

Trust Board (business and risk)
Tuesday 29 October 2019 at 9.30am
Room 49/50, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	9.30	Welcome, introductions and apologies	Chair	Verbal item	1	To receive
2.	9.31	Declarations of interest	Chair	Verbal item	1	To receive
3.	9.32	Minutes and matters arising from previous Trust Board meeting held 24 September 2019	Chair	Paper	8	To approve
4.	9.40	Service User Story	Director of Operations	Verbal item	10	To receive
5.	9.50	Chair and Chief Executive's remarks	Chair Chief Executive	Verbal item Paper	10	To receive
6.	10.00	Risk and assurance				
		6.1 Strategic overview of business and associated risks	Director of Strategy	Paper	15	To receive
		6.2 Board Assurance Framework (BAF)	Director of Finance & Resource	Paper	15	To receive
		6.3 Corporate / organisational risk register (ORR)	Director of Finance & Resource	Paper	15	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
7.	10.45	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	Verbal item	5	To receive
		7.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy and Director of Provider Development	Paper	10	To receive
		7.2.1 WYHHCP draft digital strategy	Director of Strategy and Director of Finance & Resources	Paper	5	To receive
8.	11.05	Performance reports				
		8.1 Integrated performance report (IPR) Month 6 2019/20	Director of Finance & Resources and Director of Nursing & Quality	Paper	45	To receive
	11.50-12	<i>Break</i>			10	
9.	12.00	Strategies				
		9.1 Digital Strategy progress update	Director Finance & Resources	Paper	10	To receive
10.	12.10	Governance items				
		10.1 Emergency Preparedness, Resilience & Response (EPRR) Compliance	Director of HR, OD & Estates	Paper	10	To approve

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		10.2 Update to the Standing Financial Instructions	Director Finance & Resources	Paper	5	To approve
11.	12.25	Assurance and receipt of minutes from Trust Board committees <ul style="list-style-type: none"> - Audit Committee 8 October 2019 - Nominations Committee 24 October 2019 - West Yorkshire Mental Health, Learning Disabilities & Autism Collaborative (WYMHLDAC) Committees in Common (C-in-C) 3 October 2019 	Chairs of committees	Paper	10	To receive
12.	12.35	Trust Board work programme	Chair	Paper	1	To note
13.	12.36	Date of next meeting The next Trust Board meeting held in public will be held on Tuesday 26 November 2019, Conference centre Boardroom, Kendray Hospital, Doncaster Road, Barnsley, S70 3RD	Chair	Verbal item	4	To note
14.	12.40	Questions from the public	Chair	Verbal item	10	To receive
	12.50	<i>Close</i>				

Minutes of Trust Board meeting held on 24 September 2019
Small conference room, Wellbeing & learning centre, Fieldhead, Wakefield

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

TB/19/78 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 six members of the public in attendance which included two staff members, one service user, and three governors from the Members' Council. 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/19/79 Declarations of interest (agenda item 2)

The following declarations were considered by Trust Board for Chris Jones (CJ), Non-Executive Director whose term of office commenced on 5 August 2019:

Name	Declaration
Non-Executive Directors	
JONES, Chris Non-Executive Director* (*term commenced 5 August 2019)	Director, Chris Jones Consultancy Ltd.

Emma Jones (EJ) commented that Sam Young (SYo) had advised the following changes to her declarations of interest:

Name	Declaration
Non-Executive Directors	
YOUNG, Sam Non-Executive Director	<i>Non-Executive Director, Great Places Housing Group - ended from 1 September 2019.</i> <i>Interim Transformation Director, Irwell Valley Homes - effective from 5 August 2019.</i>

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

TB/19/80 Minutes of and matters arising 30 July 2020 (agenda item 3)

It was **RESOLVED to APPROVE the minutes of the public session of Trust Board held 30 July 2019 as a true and accurate record with the correction of a typographical error.** The following matters arising were discussed.

- TB/19/69b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (regarding a performance dashboard) - Rob Webster (RW) commented that at the System Oversight & Assurance Group (SOAG) meeting on 23 September 2019, the SOAG discussed the performance dashboard under development, with comparison to other areas Integrated Care Systems (ICSs) including South Yorkshire & Bassetlaw and the rest of north of England. The dashboard will be included in SOAG meeting papers with a named contact for each organisation who will then distribute accordingly.
- TB/19/70a Integrated performance report M3 2019/20 (regarding the difference between indicators used) - Mark Brooks (MB) commented that clarification was provided at the meeting.
- TB/19/71a Estate Strategy progress (regarding incorporating learning into new Strategy) - Alan Davis (AGD) commented that the development of a new Estates Strategy was progressing and learning from the previous Strategy was an important part of the development. It would also be important to include the learning and experiences from service users.
- TB/19/72a Equality and diversity annual report 2018/19 (regarding Trust Board training session) - Tim Breedon (TB) commented that this would be rescheduled to take place before the end of the year.

Sam Young entered the meeting.

- TB/19/52 TB/19/52 Performance reports (regarding Board statement on agency controls) - MB commented that this would be discussed by the Finance Oversight Group.
- TB/19/53a Update on Learning Disability Services and National Context (regarding potential training for staff) - AGD commented that the education group had discussed a whole range of issues around mandatory and core training and training in relation to learning disabilities was part of that. A business case would need to be developed for consideration as there would be significant resource implications, particularly in inpatient areas. This also led onto discussion around dementia friendly training. The policy would be revisited in relation to what training was considered mandatory and

what was considered core. AM asked which committee would have oversight. AGD commented that the outcome of the training policy review would be reported to the Workforce & Remuneration Committee. RW commented that at a joint executive meeting with Calderdale & Huddersfield NHS Foundation Trust, it was discussed and agreed how good practice in relation to learning disability services could be shared between trusts.

- TB/19/53b TB/19/53b Incident Management Annual Report 2019/19 (regarding reporting of incidents against staff) - TB commented that further information would be included in the Integrated Performance Report from Quarter 3.
- TB/19/36a Guardian of safe working hours annual report (regarding workforce challenges in West Yorkshire) - AGD commented that the Medical Directors and Human Resources Directors across West Yorkshire had met and had a constructive conversation around medical workforce challenges with some joint actions to take forward. A positive area from the discussion was around how trusts could work collaboratively on recruitment.
- TB/19/42 Receipt of minutes of partnership boards (regarding updated terms of reference for partnership boards) - AM commented that these would be provided when received from partners.

TB/19/81 Service User Story (agenda item 4)

The Trust Board heard a service user story in relation to restrictive practices. Sean, a service user, attended to give his story in his own words, supported by staff members Danielle and Jen.

On Waterton Ward it is rarely that people get restricted on the ward, it depends on how unsafe the situation is, they escort people to seclusion without physically touching them, this is something that has improved since I was first admitted to Newton Lodge.

We were allowed to go to get things that belonged to separate individuals in the kitchen and controlled items, they have stopped us now from going in the kitchen and controlled items' room. However people's things and food items started to go missing so this kept our property safe.

When I first came to Newton Lodge I started taking drugs and nothing happened to me but now things have changed. I went through a period with my peers taking banned substances and the nurses and doctors came hard on us with restrictions such as putting us on 1:1 levelling with our bedroom door open. When this didn't work they stopped us from mixing with other people from other wards in the main dining room. They also watched in the toilet and even taking a shower.

These rules and regulations were positive changes that kept us safe from ourselves and others and they keep the ward running smoothly in Newton Lodge as we are regarded as a small society and these changes help us live better lives in this type of environment.

Not all restrictions are negative they help us feel safe in secure services.

Jen commented that there had been an ongoing piece of work to look at restrictive practices in forensic services. Due to the use of banned substances taking place they had to be increased for a period of time to manage the situation. These were then lifted, since then there have not been any further instances of use. Danielle added that these improvements

were just the beginning and they were hoping to get more service user involvement going forward.

CH commented that the story reflected that sometimes restrictive practices were needed to keep people safe.

TB commented that there can be challenges in introducing this style of approach. It was a big piece of work, including getting people to make a cultural shift to manage situations in a different ways and for service users to also understand why the changes were taking place and the benefits.

CD commented that it sounded like the practice had come a long way and that it was good to hear that service users were being involved and that there was good communication between service users and staff.

RW commented that the Board had discussed restrictive practices, which were also discussed at an Extended Executive Management Team meeting. It highlighted the work the Trust was doing to consider what was appropriate under different circumstances, with good communication and engagement with the people who are affected.

The Board thanked Sean for attending and sharing his story, and Danielle and Jen for supporting him to do so.

It was RESOLVED to NOTE the Service User Story.

TB/19/82 Chair and Chief Executive's remarks (agenda item 5)

Chair's remarks

AM highlighted the following:

- The Trust's Annual Members' Meeting (AMM) was held on 16 September 2019. Prior to the commencement of the formal meeting there was a showcase of services and AM thanked the members of staff, volunteers, governors and members who attended. There was an interesting and broad range of questions from attendees and a fantastic performance from Cross the Sky Theatre Group.
- There will be issues discussed in the private session of the Trust Board, and there was also a private strategic board meeting on 3 September 2019 which included an initial discussion on the Trust's five year plan. These are items that have met the test of being discussed in private before they come into the public agenda, typically for reasons of commercial confidentiality.
- Today the Board will discuss the following items in private:
 - Those aspects of financial performance considered to be commercial in confidence.
 - Serious incidents under investigation.
 - Commercially confidential business developments in West Yorkshire and South Yorkshire including the Integrated Care Systems (ICSs).
 - The Trust's draft five year plan.
 - Minutes of private partnership board meetings.

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. He highlighted the following since its publication:

- Arrangements are in place for Brexit to ensure business resilience and continuity, with both himself and AGD attending meetings which discussed the national arrangements, which were impressive and reassuring. The NHS was good at business continuity and resilience and there was a well established system for local resilience. The NHS Confederation publishes a weekly Brexit bulletin on their website which Board members can access for the latest developments and their impact on the NHS.
- Draft control totals had been provided informally, with formal notification expected imminently.
- Workforce elements within the People Plan were being discussed including how the plan would be launched and implemented. There were big issues around capacity to deliver and data availability.
- As part of the zero suicide approach there was a free training package which the Trust was encouraging all staff to complete. RW commented that Tim Mellard, a member of staff, successfully stopped someone from taking their life recently, which they felt they were able to do as they had completed the training.

CD noted that within the national plans there was a gap in relation to social care. RW commented that this had been discussed at the Trust Board strategic session and also at a West Yorkshire & Harrogate planning meeting, where all partners felt that the plan needed further work. A green paper was also expected in relation to social care. The budgets for local authorities who provide social care had been set.

AM asked how the plans reflected environmental sustainability, as this was an important issue for the Trust, the NHS and the wider system.. RW commented that there was strong recognition that it was an important part and colleagues were reflecting on areas that need to be considered such as air quality, travel and buildings.

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

TB/19/83 Performance reports (agenda item 6)

TB/19/83a Integrated performance report Month 5 2019/20 (agenda item 6.1)

TB highlighted the following in relation to the Summary and Quality dashboards

- Admissions of children and young people onto acute adult ward continues to be an area of focus.
- Complaints processing time is making some progress, with issues in relation to reporting and capacity being resolved and positive work taking place on the improvement plan.
- Incident reporting showed an increase in moderate and severe harm incidents which may decrease once they are evaluated.
- Out of area placements maintained the improvement in performance.
- Medicines omissions increase is being reviewed. Increase may have been the result of some of the guidance in relation to reporting not being reissued.
- Safer staffing reporting establishment has now been reviewed and approved and reports will be updated to reflect this.
- Restrictive practices increase is being reviewed, and early indications show that this was in relation to three individuals.
- CQC action plan submitted, with the summary and new quality improvement approach to be discussed under a separate agenda item.

Laurence Campbell (LC) asked what had caused the delay in progress of the complaints improvement plan. TB commented that capacity had been diverted to support the requirements of the CQC inspection, which was now back in place, along with some local recruitment into the customer services team. Changes are needed to the Datix reporting system and this is now a priority. A recommendation has been made to extend the completion date of internal audit actions in relation to complaints.

LC asked when data would be available for the % service users on CPA given or offered a copy of their care plan, as the report shows that it was due in July 2019. CH commented that there were data quality issues around 12 month review around CPA. Background work had provided assurance that the practice was taking place and, once this was resolved, work will take place on confirming whether service users have received a copy of their care plan.

CD asked if the percentage of learning disability referrals is showing a worrying trend. KQ added that this was also an area she wanted to raise as the forecast was 95%. CH commented that the forecast would be reviewed. A lot of work was taking place in the teams, however there had been an impact due to staff vacancies and some issues on data quality. Each of the teams has an action plan setting out how they will improve performance around assessment times and it was anticipated that the data should start to show improvement in the next three months.

Erfana Mahmood (EM) asked if there is a trend emerging in patient safety incidents, which has been increasing since May 2019. TB commented that although a higher number, they were within the normal range and were anticipated to reduce. Any trends were reviewed on a quarterly basis. CD commented that the details were reviewed by the Clinical Governance & Clinical Safety Committee. TB commented that there were also helpful discussions about the use of data, with a request to look back over the trends to see how effective learning had been. RW commented that it was important to remember that, for each of the incidents, there is an individual involved and the Trust needs to ensure the needs of each specific individual are addressed, as well as considering trends and the numbers.

CD asked how old the child /young person was who was admitted to an adult ward. MB commented that they were 17, however they turned 18 during their stay. TB commented that it would only be in exceptional circumstances that people under 16 would be admitted.

SYo asked when reporting would commence for psychology waiting times. MB commented that there had been some long term sickness absence issues within the performance team which may delay the reporting until Quarter 4. LC asked if the data in relation to Mental Health Act areas would also be delayed. SThi commented that this was planned to commence in October/November. SYo asked, with regard to indicators where data was not yet available, if there was any other information that could be provided for assurance. CH commented that currently the waiting times were recorded manually and used for the report into the Clinical Governance & Clinical Safety Committee. RW suggested that a recommendation be provided on when reporting would commence and any other data that could provide assurance.

Action: Executive Management Team

AM asked when reporting would commence on the number of records with an up to date risk assessment. TB commented that this is expected to commence in Quarter 3. MB commented that it appears there has been an increase in data quality issues since the introduction of SystemOne as staff are recording information in different ways and it was taking time to ensure the reporting is accurate. Performance and finance reviews took place with each BDU on 23 September 2019. It is important to ensure that the core data is accurate on the indicators the Trust has to provide to commissioners to then be able to take

forward into other areas. CH commented that work is ongoing in terms of monitoring risk assessments and starting to build the reports. RW requested that SY raise this with the clinical records system programme board.

