South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 30 July 2019 at 9.30am
Conference Centre Boardroom, Kendray Hospital, Doncaster Road, Barnsley, S70 3RD

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.30**	**Welcome, introductions and apologies**	Chair	**Verbal item**	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 30 April 2019 and 25 June 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 Deputy Chief Executive's remarks**	Chair Deputy Chief Executive	**Verbal item** **Paper**	10	To receive
6.	**10.00**	**Risk and assurance**				
		6.1 Board Assurance Framework (BAF)	Director of Finance & Resource	**Paper**	15	To receive
		6.2 Corporate / organisational risk register (ORR)	Director of Finance & Resource	**Paper**	15	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
7.	**10.30**	**Business developments**				
		7.1 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates and Director of Strategy	**Paper**	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.	**10.50**	**Performance reports**				
		8.1 Integrated performance report (IPR) Month 3 2019/20	Director of Finance & Resource and Director of Nursing & Quality	**Paper**	45	To receive
	11.35-45	*Break*			*10*	
9.	**11.45**	**Strategies**				
		9.1 Estates Strategy progress update	Director of HR, OD & Estates	**Paper**	10	To receive
10.	**11.55**	**Governance items**				
		10.1 Equality and diversity annual report 2018/19	Director of Nursing & Quality	**Paper**	10	To approve
		10.2 Committee membership	Chair	**Paper**	5	To approve
		10.3 Five year plan	Director of Finance & Resources	**Paper**	5	To receive
11.	**12.15**	**Receipt of public minutes of partnership boards**	Chair	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
12.	**12.20**	**Assurance and receipt of minutes from Trust Board committees** - Audit Committee 9 July 2019 - Nominations Committee 15 July 2019 and 26 July 2019 - Workforce & Remuneration Committees 22 July 2019 - West Yorkshire Mental Health Services Collaborative (WYMHSC) Committees in Common (C-in-C) 28 June 2019	Chairs of committees	**Paper**	15	To receive
13.	**12.35**	**Trust Board work programme**	Chair	**Paper**	1	To note
14.	**12.36**	**Date of next meeting** The next Trust Board meeting held in public will be held on 24 September 2019, Small Conference Room, Wellbeing & Learning Centre, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP	Chair	**Verbal**	4	To note
15.	**12.40**	**Questions from the public**	Chair	**Verbal**	10	To receive
	12.50	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 30 April 2019
Room 49/50, Folly Hall, Huddersfield

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Laurence Campbell (LC)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Mark Brooks (MB)	Director of Finance and Resources (author)
	Tim Breedon (TB)	Director of Nursing and Quality/Deputy Chief Executive
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
Apologies:	Member	
	Dr. Subha Thiyagesh (SThi)	Medical Director
	Attendee	
	Carol Harris (CH)	Director of Operations
In attendance:	Dave Ramsay (DR)	Deputy Director of Operations
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
	Emma Jones (EJ)	Company Secretary (author)
	Dr Richard Marriott (RM)	Consultant Psychiatrist / Guardian of Safe Working (item 8.3)

TB/19/31 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies as above were noted with Dave Ramsay in attendance for Carol Harris. At the commencement of the meeting there were seven members of the public in attendance which included three 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/19/32 Declarations of interest (agenda item 2)

The following declarations were made and considered by Trust Board.

Name	Declaration
Non-Executive Directors	
YOUNG, Sam Non-Executive Director	Additional interest: Spouse, is employed as the Head of End User Computing for Macmillan Cancer Care
CAMPBELL, Laurence Non-Executive Director	Removal of interest: NHS complaints advocacy for Kirklees.

There were no further declarations over and above those made in the annual return in March 2019 or subsequently.

It was RESOLVED to formally NOTE the Declarations of Interest. It was noted that the Chair had reviewed the declarations made and concluded that they do not present a risk to the Trust in terms of conflict of interests.

TB/19/33 Minutes of and matters arising 26 March 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 26 March 2019 as a true and accurate record. The following matters arising were discussed:

- TB/19/21a Integrated performance report M11 2018/19 - Tim Breedon (TB) commented that the Friends & Family test results were now included.
- TB/19/22a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) - AM commented that a letter was sent seeking a meeting to clarify governance arrangements. No response had been received to date.
- TB/19/24a Eliminating mixed sex accommodation (EMSA) declaration - TB advised that the "other" was not just in relation to inter-ward movements but also short term closures due to acuity. A report would be received by the Clinical Governance & Clinical Safety Committee.
- TB/19/15d public question regarding initiative about future New Optimal Health Care Model for the Trust with the specific focus on Prevention - TB commented that a response has been provided.
- TB/18/78 Chair and Chief Executive's remarks (Chief Executive's report) - Alan Davis (AGD) advised that the policy in relation to managing violence and aggression towards staff had been updated in line with the new legislation.

TB/19/34 Service User Story (agenda item 4)

The Trust Board heard a service user story in relation to the Learning Disability service read by Dave Ramsay (DR):

> "James" is young man with moderate learning disabilities who was referred to our adult community learning disability services in Barnsley aged 17yrs due to his behaviour (violence, aggression and property damage).
>
> Despite receiving community support from our nursing and clinical psychology teams, James's mental health deteriorated and his community placement broke down.
> Aged 19yrs James was detained under the Mental Health Act and he spent a short period of time in our psychiatric intensive care unit (PICU) service in Barnsley before being transferred to an out of area hospital placement to continue his treatment and recovery. Unfortunately that placement was terminated shortly after his admission due to serious safeguarding concerns about the care provided to him and James was transferred back to the PICU service in Barnsley.
>
> The local community intensive support team provided an in-reach service to the PICU - working in partnership with the inpatient team to support James's recovery, by combining psychiatric expertise with specialist knowledge and skills in supporting people with learning disabilities and complex and enduring behavioural issues. Supporting James in the PICU environment was challenging, but eventually he was discharged to a supported living placement in the local community. Unfortunately he

struggled in this placement and his aggressive behaviour escalated resulting in him assaulting another tenant and a member of staff. James was subsequently arrested and held in police cells for over 72hours, before being transferred to a low-secure hospital where he was regularly managed in seclusion for up to 18hours/day.

Our Intensive Support Team (IST) continued to provide support to James and the inpatient staff team during this admission, and a significant therapeutic relationship was established – supported by regular sessions with a psychologist. This consistency of relationship enabled James to disclose for the first time that he had experienced significant physical, emotional and sexual abuse during his childhood. The disclosure proved to be a significant turning point in James's recovery and the level of aggression he displayed. After 6months he was deemed to no longer require a secure hospital admission and was transferred to another out of area hospital placement in the North East of the country.

Again the Barnsley IST continued to support James during his time there; working jointly with the new hospital team, local authority staff, commissioners and James's family to ensure continuity of therapeutic activities and crucially continuity of relationship with services. Regular multi-agency communication through care programme approach (CPA) meetings, multi-disciplinary team (MDT) meetings and care and treatment reviews (CTRs) were essential in enabling the collective team to focus on James's treatment and recovery, ensuring they were grounded in the longitudinal assessment and formulation work completed over the preceding years.

After 12 months, James was discharged from hospital and he is now living back in Barnsley in his own flat which is attached to a residential care home. He is supported with 1:1 staff and regularly says how happy he is with his 'new life'. He is continually having new experiences and developing new skills – he has developed a particular passion for horse riding – and he is due to commence college in September. He is hoping to move into a more independent tenancy in the next 12-24 months.

DR commented that he felt that it provided a good example of the work the service is involved in each and every day. Although this has been a long journey of recovery for James - with many pitfalls and disappointments along the way - this is a real story of success, of a young man navigating huge life challenges but ultimately finding a way (with help) to live a good life in his local community with optimism for the future. The story demonstrated on-going co-ordination from our Intensive Support Team, which stayed with James throughout his journey through services, over a number of years and in various parts of the country, and the positive working relationships between all parties within James's multi-agency support network, was central to him achieving his positive outcome.

TB commented that the story highlighted the importance around communication, people's understanding of what they need from the system, and how much time it takes to build trust with the individual and families in order to provide benefit. It is also important to minimise the number of changes of workers with the individuals and highlighted the benefits of continuity of care in teams. The move of service users from children's services to adult services can mean a loss of information and trust through transition and more was needed in the system to make the continuity of services the better.

Charlotte Dyson (CD) commented that it was good to hear a story in relation to the Trust's learning disability services and that transition was an area discussed frequently by the Clinical Governance & Clinical Safety Committee. CD asked if there was potential to extend services beyond 18. TB commented that there were various areas of services where this was possible and the Trust was looking at mapping and minimising the disruption as part of

the transition as well as services staying in touch longer with previous service users once they had moved.

Kate Quail (KQ) commented that it provided an example of where the Trust is good at providing support when people are in the Trust's services. KQ commented that it would be good to look back to the younger years of what services were provided across the system that may have assisted earlier. It is also the Trust's role to promote the system including early intervention and a collective approach.

RW commented that this story should be used as an example the next time the Board made decisions relating to learning disabilities, by thinking about what would this mean for James. Learning disability services are part of transforming care partnerships. The Barnsley, Calderdale, Kirklees and Wakefield services partnership will merge with Leeds and Bradford under a single partnership so that services provided can be better coordinated across the footprint. Learning disabilities will be an area of focus in the 10 year plan to improve the services and bed base. It was important for the Board to recognise that this partnership exists and Sean Rayner (SR) is the Trust's representative on the partnership. The Trust is the lead for the operational delivery network for Yorkshire and Humber and it should be raised through this network about how the learning is being captured to inform how the transition works for people across the community.

Action: Sean Rayner

The Board thanked the service user for sharing their story.

It was RESOLVED to NOTE the Service User Story.

TB/19/35 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- Members' Council election - voting closed on 18 April 2019 and new governors will commence in role from 1 May 2019. Details are on the Trust's website. There are now no vacant seats on our Members' Council which is positive news and we look forward to welcoming our new and re-elected governors.
- The next Members' Council meeting will be held on 3 May 2019 at the Textile Centre of Excellence in Huddersfield. One of the items on the agenda is a recommendation for reappointment of a previous Non-Executive Director supported by the Nominations' Committee.
- The Board will be discussing the following items in private session today, which are considered as commercial in confidence:
  - Investment appraisal framework
  - Corporate/organisational level risk register – one specific risk
  - Those aspects of financial performance considered to be commercial in confidence
  - Commercially confidential business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs) and an End of Life Alliance agreement in Wakefield.
  - Financial sustainability plan
  - Draft Integrated Performance Report indicators for 2019/20
  - Minutes of private partnership board meetings.
  - Corporate Trustee for charitable funds meeting which is held quarterly

Chief Executive's report

RW commented that "The Brief" communication to staff, that was included in the paper, provided an update on the local and national context as well as what was happening across the organisation and highlighted the following since its publication:

- A national workforce strategy is due to be published, however it has been delayed.
- Guidance for five year plan that integrated care systems (ICS) have to develop by autumn has been delayed to May. It should however not stop the planning process as we know what is in the long term plan, what the targets might be and financial allocations are set for the medium term.
- The NHS Assembly met, which comprises 52 people drawn from across the health and care system including service users, carers, frontline staff, managers, leaders and think-tanks. The aim of the Assembly is to advise on the work of NHS England and NHS Improvement and the discussion was around the approach to the Long Term Plan, its implementation and changes to legislation.

CD commented that The Brief monthly communication and The View weekly communication reflects what the Board has discussed, and asked if staff have communicated back about whether it feels right to them. Salma Yasmeen (SY) commented that an annual internal communication survey is conducted and year upon year it has shown an increase in the percentage of staff who feel informed. RW commented that, since this way of communication was introduced, there had been a double digit improvement and overall a positive response. Work is also taking place to engage staff in response to bullying and harassment and making this Trust a great place to work, led by AGD and also conversations around quality and engagement with the Care Quality Commission (CQC) are being led by TB. Directors are having a conversation each week in different teams and listening events will take place in June 2019. TB commented that the conversations were a way of closing the loop and at each Extended Executive Management Team meeting, where The Brief is first communicated, comments are also provided back on the previous version. The most important part is making The Brief relevant to all staff. AGD commented that through April, May, and June directors were visiting teams to engage further and ask staff what the key areas for action should be. It has been positive to listen to teams about what is and isn't working and sharing areas of good practice. RW commented that it was important that the Board continued to be visible to all staff when out in the Trust. KQ commented that when she visits services the feedback received is that the level of communication feels right and staff are realising the benefit.

AM commented that the feedback received from staff indicated that some staff still did not receive the communications if they don't use email and asked for an update on the release of the staff app. SY commented that final details were being confirmed with the supplier. The app is free and would provide basic areas of communication at this stage. There would also be a re-launch of iHub for staff with 2,000 staff already registered users, which further enables conversations around making the Trust a great place to work and support around the CQC inspection.

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

TB/19/36 Performance reports (agenda item 8)

TB/19/36a Guardian of safe working hours annual report (agenda item 8.3)

Dr Richard Marriott (RM) highlighted the following:

- Rotas are compliant with requirements and working well. Confident that these have been managed correctly.

- Ongoing issues for trainees about the implementation of the contract.
- Survey of those who had not done any exception reports indicated that they felt they did not need to do any.
- Largely speaking, they are happy with the working hours and how they are managed in the Trust, with concerns remaining around the contract.
- Under recruited at the moment with potentially 6-7 vacancies, priority moving forward is making the experience as positive as possible so they want to come back to work with the Trust.

CD asked how the Trust was utilising the information provided about getting junior doctors to continue to work with us and how the Trust compared to other organisations. RM commented that some areas were outside the remit of the role of Guardian of Safe Working, although it was an important issue. Through being part of the interview panel for the colleague tutors, it showed there was lots of interest in some areas but not all. It was key that the educational tutors and supervisors were in place to provide support and development. AGD commented that it was important to find ways that the Trust could offer something that prospective employees find attractive to encourage recruitment and retention.

Erfana Mahmood (EM) asked if anything further could be done to manage exceptions. RM commented that a meeting takes place with all junior doctors when they commence with the Trust to go through requirements and encourage reporting and there was a forum every three months. Largely speaking they are happy with the hours, some of the other concerns which are discussed in the forum were areas that local leads could potentially assist with to improve further. One of the areas raised has been that trainee doctors only receive six weeks of mental health training which means they need lots of support when they commence with the Trust. RW commented that it was important to ensure that for any risks, if there are gaps, that they are appropriately managed and escalated.

Action: Dr. Subha Thiyagesh

RW commented that AGD, in his role as lead across West Yorkshire & Harrogate, could feed into the discussions to see if these areas could be resolved collectively.

Action: Alan Davis

It was RESOLVED to RECEIVE, REVIEW and CONFIRM assurance that the Trust has met its statutory duties.

Dr Richard Marriott left the meeting.

TB/19/37 Risk and assurance (agenda item 6)

TB/19/37a Strategic overview of business and associated risks (agenda item 6.1)

SY reported that it had been a changing environment in last six months, particularly responding to the NHS Long Term Plan. Changes in the SWOT analysis included feedback from the Board on the areas of quality for inclusion, the integrated care systems (ICS) playing a stronger role, and high level of activity.

Laurence Campbell (LC) commented that it was important that there was a coherent alignment between the corporate/organisational level risks and the Board Assurance Framework (BAF) to pick up the strategic risks. SY commented that this was being looked at further. AM commented that it should also be cross referenced with the investment appraisal framework. RW commented that the paper showed a significant update as the context was changing all the time. It was important to consider cross referencing without making it too difficult to read.

Action: Salma Yasmeen

CD commented that it reflects the organisation, priorities and risks, however the commercial point of view needed further work. Sam Young (SYo) commented that she had some further comment on areas for inclusion in the next update. AM requested that any comments on detail be fed back to SY.

Action: All

RW commented that SR and SY had been working on a prospectus for each of the Trust's main locations. SY commented that the communications team had been working with service managers to develop these, along with working with Business Delivery Units (BDUs) on stakeholder mapping and analysis, with the aim to have drafts in place by June 2019. RW commented that part of the discussion at the Trust Board strategic session in May 2019 would be around external facing and stakeholder management work which should assist.

It was RESOLVED to NOTE the content of the report and ADVISE on further developments required.

TB/19/37b Board Assurance Framework (BAF) (agenda item 6.2)
MC reported that the BAF included the outcome of Quarter 4 for 2018/19 framework and also included what the changes to the strategic risks would be in 2019/20 following discussion at the Trust Board strategic session in February 2019. MB highlighted the following:

- Each strategic risk was reviewed by lead directors and discussed by the Executive Management Team (EMT) prior to Trust Board.
- Strategic risk 2.4: Increased demand for and acuity of service users leads to a negative impact on quality of care - it was felt it should move from a RAG rating of amber to yellow and rationale included in the report on actions taken and the self-assessment completed in preparation for CQC inspection.
- Strategic risk 3.1: Deterioration in financial performance leading to unsustainable organisation and inability to deliver capital programme - financial plan achieved for 2018/19, therefore move from a RAG rating of amber to yellow.
- Strategic risk 3.4: Capacity / resource not prioritised leading to failure to meet strategic objectives - need to keep an eye on capacity and resource, RAG rating to remain as green.
- As the BAF included the high level strategic risks they would not change hugely year on year.
- In 2019/20, there would be a fourth strategic objective about making the Trust a great place to work and strategic risks would be realigned as needed.

The Board noted and supported the RAG ratings outlined.

LC asked in relation to patient level costing, which would be a new development financially in 2019/20, whether there should be one fully defined costed clinical model and unwarranted variation under improving resources. TB commented that unwarranted variation was included under improving health, although resource aspect may not be covered. MB commented that a separate paper had been taken to EMT outlining the need to move to patient level costing.

CD commented that more insight and business intelligence was needed and whether this was adequately reflected. RW commented that the need for capacity recognised by EMT which included expertise in analysis and how to turn this into good intelligence to increase productivity. These areas are covered in the risk register, however they could potentially be drawn out as separate strategic risks. AM suggested that it could be included under delivering efficiency improvements and made more specific.

Action: Mark Brooks

AM commented that the Board would have a further discussion on the BAF for 2019/20 at the next Trust Board strategic session in May 2019.

It was RESOLVED to:

- **NOTE the controls and assurances against the Trust's strategic objectives for Quarter 4 2018/19;**
- **AGREE the ongoing targets for addressing gaps in controls and assurance in the paper 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.**

TB/19/37c Corporate / organisational risk register (ORR) (agenda item 6.3)
MB highlighted the following:

- Risks are aligned to individual committees and reviewed in depth to understand the controls and actions.
- The ORR is reviewed on a cyclical basis by the EMT and the report identifies the discussion and updates made in Quarter 4.
- Triangulation of risk, performance and governance risk report to the Audit Committee which includes the collective consideration of the ORR, BAF, strategic overview of business and associated risks, and integrated performance report (IPR).
- Two risks were recommended for closure at this level, where EMT were satisfied they have reached where they need to in relation to risk scoring.
- Two new risks have been included at the corporate/organisational level including a patient safety risk which has been considered by the Clinical Governance & Clinical Safety Committee (CG&CSC).
- The risk scoring in relation the clinical records system should now be able to be reduced following implementation.

TB commented, in relation to the new corporate/organisational level risk regarding patient safety, that a number of risks were already included on BDU risk registers, however it felt appropriate that a collective risk was included at this level. The risk had been discussed by the Clinical Governance & Clinical Safety Committee to ensure key areas continue to receive a specific amount of focus. CD commented that the committee felt it was important to show the commitment to patient safety overall and the different factors involved in that. The committee felt these included anti-ligature, learning from deaths, and complaints, along with others. RW commented that when the Board discusses the complex nature of services and pressure, the first consideration was safety first always. Having the collective risk draws that discussion together further.

AM asked for further information on the new corporate/organisational level risk in relation to succession planning and talent management. AGD commented that this was an issue which had been raised across the NHS and a lot of work was taking place regarding talent management and how the Trust could nurture it within the organisation. This risk would be discussed further by the Workforce & Remuneration Committee.

LC commented that the review of the risks aligned to committees was working well, which allowed committees time to have a detailed discussion. CD agreed it worked well. AM commented that the inclusion of the risk grading matrix with the report was helpful to allow for a detailed review of the scoring. RW commented that the arrangements had improved including the review of risks outside of risk appetite and felt they included a sense check of the key risks within the organisation.

It was RESOLVED 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;**
- **NOTE the two new risks escalated to corporate/organisational level; and**
- **AGREE the two risks recommended for closure.**

TB/19/38 Business developments (agenda item 7)

TB/19/38a South Yorkshire updated including the South Yorkshire & Bassetlaw Integrated Care System (agenda item 7.1)

AGD commented that the Trust was continuing to seek further conversation about its role in governance arrangements.

SY highlighted the following:

- Bid for individual placement support was successful. The Trust was now working with partners to develop a joint bid and working to agree who the lead provider would be.
- Emergency care provider group was working on supporting people in crisis with the aim for a draft proposal to come to each provider for sign off.
- Suicide prevention work taking place led by the local authority in Barnsley.
- Deep dive taking place on autism and autism spectrum disorder (ASD).
- The Trust was contributing to work taking place on workforce.

RW commented that the liaison and diversion service went live with the service provided in Sheffield, Rotherham, Doncaster and Barnsley, which demonstrates that the Trust's reach goes beyond Barnsley in South Yorkshire.

The Board thanked staff for the safe and successful transition of the liaison and diversion service.

It was RESOLVED to NOTE the update provided.

TB/19/38b West Yorkshire and Harrogate Health and Care Partnership update (agenda item 7.2)

SY highlighted the following:

- All trusts had accepted their control total except one, with the integrated care system (ICS) supporting them to be able to accept.
- Check and confirm sessions are in place to provide clarity on what is being delivered together, the capacity, and feedback which would be discussed by the West Yorkshire Mental Health Services Collaborative Committee in Common (WYMHSC C-i-C).
- Angela would take over as Chair of the WYMHSC C-i-C for the next 12 months.
- NHS England and NHS Improvement are working on an 'implementation framework' which will describe in more detail the requirements for 5-year strategies.
- The Leadership Group took part in a workshop 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. From that, work was taking place to develop health champions.
- Launch of 'looking out for our neighbours' campaign had been successful.

AM asked as part of the five year plan development, how equality and inclusion would be included along with addressing environmental sustainability. SY commented that the Trust already has a strong relationship with Healthwatch, a range of carer groups, and other third sector groups and would continue to build on that. There was a survey that has gone widely into the public and the Trust has helped publicise it. RW commented that the overall plan was built from the six place based plans, where sustainability and environment vary in each plan. In June 2019, the partnership board for West Yorkshire & Harrogate would meet to discuss what the focus and emphasis may be and it could be picked up there. AM commented that the focus was welcomed and that there also needed to be a focus on children and young people through those plans.

CD asked in relation to the performance dashboard for the ICS, how the Trust would feed into the development so that it was clear what the Trust was responsible for. RW commented that, in South Yorkshire & Bassetlaw, which was slightly ahead on performance, this would be in relation to Barnsley as a place being held to account for performance. It was unclear at this stage how this would develop, although it was assumed this would be how the Trust was being held to account currently by regulators. In West Yorkshire & Harrogate, the development of the ICS was one phase behind. Peer reviews are taking place with the work to come together in September 2019.

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; and**
- **Kirklees.**

TB/19/39 Performance reports (continued) (agenda item 8)

TB/19/39a Integrated performance report M12 2018/19 (agenda item 8.1)

TB highlighted the following from the Summary and Quality dashboards:

- Young person on adult wards - four days occupancy by one service user, remains an area of focus and only used if it is considered the least worst option with safeguards in place.
- Safer staffing fill rate - 118% but significant staffing challenges remain in response to increased acuity.
- Information Governance (IG) - showing a reduction which was positive, however it still needs focus to consistently reduce.
- Out of area usage - included under Locality.
- Friends & Family Test - excellent performance with mental health scoring 95% and community services 99%.
- Medicine omissions - maintained positive performance.
- Falls - an increase in the number of falls has been reported given service user acuity and complexity. Increased observations and staffing being put in place.
- Staff supervision - positive results for Quarter 4.
- CQUIN performance - positive in the year, with circa 98% achieved.
- Incidents - total number of reported incidents remains in line with recent trend and the expected range, although increase in red and amber incidents which will be looked at by Clinical Governance & Clinical Safety Committee. Risk panel reporting into Operational Management Group (OMG).
- CQC action plan - doing everything we can to ensure actions are completed. Detailed report to Clinical Governance & Clinical Safety Committee.

EM asked for further information in relation to the spike in pressure ulcers. TB commented that they are reported at a point in time, then reviewed and may return back within range when reported the next month. The spike had been noted in the risk panel and would be subject to detailed review. KQ asked if they were cross referenced with staffing levels. TB commented that they were at a local level and also at OMG.

KQ commented that the report stated that an increase in falls is related to increased acuity and asked if risks were assessed and increased based on needs. TB commented that they were, however when acuity was substantially increased the risk would also increase.

AM asked for further clarification in relation to safer staffing fill rates where five wards remained the same. TB commented that they were just below 80% and were reported every time. LC asked about the change in specialist services fill rates. TB commented that they had changed in terms of some of the care packages being delivered.

CD asked in relation to CAMHS 18 weeks waits if there was an overall trend since September 2018. TB commented that March 2019 data was not yet available, however it was hoped it would show a decrease and it remains an area of focus by the Clinical Governance & Clinical Safety Committee.

AM asked in relation to reducing physical interventions where there is a red RAG rating in relation to the CQUIN. Some detailed discussion has taken place at the Clinical Governance & Clinical Safety Committee where assurance was provided about the range of activity, although there was still an increase. TB commented that reporting requirements were being reviewed in comparison to others as potentially several matters were being reported as one in other trusts.

EM asked if the downward trend in out of area placements was due to SSG actions. MB commented that it was through continued action but may be too early to tell if it was a trend.

RW commented that operationally the Trust needs to continue to take falls, incidents, the use of prone restraint, and pressure ulcers seriously, with discussions continuing at the Operational Management Group (OMG) and EMT meetings. When considering areas for the 2019/20 IPR, child and adolescent mental health services (CAMHS) waiting times must have the right indicators separated by BDU, and the Trust's ambition around the use of restraints, falls, and pressure ulcers.

MB highlighted the following in relation to NHS Improvement Indicators:

- All improving access to psychological therapies (IAPT) targets have been met.
- Limited national metric data currently available for March given the impact of SystmOne implementation. Most data expected to be available by early May. Based on February's performance would not expect a large change.

MB highlighted, in relation to Locality, that the garden area in Ward 18 had been reviewed for overall safety and new anti-ligature, anti-climbing and netting would be put in place. Further anti-ligature work was taking place across the Trust.

AM commented that average length of stay was in excess of target in a couple of areas and could be an area for consideration in the IPR for 2019/20 in terms of consistency.

SY highlighted the following in relation to 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.
- Out of area is expecting to see some outcomes out of the first lot of SSG work.
- Stroke pathway is under development with Barnsley Hospital and Barnsley Clinical Commissioning Group (CCG), with particular focus on the model, activity and finances. There were potential risks in terms of timescales.

KQ asked when work would commence around the optimisation of SystmOne. SY commented that conversations were taking place at EMT. The focus was currently on catch up and stability, with an aim to move forward with optimisation plans in June 2019.

Sean Rayner left the meeting.

RW commented that the SystemOne implementation was an example of where the programme approach has worked well. EMT have been discussing all the work that is taking place in children's services such as CAMHS and it is felt that it could be coordinated more effectively using this approach. Proposal will come regarding how the implementation is structured going forward.

AM commented that engagement and involvement work taking place wasn't always clear in the IPR and could be an area for consideration in the IPR for 2019/20.

MB highlighted the following in relation to Finance:

- Detailed discussion at the Executive Management Team meeting on 25 April 2019 with Non-Executive Directors in attendance.
- Pre Provider Sustainability Funding (PSF) deficit in for 2018/19 of £1.6m compared to the revised plan of £2.0m.
- Included in the March position is 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.
- 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.
- Expenditure on out of area beds of £355k takes the full year spend to £3.9m and is the highest ever by the Trust. One individual case accounts for £0.6m of this cost.
- 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.

AM commented that it was important to recognise the work that has been done throughout the organisation and the controls in place through our governance arrangements.

AGD highlighted the following in relation to 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%. Forensic is an area of focus for proactive prevention processes.

- Staff turnover reduced year on year from 12.6% to 11.9%. It is an important area of focus in a competitive market for staff.
- All mandatory training targets have been achieved and in a number of areas exceeded.

EM asked where the Trust would measure in relation to the trend for medical staff data for turnover. AGD commented that it was only small numbers and junior doctors rotated every six months. Further details would be in the agency reports which showed the spend on medical staff. EM asked where the detail of vacancies was discussed, versus the financial spend. MB commented that this information was reviewed monthly by the staffing group. AGD commented that the detail was included in the agency report received by the Workforce & Remuneration Committee.

RW commented that areas of focus were Barnsley, where sickness rates and turnover had historically been lower, along with CAMHS and Forensic services with conversations taking place at EMT. AGD commented that Barnsley sickness absence rates had remained stable in spite of significant change. Further work was taking place on stability rates for newly qualified nurses which is an additional area which needs focus.

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

TB/19/39b Safer staffing report (agenda item 8.2)
TB highlighted the following:

- The report is presented in a prescribed format and was discussed in detail by the Clinical Governance & Clinical Safety Committee.
- The report highlighted the difference between the overall position and local position where there are significant areas of pressures.
- The use of bank staff, outcome of the establishment review, and challenges to recruitment.
- Looking at a way of aligning with all other workforce initiatives, rather than mandated reporting so the two areas are linked.

LC asked for further information in relation to care hours per patient data. TB commented that the data was in its early stage of reporting and a discussion had taken place with NHS Improvement on areas where the Trust was higher and ratios which were better than in other areas. Some providers were including allied health professionals in their data and some are not which needs to be considered further along with the difference in ward sizes. Further information would be provided to the Clinical Governance & Clinical Safety Committee.

CD asked, in terms of the establishment review, whether some of the data had been included. TB commented that some of the early data was now available and needed to be updated.

LC asked in relation to the nurse overall day fill rate whether it was on a downward trend or related to specialist cases. TB commented that it was often related to learning disability services and also specific one to one care packages.

RW commented that the Board should note the previous investment made in safer staffing 2-3 years ago and the investment the Trust wants to make. The way the Trust manages staffing across the whole of the Trust needs to remain an area of focus and in relation to care hours per patient it did appear that the Trust had larger ward sizes in comparison to others.

It was RESOLVED to NOTE the report.

TB/19/40 Strategies (agenda item 9)

TB/19/40a Digital Strategy progress update (agenda item 9.1)

MB highlighted the following:

- Most significant programme of work has been the 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.

AM commented that the report highlighted areas of positive performance and that when discussing strategic objectives it was important that digital is considered throughout.

The Board noted the positive performance and thanked the wider IM&T team for their work.

It was RESOLVED to NOTE and COMMENT on the update of progress made against the Trust's Digital Strategy.

TB/19/40b Update of the Risk Management Strategy including review of Risk Appetite Statement (agenda item 9.2)

MB reported that the current Strategy was approved by Trust Board in 2017 and was now due for review. The recommended updates had been considered by the Executive Management Team and Audit Committee and there was a separate procedure document which sits behind the Strategy. Following review no change to the Risk Appetite was recommended.

AM requested that future updates were received with tracked changes when coming for approval at Trust Board. LC commented that the Audit Committee had received the suggested updates in tracked changes which had been supported prior to coming for Trust Board approval.

AM provided the following suggested amendments:

- References four risk committees. The Equality & Inclusion Forum is now a Committee following the Board's approval under agenda item 10 and they currently have oversight of one organisational level risk.
- Noting that the Audit Committee Chair was currently also a member of other committees.
- The roles of different individuals and groups such as the Organisational Management Group.
- Equality Impact Assessment (EIA) to be reviewed as to whether the implementation of this strategy could impact any of the protected characteristics differentially.

Action: Emma Jones

It was RESOLVED to APPROVE the update to the Risk Management Strategy and NOTE the Risk Appetite remained unchanged.

TB/19/41 Governance matters (agenda item 10)

TB/19/41a Audit Committee Annual Report 2018/19 including updated terms of reference for Trust Board committees (agenda item 10.1)

Laurence Campbell (LC) reported that all committee chairs and lead Directors were invited to attend the Audit Committee which received the annual reports of each Board committee and highlighted the following from the discussion:

- Overall there was assurance across the committees that they are meeting their terms of reference.
- There was a slightly inconsistent approach to membership numbers of Non-Executive Directors and executive directors which may need to be reviewed further.
- Workload was also discussed, including the possibility of realigning some areas between the Clinical Governance & Clinical Safety Committee and the Mental Health Act Committee.
- The current draft Head of Internal Audit Opinion is one of significant assurance.

RW commented that the report was helpful and a good process was in place for the annual review of committees. A point was also raised in relation to whether a separate finance and performance committee was needed which needed further discussion and consideration.

CD commented that the agenda was challenging for the Clinical Governance & Clinical Safety Committee. Have done some work with KQ, Yvonne French, Assistant Director Legal Services now also attends Clinical Governance & Clinical Safety Committee to provide further oversight from the Mental Health Act Committee. A potential new finance and performance committee may assist with the workload of the Clinical Governance & Clinical Safety Committee.

Emma Jones (EJ) commented that amendments had been made to the terms of reference of committees in response to internal audit recommendations. AM commented that now the Equality & Inclusion Forum was recommended to become a committee, the previous governor member, who is not a director of the Board, would in future be in attendance, in accordance with the Trust Constitution. In practice that would not change how the group works. RW commented that the link between the Members' Council and the previous Equality & Inclusion Forum had been helpful and there may be other ways to incorporate the views of governors to ensure we are focusing on the right kind of protected characteristics.

RW commented in relation to a potential finance and performance committee, that this would assist with the delivery of the financial sustainability plan. LC commented that it was important to consider where oversight was needed rather than the form of the group. EM commented that such a group could enable commercial aspects and investment discussions to take place with rigour. KQ agreed that a group to focus on those aspects was important although a committee may not be needed and to include performance elements may be too much for one group to do in detail over and above the financial sustainability plan. RW commented that adhoc arrangements had been in place with a sub group of Non-Executive Directors attending the Executive Management Team meeting for a more detailed discussion on finance. However, there would be further requirements nationally on performance such as waiting time standards for mental health that would need focus. AM commented that it was anticipated that a more detailed proposal would come to the next Trust Board meeting

It was RESOLVED 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 with further discussion as part of the Financial Sustainability Plan.**

TB/19/41b Internal meeting governance framework (agenda item 10.2)

MB reported that 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 Collaborative (WYMHSC) Committee in Common, which meets quarterly as Committees in Common with three other trusts in West Yorkshire.

The Board discussed the following additional amendments:

- Charitable Funds Committee to be reflected as a committee of the Corporate Trustee.
- Operational Governance Group to be added under Charitable Funds Committee.
- Reference to Trust Board and Members' Council meetings being held in public.
- JLMC and Trust Partnership Forum to be a dotted line to the Workforce & Remuneration Committee as reports are received by exception.
- Update the name of the Equality & Inclusion Forum to Committee following the Board's approval under agenda item10.

Action: Emma Jones

It was RESOLVED to RECEIVE the update to the internal meetings' governance framework.

TB/19/41c Draft Annual Governance Statement 2018/19 (agenda item 10.3)
MB reported that the draft Annual Governance Statement followed a prescriptive format set by regulators. Following approval of the draft it will be provided to external auditors for review prior to final approval by the Board in May 2019. Some figures are still awaiting final end of year data.

AM provided the following suggested amendments:

- Objectives for the Chief Executive are agreed with the Chair.
- Confirmation of who appraises directors.
- Reference to Council of Governors to be updated to Members' Council.
- Reference to Bi-annual training to be changed to biennial.
- Number of audit reviews to be reconfirmed.
- Information Governance training to be updated to 2019.
- Bullet points in relation to Equality & Inclusion Forum to be reviewed.

Action: Mark Brooks

AM commented that the AGS was comprehensive and provided an excellent summary which showed the Trust has good governance and controls in place.

It was RESOLVED to REVIEW the draft Annual Governance Statement and COMMENT accordingly.

TB/19/41d Compliance with NHS provider licence conditions and code of governance - self-certifications (agenda item 10.4)
MB reported that the paper included the first self-certifications required by NHS Improvement with the next due in June 2019. It provides 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.

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.

TB/19/41e Operational plan 2019/20 (agenda item 10.5)
MB reported that delegated approval had been given on the final operational plan to the Chair, Chief Executive, and Chair of Audit Committee. This version would be available on the Trust's website and was being received in public session of the Trust Board for completeness.

It was RESOLVED to NOTE the final version of the 2019/20 operating plan which will be made available on the Trust's website.

TB/19/41f Update of the Scheme of Delegation (agenda item 10.6)
MB reported that the draft updates to the Scheme of Delegation had been included in tracked changes and included recognising the role of the Members' Council in appointing the Chair and Non-Executive Directors, areas around Estates in terms of the final disposal transactions, tightening of internal financial approval levels around financial challenge, and which strategies require the approval of Trust Board.

The Board discussed the following additional amendments:

- Consideration of any specific powers delegated to the Senior Independent Director.
- Update references in relation to innovation and change.
- Approval of memorandums of understanding by Trust Board.
- Removal of discipline of employees.
- Update the name of the Quality Strategy.
- Update the name of the Equality & Inclusion Forum to Committee following the Board's approval under agenda item10.
- Whether the learning from healthcare deaths policy needs to continue to be approved by Trust Board.
- Update the name of NHSLA to NHS resolution.
- Reflect that the Charitable Funds Committee is a committee of the Corporate Trustee.

Action: Mark Brooks

It was RESOLVED 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 and**
- **APPROVE the updated Scheme of Delegation and to RECOMMEND the final for approval to the Members' Council.**

TB/19/41g Going Concern (agenda item 10.7)

MB reported that 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 external auditors require evidence with respect to how that conclusion has been derived with the principles to be followed outlined in the paper.

It was RESOLVED to APPROVE the preparation of the 2018/19 annual accounts and financial statements on a going concern basis.

TB/19/42 Receipt of 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 9 April 2019 - SY commented that the terms of reference were discussed with no change to the Trust's membership. The integrated care outcome framework was discussed with recognition that mental health outcomes were not as strong as they could be. The joint strategic needs assessment approach was agreed which will assist with being able to analyse data at a departmental level. RW commented that the Board would need to receive the revised terms of reference if it became a formal member.

Action: Salma Yasmeen

- Calderdale Health and Wellbeing Board 21 February 2019 - TB commented that the Trust was signed up to the domestic abuse pledge.
- Kirklees Health and Wellbeing Board 28 March 2019
- Wakefield Health and Wellbeing Board 21 March 2019
- West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group 19 March 2019 & 24 April 2019

- West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive 2 April 2019 - RW commented that the System Leadership Executive has been discussing the financial plans for 2019/20.

It was RESOLVED to RECEIVE the updates provided.

TB/19/43 Assurance from Trust Board Committees (agenda item 12)

Audit Committee 9 April 2019

LC highlighted the following:

- 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 the Minutes of the Committee meeting held on 8 January 2019 (attached to Trust Board papers).

Clinical Governance & Clinical Safety Committee 2 April 2019

CD highlighted the following:

- Care Quality Commission (CQC) action plan.
- CQC letter.
- Wetherby YOI report.
- Whistleblowing Freedom to Speak up Guardians.
- Bullying & Harassment – for discussion at Workforce & Remuneration Committee
- Approved the Minutes of the Committee meeting held on 12 February 2019 (attached to Trust Board papers).

Nominations' Committee 9 April 2019

AM highlighted the following:

- Nominations' committee annual report and revised terms of reference - prior to receipt and approval by Members' Council.
- Review of skills and expertise required on the Board, including recommendation for the re-appointment of a Non-Executive Director to the Members' Council.
- Lead Governor appointment process - prior to review by Members' Council.
- Committee work plan for 2019/20.
- Approved the Minutes of the Committee meetings held on 16 July 2018 and 28 September 2018 ((attached to Trust Board papers).

It was RESOLVED to RECEIVE the updates provided.

TB/19/44 Trust Board work programme 2019/20 (agenda item 13)

Trust Board is asked to NOTE the work programme.

TB/19/45 Date of next meeting (agenda item 14)

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.

TB/19/46 Questions from the public (agenda item 15)

TB/19/46a - Is the scanning of records done by an outside company and does it convert them into text?

MB commented that the Trust had its own scanning bureau which has to operate to a standard definition which allows the destruction of original records.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 25 June 2019
Rooms 5 & 6, Laura Mitchell, Halifax

Present:	Angela Monaghan (AM)	Chair
	Laurence Campbell (LC)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Tim Breedon (TB)	Director of Nursing and Quality/Deputy Chief Executive
	Dr. Subha Thiyagesh (SThi)	Medical Director
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Mark Brooks (MB)	Director of Finance and Resources
Apologies:	Members	
	Charlotte Dyson (CD)	Deputy Chair/Senior Independent Director
	Sam Young (SYo)	Non-Executive Director
	Attendees	
	Salma Yasmeen (SY)	Director of Strategy
	Emma Jones (EJ)	Company Secretary
In attendance:	Carol Harris (CH)	Director of Operations
	Sean Rayner (SR)	Director of Provider Development
	Simone Kane (SK)	Management Assistant (author)

TB/19/47 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies as above were noted. At the commencement of the meeting there were 3 members of the public in attendance which included 1 governor. 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.

The Board welcomed Mike Lodge, Calderdale Council, discussing Calderdale Cares, which was taken as the first item on the agenda due to Mike having other commitments – see (item 7.2i).

TB/19/48 Declarations of interest (agenda item 2)

Name	Declaration
Non-Executive Directors	
QUAIL, Kate Non-Executive Director	Owner/Director of The Lunniagh Partnership Ltd, Health and Care Consultancy. Carries out Care and Treatment Reviews (CTRs) – advised will not be carrying these out for any SWYPFT service users in future.

There were no further declarations over and above those made in the annual return in March 2019 or subsequently.

TB/19/49 Minutes of and matters arising 30 April 2019 (agenda item 3)

There were apologies for the late circulation of the minutes of 30 April 2019. No corrections were raised. The minutes to be formally approved at the July 2019 Trust Board meeting.

Action: July Board

The following matters arising were discussed:

- 19/34 - Sean Rayner (SR) explained a meeting took place yesterday and the transition is the subject of a specific bid proposal. This is covered under a separate agenda item.
- 19/36a - Alan Davis (AGD) stated the 3 HR directors and medical directors across West Yorkshire are meeting and that he would provide an update in July. STh confirmed the first part of the action has been completed and closed.
- 19/41f - This has been approved at the Members' Council.

TB/19/50 Service User Story (agenda item 4)

The Trust Board heard a service user story in relation to a change to the Neurodevelopmental pathway in Child & Adolescent Mental Health Services (CAMHS). Helen Walsh (HW) attended to present the service user story, discussing the change to the Neurodevelopmental pathway in CAMHS, in which two processes and teams have been brought together into one pathway, looking at all the issues a child has as a whole, as opposed to separately. The family concerned has twin boys, with one boy going down the 'old' pathway, and one going on the 'new' pathway – providing direct comparison.

Following the old pathway the family provided feedback and reported that they found the first process very long, they didn't always know what was happening, it felt confusing and they felt left on their own. It was recognised in screening that the child had traits on the spectrum, and under the old pathway this meant re-starting the process and being put on a process for an autism assessment.

The second child was originally referred to the old pathway, but transferred over to the new. The referral had been accepted for an ADHD assessment, and following assessment it was noted he did not have ADHD, and more likely was on the spectrum. Under the new changes the whole process was resolved in one pathway from assessment through to diagnosis.

The family wanted the Trust to know of their experience, and that the new pathway was quick, efficient, and they were looked at as a whole. A direct quote from the family was that it was the: "first time we felt like we had been treated like human beings".

Rob Webster (RW) reminded the Board that until the last year the waits on the pathways were years, not months, and that this would have meant substantial delays in the "old" pathways. We are now in a position where, by August, the pathway waits will be in line with NICE guidelines of within 6 months, which is a much improved experience. CD asked for an understanding of the referral and assessment process.

HW explained the new assessment process:

- One set of referral documents, with useful information included.
- Offered appointment with parents regarding developmental history.
- Alongside this is a clinical 1:1 with the young person at the same time.
- From initial assessment the young person will access any additional assessments required.
- If there is complexity the additional assessments can be quickly completed.
- All information is discussed together, to finalise whether there is diagnosis or not.

- Feedback appointment with full report which covers all aspects.

Laurence Campbell (LC) stated that the changes sound very positive, and questioned whether this learning can be transferred to other services and places. Carol Harris (CH) explained that the CAMHS service does not work in the same way in every location. It was noted that it is interesting how many other issues are highlighted at the initial assessment, and HW advised this was one of the main drivers for reviewing the pathway and making the service more integrated. CH confirmed that there is definitely learning that can be taken into other services.

The Board was advised that it was HW's vision, tenacity and drive that made this change happen. RW advised that clearly this has made a big difference to individuals, and is very much aligned with the Trust values. The challenge is how we can do this in other places. There is stress and pressures in other services, and there is a need to look at how to support people to make change happen in other services.

The Board thanked HW for attending, and to the service user for sharing their story. CH to report back on how the learning from this change can be used to benefit other services

ACTION: Carol Harris

It was RESOLVED to NOTE the Service User Story.

TB/19/51 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- There will be issues that are being discussed in the private session of the Trust Board, and there was also a private strategy meeting in May. These are items that have met the test of being discussed in private before it comes into the public agenda typically for reasons of commercial confidentiality.
- The Board had the following items in private, which are considered as commercial in confidence or related to individual care:
  - Those aspects of financial performance considered to be commercial in confidence.
  - Serious incidents under investigation.
  - CQC inspection update
  - Commercially confidential business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs).
  - Minutes of private partnership board meetings.
- The strategic meeting held in May discussed:
  - Organisational development strategy.
  - Interactive session around stakeholder mapping and relationships.
  - Briefing session on CQC well led review for board members.
- To note the Trust is recruiting for a new financially qualified non-executive director with senior financial management experience. The open evening was held yesterday and will close on 3 July 2019.

Chief Executive's report

RW commented that "The Brief" communication to staff was included in the papers and provided an update on the local and national context as well as what was happening across the organisation and highlighted the following since its publication:

- The NHS Confederation conference was held last week. Strong emphasis on moving forward, implementation of long terms plan, the People Plan and the role of Integrated Care Systems (ICS) in delivering improvements of care. Simon Stevens (CEO of NHSE/NHSI) talked about the NHS being a good employer and this was reinforced in all the sessions attended.
- Second of the Listening Events was held 24.06.19 in Kirklees following an earlier event in Barnsley. The feedback was good and constructively challenging. Discussions included the direction of the organisation. Staff were positive and proud of the work around children, and continue to reinforce the positive nature of team work and resilience; wanting more support on a range of things such as buildings, IT and stronger communications. In addition there were requests for further engagement with GPs and primary care networks, endorsement for staff to make changes and given permission to do so. The feedback will be taken into the Organisational Development (OD) programme. There is a mixture of people attending the events, but not felt to be enough frontline staff and thought needs to be put into ensuring engagement reaches everyone affected.

Tim Breedon (TB) reported from the session he attended it was pleasing to see staff translating the organisational plan into what it means to them with very good examples provided. AM felt it illustrated the benefits of gaining a range and diversity of views. AM noted that engagement with the GPs is one of the areas highlighted for further work in the stakeholder engagement plan.

AGD discussed the team listening events, which had engaged over 700 staff, and team working. Positive feedback around supportive teams and team leaders had been received. More negative feedback had been received around team development not taking place. There was strong support for better engagement – particularly around being involved in decisions on individual jobs and making things better.

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

TB/19/52 Performance reports (agenda item 6)

TB/19/52a Integrated performance report M2 2019/20 (agenda item 6.1)
TB highlighted the following in relation to the Summary and Quality sections:

- Under-18 admissions to adult beds – TB advised that the data had been omitted from the summary dashboard due to formatting issues on the front dashboard, but is included in the national metrics section. Unfortunately there has been a recurrence of admissions after a couple of months of good improvement, and there is a need to keep a strong focus on this issue. A new CAMHS group is helping to bring the work together, with a coordinated internal child and adolescent mental health services (CAMHS) improvement programme in place. TB is attending the new CAMHS system governance oversight group and will be taking this issue forward through this group. As part of Tier 4 CAMHS work, when a bed is required for a young person all beds throughout the country are checked for admission possibilities in the first instance, prior to using an adult bed. TB stressed using an adult bed is only used when it is the "least worst" option and specific safeguards are put in place to ensure the safety of the individual.

RW reported that there have been occasions where there have been no beds available in the country, hence the need for adult provision to be used.

AM asked what more we are doing to increase capacity and resource at the preventative end, to avoid the need for admission. CH reported that as part of the development of the

new model of care there has been some investment in home treatment teams. There will always be consideration if a person can be cared for at home first prior to any admission. LC suggested this would be a good subject for a service user story. CH to identify if there is a suitable patient story to come to the Trust Board.

ACTION: Carol Harris

AGD emphasised the importance of the new inpatient CAMHS facility being built in Leeds for West Yorkshire residents. AM noted that a planning application has recently been submitted. RW explained there is no single commissioning model as yet in terms of all the tiers in CAMHS. It is recognised that areas have different models and that the picture is not as joined up as it should be. The Trust can play a role in helping improve this.

Kate Quail (KQ) mentioned targeted and universal prevention work taking place in schools. AM asked how does the Board keep a view on this with sufficient focus and resource, to be confident that we deliver the right approach? AGD asked what in the system has failed given the number of children and young people placed on adult wards in May? It was suggested this is reported as a priority programme in the IPR to give the Board assurance and highlight progress and risks. CH/Salma Yasmeen (SY) to develop a report to include in the IPR on an ongoing basis.

ACTION: Carol Harris/Salma Yasmeen

TB highlighted the following:

- Safer staffing – overall okay, very significant local pressures remain in some places.
- Information Governance (IG) confidentiality breaches – increased this month following a reduction in previous two months. This indicates that positive progress requires embedding in the Trust.
- Out of area - bed numbers increased in May, but lower daily costs given cessation of charges for one complex package of care.
- Aware of acuity and demand pressures, significant regulator workload which has a huge impact on clinical areas of expertise.
- Complaints – progress in terms of quality of responses. Some delay in implementation of the recovery plan due to a reduction in senior management capacity. The numbers are reducing, with people having more local resolution. We are now considering how we ensure the loop is closed in terms of operational turn-around of the query. Expected to get to target in original plan by September, which is challenging.
- Friends & Family Test (FFT) results for mental health – the text message reminders were out of action during the RiO/SystmOne transition which may have reduced numbers.
- Medicine Omissions – deterioration again this month. Data collection issue is being looked at currently. There are some wards doing exceptionally well. The Board will retain a focus on this.
- Falls – decrease in falls back to previous levels which is positive.
- Care Quality Commission (CQC) – have received verbal feedback from the well-led review, with positive messages about leadership in the organisation, and are awaiting the formal report by the end of July 2019.

Erfana Mahmood (EM) asked about the prone restraints, noting that the figure has crept up slightly. TB advised that it is being reviewed. The clinical governance and safety committee (CGCSC) continues to have focus on this area. CH noted that some wards have particularly high acuity and the number of restraints often relates to specific service users.

EM asked about the number of patient incidents with severe/moderate harm. TB explained that the recent figure is the unvalidated level on reporting, which tends to be higher in a

prudent organisation. This can change once the incidents have been reviewed. He advised that all incidents rated as red are fully reviewed.

