits have always been part of our plan before go live and suggested the second audit started week commencing 14 January and completed within two weeks. LC requested that the conclusions from this audit are provided to Audit Committee members. MB stated that if complete this would be taken to Trust Board on 29 January 2019. Alternatively it would be circulated electronically or provided to the next EMT the NEDs are present at.

ACTION: Tim Breedon

With regard to the rest of the report

- LC noted a possible typo re BDUs
- Page 4 - MB explained that following discussion with TB in respect of patient safety alerts these are reported on by exception in the narrative within the IPR. LC asked for clarification of what constitutes an exception.

ACTION: Tim Breedon

- Page 10 - LC asked how the audit on CIPs/transformation was progressing. RA stated he was attending an opening meeting next week.
- Page 25 - KPI - MB stated that typically things were on track with target dates largely met. Where they have not been met were isolated incidents and typically with a valid reason. MB also updated on the recommendation tracker and explained that all actions which had previously noted a change in completion date have been taken through EMT for approval. Most have now completed. He also noted that 360 are considering how the cell in the report can be locked such that users cannot change completion dates without going through some form of approval process
- Page 27 - additional pay spend - LC stated no completion date. MB to check.
- Page 31 - LC asked about the technical solution. MB explained there was no obvious internal technical solution - It is something being considered as part of IT priorities, but currently there are greater priorities. He suggested the action be closed and monitored via the IM&T work plan
- P26 - SYo noted 2 outstanding actions and wasn't clear on the reasons why. MB to check

ACTION: Mark Brooks

AC/19/19 Counter fraud progress report (agenda item 19)

Olivia Townend (OT) Audit Yorkshire presented an update on progress against the work plan, summarising key findings from work undertaken for the last reporting period. OT advised in relation to the passport investigation (page 2) the report stated the employee had been interviewed. OT stated this was incorrect and confirmed the employee would be interviewed within the next 2 weeks. She also explained that following her return to work following a period of sick leave additional resource is being allocated to the Trust to enable increased focus on the work plan.

It was RESOLVED to NOTE the report

AC/19/20 External audit update (agenda item 20)

Caroline Jamieson (CJa) presented the external audit update and confirmed a benchmarking report would be forwarded to MB.

ACTION: Caroline Jamieson

It was RESOLVED to NOTE the update

AC/19/21 Losses and special payments (agenda item 21)

RA reported that the Trust has made payments of £8,329 since the last report to Audit. The majority of this (£7,501) relates to the write off for aged debts. These are formally approved by EMT. EM questioned whether the Audit Committee need to see this level of detail. MB explained that it is part of the Trusts' standard financial instructions and scheme of delegation which are both based on national expectations.

It was RESOLVED to NOTE the update

AC19/22 Any other business (agenda item 22)

No other business was raised.

AC/19/23 Consideration of any changes to the organisational risk register relevant to the remit of the Audit Committee (agenda item 23)

No changes to the organisational risk register were requested other than those discussed under agenda item 5.

AC/19/24 Items to report to Trust Board (agenda item 24)

The following items were agreed as:

- Data breaches - The committee asked management for a deep dive on IG breaches and to look at new ways to improve our performance in avoiding the often serious consequences of these breaches;
- Cyber Risk - We need to review our cyber risks and mitigations in the light of the matters raised in the training session of 8 January;
- Triangulation Report - There were 3 new areas in the IPR and not the ORR for consideration by EMT;
- Committee Self Assessment - 2 new questions added focusing on effective coverage of TORs and effectiveness of division of duties between committees;
- Clinical Risk - Is there a quality risk in relation to Community Service staffing levels
- Compliants Internal Audit, Limited Assurance - Issues around Datix fit-for-purpose question, KPI coverage and possible solutions at other Trusts;
- CIS (SystmOne) - Internal Audit phase 2 report required before go-live.

AC/19/25 Work programme (agenda item 25)

The Committee requested the following two items be added to the work programme:

- Declaration of interest for staff – risk assessment
- Internal audit progress report

ACTION: Jane Wilson

It was RESOLVED to NOTE the work programme.

AC/19/26 Date of next meeting (agenda item 26)

The next meeting of the Committee will be held on Tuesday 9 April 2019 at 14.00 in Meeting Room 1, Fieldhead, Wakefield.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 12 February 2019
Meeting room 1, Block 7, Fieldhead, Wakefield

Present:	Angela Monaghan (AM)	Chair of the Trust
	Charlotte Dyson (CD)	Deputy Chair (Chair of the Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
Apologies:	Committee	
	Dr Subha Thiyagesh (SThi)	Medical Director
	Kate Quail (KQ)	Non- Executive Director
	Others	
In attendance:	Mike Doyle (MD)	Deputy Director of Nursing & Quality
	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Dave Ramsay (DR)	Deputy Director of Operations (Item 16.1)
	Carol Harris (CH)	Director of Operations
	Sue Barton (SB)	Change Governance Manager (for item 7)
	Kate Dewhirst (KD)	Chief Pharmacist (for item 24.1)
	Sue Threadgold (ST)	Deputy Director of Forensic Services (for item 16.2)
	Tim Mellard (TM)	Practice Governance Coach for Wakefield Acute Care Pathway (for item 28)
	James Waplington (JW)	General Manager for Wakefield OPS (Item 28)
	Catherine Beynon-Pindar (CBP)	CQC (in attendance)
	Ranjit Das	Insight Programme Participant

CG/19/01 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting. The apologies, as above, were noted and that Catherine Beynon-Pindar from the Care Quality Commission (CQC) was in attendance along with Ranjit Das, Insight Programme Participant. It was noted that there were several people attending to cover items on the agenda, as noted above. Timings have been added to the agenda in line with internal audit recommendations.

CG/19/02 Declaration of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2018 or subsequently.

CG/19/03 Minutes of previous meeting held on 20 November 2018 (agenda item 3)

The minute regarding CG/18/137 CAMHS and NHS benchmarking should also include an action to add benchmark information and caseload details for each district in future reports

Action: Dave Ramsay

It was RESOLVED to APPROVE the minutes of the meeting held on 20 November 2018

CG/19/04 Matters Arising (agenda item 4)

Actions from the meeting held on 20 November 2018 were noted and the action log was updated as appropriate.