Action: Salma Yasmeen

LC asked about the data quality maturity index. MB commented that the NHS Improvement national metric had been introduced as a self-assessment and this could be looked at for the quality metrics. RW commented that work was needed on how this could be done to consider timeliness, consistency, and robustness. MB commented that it was currently a judgement, based on what other trusts have done.

AM asked if information governance (IG) confidentiality breaches were showing a trend. MB commented that there had not been any breaches reportable to the Information Commissioners Office (ICO) for a period of time. There has been a trend over the past two years ago in terms of a reduction in ICO reportable incidents. The majority of breaches occurring are where conversations are overheard or incorrect addresses used. Specific training has been provided for teams in more geographically dispersed parts of the trust. When an incident occurs, general managers receive a letter and are asked for an action plan. Communications to staff are continuing, however the incidents were largely down to individual human error.

KQ asked, in relation to the proportion of people detained under the Mental Health Act who are categorised as Black, Asian and Minority Ethnic (BAME), whether ethnicity recording problems are continuing. SY commented that recording ethnicity is a mandatory requirement within SystmOne, however sometimes during assessment staff are not able to discuss ethnicity and staff can note that ethnicity was "not disclosed". CH commented that further work is needed in relation to the use of the category 'not disclosed'.

LC asked if a review is taking place of the four wards where the safer staffing fill rates fell below 80%. TB commented that the safer staffing group would be reviewing fluctuations at their meeting on 24 September 2019.

MB highlighted the following in relation to national metrics:

- Out of area bed days is now RAG rated amber, and based on current performance in September 2019 this may be rated green. This reflected the tremendous amount of work taking place by staff.
- Typically national metrics were green, however some had moved into red being marginally below target.
- Maximum 6-week wait for diagnostic procedures has shown breaches in paediatric audiology, with targeted work taking place to see if this was due to data quality issues.
- IAPT treatment within 6 weeks of referral was marginally red and a potential trend is emerging on downward performance that needs addressing.
- Data quality maturity index was marginally red.

RW commented that the improvements in out of area placements is positive for service users and families as well as the Trust's finances.

CH highlighted the following in relation to locality:

- The Barnsley neighbourhood team specification has been approved, with Phase 1 implementation due to take effect from April 2020.
- Barnsley smoke free mobilisation is underway.

- Barnsley mental health services are engaged in conversations around neighbourhoods and integration, with significantly high demand and pressures on inpatient services. RW commented that pressure in mental health services is matched by pressure in community services. AM asked if this is impacting on delayed transfers of care. CH commented that it will be having an impact. RW requested a briefing ahead of the integrated care partnership group on 26 September 2019.

Action: Carol Harris

- Practice improving in Calderdale and Kirklees around bed usage, however pressure remains.
- Older adults' wards remain under pressure in Calderdale and Kirklees.
- A bid for a forensic community service has been updated and submitted to NHS England/Improvement.
- Forensic outreach service for learning disabilities (FOLs) recruitment continues with successful appointments to several key posts.
- Work on the recovery plan for forensic child and adolescent mental health services (secure estate) continues with good progress being made.
- Wakefield has secured a place as a field leader test pilot site as part of the national urgent and emergency mental health clinical reviews standards programme.

SY highlighted, in relation to priority programmes, that the high-level optimisation plan for SystemOne commenced in August 2019. Care plan work is continuing and is progressing for testing in a live environment. The programme steering group had a long and detailed discussion on significant pieces of improvement and optimisation work, including the risk assessment tool. Super users have been identified as improvement champions to support the optimisation work with positive engagement taking place.

AM asked for an update in relation to the communications, engagement and involvement work. SY commented that there has been a high level of focus on excellence and the Trust having a stronger role in ICSs. The volunteering service will also be undergoing a formal accreditation process.

RW questioned whether the RAG rating for SystemOne should be green given the potential data quality issues, along with delayed optimisation planning and milestones and recognition that better communication is needed. SY commented that the EMT had a similar conversation. However the programme is still on track to be delivered. SYo agreed that it did not feel green, although there is a plan in place that is on track, and asked if reflection is needed on the current system and processes. SY commented that the steering group has requested a further review of the capacity and resource requirement to deliver. TB commented that further details in relation to milestones was requested which may provide a different view on possible risks going forward. SThi commented that, clinically, there had been robust discussion and challenge to ensure that the right actions were taking place, with assurance provided.

MB highlighted the following in relation to finance/contracts:

- Detailed discussions are taking place in the Finance Oversight Group (FOG).
- Significant reduction in out of area placements, which were £75k in month and £837k year-to-date. Whilst not yet a sustainable position, cumulatively this represents less than half of the cost incurred compared to the same period last year.
- Pre-Provider Sustainability Funding (PSF) surplus in month 5 of £188k, which is £133k favourable to plan. Cumulative deficit is £1.3m which is £0.4m favourable to plan. The cumulative position includes £0.7m of pay increases paid fully in April.

- Cumulative income is £0.4m lower than plan due to the recognition of a number of risks relating to CQUIN, occupancy, and also income received from the spot purchase of beds.
- Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 46% above the cap. If spend exceeds 50% of the cap this will have an adverse impact on our financial risk rating
- Net underlying savings on pay amounted to £450k in-month and £1.6m year-to-date
- CIP delivery of £3.6m is in line with plan. Currently £1.1m CIPs are unidentified for the full year.
- Cash balance increased to £31.5m in August
- Given the improvement in margin the financial risk rating improved from 3 to 2

LC commented that the budget for non-pay expenditure seems in line through to March 2020. MB commented that the budget recognised the risk and concern in relation to out of area placements and also some discretionary spend scheduled to take place in the latter part of the year.

AGD highlighted the following in relation to workforce:

- Sickness absence up to the end of August is 5%, which is higher than the same period last year.
- Staff turnover reduced from 12.6% to 11.1% month on month and is almost 2% lower than the same period last year.
- Appraisal completion for Band 6 and above is 80.3% compared to a target of 95%
- Overall performance against mandatory training targets remains good.
- Gross level of vacancies before backfill has increased to 13.2% largely as a result of the need to recruit staff into positions created by additional investment and the time this takes.

SYo noted the lower appraisal percentage in Calderdale. AGD commented that, speaking to staff, it is felt that appraisals are taking place, it is just the recording of them on the system which needs following up. CD asked if it links with supervision numbers. AGD commented that they are recorded in two different systems, however work is taking place to look at whether the e-rostering system could record both. AM commented that triangulation of workforce areas was another point that CJ had asked her to raise, in relation to high turnover and sickness, looking at how that may connect with incidents, appraisals and supervision. AGD commented that the Workforce & Remuneration Committee is focusing on sickness absence, turnover, and appraisals in forensic services and what actions or reporting process could be used. TB commented, in relation to incidents and complaints, that they are reviewed at local BDU level and if there are areas requiring escalation this would be included under the locality section of the IPR. AGD commented that it is important the staff engagement and listening exercises continue, as they had provided rich information around service pressures and the importance of making the Trust great place to work. RW commented that another example was Specialist BDU and CAMHS where the data showed that appraisals recorded are lower, sickness is average, turnover is one of the highest, and the service is under pressure. CH added that there are also some challenges in learning disability services that need to be addressed.

LC commented that the turnover in support services seems to have had a high spike. AGD commented that he would use caution when looking at a monthly spike, however there had been a slightly higher turnover in Estates & Facilities and IM&T.

RW asked what proportion of sickness absence was long term. AGD commented that approximately 70% is long term, which is an absence of more than four weeks. The Trust is

focusing on proactive work to support staff returning before four weeks as it is known that, after this point, it becomes more difficult to bring people back.

It was RESOLVED to NOTE the Integrated Performance Report.

TB/19/83b Serious incident report Quarter 1 2019/20 (agenda item 6.2)

TB highlighted the following:

- Report has been considered by the Clinical Governance & Clinical Safety Committee with comments included on the cover paper.
- Importance of remembering that behind all the numbers were individuals and the learnings continued to be discussed.
- There were no never events.
- There were two homicides, which is unusual for the Trust and there is a particular process that needs to be conducted with an external investigator appointed.
- Rolling quarter 4 data showing the Trust is within normal range compared to benchmarking data with other organisations.
- Some investigation timescales were outside targets, which were discussed with commissioners and extensions agreed.
- Learning from incidents occurs at many different levels in the organisation, with some examples included on the cover paper.

CD noted the level of reported incidents of physical aggression and threats to members of staff. TB commented that this still remains the most frequently reported type of incident, which linked to the work taking place on reducing restrictive practices and also reflected the levels of acuity on our acute and psychiatric intensive care unit (PICU) wards. AGD added that managing violence and aggression at work is one of the areas of focus that has come out through the staff engage and listen events. TB commented that, at the North East Yorkshire & Humber Director of Nursing meetings, there had been discussion about an increase in incidents across the system.

AM asked, in relation to links with the police, what was that happening across the Trust's footprint. TB commented that there are links across all areas, with stronger links in Wakefield. CH commented that there had been a meeting previously with the Chief Constable for Wakefield. This had been helpful in confirming that the police will take seriously acts of violence against staff where the perpetrator has capacity. RW added that this was a meeting with the Trust on behalf of all chief constables across West Yorkshire. Arrangements had been put in place to ensure that this level of understanding and approach to violence from service users was understood. AGD commented that some staff had developed a tolerance towards some aggressive and threatening behavior due to the acuity of some service users, however it is important that this does not grow or become inappropriately tolerated.

SYo commented that some incidents suggest that they are still linked to the Trust's smoking policy. TB commented that these may be to do with the introduction of vaping and how that was impacting some areas. CH added that vaping had been introduced in inpatient areas in single bedrooms or some areas of the courtyard, however this had not solved all problems. In the last couple of Mental Health Act Care Quality Commission (CQC) inspections it had not been raised as an issue, whereas it had previously. A review of the implementation of the change to the policy was due to take place and would be reported back.

Action: Carol Harris / Subha Thiyagesh

It was RESOLVED to RECEIVE the Incident Management Quarter 1 Report for 2019/2020 and NOTE the assurance from the Clinical Governance and Clinical Safety Committee.

TB/19/83c Brexit update (agenda item 6.3)

AGD highlighted the following:

- Nationally there were concerns around stockpiling, with clear communications needed to ensure this was not taking place.
- In relation to medicines management, nationally a lot of assurance had been provided including a six week buffer stock using processes already in place to manage shortages. Anecdotal areas were discussed including whether current shortages were linked with Brexit, despite assurances that they were not.
- Should Brexit take place on 31 October 2019, it may impact staffing in social care, which in turn may impact on other areas of health and care.
- Assurances have been provided nationally and there were established contingency plans in place in the local area.

CD asked, in relation to communications, whether something would be placed on the Trust's website. AGD commented that there may be some messages in future in relation to service users to ensure they felt assured. SY commented that there were guidelines about what can be communicated. AM commented that CJ had also raised the importance of ensuring the Trust provides assurance to vulnerable service users. AM commented that generally, it was felt there may be an impact on mental health due to the uncertainty of the environment in which the Trust is operating, which may create a feeling of anxiety.

It was RESOLVED to NOTE the content of the report.

TB/19/84 Business developments (agenda item 7)

TB/19/84a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 7.1)

AGD reported that he and AM met with Sir Andrew Cash, lead executive for the SYBICS, about the Trust's relationship with the SYBICS. This had been a constructive and helpful meeting, with recognition that the Trust is a full and key member of the ICS. The Trust was also part of the capital plans for the SYBICS.

SY reported that in SYB, work is taking place to establish a mental health provider alliance. AGD added that the Trust had always had a strong working relationship with other mental health service providers and establishing an alliance would formalise that.

AM commented that the SYBICS dashboard showed the SYBICS's performance compared favourably with the other first wave ICSs. However, both the Early Intervention into Psychosis (EIP) and Improving Access to Psychological Therapies (IAPT) measures for Barnsley were showing as RAG rated red at present, and then green for year end, when it was believed that EIP services were performing well. SY commented that there has been a slight issue around data which has been fed back and they would ensure the year-end position is accurate. MB commented that IAPT did not use SystemOne and there was one particular metric which was not being achieved which would be reviewed in relation to the year-end position. SY to check the EIP figures for June 2019 and ensure they are corrected for future reports.

Action: Salma Yasmeen

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

TB/19/84b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 7.2)

SY reported in relation to the WYHHCP that work was taking place to develop the ICS's 5-year plan in response to the NHS Long Term Plan. The plan builds on the programmes and work initiated and developed over the last few years across each of the places that make up the ICS. Engagement with partners has shaped the draft plan that is being further developed. Significant transformation funding had also been made available to support key programmes and initiatives including the mental health, learning disabilities and autism programme.

Sean Rayner reported, in relation to transformation funding for community mental health teams, that originally the Trust's bid had been declined. Further work had taken place with NHS England persuaded that we should have access to resources and advising that funding would be provided for one year. The programme board met on 20 September 2019 and reviewed a draft mental health, learning disability and autism strategy which is aimed to be completed in December 2019. On 7 October 2019 there would be a national 'every mind matters' campaign targeting self-care and the wellbeing of others.

SY highlighted, in relation to Calderdale, that the Trust was a lead sponsor for the mental health group as part of Active Calderdale. In relation to Kirklees, momentum was developing in relation to creating a formal mental health alliance to strengthen the way of working and the Kirklees IAPT team had developed a model of care offer to primary care networks.

EM commented that the paper outlined the positive benefits of partnership working through the WYHHCP.

AM asked, in relation to Primary Care Networks (PCN), how people were being informed of the developments. SY commented, in relation to Calderdale and Kirklees that discussion was taking place about what it means for the system and conversations were taking place with staff through listening events. Calderdale had undertaken significant organisational development work as part of Calderdale Cares, whereas the work in Kirklees was emergent. SR commented, in relation to Wakefield, PCNs were focusing on communications with their constituent practices and funding under transformation would give partners a specific area of focus to make things better for that population.

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/19/84bi Calderdale Health & Wellbeing Plan (agenda item 7.2.1)

SY reported that the refreshed Calderdale Health and Wellbeing Plan was discussed and endorsed at the Calderdale Health and Wellbeing Board in August 2019.