RW asked if the next report could include details of how many restraints have been carried out on a single individual to show whether there was a general trend or a specific increase due to individual issues. Similarly it was discussed if there is further benchmarking data available that can be used to put the matter into some sort of context. RW had attended the North East, Yorkshire & Humber meeting where the numbers of restraints had been benchmarked, for example. TB to include further prone restraint information in the next IPR.

ACTION: Tim Breedon

AM picked up on IG breaches and what more could be done to reduce and remove these. Mark Brooks (M)B advised that there was a deep dive in audit committee which provided audit committee members with good assurance. The Trust has introduced writing to general managers where issues have arisen and asked for action plans to address the concerns. Where there has been negligence in approach, disciplinary action can be and is considered. There is regular communication in place and MB noted that the number of incidents reportable to the Information Commissioner's Office (ICO) has reduced substantially over the past four years. MB considers the regularity of the awareness campaign to be a key factor in reminding people of their responsibilities. All incidents are investigated and there are areas identified for improvement. RW advised there could be further communication and awareness about the fact that disciplinary action can be taken. EM stated that the figures are low for a Trust of its size, but agreed this needs to be further reduced/removed.

LC noted the yellow, red and amber incidents have dropped. TB advised the drive around reporting and analysis continues and is kept in focus.

LC raised the issue of fill rates falling in some areas. TB explained that the safer staffing group continues to review fill rates, which remain over 100% in aggregate.

Out of area beds – AM challenged the higher usage reported in May – there has been huge effort put into this issue and there are still high numbers and high costs being incurred. CH reported there has been a spike again, with a reduction prior to this. The driver diagram and a more detailed report will be coming to Board in July. Work stream leads have provided feedback. If there was one single issue that caused people to require an out of area bed placement this would have been addressed, but it is a culmination of a wide variety of causal factors. Our external partner, SSG, is providing us with some support which is helping with pace, drive and challenge. It has been identified that we need to reduce the number of people that require acute care. There is ongoing work around community caseloads and effective gatekeeping is essential and we are striving for this to be in place for every case in every area. In addition we are focusing on patient flow, with the aim of a single approach to this, looking at how admissions are facilitated and discharges are brought forward. MB stated that the trend graph over 12 to 15 months is an improved position, and should recognise that Wakefield has not had an out of area placement since August last year. Similarly Barnsley has not required an out of area bed placement for a considerable period of time. CH also stressed that we continue to work closely with partners on this issue and a system wide approach is being taken.

It was noted that bids for crisis team funding have been completed and submitted. RW emphasised the need for fidelity to the model if we are to reduce out of area placements and deliver good community based care.

AM questioned whether there are any areas where there are capacity or resource gaps as opposed to change in behaviours or culture. Dr Subha Thiyagesh (SThi) highlighted the

need for culture change and the positive impact this is having. CH to prepare a detailed update report for the July Trust Board meeting.

ACTION: Carol Harris

It was RESOLVED to NOTE and recognise the wide range of work and effort into this.

MB highlighted the following in relation to the national metrics:

- SystmOne implementation and data catch up – some of the metrics are currently requiring increased checking due to the new system implementation. There is also continued familiarisation required with the new system and how data is entered and reported. As such, not all metrics have been reported this month. For access measures in particular the impact of the data catch up means that it will take a few weeks to be certain of the comprehensiveness of data quality.

EM queried early intervention. MB reported it is potentially a data quality issue which will be kept in focus and reported back at the next meeting.

AM noted that it is positive that the clients in employment has turned green.

CH highlighted the following in relation to the locality section of the report:

- Barnsley general community – Neuro-rehab unit had an open day on 21 May. Work is ongoing in relation to stroke services, and the proposed model.
- Barnsley mental health – community focused hub – reported better communication with teams.
- Calderdale/Kirklees business delivery unit (BDU) – intensive support team work on improving access to psychological therapies (IAPT) continues. David Black from NHS England has been in touch in relation to lower performance in relation to the access target and there are meetings in place with progress updates to be brought back to Board.
- Forensic BDU – work supported by human resources (HR) focusing on leadership, sickness and absence. Highest turnover of service lines. Also focusing on wellbeing and reducing bullying and harassment.
- Specialist BDU – Learning Disability - staff vacancies remain relatively high which does cause problems in relation to waiting lists and times.
- Wakefield BDU – Highlighted the good work on Stanley Ward in relation to medication issues. They are using safety Crosses and have had positive results.

LC asked about the performance notice mentioned and what this was. CH reported this was the notice in Wetherby Young Offenders Institute as previously raised in Board meetings.

MB highlighted the following in relation to priority programmes:

- RiO – access to RiO will cease in five days. We can still access data as an organisation through the archive, but clinicians will not have access directly. The SystmOne go-live continue to progress well with a plan for optimisation of the system due to commence shortly. The data catch up has been completed.
- Out of area bed placements have already been discussed earlier in the meeting.

MB highlighted the following in relation to financial performance:

- YTD we are ahead of plan with a £1.2m deficit. Need to generate a £1m gain in the rest of the year to meet the control total.

- Pay increase in excess of £700k in one lump sum was made in April which impacts significantly on the year-to-date result.
- Financial rating has moved from 1 to 3 and is unlikely to improve from this until end of Q3/early Q4.
- Out of area beds – higher than planned – £115k relating to one service user.
- Staffing costs are showing a net saving to date given the current vacancy levels.
- Agency costs – increased over the last 12 months – on the current trajectory we will be almost £2m over on agency compared to by the end of year. This is heavily influenced by medical locum spend. There are action plans in place to address as far as possible, but there are national supply issues with some staff groups and specialities.
- Cost improvement programmes (CIPs) – there are more unidentified than at start of year largely due to concern over delivery of savings on drugs costs.

LC discussed agency coming up as an issue, and whether it is something to build into the monitoring work at the Finance Oversight Group.

RW questioned bringing back the statement on reducing agency used by the Board previously. As a Board it would be beneficial for the board statement on agency controls to be refreshed. Board statement on agency controls to be updated CH/MB.

ACTION: Carol Harris/Mark Brooks

There is a net risk to achievement of the control total of £1.5m at this stage.

AM asked what the most significant CIPs are and MB highlighted:

- Increase in vacancy rates
- A range of savings in non-pay
- Out of area bed placements

RW stated there needs to be gains in internal productivity and we need to encourage team-led improvements in order to improve the financial position.

It was noted there is detailed discussion through the new Financial Oversight Group (FOG) meeting fortnightly. One of the meetings is around the numbers for the month and the other about CIPs and sustainability.

AGD highlighted the following in relation to Workforce:

- Vacancies –underspending on staff costs due to the number of vacancies. Need to have the intelligence behind this in terms of where they are and what the impacts are. 10% turnover would be seen as expected in an organisation of this size.

EM commented that the sickness reporting is going well. AGD agreed there has been robust work ongoing around sickness, with focused action to support a reduction. SThi advised there is a link between reducing sickness, wellbeing and recruitment. It was discussed how wellbeing impacts on recruitment in terms of staff choosing to work in the Trust.

Engage and listening events have taken place with staff. The wellbeing group is working on collation of feedback and an action plan to draw on key themes, and importantly supporting the BDUs in delivering the actions. The wellbeing group has representatives from BDUs, Occupational Health, Staff Side, Human Resources and Support Services.

It was RESOLVED to NOTE the Integrated Performance Report

TB/19/53a Update on Learning Disability Services and National Context (agenda item 6.1i)
TB reported there are currently three significant issues relating to learning disability services:

- BBC Panorama programme on abuse at Whorlton Hall
- LeDeR annual report
- CQC report - Segregation (long term)

Panorama programme - TB emphasised the appalling and shocking issues raised in the BBC programme. It was noted the Trust does not provide long stay hospital beds. Horizon centre is for short term treatment and assessment. We do not supervise out of area placements ourselves as an organisation and they are commissioned by clinical commissioning groups (CCGs). There may be occasional temporary placements where the Trust remains involved.

LeDer Report - There are matrons working in Calderdale and Huddersfield Foundation Trust (CHFT) and Mid Yorkshire Hospitals Trust linked to our service to provide support. In terms of respiratory related deaths, which came out of the report, a specialist practitioner has been recently employed by the Trust. Mandatory training is being looked at in this area for all staff.

Long term segregation - People in segregation in the Trust are in their own area (lounge, bedroom, dining area etc), with access to the community and direct contact with people in the multi-disciplinary team and elsewhere as appropriate. Often seclusion is about the service user's ability to manage living around other people – which is different to those in seclusion where people are isolated from contact, often in a defined area. Our position is that all service users are assessed by multi-disciplinary teams with appropriate care plans.

The new approach in terms of pathways supports the direction of travel and transition.

AM commented on recognising autism and ADHD within these concerns. She asked if we provide learning disability awareness training and whether it should be mandatory. SThi noted the similarities with dementia training for staff. CH suggested that this would need further consideration and that we need to consider practical ability to deliver and priorities within the resources we have. TB suggested it could be considered as part of induction training. AGD reported that there needs to be a plan behind any mandatory training so that it does not fall down in terms of resources.

RW advised that it is a recommendation from the long term plan, and may require some targeting resources with it. He would like the Trust to commit to training for all staff whether there is a national programme or not.

AM stated that, given the Trust's position as a specialist in this area, we should be increasing awareness of our own staff.

KQ asked for confirmation that we agreed with the three recommendations relating to segregation. TB confirmed this is the case. AGD/TB to report back on the potential training solution for all staff.

ACTION: Alan Davis/Tim Breedon

TB/19/53b Incident Management Annual Report 2018/19 (agenda item 6.2)
The report has been through the Clinical Governance and Clinical Safety Committee (CGCSC). There has been an increase in the number of incidents in the year, with no never events within the organisation reported. The committee felt there were good systems and processes in place to ensure that all the information was properly considered and addressed. The report provides important data to support improvement.

EM gave feedback that it was a very good report to read and AM stated that the committee also commented on the high quality of the report.

LC commented on the violence on staff which appears to be an increasing trend. TB reported that this is also being discussed as part of the staff wellbeing agenda. RW advised that we shouldn't speculate on the cause, and should look at the evidence. RW and CH have met with the police recently and they confirmed that it can be appropriate for somebody receiving services to be subject to criminal proceedings. CH noted there are different approaches taken by different police forces in our geography. The positive relationship with the police was also noted. TB to report on the causes of the increased number of incidents of violence against staff.

ACTION: Tim Breedon

AM asked if levels of absence due to assaults and violence can be broken down. Discussed that this would not be easy as can only be broken down into current categories. CH reported there are discussions in Forensics around supporting staff resilience and looking at alternatives to going off sick after serious incidents, trying to be more proactive, working with staff. Staff side representatives are part of the wellbeing group and these discussions.

It was RESOLVED to RECEIVE the Incident Management Annual Report for 2018/19 and the assurance from the Clinical Governance and Clinical Safety Committee.

TB/19/54 Business developments (agenda item 7)

TB/19/54a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.1)

Engagement as an organisation within the South Yorkshire agenda has improved.

AM asked if we are clear about the opportunities and potential impact for SWYPFT in South Yorkshire. AGD advised that we are involved and that there is opportunity to influence in the area more than previously. The mental health work between the three main provider organisations has always been strong, and is developing well in terms of collaborative work.

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

TB/19/54b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.2)

- The partnership board had its inaugural meeting in June.
- Voluntary and community sector event held Tuesday 21 May which was positively received
- A number of funding bids have been made recently including transforming community mental health and crisis care
- Calderdale (page 6 - 4.1) –. Calderdale Cares is being progressed and Primary Care Networks are in the process of being established. There is good evidence about quality improvement that takes place through working across agencies.

Collaborative bids are to be submitted across the partners. We have gone through a collaborative arrangement for additional community staff and crisis care. It is now at a point where the partnership can use the governance in place through the Committee in Common.

AM commented that there was a question from a governor at the recent engagement event in Leeds regarding the potential blurring of commissioner and provider roles and this may need explaining to the members' council.

RW discussed 3.6.1 (Mental Health, Learning Disabilities and Autism Collaborative) – SWYPFT have signed up for and are funding health champions of people with a learning disability. This cadre of people with a learning disability provide advice and leadership on a range of issues. We need to think about how we use this network in developing services in the future.

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

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

TB/19/54bi Calderdale Cares - One year on (agenda item 7.2i)

Mike Lodge attended from Calderdale Council. Calderdale Cares is the Council's approach to health and integration and is very much a partnership exercise. Mike advised that the last year was a shadow year, experimenting and testing. Groupings have been made on a locality basis of GP practices with populations of 30-50k. The Primary Care Networks dovetail neatly with this approach. There was a slight pause whilst the practices were arranged into networks. The localities are fully committed to working in partnership. Points to note:

- Progress has been quicker in North and Central Halifax.
- Central Halifax carried out a large exercise of getting together front line workers and established this with co-chairs.
- North Halifax has appointed a co-chair.
- Other localities have taken a little longer to establish.
- All five are now in place.

Moving on from the shadow year there are a number of opportunities:

- Adult services are re-commissioning home care services based on locality
- CHFT have arranged some of their community services based on localities.

The local councillors are keen to be involved, and the council's cabinet appointed councilors to each of the five localities which is a very positive initiative.

Examples in the report from the Work Wellness project:

- Discussed example of practice manager, and positive stories of helping people and people getting back into work.
- Working alongside other agencies such as Department for Work & Pensions, Healthy minds etc.

The Board thanked Mike for the overview. KQ gave positive feedback, and asked about the alliance that the CCG is forming. Mike did not have all the details but explained the alliance will be built on the localities work, which is positive.

RW reminded board members there is a leadership group which he attends looking at these issues. The Trust can provide additional support across three broad areas:

- Sports, Art, Leisure, Wellbeing (Spirit in Mind, Recovery College, Creative Minds).
- Mainstream services – The Trust delivers a wide range of services and we need to ensure that they are seen appropriately, extensively through the alliance.
- Governance/Structures – to think carefully about how the alliance is formed and the work that is done with it. A collective view of the service needs to be decided upon.

KQ added we can support moves towards social prescribing.

AM reported that she attended the visioning workshop on climate change and population health in Calderdale, and discussed making sure that this figures as part of the thinking in the whole package, including the link and impact of climate change on people's health.

RW advised there is a presentation which shows the contribution that the NHS makes towards air quality, which would be of interest.

The Board thanked Mike Lodge for joining the Trust Board.

It was RESOLVED to NOTE and COMMENT on the update.

TB/19/54bii Wakefield's Integrated Care Partnership (agenda item 7.2ii)
SR reported that all papers have been previously provided to Board and all partners had the opportunity to comment. Final versions have been presented to Board. There is an aim of multi-agency working based on previously agreed arrangements

Risks and issues pulled out and highlighted in the report to Board:

- There are risks if the Trust is not party to the arrangements, and also in terms of emerging alliances, as we wouldn't necessarily be involved in how they develop and shape.

AM asked to check that all parties are involved, and SR advised he feels assured this is the case to the best of his knowledge.

LC asked in relation to page 3 of the document – connecting care executive – what is the necessity for this? SR advised increasingly less so over the course of time. RW suggested it is expected most of the business will be conducted collaboratively It is also the case CCGs face reductions in budget and work much more closely with councils in commissioning together. There will need to be governance on how they work together, and therefore some kind of executive function will be required to bring the new arrangements into line.

LC asked about dispute resolution and felt this appeared vague in the documentation about what this exactly means. SR agreed and that it would need to be tested to fully understand how the operational arrangements work. However, he also emphasised the point that the agreement states 'no partner is bound' and that the ultimate action would be to break the agreement.

RW asked to clarify the diagram on page 4 – MH Alliance – under membership. SR reported there are a number of members missing and he will review. AM asked if the scope includes learning disabilities (LD) and autism, and SR advised that it doesn't at this point. It was noted these arrangements are non-binding and do not constitute a significant transaction from a governance perspective. SR to review the diagram on page 4 and advise of any changes.

ACTION:Sean Rayner

SR was thanked by the Board for his hard work into this area.

It was RESOLVED to:

- **NOTE the update on the next stages for Wakefield in further integrating health and social care across the district;**
- **APPROVE a recommendation for the Trust to be a party to the revised terms of reference for the Wakefield Integrated Care Partnership, and a member of the Partnership; and**
- **APPROVE a recommendation for the Trust to be a party to the updated system partnership principles of ways of working together in Wakefield.**

TB/19/55 Strategies and policies (agenda item 8)

TB/19/55a Communications, Engagement and Involvement Strategy - progress update (agenda item 8.1)

TB reported that the Comms survey results show a continued and significant improvement in satisfaction orates.

AM gave feedback on the good work, and good reading of the report.

LC observed that the internal networking had "shot up" in terms of staff being informed.

CH noted that specialist services were reported as top in feeling engaged, and hopefully we will see this result in a change in the NHS staff survey results.

RW asked about the appointment of a new Comms and engagement lead. TB reported this was completed last Friday and an announcement would follow due process.

It was RESOLVED to NOTE the update.

TB/19/56 Governance matters (agenda item 9)

TB/19/56a Update on Annual Report and accounts including Quality Account 2018/19 (agenda item 9.1)

The accounts remain confidential documents until they are laid before parliament which MB expects to be by mid-July.

It was RESOLVED to:

- **NOTE the update**
- **RECEIVE in public the external audit reports relating to the annual accounts and quality account.**

TB/19/56b Trust Board self-certification (FT4) - Corporate Governance Statement 2018/19 (agenda item 9.2)

MB introduced this paper and explained it is the second phase of self-certification reporting for compliance with our licence terms. Rationale is provided as to why we comply with the licence. The report has also been reviewed at the Executive Management Team (EMT) meeting. It was also noted that good practice is to have a well led governance review every three years. The Trust has relied upon the CQC well led review in each of the recent years and therefore need to consider when would be the right time to have a well led governance review with an external provider.

AM advised the Board to consider the cost of doing this with a third party, and the risks in not doing so with our regulator, which would inform part of the consideration (risks and benefits).

Minor comments from AM (page 2) should say 2018 not 2019. (Page 8) staff governors as Freedom to Speak Up Guardians to be reworded as not all staff governors have taken up this role. (Page 9) the chair appraisal is reported to council but not the non-executive directors' appraisals. MB will amend these. MB to assess the need for an external well led review. MB to make final changes to the self-certification assessment and submit.

ACTION: Mark Brooks

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

- **the Corporate Governance Statement 2018/19; and**
- **the training for Governors 2018/19.**

TB/19/56c Annual Safety Services Report 2018/2019 and 2019/2020 Action Plans (agenda item 9.3)

This report has also been reviewed by the Executive Management Team and Clinical Governance & Clinical Safety Committee. It does not sit in isolation, linking to a number of other annual reports. AGD raised the following key points:

Sprinkler systems – there was a decision to install all new developments with sprinkler systems. Programme of installation is ongoing.

When looking at Health and Safety – management of violence and aggression has been a key area of focus.

MB asked AGD to confirm to Board members that there is assurance of compliance with all relevant legislation. AGD confirmed that compliance is being met.

LC asked on the issue relating to lone working devices. AGD advised it depends on the team, some areas require the lone worker devices, and others feel there are better options to manage the risk. This is being audited in terms of compliance. OMG receive regular reports and updates.

RW asked to confirm actions arising in terms of CQC where there may be a Health and Safety element. AGD advised the patient call system has not been included in the report; it features in the minor capital report. MB suggested that the CQC action plan is reported in the IPR. Patient call system is being actioned, and if unsuccessful there would be risk.

AM advised the CGCS committee felt the structure was good and clear.

It was RESOLVED to APPROVE the Annual Safety Services Report 2018/2019 and 2019/2020 Action Plans.

TB/19/56d Finance and performance governance - Terms of Reference (agenda item 9.4)

Finance Oversight Group (FOG) - LC reported there was a comment raised at the meeting regarding terms of reference, about whether it would be appropriate to have clinical representation, either as well as, or in addition to, what was included in the draft terms of reference. AGD felt it was important to ensure we provide the best quality of care and including a clinical representative sends a positive message to the organisation. Currently,

there is insufficient non-executive director capacity to add to the number of on the group. It was agreed:

- MB comes off as a member and a clinical member would instead be included as a member. MB would attend the meeting.
- It was agreed in Board that the clinical member would be TB.
- The lead director for the meeting will be RW.

These were agreed and approved, and will be stepped down once an additional non-executive has been recruited and a Finance and Performance Committee established.

It was RESOLVED to APPROVE the terms of reference for the Finance Oversight Group, subject to any amendments agreed in the Trust Board meeting.

TB/19/57 Receipt of minutes of partnership boards (agenda item 10)

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

- Barnsley Health and Wellbeing Board 4 June 2019
- Calderdale Health and Wellbeing Board 20 June 2019 - To ensure there is appropriate representation at the next phase of business plan around new service developments
- Kirklees Health and Wellbeing Board 13 June 2019
- South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board 10 May 2019
- West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group 24 April 2019 & 21 June 2019
- West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive 7 May 2019

It was RESOLVED to RECEIVE the updates provided.

TB/19/58 Assurance from Trust Board Committees (agenda item 11)

<u>Audit Committee 21 May 2019</u>
LC highlighted the following:

- Annual meeting to review, and propose to Trust board the approval of annual report accounts and quality account, together with the internal audit report. Was completed and received by Board.
- Approving minutes of meeting 21 May 2019.

<u>Clinical Governance & Clinical Safety Committee 14 May 2019 and 11 June 2019 Tim</u>
TB highlighted the following:

- Highlights have been discussed in agenda.

<u>Equality & Inclusion Committee 4 June 2019 Chair</u>
AM highlighted the following:

- Performance dashboard has been further developed and metrics agreed.
- Updates on equality standards.

- EDS2 panels – now rated as 'achieving', as opposed to 'developing', which is positive.
- Received equality strategy annual report.

Mental Health Act Committee 14 May 2019 Kate
KQ highlighted the following:

- CQC observed last meeting.
- Amendment to Mental Capacity Act and Mental Health Act – significant pieces of work.
- Presentation on reducing restrictive practice.
- Young people under 18 and 136 suite.

RW discussed the reducing restrictive practice presentation at the Extended Executive Management Team which was very good. The language used in the area was discussed by EMT, where the common term used is "MAV", "managing aggression and violence". EEMT agreed that this was unhelpful as it associates people we support with aggression and violence. The aim is move away from references for "MAV" and RW urged the Board to champion this.

Workforce & Remuneration Committee 7 May 2019 Sam
AM highlighted the following:

- Approved minutes of meeting held on 12 February 2019.

It was RESOLVED to RECEIVE the updates provided.

AM advised that updates from the Finance Oversight Group be included in on future Trust Board agendas.

ACTION: EJ to update to agenda

TB/19/59 Use of Trust Seal (agenda item 12)

It was RESOLVED to NOTE use of the Trust's seal since the last report in March 2019.

TB/19/60 Trust Board work programme (agenda item 13)

A summary is provided in the IPR, and due to those arrangements will be removed from TB work programme.

ACTION: Emma Jones

It was RESOLVED to NOTE the work programme.

TB/19/61 Date of next meeting (agenda item 14)

The next Trust Board meeting held in public will be held on Tuesday 30 July 2019, Conference Centre Boardroom, Kendray, Barnsley.

TB/19/62 Questions from the public (agenda item 15)

TB/19/62a - Question around understanding the elements of transformational change foreseen to help support partnership working, and the element of commissioning services bidding for (eg; Forensics, YP side). Views in terms of growth and income generation to try and gain funding via partnerships.

MB advised that some of this would be commercially confidential and discussed in the private Session. MB suggested that this conversation would be more beneficial outside the Trust Board meeting and agreed would discuss what he is able to with Karen after the Board meeting.

Minute taking

Thanks were expressed to Simone Kane (Forensic BDU) for stepping in to take the Minutes at the Board today.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 25 JUNE 2019 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Min reference	Action	Lead	Timescale	Progress
TB/19/50 Service User Story	CH to report back on how the learning from this change can be used to benefit other services	CH	July 2019	The learning is being shared in discussions with commissioners. There are different provisions across the Trust geography with parts or all of the pathway provided by different providers.
TB/19/52 Performance reports	CH to identify if there is a suitable patient story to come to the Trust Board	CH	September 2019	This has been requested from the inpatient service matron. When a story with consent is available, this will be prepared.
	CH/SY to develop a report to include in the IPR on an on-going basis	CH/TB	July 2019	This will now be included in the priority programmes.
	TB to include further prone restraint information in the next IPR	TB	July 2019	TB confirmed this is on track to be included in the next IPR
	CH to prepare a detailed update report for the July Trust Board meeting	CH	July 2019	There is an out of area report in the private session.
	Board statement on agency controls to be updated	CH/MB	September 2019	
TB/19/53a Update on Learning Disability Services and National Context	AGD/TB to report back on the potential training solution for all staff	AGD/TB	September 2019	Under consideration in education governance group meeting. Recommendation awaited.
TB/19/53b Incident Management Annual Report 2019/19	TB to report on the causes of the increased number of incidents of violence against staff	TB	September 2019	TB confirmed this is on track to be reported in IPR
TB/19/55bii Wakefield's Integrated Partnership	SR to review the diagram on page 4 and advise of any changes	SR	July 2019	Complete. SR e-mailed Wakefield CCG following the meeting to advise on the changes required.
TB/19/57b Trust Board self-certification (FT4) – Corporate Governance	MB to assess the need for an external well led review	MB	July 2019	Following a discussion with NHS Improvement it has been advised that currently the CQC well led review is

Min reference	Action	Lead	Timescale	Progress
Statement 2019/19				considered appropriate to meet the needs of an external governance review.
	MB to make final changes to the self-certification assessment and submit	MB	July 2019	Complete.
TB/19/59 Assurance from Trust Board Committees	AM advised that updates from the Finance Oversight Group be included in agenda in future. EJ to update to agenda.	EJ	July 2019	Complete. Include on the agenda for the private session.
TB/19/61 Trust Board Work Programme	A summary is provided in the IPR, and due to those arrangements will be removed from TB work programme.	EJ	July 2019	Complete.

Outstanding Actions from 30 April 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/34 Service User Story	The Barnsley, Calderdale, Kirklees and Wakefield services partnership will merge with Leeds and Bradford under a single partnership so that services provided can be better coordinated across the footprint. Learning disabilities will be an area of focus in the 10 year plan to improve the services and bed base. It was important for the Board to recognise that this partnership exists and Sean Rayner (SR) is the Trust's representative on the partnership. The Trust is the lead for the operational delivery network for Yorkshire and Humber and it should be raised through this network about how the learning is being captured to inform how the transition works for people across the community.	SR		Complete SR confirmed meeting took place 24/06/19 and the transition is the subject of a specific bid proposal. This is covered under a separate agenda item.
TB/19/36a Guardian of safe working hours annual report	Erfana Mahmood (EM) asked if anything further could be done to manage exceptions. RM commented that a meeting takes place with all junior doctors when they commence with the Trust to go through requirements and encourage reporting and there was a forum every three months. Largely speaking they are happy with the hours, some of the other concerns which are discussed in the forum were areas that local leads could potentially assist	SThi		Complete

Min reference	Action	Lead	Timescale	Progress
	with to improve further. One of the areas raised has been that trainee doctors only receive six weeks of mental health training which means they need lots of support when they commence with the Trust. RW commented that it was important to ensure that for any risks, if there are gaps, that they are appropriately managed and escalated.			
	RW commented that AGD, in his role as lead across West Yorkshire & Harrogate, could feed into the discussions to see if these areas could be resolved collectively.	AGD	July 2019	AGD stated the 3 HR directors and medical directors across West Yorkshire are meeting and that he would provide an update in July. AGD has confirmed that this meeting has been arranged for the 21 August 2019.
TB/19/37a Strategic overview of business and associated risks	Laurence Campbell (LC) commented that it was important that there was a coherent alignment between the corporate/organisational level risks and the Board Assurance Framework (BAF) to pick up the strategic risks. SY commented that this was being looked at further. AM commented that it should also be cross referenced with the investment appraisal framework. RW commented that the paper showed a significant update as the context was changing all the time. It was important to consider cross referencing without making it too difficult to read.	SY	October 2019	
	CD commented that it reflects the organisation, priorities and risks, however the commercial point of view needed further work. Sam Young (SYo) commented that she had some further comment on areas for inclusion in the next update. AM requested that any comments on detail be fed back to SY.	All/SY	October 2019	
TB/19/37b Board Assurance Framework (BAF)	CD commented that more insight and business intelligence was needed and whether this was adequately reflected. RW commented that the need for capacity recognised by EMT which included expertise in analysis and how to turn this into good intelligence to increase productivity. These areas are covered in the risk register, however they could	MB	July 2019	The wording of one of the strategic risks has been updated to incorporate the need for strong analysis. Updated BAF on the agenda.

Min reference	Action	Lead	Timescale	Progress
	potentially be drawn out as separate strategic risks. AM suggested that it could be included under delivering efficiency improvements and made more specific.			
TB/19/41f Update of the Scheme of Delegation	The Board discussed the following additional amendments: ➢ Consideration of any specific powers delegated to the Senior Independent Director. ➢ Update references in relation to innovation and change. ➢ Approval of memorandums of understanding by Trust Board. ➢ Removal of discipline of employees. ➢ Update the name of the Quality Strategy. ➢ Update the name of the Equality & Inclusion Forum to Committee following the Board's approval under agenda item10. ➢ Whether the learning from healthcare deaths policy needs to continue to be approved by Trust Board. ➢ Update the name of NHSLA to NHS resolution. ➢ Reflect that the Charitable Funds Committee is a committee of the Corporate Trustee.	MB		Complete. This was approved at Members Council.
TB/19/42 Receipt of minutes of partnership boards	RW commented that the Board would need to receive the revised terms of reference if it became a formal member.	SY		

Outstanding actions from 29 January 2019

Min reference	Action	Lead	Timescale	Progress
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. Updated BAF is an agenda item
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. Updated BAF is an agenda item
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.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 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. The June version of this is attached **[Annex A]**. Following the Brief there have been a number of developments: ➢ A new Prime Minister has been selected which may result in changes to the cabinet and ministerial teams. A verbal update will be provided to the Board when we meet. ➢ A Green Paper on public health and inequalities has been published. An on the day briefing from NHS Providers is attached at **[Annex B]**. The Social Care Green paper has yet to be published. ➢ The Department of Health and Social Care and NHS England have issued further guidance requesting that NHS providers reduce their planned capital expenditure by an average 21% for each Integrated Care System. This work has concluded in West Yorkshire and Harrogate with the required reductions being delivered. Further detail is included on the Board agenda. This reduction is due to provider spending which often comes from cash reserves exceeding the delegated capital expenditure limit nationally. All risks to the Trust have been identified. A draft memorandum of understanding for the West Yorkshire and Harrogate has been prepared by NHS England. This dictates the levels of support available, the final transformation funding and the expectations of national bodies in terms of delivery. ➢ Primary Care Networks have been agreed in each of our areas with different approaches being adopted in each for example; Barnsley has gone for one super primary care network; Wakefield has gone for seven primary care homes that build on the existing arrangements and; North Kirklees has four relatively new primary care networks. We are working to ensure that relationships with these new bodies are constructive.

	➢ The continuing issue of NHS Pensions and the impact on capacity in hospitals has led to the government issuing a consultation on possible solutions. There is a widespread view that the solutions offered will not tackle the problem and the consultation responses are likely to include alternatives. The Trust has already paid for sessions with staff affected so that they can appreciate their options in terms of paying tax owed. Over and above this we are not as yet seeing a significant impact in our organisation in terms of capacity.
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

27 June 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

Helen Wiggins, carer volunteers, and partners working together to celebrate carers week at Folly Hall in Huddersfield.

With **all of us** in mind.

Our **priorities** for **2019/20** so that we can be **OUTSTANDING**

NHS
South West Yorkshire Partnership
NHS Foundation Trust

OUR AIM	WHAT WE'LL DO	THE OUTCOME
IMPROVE HEALTH 	• Work with our partners to join up care in our communities • Improve our mental health offer for older people • Advance our wellbeing and recovery approach	We deliver our role in integrated care in every place
IMPROVE CARE 	• Provide safe care every time and in every service • Provide all care as close to home as possible • Make care quickly and easily available, to reduce waiting times • Embed #allofusimprove to enhance quality	Our CQC ratings and reports improve in every service
IMPROVE RESOURCES 	• Spend money wisely and reduce waste • Make the most of our clinical information • Make better use of digital technology	We achieve our financial plan and targets
MAKE THIS A GREAT PLACE TO WORK 	• Support the wellbeing of #allofus • Have better conversations with all of our people • We will not tolerate bullying and harassment	All our staff have a high quality appraisal and give us great feedback

With **all of us** in mind.

JOB NO 1019 APR19

Improving Health:
Joining up care in every place

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The **Forensic Outreach Liaison Service** (FOLS) for people with learning disabilities and/or autism launches on 1 July, in partnership with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust.

Developments in **West Yorkshire and Harrogate**:

- Funding for men at risk of **suicide** and for suicide bereavement support services
- Trust Board have agreed we will be a lead provider on **forensic services** - for adults, children, and LD
- We are part of a collective bid for **eating disorders** support
- **Learning disabilities** transforming care partnerships have now merged into one and will focus on finding opportunities for improvement
- We are supporting **CAMHS** developments across the area.

Developments in **South Yorkshire and Bassetlaw**:

- Establishing a committee in common as part of the governance arrangements
- Liaison and Diversion across South Yorkshire continues to be developed
- QUIT **smoking cessation** bids
- Changes to implement new model for **stroke** services
- Marketing of new beds in **neuro-disability** services.

Improving Health:
Joining up care in every place

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Primary care networks are being developed in all of our areas. The networks represent a shift in the way health and care is provided.

GP practices, community services, social care and others will be expected to work together in a way they have never done before.

There will be 9 networks in Kirklees, 5 in Calderdale, 7 in Wakefield, and in Barnsley there will be 6 supported by one supra-network. We are working as part of all of these to join up care.

Developments in our work to join up care:

- Trust Board have agreed to sign up to the **Wakefield Integrated Care Partnership**
- We are a leading part of the **Wakefield Mental Health Alliance**
- We have fed back to the Council on the things we want to see included as part of **Calderdale Cares**
- We are looking at revised governance for the **Kirklees Strategy**
- The **Barnsley Integrated Care Partnership** is continuing

With **all of us** in mind.

Improving Care: Safety and quality

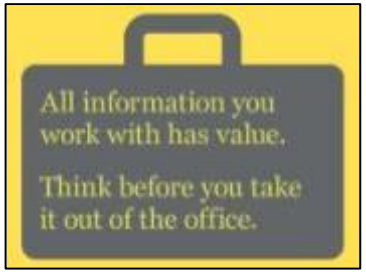
NHS South West Yorkshire Partnership NHS Foundation Trust

In May we had:

- 1233 incidents - 1089 rated green (no/low harm)
- 136 rated yellow or amber
- 8 rated as red
- 5 serious incidents – 1 apparent suicide, 1 self harm with suicidal intent, 2 cause of death unknown/awaiting confirmation, and 1 category 3 pressure ulcer

There were **11 confidentiality breaches in May,** an increase on last month. Breaches can have a big impact on the lives of our service users and carers – and can have consequences for staff too. Please remember to **think**, and **check** before your **share.**

Take a look on the intranet at the new IG campaign, focused on making sure information is safe when taken out of the office.



We have seen a **decrease in the number of falls** for the month. This has reduced to 40, down from 59 in April.

The number of **pressure ulcers** reported has increased from 41 to 46.

With **all of us** in mind.

Improving care:
Our performance in May

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **99%** of people recommend our community services
- **86%** of people recommend our mental health services
- **303** out of area bed days
- **92%** inpatients with a Cardiometabolic Assessment (CMA)
- **60.3%** moving to recovery on IAPT
- **26.3%** referral to treatment in CAMHS timescales (April)
- **5** people under 18 admitted onto adult inpatient wards
- **86.1%** of people dying in a place of their choosing
- **85.7%** of prone restraint lasted less than 3 minutes
- **27%** medicines omissions

Medicines omissions performance rose further in May compared to previous months and stands at 27%.

Ward audits have taken place and action plan is now in place.

The number of **restraint incidents** during May has increased compared to previous months. % of **prone restraints** lasting more than 3 minutes has reduced since April, now at 85.7% - in target.

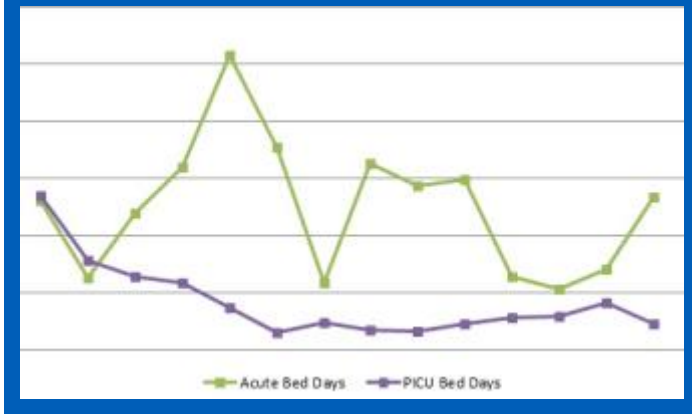
86.1% of people are **dying in a place of their choosing** – up on last month's results.

With **all of us** in mind.

Improving care: #allofusimprove
Out of area beds

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We exist to support people to live well in their community. This means delivering care closer to home, reducing mental health hospital admissions and stopping sending people out of area.



We are already making a difference. Barnsley has no out of area beds and Wakefield hasn't sent someone out of area since September 2018.

We're making important changes and need you to really get behind this work to make it a success. Wherever you work, we're all part of one big team caring for local people.

To achieve this we will be focusing on:

- **Appropriate inpatient stays**
- **Effective home-based treatments**
- **Capacity in community services**
- **Trauma informed personality disorder pathways**
- **Robust SPA**
- **Work with primary care**
- **Improve reporting**
- **Develop dashboard**

With **all of us** in mind.

Care Quality Commission (CQC)

South West Yorkshire Partnership NHS Foundation Trust

Our well-led review

The review was carried out on the 11 and 12 June.

The CQC told us they had experienced open and honest **communication** from everyone. The CQC also commented on a strong sense of **vision and values** amongst our leaders. They recognised the progress made in our **governance structures** whilst acknowledging some needed more time to fully embed.

Concerns were raised about our **risk assessments**, **medicines issues and omissions**, and **rapid tranquilisation** processes. An action plan is now in place to address these. Critical thing is to do the simple things well and consistently.

Next steps

We are now expecting the CQC to send us our core service and well-led reports by the end of July.
We will then have 10 working days to make any factual accuracy comments.
The report will then be made public.

Thank you to everyone for your work on the CQC preparation and follow ups.

With **all of us** in mind.

Improving resources: Our finances in 2019/20

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator		Year To Date	Forecast
1	NHS Improvement Finance Rating	3	1
2	Normalised Deficit (excl PSF)	(£1.2m)	(£0.2m)
3	Agency Cap	£1.3m	£7.3m
4	Cash	£24.6m	£25.9m
5	Capital	£1m	£7m
6	Delivery of CIP	£1.4m	£10.6m

The overall risk rating is a 3 (out of 4 with 1 being the highest). This is planned to improve over the course of the financial year.

May 2019 finance performance is ahead of our plan but remains in deficit. In month we spent £0.5m more than the income we received. Actions are focussed on returning this run rate to surplus.

Agency expenditure continues to be a financial pressure, and currently the biggest risk to the overall finance rating. We spent £0.6m in May which is similar to spend in April. This is 28% higher than the same period last year.

The Trust cash position remains healthy at £24.6m.

Capital expenditure is line with plan although nationally capital plans continue to be scrutinised and re-prioritised.

Cost reduction plans (CIPs) are in line with plan. There remains £1.4m of unidentified savings which need to be delivered.

With **all of us** in mind.

Improving Resources: Reducing Waste

NHS
South West Yorkshire Partnership
NHS Foundation Trust

This year our target is to break even, spending no more than we receive.

Last month we spent **£457k** more than we received. Our focus is on cutting costs and reducing waste so we can get back to a surplus.

Our cost improvements are in line with our plan.
We still have a gap and need to identify an additional **£1.4million** in cost reductions, by reducing waste and carrying out improvements.
Everyone has a part to play. By making small changes you can help us reduce waste.

Please spend time discussing with your teams:

- Are we spending our money the best way we can?
- How can we improve?
- What can we do differently to reduce inefficiency and waste?

Join conversations on the i-hub and share your ideas.

Out of area placements cost us £3.9m in 18/19. We're aiming for **zero** placements. This is already being achieved in Barnsley and Wakefield.

Have you seen our new campaign?

"This is definitely work related - it's all anyone in my office talks about"

This month we're reminding you how you can cut waste by being careful with the data on your phones. Make sure you use Wi-Fi where you can.

With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Improving Resources:

SystmOne for mental health – Optimisation

Over the next year, we'll be co-producing improvements to SystmOne that will enable better practice. This is optimisation.

Thank you to all those staff who were involved in the records catch up from RIO to SystmOne. Together we transferred over **7,500** patient records in just four weeks, and have now completed data quality checks on a % of those records. **It's a huge achievement and builds on a successful go live for the Trust.**

A new care plan is currently being tested and will be coming soon. We are making this change following feedback from the CQC.

Remember, RIO will no longer be available from 9am on Friday 28 June 2019.

If you are unsure about how to use any aspect of the system please see the guides on the intranet, log a call with the service desk or book top-up training. Members of the training team will also be attending future service team meetings to cover any service specific questions.

With **all of us** in mind.

Making this a great place to work

We want the Trust to be a great place to work for **#allofus**. HR conversations have now taken place with over 7**00 people directly.** You have told us:

- **Staff engagement** – Some positive examples of local engagement; support within teams is good
- **Quality of appraisal** – evidence of it working for some people; good focus on staff personal development; lack of career progression and next steps for people is a worry
- **Workplace health and wellbeing** – concerns raised about agile working; pressures felt about clinical demand and staff shortages, and the impact this has on wellbeing
- **Tackling bullying and harassment** – 'subtle' bullying and personal safety on the wards is a concern for some

Join the conversation at our director listening events.
We have held director listening events in Barnsley and Kirklees
Common themes discussed include:

- **Seeing the bigger picture and knowing our place in the system**
- **Recruitment and retention**
- **Resources needed to support co-production**
- **Availability of technology to support agile working**
- **Building on creativity and alternative therapies**

If you haven't attended one yet come along to our Wakefield and Calderdale events your have your say

Get your nominations in now

With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Making this a great place to work

Sickness absence was 4.6% in May, above our target. Turnover was 10.4%. There's support for #allofus

Familiarise yourself with the recent changes made to our sickness policy, found on the intranet.

Make sure you schedule in your values-led appraisal. It's your chance to have a two-way conversation.

Find out who your freedom to speak up guardians are and how they can help you.

Download our MySWYFT staff app. Found out more by watching out 'how to' films on the intranet.

Kirklees learning disability health team held a 'Happy and healthy' event to mark Learning Disability Week 2019, attended by 47 service users.

Join the conversation with our new challenge on the i-hub, all about **'Going green'**. This is your opportunity to tell us your ideas on how we can reduce our impact on the environment.

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Understand the big picture and how we connect to it. Do you know how you will connect with primary care networks?

Don't forget - safety first and quality counts, keep a focus on what we need to do to stay safe

Get involved in #allofusimprove and take part in the i-hub challenges

Help us reduce waste and manage our finances

Download the MySwyft staff app

Invest in your appraisal and get involved in HR conversations

Celebrate your achievements by entering the Excellence awards 2019

With **all of us** in mind.

27 June 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 the Comms team.

#allofusimprove - our priorities for the year ahead

Our aim is to be outstanding. We have set our priorities for the year ahead. Every team should discuss these and have a conversation about what they mean for you and how your priorities will link to these.

Printed versions have been sent to all teams- it was better value to have them printed in bulk than for each team to print them individually. If you need more copies contact Comms.

Improving health: Joined up care in every place

The Forensic Outreach Liaison Service (FOLS) for people with learning disabilities and/or autism launches on 1 July, in partnership with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust. The service supports people in West Yorkshire and Barnsley, safely managing risk and avoiding contact with the criminal justice system or admission to secure hospitals. Find out more about the team and the service on our website.

Integrated care systems
Developments in West Yorkshire and Harrogate:

- Funding for men at risk of **suicide** and for suicide bereavement support services
- Trust Board have agreed to be a lead provider on **forensic services** - for adults, children, and LD
- We are part of a collective bid for **eating disorders** support
- **Learning disabilities** transforming care partnerships have now merged into one and will focus on finding opportunities for improvement
- We are supporting **CAMHS** developments across West Yorkshire and Harrogate.

With **all of us** in mind.

Developments in South Yorkshire and Bassetlaw:

- Establishing a committee in common as part of the governance arrangements
- Liaison and Diversion across South Yorkshire continues to be developed
- QUIT smoking cessation bids
- Changes to implement new model, for **stroke** services
- Marketing of new beds in **neuro-disability** services.

Improving health: Joined up care in every place

Primary care networks
Primary care networks are a critical component of the vision for health and social care set out in the NHS Long Term Plan. Networks are much more than groups of general practices. They represent a fundamental shift in the way health and care is provided. GP practices, community services, social care and others will be expected to work together in a way they have never done before.

Networks should typically serve populations of 30,000 to 50,000, consist of more than one GP practice, and cover an appropriate geographic area. There will be 9 networks in Kirklees, 5 in Calderdale, 7 in Wakefield, and in Barnsley there will be 6 supported by one supra-network. We are working as part of all of these to join up care.

Local joined up care
We are working to join up care through our partnerships in West Yorkshire and in South Yorkshire. We are also working on a local level in each of our places, such as the Wakefield Integrated Care Partnership, Wakefield Mental Health Alliance, Calderdale Cares, Kirklees Strategy and the Barnsley Integrated Care Partnership. We deliver care throughout this footprint.

Developments in our work to join up care include:

- Trust Board have agreed to sign up to the **Wakefield Integrated Care Partnership**
- We are a leading part of the **Wakefield Mental Health Alliance**
- We have fed back to the Council on the things we want to see included as part of **Calderdale Cares**
- We are looking at revised governance for the **Kirklees Strategy**
- The **Barnsley Integrated Care Partnership** is continuing

Improving care: Safety and quality

We put safety first, always.

In May we had:

- 1233 incidents - 1089 rated green (no/low harm)
- 136 rated yellow or amber
- 8 rated as red
- 5 serious incidents – 1 apparent suicide, 1 self harm with suicidal intent, 2 cause of death unknown/awaiting confirmation, and 1 category 3 pressure ulcer

We have seen a decrease in the number of falls for the month. This has reduced to 40, down from 59 in April.

The number of pressure ulcers reported has increased from 41 to 46. None of these were identified as being avoidable.

Information governance
There were 11 confidentiality breaches in May, a significant increase on last month. These are often down to human factors and can result in disciplinary action so take extra care. Please remember to always double check details and always stay focused.

Everyone across the Trust works hard to maintain our patient and staff's right to confidentiality – but there is always more that can be done to prevent incidents. In the last two months we have had two incidents where staff have taken Trust laptops, diaries and service user personal information home, not removed them from their cars overnight, and the property has been stolen.

So this month's campaign focuses on thinking about what you are removing from Trust sites and how you are going to keep it safe. There may be times during the working day when you need to leave your laptop in your car. If this is the case make sure you keep it hidden and secure (not on the back seat for example) and assess any potential risks or problems. This is Trust policy. Equipment and sensitive information should not be left in cars overnight as this is when break-ins are more likely to happen.

In the last 12 months NHS organisations have been fined more than a million pounds and one NHS employee fined 5,000 for failing to protect personal information. None of us want this to happen at our Trust, so this new campaign is designed to raise all of our awareness of our individual responsibility to protect data.

Please print of this new poster and display in your patient and staff areas, Data Protection is all of our business so please ensure your team prints off and displays.

If you have any concerns around information governance in your area then please contact the IG team for advice.

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

Improving care: Performance (May)

- **99%** of people recommend our community services
- **86%** of people recommend our mental health services
- **303** out of area bed days
- **92%** inpatients with a Cardiometabolic Assessment (CMA)
- **60.3%** moving to recovery on IAPT
- **26.3%** referral to treatment in CAMHS timescales (April)
- **5** people under the age of 18 were admitted onto adult inpatient wards
- **86.1%** of people dying in a place of their choosing
- **85.7%** of prone restraint lasted less than 3 minutes
- **27%** medicines omissions

Medicines omissions performance has further deteriorated in May compared to previous months and stands at 27%.

Some issues with data collection have been identified which are impacting on the reported position. The pharmacy team have undertaken some ward audits and it has been identified that if a patient is absent from the ward then this is being counted as an omission, which should be excluded. Further work to continue and action plans are being drawn up. Shared learning from both within the Trust and peer organisations is also being undertaken.

The number of restraint incidents during May has increased compared to previous months. Prone restraints lasting 3 minutes or more has decreased and now stands at 85.7%.

86.1% of people are dying in a place of their choosing – up on last month.

CAMHS - in May, 5 people under the age of 18 were admitted onto adult inpatient wards. 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, including 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.

Improving care: #allofusimprove
Care closer to home – out of area beds

As part of our Trust priority to provide care as close to people's homes as possible we have been working on building a greater community focus and reducing the need for service users to spend time in hospital beds. This helps us to provide better care for people, meaning we can reduce the need for hospital stays, and the pressure this often puts on us to send people out of area if our inpatient units are already full. We are already making a difference. Barnsley has no out of area beds and Wakefield hasn't sent someone out of area since September 2018.

Our work is not just about reducing the need for out of area beds but is about helping people to live well in their communities. There is a lot of work taking place across the Trust to provide care for people as close to where they live as possible, it is one of our priorities for 2019-20. As part of this work we will be taking forward more improvement work in the coming months. During this time we will need to work together and support each other through any change, ensuring staff and service users are supported.

For people that do still require a hospital admission we are taking forward work to ensure that the length of stay is timely and in a local setting if that is appropriate.

This work is about what we can do as a Trust but also about what the whole health and social care system can do. We will be working with partners and local communities to make sure services and care is provided at the right time and in the best possible place for our service users.

We promise to keep you informed about what the work taking place and will need many staff to be involved in helping us find solutions and supporting changes. Our vision is to care for people in their own communities so well that we can be within capacity on our wards and in turn improve quality of stays for those that really need it. By working together we can achieve this.

South West Yorkshire Partnership NHS Foundation Trust

CQC update

Our well-led review

- The review was carried out on the 11 and 12 June.
- Our Executive Management Team, senior leaders and Non-Executive Directors were interviewed and a number of focus groups were held.
- The CQC told us they had experienced open and honest **communication** from everyone. The CQC also commented on a strong sense of **vision and values** amongst our leaders. They recognised the progress made in our **governance structures** whilst acknowledging some needed more time to fully embed.
- Concerns were raised about our **risk assessments**, **medicines issues and omissions**, and **rapid tranquilisation** processes. An action plan is now in place to address these.

Next steps

- We are now expecting CQC to send us our core service and well-led reports by the end of July.
- We will then have 10 working days to make any factual accuracy comments.
- The report will then be made public.

Toolkit

- Remember we have a toolkit full of useful resource, available on the intranet.

Thank you to everyone for your work on the CQC preparation and follow ups.

Improving resources: Our finances 2019-20

The overall risk rating is a 3 (out of 4 with 1 being the highest). This is planned to improve over the course of the financial year.

May 2019 finance performance is ahead of our plan but remains in deficit. In month we spent £0.5m more than the income we received. Actions are focussed on returning this run rate to surplus.

Agency expenditure continues to be a financial pressure, and currently the biggest risk to the overall finance rating. We spent £0.6m in May which is similar to spend in April. This is 28% higher than the same period last year.

The Trust cash position remains healthy at £24.6m.