- CG/18/118 Transformation Programme Review update. Committee asked that this was turned white until after the meeting had taken place.

CG/19/05 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 5)

CD noted that she would like to concentrate on the new draft risk regarding:-

- Inpatient Safety
- Ligature
- Learning from Deaths
- Complaints
- Suicide Prevention

Tim Breedon (TB) advised that EMT had considered the above items for inclusion on the Organisational Risk Register (ORR) and had decided to include all items under a risk of serious harm occurring from known patient safety risks. The learning from deaths risk was previously considered at the Clinical Reference Group in December. The Inpatient Safety/ Ligatures risk has previously been considered at local BDU level and it was agreed that the registers would be reviewed collectively to assess the need for escalation to the ORR.

Angela Monaghan (AM) and CD questioned why these 5 were chosen. TB advised that they related to the key areas of concern and are featured in the patient safety strategy as areas for ongoing improvement..
The committee noted the challenge describing a high level risk to cover all the identified items and acknowledged that this may require further refinement. The committee supported the inclusion of this risk on the ORR

The discussion then returned to review the current risk register entries and AM noted that a few items had gone past their completion dates:-

RISK ID 275 Organisational Change Policy – Sept 2018
Alan Davis (AD) noted that this has now been signed off after an extension was given by EMT.

RISK ID 1078 - Waiting Lists – This is to be discussed later in the agenda.

RISK ID 1362 - Falsifying Medicines – This is due for completion at the end of the month. The Committee questioned if we were on track and TB informed that no risk had been identified or highlighted.

RISK ID 1370 Waste Management Contract – There had been issues around the contract and the Committee asked for an update. AD reported that this could now be removed from the risk register as this was now resolved.

Action: Aimee Gray

RISK ID 1319 Out of Area - Pathway supporting people with personality disorder. This has been delayed in relation to SSG and Carol Harris would look at this and update.

Action: Carol Harris

The Committee agreed that completion dates need close monitoring.

It was RESOLVED to NOTE the changes in the current Trust-wide Corporate risk register and confirm that the current risk levels are appropriate, subject to the comments above.

CG/19/06 Quality Accounts, Including Quality Priorities (agenda item 6)

TB advised as follows;
Quality priorities have been developed for action in 2018-19 which align to the Quality Strategy priorities

- The Quality Account project plan is on track to meet requirements..
- A timetable of activity has been planned for the production and authorisation of the quality account.
- There are no changes to the 'Detailed requirements for quality reports 2018/19' (NHSI)
- The mandatory data items for 2018/19 are:
  - ✓ Early intervention in psychosis (EIP) – people experiencing a first episode of psychosis treated with a NICE – approved care package within two weeks of referral.
  - ✓ Inappropriate out-of-area placements for adult mental health services.
- Members council quality group has proposed a local indicator which is waiting times in physical health monitoring in mental health service users (as defined in CQUIN guidance).
- Data testing of local and mandated items has been arranged for February & April 2019 with Deliotte.

It was RESOLVED to NOTE the progress on the production of the Quality Account.

CG/19/07 Transformation & Priority Programmes Update (agenda item 7)

Sue Barton (SB) updated the Committee regarding Transformation & Priority Programmes Update (TPP).

Community Mental Health Transformation Review update. The plan is now complete and the full report will be completed by end of February 2019. The Committee asked that the full report be brought back to the April Committee meeting.

Action: Sue Barton

It was noted by the Committee that Older Peoples Mental Health model remains an issue. SB reported that conversations are taking place with Commissioners. It is proposed that the Community model is to be implemented in 19/20 but not the Inpatient as Commissioners have not signed up to the inpatient model. This proposal will be taken to EMT for agreement.

QIA's have been done for both Inpatient and Community.

A post project review on Perinatal Mental Health to be included in the routine update for the next meeting in April

Action: Sue Barton

TB updated the Committee on the progress of the Clinical Records System (CRS). The CRS has been considered in detail at Trust Board together with the associated clinical risks and impact of the programme on delivery

The key area for the Committee was in regard to training of staff. Focus has been on this and specific targets are frontline staff with whom we are working closely. We have an 85% target for the training and we are nearing that at 81%. Large group awareness sessions are taking place to assist staff with the undertaking of training.

Care plan functionality is also an issue but we have a work around in the interim but further assurances are needed before go live. There has been a detailed discussion at Trust Board regarding this.

Mike Doyle (MD) highlighted that the CQC Provider Information Request (PIR) submission date is also the same date as Go Live which could have an impact. AM informed the Committee that this issue has been raised at Trust Board and the CQC have been made aware of the situation of the two coinciding on the same date.

TB noted that a routine update will be brought back to the Committee in April.

Committee wanted to note the significant work that has taken place and good progress that has been achieved.

It was RESOLVED to RECEIVE the update and NOTE the progress.

CG/19/08 Care Quality Commission Action Plan (agenda item 8)

TB updated the Committee regarding the progress of the works currently underway. There is still some progress to be made and the governance arrangements remain appropriate. The service self-assess their position and this is then submitted to the Clinical Governance Group for check and challenge. All action plan progress is reported into OG and into the IPR each month. In addition the Quality monitoring visits are scheduled on a risk based system.
MD informed the Committee that a joint meeting had taken place between the Quality Improvement Group and OMG on the 6 February 2019 to address any outstanding issues. Improvement had been noted since this meeting on reds and ambers. CD informed the Committee that the Non Executive Directors (NEDs) have discussed this report and would

like to keep the pace and commitment by the teams to deliver against the agreed actions and to embed this to become the norm.

Overall staff have been reporting a more positive response to progress against the MUST do actions than has been observed during the quality monitoring visits. On the acute wards and PICU several teams have made progress against actions, whilst other wards are struggling with the same action. On the acute wards and PICU wards there are a number of actions that have made little progress. Teams have not consistently adopted actions from the plan that were identified for another Core service.

The findings of the quality monitoring visits will be presented to the quality improvement group on 6th February 2019. Areas where progress is minimal will be managed using a quality improvement approach to accelerate sustainable improvement.. OMG to receive progress reports on amber /green and amber/ red actions.