It was RESOLVED to ENDORSE and SUPPORT the Calderdale Health and Wellbeing Plan.

TB/19/85 Governance matters (agenda item 8)

TB/19/85a Medical Appraisal / Revalidation Annual Report 2018/19 (agenda item 8.1)

SThi highlighted the following:

- Report has been considered by the Clinical Governance & Clinical Safety Committee.
- Performance compares very well with national benchmarking.
- 92% successfully completed the appraisal process during 2018/19. 8% had an agreed postponement in line with the Medical Appraisal Policy and all due appraisals have now been completed.
- 25 revalidation recommendations made between 1st April 2018 and 31st March 2019, with all upheld by the General Medical Council (GMC).
- Next steps include consolidation of the Revalidation Oversight Group, which was set up last year, with a lay member present to support the Responsible Officer and team.
- Ensuring the quality of appraiser training is maintained with the introduction of new trainers.
- Review process for patient feedback in light of GMC consultation/updated guidance.

It was RESOLVED to

- **RECEIVE this report, noting that it will be shared, along with the Annual Organisational Audit, with the Tier 2 Responsible Officer at NHS England.**
- **RECOGNISE that the resource implications of medical revalidation are likely to continue to increase year on year; and**
- **APPROVE the NHS England Designated Body Annual Board Report Statement of Compliance, attached as appendix 5 of this report confirming that the Trust, as a Designated Body, is in compliance with the regulations.**

TB/19/85b Sustainability Annual Report 2018/19 (agenda item 8.2)

AGD reported that there had been a large number of positive actions over past few years, including a focus on technology to reduce the Trust's carbon footprint. In future, there would need to be a different approach, including the rights and responsibilities of individuals and the Trust's contribution to environmental sustainability. Broad engagement would be needed and full commitment as an organisation to make further improvements.

CD asked how the sustainability work fits with partner organisations and how could the work be elevated to ensure the Trust was having the right conversations. AGD commented that the primary responsibility was what the Trust needed to do, then as a partner how we meet our commitments within partnership arrangements. SY added that some of those conversations were already taking place through partnership forums. AM commented that she had been invited to join the climate emergency forum in Calderdale. RW commented that as part of the Trust's plans a review was needed of what others were doing as well as whether the actions could be quantified.

AM noted that there had been an iHub conversation with staff around environmental sustainability and 'Going Green' conversations were taking place across the Trust in each of its places, to get staff and volunteer engagement. AGD commented that there did seem to be the appetite to improve further, however complaints were still received from staff about being unable to park at Trust locations and further work was needed to change people's mindset about going green and sustainability.

SYo commented that she welcomed the report and that sustainability should form part of all Trust strategies. AM commented that one idea to emerge from discussions so far had been that every policy and strategy should have an environmental impact assessment.

It was RESOLVED to NOTE the content of this report.

TB/19/85c Workforce Equality Standards (agenda item 8.3)

AGD reported that the paper was discussed in detail by the Equality & Inclusion Committee and highlighted the following key areas of positive development since 2018:

- The Board and Directors are more diverse in terms of both ethnicity and gender.
- The percentage of black, Asian and minority ethnic (BAME) staff experiencing harassment, bullying and abuse from patients, relatives or the public in the last 12 months has improved.
- The percentage of BAME staff experiencing discrimination at work from their manager/team leader has improved.
- The Moving Forward programme to support BAME staff development is in place with very positive feedback.
- The BAME Staff Network continues to play an active role in promoting equality and inclusion in the Trust.
- The Disability Staff Network has established a steering group and is in the process of agreeing a work plan for the forthcoming year.

The key areas for improvement and focus for 2019/20 are:

- Tackling harassment and bullying by service users and carers.
- Implementing a new framework for reducing bullying and harassment, which will include the development of specialist harassment advisors with a focus on racially motivated incidents.
- Widening access to consultant Clinical Excellence Awards.
- Rolling out of the Reciprocal Mentoring scheme.
- Continue to support the BAME network, the New Horizons project and the Stepping Up, Ready Now and Moving Forward programmes.
- Development of a Disability Policy.
- Continue to develop the Staff Disability Network.

RW commented that it was important to note the significant improvement in the WRES and positive comments made by the CQC. The Trust was making good progress, with more work to do on bullying and harassment.

AM commented that the Equality & Inclusion Committee welcomes the active engagement from the staff equality networks in the work of the committee, with the chairs invited to attend meetings.

It was RESOLVED to APPROVE the WRES summary report and action plan and WDES action plan.

TB/19/85d Care Quality Commission (CQC) inspection update (agenda item 8.4)

TB highlighted the following:

- Action plan submitted to CQC in the prescribed format following inspection.
- As an organisation, work would take place under a quality improvement approach, supported by the Clinical Governance & Clinical Safety Committee.
- The first draft of the internal plan included all items submitted to the CQC in a different format, with the full plan to be reviewed by the Clinical Governance & Clinical Safety Committee in November 2019.
- An engagement meeting with the CQC was scheduled for 25 September 2019 to receive initial feedback on the action plan submitted.

LC asked what work would take place to maintain the good rating. TB commented that previous action plan processes had felt transactional, and conversations were now taking

place about what needs to be done to maintain or achieve a good rating going forward. RW commented that the recent Board development session included measuring for improvement and there may be some elements where the approach could be used.

LC commented that, previously, it felt as if there had not been much engagement on the action plans at Board level. TB commented that the CQC section would be included in the IPR to track performance monthly. CD commented that the way in which assurance is provided to the full Board could be discussed further by the Clinical Governance & Clinical Safety Committee.

Action: Tim Breedon / Charlotte Dyson

SYo asked if there was work on how to move areas that are currently rated as good to outstanding. TB commented that this would form part of a separate piece of work around the whole quality improvement approach.

It was RESOLVED to RECEIVE the CQC report and NOTE the assurance from the Clinical Governance and Clinical Safety Committee.

TB/19/85e Five year plan (agenda item 8.5)

MB reported that the SYBICS plan would be circulated and requested that any comments on the SYBICS & WYHHCP plans be provided for feedback to the ICSs. The Trust's plan would be discussed under the private session.

RW commented that the WYHHCP Board had highlighted that their plan was a long document, partly due to national requirements. The WYHHCP would be looking at what significant changes are going to be put in place that could be emphasised, with a short summary to be developed.

CD asked what links to universities the Trust had in relation to providing mental health support for students. RW commented that the Trust had links to the University of Huddersfield and had specific IAPT support for students.

It was RESOLVED to NOTE the contribution of the Trust and process undertaken in developing the draft 5 year ICS plans.

TB/19/85f Finance, Investment & Performance Committee (agenda item 8.6)

MB reported that the draft Terms of Reference (TOR) had been reviewed by the Finance Oversight group (FOG) and Executive Management Team (EMT) prior to Trust Board.

LC noted that the new committee would now include performance. MB commented that the aim was to support the Board discussion on the Integrated Performance Report (IPR) by having more detailed discussions and focus on areas of performance at the committee.

EM asked how assurance would be provided back to the full Trust Board. MB commented that, as with other committees, the minutes would be received by the Board and the committee chair would raise any issues from the meeting. AM commented that it would be included under the standing agenda item on assurance from Trust Board committees. AGD commented that it is important that the discussions at committee enhance the discussion of the Board, rather than remove it.

RW commented that committees could also look at how the Trust can promote areas of good and outstanding practice. AM noted that an achievements report is received by the Clinical Governance & Clinical Safety Committee.

It was RESOLVED to APPROVE the proposed Terms of Reference for the Finance, Investment & Performance Committee.

TB/19/86 Receipt of minutes of partnership boards (agenda item 9)

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

- Calderdale Health and Wellbeing Board 8 August 2019
- Wakefield Health and Wellbeing Board 19 September 2019 - SR commented that the building sustainable communities discussion was important for the Trust as it would impact on mental ill health prevention.
- South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board 14 September 2019 - AGD did not attend meeting on 14 September 2019.
- West Yorkshire & Harrogate Health & Care Partnership Board 3 September 2019 - RW commented the workforce discussion highlighted the need to ensure a diverse leadership and workforce would be central to our plans.

It was RESOLVED to RECEIVE the updates provided.

TB/19/87 Assurance from Trust Board Committees (agenda item 10)

Clinical Governance & Clinical Safety Committee 10 September 2019 and, including ratified Minutes from 11 June 2019

CD highlighted the following:

- Care Quality Commission (CQC) action plan
- Clinical Records System optimisation phase one
- Waiting list improvement plan - a report was received twice a year by the Committee which included Barnsley psychology ASD/ADHD. The reporting had improved so the Committee could be much clearer on issues and action plans to reduce waiting times. The Trust was working with commissioners to improve the pathways.
- Child & Adolescent Mental Health Services (CAMHS) - included a review of the CQC inspection findings and action plans.
- Forensic CAMHS - significant improvements had been made.
- Received reports on safeguarding, learning lessons, mandatory training, and patient experience.
- Approved Minutes of the Committee meeting held on 11 June 2019 were attached to Trust Board papers.

Equality & Inclusion Committee 10 September 2019, including ratified minutes from 4 June 2019

AM highlighted the following:

- Mental Health Act (MHA) Committee – MHA data noted.
- Equality Impact Assessment (EIA) focus.
- Performance dashboard – starting to be populated with further development work still to take place, helping focus on the right areas.
- Feedback from staff networks.
- Workforce Race Equality Standards (WRES) report and action plan.
- Workforce Disability Equality Standards (WDES) data and action plan.
- Approved Minutes of the Committee meeting held on 4 June 2019 were attached to Trust Board papers.

Mental Health Act Committee 29 August 2019, including ratified minutes from 14 May 2019

KQ highlighted the following:

- Care Quality Commission (CQC) action plan – review of elements that relate specifically to the Mental Health Act (MHA).

- Mental Capacity Act workstreams - would have resource implications.
- Code of Practice Group – clinically-led oversight forum to take forward areas from CQC MHA visits.
- CQC MHA visits - improvement on outstanding actions from visits.
- Approved Minutes of the Committee meeting held on 14 May 2019 were attached to Trust Board papers.

MB commented that, in relation to Independent Hospital Managers, when IR35 came into place the Trust took national advice regarding their taxation status and they were paid as an independent supplier. Recently the Trust had an HMRC inspection which concluded that they were required to be paid through payroll from 1 November 2019. This was consistent with the practice of other trusts.

TB/19/88 Use of Trust Seal (agenda item 11)

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

TB/19/89 Trust Board work programme (agenda item 12)

AM commented that the work programme had been updated to reflect the change of the meeting held in public from December to November. The December meeting would now be a strategic session.

RW requested that the Sustainability Strategy be added to the list of strategies and policies on the work programme.

Action: Emma Jones

Trust Board RESOLVED to NOTE the changes to the work programme.

TB/19/90 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on Tuesday 29 October 2019, Room 49/50, Folly Hall, St Thomas Road, Huddersfield, HD1 3LT.

TB/19/91 Questions from the public (agenda item 14)

TB/19/91a - In relation to staffing levels and recruitment and retention, is the issue bigger in Wakefield than in other parts of the Trust?

AGD commented that some of the challenges with recruitment are due to national shortages and no one area has a more significant challenge when compared to others.

TB/19/91b - Are staff moved between areas to support shortages?

AGD commented that there had been some new investment in some areas to support shortages. CH added that when new posts go out for recruitment that sometimes current staff apply for them, which may leave gaps in other areas. The Trust was actively trying to recruit to all vacancies and, on a day-to-day basis, if there are staff pressures in a particular area staff may be moved temporarily to help support an area at risk.

TB/19/91c - When a part of a community team only has one Community Psychiatric Nurse (CPN) is this a concern?

TB commented that the Trust is working on using the same safer staffing approach in the community that is used in inpatient areas. Community teams are where staff are more likely to get moved between areas to cover shortfalls. AGD suggested that if governors received feedback from the community regarding service pressures that this is discussed with the

Trust to understand if there are concerns and actions that Trust is taking to address them. Governors could then communicate this back.

TB/19/91d - Do police officers feel that they are not getting support from the Trust regarding service users, which means in turn that they are not supporting the Trust effectively?

CH commented that local meetings are held with the police to discuss any individual issues or concerns.

Signed:

Date:

DRAFT

TRUST BOARD 24 SEPTEMBER 2019 – ACTION POINTS ARISING FROM THE MEETING

 = completed actions

actions from 24 September 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/83a Integrated performance report Month 5 2019/20	SYo asked when reporting would commence for psychology waiting times. MB commented that there had been some long term sickness absence issues within the performance team which may delay the reporting until Quarter 4. LC asked if the data in relation to Mental Health Act areas would also be delayed. SThi commented that this was planned to commence in October/November. SYo asked, with regard to indicators where data was not yet available, if there was any other information that could be provided for assurance. CH commented that currently the waiting times were recorded manually and used for the report into the Clinical Governance & Clinical Safety Committee. RW suggested that a recommendation be provided on when reporting would commence and any other data that could provide assurance.	EMT		
	AM asked when reporting would commence on the number of records with an up to date risk assessment. TB commented that this is expected to commence in Quarter 3. MB commented that it appears there has been an increase in data quality issues since the introduction of SystemOne as staff are recording information in different ways and it was taking time to ensure the reporting is accurate. Performance and finance reviews took place with each BDU on 23 September 2019. It is important to ensure that the	SY		

Min reference	Action	Lead	Timescale	Progress
	<p>core data is accurate on the indicators the Trust has to provide to commissioners to then be able to take forward into other areas. CH commented that work is ongoing in terms of monitoring risk assessments and starting to build the reports. RW requested that SY raise this with the clinical records system programme board.</p> <p>Barnsley mental health services are engaged in conversations around neighbourhoods and integration, with significantly high demand and pressures on inpatient services. RW commented that pressure in mental health services is matched by pressure in community services. AM asked if this is impacting on delayed transfers of care. CH commented that it will be having an impact. RW requested a briefing ahead of the integrated care partnership group on 26 September 2019.</p>			
TB/19/83b Serious incident report Quarter 1 2019/20	<p>SYo commented that some incidents suggest that they are still linked to the Trust's smoking policy. TB commented that these may be to do with the introduction of vaping and how that was impacting some areas. CH added that vaping had been introduced in inpatient areas in single bedrooms or some areas of the courtyard, however this had not solved all problems. In the last couple of Mental Health Act Care Quality Commission (CQC) inspections it had not been raised as an issue, whereas it had previously. A review of the implementation of the change to the policy was due to take place and would be reported back.</p>	CH/SThi		
TB/19/84a South Yorkshire update including South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	<p>AM commented that the SYBICS dashboard showed the SYBICS's performance compared favourably with the other first wave ICSs. However, both the Early Intervention into Psychosis (EIP) and Improving Access to Psychological Therapies (IAPT) measures for Barnsley were showing as RAG rated red at present, and then green for year end, when it was</p>	SY		

Min reference	Action	Lead	Timescale	Progress
	believed that EIP services were performing well. SY commented that there has been a slight issue around data which has been fed back and they would ensure the year-end position is accurate. MB commented that IAPT did not use SystemOne and there was one particular metric which was not being achieved which would be reviewed in relation to the year-end position. SY to check the EIP figures for June 2019 and ensure they are corrected for future reports.			
TB/19/85d Care Quality Commission (CQC) inspection update	LC commented that, previously, it felt as if there had not been much engagement on the action plans at Board level. TB commented that the CQC section would be included in the IPR to track performance monthly. CD commented that the way in which assurance is provided to the full Board could be discussed further by the Clinical Governance & Clinical Safety Committee.	TB/CD		
TB/19/89 Trust Board work programme	RW requested that the Sustainability Strategy be added to the list of strategies and policies on the work programme.	EJ		Complete. Work programme updated.