Capital expenditure is line with plan although nationally capital plans continue to be scrutinised and re-prioritised.

Cost reduction plans (CIPs) are in line with plan. There remains £1.4m of unidentified savings which need to be delivered.

27 June 2019

South West Yorkshire Partnership NHS Foundation Trust

Improving our resources: Reducing waste

This year our target is to break even, spending no more than we receive.

Last month we spent £457k more than we received. Our focus is on cutting costs and reducing waste so we can get back to a surplus. Our cost improvements are in line with plan. We still have a gap in the plan though, and need to identify an additional £1.4million in cost reductions, by reducing waste and making improvements. **Everyone has a part to play. By making small changes you can help us save money.**

Out of area placements cost us £3.9m in 18/19. We're aiming for **zero** placements. This is already being achieved in Barnsley and Wakefield.

Our latest campaign to highlight ways we can reduce spend in the Trust is focused on the data we use on our mobile phones. Extra data can incur extra costs on our existing mobile phone contracts. Last year we had two people who spent over **£500** each by exceeding their data allowances on Trust phones. By avoiding unnecessary downloads or joining WiFi networks where you can, we can help cut costs and reduce our bills.

Please spend time discussing with your teams:

- Are we spending our money the best way we can?
- How can we improve?
- What can my service do differently to reduce inefficiency and waste?

Join conversations on the i-hub and share your ideas for reducing waste.

Improving resources: SystmOne for mental health

Optimisation

Thank you to all those staff who were involved in the records catch up from RIO to SystmOne. Together we transferred over **7,500** patient records in just four weeks and have now completed data quality checks on a % of those records. It's a huge achievement and builds on a successful go live for the Trust.

A new care plan module is currently being tested and will be coming soon. We are making this change following feedback from the CQC.

Following on from this a reminder that RIO will no longer be available from 9am on Friday 28 June 2019.

There is still work to do to make sure that SystmOne works in the best way for everyone. We will be working with teams as part of optimisation, taking on board your comments and feedback – and then making changes where we can to make the system work better. Workshops are planned for the coming months to include staff in helping to prioritise improvements and changes.

If you are still unsure about how to use any aspect of the new system please see the comprehensive guides on the intranet, log a call via the service desk or get yourself booked on top up training. Also please note that members of the training team

will be attending future service team meetings, where requested or invited, to cover any service specific questions.

Making this a great place to work

#allofus - making our Trust a great place to work
Following the results of the staff survey we want to make sure that our Trust is a great place to work for everyone. The HR team have been visiting teams across the Trust and have met with over 700 people so far. The feedback has been invaluable and will help us improve staff experience. We are focussing on four key themes: So far you have told us:

- **Staff engagement** – Some positive examples of local engagement; support within teams is good
- **Quality of appraisal** – evidence of it working for some people; good focus on staff personal development; some concerns from staff in inpatient wards having the time to do quality appraisals; lack of career progression and next steps for people is a worry
- **Workplace health and wellbeing** – concerns raised about agile working; pressures felt about clinical demand and staff shortages, and the impact this has on wellbeing
- **Tackling bullying and harassment** – 'subtle' bullying and personal safety on the wards is a concern for some; the ease in which banter can develop into more.

Colleagues can also complete the Staff Family and Friends Test. Any information will be treated in confidence.

Join the conversation at our director listening events
Each year we hold a round of events across Barnsley, Calderdale, Kirklees and Wakefield to discuss progress we've made, check what's working well and what needs to change. We have already held listening events in Barnsley and Kirklees.

Common themes discussed include:

- Seeing the bigger picture and knowing our place in the system
- Recruitment and retention
- Resources needed to support co-production
- Availability of technology to support agile working
- Building on creativity and alternative therapies

If you haven't attended one yet book yourself on one of the two remaining events, taking place in Calderdale and Wakefield:

Look out also for our director walkabouts coming soon.

Excellence 2019
We have now launched our Excellence awards, your chance to celebrate the great work of your colleagues and teams by nominating them for an award.
There are five categories open to any Trust service or team (including integrated teams) whether clinical or non-clinical. There are also four categories for individuals working in any

clinical or a non-clinical role. Entries for 2019 are now open and there's a category for everyone:

Team/service awards

- Excellence in improving health
- Excellence in improving care
- Excellence in improving use of resources
- Engagement and involvement excellence
- Partnership working excellence

Individual awards

- Unsung hero
- Leader of the year
- Outstanding achievement
- Rising star

Shortlisted entries will be invited to a special celebration event on **Tuesday 19 November 2019** at the Cedar Court Hotel in Wakefield. Our Excellence 2019 awards will be held as part of a staff achievement celebration, where we'll also be celebrating learners and colleagues who have worked for the NHS for 25 and 40 years.

The deadline for entries is **23 August**.

Making this a great place to work

- Sickness absence was **4.6%** in May, above our target of **4.5%.** Turnover was **10.4%.** Remember there is wellbeing support available to #allofus.
- There have been some recent changes to our sickness policy and procedures. Familiarise yourself with the changes and make sure your teams are aware. You can find a useful summary of the changes and what they mean for staff on our intranet.
- Make sure you know who your freedom to speak up guardian is and what they can do to help you.
- Your values led appraisal is an opportunity for a supportive two way conversation about your achievements, your personal development and training needs, your health and wellbeing, your job related objectives, and our Trust behaviours. 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.
- Kirklees learning disability health team held a 'Happy and healthy' event to mark Learning Disability Week 2019. 47 service users attended the event in Dewsbury Minster.

MySWYFT – staff app now available

My SWYFT is the app for our staff. Designed for staff on the go, it provides important Trust information and news at your fingertips.

The app is not available publicly on the App or Play Store as it's only for Trust staff. Downloading and installing it is completely safe to do. It has been developed with zero cost to the Trust and will be maintained and updated weekly. Find out how to download our new staff app on the intranet.

27 June 2019

South West Yorkshire Partnership NHS Foundation Trust

Going green – our i-hub challenge

Do you have an idea on how the Trust can make improvements to be more environmentally sustainable? Climate change is something affects us all, both now and in the future so we need to do that we can to make things better.

Our latest i-hub challenge is asking for your ideas. Get online and tell us what you think. It could make a big difference to both ours and future generations.

South West Yorkshire Partnership NHS Foundation Trust

Take home messages

1. *Understand the big picture and how you connect to it. Do you know how you will connect with primary care networks? Have a conversation in your teams about how you and your service fit.*
2. *Don't forget – safety first and quality counts, keep a focus on what we need to do to stay safe*
3. *Get involved in #allofusimprove and take part in the i-hub challenges*
4. *Help us to reduce waste and manage our finances*
5. *Download the MySWYFT staff app*
6. *Invest in your appraisal and get involved in HR conversations*
7. *Celebrate your achievements by entering the Excellence awards 2019*

23 July 2019

on the day BRIEFING

NHS Providers

On the day briefing: the prevention green paper

The Department of Health and Social Care and the Cabinet Office have published Advancing our health: prevention in the 2020s, a green paper setting out the case for change in the way we approach prevention, identifying key drivers of ill health including deprivation, inequalities, health-related behaviours such as smoking and physical inactivity, and mental health difficulties. Health is shaped by the services we receive, the choices we make, the conditions in which we live and our genetics.

The green paper commits to an approach which takes health as an asset, and as a foundation of thriving communities and a strong economy. It commits to moving away from a culture in which we take for granted good health, only paying attention to it when we experience health problems that we expect the NHS to fix. The green paper is accompanied by a consultation inviting views on the proposals and further measures to support prevention, and will be open for submissions until **14 October 2019**. NHS Providers will canvass views from our membership and submit a response.

Summary of key points

- The green paper sets out a vision for prevention in which health is treated as an asset, and the population empowered to 'co-create' their own health. Many of the measures announced focus on personalisation, and addressing inequalities between the most and least deprived members of the population.
- The Department of Health and Social Care (DHSC) will support prevention by embedding genomics in healthcare, expanding and modernising screening programmes, and taking a predictive approach to prevention to identify risks before they manifest in a personalised way.
- The NHS Long Term Plan has a key role to play in the wider approach to prevention, with measures such as expanding the diabetes prevention programme, introducing social prescribing and establishing alcohol care teams and support to stop smoking. There will be further support and advice for people to stay active including into old age.
- The green paper sets out ambitions to address the causes of ill health, and announces a 2030 smoke-free goal, action on childhood obesity, measures to improve food labelling, encouraging industry to reformulate foods and exploration of further levies on high sugar foods.
- The green paper addresses mental health as a key pillar of good health, and introduces a range of measures to support mental health in health services and schools, including a duty for schools to teach about mental health and campaigns to increase awareness of mental health.

- The government will explore ways of supporting the wider determinants of health, including supporting local authorities to incorporate health into planning of places and services, and improve access to green spaces.

Digital opportunities for prevention

The green paper sets out a number of actions related to technology and the use of data to better predict health problems and address them early, through 'intelligent public health' and precision medicine, focused support and advice for those at greatest risk, and identifying current and future threats to health.

- The green paper sets out actions for Public Health England (PHE) to take in partnership with NHSX and other partners to build a portfolio of innovative projects. Through the partnership PHE and NHSX will build trust with the public about use of their health data, refine an approach to analysis and insight to identify those at risk, and develop exemplar projects to establish an evidence base for personalised prevention.
- The green paper describes vision for screening in the NHS comprised of the following principles:
  - Maximising uptake, by making screening easier to access and reducing variation in take-up
  - Stratify risk in existing national screening programmes so that they are more personalised and focus interventions where they was most needed
  - Focused screening within high risk populations offered for a greater range of conditions, for example exploring introducing lung cancer screening for smokers
  - Better use of technology such as expanding the genomics offer, better use of data and embedding the use of artificial intelligence in the health system
  - Faster implementation of recommended interventions and programmes with clear accountability for delivery and investment in IT
- The NHS health check programme will be reviewed in order to ensure that risks are more consistently followed up and explore whether a more tailored service could maximise its benefits, including increasing uptake, identifying those most at risk, reviewing the range of services offered as part of the health check, and considering developing a digital service.
- Precision medicine, including the use of genomics to identify the correct care pathway according to an individual's risk factors and genetics, will be supported by a National Genomics Strategy published in autumn 2019. The green paper sets out an ambition for genomics to be embedded in routine healthcare, with 5 million genomic analyses carried out by 2023/24.
- The green paper commits to tackling the risk of antimicrobial resistance (AMR), and the government has appointed Professor Dame Sally Davies as the UK special envoy on AMR to support a global effort against AMR, working with the World Health Organisation (WHO).
- A vaccination strategy, to be published by spring 2020, seeks to maintain and develop a world leading immunisation programme, and increase uptake of second dose MMR vaccines to at least 95%, via enhanced use of local immunisation coordinators and primary care networks and incorporating the

new and more cost-effective vaccines into the programme. The green paper also commits to tackling misinformation about vaccines.

- The government will develop and launch a composite health index, providing a top-level indicator of health tracked alongside the nation's GDP, measuring changes in health over time to assess the health impacts of wider policies.

Tackling risk factors

The green paper describes the biggest challenges that increase chances of developing health conditions that contribute to increased number of years lived with a disability, including smoking, diet, activity and mental health. It identifies that obesity contributes to 6.4% of years lived with disability (YLDs). It sets out a number of proposals aiming to reduce these risk factors.

Smoking

- With the aim of reducing smoking rates to 12% by 2022 and to zero by 2030, the green paper commits to an ultimatum for the tobacco industry to make smoke tobacco obsolete by 2030, with smokers either quitting or moving to reduced risk products like e-cigarettes. The green paper also commits to further measures discouraging people from starting to smoke in the first place, building on existing measures such as advertising bans and plain packaging.
- The green paper sets out an aim to use funds raised by options such as requiring tobacco companies to pay for the cost of tobacco control and related healthcare costs to focus stop smoking support on groups most in need, such as pregnant women, social renters, people in mental health wards, and those in deprived communities.

Obesity

- The green paper also explores options for reducing obesity rates, with only a third of adults currently at a healthy weight and obesity rates doubling since 1993. It identifies a need to make healthy choices easier, improving access to fruit and vegetables and discouraging excessive consumption of high fat, salt and sugar (HFSS) foods.
- The green paper commits to exploring options for mandatory calories labelling in restaurants and cafes, and banning the promotions of HFSS foods by price and location in shops, as well as a 9pm watershed on TV advertising of such products.
- Five childhood obesity trailblazer authorities will have access to £1.5 million of funding and support over the next three years to test the potential for existing local levers to restrict out-of-home HFSS advertising, creating healthier food environments through the planning system, and incentivising businesses to improve their retail offer and improve accessibility and affordability of healthier foods.
- The government will commission an infant feeding survey to provide information on breastfeeding and assess the impact of actions on infant feeding, including challenging businesses to improve the nutritional content of commercially available baby food and drinks, and improving the labelling of infant food to enable parents to make informed decisions.

- In consideration of Brexit, the government will consult by the end of 2019 on how to build on the success of the current nutritional labelling scheme, considering the evidence underpinning the many forms of labelling and ensuring the UK continues to be world-leading in providing shoppers with I the information they ned to make healthy decisions while taking into account trade arrangements following departure from the EU.
- The green paper commits to reviewing the evidence of the impact of the soft drinks industry levy (SDIL) and considers extending it to sugary milk drinks as well.
- The green paper sets out an ambition to reduce salt intake from the current average of 8g per day to 7g by introducing salt reduction targets for industry to achieve by mid-2023 and influencing consumer behaviour both through marketing and via the NHS.
- The government will work with NHS England to develop approaches to improve the quality of brief advice given on weight management in general practice. It will also work with NHSE, PHE and NHSX to review the current digital weight management offer on the NHS Apps Library.

Physical activity

- The green paper identifies the positive impact of physical activity on mental and physical health, and sets out the aim of increasing people's physical activity levels in line with the recommended 150 plus minutes of aerobic activity per week. The government has also asked the UK Chief Medical Officers to review the current guidelines.
- The green paper commits to working with partners to launch a new 'digital design challenge' for strength and balance exercises to tackle the low levels of strength particularly among women. Participants will be asked to develop a free product or service to encourage people to do regular activities to increase their strength and balance.
- The green paper sets out actions to extent the national Moving Healthcare Professionals partnership supporting healthcare professionals to promote physical activity to their patients.
- A cross-government approach will be taken to encourage local authority planning decisions to promote active lifestyles, for more people to switch to public transport, cycling and walking, for nurseries to build physical activity into daily routines, and strengthen the evidence base for the social and economic value of physical activity.
- The government commits to supporting greater physical activity among the older population by encouraging activity among post-menopausal women, and supporting people to stay in work for longer.

Alcohol and drug use

- The 4% of the population made up of the heaviest drinkers account for 30% of all units of alcohol consumed. The highest risk of harm is concentrated among those in the lowest income bracket.
- The government will work with industry to increase the availability of alcohol-free and low-alcohol products by 2025 and review the evidence for increasing the alcohol-free descriptor threshold from 0.05% ABV to 0.5%.

- DHSE will work with PHE, the Home Office and other partners to further develop policy around opioid use, and work with the Recovery Champion to develop a shared understanding of the current challenges facing the substance misuse treatment and recovery workforce, as well as developing an action plan for the treatment of heavy cannabis users, brief interventions for other cannabis users, and raising awareness of cannabis-related harm.

Mental health

The green paper reiterates the commitment made in the NHS Long Term plan to spend a further 2.3 billion a year on mental health services by 2023/24, treat a further 380,000 people a year with psychological therapies, and provide an additional 24,000 women a year with access to perinatal mental healthcare by 2023/24. The green paper sets out a commitment to close the prevention gap and achieve parity of esteem for mental health prevention, through a number of measures:

- The green paper acknowledges the need to lay the foundations for good mental health by taking urgent action to tackle the risk factors that can lead to poor mental health, such as adverse childhood events, violence, poverty, debt, housing insecurity, social isolation and bullying and discrimination. There is a need to invest in the protective factors such as safe and secure housing, strong attachments in childhood, and access to green spaces.
- DHSC commits to taking additional action on mental health, including:
  - Providing children and young people with advice to deal with difficult emotions and situations that lead to mental health problems, through the Rise Above programme.
  - Encouraging local authorities to put in place mental health promotion plans.
  - Investing up to 600,000 in sector-led improvements to support local authorities to strengthen their suicide prevention plans.
  - Providing £1 million to the Office for Students to run a competition to drive innovation in mental health support for students.
  - Launch an Every Mind Matters campaign in October 2019 to make 1 million adults better informed and equipped to look after their mental health, support others, and address mental health stigma.
- Wider government action will take place to support this work as follows:
  - Establish a statutory Breathing Space programme to provide respite to those with problem debt while they seek mental health support, by the end of the year.
  - Revise statutory guidance for schools to ensure they understand how mental health is embedded in existing requirements and ensure staff can identify and support children with mental health issues, with training for all new teachers in spotting the signs of mental health issues.
  - A requirement for schools to teach about mental health and wellbeing as part of sex and relationships education, with schools being encouraged to implement this by September 2019 and required to do so by September 2020.
  - The green paper identifies that the poorest areas of England have poorer health and less green space than wealthier areas. Nature-based interventions will be implemented through the 25 year environment plan and social prescribing.

Prevention in the NHS

Building on the commitments in the long term plan to double funding for the diabetes prevention programme, to offer NHS funded tobacco treatment and alcohol care teams in inpatient settings, and to set out goals for narrowing health inequalities, the green paper commits to actions which make the NHS a 'national wellness service', including:

- Allowing people to connect their own data into their health record if they choose
- Providing people with personalised advice based on aggregated data
- Giving people the tools and motivation to make informed choices
- Establish a Social Prescribing Academy to champion social prescribing and support national plans to make it available throughout England via 1,000 trained social prescribing link workers by 2020, and brokering relationships across health, local government, justice, arts, culture, sport, the outdoors and other sectors.
- Exploring further options to expand the role of community pharmacists through a Community Pharmacy contractual framework to redefine the integral role of community pharmacies in identifying and referring patients with health conditions, offer a wider range of advice and support.
- While local authorities will continue to commission public health services, the NHS and local authorities will be expected to work more closely together and embed prevention into the full range of health and other services. The green paper sets out an aim for collaborative commissioning to become the norm, requiring local authorities and the NHS to work closely together.
- Through Integrated Care Systems, public health services may be commissioned via a lead commissioner or pooled budgets. The green paper acknowledges that local areas need to decide what works best however they are encouraged to use the levers available to them to develop joint approaches and make best use of health and wellbeing boards.

Addressing the wider determinants of health

The green paper addresses the wider determinants of health including healthy places, early years and housing as key foundations upon which people build their health asset.

- The government will modernise the healthy child programme so that it is universal in reach and personalised in response, to enable focused services targeted at additional needs, and ensuring better links to health records, as well as improving support for perinatal mental health and the development of babies and young children. The government will consult on this separately.
- The government aims to improve childhood oral health and will consult on rolling out a school tooth brushing scheme, and explore ways of removing funding barriers to fluoridating tap water.
- The green paper restates the commitment to tackle knife crime and violence, enable social connection and tackle loneliness, and support the development of energy efficient, adaptable and accessible

homes for all generations, as well as encouraging local systems to 'put health into place', incorporating health into planning decisions.

- The government will improve public awareness about pollution, air quality and use surveillance and health data to evaluate long term trends in health associated with air quality.

NHS Providers view

Today Saffron Cordery, deputy chief executive of NHS Providers, said:

"This is a welcome opportunity to recognise prevention and public health as a central pillar of a sustainable health and care system. Prevention is crucial in supporting the delivery of the ambitions of the NHS long term plan. We all have a role to play in ensuring people are living not only longer but healthier lives too. Trusts take their role in prevention and empowering people to manage their own health very seriously and are committed to delivering on the proposals set out in the long term plan.

"The proposals outlined in this green paper are a step in the right direction, but there is much more we must do. It is positive to see the prominent role accorded to mental health in the green paper and the drive to narrow inequalities in society. But much of this has been said before, and must now be backed up with action. One of the key determinants of the number of years lived in good health is level of deprivation, and without concerted and coordinated action to address the inequalities faced by those living in the most deprived communities, measures to support healthier lifestyles cannot meet their full potential.

"For this to be a serious and credible exercise, we must see a reverse to the deep cuts in council public health budgets, and budgets for wider local authority services, in recent years. We know there is a link between these cuts affecting local support services and the rise in demand for NHS care - this must be urgently addressed in the upcoming spending review.

"The NHS has a vital part to play, but the impact of this commitment to prevention depends not only on the efforts of NHS services to prevent but also a collaborative effort across government, local authorities and the wider system to address the wider determinants of health."

Contact: Leanora Volpe, policy officer, Leanora.Volpe@nhsproviders.org

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019
Agenda item 6.1

Title:	**Board Assurance Framework (BAF) Quarter 1 2019/20**
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 2019/20 BAF for review and discussion at the Trust Board.
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 2019/20, 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, including the fourth objective for 2019/20 'Making the SWYPFT a great place to work':

Our four strategic objectives	
Improving health	Improving care
Improving resources	Making SWYPFT a great place to work

Further changes in 2019/20 follow the discussions that took place between Board members at the February 2019 Trust Board strategy session and Trust Board meeting on 30 April 2019 which are:

- Addition of a further strategic risk 1.4 Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services.
- Move of previous strategic risk 2.2 to 4.1 Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience.
- Update to the wording of strategic risk 3.1 Deterioration in financial performance leading to unsustainable organisation and inability to provide services effectively.

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	Assurance levels			
		18/19			19/20
		Q2	Q3	Q4	Q1
Improving health	1.1 Differences in published local priorities could lead to service inequalities across the footprint	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	Y	Y	Y	Y
	1.3 Differences in the services may result in inequitable services offers across the Trust	Y	Y	Y	Y
	1.4 Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services	N/A	N/A	N/A	A
Improving care	2.1 Lack of suitable and robust information systems backed by strong analysis leading to lack of high quality management and clinical information	Y	Y	Y	Y

	2.2 Failure to create learning environment leading to repeat incidents	Y	Y	Y	Y
	2.3 Increased demand for and acuity of service users leads to a negative impact on quality of care *(2.4 in 2018/19)*	A	A	Y	Y
Improving resources	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to provide services effectively	A	A	Y	Y
	3.2 Failure to develop commissioner relationships to develop services	Y	Y	Y	Y
	3.3 Failure to deliver efficiency improvements / CIPs	A	A	Y	Y
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	G	G	G	G
Making SWYPFT a great place to work	4.1 Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience *(2.2 in 2018/19)*	Y	Y	Y	Y

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

Strategic objective	Areas updated
Improving health	Strategic risk RAG ratings reviewed and remain unchanged.
	Rationale for current assurance level updated.
	Strategic risk 1.1 – New assurance identified (A33).Gaps in controls and assurance updated.
	Strategic risk 1.2 – New assurance identified (A33).Gaps in controls and assurance updated.
	Strategic risk 1.3 - New assurance identified (A33).Gaps in assurance updated.
	Strategic risk 1.4 - Additional strategic risk for 2019/20. Controls and assurances aligned. New control identified (C13).
Improving care	Strategic risk RAG ratings reviewed and remain unchanged.
	Rationale for current assurance level updated.
	Strategic risk 2.1 – New control identified (C20). New assurance identified (A31). Gaps in controls and assurance updated.
	Strategic risk 2.2 – New control identified (C82). Gaps in assurance updated.
	Strategic risk 2.3 - Update to number from 2.4 in 2018/19. Controls and assurances realigned. New control identified (C79). . New assurance identified (A31). Gaps in assurance updated.
Improving resources	Strategic risk RAG ratings reviewed and remain unchanged.
	Rationale for current assurance level updated.
	Strategic risk 3.1 - Update to the wording of the risk from 2018/19. New control identified (C82). New assurance identified (A33). Gaps in controls and assurance updated.
	Strategic risk 3.2 - New assurance identified (A33).Gaps in controls and assurance updated.
	Strategic risk 3.3 - New control identified (C82). Gaps in controls and assurance updated.
	Strategic risk 3.4 - New control identified (C80). Gaps in assurance updated.
Making SWYPFT a great	Strategic risk RAG ratings reviewed and remain unchanged.
	Strategic risk 4.1 - Previous strategic risk 2.2 from 2018/19 moved. Controls and assurances realigned. New control

	place to work identified (C81). Gaps in controls and assurance updated.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE and the controls and assurances against the Trust's strategic objectives for Quarter 1 2019/20; and** ➢ **AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified.**
Private session:	Not applicable.

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust

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

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

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

Strategic Objectives

Approved by Trust Board and reviewed regularly

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

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

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

Principal risks linked to strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

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

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

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

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Board Assurance Framework (BAF) 2019/20

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, EIC=Equality & Inclusion Committee

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				
			2018/19	2019/20			
			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	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	Y	Y			
	1.3 Differences in the services may result in inequitable services offers across the Trust	10	Y	Y			
	1.4 Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services	12	N/A	A			
Improving care - Safety first, quality counts and supporting our staff	2.1 Lack of suitable and robust information systems backed by strong analysis leading to lack of high quality management and clinical information	15	Y	Y			
	2.2 Failure to create learning environment leading to repeat incidents	17	Y	Y			
	2.3 Increased demand for and acuity of service users leads to a negative impact on quality of care	19	Y	Y			
Improving resources - Getting ready for tomorrow: operational excellence	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to provide services effectively	22	Y	Y			
	3.2 Failure to develop commissioner relationships to develop services	25	Y	Y			
	3.3 Failure to deliver efficiency improvements / CIPs	27	Y	Y			
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	29	G	G			
Making SWYPFT a great place to work	4.1 Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience	32	Y	Y			

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			

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
1.4	**Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services**	A

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.
- Good rating at most recent CQC well-led review
- 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.
- Trust executive director is SRO on behalf of Integrated Care Partnership for implementation of Primary Care Networks (PCHs) in Wakefield
- 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 12 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: Governance, Performance Management framework, Data Quality framework significant assurance.
- Clear value proposition for our Social Prescribing offer in Wakefield through Live Well Wakefield

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, 1.4
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, 1.4
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 groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	C08	DFR	1.1,1.4, 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, 1.4, 3.3
Engagement and representation on South Yorkshire integrated care system mental health work streams and partnership group. (I,E)	C77	DS	1.1, 1.4

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
Impact of not having a clear and well communicated value proposition (DS)	September 2019

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
Trust Board strategy sessions ensuring	Quarterly Board strategic meetings. (P)	A04	CEO	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**
clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives	(I)			
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 2019and 19/20 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, 1.4, 2.3
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, 2.3, 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 2019/20 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 , Clinical Governance &Clinical Safety Committee (CGCS) and Members' Council	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 2019and 19/20 report included in 19/20 work plan. (P, N) (E)	A12	DNQ	1.1, 1.2, 2.3
Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement	Operational plan for 2019/20 approved at Trust Board March 2019. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. (P, N) (I).	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan	Audit Committee and Trust Board – April 2019. (P) (I))	A14	DFR	1.1, 1.3, 2.3

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
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 2019, 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, 2.3
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, 1.4

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 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 Jun 2019 to Sep 2019 as plans will be completed once implementation plans for the long term plan within each integrated care system are agreed*	Sept 2019
Unclear if there is clear understanding of the full range and value of the services the Trust provides by all key stakeholders. Engagement plan and prospectus being developed (DS)	Sept 209
Each integrated care system is required to develop a 5 year plan to implement the NHS long term plan	Nov 2019
Not a scheduled programme of board to board or exec to exec meeting in place with all partners	

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, 1.4
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, 1.4
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, 1.4, 4.1

Gaps in control - what do we need to do to address these and by when?	**Date**
Agreement and implementation of new leadership structure for all operational services to maximise clinical leadership across pathways and operational leadership in each place	Dec 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 monitored and scrutinised through	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT).	A07	DS	1.1, 1.2, 1.3, 2.1,

Assurance (Strategic Risk 1.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Executive Management Team (EMT) and reported to Trust Board through IPR	(P) (I)			3.4
Service user survey results reported annually to Trust Board and action plans produced as applicable	NHS mental health service user survey. Results are reported to Trust Board when available with associated plans (P,N) (I, E))	A08	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
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, 2.3, 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 2019/20 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 19/20 and 19/20 report included in 19/20 workplan (P,N) (E)	A12	DNQ	1.1, 1.2, 2.3
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 2019/20 approved at Trust Board March 2019. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. (P, N) (I)	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Monitoring of organisational development plan through Executive Management Team (EMT) 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
Benchmarking of services and action plans in place to address variation	Benchmarking reports are received by Executive Management Team (EMT) and any action required identified. (P, N) (I, E)	A20	DFR	1.2, 3.1, 3.2, 3.3

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**
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, 1.4, 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, 1.4, 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, 1.4

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 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
Assessment of place based plans in light of the impact of the NHS long term plan *Note, expected completion date changed from Jun 2019 to Sep 2019 as plans will be completed once implementation plans for the long term plan within each integrated care system are agreed*	Sep 2019
Each integrated care system is required to develop a 5 year plan to implement the NHS long term plan	Nov 2019
Not a scheduled programme of board to board or exec to exec meeting in place with all partners	

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	1.4
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	DNQ	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 is now embedded and working with the Board trio (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 2019 and 19/20 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, 1.4, 2.3
Transformation change and priority programme plans monitored and scrutinised through Executive	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT.	A09	EMT	1.1, 1.2, 1.3, 2.3, 3.4

Assurance (Strategic Risk 1.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Transformation Boards and IPR	Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)			
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, 2.3
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 2019, various engagement events across the year plus Annual Members' Meeting September 2018. (P, N) (I, E)	A15	DHR, DS,	1.1, 1.3, 2.3
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, 1.4

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 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*
Review of model hospital data and determine how this can best be used in the Trust	*Oct 2019*
Each integrated care system is required to develop a 5 year plan to implement the NHS long term plan	*Nov 2019*

Strategic Risk 1.4
Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services

Controls (Strategic Risk 1.4)			
Systems and processes - what are we currently doing about the Strategic Risks?	**Control Ref**	**Director lead**	**Strategic risk/s**
Senior representation on West Yorkshire mental health collaborative and associated workstreams. (I)	C03	DPD	1.1, 1.4
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, 1.4
Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	C08	DFR	1.1, 1.4, 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, 1.4, 3.3
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, 1.4
Representation and engagement in place based integrated care developments	C13	DS/DPD	1.4
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, 1.4, 4.1
Engagement and representation on South Yorkshire integrated care system mental health work streams and partnership group. (I,E)	C77	DS	1.1, 1.4

Gaps in control - what do we need to do to address these and by when?	**Date**
Finalisation of an engagement plan and prospectus (DS)	Sept 2019

Assurance (Strategic Risk 1.4)				
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 are reported to Trust Board when available with associated plans (P,N) (I, E))	A08	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
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 2019, various engagement events across the year plus Annual Members' Meeting September 2018. (P, N) (I, E)	A15	DHR, DS,	1.1, 1.3, 2.3
Reports from Transforming Care Board	Update reports into EMT. (P, N) (I)	A18	DFR	1.2, 1.3

Assurance (Strategic Risk 1.4)				
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 Calderdale, Kirklees and Wakefield Partnership Board				
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, 1.4, 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, 1.4, 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, 1.4
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
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	1.4, 2.1, 2.2, 4.1
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	1.4, 3.1

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Development of a clear value proposition linked to vision, mission and values (DS)	Sept 2019
Collate learning and insight from engagement surveys with feedback to identify themes (DS)	*Dec 2019*

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			

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 backed by strong analysis 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 backed by strong analysis 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**
Access to the model hospital to enable effective national benchmarking and support decision-making	C20	DFR	2.1
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 optimising the use of SystmOne . (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, 4.1
Datix incident reporting system supports review of all incidents for learning and action.(I)	C27	DNQ	2.1, 2.2, 4.1
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, 4.1
Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	C30	DNQ/MD	2.1, 2.3, 4.1
Quality Improvement network established to provide trustwide learning platform. (I)	C31	DNQ	2.1, 2.2, 4.1
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, 3.1, 3.2, 4.1

Gaps in control - what do we need to do to address these and by when?	**Date**
Limited use of reports generated using the data warehouse tool with resource recently focused on SystmOne implementation.	2019
Limited data on caseload, real time waiting list issues, face to face time.	2019
Limited actual use of benchmarking information in the Trust. Review use of model hospital data	Oct 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

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**
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 2019/20 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 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 optimisation 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
Quality strategy implementation plan reports into CGCS	Routine reports into CGCS (I)	A29	DNQ	1.4, 2.1, 2.2, 4.1
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
Data quality focus at OMG and ICIG	Regular agenda items and reporting of at ICIG and OMG (P, N) (I)	A31	DNQ	2.1

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
	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. System was implemented in February and March 2019*	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
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. Complete*	Quarter 4
Data input for SystmOne implementation catch up is not yet complete. On track for June completion.	June 2019

Strategic Risk 2.2
Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation

Controls (Strategic Risk 2.2)			
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, 4.1
Datix incident reporting system supports review of all incidents for learning and action (I)	C27	DNQ	2.1, 2.2, 4.1
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, 4.1
Weekly risk scan where all red and amber incidents are reviewed for immediate learning (I)	C30	DNQ/MD	2.1, 2.2, 4.1
Quality Improvement network established to provide trustwide learning platform (I)	C31	DNQ	2.1, 2.2, 4.1
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, 3.1, 3.2, 4.1
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, 4.1
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
Quality improvement approach and methodology (I)	C82	DNQ	2.1, 2.2, 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

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
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, 1.4, 2.3
Serious incidents from across the organisation reviewed through the	Process in place with outcome reported through quarterly serious incident	A19	DNQ	1.2, 2.3

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**
Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation	reporting including lessons learned to 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	2.2, 4.1
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	1.4, 2.1, 2.2, 4.1
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

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
Further assurance required to address similar repeated themes in relation to communication and risk assessment are identified through investigations	Sep 2019
Impact of introducing new inpatient structure to improve operational grip in respect of record keeping standard compliance. Inpatient strategy improvement plan evaluation data to be finalised prior to calendar year-end	Dec 2019

Strategic Risk 2.3
Increased demand for and acuity of service users leads to a negative impact on quality of care

Controls (Strategic Risk 2.3)			
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	2.3
Out of area bed reduction joint action plan with CCG. (I, E)	C51	DO	2.3
Performance management process and IPR at various levels of the organisation. (I)	C52	DFR	2.3
Safer staffing policies and procedures in place to respond to changes in need. (I)	C53	DNQ	2.3
TRIO management system monitoring quality, performance and activity on a routine basis. (I)	C54	DO	2.3
Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	C55	DO	2.3
Waiting list management improvement plan in place to support people awaiting a service/treatment. (I)	C56	DO	2.3
Process to manage the CQC action plan	C79	DNQ	2.3

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

Assurance (Strategic Risk 2.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board. (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 reported regularly to Trust Board via the IPR with associated plans. (I, E)	A08	DNQ	1.1, 1.2, 1.3, 1.4, 2.3, 2.3
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, 2.3, 3.4
Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board , CG&CS and MC	Unannounced and planned visits programme in place – report to CG&CS Committee 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, 2.3
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, 2.3

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**
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 2019, various engagement events across the year plus Annual Members' Meeting September 2018. (P) (I)	A15	DHR, DS, DMCEC	1.1, 1.3, 2.3
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, 2.3
CQC self-assessment process	Reviewed by EMT as part of preparation for CQC inspection process	A32	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, N) (I)	A39	DNQ	2.3, 2.3
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	2.3
Staff wellbeing survey results reported to Trust Board and/or Workforce & Remuneration Committee and action plans produced as applicable	Results will be reported when available. (P, N) (I)	A41	DHR	2.3
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	2.3, 3.4

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Impact upon patients and families of out of area placements. (Linked to ORR 1319) *Independent SSG report completed and recommendations being implemented during 19/20*	Dec 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. Additional investments made for 2019/20 and focus applied on recruitment and retention. Significant progress noted in Calderdale and Kirklees across all pathways. Work ongoing to address the gap in assurance for Wakefield and Barnsley*	Oct 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 Y	Q2	Q3	Q4

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

Ref	Description	RAG Rating
3.1	**Deterioration in financial performance leading to unsustainable organisation and insufficient cash to provide services effectively**	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 2019/20.
- 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, treasury management, payroll – significant assurance.
- Integrated Performance Report (IPR) summary metrics provide assurance on majority of our performance and clearly identifies where improvement is required.
- Various income reductions in recent years
- Procurement activity in Barnsley.
- 2018/19 deficit recorded and 2019/20 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 2019/20 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 provide services effectively

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, 3.1, 3.2, 4.1
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 2019/20 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 2019/20 approved at Trust Board March 2019. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports..(P, N) (I)	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
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, 1.4, 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, 1.4, 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	(P) (I) Annual Governance Statement 2018/19 reviewed by Audit Committee and approved by Trust Board in May 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 2019 (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	1.4, 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 April 2019 prior to approval by Trust Board and Members' Council. (P) (I)	A46	DFR	3.1
Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG)	Standing agenda 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**
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. Complete*	Quarter 4
£1.6m of unidentified CIP for 2019/20	October 2019*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 2019/20 not yet in place.	April 2019
Recurrent position is a deficit in excess of £4m	
Level of board scrutiny to be increased by introduction of a Finance Committee	Oct 2019

Strategic Risk 3.2
Failure to develop required relationships or commissioner support to develop new services/expand existing services leading to contracts being lost, reduction in income

Controls (Strategic Risk 3.2)			
Systems and processes - what are we currently doing about the strategic risks?	**Control Ref**	**Director lead**	**Strategic risk/s**
Formal contract negotiation meetings with clinical commissioning and specialist commissioners underpinned by legal agreements to support strategic review of services. (I, E)	C08	DFR	1.1, 1.4, 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, 3.1, 3.2, 4.1
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. Draft prepared and will be reviewed by EMT and other stakeholders before the end of September*	Sept 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 2019/20 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, 1.4, 3.1, 3.2, 3.3
2019/20 contracts reflect growth in line with mental health investment standard	Contracts in place for 2019/20 (P) (I,E)	A33	DFR	1.1, 1.2, 1.3, 3.1,

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**
as well as some specific service pressures				3.2
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 2019. (P) (I)	A44	DS	3.1, 3.2
Attendance at external stakeholder meetings including Health & Wellbeing boards	Minutes and issues arising reported to Trust Board meeting on a monthly basis.(P, N) (I,E)	A48	DO	3.2
Documented update of progress made against comms and engagement strategy	Monthly IPR to Executive Management Team (EMT) and Trust Board. (P, N) (I)	A49	DS	3.2

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**
Refresh of actions to support the stakeholder engagement plans. (*Note, expected completion date changed from Oct 2018 to Dec 2018, work ongoing)*	Dec 2018
Assessment of updated commissioning intentions. *(Note, expected completion date changed from Dec 2018 to Jan 2019 as publication of national guidance and long term plan has been delayed)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 Jun 2019 to Sep 2019 as plans will be completed once implementation plans for the long term plan within each integrated care system are agreed*	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, 1.4, 3.3
Annual financial planning process, CIP and Quality Impact Assessment (QIA) 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
Introduction of a Finance Oversight Group chaired by a non-executive director	C83	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*
Finance Oversight Group has not yet commenced			*June 2019*

Assurance (Strategic Risk 3.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance/reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
Integrated Performance Report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board. (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 2019/20 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	. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports.. Final plan for 2019/20 approved 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)	A20	DFR	1.2, 3.1, 3.2, 3.3

	(I)			
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) (I)	A21	DFR	1.2, 1.4, 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, 1.4, 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**
Currently £1.7m of unidentified CIP for 2019/20	September 2019
Balanced financial plan for 2019/20 not yet in place. Financial sustainability partly developed with further opportunities for improvement required.	September 2019
Level of Board scrutiny to be increased by introduction of a Finance Committee	October 2019

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

Controls (Strategic Risk 3.4)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Agreed workforce plans in place which identify staffing resources required to meet current and revised service offers. Also describe how we meet statutory requirements re training, equality and diversity. (I)	C71	DHR	3.4
Director portfolios clearly identify director level leadership for strategic priorities. (I)	C72	CEO	3.4
Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (I)	C73	DS	3.4
Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (I)	C74	DS	3.4
Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. **(I)**	C75	DFR	3.4
Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2018/19 priorities. (I)	C76	DS	3.4
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.	C80	DS	3.4

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

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, 2.3, 3.4
Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems	Objectives for 2019/20 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	Monthly financial reports to Trust Board and NHS Improvement plus quarterly	A13	DFR	1.1, 1.2, 3.1, 3.3,

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**
annual plan, externally scrutinised and challenged by NHS Improvement	exception reports. 19/20 operating plan approved by Trust Board in March 2019 and submitted to NHSI in April 2019(P, N) (I)			3.4
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	2.3, 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. . *(Note, expected completion date changed from Jun 2019 to Sep 2019 as plans will be completed once implementation plans for the long term plan within each integrated care system are agreed*	Sep 2019

Strategic Objective: 4. Making SWYPFT a great place to work	Lead Director(s)	Key Board or Committee	Current Assurance Level			
	As noted	WRC	Q1 Y	Q2	Q3	Q4

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

Ref	Description	RAG Rating
4.1	**Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience**	**Y**

Rationale for current assurance level (Strategic Objective 4)
• Staff 'living the values' as evidenced through values into excellence awards. • Staff turnover rates slightly higher but comparable with other trusts in Yorkshire • Staff sickness absence higher than target, but lower than majority of other trusts in Yorkshire • Staff survey feedback • 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. • CQUIN targets largely achieved. • Integrated Performance Report (IPR) summary

Strategic Risk 4.1
Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience

Controls (Strategic Risk 4.1)			
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, 4.1
Customer services reporting includes learning from complaints and concerns (I)	C26	DNQ	2.1, 2.2, 4.1
Datix incident reporting system supports review of all incidents for learning and action (I)	C27	DNQ	2.1, 2.2, 4.1
Patient Safety Strategy developed to reduce harm through listening and learning (I)	C29	DNQ	2.1, 2.2, 4.1
Weekly risk scan where all red and amber incidents are reviewed for immediate learning (I)	C30	DNQ/MD	2.1, 2.3, 4.1
Quality Improvement network established to provide trust-wide learning platform (I)	C31	DNQ	2.1, 2.2, 4.1
Quality Strategy achieving balance between assurance and improvement (I)	C32	DNQ	2.1, 2.2, 2.3, 4.1
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, 3.1, 3.2, 4.1
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, 4.1
Annual learning needs analysis undertaken linked to service and financial meeting. (I)	C35	DHR	2.2, 4.1
Education and training governance group established to agree and monitor annual training plans (I)	C36	DHR	2.2, 4.1
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, 4.1
Mandatory clinical supervision and training standards set and monitored for service lines (I)	C38	DHR	2.2, 4.1
Medical leadership programme in place with external facilitation as and when required	C39	MD	2.2, 4.1
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, 4.1
Recruitment and Retention action plan agreed by EMT (I)	C41	DHR	2.2, 4.1
Recruitment and Retention Task Group established (I)	C42	DHR	2.2, 4.1
Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs) (I)	C43	DHR	2.2, 4.1
Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures (I)	C44	DHR	2.2, 4.1
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, 4.1
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, 4.1

Controls (Strategic Risk 4.1)			
Systems and processes - what are we currently doing about the Strategic Risks?	**Control Ref**	**Director lead**	**Strategic risk/s**
Regular meetings established with Sheffield and Huddersfield University to discuss undergraduate and post graduate programmes	C81	DHR	4.1

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. *Mentorship programme launched. Medical leadership programmes due to be launched.*	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 4.1)				
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
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	2.2, 4.1
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	1.4, 2.1, 2.2, 4.1
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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019
Agenda item 6.2

Title:	**Corporate/Organisational Risk Register Quarter 1 2019/20**
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 July 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 objectives 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. In 2019/20, there is a fourth strategic objective 'Making SWYPFT a great place to work' and there is a recommendation within this paper regarding possible risks to realign to this objective.  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+ risk**:

	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.

The following changes have been made to the ORR since the last Board report in April 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.	Actions updated	Reviewed by lead Director and EMT. Actions updated.

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. Actions reworded and three additional controls identified.
	1078	Risk that the long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment.	Description risk level, controls and actions updated	Reviewed by lead Director and EMT. Description of risk updated. Risk likelihood changed from 3 'possible' to 2 'unlikely'. Completed actions moved to controls and a new 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 one further action identified.
	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 ➢ Suicide prevention	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls.
	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls.
	852	Risk of information governance breach leading to inappropriate	Actions updated	Reviewed by lead Director and EMT. Wording of actions

		circulation and / or use of personal data leading to reputational and public confidence risk.		updated.
	1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.	Actions updated	Reviewed by lead Director and EMT. Complete action removed and one further action identified.
	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.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls. One further action identified.
	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.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls. One further action identified.
	1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	Actions updated	Reviewed by lead Director and EMT. Further action identified.
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	Risk level and actions updated	Reviewed by lead Director and EMT. Risk likelihood changed from 4 'likely' to 3 'possible', based on the most current assessment of the market this is now considered a possible scenario as opposed to being likely. New action identified.
	1319	Risk that quality of care will be compromised if people continue to be sent out of area.	Actions updated	Reviewed by lead Director and EMT. Two complete actions removed. One further action identified.
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	Controls updated	Reviewed by lead Director and EMT. One further control 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.	Risk level and actions updated	Reviewed by lead Director and EMT. A complete action removed. Risk likelihood changed from 4 'likely' to 3 'possible'. Given the relatively low numbers

				of children and young people that are placed on an inpatient ward out of the total cohort, this has been re-evaluated as a possible eventuality as opposed to being likely.

Risks below 15 (managed within risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	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.	Controls and actions updated	Reviewed by lead Director and EMT. Two new actions and one new control identified.
	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.	Risk level, controls and actions updated	Reviewed by lead Director and EMT. Six actions completed and controls updated. Risk consequence changed from 4 'major' to 3 'moderate' and likelihood changed from 3 'possible' to 2 'unlikely' following the transition from RiO to SystmOne. Risk now managed 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 the Quarter 1 review, EMT reviewed the triangulation of risk performance and governance report (Audit Committee 9 July 2019) and considered red RAG rated areas in the Integrated Performance Report (IPR) which were not on the ORR:

- 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 at this time. This will continued to be monitored through the IPR.

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 ➢ **DISCUSS if Risk ID 1154 and Risk ID 1157 should be realigned to the fourth strategic objective for 2019/20 'Making SWYPFT a great place to work'.**
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 four strategic objectives	
Improving health	Improving care
Improving resources	Making this a great place to work

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
EIC = Equality & Inclusion Committee

Actions in green are ongoing by their nature.