The Committee noted that this is a useful document and suggested that a back to basics approach to be embedded, Carol Harris (CH) noted that a move to a single leader (matron) will help in being consistent across all districts.

MD reminded the committee that the Quality Monitoring Visits (QMV) reports are not just confined to the CQC actions and include all quality domains., Following the QMV recommendations are given alongside any action to be taken. Some QMV have been cancelled and AM asked if these were to be rescheduled. TB informed the Committee that they are to be rearranged.

AM raised a query regarding the last column of the plan, which saw green next to a red. MD informed that this could be down to a deficit which could still be achievable.

The Committee queried the ratings on the document and questioned as to whether these could be aligned. MD to consider this.

Action: Mike Doyle

It was RESOLVED to note progress on the CQC action plan and NOTE the areas of risk.

CG/19/09 Care Quality Commission Mental Health Act (agenda item 9)

TB advised the Committee that in future the CQC MHA Action Plans would be performance managed through OMG and progress reports would be taken into the Mental Health Act Committee (MHAC). The MHAC will then highlight any areas that they feel require consideration by this Committee.

There was nothing to highlight to CGCS on this occasion.

It was RESOLVED to NOTE the update.

CG/19/10 Trust achievements (agenda item 10)

The Committee noted the significant number of Trust achievements across all areas of the organisation and also the importance of sharing our achievements externally.

CG/19/11 Waiting List Improvement Plans (agenda item 11)

The committee reviewed all the waiting list improvement plans and supported the recommendations Committee noted that the information given within the waiting lists updates could be confusing due to the differences in commissioned activity in each district. It was noted that all the information was available however confusing to read. Committee agreed a revision would be helpful. CH will discuss with Deputy Directors.

Action: Carol Harris

ASD / ADHD

There has been significant progress in that some CCGs are engaging with projects to clear their waiting lists and commissioning recurrent (rather than spot purchased activity) in Autism.

There are still however gaps in commissioned activity when mapped against actual demand in some pathways in some localities.
Without an increase in commissioned activity where gaps are identified, the waiting lists will increase

The capacity gaps that relate to **ADHD** for Kirklees and Barnsley are due to the low level of commissioned activity.

As in Wakefield, we expect the demand and capacity gap for Kirklees and Calderdale **Autism** to be managed through a Referral Triage process.

The capacity gap in **Autism** that relates to Barnsley is due to the low level of commissioned activity and that there is no Referral Triage process agreed.

Without an increase in commissioned activity, where there are gaps, the waiting lists will increase.

There is a plan in place to clear all waiting list for **Autism** for Kirklees and Calderdale CCGs are delivering good outcomes.

There is work taking place to increasing capacity for ADHD in Kirklees, have a pathway for ADHD in Calderdale and increase capacity for ADHD and Autism in Barnsley

Barnsley & Wakefield

Barnsley

There has been some progress, the new psychology pathway appears effective at reducing the number of people being allocated for intensive psychological interventions. Following its introduction there has been a significant reduction in the number of people awaiting therapy

The number of people waiting for psychological therapy within the Core Psychology service has dropped.

Wakefield

The initiatives adopted across the service have impacted positively on waiting times for Psychological Therapy in Wakefield, improving access and service user experience over the past 21 months.

However, there have been significant challenges with vacant posts mainly due to retirement; but there has been successful recruitment and we are expecting to be fully staffed on the

West by May 2019. There has also been reduced staffing on the East due to long term sickness and maternity leave which has had an adverse impact on waiting times.

AM asked if the new pathway had been adopted in other areas and CH confirmed that it had.

Psychology Calderdale & Kirklees

The Trust has raised concerns with Calderdale CCG regarding the underfunding and staff capacity of secondary care Psychological therapies.

The CCG have agreed that the service is insufficiently resourced but is unable to increase its funding to enable it to deliver against the 18 week referral to treatment pathway.

The numbers of people referred has significantly increased and waiting times to access secondary care psychology treatment has grown as a consequence.
CCG governance meets on 7th February to discuss the review findings and recommendations / whole system review.

The trust have had several meetings with the CCG and other key providers to agree actions to manage demand and mitigate risk linked to extended waiting times for Therapy.

AM queried as to why referrals had increased. DR informed that this could be down to patients being psychologically informed by a CBT practitioner. This can be used as an alternative to group work. The Committee questioned if this course of action wasn't successful would the patient return to the back of the queue for the waiting list. CH will enquire.

Action: Carol Harris

The Committee would like this to be monitored and an update to come back in June.

Action: Carol Harris

The Committee RECEIVED and NOTED the updates

CG/19/12 Quality Strategy update (agenda item 12)

The Committee agreed to defer this item until the 2 April Committee meeting.

CG/19/13 Patient Experience report (agenda item 13)

TB provided the Committee with a summary of two items.

- Internal Audit Report
- Data from Patient Experience Report

TB informed the Committee that the purpose of the audit was to support the improvement plan and had been scheduled to occur during the first phase of the plan. There had been a delay with the improvement plan due to some staffing issues which meant that the audit took place before some of the key actions had commenced The audit did identify the key items that we also identified. We now have someone in place to lead the improvement work and to execute the plan.

Progress has been made within the service, for example, management of MP contacts, revision of Trust process to provide compassionate, timely responses to informal concerns and reduction in the time it takes to complete the sign off process.

CD queried whether the internal audit action plan has been implemented and TB confirmed that it had and that the recovery plan is in place. TB went on to note that the complaints backlog has been cleared and that we are now heading in the right direction.

The Committee would like the pace to be kept regarding the above.

AM noted the pressure that has been on the team and is pleased that this has been highlighted. The Committee agreed the work they undertake is complex.

Committee will monitor through Integrated Performance Report (IPR).

MD highlighted to the Committee that the Patient Experience Report, page 9. Complaints within 40 days that complaints have actually reduced, a new graph will be given regarding this information

Action: Mike Doyle

The Committee enquired as to whether the columns on the Feedback Overview slide (page 6) could be broken down to be clearer

Action: Mike Doyle

TB advised the Committee that Freedom of Information Requests (FOI) are increasing and therefore taking more resource. Meetings have taken place to review our processes and consider pooling internal resources to address this issue

The Committee agreed that the reports are useful and detailed.