Outstanding actions from 30 July 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/68a Board Assurance Framework (BAF)	LC commented in relation to controls under 3.1, the Finance Oversight Group (FOG) is not mentioned. MB commented this was in relation to when the paper was written and reference would be included going forward.	MB	October 2019	Complete. Board Assurance Framework (BAF) reviewed. Report on the agenda for 29 October 2019.
	Sam Young (SYo) commented that there were some gaps in assurance and controls where there was no date or a year rather than a month and requested further clarification of due dates.	All	October 2019	Complete. BAF reviewed. Report on the agenda for 29 October 2019.
TB/19/68b Corporate / organisational risk register (ORR)	Risk ID 1078 - The Board noted the change and requested that the risk scoring be kept under review.	CH	October 2019	Complete. Corporate / organisational risk register (ORR) reviewed. Report on the agenda for 29 October 2019.

Min reference	Action	Lead	Timescale	Progress
	Risk ID 1132 - The wording for Risk ID 1132 in relation to long waiting lists could be reviewed in a similar light when discussed by the Clinical Governance & Clinical Safety Committee. KQ requested that the impact on carers and family be captured when discussed at the committee and included in the controls and assurances.	CH	October 2019	Complete. ORR reviewed. Report on the agenda for 29 October 2019.
	Risk ID 1368 - AM requested that the risk scoring be reviewed in line with the previous scoring.	AGD	October 2019	Complete. ORR reviewed. Report on the agenda for 29 October 2019.
	AM requested that the EMT reflect on the risk profile heat map and whether the average risk score, which is reducing, reflects the environment in which the Trust is operating.	EMT	October 2019	Complete. ORR reviewed. Report on the agenda for 29 October 2019.
	LC commented that a potential new risk for consideration, which was raised by the Audit Committee, was in relation to partnership working as people become dependent on other partners' performance.	SY	October 2019	Complete. ORR reviewed. Report on the agenda for 29 October 2019.
	AM asked if it would be helpful for a deep dive to take place on a couple of risks at each business and risk Trust Board meeting. LC commented that this was currently taking place at committee meetings. MB suggested that committee chairs lead the discussion at Trust Board following on from the discussions taking place at committees.	Committee chairs	October 2019	Complete. ORR reviewed. Report on the agenda for 29 October 2019.
TB/19/72a Equality and diversity annual report 2018/19	AM commented that a Trust Board training session on equality and diversity was due to be rescheduled.	TB		Complete. Training session scheduled.
TB/19/73 Receipt of minutes of partnership boards	AM commented that the format of receipt of the minutes of partnership board would be reviewed through agenda setting to consider whether these could be incorporated under other agenda items.	AM		Complete. Now included under the business development items.

Outstanding Actions from 30 April 2019

Min reference	Action	Lead	Timescale	Progress
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	Completed. Strategic overview of business and associated risks reviewed. Report on the agenda for 29 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	Completed. Strategic overview of business and associated risks reviewed. Report on the agenda for 29 October 2019.

Trust Board 29 October 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:	<p>The Brief, provided monthly to all staff and cascaded through the Extended Executive Management Team (EEMT), delivers a summary of the Trust's performance against our strategic objectives. The September version of this is attached [Annex A].</p> <p>Following the Brief there have been a number of developments and updates:</p> <ul style="list-style-type: none"> ➤ The Queen's Speech included reference to a targeted NHS Bill. This followed an extensive consultation process lead by NHS England. The need for such a bill was endorsed by a group of national leaders in a letter to the Secretary of State which I signed on behalf of the West Yorkshire and Harrogate Health and Care Partnership. A copy of the briefing into the potential legislative changes is attached at [Annex B]. There are a number of potential changes which support collaboration and appear to back the role of integrated care systems in future delivery. ➤ The NHS People Plan continues to be in development. The work on the maturity of the system in West Yorkshire & Harrogate (WY&H) has concluded and the report has been received by the System Leadership Executive. This indicates more capacity will be needed to deliver the workforce strategy in the integrated care system (ICS), as well as identifying a number of positive developments and innovative practices. The final plan is expected in November 2019. ➤ Preparations for an exit from the EU continue and there is a separate report covering this in the Board papers. ➤ Development of the Long Term Plan submissions for West Yorkshire & Harrogate (WY&H) and South Yorkshire & Bassetlaw (SY&B) continues. Both Partnerships have received positive feedback on their submissions. We are working with our partners in each place to consider how the plan affects our plans for the Trust. The Board should note that this process is helping to develop a shared understanding of the likely

	<p>investment profile in our services in future years as well as service improvements and changes that follow. Further detail is covered in the papers. The WY&H plan will be signed off at the Partnership Board on 3 December 2019.</p> <ul style="list-style-type: none"> ➤ The Care Quality Commission (CQC) published its Annual State of Care Report. This highlighted significant pressure on learning disability and Child & Adolescent Mental Health Services (CAMHS) services as well as a general trend of reducing quality being seen in their inspection of these services. This reflects to some extent the position elsewhere in our region. We are actively supporting some independent sector partners to improve quality of their offer. Both learning disabilities and CAMHS are priorities for the Integrated Care Systems and we are working together to make sure we are delivering good care in both WY&H and SY&B. An on the day briefing for the CQC report is attached for information at [Annex C]. ➤ A further tranche of capital funding has been made available across England to support acute hospitals. This includes around £600million of development in Leeds which will benefit services for children across the region. NHS Providers has continued to lobby Government on behalf of community and mental health providers to ensure that we are also recipients of much needed capital in the future. We should note that substantial capital for Mental Health services has been secured in West Yorkshire & Harrogate. ➤ The official opening of The Unity Centre took place on 10 October 2019. Board members joined service users and partners as Horatio Clare, a journalist and former patient, performed the official ceremony. Horatio's speech was a wonderful affirmation of the quality of services we provide and the challenge to us to always seek to do better. A copy of his speech is attached at [Annex D]. ➤ Planning for winter is progressing well in each of the places we work. There is a strong desire nationally for greater assurance at this time and we are working together to deliver this.
Recommendation:	Trust Board is asked to NOTE the Chief Executive's report.
Private session:	Not applicable.

A large circular graphic composed of numerous blue brushstrokes of varying lengths and directions, arranged in a circular pattern around a central white circle.

The Brief

26 Sept 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



Barnsley dietitian Sarah Armer is shortlisted for a national **Our Health Heroes** award. She spent four days being fed through a tube to better understand patients' experiences. Voting closes on 11 October.

With all of us in mind.

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

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.

Improving Health: Joining up care in every place

Developments in our work to join up care include:

Calderdale

We are supporting Calderdale's health and wellbeing strategy which has a clear focus on prevention and on mental health. This has now been signed off. They are 1 of 12 areas to receive funding from Sports England to support people to become more active. We will be leading on how people with mental health can become more physical and active.



Kirklees

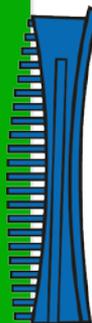
A partnership workshop was held on 25 Sept with providers and commissioners as part of the mental health alliance work.

Over 100 people attended the learning disability fun day organised by Creative Minds and Kirklees LD team in Huddersfield in September.



Barnsley

We have been working with partners to develop an integrated service spec for our general community and memory services. This spec has now been agreed by Barnsley CCG's governing body. We will now be working on developing the model ready for implementation next April. Drop in sessions are being planned from now until April. See the intranet for more details.



Wakefield

The Mental Health Alliance is looking at the best way to invest an additional £1m in mental health services across Wakefield. Work is also progressing on primary care homes, involving Live Well Wakefield, and on children and young people's services.



With all of us in mind.

Improving Health: Joining up care in every place

Barnsley revised service specs

Barnsley CCG have announced plans to redesign the service specs for Barnsley recovery college and Barnsley CAMHS.

People are being invited to provide comment on their experiences of both services so that the new spec can meet local need. See Barnsley CCG's website for more details of how to get involved.

Trauma informed personality disorder (TIPD)

A launch event was held on 17 Sept for this new Trustwide approach to working with people with trauma informed personality disorders. This will lead to consistent and collaborative care and crisis planning. Training and awareness sessions are being planned across acute and community teams.

Kirklees IAPT has developed an offer to their Primary Care Network for them to access psychological therapies. If successful this will be rolled out across our areas.

Barnsley's Home First pilot has been running throughout September and involves partners working together to get patients out of hospital quicker and in a better condition.

Our neighbourhood rehabilitation and crisis response team visit people at home to ensure they get the right level of care.

This ensures the right care happens in the right place.



With all of us in mind.

Improving Care: Safety and quality

In August we had:

- 1196 incidents - 1013 rated green (no/low harm)
- 173 rated yellow or amber
- 10 rated as red
- 2 serious incidents – 2 apparent suicides. Please look at the suicide prevention plan and take part in ‘save a life’ training on ESR – it only takes 20 minutes!

There were **11 confidentiality breaches** in August, **up** from last month. This month we are asking people to be careful with leaving information unattended.

Please remember to protect patient and staff confidentiality by locking your computer if unattended and making sure all “paper” information is processed and stored appropriately.



Orcha relaunch

We're relaunching our work with Orcha – a web service that helps clinicians choose the best mobile apps to support people in our care. For more information contact **Kate Ledger.**



With **all of us** in mind.

Improving care: Our performance in August

- **96%** of people recommend our community services
- **86%** of people recommend our mental health services
- **146** out of area bed days
- **92%** inpatients with Cardiometabolic Assessment (CMA)
- **1.6%** delayed transfers of care
- **36%** referral to treatment in CAMHS timescales
- **1** person under 18 admitted onto adult inpatient wards
- **92.5%** of prone restraint lasted less than 3 minutes
- **262** restraint incidents
- **24.7%** medicines omissions
- **52.2%** of people completing IAPT treatment and moving into recovery

Medicine omissions have risen again this month to **24.7%**. Work continues across all services to improve performance, including reviewing records and pharmacy visits to areas identified as hotspots.



85.7% of people dying in a place of their choosing – this is consistently over our target of 80%.

The Royal College of Psychiatrists has highlighted a **56%** reduction in the use of restrictive practices on Nostell ward.

The improvements come just nine months into a national 18 month improvement programme led by the Royal College.



With **all of us** in mind.

CQC next steps

In August the CQC rated us as **GOOD**. The work continues to make our Trust the best it can be:

- The CQC gave us some '**must do**' actions which we are progressing. Quality plans to address these have been submitted to the CQC
- Quality improvement groups to support safety are being established (focusing on risk assessment, safe medicines management, care records)
- There is on-going assurance work on wards for working age adults by ward managers and matrons
- There will be a workshop for our core services on 30 September, focusing on what the CQC have told us we '**should do**'. Contact Karen Batty for details or if you want to attend.



We will continue to build on our rating to further improve our services, and address issues where they have been identified.

Improving resources: Our finances in 2019/20

Performance Indicator		Year To Date	Forecast
1	NHS Improvement Finance Rating	2	2
2	Normalised Deficit (excl PSF)	(£1.3m)	(£0.2m)
3	Agency Cap	£3.2m	£7.3m
4	Cash	£31.5m	£28.5m
5	Capital	£2m	£6.4m
6	Delivery of CIP	£3.6m	£10.6m
7	Better Payment	99%	

The overall risk rating is a 2 (out of 4 with 1 being the highest). This is higher than last month due to the in-month surplus position.

August finance performance is ahead of our plan and is the first monthly surplus this year. In this month we spent £0.2m less than the income we received. Continued financial control and limitation on expenditure is needed to maintain this as we need to deliver a surplus of over £1m in the remainder of the year to achieve our financial target and be able to access a further £1.8m cash that we can invest in capital projects.

Our usage of out of area beds is much improved so far this year and we need to maintain this level of improvement. Agency expenditure continues to be a financial pressure with significant variance to plan. We spent £0.6m in August.

The Trust cash position remains healthy at £31.5m. This means we can continue to pay bills promptly. The Trust capital programme continues to be reviewed in line with Trust and national priorities. We continue to invest in Estates and IM&T programmes.

Cost reduction plans (CIPs) are in line with our plan. To achieve the £10.6m target a further £1.1m of schemes need to be identified and delivered.

Improving Resources



New i-hub challenge on spending wisely and reducing waste

This a time-limited challenge open to all staff until **31st October**. It is sponsored by our Non-Executive Director Chris Jones, and supported by the executive trio Tim Breedon, Carol Harris and Dr Subha Thiyagesh.

Whether it's big or small, whether it saves £1m or £5 we want to hear about it. We all want to make sure that we spend wisely so all your suggestions are welcome- big or small!



We're upgrading to Windows 10

We need to upgrade all Trust laptops and desktops to Windows 10 by 14 January 2020. After this date the system we currently use (Windows 7) won't be supported, which poses a security risk.

The IM&T team will be in touch with you soon to arrange your upgrade – keep an eye out for more information coming soon.



Please don't save documents on your computer desktop or documents folder.

When we update to Windows 10 information saved here will be lost so save documents to your personal drives.

Don't forget...you have until the end of November to complete your **Institute of Healthcare Improvement (IHI)** training.