Trust Board (business and risk) - 30 July 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 of timescales) ➢ 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 – July 201

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		➢ Microsoft software licensing strategic roadmap in place. ➢ Cyber security has been incorporated into mandatory Information Governance Training, revised during 17/18. The Trust achieved the compliance requirement for level 2. ➢ 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 – approved by EMT and roll out has commenced (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	

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

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
275	Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding.	➢ Agreed joint arrangements for management and monitoring delivery of integrated teams. ➢ Weekly risk scan by Director of Nursing and Medical Director. ➢ BDU / commissioner forums – monitoring of performance. ➢ Monthly review through performance monitoring governance structure via Delivery EMT of key indicators and regular review at OMG of key indicators, which would indicate if issues arose regarding delivery, such as delayed transfers of care, waiting times and service users in settled accommodation. ➢ Regular ongoing review of contracts with local authorities. ➢ New organisational change policy to include further support for the transfer and redeployment of staff. ➢ Attendance at and minutes from Health & Wellbeing board meetingsAttendance and monitoring at contract forums ➢ Annual planning process	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Involved with partners in the co-development of integrated care partnerships in each place as Trust priority programmes of work ➢ Calderdale is captured in the Calderdale Cares document and delivery is overseen through the Health and Wellbeing Board. (DNQ) ➢ Kirklees – part of the provider development board to develop wider system integration of care closer to home and 0 – 19 services in Kirklees (DO/DPD) ➢ Barnsley – part of the Integrated Care Delivery Group (DS) ➢ Wakefield – active involvement in the mental health provider alliance and integrated care partnership (DPD) ➢ Active involvement in both West and South Yorkshire integrated care systems (DHR, DS, DPD)Engagement in each place with local authority partners through meetings and joint working. (DO)	DS	Ongoing risk given external influenc e outside our control	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performanc e report) Annual review of contracts and annual plan at EMT and Trust Board	6 Yellow /Moder ate (4-6)	CG&CS AC	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 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. Final report due to EMT in July(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 – July 2019
1078	Risk that young people will suffer harm as a result of waiting for 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	2 Unlike; ly	8 Amber / High risk (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ First Point of Contact has demonstrated a positive impact in Kirklees and has been implemented in all areas. This is still being embedded. (DO) ➢ Recruitment to vacant positions is underway to increase capacity. This includes the consideration of new roles to improve opportunities to recruit. (DO) ➢ Calderdale CCG has led on development of a new diagnostic assessment pathway and is currently considering options for investment in a waiting list initiative. (DO) (Date to be confirmed by CCG). ➢ Fulfil requirements of the NHS Long Term Plan. (DO) ➢ Waiting list initiatives details and outputs reported to	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 – July 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
		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. ➢ Improved finances included in 2019/20 contracts ➢ CAMHS assurance meeting chaired by Chief Exec of SWYPFT and Chief Officer of Wakefield CCG oversees the delivery of young people's mental health and associated action plans.					Clinical Governance & Clinical Safety Committee			Individual district performance 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.	➢ 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 Possible	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 and will be a regular report at OMG in 2019/20. (DO) ➢ Waiting list initiatives agreed with Barnsley and Calderdale CCGs. Demand will be reported via contract meetings during 2019/20 ➢ 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) (July 2019)	DO	July 2019	Performance reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performance 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 – July 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	4 Major	3 Possible	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&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 Note - A failure to effectively manage compliance	Every three months prior to business and risk Trust Board – July 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
		and Estates been briefed and action undertaken accordingly ➢ 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.											with the Trust Fire/Smoking policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings.	
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&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – July 2019
1424	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) ➢ Alignment of WY&H ICS suicide prevention strategy	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

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
	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. ➢Updated clinical risk report that captures a wider range of risk information for OMG ➢Mental health safety improvement partnership in place with NHSI/CQC ➢Clinical risk assessment training programme					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)			Safety report & incident report				July 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. ➢2019/20 contracts agreed and in place	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) ➢Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 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
852	Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	➢ Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target of 95% ➢ Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. ➢ Trust has appropriate policies and procedures that are compliant with GDPR. ➢ Trust has good track record for recording incidents and all incidents are reviewed weekly with investigations carried out where needed and action plans put in place. ➢ Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues. ➢ Monthly report of IG issues to EMT. ➢ Internal audit perform annual review of IG as part of IG Toolkit. ➢ GDPR implementation plan.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Targeted approach to advice and support from IG Manager through proactive monitoring of incidents and 'hot-spot- areas. Individual letters asking for action plans from services where there have been a recurrence of incidents(DFR) ➢ IG awareness raising sessions through an updated communications plan. (DFR) ➢ Rebranded materials and advice to increase awareness in staff and reduce incidents. (DFR) ➢ Increase in training available to teams including additional e-learning and face-to-face training. (DFR) ➢ Commitment to support comprehensive attendance at the ICIG meeting (DO)	DFR	ICO external monitoring of progress by external evidence / desk based reviews	Progress monitored through EMT and weekly risk scans	4 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 2019
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.	➢ Financial planning process includes detailed two year projection of cash flows. ➢ Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately. ➢ Capital prioritisation process to ensure capital is funded where the organisation most needs it. ➢ Stated aim of development of financial plans that achieve at least a small surplus position. ➢ Estates strategy with the intent of selling surplus buildings. ➢ CIP identification and review process. ➢ Treasury Management policy.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Increased robustness of CIP and expenditure management. (DFR) ➢ 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 ICS. (DFR / CEO / DPD) ➢ Development of a Finance Committee to focus on financial sustainability (CEO/DFR) (July 2019)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO3	Every three months prior to business and risk Trust Board – July 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
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 ICSs in both West and South Yorkshire. ➢Communication, engagement and involvement strategy. ➢Updated Trust strategy in place. ➢Liaison with regulators ➢Approved commercial strategy ➢2019/20 contracts agreed and in place	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Implementation of longer term financial sustainability plan. (DFR) ➢ 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) ➢ Development of a Finance Committee to focus on financial sustainability (CEO/DFR) (July 2019)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 1 & 3	Every three months prior to business and risk Trust Board – July 2019
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	➢Board and EMT oversight of progress made against transformation schemes. ➢Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP. ➢Active engagement on place based plans. ➢Enhanced management of CIP programme. ➢Updated integrated change management processes. ➢2019/20 contracts agreed and in place	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Implementation of longer term financial sustainability plan. (DFR) ➢ 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) ➢ Development of a Finance Committee to focus on financial sustainability (CEO/DFR) (July 2019)	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	4 Yellow /Moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Every three months prior to business and risk Trust Board – July 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.	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Proposal for On Boarding System to include recruitment Microsite (DHR) (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 influenc e outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performanc e report)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to business and risk Trust Board – July 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
		➢ Retention plan developed. ➢ Workforce plans linked to annual business plans. ➢ Working in partnership across W Yorks on international recruitment.												
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.	➢ Monitoring turnover rates monthly. ➢ Exit interviews. ➢ Flexible working guidance. ➢ Flexible working arrangements promoted. ➢ Investment in health and well-being services. ➢ Retire and return options. ➢ Apprenticeship scheme balancing the age profile. ➢ Recruitment and Retention action plan agreed. ➢ Workforce planning includes age profile.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Refresh of workforce plans. (DHR) (June 2019)	DHR	Ongoing	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 2019
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	➢ Absence management policy. ➢ Occupational Health service. ➢ Trust Board reporting. ➢ Health and well-being survey. ➢ Enhanced occupational health service. ➢ Well-being at Work Partnership Group. ➢ Health trainers. ➢ Well-being action plans. ➢ Core skills training on absence management. ➢ Extend use of e-rostering. ➢ Retention plan developed.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Wellbeing plan to be established in each BDU. (ALL)	DHR	31/08/1 9	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 2019
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	➢ Annual Equality Report. ➢ Equality and Inclusion Form. ➢ Equality Impact Assessment. ➢ Staff Partnership Forum. ➢ Development and delivery 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 Moder ate	3 Possib le	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) ➢ Delivery of WRES and EDS2 action plans. (DoN)	DHR	Ongoing	EMT (quarterly) E&I Committee (quarterly)	6 Yellow / moder ate (4-6)	WRC E&IC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July 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	3 Moder ate	3 Possib le	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 / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF,	Every three months prior to business and risk Trust

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
		Staff. ➢ Extension of the Staff Bank. ➢ Development of Medical Bank. ➢ OMG to Overview. ➢ Director of Delivery supporting reduction in agency usage. ➢ Retention plan developed.											SO2 & 3	Board – July 2019
1169	Risk that improvements in performance against the metrics covering open referrals, unvalidated progress notes and un-outcomed appointments are not made leading to clinical risk and poor outcomes for service users.	➢ Information is available daily at HCP, team, BDU and Trust level. ➢ A regular summary is reviewed at Operational Management Group (OMG) to track progress	3 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 – July 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 ICSs. ➢ Skilled business development resource in place. ➢ Commercial strategy	3 Moderate	3 Possible	9 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) ➢ Development of a value proposition (DS)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 2019
1216	Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements placed on the Trust that are not met or result in a financial penalty.	➢ Implementation plan ➢ Existing data protection policies reviewed and compliant by 25 May 2018 ➢ Attendance at Yorkshire & Humber IG meetings ➢ Internal audit completed on readiness and all actions closed ➢ Training provided by Deloitte to Board members ➢ Regular updates to Board and audit committee ➢ Actions identified in internal audit report implemented	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – 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 factored in to the 2019/20 internal audit plans	DFR DNQ	Implementation plan – 31/10/18 October 2019	Regular reports to ICIG group Reports to Audit Committee	6 Yellow / moder ate (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 – July 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
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 Moder ate	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) ➢Workstreams in place to address specific areas as agreed following the SSG review ➢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) ➢Implementation of actions identified through independent review of our bed management processes. Progress is monitored via the steering group and reported to the partnership group (DO)	DO	October 2019	OMG	4 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – July 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. ➢2019/20 contracts agreed and in place	3 Moder ate	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 / moder ate (4-6)	Trust Board	Risk appetite: Financial risk 1 – 6	Every three months prior to business and risk Trust Board – July 2019
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	3 Possib le	12 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of new CAMHs inpatient facility in Leeds for West Yorkshire. (DO) (2020) ➢ 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 – July 201

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)
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.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
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	Risk of problems with succession planning / talent management.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Yellow / Moderate (4-6)

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

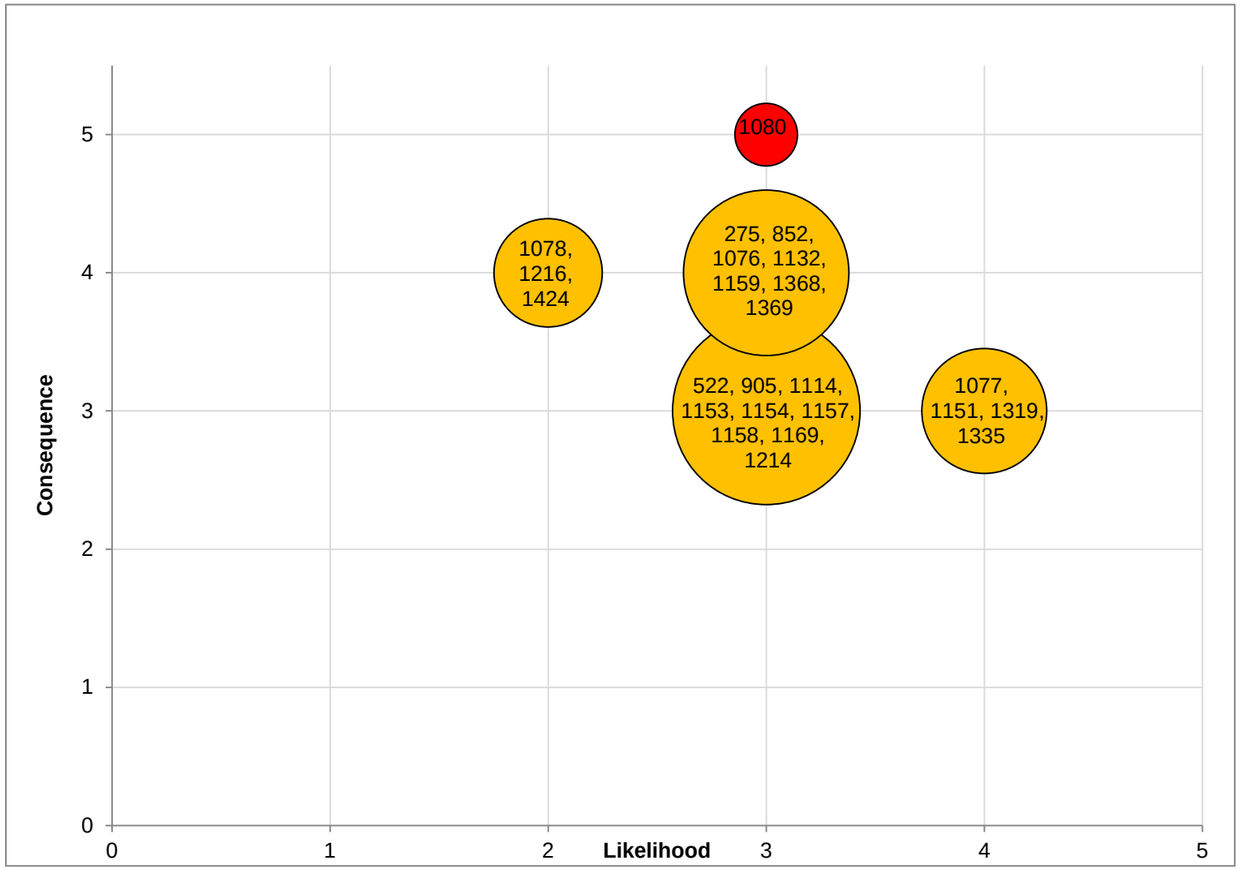
South West Yorkshire Partnership NHS Foundation Trust

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 long waiting lists to access CAMHS and ASD services lead to delay in young people starting treatment. (1078) = 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) = 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 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) = Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing. (1369)		
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 local tendering of services will increase, impacting on Trust financial viability. (1214)	= 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) = 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), (1214), (1216), (1319), (1335), (1368), (1369), (1424)		
Negligible (1)					

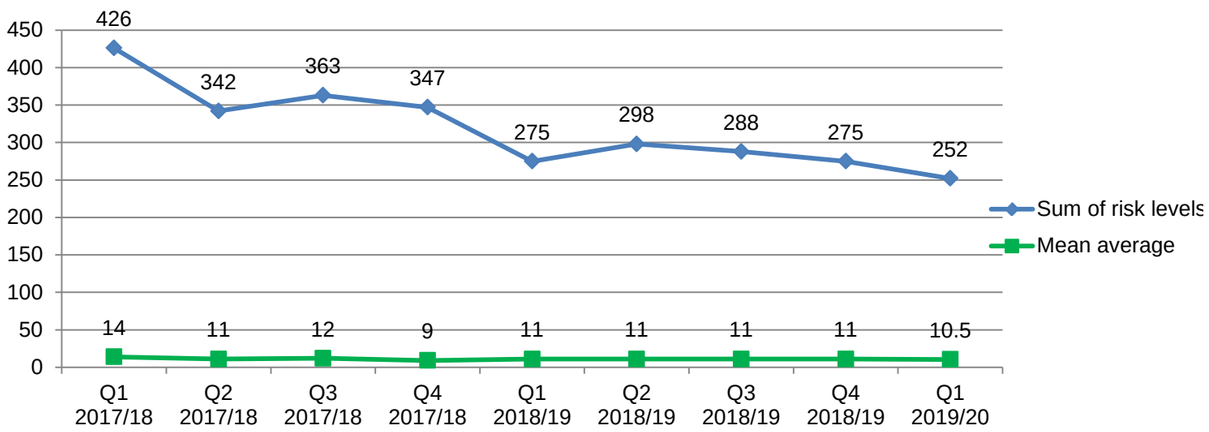
=	same risk rating as last quarter	<	decreased risk rating since last quarter	RA	risk appetite
!	new risk since last quarter	>	increased risk rating since last quarter		

With **all of us** in mind.

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



Average risk level (outside risk appetite)								
2017/18				2018/19				2019/20
Q1 (31 risks)	Q2 (31 risks)	Q3 (33 risks)	Q4 (35 risks)	Q1 (23 risks)	Q2 (27 risks)	Q3 (26 risks)	Q4 (25 risks)	Q1 (24 risks)
14	**11**	**12**	**9**	**11**	**11**	**11**	**11**	**10.5**



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.
8	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.
9	1214	Risk that local tendering of services will increase, impacting on Trust financial viability
8	1216	Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements placed on the Trust that are not met or result in a financial penalty.
12	1319	Quality of care will be compromised if people continue to be sent out of area.
12	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.
12	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.

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 July 2019

Agenda item 7.1

Title:	**South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYB ICS)**
Paper prepared by:	Director of Human Resources, organisational development and estates / Director of strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the South Yorkshire and Bassetlaw Integrated Care System (ICS), and Barnsley integrated care developments.
Mission/values:	The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnership working across the different health economies. It is therefore important that the Trust plays an active role in the South Yorkshire and Bassetlaw ICS.
Any background papers/ previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYB ICS (formerly Sustainability and Transformation Partnership), including Barnsley Integrated Care Developments.
Executive summary:	**1. SYB response to the NHS Long Term Plan** The ICS is refreshing the vision and ambition for South Yorkshire and Bassetlaw in setting out a five year strategic plan in response to the Long Term Plan (LTP). To enable coordination and development of the plan over the next few months the ICS has: ➢ Established a **cross-system task and finish group** to help partners coordinate the development of the plan ➢ The **first guiding coalition workshop was held in July** to support wider engagement on developing the plan priorities. Trust representatives attended the workshop. ➢ The **System Health Executive Group** will ensure the development of the plan progresses as agreed and expect to review a draft plan in September 2019 ➢ It is anticipated that the **plan will be ready to share with Boards and Governing Bodies between 14-18 October.** Board will need to agree the process for formal review outside of the normal Trust Board due to the timescales. ➢ The plan will **build on the work and plans of the 5 places** and the work across SYB. ➢ Use the **2019/20 plans to form year one of the system strategic plan.** ➢ **Healthwatch have completed a series of public engagement activities including focus groups and surveys** drawing together the themes and findings. The themes include a need for a greater focus on mental health, children and young people, access and prevention **2. Priorities of joint working for Local Authorities** The Collaborative Group discussed and agreed the importance of the whole system working together on three key priorities and an update was provided:

a) **Complex Lives**: Supporting people experiencing multiple disadvantage, work has commenced to develop initiatives to support rough sleepers, and vulnerable women that have a forensic background.
b) **Connectness**: Dealing with loneliness, a programme of work is currently being scoped and the impact.
c) **Physical Activity/Active Travel**: Getting the population more physically active.

3. SYB QUIT Programme

The South Yorkshire and Bassetlaw QUIT programme is an innovative systematic intervention for people who are tobacco dependent, based on current best practice and research. It builds on learning from Canada and London, where similar hospital-based programmes had a significant impact on not only health outcomes, but also on short and medium term hospital re-admissions.

Hospitals in SY&B see a large proportion of its population as patients each year, many of whom are admitted for at least several days. It is estimated that 25% of hospital patients are current smokers. Their admission period is a unique opportunity during which they could be supported to make one of the single most effective changes possible to improve their long-term health.

We recognise that working together at system level we will have a consistent approach and a clarity of message that can add real value. All our hospitals have appointed senior executive sponsors and are signed up to delivering the programme.

The programme was launched in Sheffield In November 2018 and is already making an impact. **The programme is being rolled out to include mental health and community providers and the Trust will be a partner in this programme moving forward. This is in addition to the services and support provided through the Yorkshire Smoke free Service**.

4. SYB Allied Healthcare Professionals Conference Awards

The event was held on 3 July in Doncaster. The conference highlighted best practice developed locally, regionally and nationally. The Barnsley Alliance that includes the Trust as a key partner was awarded the AHP Quality Award at Place level for developing and delivering joined up care and faster recovery and rehabilitation following a hospital stay.

5. SYB ICS- Primary Care Networks (PCNs)

30 PCNs have been established across SYB, with Barnsley having the largest single PCN in the country.

6. ICS place review - Barnsley

The ICS CEO Lead and members of the ICS Core team together with representatives from NHSI will conduct quarterly place reviews. **The first place review for Barnsley was held in May 2019.** The review focused on performance, integration and joined up care and service developments including Primary Care at scale. The team also visited the Acorn Unit at BHNFT and met with staff from the Right Care Barnsley team. Formal **Feedback from the Review was positive.**

	7. Barnsley Integrated Care update The Barnsley Clinical Commissioning Group (CCG) continues to work with partners including the Trust to develop joined up integrated care. The CCG have been discussing with partner organisations, including the Trust, proposals for a new model for health care provision and commissioning for Barnsley involving an integrated care system. Partners across Barnsley continue to work together to develop integrated models of care including Primary Care Networks (PCNs), neighbourhood model, Frailty, and developing an integrated model of care for Stroke and Frailty. Barnsley CCG has supported the development of one single PCN that covers every single practice in Barnsley making this the largest PCN in the country. The Clinical director for the PCN will be the Accountable Clinical Director as specified in the new GP contract and LTP. To support the PCN six Neighbourhood Networks have been established. These networks are based on the existing Barnsley GP localities Each has a population of 30,000-50,000 with the exception of Penistone which has 56,000. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYBICS and Barnsley integrated care developments.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 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 Director provider development
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 June Trust Board.
Executive summary:	The Trust Strategy refresh outlines the importance of the Trust's role in each place it provides services, including the 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 July 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) focusing on developments that are of importance or relevance to the Trust. The paper will also include a brief update on key developments in local places that the Trust provides services 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 are set out in the 'Our Next Steps to Better Health and Care for Everyone' document.

WY&H HCP is a trailblazer and one of the earliest Integrated Care Systems (ICS) that is supported by the ICS development programme. Since May 2018 the ICS has received national recognition for the way the 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. Key points from the June meeting include the following:

- The ICS was well represented at the recent NHS Confederation conference that focused on collaboration, mental health and the role of health in the wider economy at the event, and a number of colleagues were contributors to the event.
- Both Simon Stevens and Matthew Gould (CEO of NHSX) visited Yorkshire on 18 June and both met a number of colleagues from WY&H.
- The NHS Interim People Plan was published on 3 June, with a strong focus on the role of ICS.
- The first public WY&H Health and Care Partnership Board Meeting took place on 4 June. A key action from the meeting had been the need for further conversations

with Health and Wellbeing Boards (HWBs) about proposals on the use of flexible transformation funding.

- The Q4 ICS assurance meeting with NHSE/I Regional Director Richard Barker and team took place on 29 April. The feedback letter from Richard was provided within the meeting papers. There will be a continuing focus on key areas including Emergency Department performance and the need to add pace to our approach to the Learning Disabilities agenda

3.2. Key updates from the ICS Programmes - received at the June SOAG meeting, **updates particularly of note for the Trust Board include**:

3.2.1 Mental Health, Learning Disability and Autism

- The Suicide prevention programme has been successful in securing £173k from NHSE/I to assist with post-vention work following a suicide, with an additional £114k for male suicide prevention. The programme was also likely to receive circa £1.4m of flexible transformation funding, the need to complete a proposition for the funding is a priority. It was agreed that further links should be made with Improving Population Health and Primary Care Networks so that housing, social and economic factors amongst others could be understood as part of the PHM Learning Cycle. The programme includes a focus on developing and providing evidence based pathways for children and young people at risk of self-harm and or suicide. **The Trust is leading this programme on behalf of the Partnership and has also developed a new risk assessment framework for under 18's that is being tested.**
- Out of area placements remains a risk and continues to challenge the system and collaborative developments around bed management continue to take place to offer a standardised improved offer. The recent bid for Children and Young People Tier 4 CAHMS provision had also been supported and was recognised as a positive step forward. **The Trust is a key partner in both these programmes of work.**
- The programme needs to remain clear on its objectives in the light of new funding to ensure that there is no duplication across the three core elements of the programme.

3.2.2 Primary and Community Care

- The programme continues to support the development of the **55 Primary Care Networks (PCNs)** and will be using the PCN Clinical Directors' session in September to co-produce a development offer. **The Trust is supporting the development of Integrated Care in each of the places it provides services and PCNs will be a key part of new models of care as they develop**
- The digital rollout for online consultations continues. However, three areas are still working through the process of agreeing the contract (Leeds, Greater Huddersfield and Harrogate)

3.2.3 Prevention at Scale

- The initial programme objectives are progressing well and there has been a reduction in all three areas. The tobacco milestones had reduced according to the trajectory and stood at 17.3%, alcohol related admissions had reduced by 9% and the National Diabetes Prevention Programme had exceeded their delivery milestones. The WY&H Diabetes Prevention Programme had also been selected as an early engagement site for the HeLP tool (Healthy Living for people with Type 2 Diabetes- online self-management support programme). **The Trust Provides Yorkshire Smoke Free Services and contributes to the milestones for the reduction in Tobacco targets.**
- Strong support has been given from the Partnership Board to widen the scope of the programme, to include wider determinants of health and health inequalities and a wider

definition of prevention. Additional resource to deliver these proposed objectives was noted at both a WY&H level and at place. **The Trust continues to work with partners to ensure that the wider determinents of health and health inequalities, that impact the people that we provide services to, are addressed in each of the places that we provide services through the delivery of the place-based plans.**

3.2.4 Workforce

- Following the publication of the NHS People Plan the programme will consider the implications for the partnership and are currently reviewing its Terms of Reference (ToR) and membership.
- The Partnership has been selected to be involved in the development of the National People Plan, which will be published ahead of the Government's Spending Review later this year. The Partnership will be involved in field testing a workforce development tool which is sponsored by the National People Board. Their ambition is for the tool to be used by all ICS/STP leaderships as an enabler of work for transformation. The national work is overseen by Prerana Issar, Chief People Officer and The Trust and Partnership CEO Lead, Rob Webster, is chairing the New Operating Model for Workforce Board. The WY&H Partnership has been selected to field test a new national workforce development tool, and work will take place over the summer and is being supported by NHS England.

3.2.5 Harnessing the Power of Communities (HPoC)

- The programme held a positive event in May that brought together Voluntary and Community Sector (VCS) organisations across WY&H to discuss opportunities and challenges in delivering the NHS LTP. An evaluation of investment on the £1m HPoC funds also took place with consideration of priorities for the programme in 2019/20.

3.3 Review of System Performance and Delivery at the June SOAG meeting

3.3.1 Finance

- The partnership Finance Forum has been established on a more formal basis and was now in a position to make recommendations to SOAG and the System Leadership Executive. A senior finance lead has recently been appointed to provide further capacity to the partnership.
- Conversations are taking place with identified partners on the detail of their plans to manage system risks.
- The ICS has been asked, alongside other ICSs, by the Department of Health and Social Care to make a 20% reduction in planned NHS capital spending for 2019/20. This is a result of the national 'capital delegated expenditure limit' being lower than the overall planned expenditure across the country. A national formula has been applied to determine what this means for individual partnerships. For West Yorkshire and Harrogate Health and Care Partnership this equates to 21%, a total of £36.8 million reduction from an original capital plan of £178.0million. Rather than cancel planned capital projects, partners have committed to work together to ensure that all schemes that are required to go ahead this year are progressed and that others are deferred. **The Trust Director of finance and resources has been leading these discussions on behalf of the Trust**

3.3.2 Performance Dashboard

- Key headlines on system performance were noted.
- IAPT performance in Kirklees was an area of concern. A number of actions to address this were noted.
- It was agreed that monitoring performance against plan, rather than against constitution standard, should be introduced where appropriate.
- Further conversations had taken place with Mental Health, Healthwatch and WYAAT colleagues to improve how their metrics were reflected on the system dashboard
  The June Dashboard is available for Board members to view and included in the papers of the partnership section of the meeting.

3.4 ICS Transformation Funding 2019/20

The **designated transformation funding** expected to be received by the ICS in 2019/20 is between £15m and £20m (based on a population share of the national designated funding available for ICSs) To date, the ICS has been notified of funding for cancer (£6.6m), GP forward view (£2.1m), maternity (£1.7m) and personalisation of care (£0.3m). The designated funding will be overseen through relevant programme Boards and spent in place.

The Partnership was notified in May 2019 that it was likely to receive **£8.75m of flexible transformation funding in 2019/20.** Decision-making authority for where flexible transformation funding should be prioritised sits with the Partnership Board. Views from the six places as to which programmes should be considered as priorities for accessing the flexible transformation funding was sought during May 2019. The following high-level priority programmes on how the £8.75m flexible transformation funding could be deployed were supported at the Partnership Board. These reflect the priorities recommended by places with some minor adjustments to ensure that priority areas like Children and Young People and population health management are supported.

- Urgent and emergency care 3.80
- Mental health, learning disabilities and autism 1.40
- Improving population health 1.40
- Specific priority areas in place (VCS) 0.90
- Children and Young People 0.40
- Programme capacity/system issues 0.85

Subsequently, each of the places that make up the Partnership were consulted and the proposals and place responses were further discussed at the System Leadership Executive in July. The recommendation to support the above priority areas has been approved by the Chair and Vice Chair of the Partnership Board. Further work to develop plans for each priority area will continue and an update will be provided to the Partnership Board in September. **The Trust is a key partner in Kirklees, Calderdale and Wakefield as well as the West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative (WYMHLD&ASC) and will continue to contribute to the development of these proposals.**

*3.*5 WY&H Finance Forum

The Directors of Finance group has played an important part in the governance of the Partnership. Until now it has operated without terms of reference and the need has been recognised to strengthen and formalise how financial issues are addressed within the Partnership. The draft Terms of Reference (ToR) seek to establish the Forum as a formal part of the Partnership governance arrangements, with clear responsibilities and reporting arrangements. The draft ToR has been developed by the Finance Steering Group, a small sub group of the Directors of Finance and discussed at the System Leadership Executive Group.

ToR is consistent with the style and format of those of other WY&H Partnership groups and is built on what the Partnership Memorandum of Understanding (MoU) says about our financial principles and ways of working.

The Finance Forum will be the primary forum for financial leadership, advice and challenge and will support the Partnership Board and System Leadership Executive Group to lead and direct the Partnership. The Forum will be accountable to the Executive Group and will formally report, through the Chair, to the Executive Group. The Forum will also make recommendations and provide advice to the System Oversight and Assurance Group. **The Trust Director of finance and resources will be a member of this group.**

3.6 The NHS Long Term Plan - Healthwatch Engagement and WY&H Digitisation and Personalisation Mapping reports

The Partnership's 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 five-year strategy. Healthwatch have now completed this work and the report was presented to the Partnership in July. The report includes the findings from two surveys and 15 focus groups that have been carried out. The findings from this report will feed in to the development of the partnership's five year plan that is in development. The report will also be shared with communications and engagement leads across the partnership. The full report can be accessed through this link. https://www.wyhpartnership.co.uk/get-involved/longtermplan

The Trust will ensure that findings from the report are reviewed and feed in to service improvement, change plans and form part of the process to refresh the Trust Communications, Engagement, Involvement and Inclusion strategy that will commence later this year.

3.7 Memorandum of Understanding with the HealthTech sector

Over the past 12 months, the Yorkshire and Humber Academic Health Partnership has been leading work to develop a new way of working with the health tech sector across the Leeds City Region. This work has involved the production of a Memorandum of Understanding (MoU) which defines a new way of working between the health tech sector, universities, and health and care organisations. The West Yorkshire and Harrogate Health and Care Partnership have been an active partner in this work. The MoU is currently being reviewed and agreed by all partners.

3.8 WY MHLD&ASC Committees in Common

The committee continues to meet 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 NHS Long Term Plan. The approved minutes of these meetings will, in future, be received in public through member boards.

3.8.1 West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative update

Progress is being made against all programmes as reported through the Trust Integrated Performance Report and through the Committees in Common for mental health, learning disability and autism providers. Key developments to note include the updates to SOAG in June and below:

- ***Transformation funding (Wave 1) for community mental health:*** a WY&H ICS bid was made by the deadline of 21 June 2019. This comprised two components: Specialist community rehabilitation service (to be tested in Kirklees, Calderdale, and Leeds); Young person offer focusing on early intervention for vulnerable people in defined populations (to be tested in Wakefield, Bradford, and Leeds). A feedback conference call is taking place on 31 July 2019 related to the outcome of this bid.

- ***Transformation funding for community crisis care*** a WY&H ICS bid was made by the deadline of 24 June 2019. This bid comprised some elements that were West Yorkshire-wide and most elements that were place-based. Confirmation was received on 12 July 2019 that all the WY&H ICS proposals would be funded. The Trust is in the process of working through with each CCG in our districts the implementation arrangements for the proposals.

- ***NHS England specialised commissioning*** **-** The intention is that by 2022/23, there will be 100% Provider Collaborative coverage nationally across all specialised mental health, learning disability and autism services. NHSE have invited 'Applications' from the ICS by 5 July 2019 and, if successful, this would result in four year contracts being awarded to the provider collaborative to lead on the delivery of these services. This builds on the new care model pilots that have been running for 12 months. **The Trust has been working with our partners in the West Yorkshire Mental Health, Learning Disability and Autism collaborative to develop applications, on behalf of WY&H ICS, for CAMHS tier 4, adult eating disorder, and adult secure forensic services. The Trust submitted a Lead Provider collaborative application for forensic adult secure on 4 July 2019 and is a key partner in the CAMHS tier 4 and in the adult eating disorder provider collaborative applications.** The next step following submission is a Yorkshire and Humber panel for NHS-led Provider Collaboratives to take place on 22 July 2019.

- ***Specialist Community Forensic Team Pilot Wave 2 Selection***
  The Trust submitted a proposal as lead provider on behalf of the Provider collaborative against this invitation for bids (following an unsuccessful bid for wave 1 in January 2019) The Trust will now work with NHS England and provider collaborative partners to take the proposal to the next stage.

4. Local Integrated Care Partnerships - Key developments

A number of the places in which the Trust provides services are part of the WY&H HCP. These include Kirklees, Calderdale and Wakefield. Barnsley is part of the South Yorkshire and 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 five Locality Networks (PCN's) have been established across Calderdale. **The Trust is a key partner in Calderdale Cares and received a comprehensive update at the last Trust Board.**

4.2 The Wakefield Integrated Care Partnership and Mental Health Alliance

The Wakefield partnership has continued to progress the integration agenda through the Integrated Care Partnership (ICP). The Mental Health Alliance has worked together to agree

the priorities for 2019/20 in line with the mental health investment standard. The detailed proposals to support the priorities (including proposals that have now been approved against the WY&H ICS bid for transformation funding for community crisis care highlighted above) were presented to the 3 July ICP Board meeting, and the 9 July Wakefield CCG Governing Body meeting. The proposals were well received by both Boards, and now with CCG Governing Body approval, the Alliance is moving to implementation phase of the proposals.

Wakefield Primary Care Networks - The Trust's director of provider development is the SRO for this programme (on behalf of the ICP Board). There will be seven Primary Care Homes (PCHs), the local version of primary care networks, in Wakefield, which went 'live' on 1 July 2019, in line with the national timetable. The Trust's service offer in Wakefield is being aligned to PCHs, 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. Further engagement continues to take place with key strategic leads across the system to clarify and develop the engagement plan, governance arrangements and scope. This should include a focus on prevention and links to the nine Kirklees Primary Care Networks as they develop, as well as develop more seamless services and pathways. The core team working on the development of the Alliance are holding a design workshop in July to clarify the vision for the Alliance, confirm the objectives and develop a high level plan; this will be shared with Board once agreed with partners. 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.

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 July 2019
Agenda item 8.1

Title:	**Integrated Performance Report Month 3 2019/20**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for June 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 (EMT) meeting on a monthly basis
Executive summary:	**Quality** ➢ Positive progress on prone restraint continues for this month. ➢ Safer staffing fill rates remain positive reflecting the sustained increase in acuity – some wards continue to experience difficulties in maintaining appropriate levels. ➢ Action to address medicine omissions position achieves desired improvement. ➢ Decrease in supervision levels under investigation. **NHSI Indicators** ➢ The Trust is meeting the target performance majority of national metrics ➢ 3 young people placed in adult wards during June equating to 56 beds days. **Locality** ➢ Significant demand pressures with intermediate care in Barnsley ➢ Barnsley early intervention in psychosis team has achieved 'top performing' status in a national audit. ➢ Successful with bids for additional crisis home treatment investment ➢ Detailed plans in place to re-purpose beds in Appleton ward following de-commissioning of 8 forensic learning disability beds. ➢ Waiting time from referral to treatment in Barnsley and Wakefield child and adolescent mental health services remain an issue. ➢ Nostell ward in Wakefield has been participating in the national reducing restrictive practices collaborative and the latest performance has shown a 50% reduction. **Priority Programmes** ➢ Work continues with all partners to join up care with high focus on the development of primary care networks and our role in them. ➢ Within the West Yorkshire & Harrogate integrated care system (ICS) areas of focus include a number of transformational funding bids, forensics provider collaborative and suicide prevention.

	➢ Action plans relating to CAMHS have been added to the priority programmes section of the report. An overarching improvement plan has been pulled together with specific action plans developed. ➢ SystmOne implementation is currently in stabilisation. Work continues to refine post go live configuration based on user feedback. **Finance** ➢ Pre Provider Sustainability Funding (PSF) deficit in month 2 of £145k, which is £37k favourable to plan. Cumulative deficit is £1.3m which is £150k favourable to plan. The cumulative position includes £0.7m of pay increases paid fully in April. ➢ Cumulative income is £0.3m lower than due to creation of a number of reserves relating to CQUIN and occupancy, and also income received from the spot purchase of beds. ➢ Out of area bed costs were £158k, which is the lowest value for some time. Cumulative spend is 39% lower than the corresponding period last year. ➢ Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 41% above the cap ➢ Net savings on pay amounted to £268k in-month and £0.7m year-to-date. ➢ CIP delivery of £2.0m is virtually in line with plan at this stage of the year. ➢ Cash increased to £25.2m in June with 2018/19 PSF monies expected in July to increase the short term cash balance. **Workforce** ➢ Sickness absence reduced to 5.2% in June and 4.9% cumulatively which is a 0.4% improvement compared to the first quarter last year. ➢ The Trust is above 80% compliance for all mandatory training programmes. ➢ Staff turnover increased to 12.0% in month with the most notable issues in the forensics and specialist services BDUs. ➢ Actual level of vacancies (pre use of temporary staffing) increased slightly in month from 10.3% to 10.7%.
Recommendation:	**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

June 2019

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for June 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 provide a report that showcases the breadth of the organisation and its achievements, meet the requirements of our regulators and provides 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 April 19, the Trust undertook work to review and refresh the summary dashboard for 2019/20 to ensure it remains fit for purpose and aligns to the Trust's updated objectives for 2019/20. These updates are planned to take effect as soon as possible with some taking effect this month. A number of other developments identified by Trust board are being worked on and will be incorporated in the IPR in the coming months. This includes further information related to mental health act assessments; additional workforce metrics to include leavers feedback; health and safety metrics; NHS access standards which we intend to flow during quarter 2.

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 four strategic objectives are:
- Improving health
- Improving care
- Improving resources
- Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
- 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 successfully went live with SystmOne for mental health during February and March 2019. 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. Particular issues relate to access target metrics and the recording of care plan approach information (CPA).

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 2019/20. Some metrics require development and it is anticipated that these will be ready by end of quarter 1, reported from July 19 onwards.

KPI	Target	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year End Forecast
Single Oversight Framework metric	2	2	2	2	2	2	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Improve people's health and reduce inequalities	**Target**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Year End Forecast**
% service users followed up within 7 days of discharge	95%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100%	99.2%	98.2%	96.2%	97.2%	100%	4
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks [1]	90%		84.6%			84.2%			82.8%			Due end July 19		95%
Out of area beds [2]	Q1 940, Q2 846, Q3 752, Q4 658	448	620	394	200	430	269	299	163	154	207	303	195	1
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA Community	Community 75% Inpatient 90%	82.0%	82.8%	84.1%	84.5%	84.5%	83.8%	83.3%	83.2%	88.1%	88.0%	87.6%	87.1%	4
Inpatient [9]		93.3%	91.2%	90.1%	91.0%	92.5%	95.3%	97.4%	96.6%	90.2%	92.6%	91.5%	92.1%	4
IAPT - proportion of people completing treatment who move to recovery [5]	50%	54.0%	52.1%	47.1%	50.8%	50.1%	57.8%	55.1%	55.0%	57.0%	54.4%	*55.6%*	Due end July 19	4
Number of suicides (per 100,000) population 6	tbc	Reporting to commence for 19/20										0.67%		N/A
Delayed Transfers of Care	3.50%	2.4%	2.4%	1.5%	1.6%	1.9%	1.7%	1.8%	1.6%	1.6%	1.4%	0.4%	0.6%	4
Improve the quality and experience of care	**Target**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Year End Forecast**
Friends and Family Test - Mental Health	85%	88%	91%	88%	89%	86%	90%	87%	84%	95%	95%	86%	86%	85%
Friends and Family Test - Community	98%	99%	97%	98%	100%	97%	99%	97%	98%	99%	98%	99%	97%	98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [4]	trend monitor	29	23	16	30	35	20	33	29	30	23	37	36	
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	16	14	15	14	20	11	10	13	9	3	11	12	
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic [7]	trend monitor		14.1%			13.0%			16.6%			14.5%		N/A
Total number of Children and Younger People under 18 in adult inpatient wards	*TBC*	3	1	2	2	3	1	1	1	1	1	5	3	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [3]	trend monitor	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	24.3%	27.0%	29.5%	32.7%	
Psychology waiting times [12]	tbc	Reporting to commence in 19/20												
Access within one hour of referral to liaison psychiatry services and children and young peoples' equivalent in A&E departments		Reporting to commence in 19/20												
Improve the use of resources	**Target**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Year End Position**
Surplus/(Deficit)	In line with Plan	(£125k)	(£139k)	£424k	(£73k)	(£80k)	£158k	£714k	(£244k)	(£1240k)	(£728k)	(£457k)	(£145k)	(£240k)
Agency spend	In line with Plan	£526k	£575k	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£613k	£641k	£691k	£7.1m
CIP delivery	£1074k	£2737k	£3615k	£4452k	£5234k	£6015k	£6779k	£8764k	£9669k	£10574k	£670k	£1353k	£2018k	£10.7m
Staffing costs compared to plan [10]	tbc	Reporting to commence in 19/20									(£367k)	(£124k)	(£268k)	tbc
Completion of milestones assumed in the optimisation of SystmOne for mental health [11]	tbc	Reporting to commence in 19/20												
Financial risk in forecast	0	Reporting to commence in 19/20									£1.5m	£1.5m	£2.8m	-
Making SWYPFT a great place to work	**Target**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**	**Year End Position**
Sickness absence	4.5%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	4.7%	4.6%	4.8%	5.0%
Staff Turnover [6]	10%	12.4%	13.0%	12.8%	12.5%	12.3%	12.0%	12.0%	12.0%	11.9%	11.9%	10.4%	12.0%	
Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	80%	N/A	N/A	71%	N/A	N/A	N/A	N/A	N/A	75%	N/A	N/A	75%	
Staff FFT survey - % staff recommending the Trust as a place to work	N/A	N/A	N/A	58%	N/A	N/A	N/A	N/A	N/A	65%	N/A	N/A	66%	N/A
Actual level of vacancies	tbc	Reporting to commence in 19/20									10.4%	10.3%	10.7%	
% leavers providing feedback	tbc	Reporting to commence in 19/20												

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 psychiatric intensive care unit 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 - 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. The reported figure is a Trust wide position.

6 - Calculation for this is the number of suicides of services users under the care of the Trust during the reporting period (as recorded on our risk management system), divided by NHS registered population as per office of national statistics data.

7 - Introduced into the summary for reporting from 18/19. Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other

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.

10 - Staffing costs compared to plan is reported per month not cumulative.

11 - Milestones assumed in the optimisation of SystmOne for mental health - reporting of this will commence once the optimisation plan is agreed. We anticipate this will be at some point during quarter 3

12 -Psychology waiting times - reporting of this will commence once the SystmOne optimisation plan is agreed. We anticipate this will be at some point during quarter 3.

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 progress on prone restraint continues for this month
- Safer staffing fill rates remain positive reflecting the sustained increase in acuity – some wards continue to experience difficulties in maintaining appropriate levels.
- Action to address medicine omissions position achieves desired improvement
- Decrease in supervision levels under investigation

NHSI Indicators

- The Trust is meeting the target performance majority of national metrics
- 3 young people placed in adult wards during June equating to 56 beds days

Locality

- Significant demand pressures with intermediate care in Barnsley
- Barnsley early intervention in psychosis team has achieved 'top performing' status in a national audit
- Successful with bids for additional crisis home treatment investment
- Detailed plans in place to re-purpose beds in Appleton ward following de-commissioning of 8 forensic learning disability beds
- Waiting time from referral to treatment in Barnsley and Wakefield child and adolescent mental health services remain an issue
- Nostell ward in Wakefield has been participating in the national reducing restrictive practices collaborative and the latest performance has shown a 50% reduction.

Priority Programmes

- Work continues with all partners to join up care with high focus on the development of primary care networks and our role in them
- Within the West Yorkshire & Harrogate integrated care system (ICS) areas of focus include a number of transformational funding bids, forensics provider collaborative and suicide prevention
- Action plans relating to CAMHS have been added to the priority programmes section of the report. An overarching improvement plan has been pulled together with specific action plans developed.
- SystmOne implementation is currently in stabilisation. Work continues to refine post go live configuration based on user feedback

Finance

- Pre Provider Sustainability Funding (PSF) deficit in month 2 of £145k, which is £37k favourable to plan. Cumulative deficit is £1.3m which is £150k favourable to plan. The cumulative position includes £0.7m of pay increases paid fully in April.
- Cumulative income is £0.3m lower than due to creation of a number of reserves relating to CQUIN and occupancy, and also income received from the spot purchase of beds.
- Out of area bed costs were £158k, which is the lowest value for some time. Cumulative spend is 39% lower than the corresponding period last year.
- Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 41% above the cap
- Net savings on pay amounted to £268k in-month and £0.7m year-to-date
- CIP delivery of £2.0m is virtually in line with plan at this stage of the year
- Cash increased to £25.2m in June with 2018/19 PSF monies expected in July to increase the short term cash balance.

Workforce

- Sickness absence reduced to 5.2% in June and 4.9% cumulatively which is a 0.4% improvement compared to the first quarter last year
- The Trust is above 80% compliance for all mandatory training programmes
- Staff turnover increased to 12.0% in month with the most notable issues in the forensics and specialist services BDUs
- Actual level of vacancies (pre use of temporary staffing) increased slightly in month from 10.3% to 10.7%

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	34.9%	35.6%	37.9%	37.0%	39.1%	34.4%	33.4%	31.5%	26.7%	24.3%	27.0%	29.5%	32.7%	N/A
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	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	50% 1/2	31% 4/13	44% 4/9	26% 4/15	1
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	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	11%	36% 4/11	28% 5/18	17% 12/71	4
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	82%	88%	91%	88%	89%	86%	90%	87%	84%	95%	95%	86%	86%	4
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	99%	97%	98%	100%	97%	99%	97%	98%	99%	98%	99%	97%	4
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	75%	N/A	N/A	71%	N/A	N/A	N/A	N/A	N/A	75%	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	70%	N/A	N/A	58%	N/A	N/A	N/A	N/A	N/A	65%	N/A	N/A	66%	N/A
	Number of compliments received	Improving Health	Caring	TB	N/A	44	27	45	48	63	26	60	49	10		15	64	14	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	N/A					*308*						21	39		N/A
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	N/A					11						1	4	Due Aug 19	N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	0	0	0	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%	86.2%	88.7%	86.3%	86.4%	86.6%	86.5%	87.5%	*87.5%*	Due July 19					4
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=9	14	16	14	15	14	20	11	10	13	9	3	11	12	
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	2.6%	2.4%	2.4%	1.5%	1.6%	1.9%	1.7%	1.8%	1.6%	1.6%	1.4%	0.4%	0.6%	4
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	87.5%	78.5%	84.9%	91.0%	86.5%	84.3%	83.2%	89.3%	*84.6%* **	Due July 19				N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%	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	1039	1168	1004	864	1085	1109	986	1098	1049	1096	1157	1265	1063	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	15	21	21	12	21	25	17	23	21	20	19	28	27	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	1	4	0	3	4	5	1	1	1	3	1	5	3	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	4	4	2	1	5	5	2	9	7	7	3	4	6	N/A
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	*17.7%*	18.4%	23.2%	22.4%	22.1%	17.8%	22.0%	29.8%	23.5%	13.9%	17.7%	24.5%	27.0%	15.8%	3
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	118%	118%	117%	116%	116%	119%	118%	119%	119%	118%	118%	117%	116%	4
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	99.5%	96.4%	92.5%	93.7%	98.3%	99.1%	96.6%	98.7%	97.5%	96.5%	96.6%	94.9%	92.1%	4
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	N/A	29	26	21	30	34	29	30	30	30	44	41	46	34	N/A
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0	1	0	1	0	0	0	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	4
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	80%	75.0%	76.3%	72.7%	72.7%	88.6%	81.3%	90.9%	82.4%	80.6%	88.0%	75.8%	87.5%	90.6%	4
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	TBC	44	43	37	52	40	41	49	39	48	59	52	37	41	N/A
	Number of restraint incidents	Improving Care	Safety Domain	TB	N/A	143	192	151	134	190	201	136	165	168	207	287	303	193	N/A
	No of staff receiving supervision within policy guidance [7]	Improving Care	Well Led	CH	80%	82.8%		83.8%			82.6%			86.7%			69.9%		4
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	92.9%	85.7%	90.0%	89.2%	90.9%	83.3%	87.9%	80.0%	92.0%	82.6%	82.6%	85.7%	100%	
	Smoking Cessation - 4 week quit rate 12	Improving Care	Effective	CH	tbc	63.0%		65%			63%			67%			Due Oct 19		
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	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	4

** 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 confidentiality 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. Data quality (DQ) issues are impacting on the reported data from March 19. Some improvement in dq has seen in the latest month and this is expected to continue.
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.
12. This metric has been identified as suitable metric across all Trust smoking cessation services. The metric identifies the 4 week quit rate for all Trust smoking cessation services. The national quit rate for quarters 1-3 2018-19 was 52%. Q1 data will be available in September18.

Quality Headlines

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

• Number of restraint incidents - the number of restraint incidents during June has decreased (193) compared to previous months.

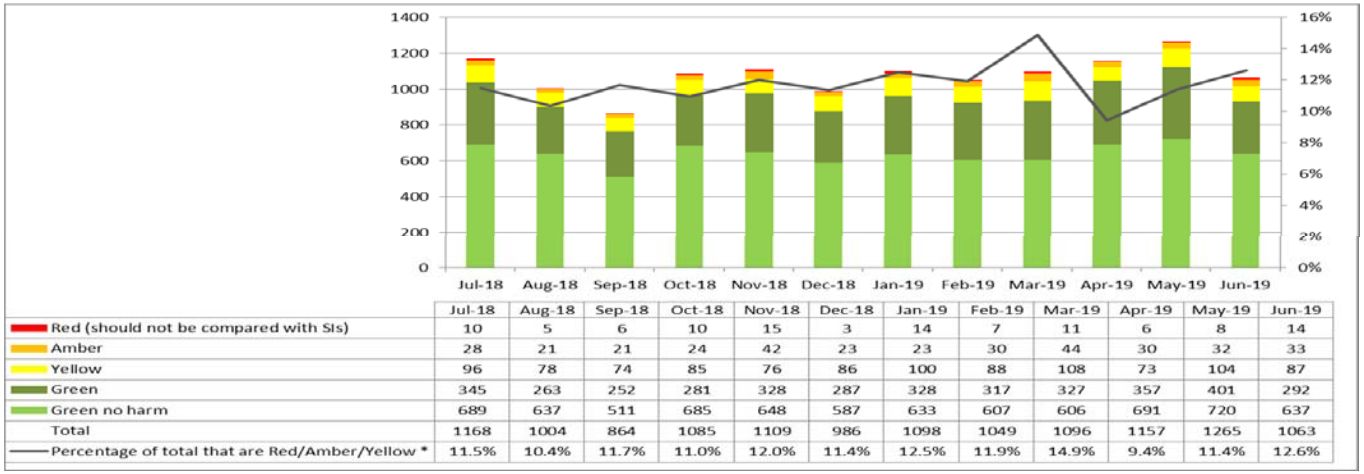
• NHS Safety Thermometer - medicines omissions – performance has improved significantly in June compared to prevoius months and stands at 15.8%. Work contiues across services to improve performance. The pharmacy team have undertaken some ward audits and it has been identified that if a patient is absent from the ward then this is being counted as an omission, this should be excluded. Further work to continue and action plans being drawn. A data collection brief has been circulated to assist with recording issues. Shared learning from both within the Trust and peer organisations is also being undertaken. Figures for medicines omissions have increased overall.

• Number of falls (inpatients) - June 19 has seen a slight increase in fall incidents during the month compared to the previous months. June 19 falls related to Calderdale, Kirklees and Wakefield remain 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.

Safety First

Summary of Incidents since June 2018

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



	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Red (should not be compared with SIs)	10	5	6	10	15	3	14	7	11	6	8	14
Amber	28	21	21	24	42	23	23	30	44	30	32	33
Yellow	96	78	74	85	76	86	100	88	108	73	104	87
Green	345	263	252	281	328	287	328	317	327	357	401	292
Green no harm	689	637	511	685	648	587	633	607	606	691	720	637
Total	1168	1004	864	1085	1109	986	1098	1049	1096	1157	1265	1063
Percentage of total that are Red/Amber/Yellow *	11.5%	10.4%	11.7%	11.0%	12.0%	11.4%	12.5%	11.9%	14.9%	9.4%	11.4%	12.6%

** 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 and 2019/20

	Q1 19/20	Q2 18/19	Q3 18/19	Q4 18/19	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Total
Death - cause of death unknown/ unexplained/ awaiting confirmation	3	0	0	1	0	0	0	0	0	0	0	1	0	1	2	0	4
Informal patient absent without leave	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Information disclosed in error	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Lost or stolen hardware	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Lost or stolen paperwork	0	1	1	0	0	1	0	1	0	0	0	0	0	0	0	0	2
Self harm (actual harm) with suicidal intent	2	0	1	0	0	0	0	1	0	0	0	0	0	0	1	1	3
Suicide (incl apparent) - community team care - current episode	4	3	4	11	2	1	0	2	1	1	5	3	3	1	1	2	22
Suicide (incl apparent) - community team care - discharged	1	1	0	2	0	1	0	0	0	0	2	0	0	0	0	1	4
Suicide (incl apparent) - inpatient care - current episode	0	0	1	1	0	0	0	1	0	0	0	0	1	0	0	0	2
Unwell/Illness	0	1	1	0	0	1	0	0	0	1	0	0	0	0	0	0	2
Allegation of violence or aggression	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1
Homicide by patient	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Physical violence (contact made) against staff by patient	1	0	1		0	0	0	1	0	0	0	0	0	0	0	1	2
Pressure Ulcer - Category 3	1	1	0	2	1	0	0	0	0	0	0	0	2	0	1	0	4
Total	14	9	10	17	5	4	0	6	2	2	7	4	6	3	5	6	50

- 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 June 2019
- Patient safety alerts not completed by deadline of June 2019 - None

Mortality

The clinical mortality review group was held on 07/06/19 which focussed on learning and action from outcomes from learning from deaths reviews, including serious incidents, structured judgement reviews and other investigations. The group focused on the record keeping theme and produced two learning library templates which will be shared with comms and promoted across the Trust.
Regional work: A meeting took place 5 July 2019 with the Northern Alliance. The meeting provided an update on work being undertaken around learning from choking incidents and a review of the policies across the region. The Trust has been approached to completed a SJRR case study (to be completed in August 2019).
Training: Further Structured Judgement Reviewer training is being arranged for September 2019.
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 (2018/19), the updated report is currently in draft.
-Structured Judgement Reviews (SJR) – There are currently no SJRs to be allocated and all reviews are currently being completed within the allocated timescale. There are no second reviews awaiting sign off.