It was RESOLVED to NOTE the feedback and support the customer service improvement plan approach

CG/19/14 Issues arising from Performance report (agenda item 14)

TB provided an update on the following:-

- Clinical Supervision – The Committee stressed the importance of supervision and agreed that a focus would be kept on this. TB informed the Committee that this had been highlighted at Extended EMT

- Levels of Risk Assessments on Inpatient Units. It was noted that units were dropping in percentage of up to date risk assessments and this has been confirmed via the Quality Monitoring Visits, CH confirmed that this had been actioned through OMG

CG/19/15 Update on topical, legal and regulatory risks (agenda item 15)

TB briefed the Committee on the following:-

- Mental Health Care to Patients presenting at A&E
- Modernisings Mental Health Act Independent Review
- Brexit impact

It was also agreed to provide an update on the Long Term Plan to the June meeting.

CG/19/16 Child and adolescent mental health services - update (agenda item 16.1)

Dave Ramsay (DR) gave a brief highlight of the report to the Committee

- Number of suicides
- Waiting times
- New investments around strengthening services

Wakefield

DR briefed the Committee of the 12 suicides and made reference to one more recent suicide which is being picked up by Wakefield Safeguarding team as a Serious Case Review (SCR). DR informed that learning has been taken immediately and across all districts. CD asked if the details listed were just Wakefield and DR confirmed. AM queried whether it was possible that the children could have known each other. DR noted that this is always possible within the same districts through social media or schools but there is no evidence as yet to support this. CD highlighted the strong partnership working in dealing with this. TB informed the Committee that there will be a deep dive investigation as there was with Kirklees. AM and DR noted that the education response is lacking and that more work is needed to be done.

Barnsley

Investment of £40k (2018/19) and £387k (recurrently) has been agreed in principle by the CCG to establish an all-age liaison model and enable a 7 day per week CAMHS crisis team service offer.

In addition £61k has been made available non-recurrently in 2018/19 as part of a waiting list initiative. This has allowed a temporary increase in service capacity for group work in anxiety/low mood and parenting.

An ASC-themed Summit was led by Calderdale CCG on 10 January 2019. The intention was to inform plans for additional investment in the diagnostic assessment pathway. As an interim the CCG has committed £200k to a non-recurrent initiative. This will increase capacity from 5 to 15 diagnostic assessments per month for 12 months. A trajectory has still to be finalised but to a large extent this investment is designed to reflect current referral levels rather than directly address waiting times.

The CCG has stated an intention to re-procure CAMHS from 2020/21. The detail of the procurement process has still to be clarified. CH noted that the position is being monitored.

DR confirmed actions had been taken to review and strengthen on-call arrangements. In addition, all-age liaison proposals were being progressed in each district. In the medium term this would obviate the need for on-call practitioners.

It was RESOLVED to NOTE the update paper.

Item 16.2 Forensic CAMHS Wetherby YOI Independent Report update

Sue Threadgold (ST) gave an overview of the report submitted to the Committee.

Concerns were first highlighted in August 2018 when senior prison personnel raised some concerns specifically about the delivery of harmful sexual behavior (HSB) but more generally about the mental health provision as a whole including some cultural issues.

7 cases were highlighted as particularly receiving less than optimum HSB delivery.

Immediate actions were initiated by SWYPFT in response to the concerns raised.

- An independent review of the service took place in November 2018.
- The report makes several recommendations that require addressing.
- The Trust continues to work with Leeds Community Health (LCH) as lead provider to provide NHSE and our respective organisations that actions undertaken will address the concerns raised and provide assurance that we are delivering a safe and effective service

An Action Plan is to be developed that provides NHSE with assurance around the delivery of mental health services to the young people in the secure estate. Also to work in collaboration with LCH to produce a discreet model for the delivery of HSB.

The Independent review took place on the 12 November and the report was received back at the end of November 2018. There were 11 recommendations within the report

Work is tirelessly underway to get a plan together with LCH that is due for submission on 15 February 2019 for NHS England's consideration.

ST informed the Committee that we are a sub-contractor of LCH and that SWYPFT and LCH have a good rapport. However there is a big challenge with the relationship with the prison at the moment as this is variable and we are working hard to build on this and have received positive feedback from the prison.

LCH will be looking for significant progress and improvement on the recommendations highlighted in the independent review

AM informed that this issue had been raised with middle ground and it was noted that there were cultural problems within the team at Wetherby in June 2017. AM queried as to whether this was the same team? ST informed that this was the same team but under other management in 2017. SWYPFT were aware of the 3 members of staff and that the 3 staff members were returned to the prison.

CD asked how we ensure we are following the action plan and if this a risk we need to escalate. ST informed the Committee that it is on the BDU action plan and that a joint governance meeting with LCH is taking place and a governance meeting with forensic BDU and management supervision.
The Committee would like an update on this at the next Committee for assurance (2 April 2019)

Action: Sue Threadgold

CG/19/17 Quality Impact Assessment review (agenda item 17)

TB provided a brief overview of the Quality Impact Assessment paper for 2018/19 and the interim report up to and including 4th February 2019.

For 2018/19 it provides the results of 115 Quality Impact Assessments (QIAs).

For 2019/20 it provides the interim position up to and including 4th February 2019. It provides the results of 43 Quality Impact Assessments (QIAs).

The Quality Improvement and assurance team have no QIA currently awaiting a challenge panel.

The Committee felt that this was a robust process and understood the current position.

It was RESOLVED to RECEIVE and NOTE the update and the areas of risk

CG/19/18 Committee Annual Report (agenda item 18)

The Committee discussed the Annual report , Survey, TOR and Work Programme

Survey

- A comment was made regarding a Deputy for the Medical Director. TB informed the Committee that a new Associate Medical Director (AMD) for Patient Safety could possibly sit as a Deputy but this is to be discussed.
- Committee Members Independent of Management Team needs rephrasing, NED majority on other committees, which is best practice. CD to speak to Emma Jones.

Action: Charlotte Dyson

The Committee agreed that they are happy with the survey.