With **all of us** in mind.

Improving Resources:

SystemOne Phase 2: Optimisation



Over the last few months, the Trust has been working closely with TPP, the supplier of our clinical system to improve the functionality of the mental health care plans in SystemOne. Working with clinicians from the Trust, TPP have completely redesigned the mental health care plans based on feedback from staff and we will be the first Trust in the country to see these being rolled-out and utilised by our staff.

What does this mean?



The changes will mean care plans are:

- More intuitive to build
- Safer and easier to find on SystemOne with a name, description and type immediately visible
- Easier to complete with a logical care plan narrative
- Easier to edit, so that the narrative can be added to/amended on an ongoing basis until the care plan is closed.



Next steps:

The first phase of roll-out commences on 14 October in forensics services. Testing in the demo environment will continue across all other services, with feedback from the forensic services roll-out being used to inform the approach to organisational roll-out.



Colleagues can prepare for the new mental health care plans to go-live by having a read of the “User Guide” on the intranet.



With **all of us** in mind.

Making this a great place to work

Actions planned

We want the Trust to be a great place to work for **#allofus**. This is everyone's responsibility. Updates on our Trust priorities are:

Health and well-being: A focus on positive mental health in the workplace including reducing stress, healthy teams and building resilience. We are looking to pilot mental health first aid training for managers and awareness sessions for staff.



Quality of appraisal: We will be piloting an e-appraisal system to provide clearer objectives and support better conversations. We want to make the process easier and support personal and professional development.



Staff engagement: Colleagues told us during the great place to work engage and listen that they want their voice to count and to contribute to service improvement. We will be updating our staff engagement plan to ensure everyone is involved.



Preventing bullying and harassment: Our framework emphasises that we all have a role in preventing bullying. We want to increase our team of bullying and harassment advisors. A series of guides have been produced to support the early resolution of any concerns.



Preventing bullying & harassment is everyone's responsibility



All colleagues

- Do not tolerate bullying or harassment
- Support colleagues experiencing bullying and harassment
- Be aware of your own behaviour at work



If you feel bullied / harassed

- Remember you are not alone
- Deal with issues ASAP
- Seek support
- Keep your behaviours positive

Values into behaviours

You can see our values...	...in how we behave every day
 We put the person first and in the centre	I ask questions and listen before acting I make careful decisions and think of my impact on others I show compassion for others, and for myself
 We know that families and careers matter	I collaborate and seek involvement I ask for ideas and opinions and always say thanks
 We are respectful, open, honest and transparent	I share what I know and respect the info I am given I keep promises and take responsibility for my actions I see diversity as a strength
 We improve and aim to be outstanding	I give clear feedback and meet expectations I actively seek and share ideas
 We are relevant today and ready for tomorrow	I am responsible with resources I work well with others to make improvements



Managers/ Team Leaders

- Discuss team behaviours regularly
- Role model our values and behaviours
- Be open to feedback
- Respond to concerns as a priority

The Trust

- 
- Develop a positive culture
 - Provide support to colleagues
 - Support the bullying & harassment advisors
 - Review our progress

Making this a great place to work



Staff now have the right to choose to move to an identical role in another team.

We feel it's better that our talented staff transfer teams rather than leave us altogether, we retain their knowledge and expertise.

A good manager supports people to develop and progress, even if that means leaving the team.

With all of us in mind.

Making this a great place to work



Sickness absence was 5% in August above our target.
Turnover was up at 11.1%. There's support for **#allofus**



The shortlist for our **Excellence awards** has been announced. Winners will be announced on 19 Nov.



Attend the **BAME staff network** celebration event in the large conference room at Fieldhead on 15 October



Staff and service users at **Newton Lodge** won a regional first place award for a performance about involvement.



Meet our new **Freedom to Speak Up Guardian** lead in one of the roadshows being held throughout Oct.

Advanced nurse practitioner Enzo Harris, who works in our learning disability service in the Horizon Centre, has become a **clinical academic research fellow** with the University of Huddersfield.



Supply of the **flu vaccination** this year has been delayed.

To protect service users the first batch we receive will be used for front line staff.

All other staff can receive the jab once more stocks come in.



With **all of us** in mind.

Take home messages

Run and attend a local brief to make sure you talk about changes in your place And the CQC action plan for your service

Put safety first always and keep the person at the centre of everything you do.

Get involved in #allofusimprove and take a look at the new challenge on the i-hub.

Help us to make SystemOne the best it can be by getting involved in optimisation.

Understand your role in helping to combat bullying and harassment

If you work on the front line, get your flu jab.

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?

Dietitian shortlisted in national awards for tube feeding experience

Barnsley dietitian Sarah Armer has been shortlisted in the 'outstanding contribution' category of the national Our Health Heroes awards. Sarah was nominated for the award after she [spent four days being fed through a naso-gastric tube](#) to better understand her patients' experiences. Having been a tube feeding specialist dietitian for 9 years, she wanted to gain a deeper insight into some of the challenges faced by the people she supports.

Now in their fourth year, the Our Health Heroes awards celebrate the thousands of people who work in healthcare, recognising their hard work and efforts. [Voting closes on 11 October.](#)

[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 email the comms team.

Improving health: Joined up care in every place

Developments in our work to join up care include:

Barnsley

We continue to work with partners in Barnsley to [improve joined up care](#).

We have been working with partners to develop an integrated service spec for our general community and memory services. This spec has now been agreed by Barnsley CCG's

governing body. We will now be working on developing the model ready for implementation next April.

Drop in session are being planned from now until April so staff can continue to be a part of the conversations. Full details can be found on the intranet.

Calderdale

We are supporting Calderdale's health and wellbeing strategy which has a clear focus on prevention and on mental health. This has now been signed off. Calderdale are 1 of 12 areas to receive funding from Sports England to support people to become more active. They received £10m. We will be leading on how people with mental health can become more physical and active, particularly where the access our services.

Kirklees

A partnership workshop was held on 25 Sept with providers and commissioners as part of the mental health alliance work. It was a positive meeting.

Over 100 people attended the **learning disability fun day** organised by Creative Minds and Kirklees LD team in Huddersfield. The event is held four times annually, with the funday on Tuesday 3 September, being the third of the year. The day was supported by partners; Huddersfield Giants Community Trust, Huddersfield Town Foundation and West Riding County FA with delivery of fun summer fete activities, games and multi-sports.

Wakefield

Wakefield Mental Health Alliance: We have worked with other providers of mental health services in Wakefield, together with Wakefield CCG and Wakefield Council, to form a provider alliance which will take responsibility for a co-ordinated approach to the delivery of mental health services. The Alliance is accountable to the Wakefield Integrated Care Partnership, and has recently undertaken a collective prioritisation process for the investment of an additional £1 million in mental health services in Wakefield. These priorities are now being mobilised. An example of this work includes the recruitment of 2 full time clinical psychologists to provide the clinical capacity to train a 4 practitioner dialectical behaviour therapy (DBT) team to deliver a DBT programme in Wakefield. We will also be providing DBT skills training for 45 practitioners across the wider Wakefield system to support the delivery of DBT and provide DBT informed interventions. Another example is the provision of £200k to the voluntary and community sector to support people in community settings and prevent mental ill health escalating.

Primary Care Homes: We are working with colleagues in primary care and the existing GP networks to support the development of the 7 Primary Care Homes (PCHs), established on 1 July 2019, which will lead to strengthening and integrating general practice with the wider service provision in the community. The aim is to personalise care and improve population health across the district. The Wakefield Live Well service has been engaged by all seven PCHs to commission additional social prescribing link workers.

Children and Young People's Plan: We are working with partners in the Wakefield Children and Young People's Partnership to prepare the Children and Young People's Plan 2019 – 2022. There is a workstream and section in the draft plan on 'Improve emotional wellbeing and mental health of children and young people', and the Trust is a key partner in shaping the plan in this context.

Improving health: Joined up care in every place

Barnsley revised service specs

Barnsley CCG has announced plans to redesign the service specs for Barnsley recovery college and Barnsley CAMHS. People are being invited to provide comment on their experiences of both services so that the new spec can meet local need. See Barnsley CCG's website for more details of how to get involved.

Barnsley's Home First pilot has been running throughout September and involves partners working together to get patients out of hospital quicker and in a better condition. It is a collaboration between Barnsley Hospital, our neighbourhood rehabilitation/crisis response team (intermediate care), reablement and social services.

Following discharge from hospital our neighbourhood rehabilitation and crisis response team visit people at home to ensure they get the right level of care. This ensures the right care happens in the right place.

Kirklees IAPT has developed an offer to their Primary Care Network for them to access psychological therapies. If successful this will be rolled out across our areas.

Trauma informed personality disorder (TIPD)

A launch event was held on 17 Sept for this new approach to working with people with trauma informed personality disorders. This includes holistic formulation of risks and needs at the heart of the person's TIPD pathway. We have a vision for consistent and collaborative care and crisis planning across our acute and community services which is formulation driven and evidence based. It is a whole new approach to support clinicians to take clinically appropriate risks.

Training and awareness sessions are now being planned across acute and community teams.

Improving care: Safety and quality

We put safety first, always.

In August we had:

- 1196 incidents - 1013 rated green (no/low harm)
- 173 rated yellow or amber
- 10 rated as red
- 2 serious incidents – 2 apparent suicides. Please look at our suicide prevention plan and take part in 'save a life' training on ESR.

Suicide Prevention 'Save a Life' Training

We're the lead partner for suicide prevention across the West Yorkshire and Harrogate Health and Care Partnership and we have adopted a 'zero suicide' ambition as a Trust for our inpatient areas. We're a member organisation of the national Zero Suicide Alliance. This is a collaborative of NHS trusts, businesses and individuals who are all committed to suicide prevention in the UK and beyond.

We recently evaluated our suicide prevention strategy and began to take a number of steps towards developing a zero suicide inpatient action plan together with a wider improvement plan to address suicide prevention across all our services.

We are asking all our staff to join the quarter of a million members of the public who have completed the zero suicide alliance '**20 minutes to save a life**' training. Please could staff access the training via ESR so they can get credit for completing the training and this will help us keep track how many staff have completed.

To access, staff need to log into their **ESR** page, click on **my learning** and locate the training by typing **378 Mersey** into the search box.

We are also asking the Chairs of Trust groups to put the training on their group agendas to ensure wider uptake across the Trust. You can access the zero suicide training online. If you are a Chair of a meeting please could you allow 20 minutes on your agenda so that those attending can complete the training. Keep a record of who attended and send to Learning and Development and attendees will be able to get credit for completion.

Information governance

There were **11 confidentiality breaches in August**, up from 5 last month.

This month we are asking people to be careful with leaving information unattended. Please remember to protect patient and staff confidentiality by locking your computer when unattended and making sure all paper information is processed and stored appropriately.

Have a look on the intranet for more information on how you can keep your information safe and a new poster which can be downloaded and displayed. Always **think** and **check** before you **share**.

If you have any concerns around information governance in your area then please contact information governance for advice or contact Julie Williams

Orcha re-launch

We're re-launching our work with Orcha – a web service that helps clinicians choose the best mobile apps to support people in our care.

Improving care: Performance (August)

- **96%** of people recommend our community services
- **86%** of people recommend our mental health services
- **146** out of area bed days
- **92%** inpatients with Cardiometabolic Assessment (CMA)
- **1.6%** delayed transfers of care
- **36%** referral to treatment in CAMHS timescales
- **1** person under 18 admitted onto adult inpatient wards
- **92.5%** of prone restraint lasted less than 3 minutes
- **262** restraint incidents
- **24.7%** medicines omissions
- **52.2%** of people completing IAPT treatment and moving into recovery

While the people recommending our community services is high the target is 98% so remains amber for this month. **It is 98% year to date.** The target for mental health is 85% meaning this is green this month. The difference in target is due to the difference in service user numbers and their demographics.

Medicines omissions performance rose to **24.7%**. Work continues across all services to improve performance. Pharmacy and medicine optimisation was raised during our recent CQC inspection as a concern so will form a part of our CQC action plan. It will continue to be a priority for us in the coming year.

The % of people dying in a place of their choosing continues to exceed target and was **85.7%** in August.

Royal College of Psychiatrists praises dramatic cut in use of 'restrictive practice'

The Royal College has highlighted the **56% reduction** in the use of physical restraint, seclusion and rapid tranquilisation on our Nostell ward at Fieldhead Hospital. It comes nine months after we joined an 18 month improvement programme led by the College.

Nostell ward provides inpatient care for people who are in crisis who cannot live safely in their home environment. The ward caters for people with a wide variety of mental health problems, who are acutely unwell and who need to be admitted to hospital.

The reductions have been achieved using innovative methods of care, including changing access rules to areas that were previously restricted by time or location, such as the patient's therapy area. The national programme, which launched in November 2018 and concludes in March 2020, aims to reduce the use of restrictive practices by one third in 41 wards across 25 mental health trusts.

Nostell Ward has reduced the average monthly use of restrictive practices from 20 at the start of the programme to nine. The programme is using a new way of improving patient care. It focuses on involving those closest to the issue – staff, service users and carers – to identify and test new ideas and uses data to understand which ideas are working. It is the first-time quality improvement has been used nationally in England for mental health, with almost half of England's mental health trusts taking part.

CQC update

In August the CQC rated us as **GOOD**. The work continues to make our Trust the best it can be:

- The CQC gave us some '**must do**' actions which we are progressing. Quality plans to address these have been submitted to the CQC
- Quality improvement groups to support safety are being established (focusing on risk assessment, safe medicines management, care records)
- There is ongoing assurance work on wards for working age adults by ward managers and matrons
- There will be a workshop for our mental health core services on 30 September, focusing on what the CQC have told us we '**should do**'.

- We discuss the plans in the clinical governance group and where any actions are applicable to any other services we will link these services in.

We will continue to build on our rating to further improve our services, and address issues where they have been identified.

Improving resources: Our finances 2019-20

The overall risk rating is a **2** (out of 4 with 1 being the highest). This is higher than last month due to the in-month surplus position.

August finance performance is ahead of our plan and is the first monthly surplus this year. In this month we spent **£0.2m** less than the income we received. Continued financial control and limitation on expenditure is needed to maintain this as we need to deliver a surplus of over £1m in the remainder of the year to achieve our financial target and be able to access a further £1.8m cash that we can invest in capital projects.

Our usage of **out of area beds is much improved** so far this year and we need to maintain this level of improvement. Agency expenditure continues to be a financial pressure with significant variance to plan. We spent £0.6m in August.