Safer Staffing

Overall Fill Rates: 116%
Registered fill rate: (day + night) 92.1%
Non Registered fill rate: (day + night) 138.1%

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

BDU Fill rates - April 19 - June 19

Overall Fill Rate	Month-Year		
Unit	Apr-19	May-19	Jun-19
Specialist Services	119%	118%	118%
Barnsley	117%	107%	110%
C & K	110%	114%	115%
Forensic	112%	108%	106%
Wakefield	143%	147%	140%
Overall Shift Fill Rate	**118%**	**117%**	**116%**

The figures (%) for June 2019:
Registered Staff - Days 85.1% (a decrease of 2.4% on the previous month); Nights - 99.0% (a decrease of 3.3% on the previous month)
Registered average fill rate - Days and nights 92.1% (a decrease of 2.8% on the previous month)
Non Registered Staff - Days 133.8% (a decrease of 0.6% on the previous month); Nights 142.3% (an increase of 0.9% on the previous month)
Non Registered average fill rate -Days and nights 138.1% (an increase of 0.2% on the previous month)
Overall average fill rate all staff - 115.7% (a decrease of 0.7% on the previous month)

Summary
No ward has fallen below the 90% overall fill rate. Of the 31 inpatient areas 22, consistent with the previous month, (70.4%) achieved greater than 100%. Indeed of those 22 areas, 11 (35.2%) achieved greater than 120% fill rate. This was a decrease of one ward on the previous month.
Registered On Days (Trust Total 85.1%)
The number of wards that have failed to achieve 80% increased by one to eight (25.6%) on the previous month. Four wards were within the Forensic BDU (Appleton, Johnson, Hepworth and Waterton). The others were Ward 18 in Calderdale and Kirklees BDU as well as Willow Ward and Stroke Rehab within the Barnsley BDU. There was also Crofton within the Wakefield BDU. There were various factors cited including vacancies, sickness and supporting acuity across the BDU. When these situations arise the Safer Staffing Project Manager supports ward staff to consider clinical resources across the site and re-deploy where appropriate. The proactively works to ensure that wards are safely staffed by accessing Bank staff initially and agency as a last resort. The Safe Staffing project Manager has also produced escalation plans for individual ward areas where required.
Registered On Nights (Trust Total 99%)
One ward (Elmdale within the C&K BDU with 76.6%) has fallen below the 80% threshold. The number of wards who are achieving 100% and above fill rate on nights fell increased to 18 wards (57.6%) this month.
Average Fill Rates for most areas showed a marked fluctuation. Barnsley BDU increased by 3% to 110%. Calderdale and Kirklees BDU increased by 1% to 115%. Forensic BDU were 106% a decrease of 2%. Wakefield BDU decreased by 7% to 140%. Specialist services were 118% . Overall fill rate for the trust decreased by 1% to 116%.
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

During June 19, there has been a slight increase in the number of confidentiality IG breaches reported compared to the reduced number reported over the last two months. These included 7 counts of information disclosed in error, 2 patient healthcare record issues, 2 lost or stolen paperwork, and 1 lost or stolen hardware.

Work continues in the Trust to support services to reduce the number of IG incidents occuring. Letters are sent to teams with breaches asking for completion of action plans and regular communications continues.

None of these incidents required reporting to the information commissioner's office.

Commissioning for Quality and Innovation (CQUIN)

All quarter 4 submissions were undertaken to timescale and the final position agreed across all contracts.

The Trust is currently working on the 19/20 CQUIN requirements and preparing the Q1 submissions. Applicable indicators were agreed with each commissioner as part of the contract negotiation process. Overall value of the scheme has reduced to 1.25% of contract value. The indicators have been identified as follows:

- Staff flu vaccinations (Barnsley)
- Alcohol and tobacco (Barnsley, Calderdale, Kirklees, Wakefield)
- 72hr follow up post discharge (Barnsley, Calderdale, Kirklees, Wakefield)
- Mental health data - Mental Health Data: Data Quality Maturity Index; Mental Health Data: Interventions (Barnsley, Calderdale, Kirklees, Wakefield)
- Use of anxiety disorder specific peasures in IAPT (Barnsley)
- Three high impact actions to prevent hospital falls (Barnsley)
- Improving awareness and uptake of screening and immunisation services in targeted groups (Barnsley Child Health service)
- Improving physical health for people with severe mental illness (Calderdale, Kirklees, Wakefield)
- Develop and submit a quality improvement plan in Q1 and report on progress and achievement in Q4 via an annual quality report (Wakefield TB)
- Healthy weight in adult secure MH services (Forensic)

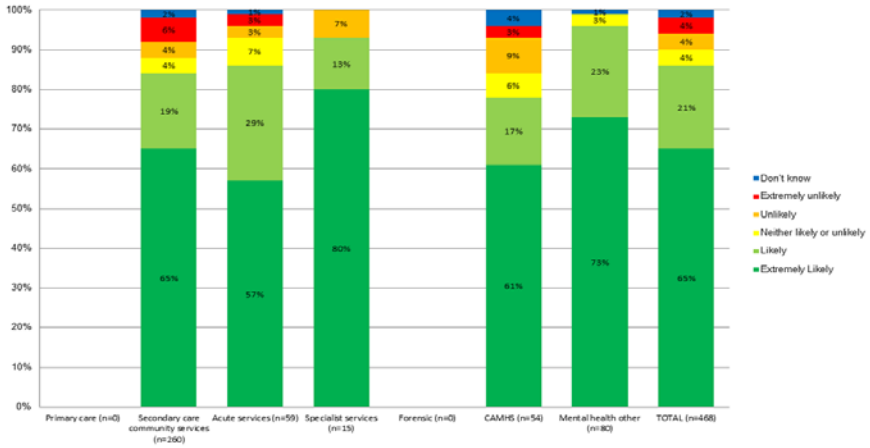
Work is underway to develop action plans to ensure maximum achievement for the year.

Patient Experience

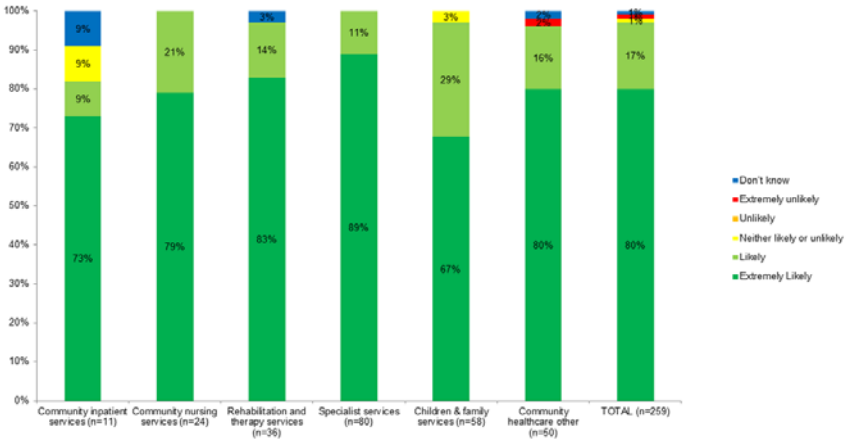
Friends and family test shows

- 90% of respondents would recommend Trust services
- The number of responses increased by 119% in June (732) from the previous month (May 334) and 52% compared to June 18 (481)
- Returns have increased due to the number of returns from the community services, the text message service recommencing and the use of volunteers collecting feedback on acute wards
- Text messages provided 30% of responses in June
- The number of responses for acute wards increased by 52%.
- Areas under development are Carers survey, CAMHs, Learning Disabilities and Recovery Colleges.

Mental Health Services



Community Services



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

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

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

During June 19, community services dipped just below threshold and this related to 4 service lines within child and family services and is linked to the low response rate - 2 respondents that responded 'Neither likely or unlikely', 3 respondents that responded 'Don't know', 1 respondents that responded 'Extremely unlikely'. The Trust continues to perform well against other providers for the friends and family test metric.

Care Quality Commission (CQC)

CQC draft reports
We are expecting our core services and well-led draft reports to be sent to us by either Friday 26th July or Monday 29th July at the latest. We will then have 10 working days two weeks to comment on any factual inaccuracies within the reports before they are made final.
.
The Factual Accuracy Check (FAC) process
The Quality Improvement and Assurance Team (QIAT) has sent out some information explaining the FAC process and what key individuals need to do when they receive their reports. Five FAC meetings have also been set up for the 1st and 2nd August. These will be with each of the four core services recently visited by CQC, plus another meeting in relation to the well-led report. The purpose of these meetings will be to review and discuss our draft reports and to decide where we may want to challenge any factual inaccuracies within the reports. QIAT will then collate all of the information and complete the FAC template before it is sent off to the Operational Management Group (OMG) and then the Executive Management Team (EMT) for sign off. The information will then be submitted to CQC who will decide whether to accept or reject the FAC challenges before the report is made public in August 2019.

Safeguarding

Safeguarding Adults
• Delivered domestic abuse training to stroke unit – an action from domestic homicide review (Barnsley).
• The section 11 for Calderdale was completed and submitted.
• The seen and heard training was delivered to support the safeguarding week in the west (Kirklees).
• Partner achievements information submitted to Kirklees safeguarding adult board.
• Information provided to the clinical governance meeting of audit conducted by the safeguarding adult board manager (Barnsley) regarding LGBTQ information and support in care homes.
• Support / advice to stroke unit regarding a 17 year old inpatient.

Safeguarding Children
• Named nurse safeguarding children has worked alongside single point of access practitioners to embed 'routine enquiry' for domestic abuse into assessments.
• The safeguarding team delivered the children's society 'seen and heard' training in three localities for West Yorkshire safeguarding week.
• Safeguarding childrens nurse advisor delivered 'the impact of parental mental illness training' as part of the multi-agency training offer in Barnsley.
• Safeguarding childrens nurse advisor attended the 'reducing parental conflict stakeholder workshop' in Calderdale.

Infection Prevention Control (IPC)

• Annual Infection prevention and control annual programme 2018-19 has been completed, all objectives achieved, annual plan 2019-20 has been produced and approved. Annual IPC programme 2019-20 Q1 objectives have been achieved.
• Surveillance: there has been no MRSA Bacteraemia, MSSA bacteraemia, or Clostridium difficile. There has been 1 ecoli bacteraemia case (SRU) which has been presented at the post incident review panel (no set trajectory for these cases).
• Q1 - Wakefield - 4, Barnsley (mental health and community) – 3, Forensics - 3, Calderdale/Kirklees – 3, Specialist Services - 3 and Corporate Support Services - 0.
• Incident breakdown – 3- Ward/ unit cleanliness issues, 2 exposure to blood, 2 sharp related incidents, no injury, 1 sharp related, injury, 2 waste disposal, 1 outbreak ward closed, 1 failure in communication, 1 e.coli bacteraemia, 1 faeces, 1 pathogen and 1 spit.
• Severity rating – 13 incidents were risk rated green and 3 yellow.
• Mandatory training figures are healthy - Hand Hygiene-Trust wide Total – 93%; Infection Prevention and Control- Trust wide Total – 91%;
• 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	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	Q4 18/19	Apr-19	May-19	Jun-19	Year End Forecast	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	97.1%	96.2%	97.2%	98.0%	99.0%	99.3%	99.8%	98.2%	97.2%	97.2%	97.2%	99.3%	97.2%	99.2%	98.7%	98.7%	4	
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100%	100%	100%	100%	100%	97.9%	31% 413	44% 410	100%	100%	100%	97.9%	100%	98.7%	100%	100%	4	
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	98.9%	97.5%	97.0%	99.0%	98.8%	97.6%	95.5%	97.4%	97.4%	97.6%	97.9%	98.9%	96.8%	99.2%	100.0%	100.0%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	97.7%	94.9%	98.4%	96.9%	99.0%	95.4%	100.0%	99.2%	98.2%	97.7%	97.1%	97.1%	99.2%	96.2%	97.2%	100%	4	
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.2%	98.2%	98.2%	98.3%	98.2%	98.1%	98.1%	98.1%	98.0%	98.2%	96.8%	98.1%	98.0%	*98.0%*			4	
Out of area bed days 5	Improving Care	Responsive	CH	Q1 547, Q2 494, Q3 411, Q4 329	436	620	394	200	430	269	299	163	154	1181	1450	899	616	207	303	195	1	
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	54.0%	52.1%	47.1%	50.8%	50.1%	57.8%	55.1%	55.0%	57.0%	54.4%	51.1%	52.4%	55.4%	54.4%	55.6%		3	
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	93.9%	94.8%	94.0%	94.6%	96.9%	91.1%	92.4%	87.1%	86.0%	91.3%	94.3%	94.4%	88.7%	83.1%	86.6%		4	
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	95%	99.7%	99.5%	99.6%	99.7%	99.7%	99.4%	99.3%	99.0%	99.4%	99.4%	99.6%	99.6%	99.2%	98.6%	99.1%		4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	56%	92.0%	91.4%	90.3%	94.2%	94.7%	88.6%	85.1%	85.3%	69.2%	81.7%	90.3%	92.6%	*80.5%*	92.0%	72.7%	88.0%	4	
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	78.7%	78.8%	79.0%	78.5%	78.2%	78.5%	*78.0%*	*78.2%*	78.2%	79.1%	78.8%	*78.2%*	*78.2%*	*87.5%*	Due July 19		4	
% clients in employment 6	Improving Health	Responsive	CH	*10%*	8.5%	9.5%	8.9%	8.6%	9.0%	9.3%	9.2%	*9.2%*	*9.2%*	8.6%	8.8%	9.3%	*9.2%*	*11.2%*			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		Inpatinet 88% Community - 78% EIP - 94.4%													Due June 20			2	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	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	Q4 18/19	Apr-19	May-19	Jun-19	Year End Forecast	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	22	1	22	8	29	2	4	15	4	16	45	39	23	5	29	56	2	
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	3	1	2	2	3	1	1	1	1	4	6	6	3	1	5	3	2	
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	192			184			199			212	192	184	199	214			N/A	
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	*Trend Monitor*	14.1%			13.0%			16.6%			15.1%	14.1%	13.0%	16.6%	14.5%			N/A	

NHS Standard Contract	Objective	CQC Domain	Owner	Target	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	Q4 18/19	Apr-19	May-19	Jun-19	Year End Forecast	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance 1	Improving Health	Responsive	CH	90%	98.8%	98.5%	99.1%	98.9%	97.0%	98.7%	98.8%	85.7%	98.6%	97.8%	98.8%	98.1%	98.9%	98.7%	***99.7%***		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%	99.9%	100.0%	99.9%	100.0%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.7%	Due July 19		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%	90.5%	95.5%	95.1%	91.0%	90.9%	90.8%	90.4%	90.7%	89.6%	90.8%	91.1%	90.9%	89.6%	84.1%			4	

** See key included in glossary.*
Figures in italics are provisional and may be subject to change.
1 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.
2 - Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
4 - This indicator was originally introduced from November 2017 as part of the revised NHSI Single Oversight Framework operational metrics. It measures 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*

5 - Out of area bed days - The reported figures are in line with the national indicator and therefore only shows the number of bed days for those clients whose out of area placement was inappropriate and they are from one of our commissioning CCGs. Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, are working with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories.
6. Clients in Employment - this shows of the clients aged 18-69 at the reporting period end who are on CPA how many have had an Employment and Accommodation form completed where the selected option for employment is '01 - Employed'

Areas of concern/to note:

• A number of metrics have not been finalised at the time of the report. This is largely related to the impact of transition to a new mental health clinical record system. Progress has been good on data catch up, but at this point in time additional data quality checking is required and not all information is fully available yet.
• The Trust continues to perform well against the majority of NHS Improvement metrics
• During June 2019, the number of service users aged under 18 years placed in an adult inpatient ward was 3 and all were aged 17 year old - 2 were admissions in May which continued into June and who have subsequently been discharged, 1 admission in June to a Calderdale ward and discharged early July. 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.
• Inappropriate out of area bed placements amounted to 195 days in June, a decrease of 108 days compared to May.
• % 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
• Provision of DEXA scanning ceased June 24th 2019
• Yorkshire Smoke Free (YSF) Barnsley tender submission and presentation – awaiting outcome.
• Predicated staffing shortages in childrens speech and language therapy (SALT) in autumn due to multiple maternity leave/staff changes which will have an impact on service delivery, working on a remedial action plan for cover
• Musculoskeletal (MSK) - referrals into the service and increasing waiting times, action plan in place to reduce waiting times
• Intermediate Care (IMC) - received winter pressure monies to increase support worker capacity over winter. Difficulty in reducing this caseload since monies stopped. Currently working at 108 (threshold 50-70). Whole system pressures across Barnsley due to increased activity
• Sickness levels above our usual average this is mainly is due to long term sickness which are genuine cancer diagnosis and treatment pathways for our staff

Strengths
• Neuro rehabilitation unit (NRU) – successful negotiations underway with commissioners regarding use of uncommissioned beds.
• Yorkshire smoke free (YSF) Wakefield pregnancy is currently one of the best performing services in Yorkshire and has been used by the commissioner as an excellent example of partnership work between the local authority, SWYPFT and Mid Yorks Trust.
• Live Well Wakefield interviewing for 7 additional social prescribing workers for the 7 primary care homes (PCH) – a result of funding from public health England via clinical commissioning groups and PCHs
• Health Integration Team (HIT) Urban House – finalists at last week's RCNi awards.
• Childrens SALT therapists delivering Elklan training are rated as AAA (highest rating) by their tutors. Elklan is an accredited training scheme.
• Lead Nurse TB – now undertaking lead nurse role for TB control board nationally
• Advanced nurse practitioner pilot in collaboration with Macmillan
• Introduction of nursing associate role to neighbourhood nursing service (NNS) and continence and urology service
• MSK – up-skilled clinicians to take on some of the extended scope practitioner role
• Intermediate care (IMC)- flexible staff who work to put the patient centre and front. Good team work with Barnsley hospitals NHS Foundation Trust and other alliance partners to support flow of patients through the intermediate care pathway.

Challenges
• Contract with Zest will end on 25 July 2019.
• Continuing to deliver high quality services against the increasing demand
• Medication errors, exploring the linkages to increased workloads
• Pulmonary Rehab remedial action plan in place with CCG 2 weekly meetings and work plan
• MSK - IT infrastructure – the whole service is on full clinical records and works over 6 sites including a local leisure centre. Despite clinicians having 4g SIM and VPN we still have times when the Wi-Fi drops and records are lost. Working with IT on a solution.
• IMC - Neighbourhood and agile working whilst maintaining group identity and to ensure staff don't become isolated and still meet frequently to move the service forward.
• IMC - training and development of care staff in the care homes, change in ethos from care to rehabilitation.

Areas of Focus
• Stroke Services – work continues in partnership with CCG and BHNFT in line with hyper acute stroke unit (HASU) and remodelling. Awaiting final independent review of proposed early supported discharge model.
• Childrens therapy – additional resource mobilisation plan being implemented. Demand and capacity work being undertaken.
• Demand and capacity work streams across a range of services e.g. palliative care, epilepsy, parkinsons, aids and adaptations
• MSK - currently looking at new ways to meet the demand of referrals coming through the system and best utilise expertise within the service.
• MSK - introducing a telephone assessment for physiotherapy patients identified at triage to self-manage or be suitable for group sessions
• IMC - building relationships with other partners such as YAS (Yorkshire Ambulance Service) to increase our hospital avoidance caseload.
• Engagement in the emerging work on the Integrated neighbourhood team specification from the CCG, which has a deadline of late August for completion .

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

Barnsley BDU:

Barnsley Mental Health
Key Issues
• The acute service line continues to experience high demand, staffing pressures and acuity leading to pressures on the wards and on-going 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. Action plans and data improvement plans are in place and there is support with staff wellbeing, with additional out of hours clinics being explored in the core pathway to meet demand.
• We are working with the clinical commissioning group (CCG) and primary care partners to scope and plan more closely integrated services at neighbourhood and primary care network level.

Strengths
• Barnsley early intervention in psychosis service (EIP) have achieved 'Top Performing' status in the national clinical audit of psychosis (NCAP) results out last week, moving up from 'Requires Improvement' last year.
• Management of patient flow.
• Continued success in recruitment to medical posts minimising agency spending

Challenges
• Demand and capacity in community services continues to be a challenge.
• Care programme approach (CPA) reviews performance requires improvement, this is thought to be a combination of practitioner pressure and data quality, more support and training is being given to teams in how to record reviews accurately on SystmOne.
• Barnsley BDU monthly sickness rates are in excess of Trust target with a hotspot in acute services. General managers continue to work with human resource (HR) business partners to review all cases and to ensure robust process and appropriate support is in place. This is monitored through team manager's 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 community services.
• Sickness management.

Calderdale & Kirklees BDU:

Key Issues
• Older adult wards remain under pressure with very high acuity and need levels particular end of life care which increases the need for additional staff.
• A bid to the integrated care systems (ICS) for additional crisis home treatment team resources (£500K) has been successful and will commence to bring in the extra staff resources.
• The 2018 national audit of early intervention in psychosis (EIP) is due to be published and the target is "PERFORMING WELL" with all the 5 Trust teams in this category and 4 teams in the "TOP PERFORMING" category meaning we are in the top 20% of performance in the country.

Strengths
• High performance on mandatory training continues.
• Sickness absence levels are low across all service lines.
• Improving access to psychological therapies (IAPT) performance continues to improve now workforce has been stabilised.
• Delayed transfers of care (DTOC) remain extremely well managed and this is reported positively by out CCG and is reflective in high national performance key performance indicators (KPIs).

Challenges
• Adult occupancy levels remain high in inpatients, intensive home based treatment team (IHBT) and on community caseloads.
• Recruitment is progressing positively in community teams.

Areas of focus
• Work streams are progressing rapidly to focus on reduction of out of area bed usage.
• CORE team model review across the Trust is underway.

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
• 8 Learning disability beds de-commissioned by NHS England (NHSE). Detailed plan in place to assess and admit out of area medium secure service users to Appleton in place once Ministry of Justice approval is granted. Weekly liaison with NHSE to monitor the plan.
• Occupancy for medium secure above 90%.
• Bid for a forensic community service has been submitted to NHSE, with further workto be completed by the end of August
• Learning disability forensic outreach and liaison service (LD FOLS) is offering a consultancy and advisory service across the core week. Recruitment continues and a number of appointments have been made and interviews planned across several weeks.
• Work on the recovery plan for forensic child and adolescent mental health services (FCAMHs secure estate) continues with good progress being made. Results of the health needs analysis have been shared and are likely to require some service re-design with key stakeholder events having taken place.
• Regional FCAMHs service review has been completed as part of the national pilot. Feedback generally very positive, Action plan now completed.
• Programme of organisational development in place across the BDU looking at culture, well-being, reducing sickness, improving engagement and communication.

Strengths
• Strong performance on mandatory training.
• Good track record delivering CQUINs.
• 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. This includes service improvement with a view to removing the performance notice.
• Recruitment of registered staff in all disciplines. A significant resource is being utilised to optimise recruitment activity.
• High turnover.
• Reducing sickness.

Areas of Focus
• FCAMHs performance notice.
• The BDU will undertake a large piece of work supported by human resources and will focus on the following areas:
*Leadership
*Sickness/Absence
*Turnover
*well-being
*Bullying and Harassment
• Ensuring the culture remains positive and reflect the values of the organisation.

Specialist BDU:

Key Issues
• Waiting times from referral to treatment in Wakefield and Barnsley child and adolescent mental health services (CAMHs) remain a concern. New investment has been secured in Wakefield and Barnsley (attention deficit hyperactivity disorder specific) to implement waiting list initiatives.
• Community learning disability staff vacancies remain relatively high – particularly in Calderdale/Wakefield and this creates some challenges re waiting times for specialist interventions. However, in the vast majority of cases those waiting are receiving support from another member of the multi-disciplinary team.
• With respect to SystmOne implementation clinicians are continuing to learn new processes to ensure accurate recording. Targeted support/training is being provided.

Strengths
• Plans are in place with respect to recruitment to three substantive posts in CAMHs – reducing reliance on agency.
• Calderdale and Kirklees clinical commissioning groups (CCGs) have committed to further autistic spectrum condition (ASC) waiting list initiative investment in 2019/20.
• All CCGs have prioritised investment in development of an all-age liaison model. In Calderdale, Kirklees and Wakefield this will be supported non-recurrently in 19/20 through new care models investment.

Areas for focus
• Robust action plans are being developed with regard to CAMHs waiting time. within an improvement programme support/governance framework. In Barnsley this incorporates the service response to the recent NHSI intensive support team review.
• Proactively addressing vacancy levels in learning disability services (including consultant posts)

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, however the acuity on the wards and maintaining safer staffing remains a significant challenge. Support for staff wellbeing is a priority.
• Out of area beds for Wakefield service users has been maintained as nil usage and intensive work takes place to adopt collaborative approaches to care planning, to build community resilience; and for presenting acute episodes, to explore all possible alternatives at the point of admission.
• Average length of stay (ALOS) 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.

Strengths
• Management of patient flow and for Wakefield nil out of area (OOA) bed usage.
• Wakefield early intervention in psychosis service (EIP) have achieved 'Top Performing' status in the National Clinical Audit of Psychosis (NCAP) results out last week, moving up from 'Requires Improvement' last year.
• Nostell ward has been participating in the national reducing restrictive practice (RRP) collaborative, as part of the mental health safety improvement programme established by NHSI in partnership with the care quality commission, with the aim of reducing the number of restraints, seclusions and rapid tranquilisations by 33% in the wards that are selected to take part. The latest performance for Nostell shows a 50% reduction (in excess of the 33%) target, and they were singled out for this success in recent national communications around the programme.
• As part of the care closer to home project, and in line with recognised excellent practice, practitioners from other BDUs have been observing the collaborative care meetings in Wakefield in readiness for establishing the model in their own areas.

Challenges
• Adult acute occupancy and acuity levels remain high.
• Adult community medical vacancies and gaps continue to be a pressure leading to financial challenges.
• Expenditure on bank and agency staffing in acute services and agency spending on medical staff in community.
• Care programme approach (CPA) reviews performance requires improvement, this is thought to be a combination of practitioner pressure and data quality, more support and training is being given to teams in how to record reviews accurately on S1.
• Mandatory training figures have reduced in certain areas – action plans are in place for each team and are being tracked by General Managers. These include specific plans relating to fire training and inpatient areas.

Areas of Focus
• Admissions and discharge flow in acute adults with an emphasis on current approach to alternatives to admission and collaborative inter-agency planning.
• Continue to improve performance in service area hotspots through focussed action planning.
• Support for staff wellbeing across the BDU and in particular the wellbeing of staff in the acute service line.

Communications, Engagement and Involvement

Communications and Marketing
• Project plan being developed for the Unity Centre opening in October, including films with Deadline Digital showing the build progress. Development of a roadmap of estates investment across all our BDUs.
• Developing a film to promote the autism friendly environments training.
• Promotion of the i-hub environmental challenge.
• Comms and design support for the Calderdale arts and health report "Living a larger life".
• Supported the launch of the forensic outreach liaison service with key messages, digital leaflets and a service directory page on our website.
• Leading on the co-development of a partnership communication campaign with Barnsley Hospital, the CCG and Local Authority to promote alliance working and partnership working successes. Film on the learning from the Dearne pilot has been produced.
• Active supporters of the West Yorkshire and Harrogate Health and Care Partnership with the 'Our Neighbours' campaign.
• Ran workshops at the West Yorkshire and Harrogate Health and Care Partnership communications and engagement network on internal comms.
• Support to EyUp! Development of internal and external infographic posters summarising the successful bids for 2018-19 - 'Where has the money been spent?' Preparations for Team Challenge 2019.
• Promotion of the MySWYFT staff app aimed at those that do not have access to Trust information every day. So far feedback has been positive. More targeted promotion planned.
• Worked with Barnsley speech and language therapy to implement a new resource library on their section of the website which will allow schools and parents to search for practical resources and download in order to help with their child's individual needs.
• New financial messages produced. IG campaign supported.
• Ongoing support to recruitment and retention, to attract new staff and help retain those already employed in the Trust.
• Continued promotion of leadership and management development courses, alongside supporting the development of a toolkit for managers.

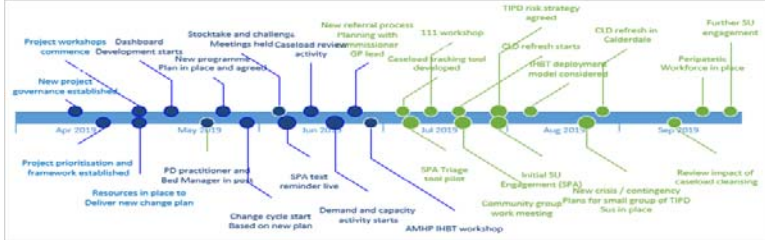
Engagement
• Director listening events arranged in all BDU areas, along with director walkabouts in areas identified through the staff survey as wanting more director contact.
• Promotion of Members' Council elections.
• Support for all staff networks, including the relaunch of the LGBT+ network.
• Stakeholder engagement analysis being carried out, which will then be developed into a stakeholder strategy and action plan.
• Trustwide prospectus developed which will be used to inform stakeholders about the Trust and what our offer is in each area.
• Co-ordinating engagement briefings for EMT colleagues in advance of Overview and Scrutiny and Health and Wellbeing Board meetings and meetings with local MPs.
• Mental Health First Aid Training for MP researchers planned for July.
• Working with West Yorkshire and Harrogate Partnership. We are actively involved in engagement activity relating to learning disability services and are involved in the West Yorkshire Mental Health and Learning Disabilities Collaborative comms and engagement network. Meetings held this month.
• Working on renewal of volunteering accreditation and assessment.
• A volunteer celebration event held was held in Wakefield to coincide with volunteer week. 55 volunteers attended the celebration, each receiving a Trust thank you card. The annual volunteer awards were presented.

This is the July 2019 priority programme progress update for the integrated performance report. It is a summary of the activity conducted in the period for June 2019. The priority programme areas of work providing an update in this report are:
• Wakefield Projects
• Barnsley Projects
• West Yorkshire Projects
• Clinical Record System
• Make care quickly and easily available, to reduce waiting times (initial focus on Barnsley CAMHs)
• Embed #allofusimprove to enhance quality
• Provide all care as close to home as possible (Out of Area)
The framework for this update is based on the Trust priorities for 2019/20 (as agreed in April 2019), and provides details of the scope, improvement aims, delivery and governance arrangements, and progress to date including risk management. Some areas of focus are for the Trust where the position is strategic and emergent; others are priority change programmes which will be delivered over 2019/20. The reporting arrangements for each programme of work are identified; some are hidden as they either report elsewhere on the IPR, do not report on the IPR, or do not report this month on the IPR. The proposed delivery is in line with the agreed Integrated Change Framework.

Priority	Scope	SRO	Change Manager	Governance Route	Improvement Aim(s)	Reporting Frequency	Narrative Update	Progress RAG rating	
IMPROVE HEALTH									
Work with our partners to join up care in Wakefield	1. To develop and deliver partnership structures and relationships that underpin integrated working 2. To deliver integrated networks in the neighbourhoods of Wakefield which meet the requirements of primary care home objectives whilst fully engaging the communities 3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us 4. To deliver improvement programmes in key areas as identified by the partnership groups. These include: • Elderly and Frailty • Mental Health (via the MH Alliance) • Dementia (via the MH Alliance) 5. SWYPFT to take a lead partnership role in the development and delivery a MH Alliance for Wakefield that oversees • the delivery of new work streams: - Crisis pathway - Personality Disorder - Suicide prevention • the delivery of the 8 projects that make up the Dementia Programme • the delivery of legacy commitments for the following: - Peri-natal mental health investment - Psychiatric Liaison Core 24 - CYP Eating Disorders - IAPT-LTC (in partnership with Turning Point).	Sean Rayner	Sharon Carter	Transformation Board	By 31/03/20• All primary care home neighbourhoods will have: - an established integrated leadership team - co-produced priority areas of focus - population health data pack available to underpin decisions - produced stories that demonstrate impact for the people in their area • Each programme area will have delivered on key improvement aims as set out at the beginning of the year.	Monthly on IPR	Update on June/July activities are as folllows: • The Wakefield partnership has continued to progress the integration agenda through the Integrated Care Partnership (ICP), previously the New Models of Care Board (NMoC). The Mental Health Alliance has worked together to agree the priorities for 2019/20 in line with the MH investment standard. The detailed proposals to support the priorities (including proposals that have now been approved against the WY&H ICS bid for transformation funding for community crisis care as highlighted below) were presented to the 3 July ICP Board meeting, for approval, and the 9 July Wakefield CCG Governing Body meeting. The proposals were well received by both Boards, and now with CCG Governing Body approval, the Alliance is moving to implementation phase of the proposals. • Wakefield Primary Care Networks - The Trust's director of provider development is the SRO for this programme (on behalf of the ICP Board). There will be seven PCHs in Wakefield, which became 'live' on 1 July 2019, in line with the national timetable. The Trust's service offer in Wakefield is being aligned to PCHs, and the lessons from this work (plus the equivalent work in Barnsley) will help shape the Trust's place based service configuration going forward. All 7 PCHs have supported the approach to their social prescribing link workers being employed through Live Well Wakefield, via a memorandum of understanding. • End of Life Care Alliance The proposed Memorandum of Understanding has been reviewed, and confirmation sent of our acceptance of this.	Progress Against Plan	
							Risks are managed by each programme of work. Areas of risk to report include: Failure to deliver timely response to bids and proposals due to lack of resource, other work priorities and skills. There is a risk that the timescales are too ambitious and do not allow for sufficient time to engage with all partners and stakeholders.	Management of Risk	
							By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year.		

Work with our partners to join up care in Barnsley	1. To develop and deliver partnership structures and relationships that underpin integrated working 2. To deliver integrated care networks in the six neighbourhoods of Barnsley which meet the requirements for primary care networks whilst fully engaging the communities 3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us 4. To deliver improvement programmes in key areas as identified by the partnership groups. These include: a. Frailty b. CVD c. Stroke 5. To develop and deliver a communication and engagement plan that promotes integrated working, inspires staff to work in different ways and helps create an empowered public that takes more responsibility for their health and wellbeing. To underpin this work with a clear plan for SWYPFT in via the Barnsley and SY internal integration group.	Salma Yasmeen	Sue Barton	Transformation Board	By 31/03/20 All six neighbourhoods will have • an established integrated leadership team • co-produced priority areas of focus • population health data pack available to underpin decisions • produced stories that demonstrate impact for the people in their area • The integrated care outcomes framework will be used by partners to begin to demonstrate impact of the different pieces of work • Each programme area will have delivered on key improvement aims as set out at the beginning of the year	Monthly on IPR	An update on work undertaken in June is as follows: • Stroke: Following a further meeting with CCG on 10th June 2019, commissioners requested a written response to their additional queries which was submitted 5th July. An independent review of the proposals is to be undertaken and then CCG will then arrange a further senior/exec level meeting. An additional steering group meeting is arranged for 24th July; weekly project team meetings continue, including finance colleagues when appropriate; TAG groups continue for TIA • A multiagency group of people attended the NHS(I) 2 day training on 'Transforming Care through Systems Leadership' event in York. This training offered the opportunity for senior people in the system to explore a range of models and evidence based approaches to deliver and sustain change. 4 further days are planned. • Area based representatives have been identifed for all agencies and meetings have commenced in all 6 neighbourhoods. Clinical Directors have been identified and work is ongoing to connect the neighbourhood work with the development of the Primary Care Networks which went live on 1 July 2019. Each neighbourhood has received a composite set of information for their area - as set out in the plan for Population Health Management - which provides data and information which can form the basis of the discussion around priorities.	Progress Against Plan	
							Risks are managed by each programme of work. Areas of risk to report include: Stroke: • Finances/contracting - potential increasing risk following remodelling from CCG. • 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. • Demand for radiology/ availability of diagnostic testing within required timescale • Social care not yet fully included in scope of stroke developments	Management of Risk	
							Implementation plan/key milestones: By 31/07/19 Programme areas have identified key improvement aims for 19/20 By 30/09/19 6 neighbourhoods have established leadership teams By 31/12/19 6 neighbourhoods have identified priority areas By 31/03/20 Stories have been shared from the networks, ICOF populated and shared, Programme areas have delivered on key improvement aims.		

Working with our partners to join up care in West Yorkshire	Work across the West Yorkshire and Harrogate Health & Care Partnership (WY&HHCP) Integrated Care System (ICS), including active membership of the West Yorkshire Mental Health Service Collaborative, to deliver shared objectives with our partners in the areas of: • Forensic services including adult, children and LD projects • LD transforming care partnerships • Children and Adolescent Mental Health services whole system pathway development • Suicide Prevention • Autism and ADHD We aim to underpin this work with a clear plan for SWYPFT via the WY internal integration group.	Sean Rayner	Sharon Carter & Sarah Foreman	Transformation Board	By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year.	Monthly on IPR	Update on June/July activities are as follows: Inaugural meeting of SWYPFTs WY internal integration group was held on 2nd July. The workstream map was updated with Trust named inputs to the workstreams. Group meeting to be used for any tactical discussion and coordination of of key points from, and response into, ICS meetings. Key workstream updates are: • The programme has been successful in securing £173k from NHSE/I to assist with post-vention work following a suicide, with an additional £114k for male suicide prevention. The programme was also likely to receive circa £1.4m of flexible transformation funding, the need to complete a proposition for the funding would remain a priority. It was agreed that further links should be made with the Improving Population Health and Primary Care Networks so that housing, social and economic factors amongst others could be understood as part of the PHM Learning Cycle. The Trust is leading this programme on behalf of the Partnership. Funding for programme manager has been secured. • Out of area placements remains a risk and continues to challenge the system and collaborative developments around bed management continue to take place to offer a standardised improved offer. • The recent bid for Children and Young People Tier 4 CAHMS provision had also been supported and was recognised as a positive step forward. The Trust is a key partner in both these programmes of work. • Organisations from across the partnership including the Trust and programme areas, including cancer, improving planned care and mental health, have come together to develop a health champions network of people with learning disabilities from across the area. A local organisation BTM will lead on the development of this work over the next 12 months. • The Trust has been working with our partners in the the West Yorkshire Mental Health, Learning Disability and Autism collaborative to develop proposals to bid for ICS transformation funding: - A WY&H ICS bid for Transformation funding (Wave 1) for community mental health was made by the deadline of 21 June 2019. This comprised two components: Specialist community rehabilitation service (to be tested in Kirklees, Calderdale, and Leeds); Young person offer focusing on early intervention for vulnerable people in defined populations (to be tested in Wakefield, Bradford, and Leeds). This proposal was unfortunately not supported. A feedback conference call is taking place on 31 July 2019. - A WY&H ICS bid for Transformation funding for community crisis care was made by the deadline of 24 June 2019. This bid comprised some elements that were WY-wide and most elements that were place-based. Confirmation was received on 12 July 2019 that all the proposals in this bid would be funded. The Trust is in the process of working through with each CCG in our districts the implementation arrangements for the proposals. • NHS England specialised commissioning - have invited 'Applications' from the ICS by 5 July 2019 to move to steady state commissioning for CAMHS tier 4, adult eating disorder, and forensics. The intention is that by 2022/23, there will be 100% Provider Collaborative coverage nationally across all specialised mental health, learning disabilities and autism services. If successful this would result in four year contracts being awarded to the provider collaborative to lead on the delivery of these services for the Partnership. This builds on the new care model pilots that have been running for 12 months. The Trust submitted a Lead Provider collaborative application for adult secure on 4 July 2019 and is a key partner in the other two service areas outlined above. The next step following submission will be is a Yorkshire & Humber Panel for NHS-led provider collaboratives to take place on 22 July 2019. • Specialist Community Forensic Team Pilot Wave 2 Selection - The Trust submitted a proposal as lead provider on behalf of the adult secure collaborative against this invitation for bids. On 11 July 2019, the Trust received notification that the proposal had been judged as 'Category Three' (of four categories). This category's definition comprised: Proposal included some good responses, but significant concerns and several answers require clarification and/or significant amendments; will require discussions with regional colleagues and applicants to identify whether these can be addressed and will require an amended proposal; expect to require additional 2-4 weeks to original timescales. The Trust will now work with NHS England and provider collaborative partners to take the proposal to the next stage.	Progress Against Plan	
							Risks are managed by each programme of work. Areas of risk to report include: Failure to deliver timely response to bids and proposals due to lack of resource, other work priorities and skills. There is a risk that the timescales are too ambitious and do not allow for sufficient time to engage with all partners. Stakeholder engagement remains a challenge to progression for the majority of the programmes. West Yorkshire Forensic Lead Provider Business Case: whether a NMOC for forensics is achievable owing to financial challenges.	Management of Risk	
							By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year.		

IMPROVE CARE									
Provide all care as close to home as possible	To reduce the use of inpatient beds (both out of area and within the Trust) in a way which contributes to increased quality and safety across the whole pathway and improves staff wellbeing.	Carol Harris	Ryan Hunter	OMG (with monthly report to EMT)	To deliver the programme of work described in the driver diagram and associated plans. The programme of work is a mixture of significant change & Important Improvement projects.	Monthly on IPR	Plans have been established and activity is now being taken forward across each of the following strands of work: • SPA / Community (core discharge) / Intensive Home Based Treatment / Inpatient (criteria led discharge and patient flow) / Trauma Informed Personality Disorder (TIPD) • All strands are now moving into delivery and presented highlight reports to the steering group in June and July. The following key meetings were held in Jun: • Out of Area Stocktake meeting with the executive trio, to review the programme and planned activities at a high level and test whether we think we've got the right plan and resource in place to deliver changes required. • Project challenge panels with Rob Stafford from SSG – to test in more detail the plans, ownership and resources on each strand of work. Positive feedback from both meetings, especially in terms of turn out and delivery / clinical lead support. As well as these meetings the following activity has taken place through June / early Jul: • 2 Criteria led discharge workshops, one to review and update the criteria, the other to focus on the process. • Patient Flow group set up and meeting – focusing on set up of system wide approach and barriers to patient flow. • IHBT – meeting with AMHP team – IHBT aiming to attend more OOH MHAs, Bid activity for resource to support enhancements to IHBT service. • TIPD – therapeutic risk taking protocol shared and reviewed. People now being identified to be part of the new collaborate care planning approach and work has started to develop new care plans. • Community activity to caseload cleanse. • SPA – triage tool testing to start, engagement with service users being planned for Jul and Sep, activity being taken forward in partnership with CCG lead in Calderdale on improving the referral process into services. • Dashboard – draft dashboard now exists for SPA and IHBT strands and work is ongoing to test data quality. Dashboard in development for other strands.	Progress Against Plan	
							Key risks identified on programme risk register are set out below. There are plans in place to mitigate and track activity against these risks and more detail is provided in the highlgiht report to EMT: •Failure to deliver timely improvement due to lack of resource, other work priorities and skills •Lack of relevant information and poor data quality could lead to poor decision making and / or poor assessment of changes, leading to: - being unable to quantify impact of some changes - changes having a negative impact - changes leading to other unintended consequences •Activity required to reduce admissions to beds may not be sustainable in the long term, either due to resources or external pressures. •Differing cultures across the trust and varying levels of engagement could lead to failure to deliver the proposed changes.	Management of Risk	
									
Make care quickly and easily available, to reduce waiting times	To deliver an outstanding CAMHS service for children, young people, and their families whilst making this a great place to work	Carol Harris	Izzy Worswick	OMG	To deliver the programme of work described in the driver diagram and associated plans. The programme of work is a mixture of significant change & Important Improvement projects.	Monthly on IPR	There are significant challenges within the CAMHS services across the Trust. These challenges have been identified through external scrutiny including a review of Barnsley CAMHS by the NHSI Intensive Support Team. Work has already commenced to address the issues. An overarching improvement plan has been pulled together and also a specific action plan has been developed to deliver on the requirements following the Intensive Support Team review. Initially the focus will be on the Barnsley service but care will be taken to spread and share learning throughout this work.	Progress Against Plan	
							Risks to be identified as part of work programme	Management of Risk	
							Implementation plan/key milestonesKey milestones include: By 31/07/19 Develop waiting list reduction plans (analysis & outline plan By 31/08/19 :Define treatment pathways + assessment capacity + outcomes By 30/09/19: Implement the process for managing clinical risk on the waiting list - policy development and review of waiting list By 31/10/19: Define early support offer		

Embed #allofusimprove to enhance quality	To build improvement capability and capacity in the Trust. To use improvement tools in key projects and capture the impact.	Tim Breedon & Salma Yasmeen	Vicki Whyte	EMT	Capability across the Trust will be increased A network of #allofusimprove Champions and Facilitators will be in place across the Trust to support continuous improvement. The #allofusimprove toolkit and helpdesk will be refreshed to support people to 'do and share' their improvements ideas. I Hub will be re-launched and used to strengthen the sharing, development and embedding of improvement and innovation across the Trust	at key milestones	Reported In June 2019 - activity made towards achieving key milestones: • Re-launched i hub with rolling programme of Trust priority conversations • 227 staff across the Trust currently completing the IHI Certificate of Quality & Safety. • 23 staff completed IHI Certificate and are now Trust Improvement Facilitators • 4 members of staff are 80% through QSIR practitioner training with ACT Academy. • Case studies published on intranet demonstrating impact. • Learning Library established to share learning from experience. • Knowledge Café on Benefits, Welfare Reform and Poverty completed.	Progress Against Plan	
							no key risks identified	Management of Risk	
							By 1/05/19 I Hub Relaunched. By 31/08/19#allofusimprove toolkit updated and in place. By 31/03/20: 250 people to complete quality improvement training 24improvement case studies developed and shared 4 x QI Silver Training sessions held 20 x Improvement Coaching & Mentoring sessions held.		
IMPROVE RESOURCES									
Make the most of our clinical information	Delivering SystmOne optimisation plan	Salma Yasmeen	Jules Williams & Sharon Carter	Transformation Board	Completion of phase 1: implementation of clinical record system, SystmOne for MH, project closure report. Completion of phase 1: SystmOne for MH post implementation review. Build on from lessons learnt into phase 2: optimisation Co create and co deliver all priority areas of Optimisation plan (areas tbc)	Monthly on IPR	Update on June activities are as follows: The project is currently in stabilisation, following Go Lives' on 25th February, 5th March 2019 and delta cut on 13th March 2019 - Catch up activities have now been completed and verified internally by clinical leads - The majority of all reports now built, validation making good progress. The MHSDS and CDS have been generated and submitted. - From June onwards we anticipate that reportable contacts will be higher than activity levels from RiO – this is due to the fact that we are now able to report on non-diarised activity which was not reportable from RiO (e.g. ad hoc telephone calls). - Project closure report for phase one: implementation has been submitted to the July Programme Steering Group for review. - Phase 2: Optimisation programme high level plan submitted to and approved by EMT on 20th June 2019. Change reference groups continue to meet as engagement vehicles for service and system improvement. From these groups: - Further training videos and guidance are in development and specific training sessions delivered as requested - Work continues to refine post go live configuration based on staff feedback. - AWorkshop is being planned for wider staff engagement on optimisation approach, scheduled for August 9th 2019.	Progress Against Plan	
							The programme level risk that remains is - "the risk that sub-optimal transition from RiO to SystmOne will result in significant loss or ineffective use of data resulting in the inability to capture and share information and produce reports" has been reviewed and incorporated into a BAU level Risk to be agreed at PSG on the 23rd July 2019. Risks to be identified as part of optimisation work plan.	Management of Risk	
							Optimisation plan in place by end of May 2019 Project closure report completed June 2019 Post implementation Review of phase 1: implementation of SystmOne completed by October 2019.		
MAKE THIS A GREAT PLACE TO WORK							These programmes of work report at key milestones directly to EMT and thus no update is required via the IPR		

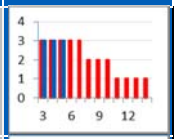
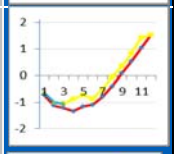
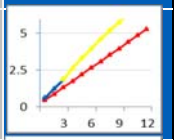
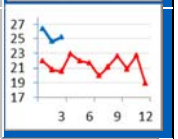
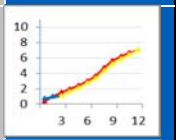
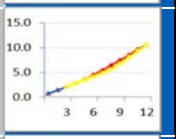
Progress against plan rating	
	On target to deliver within agreed timescales / project tolerances
	ability/confidence to deliver actions within agreed timescales / project tolerances
	ability/capacity to deliver actions within agreed timescales / project tolerances
	Actions will not be delivered within agreed timescales / project tolerances
	Action complete

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

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

Overall Financial Performance 2019/20

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	3	2	The overall risk rating is 3 (out of 4 with 1 being the highest). It is limited to a maximum of a 3 due to the impact of the year to date deficit position. This is in line with plan.	
2	Normalised Deficit (excl PSF)	(£1.3m)	(£0.2m)	June 2019 finance performance excluding Provider Sustainability Fund (PSF) is ahead of plan at a deficit of £0.1m. Year to date there is a deficit of £1.3m. Performance is forecast to improve over the course of the year and as such the planned £0.2m year end deficit is still considered as achievable. Continued financial control and increased cost improvements will be required to deliver this.	
3	Agency Cap	£1.9m	£7.4m	Agency expenditure is higher than plan with £0.6m spent in June, £0.2m above the agency cap set by NHS Improvement. Current year-end projection is to exceed our agency cap by £2.1m.	
4	Cash	£25.2m	£25.7m	The Trust cash position remains healthy at £25.2m. Cash is forecast to increase in Qtr 2 as the outstanding 2018/19 PSF (£3.8m) is received.	
5	Capital	£1.1m	£7m	Expenditure for the year to date, and forecast, are in line with plan. All Trusts have been asked to review the prioritisation of capital schemes with a view to making a reduction in 2019/20.	
6	Delivery of CIP	£2.1m	£10.6m	Delivery is in line with plan for the year to date. Unidentified CIPs which require mitigation have increased to £1.9m (from £1.6m last month) due to a revised assessment against the consolidation of temporary staffing scheme.	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value and is ahead of plan	

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

Contracting - Trust Board

Contracting Issues - General

Additional recurrent and non-recurrent mental health investments have now been agreed through the Wakefield Mental Health Alliance and approved through the Wakefield CCG Governing Body. The priority areas agreed which will have a direct impact on SWYPFT in 2019/20 relate to recurrent investments to increase capacity within the intensive home based treatment team, expand capacity for police liaison and provide new capacity to offer dialectic behavioural therapy within community mental health teams.

CQUIN

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

Contracting Issues - Barnsley

The detail of the £1.2m mental health investment plan for 2019/20 has been agreed as improving access to psychological therpaies (IAPT) expansion, extension to development of all age and crisis liaison services and support for children and young people with a diagnosis of attention deficit hyperactivity disorder (ADHD) waiting for treatment. Review is ongoing in relation to neighbourhood nursing.

Contracting Issues - Calderdale

Key ongoing work priorities include early intervention in psychosis (EIP), reduction in out of area (OOA) in adult mental health, continued development of perinatal services and further development of children and young people's services in line with implementation of the THRIVE model. 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

Key ongoing work priorities include continued development of psychological therapies for adults covering both core and long term conditions services, expansion of early intervention in psychosis services, continued development of perinatal services transformation of mental health services for older people to support provision of care closer to home through community based provision. Commissioners are making additional investment to support the further development of pathways for people with personality disorder

Contracting Issues - Wakefield

Key ongoing work priorities include continued development of 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 recurrent and non-recurrent mental health investments have now been agreed through the Wakefield Mental Health Alliance and approved through the Wakefield CCG Governing Body. The priority areas agreed which will have a direct impact on SWYPFT in 2019/20 relate to recurrent investments to increase capacity within the intensive home based treatment team, expand capacity for police liaison and provide new capacity to offer dialectic behavioural therapy within community mental health teams.

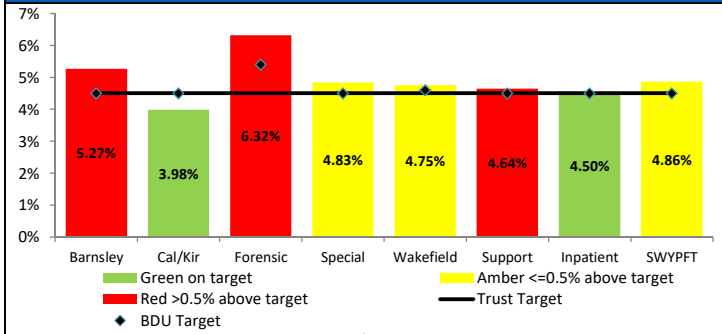
Contracting Issues - Forensics

The 2019/20 contract offer with NHS England is agreed. 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.