TOR

The Committee queried whether the FTSUG guardians should be included in the TOR
The Committee approved the TOR

Work Programme

The Committee discussed the work plan and agreed that a detailed review will be undertaken at the next Agenda setting meeting to ensure alignment with the Trust Board programme and our reporting schedules

CG/19/19 CQC Annual Report Review - National (agenda item 19)

The above report was not available at the time of this Committee meeting.

CG/19/20 Eliminating Mixed Sex Accommodation (agenda item 20)

MD gave a brief summary of the papers and noted that

During 2018 there have been no reported EMSA breaches. The Trust is, therefore, in a position to declare EMSA compliance as follows.

"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire Partnership NHS Foundation Trust is committed to providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.
"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."

The clinical governance group is also looking at other bed management issues as these can result in service users not having the best experience.

The number of EMSA incidents recorded on Datix fell from 23 in 2016, 11 in 2017 to 9 in 2018 (gender specific).

CD asked how we manage transgender within the Trust and MD informed that we have a policy to cover this issue.

CD informed the Committee that a man had to walk through a female ward at Enfield for an assessment. TB noted this it is to be picked up via the QMV visit.

Action: Mike Doyle

It was resolved to APPROVE the compliance declaration

CG/19/21 Internal Audit Report (agenda item 21)

21.1Governance Report
The Committee felt that this was a positive report and noted the positive comments focused on the Clinical Governance & Clinical Safety committee. The actions identified are in progress.

21.2 Complaints Report
This report was referenced in the customer services item at agenda item 13

CG/19/22 Annual Reports (agenda item 22)
MAV Annual Report
MD gave a summary of the MAV Annual Report to the Committee

Measures of violence and aggression such as physical violence (contact made) on staff by patient, physical violence (contact made) on patient by patient, restraint and seclusion have all increased in 2017/18. Analysis shows that increases in these areas in mostly confined to Wakefield BDU inpatient. Work to ensure the timely training of new starters will continue and work will continue in increasing the number of wards participating in Safewards and the number of Safewards interventions being implemented. A review of the training courses has taken place in relation to techniques and language used.

The Committee discussed the document on restraints and found this to be very helpful in understanding the types of restraints used.

As an organisation we have a good culture of incident reporting and would want to maintain this culture. Whilst other organisations may report differently, we would always promote adherence to the CQCs standards.

The Committee noted that on page 10 on the document it can be seen that SWYPFT appear below the average for incidents of restraint in older people.

It was noted that other Trusts that are reporting 0 could be reporting incidents differently and we are adhering to guidelines. The benchmarking for this is being discussed through CEO and DON forums. SWYPFT do not think it is safe not to have prone restraint although it is always last resort and SWYPFT are always looking for alternatives that are safe.

The Committee queried whether bank and agency staff have to be trained to the same level to which MD noted that they do.

AM raised a question as to whether if police restraints in the 136 suite is reported into our figures. MD informed the Committee that it is not.

CD enquired about the use of bodycams as the police are now trialling these. TB reported that Northumberland, Tyne and Wear NHS Foundation Trust (NTW) have a number of staff members on PICU that are now using bodycams.

AD wanted to note that we must remember the staff members who are involved in restraints as well as the patients and asked if this could be reiterated in the RRPI group.

Action: Mike Doyle

The Committee agreed that they would like this to be included in the next report.

Overall the Committee found the report helpful and confirmed that this provided positive assurance on a number of areas that has been raised previously .

It was RESOLVED to NOTE the report and the positive action on this agenda

CG/19/23 Serious Incidents Update (agenda item 23)

TB gave a brief update to the Committee on key Serious Incidents.

It was RESOLVED to NOTE the update.

CG/19/24 Sub-groups – exception reporting (agenda item 24)

Drug & Therapeutic (agenda item 24.1)

Kate Dewhirst gave a brief overview to the Committee.

A medicines omission tool is being used and an audit is taking place, the figures have already improved this month and this is being pushed through OMG and then hopefully into other groups. Electronic prescribing and administration will provide a sustainable solution. We are waiting to hear as to whether national funding has been secured in March 2019 following approval of the business case by EMT in January.

It was suggested that it would be beneficial for a Pharmacist to attend clinical meetings to embed every day practice regarding medicine omissions

The Committee discussed the impact of Brexit in relation to drugs. KD informed that a total of 6 unlicensed drugs may be affected and would impact on 30 patients. KD informed that 2 of these drugs would be easy switches. Verbal feedback from company that supplies the drugs are looking at changing protocols in house to cover the issue.

It was RESOLVED to NOTE the report.

Safety & Resilience (agenda item 24.2)

Fire safety training was discussed in relation to inpatient wards. Ian Cass is working with wards on more practical training. The TAG is working well and has the correct attendance.

It was RESOLVED to NOTE the report.

Infection Prevention and Control (agenda item 24.3)
Mandatory training is at 89%. The team are not at full capacity at the moment however are continuing to provide the same level of service.
It was RESOLVED to NOTE the report.

Safeguarding adults & children (agenda item 24.4)
It was noted that a further 55 arrests had been made in the child sexual exploitation case in Kirklees and we are working closely with partners on this and have found a workable pathway.
It was RESOLVED to NOTE the report.

Managing Aggression and Violence (agenda item 24.5)
Feedback as above at agenda item 22.
It was RESOLVED to NOTE the report.

Any feedback from other TAGs/groups (agenda item 24.6)
None.

CG/19/25 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 25)

Issues were identified as:

- CQC Action Plan
- Waiting Lists
- Patient Experience Internal Audit
- Forensic CAMHS
- MAV

CG/19/26 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance & Clinical Safety Committee (agenda item 26)

CD wanted to clarify with the Committee that the register reflected what had been discussed today and Committee agreed that the Patient Safety Risk regarding restraint be included within the Patient Safety Strategy. To be considered by EMT.

Action: Tim Breedon

AM made reference to the risk appetite and would like it to be made more clear about what we expect to see in risk appetite.

Action: Emma Jones

CG/19/27 Work Programme (agenda item 27)

The Committee agreed to do a detailed review of the Work Programme at the next agenda setting on the 26 April 2019. Work programme to align with Trust Board programme.