The Trust cash position remains healthy at £31.5m. This means we can continue to pay bills promptly.

The Trust capital programme continues to be reviewed in line with Trust and national priorities. We continue to invest in Estates and IM & T programmes.

Cost reduction plans (CIPs) are in line with our plan. To achieve the **£10.6m** target a further £1.1m of schemes need to be identified and delivered.

Improving our resources: Reducing waste

New i-hub challenge - spending wisely and reducing waste

This time-limited challenge is open to all staff until 31st October. It is sponsored by our Non-Executive Director - Chris Jones, and supported by the executive trio, Tim Breedon, Carol Harris and Dr Subha Thiyagesh.

We know you're the best people to tell us are we spending our money the best way we can. This conversation is about everyone and everything we do in our day to day jobs. We want to hear about your ideas, thoughts or avenues for investigation that would help us to reduce waste and improve our use of resources.

Whether it's big or small, whether it saves £1m or £5 we want to hear about it. We all want to make sure that we spend wisely. All your suggestions are welcome- big or small.

We're upgrading to Windows 10

We need to upgrade all Trust laptops and desktops to Windows 10 by 14 January 2020. After this date the system we currently use (Windows 7) won't be supported, which poses a security risk.

The IM&T team will be in touch with you soon to arrange your upgrade – keep an eye out for more information coming soon.

Please don't save documents on your computer desktop or documents folder.

When we update to Windows 10 information saved here will be lost so save documents to your personal drives.

Don't forget...you have until the end of November to complete your **Institute of Healthcare Improvement (IHI) training**.

Improving resources: SystmOne for mental health Phase 2 – Optimisation

Rollout of new mental health care plan commences in forensic services on 14 October

We have listened to staff feedback following engagement and testing of the new mental health care plans and have made changes to simplify the process and improve linkages between different types care plans.

The first phase of roll-out now commences on 14 October in forensics services. Testing in the demo environment will continue across all other services, with feedback from the forensic services roll-out being used to inform the approach to organisational roll-out.

You can prepare for the roll-out of the new mental health care plans by having a read of the "user guide" on the intranet. Demonstrations of the new care plans will be happening at SystmOne Improvement Groups throughout October.

To find out how to get involved with your local SystmOne Improvement Group and see the new care plans prior to go live, contact your line manager or the SystmOne Programme Manager.

Making this a great place to work Actions planned

We want the Trust to be a great place to work for **#allofus**. This is everyone's responsibility. Updates on our Trust priorities are:

Health and well-being

Our well-being plans this year are focussing on positive mental health in the workplace including reducing stress, healthy teams and building resilience. We are looking to pilot mental health first aid training for managers and awareness sessions

for staff. Occupational health is also developing their service offer for example to support colleagues following incidents at work. The stress management pathway is also being reviewed. We want everyone to feel they can have an early conversation with their manager should they require support. Our leadership development activity is supporting this work by promoting health at work, supportive leadership practices and healthy teams.

Quality of appraisal

Learning and Development are leading on piloting an e-appraisal system which will make the process easier and support better conversations. Supporting a shift towards digitisation removing the need for paper, the new e-appraisal system is employee-led and allows teams to be better connected in having performance discussions, specifically benefiting those working in agile teams. Components of the new system include a 'golden thread' between an individual's job-related objectives, values-based behaviours, and the Trust's Strategic Priorities. The system will also provide real-time talent, performance and workforce data at all levels meaning the Trust can deliver more informed cost effective decisions for development and investment.

The pilot takes place up to the end of December 2019 with evaluation to inform Trust-wide implementation for April 2020. Newton Lodge teams in Forensic services and Kirklees Learning Disabilities provide a clinical perspective for the pilot, whilst Estates & Facilities and HR are also participating. Further communication and information will follow in due course.

Staff Engagement

During the Great Place to Work engage and listen colleagues told us how important it is for their voice to count in the workplace. Also how they want to be engaged in improving the service and doing their job better. In Quarter 3 the HR team will be developed a revised staff engagement plan. We want to ensure all staff groups are involved and that colleagues' contribution is recognised and valued. There were many positive examples of staff engagement when the HR spoke to teams earlier in the year and we want to ensure this is happening in every part of the Trust.

Preventing bullying and harassment

The framework (see next slide) emphasises that [we all have a role in preventing bullying](#). We are encouraging teams to discuss the Trust's values and behaviours, and how these are part of their everyday work.

We also want to increase our team of bullying and harassment advisors who offer a confidential listening and signposting services to colleagues. A series of guides have been produced to support the early resolution of any concerns.

Over the next 12 months we will be focussing on different aspects of bullying and harassment and encouraging anyone affected to seek support.

Making this a great place to work Transfer talk

We're launching a 'Transfer Talk' campaign to publicise the introduction of internal job transfers for clinical roles across the Trust. Our new campaign uses nostalgic cartoon visuals and a sporting analogy to explain how the new process will work.

Like sports teams transferring within a league, so our staff will be able to move around our internal job market.

We are introducing internal job transfers for clinical roles across the Trust. For those who are eligible this will mean they can move into a like-for-like job with no need for usual interview and selection procedures.

This will mean that staff will have the right to choose to move to an identical role in another team. We feel it's better that our talented staff transfer teams rather than leave us altogether, we retain their knowledge and expertise.

We are committed to finding ways to help people move between teams and locations as part of our recruitment and retention strategy. We recognise that we have a responsibility to assist our staff in achieving their career aspirations and it is hoped that the internal transfer scheme will support this.

It is also recognised that people's circumstances can change at any time and due to the large footprint of the Trust it is healthy to promote internal transfers in order to support work/life balance.

The staff transfer scheme will be open to all qualified clinical staff. Other roles including health care support worker roles will be dealt with on a case by case basis.

The scheme will be open shortly.

Making this a great place to work

- **Sickness absence** was **5%** in August, above our target of **4.5%**. Turnover was **11.1%**. Remember there is wellbeing support available to #allofus.
- The **Excellence awards** shortlists have been announced and can be found on our [website](#). The winners will be announced on 19 November. Email Excellence for more details.
- Come and join the **BAME staff network** in celebrating the achievements from the past year. Find out about the work they are doing to make the Trust a great place to work. It's also a great opportunity to network and meet other BAME staff members. Guest speakers include Christine Wint, senior programme leader for 'building leadership for inclusion' at the national leadership academy; and Jackie Walumbe, clinical research fellow at Oxford University. For further information or to register your place, contact the BAME staff network.
- Congratulations to **staff and service users at Newton Lodge** who won the Yorkshire and Humber Involvement Network competition at this year's annual involvement conference. Securing a £250 prize, Newton Lodge was tasked with producing a short performance focusing on the theme of technology. The two-minute-long performance, co-produced by both service users and staff, showcased how technology is used at the service, with performers wearing an array of costumes; all of which were produced in-house at Newton Lodge. Staff and service users are now deciding on how to spend the £250, with suggestions including new arts and craft materials for creative therapies.
- Make sure you know who your **Freedom to Speak Up Guardian** is. We now have a new Freedom to Speak Up Guardian lead, **Georgina Williams** who during October will

be out meeting members of staff to tell them about the F2SU. During Speak Up Month (October) she will be hosting informal stalls throughout the organisation in a canteen near you. Come along for an opportunity to say hello and find out more.

- 1 October, Kendray Hospital canteen, 11:30-1:30pm
- 7 October, Fieldhead Hospital Restaurant, 11:30-1:30pm
- 21 October, Folly Hall Mills café, 11:30-1:30pm
- 29 October, Laura Mitchell Health and Wellbeing Centre, café, 11:30-1:30pm

Advanced nurse practitioner Enzo Harris has been successful in his application to become a clinical academic research fellow with the University of Huddersfield.

The Trust has been working with the department of nursing and midwifery at the University of Huddersfield to develop this exciting new role, which gives a mental health or learning disability nurse the skills and knowledge needed to improve healthcare and patient outcomes, think differently about clinical practice and develop their academic career.

Enzo, who works on the Horizon Centre at Fieldhead in Wakefield, will combine high quality clinical practice with training and study for a PhD while acquiring the skills and knowledge to operate confidently in both the NHS and University. He will start the 4-year part-time fellowship in January 2020.

Flu vaccination update

Supply of the **flu vaccination** this year has been delayed. We have only 960 vaccines until 25 October. To protect services and service users the first batch we receive will be used for front line staff. All other staff can receive the jab once more stocks come in.

If you work on the front line make sure you get your jab, so you can keep you, your family and our service users safe.

This year, we are supporting Unicef's 'have a vaccine, give a vaccine' campaign. By having your flu jab, you can help protect vulnerable children from dangerous diseases such as measles, tetanus and polio.

For each member of staff who has a flu jab, we'll donate one life-saving vaccine to a child in need.

Take home messages

1. *Run and attend a local brief to make sure you talk about changes in your place... and the CQC action plan for your service*
2. *Put safety first always and keep the person in the centre of everything you do.*
3. *Get involved in #alofusimprove and take a look at the new challenge on the i-hub.*
4. *Help us to make SystmOne the best it can be by getting involved in optimisation.*
5. *Make our Trust a great place to work by understanding your role in helping to combat bullying and harassment.*
6. *If you work on the front line, get your flu jab.*

The Queen's speech 2019

The second Queen's Speech of the 2017 Parliament sets the priorities for Boris Johnson's new government and the planned legislative agenda for the year ahead.

The Prime Minister said that the Queen's Speech "*delivers on my promise as Prime Minister to get this amazing country of ours moving again.*" He emphasised that people don't want to wait any longer "*for improvements in their hospitals*" and that he has been proud to "*be the midwife to the biggest hospital building programme in a generation, alongside the 20 urgent hospital upgrades I announced on my first day in the job.*"

However, the current political context has made this year's Queen's Speech more controversial than any in recent history, with questions hanging over how deliverable the speech will be given that Boris Johnson is leading a minority government, and with much depending on the nature and timing of the UK's exit from the EU.

This briefing contains an overview of key announcements relevant to health and social care, including the two health-related bills that have secured legislative time, along with a summary of other legislation of interest and draft bills.

Health and social care focused announcements

The Queen's Speech has introduced two bills directly related to health and social care (the Health Service Safety Investigations Bill and the Medicines and Medical Devices Bill), with the possibility of two more (on the NHS long term plan and on adult social care). The government has also committed to continuing to reform the current Mental Health Act.

Subject to political changes, the two confirmed bills will likely be introduced before Christmas. The draft legislation to implement the recommendations of the NHS Long Term Plan is currently expected to be published in January for pre-legislative scrutiny.

Health Service Safety Investigations Bill

“Legislation will be taken forward to establish the Health Service Safety Investigations Body. This will be the world’s first such body, charged with independence and powers to investigate incidents that occur during the provision of NHS services that have, or may have, implications for the safety of patients.”

Provisions of the Bill will include:

- Establishing a Health Service Safety Investigations Body as a new Executive Non-Departmental Public Body, with powers to conduct investigations into incidents that occur during the provision of NHS services and have, or may have, implications for the safety of patients.
- Prohibiting the disclosure of information held by that investigations body, except in limited circumstances. This will allow participants to be candid in the information they provide and ensure thorough investigations.
- Improving the quality and effectiveness of local investigations by developing standards and providing advice, guidance and training to organisations.
- Amending the Coroners and Justice Act 2009, giving English NHS bodies the power to appoint medical examiners and placing a duty on the Secretary of State to ensure that enough medical examiners are appointed in England.

The draft HSSIB Bill went through pre-legislative scrutiny. You can read NHS Providers’ submissions to this work, and the parliamentary and government reports as below:

- Full submission: <https://nhsproviders.org/resource-library/submissions/submission-to-the-joint-committee-on-the-draft-health-service-safety-investigations-bill>
- Follow up letter: <http://nhsproviders.org/media/495496/nhs-providers-letter-to-joint-committee-on-hssib-22-june-2018.pdf>
- Oral evidence: <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/draft-health-service-safety-investigations-bill-committee/draft-health-service-safety-investigations-bill/oral/84918.html>
- Report by the Joint Committee on the Draft Health Service Safety Investigations Bill: <https://publications.parliament.uk/pa/jt201719/jtselect/jthssib/1064/106402.htm>
- Government response: <https://www.gov.uk/government/publications/government-response-to-health-service-safety-investigations-bill-report>

Medicines and Medical Devices Bill

“A Medicines and Medical Devices Bill will capitalise on opportunities to ensure that our NHS and patients can have faster access to innovative medicines, while supporting the growth of our domestic sector.”

Provisions of the Bill will include:

- Replicating powers over medicines and medical devices regulations contained in EU law.
- Making it simpler for NHS hospitals to manufacture and trial the most innovative medicines and diagnostic devices.
- Enabling the UK to be a world leader in the licensing and regulation of innovative medicines and devices, ensuring patients have access to the best possible treatments and supporting our domestic life sciences industry.
- Ensuring that the government can update legislation relating to medical devices, medicines, veterinary medicines, new innovative practices and clinical trials both in response to patient safety concerns and as it agrees the future global relationship of the UK in these areas.

NHS long term plan

“New laws will be taken forward to help implement the National Health Service’s Long Term Plan in England.”

The government has committed to implementing NHS England’s proposals for legislative change to support the delivery of the long term plan. Specifically, the government plans to:

- Consider NHS England and NHS Improvement’s recommendations for legislative changes thoroughly and bring forward detailed proposals shortly.
- In due course, publish draft legislation that will accelerate the long term plan for the NHS, transforming patient care and future-proofing our NHS.

NHS Providers has undertaken significant engagement with NHS England and NHS Improvement on the development of the proposals. You can see our recent on the day briefing summarising the proposals and key developments here: <https://nhsproviders.org/resource-library/briefings/on-the-day-briefing-legislative-proposals-for-an-nhs-bill>

Adult social care

“My Government will bring forward proposals to reform adult social care in England to ensure dignity in old age.”

The government plans to:

- Consult on a 2% precept that will enable councils to access a further £500m for adult social care. This funding will support local authorities to meet rising demand and will continue to stabilise the social care system.
- Bring forward substantive proposals to fix the crisis in social care to give everyone the dignity and security they deserve. This will include setting out legislative requirements.

Mental health reform

“My Ministers will continue work to reform the Mental Health Act to improve respect for, and care of, those receiving treatment.”