Workforce

Human Resources Performance Dashboard - June 2019

Sickness Absence



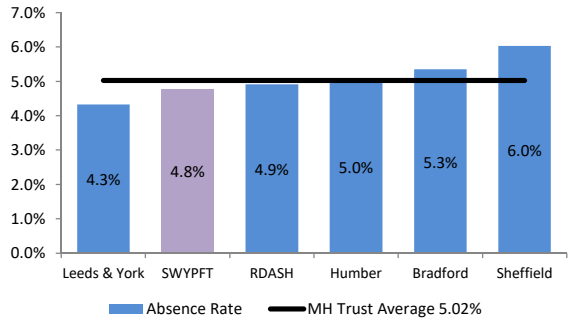
Current Absence Position and Change from Previous Month - June 2019

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	Inpat	WYPF
Rate	5.9%	3.8%	7.1%	4.9%	3.9%	4.9%	5.9%	5.2%
Change	↑	↓	↑	↓	↓	↑	↑	↑

The Trust YTD absence levels in June 2019 (chart above) were above the target at 4.86%.

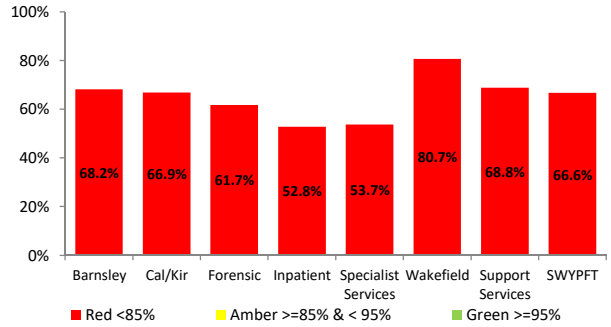
0

0



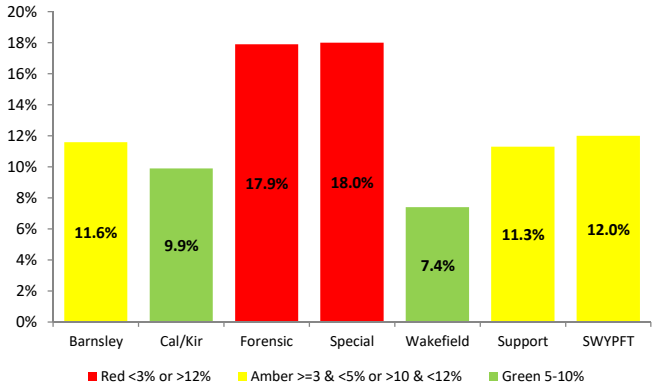
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the period April 2018 to October 2018.
During this time the Trust's absence rate was 4.78% which is below the regional average of 5.02%.

Appraisals Band 6 & Above

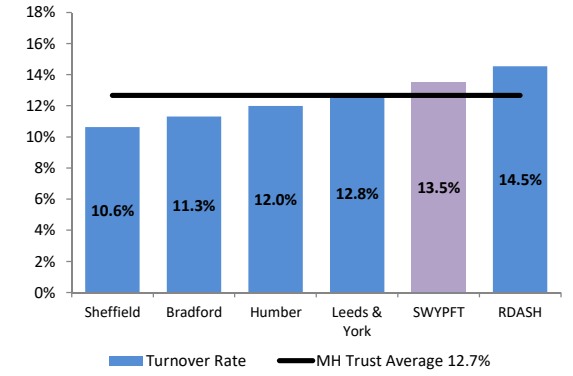


The above chart shows the appraisal rates for the Trust to the end of June 2019.
From June to August, the figures will only include staff on Band 6 and above. From September's report onwards, they will include all staff.
The Trust target for appraisals for staff on Band 6 and above is to reach 95% by the end of June each year.

Turnover and Stability Rate Benchmark

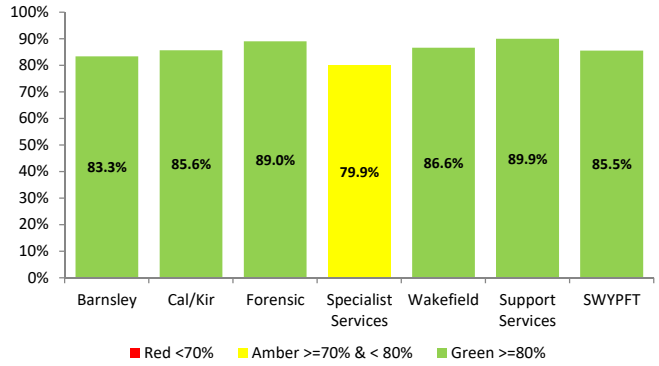


This chart shows the YTD turnover levels up to the end of June 2019.
*The turnover data excludes recently TUPE'd services



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 Training Attendance



The chart shows the 12 month rolling year figure for fire lectures to the end of June 2019. Specialist Services have dropped slightly but all other BDUs and the Trust continue to achieve the 80% target.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.4%	4.5%	4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	4.7%	4.7%	4.9%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.4%	4.7%	4.8%	5.1%	5.7%	5.8%	5.7%	5.8%	5.1%	4.6%	4.7%	4.7%	5.2%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	72.2%	87.7%	92.8%	95.0%	95.8%	98.1%	98.2%	99.1%	99.1%	99.1%	6.3%	19.8%	66.2%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	9.4%	21.6%	48.1%	78.6%	87.2%	94.3%	95.0%	96.5%	97.5%	97.5%	0.2%	1.5%	7.8%
Aggression Management	Improving Care	Well Led	AD	>=80%	81.6%	82.9%	83.0%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	81.7%	81.6%	82.8%	84.0%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	84.5%	84.8%	83.3%	81.6%	80.1%	80.2%	81.2%	82.1%	81.4%	80.7%	80.2%	80.1%	81.3%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	85.8%	85.9%	86.0%	85.8%	85.8%	86.1%	87.4%	87.8%	88.7%	88.4%	87.9%	88.7%	88.3%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	89.7%	89.8%	90.1%	89.8%	90.2%	90.7%	91.3%	90.9%	91.0%	90.3%	89.6%	89.8%	90.3%
Fire Safety	Improving Care	Well Led	AD	>=80%	86.6%	86.6%	87.4%	86.3%	86.8%	86.7%	88.1%	85.2%	84.9%	84.6%	84.6%	84.6%	85.7%
Food Safety	Improving Care	Well Led	AD	>=80%	77.5%	80.8%	81.9%	81.7%	81.9%	84.1%	82.2%	82.3%	83.7%	83.4%	83.6%	83.6%	83.3%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	87.3%	87.8%	88.5%	89.1%	89.3%	89.1%	89.7%	89.5%	90.4%	89.9%	90.5%	90.8%	91.1%
Information Governance	Improving Care	Well Led	AD	>=95%	92.1%	91.9%	92.2%	92.1%	92.3%	90.2%	90.8%	96.1%	97.6%	98.5%	97.2%	94.3%	94.5%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	85.6%	85.7%	86.1%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	90.5%	90.4%	91.4%	91.8%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	91.3%	92.2%	91.7%	90.9%	91.4%	92.6%	92.3%	92.7%	92.5%	91.7%	91.2%	91.7%	91.6%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	86.5%	88.1%	87.3%	85.9%	85.8%	87.7%	86.7%	86.7%	86.4%	84.5%	84.2%	85.2%	86.8%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led		>=80%	82.8%	83.8%			82.6%			86.7%			69.9%		
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	91.3%	91.7%	91.7%	91.5%	92.1%	93.0%	93.7%	93.2%	93.4%	92.9%	92.4%	92.5%	93.2%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	89.4%	90.1%	90.4%	90.0%	90.4%	89.4%	91.4%	91.3%	90.9%	91.1%	89.6%	91.0%	91.7%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	94.9%	95.8%	95.2%	94.6%	94.6%	94.1%	94.5%	93.9%	94.5%	94.9%	94.0%	94.8%	95.1%
Bank Cost	Improving Resources	Well Led	AD	-	£768k	£646k	£730k	£845k	£615k	£674k	£678k	£752k	£1048k	£772k	£625k	£844k	£695k
Agency Cost	Improving Resources	Effective	AD	-	£484k	£526k	£566k	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£613k	£641k	£619k
Overtime Costs	Improving Resources	Effective	AD	-	£5k	£11k	£5k	£8k	£4k	£5k	£7k	£7k	£8k	£48k	£12k	£28k	£34k
Additional Hours Costs	Improving Resources	Effective	AD	-	£23k	£31k	£32k	£29k	£30k	£31k	£24k	£26k	£27k	£40k	£46k	£38k	£37k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£420k	£461k	£471k	£507k	£586k	£571k	£572k	£602k	£476k	£482k	£479k	£494k	£521k
Business Miles	Improving Resources	Effective	AD	-	259k	291k	269k	279k	267k	299k	279k	286k	270k	289k	274k	240k	293k
Health & Safety																	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	Reporting commenced 19/20										7		

1 - this does not include data for medical staffing.

Workforce - Performance Wall cont…

Mandatory Training
• The Trust is above 80% compliance for all 14 mandatory training programmes with 7 being above 90%. Information Governance training has a target of 95% and is currently slightly below this.

Appraisals
• Appraisal completion rate for band 6 and above has increased to 66.2% however performance to end of June is below expected levels and is below the level achieved for the same time last year. There is a time lag in terms of recording appraisals so an increase is expected by the end of July.

Sickness Absence
• The sickness rate in June has increased slightly to 5.2% and is 4.9% cumulative. This compares to 5.3% in Q1 last year. Both Forensic and Barnsley BDUs had sickness absence in excess of target in month.

Turnover
• Turnover continues to be an area of focus and the recruitment and retention task group have developed an action plan which is monitored through the workforce and remuneration committee.
• June staff turnover was 12% which is an increased compared to previous month, with particular hotspots in Forensic and Specialist services BDUs.

Health & Safety
• During quarter 1 there were 7 RIDDOR incidents, 6 physical assaults and 1 injury during restraint.

Guardian of Safe Working Report - Q1 (April - June 2019)

High level data

Number of doctors in training (total):	50
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:	0.25 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. None of the 4 CT posts in Barnsley are vacant.

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.

Rota gaps and cover arrangements

Gaps by rota April/May/June '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	0	0	0	0	0
Calderdale 1st	36 (20%)	36 (100%)	0	0	0
Kirklees 1st	11 (12%)	11 (100%)	0	0	0
Wakefield 1st	0	0	0	0	0
Total 1st	47 (7%)	47 (100%)	0	0	0
Wakefield 2nd	14 (15%)	0	0	14 (100%)	0

Costs of Rota Cover April/May/June '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	0
Calderdale	36 (361)	£12635.00	0	0	£12635.00
Kirklees	11 (168)	£5880.00	0	0	£5880.00
Wakefield	0	0	0	0	0
Total	47 (529)	£18515	0	0	£18515.00

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 no shifts were unfilled and none have had to be offered to agency staff during this quarter.

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 (1) doctors have now joined the trust and we expect more to join us in the summer. Unfortunately there were no new core trainees appointed to the Calderdale in Kirklees scheme to start in February 2019 but recruitment figures for August 2019 are better. 3 vacancies will be advertised for the February 2020 rotation. For August 2019 all vacant slots have been filled by MTI and WAST doctors. The Leeds-Wakefield rotation and the South Yorkshire Rotation are both fully recruited for August 2019 and no gaps are expected for February 2020.

• 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 with all 1st on-call vacant slots filled by the medical bank in this quarter. Also, new administrators are developing experience and getting used to processes to manage gaps.

• Junior Doctors' Forum – This continues to meet quarterly, offering a forum for trainees to raise concerns about their working lives and to consider options to improve the training experience. Where concerns do not relate directly to the contract, issues are raised with the relevant Clinical Lead or the AMD for Postgraduate Medical Education.

• Education and support – The Guardian will continue to work closely with the AMD for Postgraduate Medical Education to improve trainees experience and to support clinical supervisors. The Guardian will continue to encourage trainees to use Exception Reporting, both at induction sessions and through the Junior Doctors' Forum.

• IT system – Initial issues with the Allocate system seem to have been resolved and this is working smoothly. However, additional information explaining the work schedules has been sent to trainees on non-resident rotas as the standard information generated by the system was found to insufficient.

Responsible Officer Quarterly Report – Q1 (April - June 2019)

MEDICAL APPRAISALS 1.4.19 – 30.6.19	
Number expected to be undertaken in period	28
Number undertaken in period	27
Number not undertaken for which the RO accepts postponement is reasonable	1
Percentage of appraisals taken place	96%
Percentage of appraisals signed off in period as satisfactory	100%
MEDICAL REVALIDATIONS 1.4.19 – 30.6.19	
Number of revalidation recommendations due in period	14
Number of positive recommendations	12
Number of deferrals	2
Number of non-engagements	0
Percentage of revalidation recommendations made	100%
RESPONDING TO CONCERNS	
Number of active cases under Maintaining High Professional Standards procedures	0

Publication Summary

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

Department of Health and Social Care
Reducing the need for restraint and restrictive intervention
This guidance from the DHSC and Department for Education is for health services, social care services and special education settings. It sets out how to support children and young people with learning disabilities, autistic spectrum conditions and mental health difficulties who are at risk of restrictive intervention.

Click here for link to guidance

NHS long term plan implementation framework
Following the publication of the NHS long-term plan, NHS England and NHS Improvement committed to publishing an implementation framework, setting out further detail on how it would be delivered. Local systems are developing their five-year strategic plans, which will describe the population needs and case for change in each area, then propose practical actions that the system will take to deliver the commitments set out in the NHS long-term plan. The framework summarises these commitments alongside further information to help local system leaders refine their planning and prioritisation. This includes detail about where additional funding will be made available to support specific commitments and where activity will be paid for or commissioned nationally.

Cick here for link to framework

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

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

Diagnostic imaging dataset: February 2019

Direct access audiology waiting times: April 2019

NHS Improvement provider bulletin: 19 June 2019:
• Amendment to national safety standards for invasive procedures (NatSSIPs)
• Share your views on maximising the success of new-in-post executive and non-executive directors
• Proposed changes to agency rules — consultation response
• Model Ambulance webinar
• Updates from our partners

Care Quality Commission (CQC) - 2018 adult inpatient survey: statistical release: Findings from this latest annual survey of people who stayed as an inpatient in hospital show that most people had confidence in the doctors and nurses treating them and felt that staff answered their questions clearly. However, there has been no overall improvement in the responses since the survey was last carried out, and this year's results show an increase in those reporting lengthy delays, greater dissatisfaction with the amount of information provided when leaving hospital, and those who felt a lack of involvement in their care.

NHS workforce statistics: March 2019 (including supplementary analysis on pay by ethnicity)

NHS sickness absence rates: February 2019, provisional statistics

NHS staff earnings estimates to March 2019, provisional statistics

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

NHS Improvement provider bulletin: 3 July 2019:
• Staff flu immunisation campaign
• Medicines and medical products supply: Government updates no-deal EU Exit plans
• Launch of the NHS Patient Safety Strategy
• Making data count — strengthening your decisions
• Opportunity to build quality and service improvement capability
• Same Day Emergency Care (SDEC) — Commissioning for Quality and Innovation (CQUIN) — third webinar
• Updates from our partners

Psychological therapies: annual report on the use of IAPT services, 2018/19

Out of area placements in mental health services: April 2019

Community services statistics: March 2019

Diagnostics waiting times and activity: May 2019

Learning disability services monthly statistics (assuring transformation): June 2019

NHS Improvement provider bulletin: 17 July 2019

Diagnostic imaging dataset: March 2019

Direct access audiology waiting times: May 2019

Number of children and young people accessing NHS funded community mental health services in England: April 2018 to March 2019, experimental statistics

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

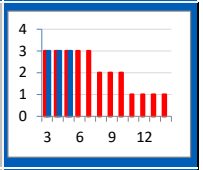
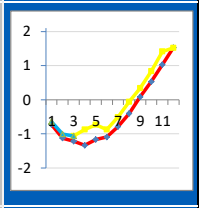
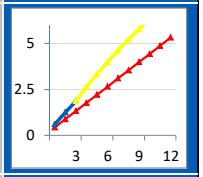
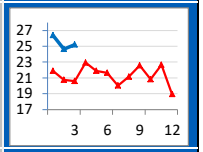
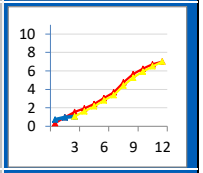
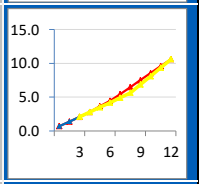
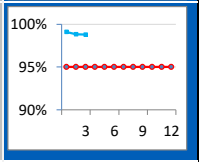
Month 3
(2019 / 20)
Appendix 1

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0 Executive Summary / Key Performance Indicators

Performance Indicator		Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	3	2	The overall risk rating is 3 (out of 4 with 1 being the highest). It is limited to a maximum of a 3 due to the impact of the year to date deficit position. This is in line with plan.	
2	Normalised Deficit (excl PSF)	(£1.3m)	(£0.2m)	June 2019 finance performance excluding Provider Sustainability Fund (PSF) is ahead of plan at a deficit of £0.1m. Year to date there is a deficit of £1.3m. Performance is forecast to improve over the course of the year and as such the planned £0.2m year end deficit is still considered as achievable. Continued financial control and increased cost improvements will be required to deliver this.	
3	Agency Cap	£1.9m	£7.4m	Agency expenditure is higher than plan with £0.6m spent in June, £0.2m above the agency cap set by NHS Improvement. Current year-end projection is to exceed our agency cap by £2.1m.	
4	Cash	£25.2m	£25.7m	The Trust cash position remains healthy at £25.2m. Cash is forecast to increase in Qtr 2 as the outstanding 2018/19 PSF (£3.8m) is received.	
5	Capital	£1.1m	£7m	Expenditure for the year to date, and forecast, are in line with plan. All Trusts have been asked to review the prioritisation of capital schemes with a view to making a reduction in 2019/20.	
6	Delivery of CIP	£2.1m	£10.6m	Delivery is in line with plan for the year to date. Unidentified CIPs which require mitigation have increased to £1.9m (from £1.6m last month) due to a revised assessment against the consolidation of temporary staffing scheme.	
7	Better Payment	99%		This performance is based upon a combined NHS / Non NHS value and is ahead of plan.	

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		Plan - Month 3	
Area	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	1.5	3	1.2	4
	20%	Liquidity (Days)	22.4	1	17.1	1
Financial Efficiency	20%	I & E Margin	-1.9%	4	-2.2%	4
Financial Controls	20%	Distance from Financial Plan	0.3%	1	0.0%	1
	20%	Agency Spend	41%	3	20%	2
Weighted Average - Financial Sustainability Risk Rating				3		3

Impact

The Trust weighted financial risk rating is currently 3. This is the capped maximum rating as we have individual metrics rated as 4. These ratings are as a direct result of the year to date deficit position and are forecast to improve over the course of the year. The forecast is to improve to 2 in Qtr 4 2019/20.

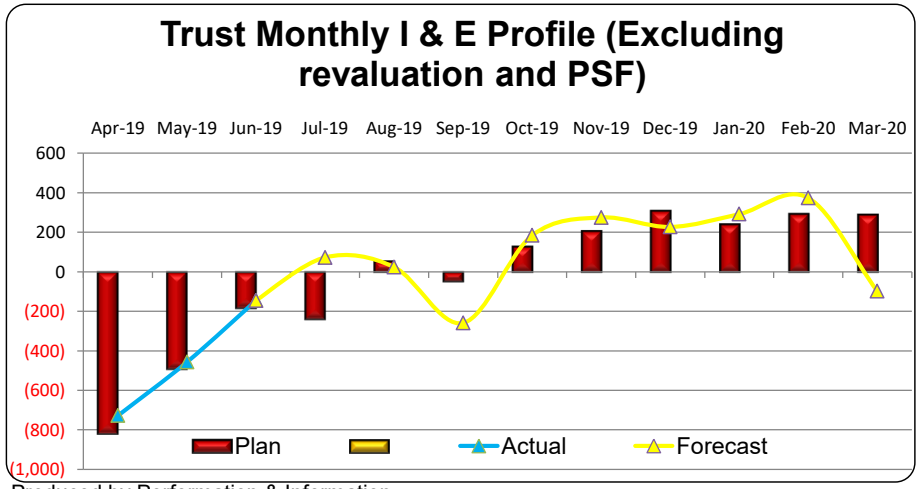
The agency rating is the only metric which is lower than planned.

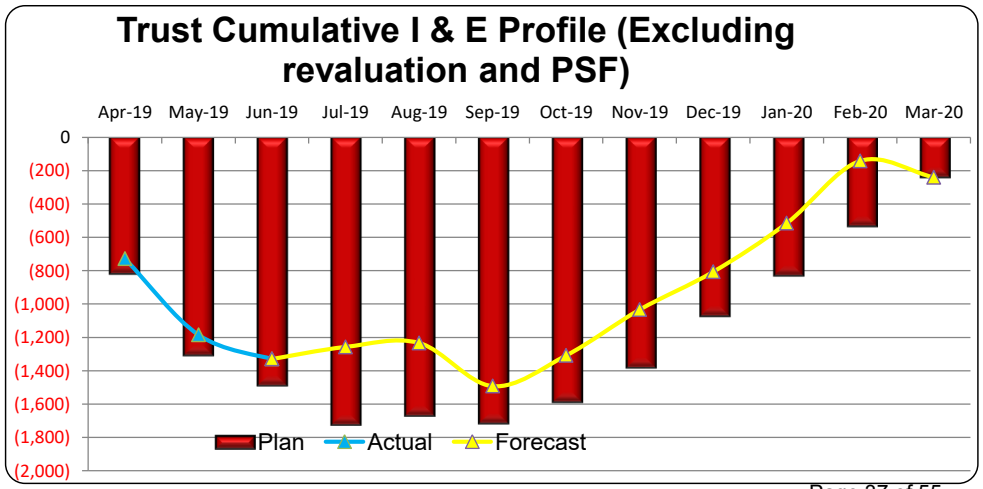
Definitions

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 £5.3m has been set for the Trust in 2019 / 2020. This metric compares performance against this cap.

2.0 Income & Expenditure Position 2019 / 2020

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				17,648	17,373	(275)	Clinical Revenue	52,906	52,384	(522)	211,993	211,428	(564)
				17,648	**17,373**	**(275)**	**Total Clinical Revenue**	**52,906**	**52,384**	**(522)**	**211,993**	**211,428**	**(564)**
				1,094	1,201	107	Other Operating Revenue	3,358	3,624	266	12,931	13,410	478
				18,743	**18,575**	**(168)**	**Total Revenue**	**56,264**	**56,008**	**(256)**	**224,924**	**224,838**	**(86)**
4,120	4,002	(118)	2.9%	(14,590)	(14,322)	268	Pay Costs	(44,430)	(43,697)	732	(176,879)	(175,602)	1,277
				(3,404)	(3,276)	128	Non Pay Costs	(10,447)	(10,000)	447	(42,393)	(42,382)	11
				(270)	(447)	(177)	Provisions	(889)	(1,619)	(730)	2,036	1,075	(961)
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
4,120	**4,002**	**(118)**	**2.9%**	**(18,264)**	**(18,045)**	**219**	**Total Operating Expenses**	**(55,765)**	**(55,316)**	**449**	**(217,236)**	**(216,909)**	**327**
4,120	**4,002**	**(118)**	**2.9%**	**479**	**529**	**51**	**EBITDA**	**498**	**691**	**193**	**7,688**	**7,929**	**241**
				(442)	(463)	(21)	Depreciation	(1,326)	(1,389)	(63)	(5,302)	(5,564)	(262)
				(227)	(227)	0	PDC Paid	(682)	(682)	0	(2,726)	(2,726)	0
				8	16	7	Interest Received	25	49	24	100	121	21
4,120	**4,002**	**(118)**	**2.9%**	**(182)**	**(145)**	**37**	**Normalised Surplus / (Deficit) Excl PSF**	**(1,484)**	**(1,330)**	**154**	**(240)**	**(240)**	**0**
				89	89	0	PSF (Provider Sustainability Fund)	265	265	0	1,765	1,765	0
4,120	**4,002**	**(118)**	**2.9%**	**(93)**	**(56)**	**37**	**Normalised Surplus / (Deficit) Incl PSF**	**(1,219)**	**(1,065)**	**154**	**1,525**	**1,525**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,120	**4,002**	**(118)**	**2.9%**	**(93)**	**(56)**	**37**	**Surplus / (Deficit)**	**(1,219)**	**(1,065)**	**154**	**1,525**	**1,525**	**0**





Income & Expenditure Position 2019 / 20

The June run rate remained in deficit but improved from previous months. Actions are focussed on returning the run rate to surplus.

Month 3

The June position is a pre PSF deficit of £145k and a post PSF deficit of £56k, this is £37k ahead of plan. The key headlines are below. Whilst favourable to plan the reporting of a deficit is a concern and the run rate must improve in order to achieve the £0.2m deficit plan for the full year.

In June there is a continued underspend in both on pay and non pay categories partly offset by income being below plan.

Income

Clinical income in month 3 is £275k lower than plan. A full breakdown of income is shown on page 7.

CQUIN income risk has been assessed. The current position includes an 8% YTD underachievement, the forecast assumes this will be recovered. It is confirmed this is a lower value than previous years as CQUIN income has reduced from 2.5% to 1.25% of applicable contract values.

Pay Expenditure

In June pay underspent by £268k. The Trust continues to run with a number of vacancies and utilises temporary staff (both internal bank and external agency) to meet clinical and service requirement. Recruitment is actively being undertaken and the Trust continues to work on its recruitment and retention action plan. Additional analysis is included within the pay information report to highlight the different expenditure levels across the services.

The NHSI maximum agency cap for 2019/20 has been set at £5.3m. In June agency costs are £619k. This is £176k (40%) higher than cap.

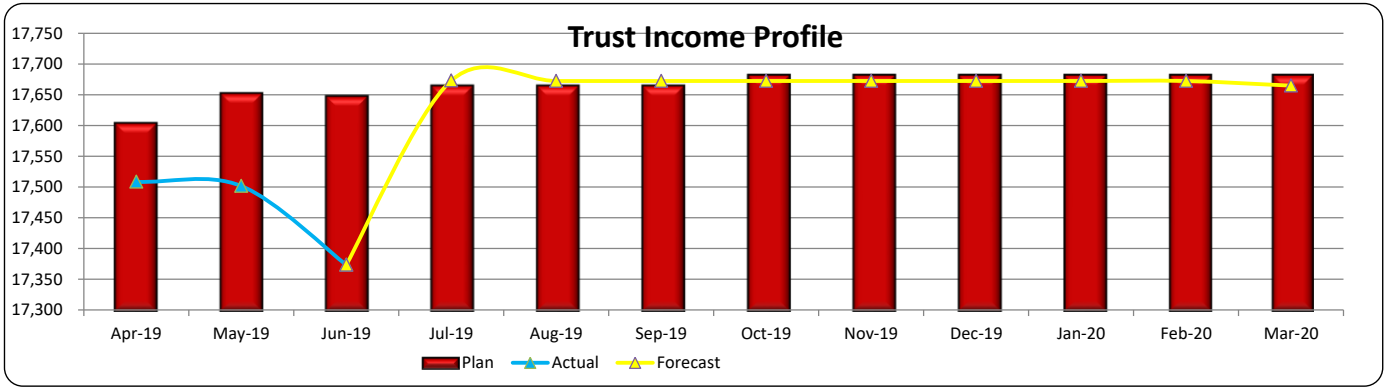
Non Pay Expenditure

Non pay is underspent by £128k in June and is at a lower level overall than in previous years. This will continue to be monitored due to the volatity in key areas such as out of area placement expenditure. More details are included within the out of area focus page.

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-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k	Total 18/19 £k
CCG	12,398	12,398	12,242	12,410	12,410	12,410	12,410	12,410	12,410	12,410	12,410	12,410	**148,726**	**146,036**
Specialist Commissioner	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	**24,297**	**23,356**
Alliance	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	**15,540**	**14,596**
Local Authority	441	441	460	446	446	446	446	446	446	446	446	446	**5,353**	**5,074**
Partnerships	614	614	670	649	649	649	649	649	649	649	649	642	**7,734**	**7,172**
Other	737	730	681	848	848	848	848	848	848	848	848	848	**9,778**	**6,708**
Total	**17,509**	**17,502**	**17,373**	**17,673**	**17,672**	**17,672**	**17,672**	**17,672**	**17,672**	**17,672**	**17,672**	**17,665**	**211,428**	**202,942**
18/19	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**	



CQUIN schemes for 2019/20 are being finalised with commissioners. Based on these schemes potential risks have been assessed and the financial risk is incorporated into the year to date position.

This equates to a potential loss of income of £144k (year to date) although the forecast assumes this will be recovered and is the majority of the income reduction in the graph to the left..

Other variances to plan include:

Level of income realised from the sale of Neuro Rehabilitation beds in Barnsley. Activity levels, and future plans, are under review.

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 and annual plans are agreed by the Workforce and Remuneration Committee. The Trust's strategic workforce plan was approved in March 2018 and is updated annually.

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.

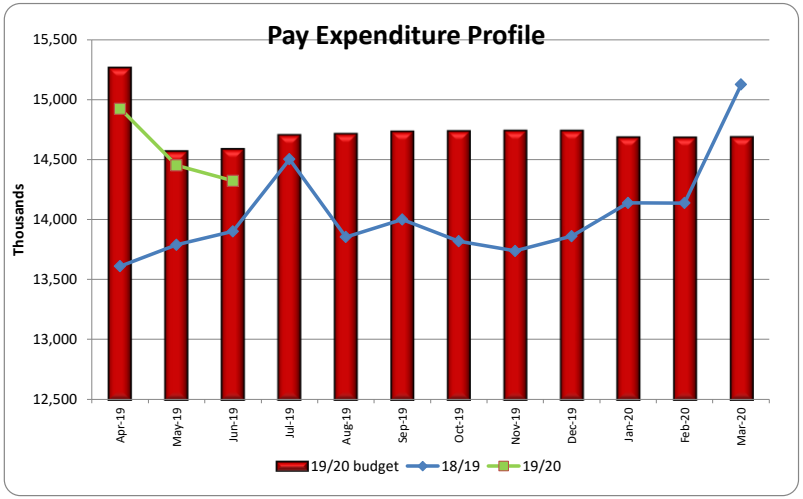
	Apr-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k
Substantive	13,647	12,904	12,980										**39,532**
Bank & Locum	663	906	723										**2,292**
Agency	613	641	619										**1,873**
Total	**14,923**	**14,452**	**14,322**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**43,697**
18/19	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**
Bank as %	4.4%	6.3%	5.0%										5.2%
Agency as %	4.1%	4.4%	4.3%										4.3%

Year to Date Budget v Actuals - by staff group

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
Medical	5,869	4,480	128	1,021	5,630	239
Nursing Registered	15,852	13,414	798	132	14,344	1,508
Nursing Unregistered	4,772	4,514	1,075	403	5,992	(1,220)
Other	10,869	10,698	108	304	11,110	(240)
Corporate Admin	3,116	2,847	53	10	2,910	206
BDU Admin	3,952	3,579	129	3	3,711	240
Total	**44,430**	**39,532**	**2,292**	**1,873**	**43,697**	**732**

Year to date Budget v Actuals - by service

	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	19,330	16,634	428	1,221	18,282	1,049
Inpatient	11,004	9,433	1,636	595	11,664	(660)
BDU Support	1,856	1,798	53	3	1,854	2
Community	5,413	5,226	80	21	5,327	85
Corporate	6,826	6,441	95	34	6,570	256
Total	**44,430**	**39,532**	**2,292**	**1,873**	**43,697**	**732**



Key Messages

Overall pay expenditure is higher in 2019/20 than previous years. This is to be expected as a result of the national pay awards and pay increments under Agenda For Change. The Trust has also been successful in securing new services such as Liaison and Diversion (from April 2019) with further investment forecast throughout the course of the year (IAPT, additional bids).

In June pay underspent by £268k. Year to date the underspend is £732k. Temporary staffing provided by both agency and bank staff totals £4.2m to date (9.5% of total pay expenditure) and this level of expenditure is being offset by vacancies. However additional staffing requirements and vacancies are often within different services or BDUs within the Trust. The service, quality and financial impact of this is considered as part of the monthly internal review.

Key variances above highlight that the largest area of underspend is within registered nursing due to known recruitment and retention difficulties. The current workforce strategy includes the utilisation of additional unregistered nurses to provide support. Recurrent workforce strategies have been developed and a focus on inpatient, particularly adult acute, is being undertaken.

To date the inpatient areas, excluding Forensics, are overspent by £133k. Development of a substantive workforce model for these areas, ensuring safety and quality, continues. Funding, based on historical levels of spend, is currently held in provisions to fund this and will be released as the model is agreed. The model includes skill mix of staff and development of additional roles such as Training Nurse Associates (TNA).

2.1 Agency Expenditure Focus

The NHS Improvement agency cap is £5.3m

Quarter 1 agency spend exceeds the cap by £0.5m

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.

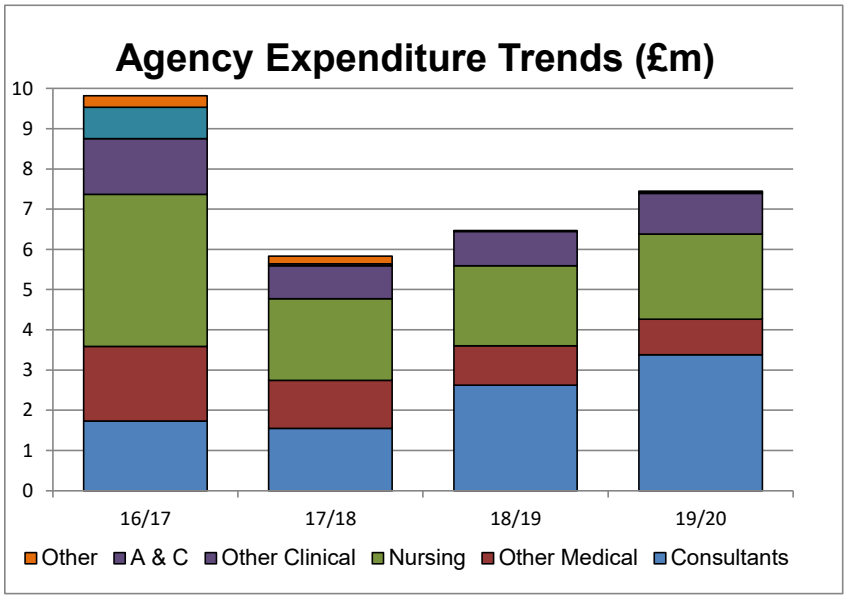
The maximum agency cap established by NHSI for 2019/20 is £5.3m which is £0.1m higher than the 2018/19 cap. In 2018/19 spend was £6.5m which breached the cap by £1.3m (24%). The NHSI agency cap has been profiled equally across the year with a maximum spend of £443k a month. The Trust plan assumed spend in excess of the cap at £5.9m.

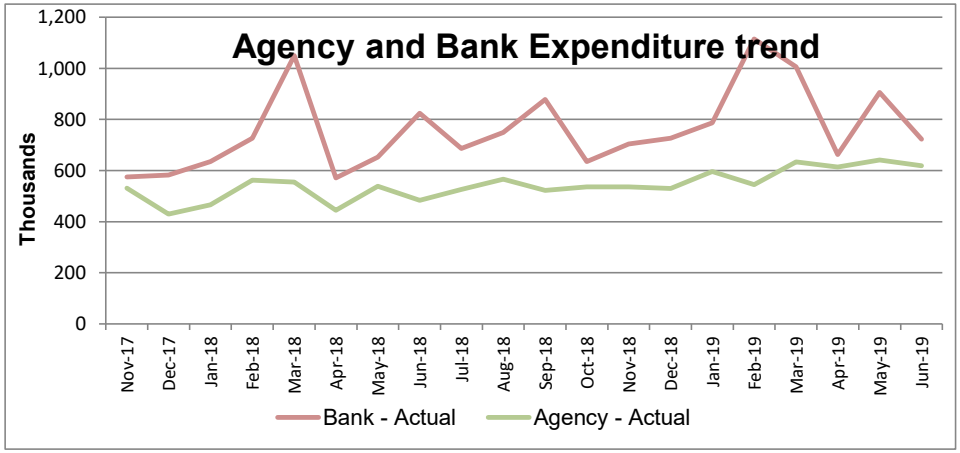
Actual agency usage continues to be reported to NHS Improvement on a weekly basis.

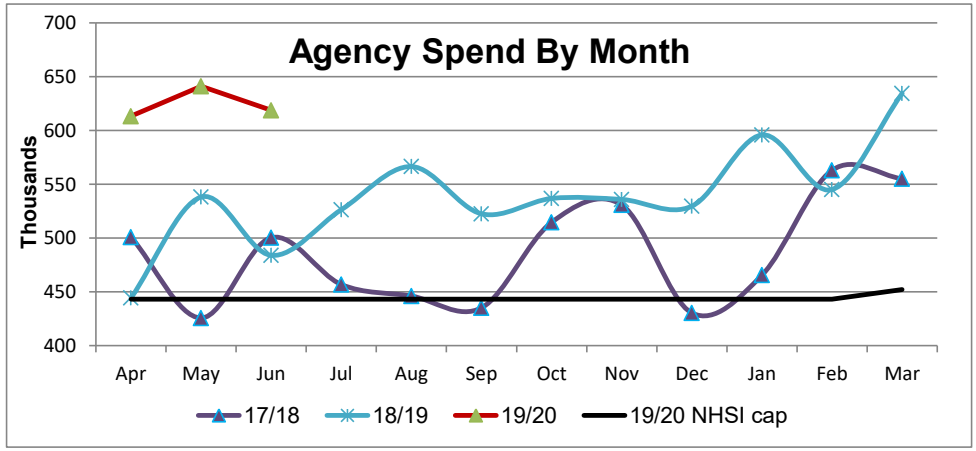
Month 3 agency spend is £619k, 40% above cap. This continues to be a higher rate than incurred in 2018/19. The Trust agency action group continues to progress actions to reduce this level of spend. Cumulatively agency spend is £1.87m which is 41% above cap and 28% higher than the same period last year.

The current forecast, based upon plans in place, is £7.4m. All medical and other clinical post action plans have been updated with key milestones dates identified.

Bank expenditure at £723k, is in line with run rates. Bank usage is not restricted to one BDU and mainly results from high acuity, high sickness and on-call cover across the wards.





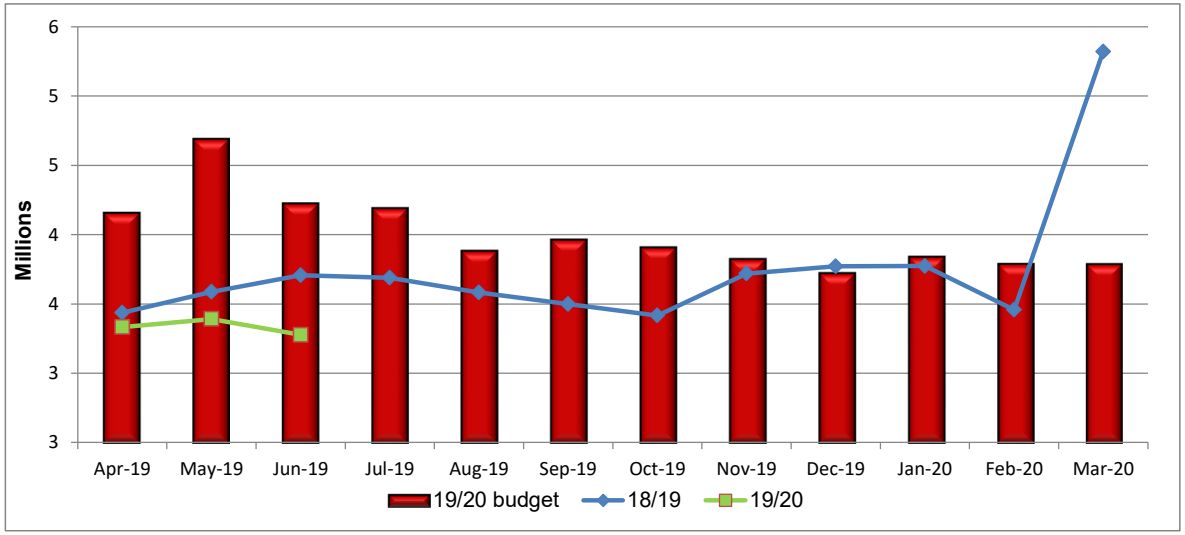


2.1 Non Pay Expenditure

Whilst pay expenditure represents over 80% of all Trust expenditure, 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-19 £k	May-19 £k	Jun-19 £k	Jul-19 £k	Aug-19 £k	Sep-19 £k	Oct-19 £k	Nov-19 £k	Dec-19 £k	Jan-20 £k	Feb-20 £k	Mar-20 £k	Total £k
2019/20	3,333	3,391	3,276										**10,000**
2018/19	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**

	Budget Year to date	Actual Year to date	Variance
Non Pay Category	**£k**	**£k**	**£k**
Clinical Supplies	724	633	91
Drugs	910	837	73
Healthcare subcontracting	1,321	1,284	37
Hotel Services	457	366	91
Office Supplies	1,087	1,129	(41)
Other Costs	1,169	1,063	106
Property Costs	1,632	1,704	(72)
Service Level Agreements	1,548	1,535	13
Training & Education	113	121	(9)
Travel & Subsistence	873	684	189
Utilities	281	322	(40)
Vehicle Costs	332	321	11
Total	**10,447**	**10,000**	**447**
	8,216	**7,879**	**337**



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

et during the 2019/20 annual planning round and, to date, there is little variation from plan. The plan included resetting those categories which have s healthcare subcontracting (use of out of area placements) and drugs. Whilst these variances are small the focus remains on ensuring that all spend is lue for money.

enditure is lower than in the previous year.

nd is within the travel and subsistence costs category which is currently £189k under plan.

Other workstreams within the non pay review group includes telecoms, IT contracts and estates as we continue to focus on waste reduction and value for money.

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 is for the out of area placements relating to adult acute beds including PICU in all areas. This excludes activity relating to locked rehab in Barnsley

Out of Area Expenditure Trend (£)

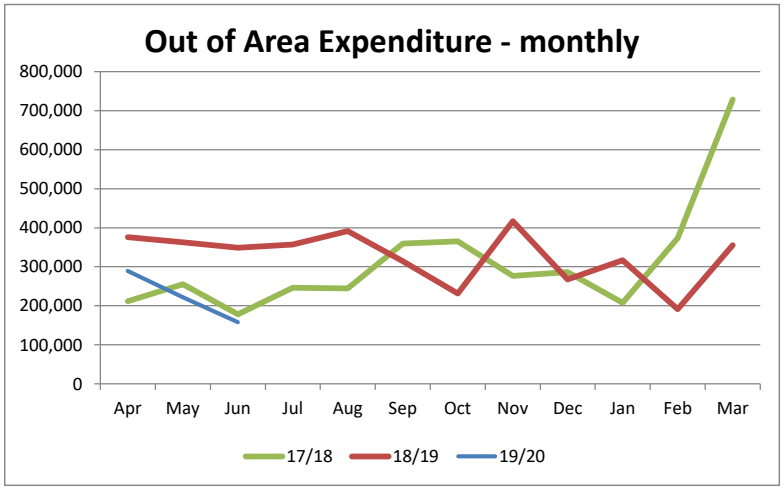
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158										**669**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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**
19/20	282	354	234										**870**

Bed Day Information 2019 / 2020 (by category)

PICU	32	26	30										**88**
Acute	160	277	174										**611**
Appropriate	90	51	30										**171**
Total	282	354	234	0	0	0	0	0	0	0	0	0	**870**



In 2019/20 the PICU out of area budget has been set to fund 2 appropriate out of area placements at any time. The acute out of area budget is phased to fund 9 out of area placements in April reducing to 5 placements by March 2020.

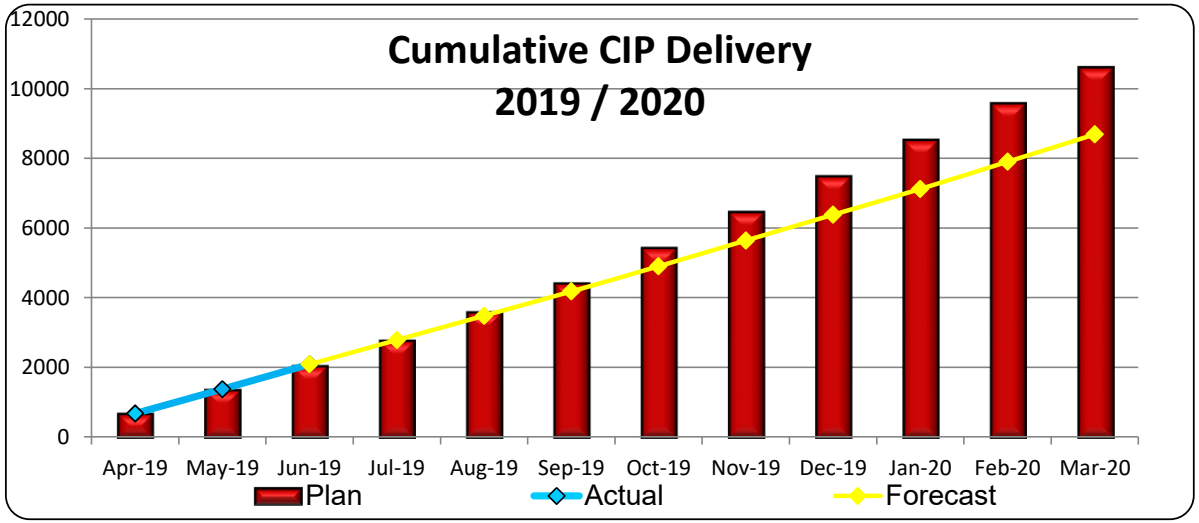
Demand for placements has reduced by 33% between May and June meaning that the year to date position is 69 less days than planned (870 used compared to 939 planned).

Expenditure in quarter 1 of £669k is £418k lower than the same period in 2018/19.

This activity is within a wider care closer to home programme. The objective is to reduce the use of inpatient beds (both out of area and within the Trust), enabling more care closer to home, in a way which contributes to increased quality and safety across the whole pathway and improves staff wellbeing. Elements of this programme includes reviewing appropriate inpatient stays and ensuring the right community and primary care support.

2.1 Cost Improvement Programme 2019 / 2020

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
TOTAL - CUMULATIVE	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	688	1,376	2,066	2,790	3,615	4,439	5,455	6,481	7,507	8,542	9,596	10,624	2,066
Achieved - plan	669	1,353	2,018	2,691	3,365	4,039	4,739	5,456	6,173	6,890	7,649	8,411	2,018
Achieved - mitigation	4	19	69	92	115	138	161	184	207	230	253	276	69
Mitigations - Upside schemes									485	969	1,454	1,938	0
Shortfall / Unidentified	**15**	**4**	**(21)**	**7**	**134**	**262**	**555**	**841**	**642**	**454**	**240**	**(0)**	**(21)**



The Trust has set a challenging CIP target for 2019/20 of £10.6m which included £1.4m of unidentified savings at the beginning of the year.

This has increased to £1.9m due to forecast risks against a number of key schemes; drugs cost reductions, non pay savings and implementation of a consolidated temporary staffing solution.

The majority of schemes, 123 out of 127 (97%) identified within BDUs and corporate services have delivered as planned. The remaining 4 have been substituted in full.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
RECURRENT - CUMULATIVE	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	418	838	1,258	1,720	2,282	2,844	3,598	4,352	5,106	5,870	6,632	7,368	1,258
Achieved - plan	378	772	1,186	1,597	2,008	2,418	2,858	3,305	3,752	4,204	4,678	5,155	1,186
Achieved - mitigation	3	17	66	87	109	131	153	175	197	218	240	262	66
Shortfall / Unidentified	**38**	**50**	**7**	**36**	**165**	**295**	**587**	**873**	**1,158**	**1,448**	**1,713**	**1,951**	**7**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
NON RECURRENT - CUMULATIVE	£	£	£	£	£	£	£	£	£	£	£	£	£
Target	269	538	808	1,070	1,332	1,595	1,857	2,129	2,400	2,672	2,964	3,256	808
Achieved - plan	291	582	832	1,095	1,357	1,620	1,881	2,151	2,421	2,686	2,971	3,256	832
Achieved - mitigation	1	2	3	5	6	7	8	9	10	12	13	14	3
Shortfall / Unidentified	**(23)**	**(46)**	**(28)**	**(29)**	**(31)**	**(32)**	**(32)**	**(32)**	**(31)**	**(25)**	**(20)**	**(14)**	**(28)**

3.0 Balance Sheet 2019 / 2020

	2018 / 2019 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	100,005	100,258	99,675	1
Current Assets				
Inventories & Work in Progress	259	232	259	
NHS Trade Receivables (Debtors)	3,019	1,840	2,520	2
Non NHS Trade Receivables (Debtors)	1,007	1,814	1,084	3
Prepayments, Bad Debt, VAT	1,559	2,614	2,685	
Accrued Income	5,138	5,575	7,239	4
Cash and Cash Equivalents	27,823	20,592	25,213	5
Total Current Assets	**38,806**	**32,667**	**38,999**	
Current Liabilities				
Trade Payables (Creditors)	(4,663)	(2,856)	(3,578)	6
Capital Payables (Creditors)	(1,070)	(555)	(388)	
Tax, NI, Pension Payables, PDC	(6,002)	(6,682)	(6,574)	
Accruals	(8,020)	(8,063)	(10,009)	
Deferred Income	(276)	(689)	(474)	
Total Current Liabilities	**(20,031)**	**(18,845)**	**(21,024)**	
Net Current Assets/Liabilities	**18,775**	**13,822**	**17,975**	
Total Assets less Current Liabilities	**118,780**	**114,080**	**117,650**	
Provisions for Liabilities	(7,221)	(6,273)	(7,155)	
Total Net Assets/(Liabilities)	**111,560**	**107,807**	**110,495**	
Taxpayers' Equity				
Public Dividend Capital	44,221	44,221	44,221	
Revaluation Reserve	9,453	9,845	9,453	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,666	48,521	51,601	7
Total Taxpayers' Equity	**111,560**	**107,807**	**110,495**	

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 original agreed plan for 2019/20 is £7.0m although this has subsequently reduced to £6.8m following a national request.

2. NHS trade debtors are higher than plan, a number of old invoices continue to be pursued to achieve resolution. This has increased following the raising of the Quarter 1 invoices; these are expected to be paid in July.

3. Non NHS debtors are lower than plan. All debts continue to be pursued.

4. Accrued income is above plan as this includes the additional PSF received at 31st March 2019 which is expected to be paid in Q2 2019 (£3.8m).