Action: Tim Breedon & Charlotte Dyson

CG/19/28 Any other business (agenda item 28)

Chantry Update

Tim Mellard and James Waplington attended the Committee to give a brief overview of the position. TM informed that the QMV that took place 20.12.18 which highlighted a number of areas for concern. A process of factual accuracy was able to demonstrate that some of the concerns were unfounded including omissions of care plans, clinical supervision rates, issues with MHA medication records and a response to a serious safeguarding incident however concerns remained in relation to:

- Staff currently under investigation continuing to work on the ward
- Timeliness of Datix reporting
- General physical health care awareness, assessment and responsiveness
- Care and treatment of service users who required assistance to leave their beds
- Moving and handling practices- including mandatory training figures
- Co-production and reviewing of care plans
- Medication omissions
- General ward culture- observation of negative patient/ staff interactions during visit

An immediate action plan was formulated the same day and reviewed the following day during a meeting involving the BDU TRIO, Deputy District Director and representatives from the nursing directorate

CD discussed the need of getting the culture and leadership right within wards. JW informed the Committee that work is already underway and an additional Band 6 Nurse had been redeployed to the ward to sure up the leadership. It was noted that the Team Manager was reported to have felt limited within the scope of their role to influence change and JW explained that the impact of this upon the Manager had been underestimated. It was agreed that a back to basics approach was needed to ensure that care standards were maintained.

AM queried as to how the team received the report. TM and JW informed the Committee that the approach was taken to speak to staff on a 1:1 basis and that great care and compassion was taken with the staff.

AM questioned as to whether other managers have reported feeling the same on other wards. TM noted that he can only speak from a Wakefield perspective but this did not seem to be the case. TM discussed that some Ward Managers were undertaking the level 5 CMI Leadership Training including the Chantry Ward Manager.

The Committee was conscious if there could have been any early warning signs that could have been picked up and that we need to be aware of this. TM explained that the QMV report highlighted the quality improvement work undertaken on the ward during the last 12 months. This demonstrated that some of the concerns raised were already being addressed at the time.

The action plan being reviewed every two weeks and reported back through the BDU meeting for assurance.

Committee agreed that this has been handled very well and needed to recognise the good practice going forward.

It was RESOLVED to receive this report and NOTE the actions and progress to date.

CG/19/29 Date of next meeting (agenda item 29)

The next meeting will be held at 14.00 on 2 April 2019 in Meeting room 1, Fieldhead Hospital, Ouchthorpe Lane, Wakefield WF1 3SP.

- The Committee wanted to reiterate the importance of not embedding documents within papers submitted to the Committee and that papers will be returned should they be sent with embedded attachments. It was also reiterated that front sheets must be completed in full as per the example circulated with the draft agenda.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Nominations' Committee held on 16 July 2018

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair of the Committee)
	Jackie Craven (JC)	Lead Governor (Publicly elected governor, Wakefield)
	Nasim Hasnie (NH)	Publicly elected governor, Kirklees
Apologies:	Marios Adamou (MA)	Staff elected governor, medicine and pharmacy
	Ruth Mason (RM)	Appointed governor, Calderdale & Huddersfield NHS Foundation Trust
	Rob Webster (RW)	Chief Executive
In attendance:	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Emma Jones (EJ)	Company Secretary (author)

NC/18/25 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Angela Monaghan (AM) welcomed everyone to the meeting. The apologies above were noted. It was also noted that other dates for the Committee meeting had been looked at prior to the Members' Council meeting on 3 August 2018 to see if there could be greater attendance by Committee members, however this was not possible around their annual leave.

NC/18/26 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return at Trust Board in April 2018 and Members' Council in April 2018 or subsequently

NC/18/27 Minutes of and matters arising from previous meeting held on 20 June 2018 (agenda item 3)

Emma Jones (EJ) advised that Marios Adamou had emailed prior to the meeting to confirm that he supported the draft Minutes for approval.

It was RESOLVED to APPROVE the minutes from the meeting on 20 June 2018. All matters arising from the meeting were complete.

NC/18/28 Non-Executive Director (NED) recruitment - recommendation for appointment (agenda item 4)

Alan Davis (AGD) tabled a paper for this item which provided a final update on the NED recruitment process and the recommendation from the final panel who conducted the interviews on 13 July 2018 following the discussion panels (governors, service users/carers, and staff including Black and Minority Ethnicity (BAME) and Disability networks) on 9 and 11 July 2018. Committee members read the paper prior to discussion.

AM advised that she had phoned all candidates following the conclusion of the final panel interviews and the two recommended candidates had verbally confirmed, subject to the support by the Committee and approval by Members' Council, that they would accept the offer of appointment.

NH asked if there was an induction programme for new NEDs. AM advised that there was a comprehensive induction programme in place which included meeting with key people, visits to services, and attendance at key meetings. Draft programme to be shared with the Committee.

Action: Emma Jones

The Committee discussed that although the meeting was quorate whether the apologies received from Committee members impacted the final recommendation from the Committee to the Members' Council. AGD reminded the Committee that the candidates were discussed in full at the last Committee meeting as part of agreeing the shortlist before they took part in the three discussion panels and final panel interviews. The tabled paper would be circulated to all Nominations Committee members after the meeting.

Action: Emma Jones

AM outlined the detailed discussion that took place by the final panel to reach their recommendation:

- The final panel interviewed five candidates, as two of the original seven shortlisted withdrew beforehand. One was appointed at another trust and the other withdrew due to their existing work commitments.
- The final panel members were provided with the full CV and supporting documentation of each applicant along with feedback from the three discussion panels.
- The final panel discussed in length whether one or two would be appointed from the process, even if neither was financially qualified. It was noted that it had been agreed to recruit two NEDs at the same time so that a separate recruitment process did not need to take place when Rachel Court left, which was expected to be between September 2017 and March 2018. Rachel Court's term had been agreed to be extended for up to 12 months to allow for some overlap to assist with continuity on the Board and also retain some of her skills, expertise and experience on the committees while the new governors were inducted.
- Out of the five interviewed, it was agreed that three of the candidates were strong and would be appointable. None of these was financially qualified, but it was noted that there remains an existing NED (Laurence Campbell) who is financially qualified and chairs the Audit Committee, so this was not deemed to be essential. It was therefore agreed to recommend the appointment of two of these three.
- Exhaustive discussion took place on the three candidates around requirements and validation. The merits of each candidate were reviewed individually and in combination, considering how their appointment would affect the skills and mix of the overall Trust Board, and feedback from the three panels was considered as part of this process, before reaching a decision.