The government will:

- Publish a White Paper by the end of this year, setting out a response to the independent review of the Mental Health Act (commissioned in 2017). This will pave the way for reform to the Mental Health Act, and tackle issues addressed by the review.
- Ensure that people subject to the Act receive better care and have a much greater say in that care.
- Improve patient choice and autonomy, for example by enabling patients to set out their preferences around care and treatment in advance.
- Reform the process of detention, care and treatment while detained, including by providing patients with the ability to challenge detention.

Brexit-related bills of interest

The Queen’s Speech includes seven bills to support the delivery of Brexit: European Union (Withdrawal Agreement) Bill, Agriculture Bill, Fisheries Bill, Trade Bill, Immigration and Social Security Co-ordination (EU Withdrawal) Bill, Financial Services Bill and Private International Law (Implementation Agreements) Bill.

Based on the status of the negotiations, the government plans for parliament to vote on the European Union (Withdrawal Agreement) Bill on Saturday 19 October. The status of the other Brexit bills is less clear. Earlier in the Brexit process, the assumption had been that certain bills (including the majority of these Brexit related Bills), would have to be implemented before the UK left the EU. However, that view is no longer held by the government and it is therefore difficult to predict when and if these bills will be introduced.

European Union (Withdrawal Agreement) Bill

“We remain committed to securing a deal with the EU and negotiating an ambitious future relationship, based on free trade and friendly cooperation. The European Union (Withdrawal Agreement) Bill will ratify that deal once secured.”

Immigration and Social Security Co-ordination (EU Withdrawal) Bill

“An immigration bill, ending free movement, will lay the foundation for a fair, modern and global immigration system. My Government remains committed to ensuring that resident European citizens, who have built their lives in, and contributed so much to, the United Kingdom, have the right to remain. The bill will include measures that reinforce this commitment.”

This bill will:

- Bring an end to free movement in UK law, to ensure that the Government can deliver a new points-based immigration system from 2021.
- Make EU citizens arriving after January 2021 subject to the same UK immigration controls as non-EU citizens, to enable the Government to deliver a single global immigration system based on people's skills.
- Clarify the immigration status of Irish citizens once the free movement migration framework is repealed. This means Irish citizens will generally not require leave to enter or remain in the UK.
- Enable the Government to deliver future changes to social security co-ordination policy.

Trade Bill

"Legislation will be taken forward to capitalise on the opportunities that will come from our newly independent trade policy and deliver for UK businesses and customers."

The purpose of this bill will be to:

- Make the most of new opportunities that come from having an independent trade policy after Brexit, delivering for UK businesses and consumers by:
 - Rolling over trade agreements with third parties,
 - Ensuring access to procurement opportunities under the Government Procurement Agreement, and
 - Protecting them from unfair trade practices or unforeseen surges in imports.

Further bills of interest

In addition to health and social care and Brexit announcements, the Queen's Speech introduced further proposals that may be of interest.

Environment Bill

"My Ministers remain committed to protecting and improving the environment for future generations. For the first time, environmental principles will be enshrined in law. Measures will be introduced to improve air and water quality, tackle plastic pollution and restore habitats so plants and wildlife can thrive. Legislation will also create new legally-binding environmental improvement targets. A new, world-leading independent regulator will be established in statute to scrutinise environmental policy and law, investigate complaints and take enforcement action."

The proposed Environment Bill is wide ranging, but a key purpose of the Bill is to:

- Improve air quality by increasing local powers to address sources of air pollution, enabling local authorities to tackle emissions from burning coal and wood, and bringing forward powers for Government to mandate recalls of vehicles when they do not meet relevant legal emission standards.

Building safety standards legislation

“My Ministers will ... bring forward laws to implement new building safety standards.”

The proposed legislation is wide ranging, but a key purpose is to:

- Learn the lessons from the Grenfell Tower fire, and put in place new and modernised regulatory regimes for building safety and construction products, ensuring residents have a stronger voice in the system.

Serious Violence Bill

“A new duty will be placed on public sector bodies, ensuring they work together to address serious violence.”

The purpose of the Bill is to:

- Create a new duty on a range of specified agencies across different sectors, such as local government, education, social services, youth offending, and health and probation, to work collaboratively, share data and information, and put in place plans to prevent serious violence.
- Amend the Crime and Disorder Act 1998 to ensure that serious violence is an explicit priority for Community Safety Partnerships, which include local police, fire and probation services, as well as local authorities and wider public services.

NHS Providers view

We welcome the priority focus the government has placed on the NHS and social care within the Queen’s Speech today. We support a set of targeted changes to the law as proposed which are aimed at enabling the integration of services and avoid a substantial restructure of the NHS. We are pleased to have been fully engaged in working up these proposals and will continue to ensure that the provider sector’s needs and views continue to be heard.

We are also pleased to see the introduction of the Health Service Safety Investigations Bill, which promises to be a significant step forward in continually improving patient safety. This will help trusts and their staff adopt a systemic approach to investigating and learning from incidents to provide the safest and best care for patients.

The review of the Mental Health Act will help to ensure that this complex piece of legislation is used appropriately and consistently. However any impact on an already stretched mental health workforce, with limited resource and capacity, needs to be taken into account.

We remain concerned about proposed changes to the immigration system. The NHS relies on recruiting and attracting staff from across the world and it is vital that immigration policy supports the ability of the NHS and social care to recruit and retain skilled staff. The criteria of any immigration system will therefore need to recognise that low paid does not mean low skilled, and that it will be several years before domestic supply increases enough to help close the sizeable workforce gap.

Finally, the government's renewed commitment today to tackling the social care crisis is welcome but there is an urgent need for swift and concrete action. Pressures on social care are making it more difficult to support vulnerable or older people to live independently and closer to home, often contributing to a rise in admissions and long stays in hospital. Securing a sustainable, properly funded and fair social care system has to be a priority for the government if we are to meet demand for appropriate care in the right setting, now and in the future.

Useful links

The transcript of the Queen's Speech is available [here](#) and the accompanying briefing documents can be accessed [here](#).

Annex: full list of bills and proposals announced

Delivering Brexit

- European Union (Withdrawal Agreement) Bill
- Agriculture Bill
- Fisheries Bill
- Trade Bill
- Immigration and Social Security Co-ordination (EU Withdrawal) Bill
- Financial Services Bill
- Private International Law (Implementation of Agreements) Bill

Support the NHS

- NHS long term plan
- Health Service Safety Investigations Bill
- Medicines and Medical Devices Bill

- Adult social care
- Mental health reform

Tackling violent crime and strengthening the criminal justice system

- Sentencing Bill
- Foreign National Offenders Bill
- Victims
- Prisoners (Disclosure of Information About Victims) Bill
- Serious Violence Bill
- Police Protections Bill
- Extradition (Provisional Arrest) Bill
- Sentencing (Pre-consolidation Amendments) Bill

Ensuring fairness and protection for individuals and families

- Domestic Abuse Bill
- Divorce, Dissolution and Separation Bill
- Online harms
- Employment (Allocation of Tips) Bill
- Employment reform
- Pension Schemes Bill
- National security and investment legislation
- Windrush Compensation Scheme (Expenditure) Bill
- Building safety standards legislation

Levelling up opportunity through better infrastructure, education and science

- Education funding
- National infrastructure strategy
- Broadband
- Air Traffic Management and Unmanned Aircraft Bill
- Airline insolvency legislation
- Railway reform
- English devolution
- Science, space and infrastructure
- High Speed Rail 2 (West Midlands - Crewe) Bill

Protecting the environment and improving animal welfare

- Environment Bill
- Animal welfare

Other legislative measures

- Electoral integrity
- Birmingham Commonwealth Games Bill
- Historical Institutional Abuse (Northern Ireland) Bill

Other non-legislative measures

- Public finances
- The Union
- Northern Ireland governance
- The armed forces
- Foreign affairs

CQC state of health care and adult social care in England 2018/19 report

Introduction and summary

The Care Quality Commission (CQC) has published *State of health care and adult social care in England 2018/19*. The report is CQC's annual assessment of health and social care in England and looks at trends in quality, shares examples of good and outstanding care, and highlights where care needs to improve. This briefing summarises key points from the report.

Key points:

- CQC has found that the overall quality of care that people receive in England has improved very slightly from last year. When people are receiving care, it is mostly of good quality. However, even where care services are of good quality, CQC has found many people can struggle to get access to the care they need and want, impacting on their experience of care.
- Access and staffing are presenting challenges across all care settings, with geographic disparities in provision presenting particular barriers in some parts of the country.
- The report highlights pressures in A&E and across the system. It states figures for emergency attendances and admissions are continuing to rise year-on-year, and patients struggling to access non-urgent services in their local community can have a direct impact on secondary care services.
- This year's report focuses particularly on inpatient mental health and learning disability services as this is an area CQC is seeing some decline in quality. While the overall quality picture for the mental health sector remains stable, and CQC has seen good and outstanding care, CQC states this masks deterioration in some specialist inpatient services.
- CQC has also seen too many people using mental health and learning disability services being looked after by staff who lack the right skills, training, experience or support from clinical staff. CQC states the lack of appropriately skilled staff it has observed in services reflects a national shortage of nurses in these areas of practice.
- In adult social care, CQC states issues around workforce and funding continue to contribute to the fragility of the sector. 2018/19 saw providers continuing to exit the market and CQC has highlighted the sustainability of the domiciliary care market is a particular concern.
- The report calls for actions in the following areas: more and better services in the community; innovation in technology, workforce and models of care; system-wide action on workforce planning; and long-term sustainable funding for adult social care.

The state of care in England 2018/19

Quality of care and access

- CQC has found that the overall quality of care that people receive in England has improved very slightly from last year. When people are receiving care, it is mostly of good quality. However, even where care services are of good quality, CQC has found many people can struggle to get access to the care they need and want and this impacts on their experience of care.
- The report highlights the challenges people face range from inconveniences in getting appointments, chasing referrals and following up on previous visits, to people may be unable to get any help or service at all.
- CQC highlights the following as particular issues:
 - a lack of access and variation in adult social care provision;
 - the complexity of commissioning and funding arrangements;
 - waiting times for treatment in hospitals;
 - rising emergency attendances and admissions;
 - rising bed occupancy rates;
 - difficulty in accessing mental health services and rising demand for mental health care;
 - barriers to getting diagnoses and assessments, particularly for dementia, autism, mental health conditions and social care; and
 - services across all sectors dealing with people's needs in isolation.
- CQC was able to detect some narrowing of regional variations in quality of care, although it has found that there are still considerable differences in the quality of care people in some places have access to.
- CQC state more and better community services are needed to stop people and their families and carers having to 'chase' services and coordinate care and treatment, and people finding they have to go elsewhere for care or reach a level of crisis that needs immediate and costly intervention.

Funding and commissioning challenges

- CQC states that providers, commissioners and others continue to operate in a challenging environment and strong funding and commissioning arrangements are important in creating the conditions for high-quality, person-centred care.
- The report highlights that there are a number of shared commissioning budgets between health and social care and joint commissioning approaches being taken in some areas. However, such integrated approaches to commissioning are not yet widespread.
- In engaging with emerging integrated care systems, CQC have observed that there is less focus on social care than might be expected to deliver good system outcomes.

Better integrated care

- CQC have begun to see evidence of more integration and/or joint working emerging around the country, although this is progressing unevenly across the country.
- Some local areas that CQC have revisited, following on from in-depth [local system reviews](#) CQC undertook in 2018, have shown improvements. For example, CQC found culture in Stoke-on-Trent had shifted and leaders in the health and care community, including elected members, shared the same vision and were supportive of each other.
- The report states some providers are being innovative in the way they approach people's care needs, for example, deploying their workforce in a different way, and the services that do this can provide local solutions and better routes to high-quality care for localities.
- CQC states that, at the moment, innovation it is still more likely to be the result of individual leadership or dedicated local effort, and is only slowly beginning to be embedded at a strategic planning level.

Workforce innovation

- CQC highlights workforce issues facing providers include concerns relating to staff turnover, difficulty in getting the right skills mix, and competition for staff when recruiting, both across the health and care community and with other industries.
- CQC states that health and social care services have seen demand rising combined with greater complexity of people's needs.
- The report states that workforce issues are also linked to funding constraints, and the withdrawal of nursing bursaries has led to a reduction of people able to train. Staffing shortages can further increase the strain on the workforce.
- CQC staff have described seeing regional variation in the ability of services to recruit and retain staff, with geography and local area factors playing a role in shaping workforce challenges. The report states that, working within national policy, the challenges will need local solutions from local communities.
- CQC staff have reported providers and system partners adopting new approaches to tackle workforce issues over the last year – for example, by having more emphasis on retaining staff. The report states that responses to increased demand have also included developing new roles and an emphasis on upskilling existing staff.

Technical innovation

- CQC have encountered a range of technologies being used to deliver care in more effective ways and to help people get a better experience of care.
- However, CQC highlights the following as barriers to adopting new technology:
 - cost;
 - the knowledge and attitudes of staff towards technology;
 - the perceived complexity of adopting new technologies;
 - the ability of existing IT infrastructures to support new technologies; and

- issues around data protection and ethics.
- CQC have seen some positive examples of technology being used to improve the experience of people with protected characteristics but these have not been commonplace. CQC states that wider communities also need to be better supported with tech-enabled care options.
- However, CQC has not yet found enough examples of joined-up thinking between commissioners and providers that has new technology central to improving the quality of care for people.
- The report states the way CQC regulates has to evolve alongside technological progress.

The sectors CQC regulates

Acute, community and ambulance services

- The report describes the 'relentless' year-on-year rise in attendances at emergency departments and acute hospital admissions as a trend that has continued 'unabated' over the last year, with urgent and emergency services 'bearing the brunt' of this demand and struggling to provide high-quality care. Despite this, CQC reports overall the majority of NHS hospitals have continued to provide good care during 2018/19, with 65% of core services rated as good and 7% rated as outstanding.
- However, safety remains the area of most concern for CQC, as 36% of services are rated as requires improvement and 3% as inadequate.
- CQC has seen some improvement in the quality of care in NHS ambulance trusts over the last year, with seven out of 10 trusts rated as good, and none rated as inadequate.
- In the community, the majority of services are providing a good quality of care, with 74% of community health core services rated as good and 8% rated as outstanding. However, CQC states improvement is needed in community sexual health services, urgent care services and inpatient services, with around 30% of all these services rated as requires improvement.
- The report highlights workforce challenges, particularly around recruitment and retention, rising demand and access to services as among the key issues for hospital and community health services.