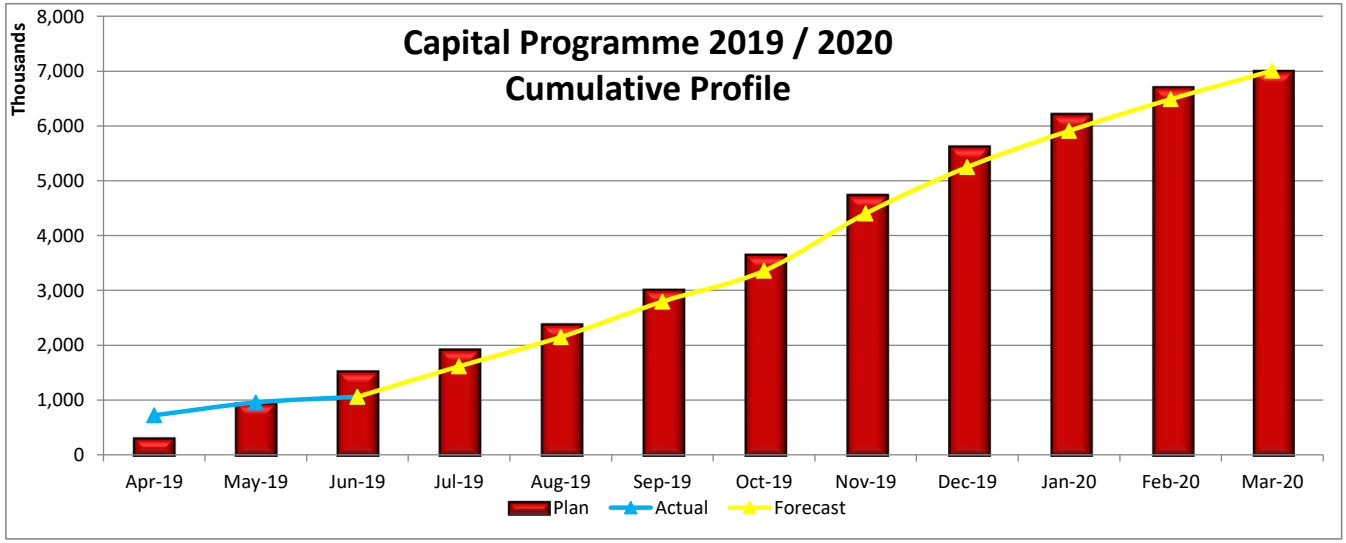
5. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 16.

6. Creditors are higher than plan although we continue to ensure invoices are paid in line with the Better Payment Practice Code (page 17).

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

3.1 Capital Programme 2019 / 2020

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	3,007	123	91	(32)	2,856	(151)	
Equipment Replacement	50	20	(3)	(23)	90	40	
IM&T	2,245	403	30	(373)	2,204	(41)	2
Major Capital Schemes							
Fieldhead Non Secure	635	635	806	171	806	171	
Nurse Call system	600	150	0	(150)	600	0	3
Clinical Record System	220	220	134	(86)	200	(20)	
VAT Refunds	0	0	0	0	0	0	
TOTALS	**6,757**	**1,551**	**1,058**	**(493)**	**6,756**	**(1)**	



National 2019 / 20 NHS capital programmes are subject to further review

Capital Expenditure 2019 / 2020

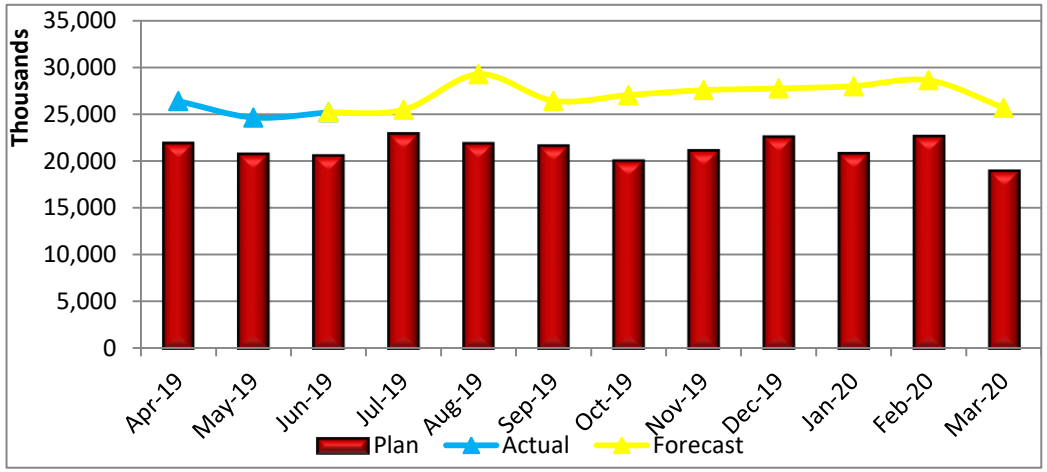
1. The originally agreed capital plan for 2019 / 20 was £7.0m and schemes are guided by the current estates and digital strategies.

NHS Improvement asked all trusts to conduct a further review and prioritisation of their capital programmes; this led to the Trust submitting a revised capital plan of £6.8m in May 2019. National reviews are ongoing.

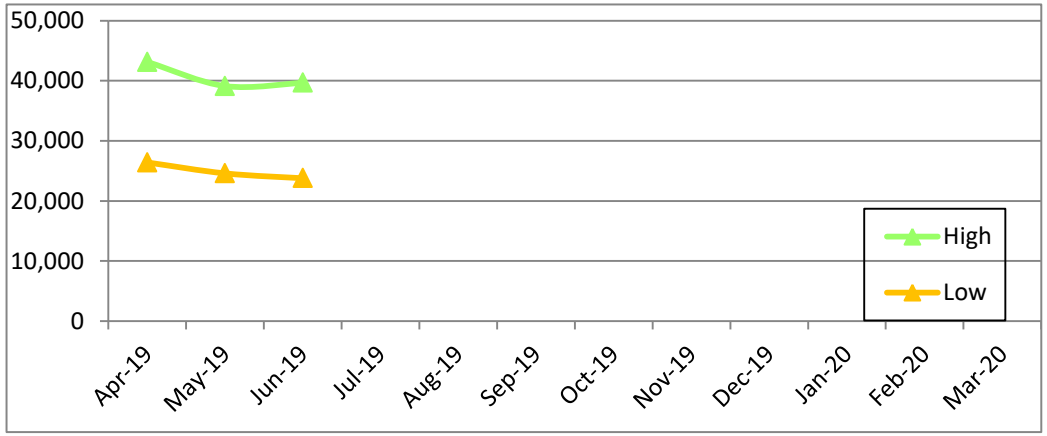
2. Procurement, ensuring best possible value for money, continue for the IM & T schemes. Hardware orders have now been placed and this is forecast to come back in line with plan.

3. Procurement of the nurse call system continues.

3.2 Cash Flow & Cash Flow Forecast 2019 / 2020



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	27,823	
Closing Balance	20,592	25,213	4,622



Effective cash management remains a key financial objective for 2019/20

Cash started the year higher than plan (as the plan was submitted prior to the year end position being finalised).

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

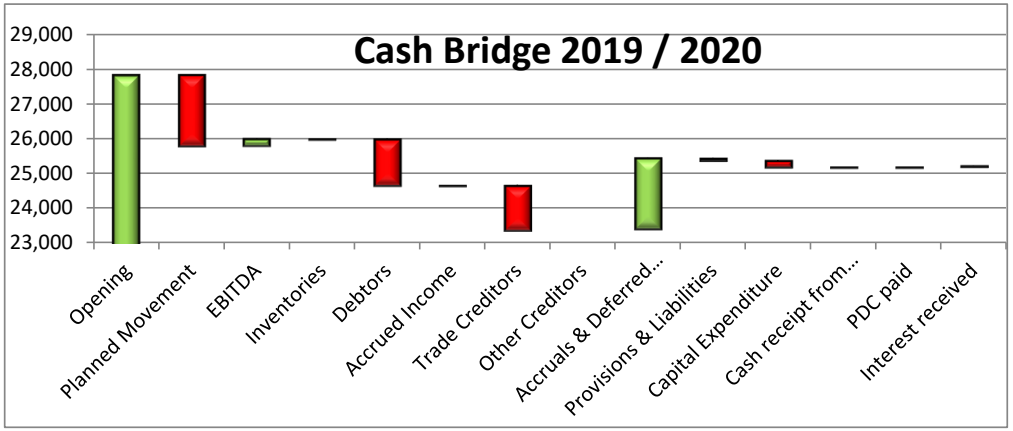
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £39.7m
The lowest balance is: £23.8m

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	**22,617**	**27,823**	5,206	1
Surplus / Deficit (Exc. non-cash items & revaluation)	761	956	195	2
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	(1,469)	(2,804)	(1,335)	3
Accrued Income / Prepayments	0	0	0	
Trade Payables (Creditors)	82	(1,194)	(1,276)	4
Other Payables (Creditors)	0	0	0	
Accruals & Deferred income	130	2,188	2,058	
Provisions & Liabilities	(2)	(66)	(64)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(1,551)	(1,740)	(189)	
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	0	0	0	
PDC Dividends received			0	
Interest (paid)/ received	24	49	25	
Closing Balances	**20,592**	**25,213**	**4,622**	



The plan value reflects the April 2019 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. The opening cash balance was higher than included in the annual plan submission.

2. The in year I & E position is better than plan.

Factors which decrease the cash position against plan:

3. Debtors are higher than planned. Work is ongoing to reduce these further and to resolve any old debt.

4. 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.

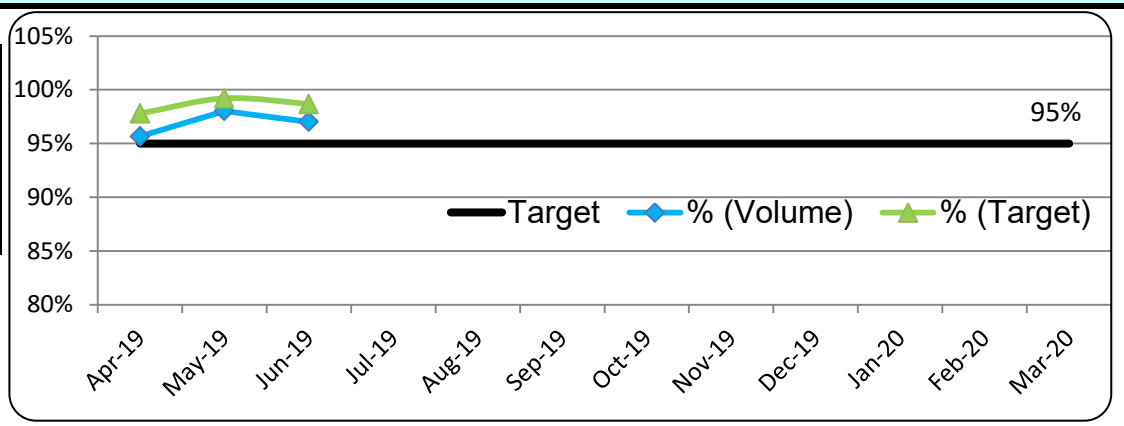
The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

4.0 Better Payment Practice Code

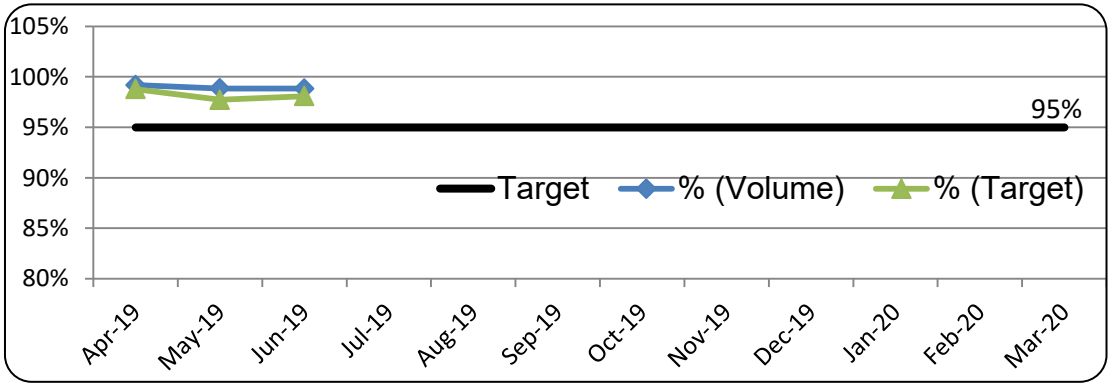
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 May 2019	98%	99%
Year to June 2019	97%	99%



Non NHS	Number %	Value %
Year to May 2019	99%	98%
Year to June 2019	99%	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 (£)
19-Jun-19	Property rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3109656	226,501
04-Jun-19	Property rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3108053	226,501
30-May-19	IT Services	Trustwide	Trustmarque Solutions Ltd	3107758	205,388
03-Jun-19	Property rental	Kirklees	Bradbury Investments Ltd	3107936	118,518
30-May-19	IT Services	Trustwide	Trustmarque Solutions Ltd	3107759	116,047
07-Jun-19	IT Services	Trustwide	Daisy Corporate Services Trading Ltd	3108544	93,125
11-Jun-19	IT Services	Trustwide	Servelec Healthcare Limited	3109039	73,322
16-May-19	CNST contributions	Trustwide	NHS Litigation Authority	3106655	64,044
20-Jun-19	CNST contributions	Trustwide	NHS Litigation Authority	3109773	64,044
17-Jun-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3109507	43,016
08-May-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3105678	42,172
31-May-19	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3107795	41,520
07-Jun-19	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3108515	33,976
10-Jun-19	Purchase of Healthcare	Trustwide	Cygnet Health Care Ltd	3108802	32,889
28-Jun-19	Property Rental	Barnsley	Community Health Partnerships	3110504	31,925
24-May-19	Property Rental	Barnsley	Community Health Partnerships	3107388	31,925
12-Jun-19	Property Rental	Barnsley	Community Health Partnerships	3109102	31,925
05-Jun-19	Purchase of Healthcare	Forensics	Cloverleaf Advocacy 2000 Ltd	3108310	31,416
03-Jun-19	Property Rental	Kirklees	Bradbury Investments Ltd	3107934	27,108
07-Jun-19	Electricity	Trustwide	EDF Energy	3108513	26,753
14-Jun-19	Communications	Trustwide	Vodafone Corporate Ltd	3109394	26,464
04-Jun-19	Communications	Trustwide	Vodafone Corporate Ltd	3108059	26,334
03-Jun-19	IT Services	Trustwide	Trustmarque Solutions Ltd	3107948	26,239
08-May-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3105678	25,758
28-Jun-19	Property Rental	Barnsley	Community Health Partnerships	3110504	25,624
24-May-19	Property Rental	Barnsley	Community Health Partnerships	3107388	25,624
12-Jun-19	Property Rental	Barnsley	Community Health Partnerships	3109102	25,624
17-Jun-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3109507	25,301

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)

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Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	5.1%	5.2%	4.9%	4.9%	5.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.1%	5.7%	5.4%	4.9%	5.0%	5.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	100.0%	100.0%	100.0%	8.1%	22.1%	68.2%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	94.1%	96.7%	96.7%	0.4%	2.7%	13.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	81.9%	83.9%	82.3%	77.8%	77.9%	81.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.8%	82.3%	82.7%	83.1%	82.4%	82.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	88.9%	86.5%	84.6%	78.0%	81.9%	80.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.8%	90.9%	89.8%	88.9%	89.7%	90.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.7%	82.4%	80.9%	81.4%	81.1%	83.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.8%	77.2%	81.7%	82.4%	83.3%	79.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.8%	90.4%	90.0%	89.9%	90.9%	91.9%
Information Governance	Resources	Well Led	AD	>=95%	94.1%	96.2%	97.8%	90.9%	92.6%	92.9%
Moving and Handling	Resources	Well Led	AD	>=80%	93.4%	87.3%	87.6%	87.9%	87.5%	87.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.0%	88.8%	87.4%	90.3%	90.3%	93.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	83.2%	84.7%	78.8%	75.6%	78.6%	81.4%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.9%	93.9%	93.2%	87.9%	98.3%	98.8%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.1%	88.8%	89.1%	90.8%	87.2%	88.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.8%	95.9%	96.2%	90.5%	95.1%	91.8%
Agency Cost	Resources	Effective	AD		£46k	£30k	£37k	£28k	£57k	£46k
Overtime Costs	Resources	Effective	AD		£3k	£1k	£2k	£3k	£1k	£0k
Additional Hours Costs	Resources	Effective	AD		£9k	£13k	£10k	£17k	£14k	£15k
Sickness Cost (Monthly)	Resources	Effective	AD		£177k	£146k	£165k	£135k	£142k	£166k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		73.4	73.85	79.37	84.36	80.88	78.97
Business Miles	Resources	Effective	AD		104k	97k	97k	97k	99k	109k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.5%	4.5%	4.5%	4.1%	4.0%	4.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.1%	4.7%	4.3%	4.1%	4.0%	3.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	100.0%	100.0%	100.0%	9.7%	25.1%	66.9%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	97.8%	98.5%	98.5%	0.2%	1.7%	5.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.4%	82.4%	81.4%	81.3%	82.2%	83.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	81.6%	79.1%	77.3%	76.3%	75.1%	75.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	88.9%	89.2%	89.6%	91.2%	91.2%	90.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	90.5%	91.6%	90.9%	90.2%	90.2%	90.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.1%	83.6%	84.5%	84.2%	84.3%	85.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	84.6%	84.2%	83.4%	82.9%	81.5%	78.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	89.6%	90.2%	89.4%	90.1%	90.0%	89.5%
Information Governance	Resources	Well Led	AD	>=95%	97.5%	97.9%	96.9%	97.9%	95.1%	95.8%
Moving and Handling	Resources	Well Led	AD	>=80%	97.8%	98.9%	99.6%	99.5%	91.3%	92.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.8%	92.5%	91.6%	91.2%	91.9%	93.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	98.6%	97.5%	98.4%	96.9%	97.9%	99.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.9%	92.7%	91.4%	91.7%	92.3%	92.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	98.9%	98.0%	98.6%	98.5%	98.9%	98.9%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	94.9%	95.9%	95.9%	96.8%	96.4%	97.9%
Agency Cost	Resources	Effective	AD		£101k	£102k	£135k	£146k	£157k	£120k
Overtime Costs	Resources	Effective	AD		£2k	£1k	£1k	£2k	£7k	£2k
Additional Hours Costs	Resources	Effective	AD		£0k	£1k	£4k	£5k	£4k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£127k	£109k	£109k	£92k	£94k	£84k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		68.26	70.03	68.72	75.61	80.5	71.04
Business Miles	Resources	Effective	AD		69k	64k	82k	66k	45k	65k

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.7%	7.6%	7.5%	5.6%	5.9%	6.3%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	8.4%	6.5%	5.6%	5.6%	6.2%	7.1%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.6%	94.4%	94.4%	3.5%	15.5%	58.8%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	96.4%	96.5%	96.5%	0.7%	0.7%	3.6%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	93.1%	93.8%	93.5%	90.1%	90.5%	87.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	94.3%	94.3%	93.9%	93.1%	90.1%	88.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.6%	93.3%	93.5%	90.3%	90.2%	92.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.3%	93.4%	94.4%	91.1%	91.8%	91.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	97.9%	98.5%	97.7%	98.3%	98.3%	98.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	94.2%	97.4%	95.9%	98.1%	92.1%	92.6%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.6%	90.6%	90.4%	90.1%	90.4%	91.6%
Information Governance	Resources	Well Led	AD	>=95%	96.4%	97.2%	96.5%	97.6%	96.3%	96.7%
Moving and Handling	Resources	Well Led	AD	>=80%	90.6%	92.7%	94.6%	90.1%	90.3%	89.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	89.6%	89.6%	89.6%	89.2%	91.9%	91.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	93.2%	93.2%	91.8%	93.9%	89.7%	91.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	96.6%	96.6%	96.1%	95.1%	94.6%	94.6%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	93.2%	94.2%	93.6%	88.4%	89.6%	89.7%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	93.3%	93.1%	92.9%	90.3%	90.3%	88.8%
Agency Cost	Resources	Effective	AD		£69k	£31k	£69k	£50k	£59k	£65k
Overtime Costs	Resources	Effective	AD		£2k	£0k	£0k	£1k	£0k	£0k
Additional Hours Costs	Resources	Effective	AD		£1k	£2k	£1k	£1k	£2k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£88k	£56k	£55k	£52k	£59k	£67k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		48.97	62.2	64.52	78.25	84.96	88.64
Business Miles	Resources	Effective	AD		8k	7k	9k	5k	6k	8k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.1%	5.0%	4.9%	4.8%	4.8%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.0%	4.6%	3.8%	4.4%	5.1%	4.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	93.5%	93.5%	93.5%	2.8%	10.9%	53.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	91.8%	92.7%	92.7%	0.0%	2.4%	9.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.1%	91.8%	90.8%	82.5%	81.6%	82.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.2%	77.4%	76.7%	78.6%	79.0%	78.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.7%	94.0%	93.5%	94.6%	93.6%	93.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.4%	93.8%	93.2%	87.5%	93.2%	93.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.6%	80.4%	80.7%	82.6%	82.4%	79.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	72.4%	72.4%	71.0%	73.3%	70.0%	73.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	89.1%	91.2%	90.7%	90.9%	89.4%	90.8%
Information Governance	Resources	Well Led	AD	>=95%	95.5%	96.2%	96.7%	96.2%	95.2%	95.1%
Moving and Handling	Resources	Well Led	AD	>=80%	87.7%	90.6%	90.2%	89.7%	91.3%	91.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.8%	93.8%	93.4%	93.4%	91.1%	93.9%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.8%	87.8%	86.9%	87.3%	84.8%	85.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.8%	93.2%	93.2%	92.1%	91.3%	92.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.8%	91.2%	91.2%	90.7%	90.3%	92.1%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	91.4%	91.9%	92.3%	92.6%	94.4%	93.2%
Agency Cost	Resources	Effective	AD		£264k	£276k	£275k	£283k	£268k	£258k
Overtime Costs	Resources	Effective	AD		£1k	£0k	£0k	£1k	£2k	£2k
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£3k	£10k	£5k	£5k
Sickness Cost (Monthly)	Resources	Effective	AD		£59k	£46k	£32k	£48k	£59k	£53k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		56.77	64.46	61.42	55.85	63.99	0
Business Miles	Resources	Effective	AD		38k	39k	35k	34k	34k	45k

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.30%	4.30%	4.30%	4.60%	4.50%	4.60%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	5.40%	4.60%	4.30%	4.60%	4.40%	4.90%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.50%	99.60%	99.60%	3.30%	12.90%	66.70%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	99.70%	99.80%	99.80%	0.00%	0.20%	2.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.70%	73.20%	68.00%	72.10%	69.10%	79.30%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.60%	84.60%	84.60%	76.90%	69.20%	69.20%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.60%	98.10%	98.60%	98.30%	98.70%	98.90%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	98.00%	98.40%	98.00%	98.10%	98.30%	98.30%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.20%	97.20%	97.90%	98.60%	97.10%	96.40%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	98.70%	99.10%	99.50%	92.00%	92.10%	92.50%
Information Governance	Resources	Well Led	AD	>=95%	97.50%	98.70%	99.20%	91.70%	94.20%	94.30%
Moving and Handling	Resources	Well Led	AD	>=80%	99.30%	98.60%	92.90%	93.40%	94.60%	95.70%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.00%	99.20%	99.20%	98.90%	99.00%	99.10%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	95.20%	95.20%	95.20%	95.00%	95.00%	94.10%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.90%	97.90%	97.90%	97.40%	97.40%	98.30%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	98.10%	98.60%	98.60%	98.00%	97.60%	97.90%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Agency Cost	Resources	Effective	AD		£26k	£22k	£12k	£14k	£15k	£6k
Overtime Costs	Resources	Effective	AD		£0k	£4k	£45k	£5k	£16k	£29k
Additional Hours Costs	Resources	Effective	AD		£10k	£7k	£17k	£10k	£8k	£11k
Sickness Cost (Monthly)	Resources	Effective	AD		£83k	£66k	£63k	£64k	£64k	£68k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		50.42	52.74	49.57	45.38	37.6	43.44
Business Miles	Resources	Effective	AD		24k	23k	29k	35k	22k	27k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.9%	4.8%	4.8%	5.7%	5.2%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	5.6%	4.7%	4.7%	5.6%	4.7%	3.8%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	99.5%	99.6%	99.6%	4.3%	23.8%	80.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	99.8%	99.8%	99.8%	0.0%	0.8%	13.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	96.2%	95.8%	96.2%	96.8%	97.6%	97.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.8%	81.8%	82.8%	79.0%	79.6%	81.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	81.6%	84.2%	83.6%	83.6%	82.9%	79.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.2%	91.9%	91.3%	89.8%	90.7%	90.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.9%	89.1%	88.9%	87.9%	89.5%	89.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	68.7%	73.6%	74.0%	72.7%	79.3%	90.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.9%	92.1%	90.5%	90.2%	91.9%	91.8%
Information Governance	Resources	Well Led	AD	>=95%	97.6%	98.5%	98.9%	98.3%	95.5%	95.4%
Moving and Handling	Resources	Well Led	AD	>=80%	89.8%	92.2%	92.6%	92.2%	93.6%	92.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.1%	92.5%	91.8%	90.8%	89.7%	91.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.6%	86.9%	86.6%	84.5%	83.9%	86.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.3%	94.4%	95.2%	94.9%	95.1%	95.7%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.9%	89.4%	90.1%	89.6%	92.4%	94.5%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	91.9%	92.7%	94.1%	95.9%	93.4%	94.2%
Agency Cost	Resources	Effective	AD		£90k	£82k	£107k	£92k	£84k	£24k
Overtime Costs	Resources	Effective	AD			£1k	£0k	£1k	£2k	£1k
Additional Hours Costs	Resources	Effective	AD		£5k	£3k	£3k	£4k	£5k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£68k	£53k	£58k	£58k	£48k	£40k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		45.52	41.04	39.69	39.49	37.44	31.39
Business Miles	Resources	Effective	AD		43k	40k	37k	38k	34k	39k

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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 July 2019
Agenda item 9.1

Title:	**Estate Strategy update**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on progress on the Estate Strategy.
Mission/values:	The Estate Strategy was developed to ensure that the Trust's buildings and properties are of a high quality, fit for purpose and offer best value.
Any background papers/ previously considered by:	The current Estate Strategy is designed to be a 10 year strategic plan for the management and development of the estate. The Trust Board agreed the strategy in 2012 and has over this period received regular updates.
Executive summary:	The Trust has now delivered all the agreed projects in the estate strategy with the completion of the Fieldhead in patient scheme in May. Whilst the current strategy runs to 2022 it is felt appropriate to bring forward the planning for a new strategy to cover the next ten years which reflects the changing clinical and commissioning environment. The last items of the current strategy requiring completion are the three disposals at Mount Vernon, Keresforth and Ossett, and progress is updated in the report. Progress on key safety schemes planned in 2019/20 around locks and removal of en suite doors is also updated. The Trust is revisiting its sustainability agenda and this will be reviewed in the year with a revised strategy for Board in December 2019. **Risk Appetite** The Estate Strategy risk appetite is consistent with the levels agreed for service and financial plans.
Recommendation:	**The Trust Board is asked to NOTE the content of the report.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019

Estate Strategy Update

1. Introduction

The Trust's current Estate strategy, which runs to 2022, has seen the modernisation of both the inpatient and community estate with significant investment as detailed in previous updates.

The last major capital spend identified in the strategy was the modernisation of the Fieldhead hospital adult inpatient wards. The last part of this development was handed over in May and is in use.

Another key area of the Estate Strategy was the disposal of underutilised and surplus sites. Whilst a significant amount of capital has been realised by the sales of properties to date (£9.2m), three significant sites are still in the disposal process and updates on these are in the report.

2. Strategy

The Trust agreed a 10 year Estates Strategy in 2012 which had 3 strategic aims: Modernise Inpatient Estate; Develop the Community Infrastructure; and Dispose of Buildings and Land Surplus to Requirements. These key aims have been completed to a large extent with major investments in all our inpatient estate, development of 4 community hubs and disposal of significant redundant estate all of which represent a significant achievement for the Trust.

This does mean that, despite the strategy still having two years to run, it would be appropriate to now consider a new strategy linked to the Trust's 5 year plan. A significant element of the new strategy will be the Trust's commitment to Enviromental Sustainability as well as new local and regional service developments. A working group has been established to start the development of the strategy which will include strong clinical and service involvement and engagement with Service Users and Carers and partner organisations.

During 2018/19, in addition to the Fieldhead non-secure project, an extensive minor capital programme totalling £1.42million across 53 different schemes, varying in nature from replacing old electrical switchgear at Fieldhead to the installation of an exercise wall and interactive activity screen to enhance activities for service users was delivered.

The department is currently overseeing the installation of a nurse call system in wards that don't have this facility, along with some vital safety work around ligature prevention, notably the installation of the new locking suites and improved door handles, the installation of shower curtains to the en-suite toilets and the works to the courtyards at the Priestley unit. These schemes have a combined expenditure of approximately £330k in addition to the Trust agreed minor capital programme.

In addition the Trust does have a sustainability strategy which has focussed on carbon reduction and has been very successful in achieving its aims and in fact has overachieved. It has been agreed with the Chair that the sustainability

strategy should be revisited in this calendar year and it is proposed that a revised document is brought to Board in December 2019. In the interim some key short term deliverables have been agreed around recycling and a reduction in the use of single-use plastic.

3. Disposals

The Trust has successfully divested itself of the majority of the estate that it identified as surplus either through need or condition. Three of the disposals are still in train as follows:-

- Mount Vernon Hospital – The sale is ongoing to a housing developer and contracts have been exchanged with a receipt anticipated in 2019/20.
- Ossett Health Centre – The sale is ongoing to a developer specialising on retirement homes. We are almost at exchange of contract with the developer and a receipt is anticipated in 2019/20.
- Keresforth Site – This disposal is a One Public Estate Disposal and is linked to land owned by Barnsley Council. This scheme is currently earmarked for housing but as yet is not at market due to planning considerations within Barnsley Council. It is anticipated that these will resolved before the end of August 2019 which will allow the disposal to move forward.

4 West Yorkshire and Harrogate (WY&H) and South Yorkshire and Bassetlaw Integrated Care Systems (ICSs)

The Trust are partners within 2 ICSs which cover West Yorkshire and South Yorkshire and have been part of the development of both Estate Strategies. The Trust capital spend is within the WY&H ICS and the Trust has contributed to the achievement of the capital expenditure control total.

The Trust's new Estates Strategy will take account of both ICSs strategies and control totals.

5 Recommendation

The Trust Board is recommended to:

- Note the contents of this report
- Consider bringing forward the renewal of the Estate Strategy

Alan Davis
Director of Human Resources, Organisational Development and Estates

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019
Agenda item 10.1

Title:	**Equality Strategy Annual Progress Report**
Paper prepared by:	Director of Nursing & Quality / Deputy Chief Executive
Purpose:	The report provides a progress update on the delivery of the Trust's Equality Strategy.
Mission/values:	The Equality Strategy sets out our commitment to ensuring that Equality is taken into account in everything we do, supporting the values of our Trust.
Any background papers/ previously considered by:	The Equality & Inclusion Committee (previously Forum) has received updates throughout the year on a number of related papers including the annual update for 17/18, which was received in June 2018. This report was reviewed by the Equality & Inclusion Committee on the 4 June 2019.
Executive summary:	The report provides a progress update against the key objectives highlighted in the Trust's Equality Strategy that was approved in 2017. The report describes progress primarily in qualitative terms and acknowledges that further work is required to improve the quantitative content for future reports. The Equality & Inclusion Committee noted the following key points: ➢ Continued successful involvement and engagement of communities and staff through a number of workshops and events to support transformation of services, including Community Mental Health Services and Older People's Services. ➢ Revised and relaunched the commitment to Family, Friends and Carers and development of a Carers' Charter. ➢ Actively reaching communities who don't engage through traditional approaches, particularly the deaf community with regard to accessing mental health services, and people with learning disabilities with regard to the uptake of annual health checks. ➢ Active promotion of transgender awareness across the Trust. ➢ Service satisfaction reviewed through analysis of feedback from both customer services and patient experience processes ➢ Established four staff networks: BAME, Disability, LGBT+ and a Staff Carers' Network. ➢ Achieving 12.5% above our 80% mandatory training compliance target for 18/19. ➢ Continued successfully meeting our reporting requirements and delivering progress in our EDS2 grading, moving to 'Achieving' status. ➢ Working towards establishing a reciprocal mentoring programme

Recommendation:	**Trust Board is asked to NOTE the progress report and the COMMENTS from the newly established Equality & Inclusion Committee.**
Private session:	Not applicable.

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Equality Strategy Annual Progress Report

2018/19

With **all of us** in mind.

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Purpose of this report

- Highlights the progress on delivery of the Trusts Equality Strategy since approval in 2018.

- The background to the strategy will be considered and progress in achieving the objectives and outcomes will reported.

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Equality strategy

- The equality strategy sets out our commitment to ensuring that equality is taken into account in everything we do. This includes providing services, employing people, involving people in our work and developing policies.

- The strategy is about treating everyone with fairness and understanding, not necessarily treating everyone the same.

- It details how we plan to meet our equality duties (Equality Act 2010) and includes areas of work against the ‘protected characteristics’

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Equality strategy legal requirements

- The Equality Act 2010 is the most significant piece of equality legislation
- It strengthens the law in important ways, tackling discrimination, inequality and making it easier for employers to understand their responsibilities.
- It brings together complex legislation and describes an approach which covers the groups offered protection from unfavourable treatment.

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Equality strategy legal requirements

Nine Protected characteristics are:

1. Age
2. Disability
3. Gender reassignment
4. Marriage and civil partnership
5. Pregnancy and maternity
6. Race
7. Religion and belief
8. Sex
9. Sexual orientation

Carers'

In keeping with Trust values and service offer as an organisation we extend this protection to **Carers'** and provided it with the same importance as the legally supported characteristics.

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Equality strategy delivery

- **The Public Sector Equality Duty** (section 149 of the equality act) places a duty on public bodies to ensure that they consider the needs of all individuals in their day to day work, for example shaping polices or how they deliver services.

- Sets a standard to treat everyone, no matter what background or personal circumstances with **dignity and respect.**

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Equality Delivery System 2 (EDS2)

The purpose of the EDS2 is to help the NHS in discussions with local partners including local people, review and improve equality performance, it also helps assists the Trust in meeting the Public Sector Equality Duty, and includes 18 outcomes grouped into 4 goals between services and staff.

Goals - services:

1. Better health outcomes for all
2. Improved patient access and experience

Goals - NHS staff:

3. Empowered, engaged and included staff
4. Inclusive leadership.

Overall aggregated grade 2018/2019

Achieving

Positives

- Commended the coproduction of Carers Charter
- Staff supporting transgender service users and families

Improvements

- Partnership working in the community to support early access to services
- Increase staff awareness on the protected characteristics and embed the equality strategy

Our latest report which will be presented at the **Equality and inclusion forum in June 2019** (Now a formal committee of the Trust Board)

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Workforce Race Equality Standards (WRES)

- The WRES requires all NHS organisations to demonstrate progress against a number of indicators of workforce equality, including specific indicator to address the low levels of Black Asian Minority Ethnic representation.

- It is a measure to ensure staff from BAME backgrounds have equal access to opportunities and receive fair treatment in the workplace.

- The WRES is one of the measures that the Care Quality Commission will use to assess whether the Trust is well led

WRES results 2018/2019

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Workforce Disability Equality Standards (WDES)

- Has been mandated through NHS standard contract from April 2019.
- The metrics are designed to capture information relating to the experience of disabled staff in the NHS. Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill when compared to non-disabled staff.
- The annual collection of the WDES metrics will allow NHS Trusts and Foundation trusts to better understand and improve the experiences of disabled staff working in the NHS

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Trust equality objectives

1. Promote a fair organisation – better health outcomes for all

2. Promote person centred care and equal access to pathways of care

3. Develop and sustain an equality competent organisation through inclusive leadership and ownership at all levels

4. Continue to improve equality of opportunity for staff and our volunteers

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Key Headlines 2018/19

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There has been progress against the equality strategy objectives and the delivery and outcome.

Progress is described mainly in qualitative terms rather than quantitative.

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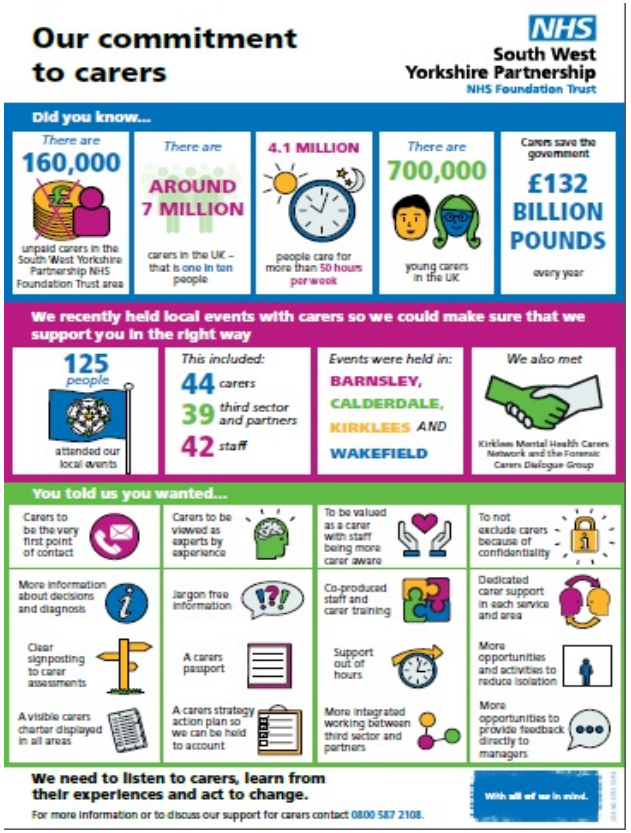
Achievements

- Continue to successfully involve and engage communities and staff, hosting a number of workshops, events to support Transformation of service including Community Mental Health Services/Older peoples services.

- Revised the commitment to Family, Friends and Carers and developed a **Carers' charter**. This was done involving our staff and carers.

- Actively reaching communities that we struggle to engage with through traditional approaches– Deaf community with regard to accessing mental health services, learning disabilities and the uptake of annual health checks.



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Achievements

- Promoting Transgender awareness across the Trust
- We review satisfaction with services through analysis of feedback through customer services and patient experience processes
- Established four staff networks, BAME, Disability, LGBT+ and a Staff Carers Network
- We achieved 12.5% above our 80% mandatory training compliance target which Between1st April 2018 and 31st March 2019.
- We continue to successfully meet reporting requirements and delivered EDS2 with involvement of stakeholders.
- Working towards establishing a reciprocal mentoring programme

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Affecting Change

- **Improving awareness through Training staff,** Delivered Gender identity Training, Transgender Training and how to work with interpreters
- **Creative minds,** working with people with learning disabilities and encourage further activity in the community and were awarded for organisation of the year from Disability Sports Yorkshire
- **Dementia Services,** Culturally sensitive memory cafes to meet the needs of people with dementia from south Asian communities
- **BAME Staff network -** We have a thriving BAME staff Network with approximately 30% of BAME staff are now members with a target to increase this to 40% in 2019. other networks are also establishing including LGBT+, disability and Staff Carers

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Trust Strategy
Delivery and Outcome Measures

Within the strategy the Trust identified seven delivery and outcome measures. The next set of slides will show some of the progress that has been made against each of the measures.

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Outcome 1

All services will have an Equality Impact Assessment (EIA) with annual review and delivery of actions monitored through BDU governance arrangements. All change programmes will be co-produced where appropriate and include equality considerations informed by EIA.

- Services have developed EIA's
- Reviews and action plans need to be regularly monitored through governance groups
- Equality Impact Assessment(EIA's) quick guide is available to support staff
- We use EIA's to see whether our plans, strategies, policies and services affected some communities or groups of people differently and worked to address the impact of that difference

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Outcome 2

We will improve data capture and accuracy of recording in respect of protected characteristics

- Incident data for violence and aggression identifies whether incident is racially or sexually motivated.
- We've developed a **RACE Forward** network to explore racially motivated incidents logged on Datix. Staff are also offered extra support and we have adopted a **Zero tolerance** approach to all incidents related to protected characteristics.
- Apparent suicides data collection has been added to Datix so this captures many of the protected characteristics
- Performance and information have produced dashboards to assist services in monitoring each of the 9 characteristics.
- SystemOne and RiO is available at service level: For Rio the total data collection and although improved from calendar year 2018 to financial year 2018/19 and there are a significant number of unknowns/ data gaps

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Outcome 3

Services will evidence equality considerations in support of Equality Delivery System (EDS2) to demonstrate how driving equality improvements can strengthen accountability to service users and the public

Business delivery units have developed action plans against the equality strategy and these include elements of EDS2

Examples of work include:-

- Production of a range of material for ECT including a DVD, arranging supported visits.
- In patient carers group running at different times and different types of events –coffee evenings
- New carers booklet for in patients (Wakefield)
- Recovery college caring for carers course
- Improved disability access within Wakefield HUBs
- Family Friend Test material updated for CAMHS services and Learning disabilities in easy read format

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- The Trust return for May **2018** was completed for 18/19 of the outcomes. The 18/19 were graded developing –these are linked to workforce requirements, the remaining have not been graded.
- The **2018** return is showing that the Trust is achieving goal 1 and 2

    - Better health outcomes for all -achieving
    - Improved patient access and experience -Achieving
    - Empowered, engaged and included staff –Developing
    - Inclusive leadership –developing

- The 18/19 outcomes completed show an improvement of 2 achieved and 5 developing –these are linked to workforce requirements, the remaining have not been graded.
- This grading has been tested with stakeholder groups.

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There has been numerous examples of services engaging with service users, carers, families and partners during the past year examples include:-

- Perinatal mental health services researching low level access from South Asian communities
- Creating a representative workforce – Apprentice information sessions, reaching out to communities
- Breast Cancer awareness sessions among Learning Disabilities service users
- Review of Community Mental Health Transformation, through focus groups, drop in sessions and surveys.
- Rehab and recovery service modelling review supporting CCG to reach service users and carers.
- Supported various campaigns including LGBT awareness

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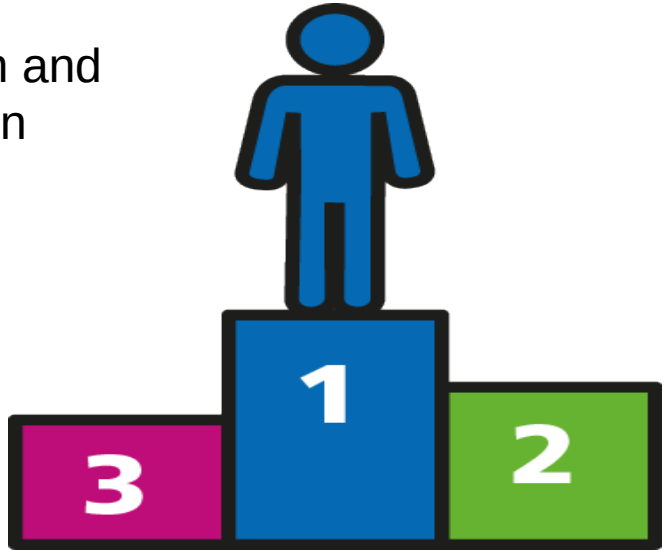
Outcome 4

We will monitor any complaints and reported incident about access to services where discrimination was a factor

- We adopt a person centre approach to complaint handling

- Customer services already monitor and report on these issues and collect information and at time of report it's a nil return



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Outcome 5

An increase in positive stakeholder perceptions via Friends and Family Test and feedback via Customer Services and dedicated surveys

- We review satisfaction with services through analysis of feedback through customer services and patient experience processes

- We helped over 5900 people give their views using the Friends and Family Test by providing survey materials in easy read and child friendly formats. We ask people to share their views about our services using a short postcard or a longer questionnaire

- This has been acknowledged as good practice by the Yorkshire and Humber Equality Leads Network. We also request equality data when people complete the test

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- Friends and family test “How likely are you to recommend services to friends and family if they required similar care or treatment”.

- In 18/19 a total of 7270 responses were received, with 92% recommending Trust services. This is a 36% increase *(17/18 5367 responses/ 18/19 7270 responses)* on the previous year’s returns.

	White British	BAME
2017/18	97%	3%
2018/19*	93%	7%

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Outcome 6

Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.

- Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.
- NHS staff survey feedback will report increased staff satisfaction with equality of opportunity.
- The Trust asked staff their view on progress regarding Goal 3 by means of a confidential survey which asked 3 questions (the survey response rate showed a slight increase on last year)

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Do you feel that all Trust staff have equal access to career opportunities and skill development in the workplace?'

Staff responded:

2019 Response – Yes 52.47% No 34.26% Don't know 13.27% (n = 324)

2018 Response – Yes 48.41% No 35.71% Don't know 15.87 % (n = 252)

Do you feel the Trust has a fair recruitment and selection process?

2019 Response - Yes 66.67% No 14.20% Don't know 19.14% (n = 324)

2018 Response - Yes 68.25% No 11.90% Don't know 19.84% (n = 252)

Do you feel that the Trust deals effectively with harassment and bullying?

2019 Response – Yes 30.86% No 24.38% Don't know 44.75% (n = 324)

2018 Response – Yes 28.17% No 23.41% Don't know 48.41% (n = 252)

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Feedback from the survey included:

"It may be easier for staff who work full time or who are in clinical posts to access training"

Yes, but the process is too lengthy and slow"
"Age did not matter when I applied for a permanent role"

"Due to low staffing levels, development opportunities have been missed in order to keep the service running"

"Higher grades appear to have greater access to diverse training options to develop around their role"

"I have always been fully supported to explore and develop professionally by the Trust"

" I have never been declined opportunities to access training"
"The trust seems to employ people from all walks of life and ethnicity"

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South West Yorkshire Partnership NHS Foundation Trust

Feedback from the survey included:

"I regularly help out at assessment centres so I see this at first hand"

"Policies are in place but not consistently implemented – depends on the line manager"

"As an NHS organisation we do ok, but unsatisfied with the amount of time it takes to resolve issues. Suspect not enough 'difficult conversations' taking place with people with poor behaviour"

"I have never been on this specific situation, although I feel the Trust could be more supportive to staff who are verbally abused by patients"

Yes, problems are looked into and action taken if required"

"I think so but have not had any experienced myself. Freedom to Speak Up guardians seem like a good idea"

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Outcome 7

NHS staff survey feedback will report increased staff satisfaction with equality of opportunity

- Q14 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion, this has remained stable at 86% in 2017 (86% is average compared to similar Trusts)

- Support from immediate managers has improved from 7.0 in 2017 to 7.1 in 2018 (7.1 is below the average of 7.2 and the change from 2017 is not statistically significant)

- Harassment bullying and abuse from service users, carer and the public is above average although between staff is below average.

With **all of us** in mind.

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Conclusion

Overall, the implementation of the equality strategy has resulted in real achievements and we're making steady progress in meeting the outcomes. However, the equality agenda features different portfolios across various services in the Trust and delivery appears fragmented. The remaining year of the strategy will require further strategic alignment and central co-ordination to ensure consistency in equality, diversity, inclusion and engagement across the Trust.

With **all of us** in mind.

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Actions for 2018/19 include

1. Scope equality, diversity, inclusion and engagement activity across the Trust and report to EMT and E&I forum.

2. Finalise Equality strategy action plan for 2019/20.

3. Ensure there are quantitative and qualitative outcome measures for the action plan.

4. Ensure information and resources are easily accessible to services.

With **all of us** in mind.

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South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019
Agenda item 10.2

Title:	**Non-Executive Director membership of Trust Board committees**
Paper prepared by:	Chair of the Board
Purpose:	The purpose of this paper is to seek Board approval for changes to the Non-Executive Director (NED) membership of Board committees.
Mission/values:	Good governance supports the Trust to deliver its vision, mission and strategic objectives.
Any background papers/ previously considered by:	In May 2019, the Trust Board agreed to establish a Finance and Performance Committee, to become operational once a financially-qualified NED had been appointed to the Board. In May 2019, the Board also approved the establishment of a NED-led Finance Oversight Group (FOG) to operate in the interim and appointed Laurence Campbell, Sam Young, Rob Webster and Tim Breedon as members. The Board approved the terms of reference for the FOG in June 2019. Membership of Trust Board committees was last reviewed and changed by the Board in September 2018, following the appointment of two new NEDs.
Executive summary:	1. In May this year, the Board recognised the need to enhance financial governance and agreed to establish a Finance and Performance Committee, once a financially-qualified NED had been appointed. The terms of reference for the proposed Finance and Performance Committee are still to be agreed. 2. In the interim, the Finance Oversight Group was established and has been meeting since 20 June, chaired by the audit committee chair, Laurence Campbell. The terms of reference for the FOG were approved by the Board in June. 3. The Trust is currently running an external recruitment process to appoint a financially-qualified NED, and it is expected that the Nominations' Committee will be making a recommendation to the governors at the Members' Council meeting on 2 August. The appointment of a new NED and the establishment of a new Board committee will require changes to be made to the NED membership of Board committees. 4. **Subject to the appointment of a financially-qualified NED being approved by the Members' Council**, the Board is asked to approve the following changes, the outcome of which will be that all NEDs will be chairing a committee:

	<u>Audit Committee</u> • Add the new NED • Remove Erfana Mahmood <u>Equality and Inclusion Committee</u> • Add the new NED • Remove Sam Young <u>Finance and Performance Committee</u> • Add the new NED as Chair • Add Kate Quail as a member • Remove Laurence Campbell <u>Charitable Funds Committee*</u> • Add Erfana Mahmood as Chair • Remove Kate Quail • Charlotte Dyson remains on the committee as a member rather than Chair. **Note, the Charitable Funds Committee is a committee of the Corporate Trustee who will be asked to ratify the changes following the Trust Board meeting.* A summary of the changes (shown in red) and proposed membership from 2 August 2019 is attached.
Recommendation:	**Trust Board is asked to APPROVE the changes to the committees as detailed in section 4 above, subject to the appointment of a financially-qualified NED being approved by the Members' Council.**
Private session:	Not applicable.