Reflecting on the process, NM added that he felt he was an independent member of the final interview panel as he had not been involved in the initial longlisting and was not at the last Committee meeting where the shortlist was agreed. JC added that she felt the interview process had been better than previous processes and she was also not involved in the initial longlisting process, which gave her a degree of independence as a member of the final interview panel.

NM commented that the three discussion panels had been a very valuable part of the processes as it was important to understand how the candidates interact with governors, staff and service users/carers. AM commented that the feedback assisted the final panel with areas for further probing and when the final recommendation was reached the final panel looked back at the feedback, which confirmed and reinforced the decision reached.

JC added that the final panel asked each of the candidates for feedback on the process and they had all commented positively on the discussion panels and felt that it had been a thorough process. The Committee asked to pass on their thanks to the members of the discussion panels for their support in the process.

Action: Alan Davis / Emma Jones

The Committee discussed and noted the key skills of the two candidates recommended for appointment:

- Erfana Mahmood - is a qualified Lawyer predominately in corporate property law, has a background in the financial sector, is currently a Senior Independent Director and Chair of Nominations Committee at a financial institution, previously a NED at Yorkshire Ambulance Service NHS Trust and for a housing association.
- Samantha Young - has a background in transformation and technology, housing, and local authorities and is a NED with a social housing provider.

AGD advised that he would have the CVs of the candidates and supporting documentation available at the Members' Council meeting on 3 August 2018 should governors wish to review them confidentially.

The Committee supported the recommendation and agreed that both candidates be appointed at the same time, commencing 6 August 2018, to allow for both to be inducted at the same time and take part in Board development work in September 2018. It was noted that there is currently a standard remuneration for NEDs and any appointment would be subject to declarations of interest, independence and fit and proper persons requirements.

It was RESOLVED to:

- **NOTE the update on the recruitment process; and**
- **SUPPORT the recommendation from the final panel to the Members' Council that the Trust appoints Samantha Young and Erfana Mahmood as Non-Executive Directors for an initial three (3) year term from 6 August 2018.**

NC/18/29 Chair and Non-Executive Director (NED) remuneration - process and timescales for review (agenda item 5)

The Committee discussed whether the Chair had a potential conflict of interest in this item and it was agreed that, as it was just to agree the process for the review based on previous processes, there was no conflict.

EJ reminded that Committee that it was on the annual work programme for the Members' Council to agree the process and timescales for the Chair and Non-Executive Directors' remuneration. As part of the Chair recruitment process in 2017, the Committee had requested a further review of the Chair's remuneration scale using NHS Provider benchmarking prior to the annual appraisal of the Chair, which would commence in November 2018.

AGD advised that the proposal was to use NHS Providers' Annual Remuneration Survey to benchmark the remuneration for the Chair and Non-Executive Directors which was published in January 2018. The survey is comprehensive and contains responses from 145 NHS organisations across England on the remuneration of their Chair and Non-Executive Directors. The proposal was also to establish a sub group of the Committee to consider the survey results and make recommendations on appropriate levels of remuneration rather than commission external consultants.

The Committee discussed and supported using the survey and that the sub group consist of a public governor, a staff governor and an appointed governor. It was proposed that Nasim Hasnie (public governor), Marios Adamou (staff governor) and Ruth Mason (appointed governor) subject to their availability will make up the sub group supported by AGD.

It was RESOLVED to AGREE to establish a sub group, supported by the Director of Human Resources, Organisational Development & Estates, to review the NHS Providers Remuneration Survey and to develop recommendations for the Members' Council on the remuneration of the Chair and NEDs.

NC/18/30 Any other business (agenda item 6)

Health Service Journal article in relation to Nominations Committees

AM advised that there had been a Health Services Journal (HSJ) article in relation to Blackpool Teaching Hospitals NHS Foundation Trust, where regulators have raised concerns about the recruitment process of their new chair. The article specifically referred to the Chief Executive being a member of the Nominations' Committee and regulators are now planning to draw up new guidance. EJ commented that NHS Improvement are responsible for making chair and non-executive appointments to NHS trusts, however they do not have the same responsibility for NHS foundation trusts. Within the Terms of Reference for the Committee the Chief Executive had been a member since becoming a foundation trust 2009. It was agreed to keep this issue in view and review as required.

NC/18/31 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 7)

Items were identified as:

- Recommended appointment of NEDs to Members' Council.
- Sub-group to be established to review the Chair and NED remuneration.

NC/18/32 Date of next meeting (agenda item 8)

The date of the next meeting is to be confirmed to meet the timescales in relation to the review of the Chair and NED remuneration.

Action: Angela Monaghan / Emma Jones

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Nominations' Committee held on 28 September 2018

Present:	Marios Adamou (MA)	Staff elected governor, medicine and pharmacy
	Jackie Craven (JC)	Lead Governor (Publicly elected governor, Wakefield)
	Nasim Hasnie (NH)	Publicly elected governor, Kirklees
	Ruth Mason (RM)	Appointed governor, Calderdale & Huddersfield NHS Foundation Trust
Apologies:	Angela Monaghan (AM)	Chair of the Trust (Chair of the Committee)
	Rob Webster (RW)	Chief Executive
In attendance:	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates
	Emma Jones (EJ)	Company Secretary (author)

NC/18/33 Welcome, introduction and apologies (agenda item 1)

Jackie Craven (JC), Lead Governor welcomed everyone to the meeting. The apologies above were noted including the Angela Monaghan (AM), Chair and Chair of the Committee as she had a conflict of interest in the agenda item that would be discussed. In accordance with the Terms of Reference, JC would chair the meeting.

NC/18/34 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return at Trust Board in April 2018 and Members' Council in April 2018 or subsequently. The Committee noted that AM had declared an interest in agenda item 3 and therefore was not in attendance.

NC/18/35 Chair and Non-Executive Director (NED) remuneration (agenda item 3)

Alan Davis (AGD) tabled a paper which outlined the current remuneration arrangements for the Chair and Non-Executive Directors and comparisons made using the NHS Providers Benchmarking remuneration survey for discussion.