Trust Board and Corporate Trustee* committee membership (proposed as from 2 August 2019)

South West Yorkshire Partnership NHS Foundation Trust

	Audit Committee	Clinical Governance & Clinical Safety Committee	Mental Health Act Committee	Workforce & Remuneration Committee	WYMHSC Committee in Common	Equality & Inclusion Committee	Finance Oversight Group / Finance and Performance Committee	Charitable Funds Committee* (*committee of the Corporate Trustee)
Laurence Campbell	**Chair**	-	Member	-	-	-	~~Chair~~	-
Charlotte Dyson	-	**Chair**	-	Member	-	-	-	~~Chair~~ Member
Angela Monaghan	-	Member	-	Member	Member	**Chair**	-	Member
Kate Quail	-	Member	**Chair**	-	-	-	Member	~~Member~~
Erfana Mahmood	~~Member~~		Member		-	Member	-	**Chair**
Samantha Young	Member			Chair	-	~~Member~~	Member	
New NED	Member					Member	**Chair**	
Rob Webster	-	-	-	Member (NV)	Member **(LD)**	Member	Member **(LD)**	-
Dr Subha Thiyagesh	-	Member	Member **(LD)**	-	-	Attends	Attends	-
Tim Breedon	-	Member **(LD)**	Member	-	-	Member **(LD)**	Member	Member
Mark Brooks	Attends **(LD)**	-	-	-	-	-	Attends	-
Alan Davis	-	Member	-	Attends **(LD)**	-	Member	Attends	-
Emma Jones	Attends	-	-	-	-	-	-	-
Carol Harris	-	Attends	Attends	-	-	-	Attends	-
Sean Rayner	-	Attends	-	-	-	Member	Attends	-
Salma Yasmeen	-	-	Member	-	-	-	Attends	Member **(LD)**

Non-Executive Director (NED)
Executive Director
Other Director
Company Secretary
LD Lead Director
NV Non-voting committee member

Members' Council Group membership and attendance

South West Yorkshire Partnership NHS Foundation Trust

	Members' Council	Members' Council Coordination Group	Members' Council Quality Group	Nominations' Committee
Laurence Campbell	Attends	-	-	-
Charlotte Dyson	Attends	Attends	Attends	-
Angela Monaghan	**Chair**	Attends	-	**Chair**
Kate Quail	Attends	-	-	-
Erfana Mahmood	Attends	-	-	-
Samantha Young	Attends	-	-	-
Rob Webster	Attends	-	-	Attends
Dr Subha Thiyagesh	Attends	-	-	-
Tim Breedon	Attends	-	**Chair**	-
Mark Brooks	Attends	-	-	-
Alan Davis	Attends	-	-	Attends
Emma Jones	Attends	Attends	-	Attends
Carol Harris	Attends	-	-	-
Sean Rayner	Attends	-	-	-
Salma Yasmeen	Attends	-	-	-

Non-Executive Director (NED)
Executive Director
Other Director
Company Secretary
LD Lead Director
NV Non-voting committee member

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019
Agenda item 10.3

Title:	**Five Year Plan**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide the Trust Board with an update of the requirements for developing and submitting a five year plan.
Mission/values:	Use of resources
Any background papers/ previously considered by:	The 2019/20 operating plan was approved by the Trust Board and the Board received regular updates regarding its development.
Executive summary:	➢ Each integrated care system (ICS) is required to develop and submit a five year plan. This will highlight how the NHS 10 year plan will be implemented ➢ Each plan will need to provide a system narrative and system delivery plan ➢ Whilst the Trust's finances are fully captured in the West Yorkshire & Harrogate ICS it will be required to contribute to the South Yorkshire & Bassetlaw plan as well ➢ Each Trust needs to submit its own plan having worked with partners in each place and provider plans need to be aligned with commissioner plans. ➢ Guidance has been provided and further guidance is expected ➢ The final ICS plans need submitting in November, but there is a draft submission required by 27 September. The ICS has asked for initial draft schedules to be completed by 23 August. ➢ An internal team will work on the Trust plan and a milestone plan is being developed. Annual leave commitments are high in August **Risk appetite** In line with the Trust risk appetite statement which aims for financial risk of 4-6. Any implications on clinical risk must also be taken into account.
Recommendation:	**Trust Board is asked to:** ➢ **DISCUSS and COMMENT on this paper; and** ➢ **CONSIDER how it wishes to be kept informed of and be able to engage with the development of the five year plan and what governance needs to be in place to enable appropriate approvals to take place at each stage of submission.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019

Five Year Plan Requirements and Timescales

Introduction

As previously reported each integrated care system (ICS) is required to generate a five year plan which will highlight how the NHS 10 year plan will be implemented. This plan will need to include:

A system narrative **-** to describe how the required transformation activities will be delivered to enable the necessary improvements for patients and communities as set out in the Long Term Plan (LTP).

A system delivery plan **-** to set the aggregate plan for delivery of finance, workforce and activity, and setting the basis for the 2020/21 operational plans for providers and CCGs. The system delivery plan will also cover the LTP 'Foundational Commitments'.

It is worth reminding board members that the Trust's finances are entirely captured by the West Yorkshire & Harrogate ICS, but given service provision in South Yorkshire it will need to feed into both ICS submissions in various ways.

Guidance and timescales

Guidance has been issued and initial templates have been provided. The timeframes for submission are identified in the table below:

Milestone	Date
Publication of the Long Term Plan Implementation Framework	June 27th
Main technical and supporting guidance issued	July 26th
CCGs and trusts submit first draft strategic planning tool templates	August 23rd
WY&H and place level aggregations of strategic planning tool	August 28th
WY&H Partnership Board to consider draft system delivery plan narrative	September 3rd
WY&H programme teams and sector groups to review strategic planning tool submissions and provide feedback to place leads	September 6th
CCGs and Trusts submit second draft strategic planning tool templates	September 16th
WY&H and place level aggregations of strategic planning tool	September 18th
System Oversight Assurance Group to sign off draft system plan submission	September 23rd
Initial WY&H system plan submission	September 27th
Regional assurance of initial WY&H system plan submissions	During October
CCGs and Trusts submit final strategic planning tool templates	November 1st
WY&H System Leadership Executive to sign off system plan	November 5th
System plans agreed with system leads and regional teams	November 15th
Further operational and technical guidance for operational planning issued	December
Publication of the national implementation programme for the Long Term Plan	December

The process will require the Trust to work with partners in each place and also to complete the planning schedules as a Trust. Within the guidance notes there are some key points of interest for Trust Board members which can be summarised as follows:

- The strategic planning tool builds up the system view by organisation.
- Strategic plans will ask for organisation level data, although at a higher level than operational plans.
- NHS England and Improvement will work with each system to agree what a realistic and stretching bottom line position is in each year.
- Financial recovery plans, consistent with the local system plan, will be required for each provider organisation and CCG not in financial balance.
- The information in the tool will need to be provided annually through to 2023/24. Sections include income and expenditure, capital, activity and workforce.
- The final version of the tool will include sections on efficiency and financial sustainability.

Guidance on the sections in the tool include the following:

Finance – will include reciprocal lines for commissioner expenditure and provider expenditure within a system. Further guidance to be provided.

Assumptions – national planning assumptions have been provided as part of the guidance

Efficiency & Financial Sustainability – will need to provide detail on actions systems and organisations are taking to remain/move towards financial sustainability. Such plans need to be both robust and stretching.

Capital – all system capital plans need to reflect a realistic position that has been carefully reviewed by each system leadership team.

Workforce – will need a breakdown by 13 staff groups and take account of new care models, new ways of working and improvements in productivity. They need to be affordable within financial plans and consistent with realistic improvements in recruitment and retention.

Activity – need to align between commissioners and providers.

Process and Governance

The Trust does not have a dedicated planning lead. For the most recent plans this role has effectively been carried out by the Director of Finance. The Head of Business Development has been asked to carry out this role for the foreseeable future and will lead the development of the 5 year plan from the Trust's perspective. As can be seen above the timescales for submission are considered to be very challenging with draft completed schedules due to be submitted to the West Yorkshire & Harrogate ICS by 23 August and a second draft by 16 September. The development of the first draft will take place during a period of high annual leave including key staff involved in the generation of the plan. Whilst the final submission is not due until November the draft submissions clearly need to be of a good standard to ensure they are meaningful and enable appropriate review and challenge. The various submission dates between now and September take place before any Trust Board meetings

(the Trust Board for September takes place on 24th, but practically the ICS will need to have approved the draft plan submission before that date).

In order to achieve what is being asked of us a milestone plan will be developed to determine how internally the requirements can be achieved.

Trust Board needs to consider how it wishes to be kept informed of and be able to engage with the development of the five year plan and what governance needs to be in place to enable appropriate approvals to take place at each stage of submission.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019

Agenda item 11 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Next meeting scheduled for 8 October 2019 (last update from meeting 4 June 2019)
Member	Chief Executive / Director of Strategy
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	Next meeting scheduled for 8 August 2019 (last update from meeting 20 June 2019)
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	➢ To be confirmed.
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=27416

Kirklees Health and Wellbeing Board

Date	25 July 2019
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	➢ Mid Yorkshire Hospital Trust Transforming for Excellence ➢ Financial position of the Kirklees Health and Adult Social Care Economy
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	18 July 2019
Member	Chief Executive / Director of Provider Development
Items discussed	➢ Employment for people with a learning disability ➢ West Yorkshire and Harrogate Health and Care Partnership 5 Year Strategy ➢ Draft Outcomes Framework ➢ Primary Care Strategy
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	12 July 2019
Member	Chief Executive
Items discussed	➢ ICS System Leader update ➢ Prevention Work Stream Update ➢ Priorities of Joint Working for Local Authorities ➢ Developing SYB ICS 5 Year Long Term Plan ➢ ICS Finance update ➢ ICS Highlight Report
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 July 2019
Member	Chief Executive
Items discussed	➢ Programme updates ➢ Review of System Performance and Delivery ➢ Wider system risks and issues
Further information:	Further information about the work of the System Oversight and Assurance Group is available at: https://www.wyhpartnership.co.uk/blog

West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive

Date	4 July 2019
Member	Chief Executive
Items discussed	➢ Update on the WY&H Finance Strategy ➢ Financial sustainability in Harrogate and Rural District ➢ Developing collective leadership for Innovation & Improvement
Further information:	Further information about the work of the System Oversight and Assurance Group is available at: https://www.wyhpartnership.co.uk/blog

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 30 July 2019

Agenda item 12 – Assurance from Trust Board committees

Audit Committee

Date	9 July 2019
Presented by	Laurence Campbell, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ Resource constraints could prevent vital project activity. ➢ Propose exercise to test whether identified actions reduce organisational level risks to projected target level. ➢ Is there a new organisational level risk needed regarding partnership working. ➢ Outstanding actions arising from partial assurance internal audit of Complaints. ➢ Charity Accounts - how do we fully demonstrate social value created ➢ Head of Internal Audit Opinion - importance of hitting original dates, currently only 66% against a minimum of 75%. ➢ Partial assurance on part of Compliance with Legislation internal audit - ownership of new legislation issue. ➢ Increase in potential fraud reporting.
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 9 April 2019 and 21 May 2019 (attached).

Nominations Committee

Date	15 July 2019 and 26 July 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Non-Executive Director appointment process. ➢ Update on Non-Executive Director recruitment. ➢ Recommendation to Members' Council on Chair and Non-Executive Director remuneration process and timescales. ➢ Recommendation to Members' Council on Lead Governor appointment.
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 3 June 2019 (attached) and 15 July 2019 (to follow)

Workforce & Remuneration Committee

Date	22 July 2019
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	➢ NHS Staff Survey Action Plans and Engage and Listen Events - Key messages ➢ Workforce Strategy Action Plan 2019/2020 - Reviewed and aligned against NHS People Plan. ➢ Organisational Development Strategy 2019/20211 - Reviewed and aligned against NHS People Plan ➢ Strategic Workforce Plan 2019/2020 - Reviewed and aligned against NHS People Plan ➢ NHSI: Learning Lessons – Identified where there are differences and reviewed
Approved Minutes of previous meeting/s for receiving	➢ Minutes of the Committee meeting held on 7 May 2019 (to follow).

West Yorkshire Mental Health Collaborative Committees in Common

Date	28 June 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	➢ Chair's report from the Committee meeting held on 28 June 2018 (attached).
Approved Minutes of previous meeting/s for receiving	➢ Chair's report from the Committee meeting held on 28 June 2018 (attached).

Minutes of the Audit Committee held on 9 April 2019

Present:	Laurence Campbell	Non-Executive Director (Chair of the Committee)
	Sam Young	Non-Executive Director
	Erfana Mahmood	Non-Executive Director
Apologies:	Members	
	Nil	
	Other	
	Charlotte Dyson	Non-Executive Director
In attendance:	Rob Adamson	Deputy Director of Finance
	Tim Breedon	Director of Nursing and Quality [item 10 & 17]
	Mark Brooks	Director of Finance (lead Director)
	Tony Cooper	Head of Procurement
	Alan Davis	Director of HR, OD & Estates [item 10]
	Leanne Hawkes	Deputy Director, 360 Assurance
	Caroline Jamieson	Assistant Director, Deloitte
	Emma Jones	Company Secretary
	Angela Monaghan	Chair [item 10]
	Kate Quail	Non Executive Director [item 10]
	Olivia Townend	Assistant Anti-Crime Manager, Audit Yorkshire
	Subha Thiyagesh	Medical Director [item 10]
	Salma Yasmeen	Director of Strategy [item 8 & 22]
	Jane Wilson	PA to the Director of Finance (author)

AC/19/27 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. No apologies were received.

AC/19/28 Declaration of interests (agenda item 2)

There were no further declarations over and above those made in the annual return to Trust Board in March 2019 or subsequently.

AC/19/29 Minutes from the meeting held on 8 January 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meetings held on 8 January 2019 as a true and accurate record.

AC/19/30 Matters arising from the meeting held on 8 January 2019 (agenda item 4)

Action log

The action log was noted.

AC/19/31 Consideration of items from the organisational risk register relevant to the remit of the Audit Committee (agenda item 5)

MB reported that the paper included risks from the Organisational/Corporate Risk Register (ORR) that had been allocated to the Audit Committee, with a summary on any changes since the Audit Committee meeting on 8 January 2019. All risks from the trust-wide ORR graded 15 and above were reported to the Trust Board on 29 January 2019. There was one risk with a score of 15 or above assessed as relevant to the work of the Audit Committee and currently exceeding the risk appetite of the Trust.

MB reminded members and attendees that a cyclical approach is taken to reviewing risks at EMT with the risks associated with a Trust objective the subject of focus and scrutiny at one EMT meeting each quarter. EJ explained that the ORR has been taken to Board and the Committee meeting is an opportunity to scrutinise risks in greater depth.

In relation to risk 1213 (SystmOne implementation) LC asked if it was too early to close the risk. MB stated it was discussed at EMT on 4 April and agreed it would remain a risk. Following further discussion in the meeting it was agreed SYa would review the existing risk and rearticulate the wording, controls and actions. In relation to risk 1217 (capacity for change) LC asked if this was in line with the risk appetite. MB stated this was also being reviewed in light of the priorities being established for 2019/20. It was agreed risk 1362 falsified medicines directive) would be removed from the risk register.

Sam Young (SYo) stated it was clear to see that lots of work had taken place closing off actions and wondered how easy it was to identify the difference each action was making in reducing risk. MB felt that in effect there are two types of risk. There are those that are time limited such as SystmOne implementation where the effect of actions taken is clearly visible and there are a number of risks which by their nature will be long-standing risks. In some cases in the latter the actions being taken enable the risk scoring to be held at the same level and not deteriorate e.g. identification of cost improvement projects (CIPs). MB also noted that the work carried out on cyber has been very comprehensive and beneficial, although the risk score remains unchanged.

LC questioned why a risk score could be lower than the risk appetite. MB said he would look into the detail, but assumed it was because the risk appetite is within a range as agreed by the risk appetite statement and the actions taken have resulted in a lower likelihood of the risk occurring. He also felt it was good to have actions in place which could reduce the scoring to a low a value as possible.

MB noted that with regard to the risks for Audit Committee's review, the issue of tendering of services has not yet gone away. He did note that in some cases there is a growing requirement for business cases within new models of care as opposed to tenders.

MB also highlighted that since this version of the ORR was produced 2019/20 contract negotiations have been largely completed and the Trust has now agreed its financial control total. The issues with the Trust's financial position have been well documented at Trust Board. One key risk is the fact the Trust is not where it needs to be in respect of identifying and delivering recurrent CIPs.

ACTION: Mark Brooks/Emma Jones

It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee.

AC/19/32 Triangulation of risk performance and governance report (agenda item 6)

EJ confirmed the report was based on the Risk Register and Board Assurance Framework (BAF) documents that were submitted to Trust Board on 29 January 2018, also the Month 11 Integrated Performance Report (IPR). LC asked if there were any issues in the BAF that were not included in the organisation risk register. EJ stated there were not. MB stated the process had been well developed and was working very well.

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.

AC/19/33 Cyber risk update (agenda item 7)

Cyber security has become an area of intense focus and scrutiny particularly since the widely publicised WannaCry Ransomware cyber-attack that took place in May 2017. MB stated that this remains subject to intense focus and scrutiny, confirming there were a number of planned activities for 2019/20 to further enhance the Trust's security. Examples of these activities are;

- New guidance would be issued around complexity of passwords
- Advance threat protection around Windows 10
- Working towards Cyber Essentials certification
- Completion of the second year of the three year capital investment plan
- Annual penetration testing
- NHS IT health check

LC stated that the agenda seemed to have been taken very seriously. MB commented that this is very much the case and the Trust cannot afford to be complacent on this matter as there are regular cyber security threats. SYo stated that it was a very good solid report and asked if Windows 10 was on track. MB advised this was due to be complete by January 2020.

It was RESOLVED to NOTE the update

AC/19/34 Delivering service change (agenda item 8)

Salma Yasmeen (SYa) confirmed that the Trust had an agreed set of strategic priorities for 2018/19 and that these were refreshed annually. The approach to supporting and delivering change is fully implemented and can be evidenced through the implementation of the Clinical Record System (CRS) programme and post implementation reviews for previous transformations that have now been completed. SYa provided an update to the Committee on the documents that would be considered at the gateways in the integrated change framework, and also gave an indication of the scheduling of when gateways occur in the change process.

LC commented that he struggled with the terminology and asked SYa to outline the different phases e.g. co-create, co-design etc. SYa explained the various phases in more detail. MB asked if this report closed this particular action off and did it need to come back to Audit Committee. LC confirmed that as it was a follow up to a previous internal audit recommendation this particular issue did not need to come back to the Audit Committee and can be removed from the work plan. SYa confirmed that post implementation reviews are taken to the Clinical Governance and Clinical Safety Committee meeting.

ACTION: Jane Wilson to remove from the annual work plan

It was RESOLVED to RECEIVE the report

AC/19/35 Review of annual accounts progress (agenda item 9)

Rob Adamson (RA) advised the Committee that the timetable for the 2018/19 financial year-end and associated review, approval and reporting requirements remained the same as in previous years and that timescales remained the same. He advised that there had been good progress to date.

The Audit Committee are required to review the annual accounts, annual report and quality accounts and make a recommendation to the Trust Board for approval of the accounts. This Audit Committee meeting is scheduled to take place on 21 May 2019. This will be followed by ratification at the Trust Board on 23 May 2019.

The Committee agreed that when draft documents become available that the annual report would be shared with the whole committee and the annual accounts would be forwarded to LC. EJ to forward the draft annual report to Audit Committee members. MB to forward the draft annual accounts to LC for review.

ACTION: Mark Brooks/Emma Jones

It was RESOLVED to NOTE the update

AC/19/36 Review other Committees' effectiveness and integration for annual report to Trust Board (agenda item 10)

Audit Committee
Chair – Laurence Campbell; Lead Director – Mark Brooks

- Self-assessment:
- Succession – raised on page 11 as an issue, take forward and put on outstanding items.
- Page 58 Workload imbalance CGCG and MHAC
- Annual Report - 3.3 it is now NHS counter fraud authority
- Page 1 delivering service change – leave April in, take October off
- Review other committees effectiveness in annual report
- LC assured by all other committees reports
- AM – do we need to increase financial oversight by means of a Finance Committee in the light of the sustainability challenge?

Clinical Governance and Clinical Safety Committee
Chair – Charlotte Dyson; Lead Director – Tim Breedon

Key areas highlighted for 2018/19 are:

- Minor changes to ToR following Internal audit
- Review of updated learning from healthcare deaths policy
- Oversee the development of the Quality account
- Review of the risks allocated to the committee
- Any typographical errors to be emailed to EJ
- It was identified that there may need to be some changes to the work plan so as to fit in with the sequencing of Board meetings and requirements. LC queried whether the committee really operated differently to other Board committees as other committees also

focus on key risks when setting work plans and agendas. KQ felt the report was very helpful. AM suggested it may be an opportunity to review frequency of meetings

Mental Health Act Committee
Chair – Kate Quail; Lead Director – Dr Subha Thiyagesh

Key areas highlighted for 2018/19 are:

- Received significant assurance from internal audit last year
- Discussing looking at including specific MHA risks into the organisational risk register
- Introduce one page tracker of CQC recommendations, specifically focus on age of actions
- Terms of Reference met all its requirements, minor amendments made
- Work plan approved following minor amendments
- Strengthened cross membership. KQ attends CG&CS agenda setting. Yvonne French also now attends CG&CS.

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 are:

- No major issues
- Committee met Terms of Reference
  - No specific actions
- Approved work programme for next year
  Any typographical errors to be sent to EJ
- AM felt it was a positive move with the new name and terms of reference of the committee. LC agreed with this.
- Freedom to Speak Up Guardians (FSUG) – EM asked if this committee was the right place for receiving any reports relating to this role. It was agreed that the prime committee for such reports is the Clinical Governance & Clinical Safety Committee. It was explained by AD that it very much depends on what the issue raised is. Some other issues may need to be covered by the WRC and others by the Audit Committee.

Equality and Inclusion Forum
Chair – Angela Monaghan; Lead Director – Tim Breedon

Key areas highlighted for 2018/19 are:

- First time this report brought into process
- Brought more in line with rest of committees
- Met all requirements for TOR this year, suggested changes to ToR.
- Decision for Board to bring to Committee status rather than Forum
- MB noted that attendance has been lower at this meeting than the committee meetings. AM stated attendance would be helped by changing from forum to a Committee.
- LC asked about the balance of non-executives on committees to executive directors should there need to be a vote. This will be raised as an issue to discuss at Trust Board.

It was RESOLVED to:

- **RECEIVE the annual reports from the committees and forum for 2018/19 to provide assurance to the Trust Board in terms of the effectiveness and integration of risk committees and that risk is effectively managed and mitigated through:**
  - **committees meeting the requirements of their Terms of Reference;**
  - **committee work programmes 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 Audit Committee annual report for 2018/19, work programme for 2019/20, and updated terms of reference.**

AC/19/37 Approval of 2019/20 internal audit plan (agenda item 11)

Leanne Hawkes (LH) 360 Assurance stated there was a robust process in place, and that the plan was flexible so things could be added. Erfana Mahmood (EM) raised the question of where financial sustainability sat. MB stated his preferred approach is for a finance committee be set up comprising of non-executives and executive directors. It was agreed this would require Board approval.

LH emphasised section A2.2 which highlights the risks in the assurance framework not covered by reviews in the 19/20 plan. LH stated that benefits realisation from the clinical record system has been discussed with MB. MB explained that the Trust will be completing a post implementation review at a suitable point as part of its standard processes. If there is a requirement for an internal audit at any stage this will be assessed following the Trust's post implementation review.

LC noted that an additional strategic objective will be added for 2019/20. LH explained that this report had been written prior to the Trust confirming 19/20 objectives and would be updated.

LC asked if the dates stated in the plans are correct. LH stated this was indicative and the exact timings would be agreed in the coming weeks.

It was RESOLVED to APPROVE the internal audit plan 2019/20.

AC/19/38 Counter fraud draft annual plan (agenda item 12)

Olivia Townend (OT), Audit Yorkshire explained that the process for approving the annual Counter Fraud plan means it will be available for the May Audit Committee meeting. A meeting has been arranged for OT to meet with MB on 18 April to discuss the draft plan. It was agreed that a fully completed draft plan would then be brought back to the Audit Committee meeting on 21 May 2019 for approval.

ACTION: Olivia Townend

It was RESOLVED to NOTE the update

AC/19/39 Scheme of delegation (agenda item 13)

MB presented an update to the Audit Committee and confirmed a full Scheme of delegation (SoD) report had been circulated to the Committee with the recommended changes based on any improvements identified, clarification of roles and general updates highlighted using track changes. Where appropriate, explanatory comments had been provided to explain the rationale. MB explained the most notable changes are:

- Recognising the role of the Members' Council in approving Chair and non-executive appointments.
- Adding Board approval into final asset disposals.
- Amending approval limits for requisitions, purchase orders and invoices.
- Updates for strategy approvals.

MB informed the Committee the updated document had been through EMT and OMG. The Committee was asked to review the proposed changes and comment accordingly, this would then require Board and Members' Council approval.

LC asked what the definition of a senior manager was in respect of appointments and dismissals reserved to the Board. MB felt this should be removed and left as Chief Executive and Director.

SYo asked if there needed to be any mention of the Freedom to Speak Up Guardian role. After discussion it was agreed there was nothing specific to the Scheme of Delegation to be included for this role.

LC will forward any typos in the paper to EJ and MB for updating.

ACTION: Mark Brooks

It was RESOLVED to AGREE the proposed changes to the Scheme of delegation

AC/19/40 Declaration of interests for staff (agenda item 14)

EJ presented a brief update to the Audit Committee on 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 current staff conflicts that present a risk to the Trust.

In February 2019, the EMT reviewed the list of 'decision making staff' and agreed those that should be published in accordance with the guidance. From the 139 staff identified in addition to Trust Board members, the declarations received to date for 57 of these staff were published on the Trust website on 29 March 2019. EJ confirmed that direct reminders had been sent to the remaining staff regarding their requirement to declare any interests.

LC raised the question if this could be merged with fraud communication. MB thought this was something that could be looked into in the future. In the short term he emphasised the need to get as many declarations completed and published as possible.

It was RESOLVED to NOTE the processes in place in relation to declarations of interest and be ASSURED that the Trust is meeting the requirements of the NHS England guidance and there are no current staff conflicts that present a risk to the Trust.

AC/19/41 GDPR update (agenda item 15)

MB presented the General Data Protection Regulations (GDPR) update to the Committee and confirmed that all relevant policies had been updated for GDPR in 2018, and that the annual review of these policies is currently taking place. The overall conclusion based on the processes put in place and the maintenance audits is that the Trust is compliant with GDPR subject to those areas where additional guidance may result in further work as required. MB confirmed a review of compliance with GDPR would form part of the 19/20 internal audit programme.

It was RESOLVED to NOTE the update

AC/19/42 Information Governance deep dive report (agenda item 16)

A deep dive report into Information Governance (IG) confidentiality breaches was provided to the Committee. MB stated the Trust took its information governance responsibilities very seriously and confirmed that regular update reports were provided at the Operational Management Group (OMG) and Improving Clinical Information Group (ICIG) meetings, along with regular updates to the Executive Management Team (EMT) meeting. He also noted that the number of incidents reportable to the Information Commissioner's Office had reduced, but there is a persistent number of confidentiality breaches each month numbering 10 to 15. MB stated there had been consistent and regular trust-wide communication on the importance of strong information governance and confirmed a refreshed communications plan is being developed. This will include anonymised incidents highlighting the impact on people. A recent addition is that individual letters are being sent to general managers with respect to confidentiality breaches in their own areas asking for details on remedial actions being put in place. MB stated that in his view a zero tolerance approach was not a good idea as it would likely lead to individuals no longer feeling confident and safe to report issues. He commented he would much rather the Trust have a culture of openness and learning, adding that the Trust do need to acknowledge that mistakes happen and also be prepared to use disciplinary procedures where required. MB stated there had been a genuine issue on resource in the IG team again, with SystmOne being the main focus, but he did expect this to be only temporary.

LC noted that a number of the incidents would have benefited from having a colleague checking the work. MB stated that some of the remedial actions identified this as a measure. SYo agreed that incidents represented an opportunity to look at how things are done, particularly when staff who are very busy look at doing things in the quickest way.

It was RESOLVED to NOTE the work that has been undertaken in this report

AC/19/43 Update on internal audit on complaints (agenda item 17)

TB provided an update to the Committee in relation to the internal audit report and action plan that took place in November 2018. TB confirmed the report acknowledged progress had been made within the service and that in response to the recommendations a management response had been developed and was being implemented. A recovery plan was currently in place to ensure the team operates efficiently whilst also being mindful of staff health and well-being needs. A senior manager had been identified to focus on executing the customer service recovery plan to enable a rapid turn-around of the processes within 4-6 months. Also a quality improvement approach was being used within the team to enable sustainable change. He did highlight that a number of issues in terms of recording, which has been rectified and developments have been made with regard to the use of the Datix system. Leanne Hawkes (LH) confirmed she would write a brief report on the current position and forward to TB. TB to attend Audit Committee meeting on 9 July 2019.

It was RESOLVED to NOTE the improvements being made with our customer service offer.

ACTION: Tim Breedon/Jane Wilson

AC/19/44 Risk management strategy (agenda item 18)

The Risk Management strategy was approved by the Trust Board in January 2017 and is now due for review. MB confirmed there are limited updates and those made reflect changes in the operating environment. An assessment has been made to ensure it is fit for purpose for a further

three years and against best practice. He reported that amendments included 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 had also been updated and reviewed by EMT for final approval by the Director of Finance as the lead Director. It was asked to be noted that the Committee appreciated the work that had gone in to the Risk Management strategy and agreed it is a very good document.

It was RESOLVED to SUPPORT the APPROVE the update to the Risk Management Strategy by the Trust Board in April 2019.

AC/19/45 Draft annual governance statement (agenda item 19)

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. MB confirmed that it is a draft statement with elements of the wording only available on completion of the year-end. The report enabled Audit Committee members to have an early oversight of the AGS and provide any feedback. MB commented that much is based on last year's report and national guidance. The draft will also go to the Board meeting on 30 April 2019, and be audited by Deloitte. The final document will be approved at the May Trust Board meeting. It was agreed that any comments should be fed through to MB and EJ no later than Friday 11 April 2019.

It was RESOLVED to NOTE the draft annual governance statement.

ACTION: All

AC/19/46 Patient level costing 2020/21 (agenda item 20)

A document on mandating patient level costing from 2019/20 within the mental health sector was published in November 2018 by NHS Improvement. RA confirmed the outcome of the consultation was, for the financial year 2019/20 onwards, it would be mandatory for NHS providers of mental health services to record and report costs at a patient level for mental health activity in line with the Healthcare Costing Standards for England. RA informed the Committee that the use of patient level costing would replace the reference cost submission. RA stated there were clear benefits to having more granular patient level costing information particularly in terms of how our monies are being spent and understanding impact of clinical variation. RA stated to implement fully it would require significant time and resource along with strong and engaged clinical leadership. A more detailed plan is required, RA agreed to work with Subha Thiyagesh (ST) on the medical leadership required to effectively implement. MB stated he has discussed this with other West Yorkshire Finance Directors and there is agreement for the cost accountants across the patch to work together on potential solutions and to share good practice.

ACTION: Rob Adamson

It was RESOLVED to NOTE this report

AC/19/47 Procurement report (agenda item 21)

TC presented the procurement update. Eighteen major contracts were let with a value of £1m including the renewal of the Trust's Allocate eRostering system, the IAPT clinical information system and three pieces of work undertaken within forensic services. Five major contracts are currently in progress including the provision of taxi services, the supply and support of an accounts payable/purchase order system and the supply and installation of a nurse call system. A total of £105k CIP (Cost Improvement Plan) savings with a further £163k cost avoidance

savings have been recorded and achieved in 2018-19. It was confirmed 78 Service Line Agreements (SLAs) 62 have currently been signed, with 11 in negotiation, and 4 at the sign off stage with 1 on hold.

TC highlighted an issue with the direct engagement contract the Trust holds with PlusUs. VAT is now being charged on that contract and the supplier is close to agreeing a revised approach with HMRC.

TC reported that the CIP target for 2019/20 was £200k recurrent savings and £100k cost avoidance.

TC to bring a paper on VAT back to meeting on 9 July 2019.

ACTION: Tony Cooper

It was RESOLVED to NOTE the Procurement Report

AC/19/48 SystmOne implementation risks and milestone (agenda item 22)

SYa confirmed the CRS programme successfully went live as planned on the 25 February 2019 for inpatients and for the remaining services on 5 March 2019. 95% staff now trained to use the system. The main issue was around period of slowness, which has now been resolved. No further slowness in system that has been reported. SYa stated there had been 2 key issues that related to end user acceptance and optimisation that have now been completed, these included the medical care plan and pharmacy e-discharge. SYa commented that each phase of the implementation programme consisted of key milestones which had to be met to enable the implementation to proceed. SYa stated that all recommended actions following the second internal audit undertaken by 360 Assurance had been actioned and reported as required. LC expressed his congratulations on the effort to enable the go-live to proceed in a successful manner.

SYa went on to state that system optimisation would proceed following a short period of stabilisation to enable staff to get used to operating the new system. Optimisation will again be treated as a transformation programme and the existing steering group will be maintained to oversee this period of system optimisation. Another key milestone is to complete the data catch up before the end of June to ensure this is finished before RiO becomes inaccessible.

SYo asked if the data catch up was on track. SYa stated that the learning disability service has already input all outstanding information. MB stated that as of 4 April the estimated catch up completion was circa 20%.

MB explained that one issue to be aware of and place focus on in the coming weeks and months is that of data quality as we will be reporting internally, to regulators and commissioners and need to ensure we understand the data reported and that it is complete. LH stated this will be a consideration in the internal audit plan for 2019/20.

It was RESOLVED to NOTE the report

AC/19/49 Treasury management (agenda item 23)

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 £161k (April 2018 to March 2019). The total received for 2017/18 was £65k.

It was RESOLVED to RECEIVE the update.

AC/19/50 Internal audit (agenda item 24)

LH presented the progress report. There have been four reports issued since the last Audit Committee meeting:

- New Clinical Records System (SystmOne): Phase Two Review - Significant/Limited Assurance
- Key Financial Systems, Payroll – Significant Assurance
- Data Quality Framework – Significant Assurance
- Data Security & Protection Toolkit – Significant Assurance

360 Assurance continue to develop the online audit recommendation tracking tool with the Trust. The current rate of implementation is at 92%. LH stated there had been lots of good work from EJ and Aimee Gray (AG) in ensuring recommended actions were progressed.

LC stated he thought that completion dates were not going to be changed. MB explained this was a timing issue as if appropriate rationale and valid reasons are given to EMT then completion dates could be changed with the express approval of EMT.

LH explained that the scope of the payroll audit had been extended following a request by management to consider two notable issues that arose during the course of the year. LC asked if the recommendations identified had been implemented. MB would confirm with Alan Davis (AD) if they had. MB to update the committee of the status of the payroll audit recommendations.

LC stated that page 44 of the tracker was not filled in. EJ to work with LH to identify why and what needs to be done to complete this.

Head of Internal Audit Opinion (HOIA)
LH confirmed the draft Head of Internal Opinion report had been included in the papers and that following completion of remaining internal audits a final version would be brought back to the meeting on 21 May 2019.

ACTION: Leanne Hawkes/Mark Brooks/Emma Jones

AC/19/51 Counter fraud progress report (agenda item 25)

Olivia Townsend (OT) presented the progress report which included:

- An update on progress against the work plan
- Details of fraud referrals currently under investigation
- An update on recent developments at the NHS Counter Fraud Authority (NHSCFA)

OT explained that there will not be any legal action as a result of the attempted mandate fraud following discussion with the Kent police.
The annual self-assessment against counter fraud standards needs to be submitted by 30 April. OT will forward on to MB for review. Both MB and LC need to approve the submission before it is sent to the Counter Fraud Authority.

ACTION: Olivia Townend/Laurence Campbell/Mark Brooks

It was RESOLVED to RECEIVE the update.

AC/19/52 External audit update (agenda item 26)

Caroline Jamieson (CJa) presented the external audit update. She explained that initial work has already taken place in respect of the Trust's asset valuation. In addition a meeting has been scheduled with Karen Batty in respect of the audit of the Trust's Quality Account. Any impact of the move from RiO to SystmOne during quarter 4 on data quality will need to be taken into consideration.

It was RESOLVED to RECEIVE the update.

AC/19/53 Losses and special payments (agenda item 27)

RA confirmed the report provided details of the payments made since the last report to the Committee on 8 January 2019 and covers payments made to 27 March 2019.

In total the Trust has made payments of £4,564 since the last report to the Audit Committee.

Of this amount the 2 largest single transactions are:

- £2,000 in compensation relating to a tribunal that took place in 2016. Payment has only recently been agreed by all parties.
- £1,529 - write-off of non NHS debtors. The majority are former Trust employees where the debt collection route has not been able to resolve.

The remaining payments are mainly due loss or damage to service user or staff property. This information has been shared with the Operational Management Group (OMG). RA confirmed that spot check processes were to be put in place within BDUs.

LC asked for more information regarding the debtors write off. MB stated that typically these arose following salary sacrifice schemes. He added that the Trust does generate financial benefits from these schemes and the debtors write off only offset these to a small extent.

ACTION: Rob Adamson

It was RESOLVED to NOTE the contents of the report.

AC/19/54 Any other business (agenda item 28)

No other business was raised.

AC/19/55 Consideration of any changes to from the organisational risk register relevant to the remit of the Audit Committee (agenda item 29)

No changes to the organisational risk register were requested other than those discussed under agenda item 5.

AC/19/56 Items to report to Trust Board (agenda item 30)

The following items were agreed as being reportable to the Trust Board:

- Risk Committee effectiveness and the current inconsistencies between non-executive and executive membership.
- Workloads and work plans for the committees in 19/20
- Does the Trust need a finance committee
- Internal Audit plan approved for 19/20;
- Information Governance deep dive;
- Patient Level Costing in 19/20 and impact on Trust priorities;
- Head of Internal Audit opinion: Significant Assurance subject to finalising outstanding reviews.

AC/19/57 Work programme (agenda item 31)

It was RESOLVED to NOTE the work programme.

AC/19/58 Date of next meeting (agenda item 32)

The next meeting of the Committee (review of Annual Report and Accounts) will be held on Tuesday 21 May 2019 at 14:00 in Meeting Room 1, Block 7, Fieldhead, Wakefield.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of the Audit Committee held on 21 May 2019

Present:	Laurence Campbell (LC)	Non-Executive Director (Chair of the Committee)
	Sam Young (SYo)	Non-Executive Director
Apologies:	Members	
	Erfana Mahmood (EM)	Non-Executive Director
	Other	
	Tony Cooper (TC)	Head of Procurement
In attendance:	Rob Adamson (RA)	Deputy Director of Finance
	Tim Breedon (TB)	Director of Nursing & Quality
	Mark Brooks (MB)	Director of Finance (lead Director)
	Leanne Hawkes (LH)	Deputy Director, 360 Assurance
	Paul Hewitson (PH)	Director, Deloitte
	Caroline Jamieson (CJa)	Assistant Director, Deloitte
	Emma Jones (EJ)	Company Secretary (author)
	Angela Monaghan (AM)	Chair of the Trust
	Olivia Townend (OT)	Assistant Anti-Crime Manager, Audit Yorkshire
	Rob Webster (RW)	Chief Executive

AC/19/59 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/19/60 Consideration of the Annual Accounts for the period 1 April 2018 to 31 March 2019 (agenda item 2)

AC/19/60a Report to the Audit Committee on the audit for the year ended 31 March 2019 - ISA 260 Audit of Accounts 2018/19 report to those charged with governance (agenda item 2.1)

Paul Hewitson (PH) reported that the ISA260 set out the conclusion of the audit and any unadjusted errors. The audit process had been another smooth year, with no changes to the accounts or notable issues identified. The audit is substantially complete subject to completion of the following principal matters:

- completion of internal quality assurance procedures;
- Whole of Provider Accounts reporting;
- receipt and checking of final, updated, financial statements and annual report;
- review of events since 31 March 2019; and
- receipt of signed management representation letter.

Rob Webster entered the meeting.

PH highlighted the following in relation to significant audit risks:

- Valuation of Provisions - it is known knew there are potential changes which could impact staff redundancy, the review looked at the circumstances, calculations, and interviewed staff side. A small issue was identified in the difference between redundancy numbers provided by management and quoted by staff side which was

not material.

- Accounting for property valuations - The Trust team were good at engaging early with Deloitte and sharing plans before the year end. There were not any issues identified through the testing. A judgemental adjustment was identified in relation to the movement in the BCIS indices from 31 December 2017 to 31 March 2018. In reviewing the Trust calculations of the impairment to be recognised in operating expenditure a small number of errors were noted, but these were not material.
- Management override of controls - Work in relation to journals has been completed, and no issues were noted. This risk did not have a significant effect upon the overall audit strategy, allocation of resources, and direction of the efforts of the audit team.

In relation to Value for Money no significant risks have been identified and no significant internal control or risk management issues noted during the audit. There are some areas for monitoring relating to the switch from RiO to SystmOne, CIP delivery and responding to the Care Quality Commission (CQC) comments. In relation to the schedule on unadjusted misstatements, this includes the asset revaluation estimate difference and aggregation of other areas. The report also outlines fraud responsibilities and representations.

MB commented that one of the audit team is related to a member of staff in a different function and this had been declared. PH confirmed that this had been checked and they were a junior member whose work was subject to two tiers of review.

LC asked in relation to single oversight framework whether it should be reported as segmentation 2. MB commented that the financial component was 1. PH will clarify and update as needed.

Action: Paul Hewitson

The Committee thanked the Trust staff involved in the account for the work completed and timely year end.

It was RESOLVED to NOTE the ISA 260 audit of the accounts for 2018/19.

AC/19/61 Consideration of the draft Quality Account 2018/19, including auditor's report and the draft auditor's private report to governors on quality report assurance (agenda item 4)

Tim Breedon (TB) commented that the draft Quality Account had been prepared following the same process as previous years, with a page turning exercise and significant discussion taking place at the Clinical Governance & Clinical Safety Committee on 14 May 2019 and updates included in the final draft version. Final areas to be updated will be the inclusion of responses from stakeholders, some minor changes to figures, and a final proof read prior to going to Trust Board on 23 May 2019 for approval.

Sam Young (SYo) commented that there were some typographical errors which would be provided to TB for amending in the final version.

Action: Sam Young

Caroline Jamieson (CJa) highlighted the following in relation to the testing of indicators:

- Early intervention in psychosis (EIP) - three instances where clock stop dates did not match, two where there were minor data quality impacts, one impacted the data which was a slight improvement.
- Inappropriate out of area placements - only one case where incorrect recording of stop/start dates and one where the start/stop date changed number of days.

- Cardio metabolic assessment - a large quality of information had already been tested by the Royal College. A sample was picked from additional information and only one case where there was no evidence that an assessment had been completed.

PH commented that the audit only identified a small number of things compared to other trusts and being able to produce the report without any problems given the change in clinical record system was a strong result.

SYo asked if the outstanding areas in the draft findings and recommendations from the external assurance review had now been completed. CJa confirmed that these had been re-performed and were included in the latest version received of the Quality Account.

PH suggested giving stakeholders less time for their response on future Quality Accounts.

It was RESOLVED to RECOMMEND the APPROVAL of the Quality Account by the Trust Board subject to the inclusion of the stakeholder responses and any final minor amendments.

Tim Breedon and Paul Hewitson left the meeting.

AC/19/60 Consideration of the Annual Accounts for the period 1 April 2018 to 31 March 2019 (agenda item 2 continued)

AC/19/60b Report from the Director of Finance on the Accounts (agenda item 2.2)

MB commented that the £1.6m deficit pre-PSF reported in the management accounts was significantly different to the reported deficit in the annual accounts and was a consequence of the asset revaluation.

LC asked if the average days lost per member of staff to sickness last year had now been confirmed. MB confirmed that this figure had now been included in the final accounts.

LC commented that the reconciliation and narrative provided was helpful.

It was RESOLVED to NOTE the report from the Director of Finance on the accounts.

AC/19/60c Internal Audit Annual Report 2018/19 including Head of Internal Audit Opinion (agenda item 2.3)

Leanne Hawkes (LH) reported that the draft Head of Internal Audit Opinion was provided at the last Committee meeting and the final opinion was one of 'overall significant assurance'. This is based on a review and assessment of the following areas:

- The design and operation of the Board Assurance Framework (BAF);
- The outcome of individual assignments within the 2018/19 Internal Audit Plan and any work undertaken from the 2017/2018 plan which was not completed at the time of the 2017/2018 opinion; and
- The extent to which the Trust has responded, in a timely manner, to actions agreed following audit recommendations, (internal audit follow up work).

Also included is the Internal Audit Annual Report for 2018/19 which contains information on the service delivery, including details of responses to the client satisfaction questionnaires as well as an assessment of compliance to the agreed Key Performance Indicators (KPIs). As part of 2019/20 reporting, there was potential that the reporting against actions agreed following audit recommendations would be on the first follow up date agreed rather than any extensions. LC commented that he understood that there was an internal process in place

where any slippage was reported to the Executive Management Team (EMT). Emma Jones (EJ) confirmed the process in place, where EMT would need to agree to any extension of action due dates.

LC asked whether the key performance measure (KPI) 5 in relation to the audit completed within audit committee timescale agreed in terms of reference had now been completed. LH commented that this had now been completed and would be updated.

Action: Leanne Hawkes

It was RESOLVED to NOTE the Internal Audit Annual Report 2018/19 including the Head of Internal Audit Opinion which provided overall significant assurance.

AC/19/60d Letter of Representation (agenda item 2.4)
CJa reported that the letter did not include any specific representations and was the standard wording with one uncorrected statement.

It was RESOLVED to SUPPORT the signing of the letter of representation by the Chief Executive.

AC/19/60e Annual accounts and Trust Accounts Consolidation (TAC) schedules including draft audit opinion and Director of Finance & Chief Executive certificates on TACs (agenda item 2.5)
MB commented that the draft accounts had been shared with LC as the Chair of the Audit Committee and financially qualified Non-Executive Director of the Trust Board. Comments provided have been included in the final version which had been audited.

CJa confirmed that the final version of the audit opinion had now been completed.

It was RESOLVED to RECOMMEND the APPROVAL to the Trust Board of the final audited accounts 2018/19.

AC/19/62 Consideration of the draft Annual Report 2018/19, including the Statement of Accounting Officer's Responsibilities and Annual Governance Statement (agenda item 3)

MB commented that the process for drafting the Annual Report had been ongoing over six weeks, with various iterations provided to Trust Board members seeking and incorporating their input. Since the draft version provided with the Audit Committee papers, there had been two changes to numbers which were typographic errors and some other minor amendments. The draft Annual Governance Statement was reviewed by Trust Board on 30 April 2019 and comments received from the Board incorporated in the draft version. The draft has been subject to external audit. The final version would go to Trust Board on 23 May 2019 for approval.

SYo commented that under the Directors' report section the governance arrangements of the committees of the Trust Board were described, however a reference was needed to the Workforce & Remuneration Committee which is covered later on under the Remuneration report section. MB to review and update as needed.

Action: Mark Brooks

It was RESOLVED to RECOMMEND the APPROVAL of the Annual Report 2018/19 including the Annual Governance Statement by the Trust Board subject to any final minor amendments.

AC/19/63 Counter Fraud Annual Plan 2020/21 (agenda item 5)

Olivia Townend (OT) reported that the annual counter fraud plan takes into account the key criteria that NHS Counter Fraud stipulates must be carried out. The plan covers four areas: Inform and Involve, Prevent and Deter, Hold to account, Strategic Governance. The following areas were highlighted:

- In relation to assessing staff understanding of counter fraud, large surveys have not been conducted as response rate was low. It is proposed that if someone refers through an allegation they will be asked some key questions and also when presentations are made to staff they use voting buttons as part of the session to capture responses.
- In relation to working with internal audit, there may be some audits in year that may cross over into counter fraud.
- There is an additional option for key staff to meet with counter terrorism staff at West Yorkshire Police regarding conducting ID checks.

The Committee discussed whether counter fraud should be mandatory training. SYo commented that there may be some key roles within the Trust for whom it should be mandatory to complete the training.

Action: Mark Brooks

It was RESOLVED to APPROVE the Counter Fraud Annual Plan 2020/21.

AC/19/64 Any other business (agenda item 6)

No other business was raised.

AC/19/65 Date of next meeting (agenda item 7)

The next meeting of the Committee will be held on Tuesday 9 July 2019 in Meeting Room 1, Block 7, Fieldhead, Wakefield.

NHS
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Minutes of the Nominations' Committee held on 3 June 2019

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)
	Ruth Mason (RM)	Appointed governor (Calderdale & Huddersfield NHS Foundation Trust)
	Marios Adamou (MA)	Staff elected governor (medicine and pharmacy)
Apologies:	Nil	Staff elected governor (medicine and pharmacy)
In attendance:	Alan Davis (AGD)	Director of Human Resources, Organisational Development & Estates (author)

NC/19/11 Welcome, introduction and apologies (agenda item 1)

Angela Monaghan (AM), Chair welcomed everyone to the meeting. There were no apologies.

NC/19/12 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return at the last Trust Board and Members' Council.

NC/19/13 Minutes of and matters arising from previous meeting held on 9 April 2019 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the meeting on 9 April 2019. It was noted that all matters arising from the meetings were now complete or not due for completion until later.

NC/19/14 Non-Executive Director Recruitment (agenda item 4)

The Committee considered the paper supporting the appointment of a financially qualified Non-Executive Director and felt there was a strong case for this appointment.

The Committee discussed the decision of the Members Council that this appointment should go through an open recruitment process and agreed to follow the format for previous appointments.

The Committee considered whether an external recruitment organisation should be appointed but felt given the significant cost and the success of handling the last appointment in-house felt that it would not be appropriate.

It was agreed that the interview panel will be the same as the last appointment consisting of: Chair, Deputy Chair, Lead Governor and Nasim Hasnie as a Public Governor.

The timetable for the appointment was discussed and it was agreed that we should look to have a four week closing date. The following timescale was agreed:

Post to be advertised nationally from 5th June 2019.

Closing date: 3rd July 2019

Shortlisting: 5th July 2019

Interviews: 12th July 2019

This would enable a recommendation to be taken to the Members' Council meeting on the 2nd August 2019.

The Committee agreed with the recommendation of the paper with the timescales above.

It was RESOLVED to APPROVE the:

- **appointment process for the Non-Executive Director;**
- **the members of the interview panel; and**
- **the closing date for applications.**

NC/19/15 Any other business (agenda item 5)

No items were raised.

NC/19/16 Issues and items to bring to the attention of Trust Board / Members' Council (agenda item 5)

Items were identified as:

- Non-Executive Director appointment process.

NC/19/17 Date of next meeting (agenda item 6)

The next meeting of the Committee will be held on Monday 15 July 2019 in Room 7, Block 7, Fieldhead, Wakefield at 1.00pm.

Chair's Report

Name of the meeting being reported on:	West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)
Date your meeting took place:	28 June 2019
Name of meeting reporting to:	South West Yorkshire Partnership NHS Foundation Trust - Trust Board 30 July 2019

Key discussion points and matters to be escalated:

This paper provides an update from the WYMHSC C-In-C on 28 June of which members of the four trusts were present. The full action notes are attached with the key decisions and actions highlighted below:

- The WYMHSC Joint Governor and Non-Executive Director's event held 24 June was discussed with members noting:
  - The need for feedback to be incorporated into future events including format, agenda content and meeting logistics.
  - A Dementia paper to be prepared for consideration at the System Leadership Executive Group by Yorkshire & Humber Dementia & Older People's Mental Health Clinical Networks to establish the learning and future positioning of the Dementia pilot work after March 2020.
  - Communication to Governors and NEDs to highlight the release of the Long Term Plan Implementation Framework and further opportunity to engage in the draft 5-year strategy before September.
  - Questions raised on the new Tier 4 CAMHS build.
  - Branding of the Mental Health, Learning Disabilities & Autism (MH, LD & A) programme to be discussed with the core Integrated Care System (ICS) comms team.
  - The actions and presentation slides from the event itself.

- Members noted the Transforming Care Partnerships (TCPs) update from Brent Kilmurray and agreed to start looking at the longer term model from a provider point of view; coming forward with an offer to present to NHSE/I. ICS MH, LD & Autism 5-year strategy work will help realise realistic programme priorities.
- NHSE Specialised Commissioning New Care Model (NCM) developments were discussed with three separate bids for CAMHS, Adult Eating Disorder and Forensic Services pilots to be submitted with an overarching ICS narrative.
- Assessment and Treatment Units (ATU) update provided with expectations that the final business case will come back to the C-In-C meeting on 3 October.
- Members provided feedback to be incorporated into the Forensics New Care Model, Provider Collaborative Application and acknowledged that the Mental Health Secure Care Specialist Community Forensic Team (SCFT) Trial Site Application (Wave 2) bid had been submitted.
- Additional bids have also been prepared for submission:
  - Investment in Crisis and Home treatment services – shared model for WY&H for investment in community mental health services over existing investment.
  - Early intervention for psychosis – establishing a service targeted at the cohort of people transitioning from children to adult services.
- Members noted that capturing a shared view of the benefits of working collaboratively is essential and will be worked through as part of the programme review process.

Report completed by:	Angela Monaghan, Chair

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)	✘	✘	✘	✘	✘	✘	✘	✘
Serious Incidents (private session)	✘	✘	✘	✘	✘	✘	✘	✘
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.	