<u>Chair remuneration</u>

The Chair's current remuneration arrangement is an incremental scale which was based on an independent review by Capita. The Capita report recognised that Chair's remuneration is more complex and variable than that for the Non-Executive Directors. The Chair's current incremental scale is: £42,420 p.a. - £45,450 p.a. - £47,975 p.a. - £50,500 p.a. - £53,025 p.a. Progression up the incremental scale is based on performance linked to the Chair's annual appraisal. The Chair's current remuneration is £42,420 p.a the bottom point of the incremental scale.

Comparisons in the paper using the NHS Providers Benchmarking remuneration survey showed the national average for all Foundation Trusts (FTs), national maximum for all FTs, national average for non-acute FTs, national maximum for non-acute FTs, average for non-acute FTs in North of England, maximum for non-acute FTs in North of England, and minimum for non-acute FTs in North of England. From these comparisons it showed that the Chair's current remuneration is below the national average for all FTs, below the national

average for all non-acute FTs, and below the average for non-acute FT in the North of England. However, it was noted that the top of the Chair's incremental scale compares favourably with comparable organisations. It also showed that the salary scale is in line with the minimum and maximum of the non-acute FTs in the North of England.

The Committee discussed the survey data in general, including that the pay scales were not lower in the North compared to the South and that the survey data was where pay levels were at the time of the reporting and not necessarily whether organisations have incremental scales.

The Committee discussed linking the Chair's remuneration to the objectives and performance of the Trust. Emma Jones (EJ) outlined the Chair's annual appraisal process with the Members' Council. The Committee noted that any incremental progression was not automatic and would be part of the Chair's annual appraisal process and requested a review of the Chair's appraisal framework in line with any areas of best practice.

Action: Emma Jones

The Committee discussed a potential cost of living increase and felt that as the Chair's remuneration had an incremental scale in place providing access to a pay uplift a further increase would not be recommended at this point in time as that would place the remuneration above the current national averages.

It was RESOLVED to NOTE the current remuneration levels remain appropriate for the Chair.

Non-Executive Directors remuneration

The Non-Executive Director's (NEDs) current remuneration is a flat rate, again based on a review by Capita, however, there was an additional responsibility allowance for NEDs in the role of the Chair of the Audit Committee and the Deputy Chair/Senior Independent Director. The NEDs current remuneration is £13,383 p.a. The Chair of Audit Committee and Deputy Chair / Senior Independent Director receive an additional £5,050 p.a. responsibility allowance, taking their remuneration to £18,433 p.a.

Comparisons in the paper using the NHS Providers Benchmarking remuneration survey showed the national average for all FTs, national maximum for all FTs, national average for non-acute FTs, national maximum for non-acute FTs, average for non-acute FTs in North of England, maximum for non-acute FTs in North of England, and minimum for non-acute FTs in North of England. From these comparisons it showed that the NEDs current remuneration slightly above the average for all FTs, below the maximum for all FTs, slightly above the average for all non-acute FTs, below the maximum for all non-acute FTs, above the average for all non-acute FTs in the North of England, below the maximum for all non-acute FTs in the North of England.

The Committee discuss a potential cost of living increase and acknowledgement of their contribution, noting that NEDs did not have access to an incremental scale. The Committee considered an increase in line with uplifts of NHS staff salaries from the 1st April 2018 and 1st October 2018 which are based on maximum levels of remuneration, with Medical staff cost of living uplift varied from 1.5% for Consultants to 3% for Associate Specialists and Staff Grades. In 2017 the Nomination Committee recommended to the Members' Council a 1% increase in line with Agenda for Change for staff back dated to 1 April 2016 which was approved. AGD confirmed that previous increases were never above what the national changes were.

The Committee also considered that the Trust had set a deficit budget for 2018/19 and were making reductions.

Taking the above into account, the Committee felt that a 1.5% inflation uplift back dated to 1 April 2018 for the NEDs was appropriate, noting that this would equate to an increase of £200.75 p.a.

AGD will draft the paper for Members' Council on behalf of the Committee.

Action: Alan Davis

The Committee thanked AGD for conducting the initial analysis of the NHS Providers Benchmarking remuneration survey which enabled them to have a detailed discussion.

It was RESOLVED to NOTE the current remuneration levels remain appropriate and RECOMMEND to the Members' Council an inflation uplift of 1.5% in line with the national pay award for staff from 1 April 2018 for the Non-Executive Directors.

NC/18/36 Any other business (agenda item 4)

No items were raised.

NC/18/37 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 5)

Items were identified as:

- Chair and Non-Executive Director (NED) remuneration.

NC/18/38 Date of next meeting (agenda item 6)

The dates of future Committee meetings would be confirmed.

Action: Emma Jones

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2019-20

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	✘		✘		✘		✘	
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	✘							
Audit Committee annual report including committee annual reports	✘							

Agenda item/issue	Apr	June	July	Sept	Oct	Dec	Jan	Mar
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘							
Guardian of safe work hours	✘							
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		✘						
Patient experience annual report		✘						
Serious incidents annual report		✘						
Equality and diversity annual report			✘					
Medical appraisal/revalidation annual report			✘					
Sustainability annual report				✘				
Workforce Equality Standards				✘				
Assessment against NHS Constitution						✘		
Eliminating mixed sex accommodation (EMSA) declaration								✘
Data Security and Protection toolkit								✘
Strategic objectives								✘
Trust Board annual work programme								✘
Operational plan	✘					✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five year plan				✘				
Policies and strategies								
Constitution (including Standing Orders) and Scheme of Delegation					✘			
Communication, Engagement and Involvement strategy		✘ (update)				✘		
Organisational Development Strategy						✘		
Risk Management Strategy	✘							
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							✘	
Treasury Management Policy							✘	
Workforce Strategy								✘

Policies/strategies for future review:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(reviewed as required)*
- Membership Strategy *(next due for review in April 2020)*
- Customer Services Policy *(next due for review in June 2020)*
- Equality Strategy *(next due for review in July 2020)*
- 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
	Performance and monitoring
Strategic sessions (including Board development work) 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.	