Mental health care

- The report states that accessing mental health services has remained a significant problem for many patients and for those patients who did access services in 2018/19 there is a mixed picture of quality.
- The majority of NHS mental health services were providing good care, with 71% of NHS core services rated as good and 10% as outstanding at 31 July 2019, compared with 70% and 8% last year.
- CQC continues to have concerns about the safety of services, with more than a third of NHS and independent services rated as requires improvement or inadequate for the key question 'are services safe?', with 30% of NHS core services were rated as requires improvement and 4% as inadequate.
- CQC has seen a general improvement in the quality of community mental health services. However, it states the quality of inpatient services has largely worsened since last year – in particular in acute wards for adults of working age and in wards for people with a learning disability or autism.

- CQC is particularly concerned about access to inpatient care. CQC is concerned that community mental health provision is not compensating for the reduction in inpatient beds, and continued investment in community services is needed to help people avoid the need for inpatient care.
- CQC has seen a slight decline in the total numbers of mental health nursing staff and a sharper decline in inpatient mental health nurses. While the numbers of community mental health nurses have increased over the same period, CQC states that feedback suggests community services are still encountering staff shortages.
- The report highlights access to services, particularly for children and young people and people with autism and/or a learning disability, safety, and the impact of current workforce challenges as key issues for mental health care.

Adult social care

- Four out of five adult social care services are rated as good, which is very similar to 2018. Compared with last year, a further 282 services are providing care for people that is rated as outstanding.
- The quality of care in community social care services is particularly high. However, 22% of nursing homes are rated as requires improvement.
- The percentage of services rated as good or outstanding has improved in every region since last year. There is less variation in quality, with CQC finding the difference between the region with the highest proportion of services rated as good or outstanding and the region with the lowest was 8.3%, and is now 6.6%.
- The number of residential and nursing home beds has been falling steadily in all regions over the last five years. Whilst the number of domiciliary care agencies has continued to increase, CQC has concerns about the sustainability of the domiciliary care market.
- The report highlights funding pressures, workforce challenges, access to services and continued uncertainty about long term funding amongst the key issues facing the sector.

Primary medical services

- CQC has found overall quality of services in the primary care sector in 2018/19 is high, however getting access to services can be a challenge, and insufficient integration between different types of services can affect people's experience of primary care.
- Overall ratings for GP practices show that 90% are good and 5% are outstanding, similar to the previous year.
- In primary care dental services, the pattern of inspection outcomes is broadly similar to last year. For the vast majority of inspections (85%), CQC took no regulatory action. 13% of inspections resulted in a requirement notice and in 2% of cases, CQC took enforcement action.
- Access to care, workforce challenges, harnessing developments in technology and integration with other services are highlighted as key issues for primary medical services.

Equality in health and social care

- In this chapter, CQC looks at how the quality of care varies between people in different 'equality groups', i.e. people who have different characteristics protected by the Equality Act 2010.
- The report states the following are key equality issues in health and social care:
 - people in equality groups can face greater barriers to accessing good health and social care services previous year. 4% of practices require improvement and 1% are rated as inadequate
 - geographical variation in the quality of care and overall pressure on services can have a greater impact on people in some equality groups, such as older people
 - CQC has observed through their inspections little overall change in equality of experience in services
 - technology-enabled care has the potential to both improve equality or increase inequality
 - while there is more attention on workforce inequality issues in health and social care, there has been little change yet in measures of equality for the workforce.

The deprivation of liberty safeguards

- The report states local authorities continue to deal with high volumes of applications under the Deprivation of Liberty Safeguards (DoLS), often with limited resources. The gap between the number of applications received and those completed narrowed between 2014/15 and 2017/18.
- CQC states a lack of understanding and confusion around the DoLS legislation remains one of the primary reasons for poor practice among providers.
- The report states involving a relevant person's representative and consulting friends, families and carers in the DoLS process can be a confusing process and families can experience a lack of information. 2020.
- CQC states that clear and committed leadership and culture around DoLS and the Mental Capacity Act, alongside in-depth and practical training, can help staff to engage better with the legislation.

NHS Providers view

CQC's latest State of Care report provides a helpful insight into the challenges facing providers, as well as the successes in maintaining and improving quality and progress in joined up working made over the last year. Rising demand and workforce shortages are placing unsustainable pressures on provider capacity and mean too many people are not able to access the care that they need in a timely way. The CQC has described this combination of factors as risking creating a 'perfect storm', and this is an important recognition of the gravity of the current situation.

We welcome the report's call for action on workforce, not only focused on increasing the number of staff working in health and social care services but also the need for appropriate skill mixes and adequate training and support for staff to be able to deliver appropriate and personalised care in every setting.

We also welcome CQC stressing the need for a sustainable funding solution for social care as well as more and better services in the community. There are welcome ambitions in the NHS long term plan around improving care and support in the community, but realising these depends on sustainable funding and staffing levels in order to be able to scale up new ways of working and ensure a sustained impact. Moreover, commissioners, trusts and other local partners within systems need to work together to design the right services and pathways, and ensure they have the flexibility, capacity and resource to deliver them.

We are however disappointed by a lack of focus in this year's report on the impact of under-investment in facilities, infrastructure and technology and the adverse effect on quality of care. Adequate capital funding for trusts is essential to improve facilities and ensure people have timely access to support and high quality care. While the government has made welcome announcements on waves of NHS infrastructure spending in recent months, there is urgent and widespread need for increased capital funding across the acute, mental health, community and ambulance sectors to both address backlog maintenance and transform services. The NHS needs a multiyear capital funding settlement and its capital budget brought into line with comparable economies. There also needs to be an efficient and effective mechanism for prioritising, accessing and spending NHS capital.

Trusts are working incredibly hard to deliver high quality care and keep patients and service users safe, but we remain concerned that pressures are likely to intensify across the health and care system this winter without more support, with the potential to impact quality as well as the experiences of patients and service users.

NHS Providers media statement

Responding to the State of Care report published by the Care Quality Commission (CQC), the deputy chief executive of NHS Providers, Saffron Cordery, said:

"We are seeing a relentless rise in demand for care in hospitals, mental health, community and ambulance services. This report provides yet more evidence of how trusts and their staff have managed – in many areas - to keep up and even improve the quality of care for patients, despite growing pressures.

But it also points to services where increasing demand, along with workforce shortages and inadequate facilities mean performance is slipping and care is falling short.

This is reflected in the difficulties we see in A & E where attendances have risen by 7% in the past year.

"But CQC is right to emphasise the challenges in mental health, where shortages of appropriately skilled staff are particularly severe.

It is telling that in a survey we published earlier this year nearly nine out of ten (88%) mental health trust leaders said pressures in the wider system had a knock on effect and increased demand for mental health

services. In the same survey, less than one in ten (9%) of trusts said they currently had the right staff in the right place.

"We urgently need investment to grow and develop our mental health workforce.

We know that mental health service users are being placed at increasing levels of risk from ageing and often unsafe buildings and more needs to be said on the need for capital funding to provide the most suitable environments for people in these settings.

"That is why, earlier this month, we described the failure to include any mental health services in the recent government announcement on capital funding as a damaging and regrettable oversight. What we need to see is a multiyear settlement on capital that brings spending into line with other comparable economies, together with a better way of ensuring the money gets to where it's needed most.

"We share CQC's concerns about the fragility of social care and the wider impact this has on the NHS, and the need for more prevention services and greater support for people at an earlier stage.

We are worried that as we approach winter the growing pressures on trusts and their staff will test resilience up to and possibly beyond breaking point, putting at even greater risk the care of patients and service users who deserve better."

Contact: Ella Fuller, Policy Advisor, ella.fuller@nhsproviders.org

Ladies and Gentlemen, and those who identify as neither, thank you for the honour you have bestowed on me today. It speaks volumes for the South West Yorkshire Partnership NHS Foundation Trust and the thinking of so many of you who work in the fragile, vital, complicated domain of mental health care that it was not a member of parliament, a celebrity or even a royal that you should have asked to do this wonderful thing, and officially open your new Unity Centre at this historic hospital. Instead you chose a former patient, an inmate, as we sometimes thought of ourselves, a service user, in the official vocabulary, to cut this ribbon. In doing so, you said, look – what we do may be hard and painful, it may sometimes be difficult and stressful for everyone involved – but it works.

I can only speak from my own experience, but what you do does work; it is working for me, it is working for friends I have made who have been through your system. I came to Fieldhead one night in winter, in a police van, accompanied by a paramedic I suspected was a famous actor, and a young policeman I believed was a stand-up comedian. I thought we were going to transfer to a helicopter and fly to London, for a performance at the National Theatre, or that we were going to take part in a live broadcast. I was very ill. When we arrived, the young policeman said, 'I'm going to hold your arm now,' and he took a firm grip, and escorted me to Stanley Ward.

The people who are escorted into this new Unity Centre will go through much of what I did in the following couple of weeks. I was frightened, lonely, frustrated, angry, anxious, insecure, suspicious, guilty, tentative, self-loathing. In psychosis and coming out of it, you run a gauntlet of paranoias, delusions, regrets and despair. Held against their will, the patients who will come here will know great highs and lows. With great luck and your first class care, many of them will make recoveries, and join the world again, shaken perhaps, somewhat changed perhaps, but infinitely better, vastly healthier than they were when they were brought in.

I know those of you who work here and those of you who train, monitor and appoint the people who will work in the Unity Centre do your utmost to make sure that the very unwell people who will be brought through the doors will get the best treatment and attention our society is capable of giving to those who need it most.

If the measure of a society is the way it deals with its most vulnerable, then in a deep moral sense, the Unity Centre, and the wards of Fieldhead, are a true

measure of the kind of people we are, of the kind of country this is, and of what kind of time is this, in which our lives will be numbered.

Being sectioned introduced me to some of the most remarkable people I have ever met, in a life which has allowed me to work and travel in over fifty countries. In Calderdale, in Halifax and here in Wakefield, I have met people, from the ladies who made our toast, to the nurses who administered our care, to the executives and chief executives who dispose of multimillion pound budgets, who impressed me beyond all reservation. Your kindness, your effort and your skill are priceless. I salute you. On behalf of the hundreds, thousands and hundreds of thousands of people who your work touches – thank you.

Sometimes on the ward I looked at the nurses and the assistants and the cleaners (who also serve the meals, and deserve more pay) and the therapists, and the staff and thought – we patients have no choice, but these people choose to come here. Every morning or evening, through the rain, they come to this place where none of us want to be, and they try to help us. That is heroism: unsung, vital, straightforward heroism. So I wanted to say, to all of you, well done.

And I want to encourage you to be as brave as some of your patients and their families and friends have to be. I saw tremendous bravery on Stanley Ward. As you know as well as any patient, nothing in acute mental health is simple. We are all, always, even the consultants – perhaps especially the consultants – feeling our way. And when lives and health are at stake it is right of course that you go cautiously. But remember, going by the book is all well and good until in twenty years' time they are looking back at the book and ripping chunks of it out. Sometimes it will be on the tip of your tongue to say something, at the tips of your fingers to do something, about which you have a feeling, and with which you suspect the book cannot help you. At that moment, please, be brave. Be radical. Try something new. If you can see a better way of doing something, stand up and be counted.

I have interviewed people across the mental health care spectrum and you all say the same thing. Austerity and social inequality are driving people insane – or into crisis, as you put it. You, as the people who make up the NHS, one of our most beloved and knowledgeable and trusted institutions, cannot be muttering this into your cups of tea. It needs to be shouted from the rooftops. You need to be briefing journalists, telling your friends, getting the story out there. Press officers and politicians are wonderful things, but they are there to

serve you, not the other way around. If you see things that are wrong or less than right, blow the whistle. I believe this is one of the best facilities in the country, perhaps in the world. But I know of and am investigating another, in a distant city, where terrible abuses have taken place. That starts with someone seeing something wrong and keeping quiet about it. In London I was told about a generation of drugs that work for people, of mental health patients who are experiencing effective treatment with minimal side effects – but those drugs are being withdrawn, not because they are ineffective but because they are not profitable to their manufacturers. Why don't the public and the politicians know about it?

We desperately need you to tell us these things, or they will pass unchallenged. Here, at the other end of the scale, I hope and expect you are much more likely to see something imaginative, something smart or daring or unusual that works. Please don't keep quiet about it.

The last thing I have to say comes from the wonderful, skilful, thoughtful woman who sectioned me. She said, of people in psychosis, they have lost the thread, the story of their lives. What we are trying to do is help them find that thread again, pick up that story and go on. She defended your right to believe in aliens, to be eccentric; she said she was eccentric herself. But she was ready to step in, to use the frightening power of the Mental Health Act to deprive you of your liberty and most of your rights, if your beliefs meant you might harm yourself or others. And so what you will do in the Unity Centre, this brave new chapter in Fieldhead's history, is to repair and change and create better and stronger and happier stories for people who will desperately need you. It is a mighty responsibility, and when you do it well, you do the best kind of work there is. I wish you every success. I thank you for your vast kindness and skill. And I salute all the great good that you do. Thank you very much indeed.

And without further ado, I declare the Unity Centre, OPEN!

Trust Board 29 October 2019 Agenda item 6.1

Title:	Strategic overview of business and associated risks
Paper prepared by:	Director of strategy
Purpose:	<p>The purpose of this report is to:</p> <ul style="list-style-type: none"> ➤ Support the Trust Board in reviewing the external environment in which the Trust operates. ➤ Evaluate the Trust's preparedness, responsiveness and strategic positioning in response to the internal/external environment. ➤ Provide assurance of the alignment between the Trust's strategy, Board Assurance Framework, priority programmes and risk management processes.
Mission/values:	<p>The process of analysing the external environment and the Trust's own readiness and capability to respond to those external factors is a key aspect of strategy development, implementation and monitoring process for the Trust.</p> <p>The Trust's strategy supports the achievement of our mission to help people reach their potential and live well in their community.</p> <p>The way in which we develop strategy in an honest, open and transparent manner demonstrates how we live the values of the Trust.</p>
Any background papers/ previously considered by:	<p>This paper summarises the strategic overview of business and associated risks for the Trust Board in the PESTLE (Political, Economic, Social, Technological, Legal/Regulatory and Environmental) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis aligned with the Trust's risk register, and the priority programmes where this is possible. The paper was previously discussed during April 2019 Trust Board.</p>
Executive summary:	<p>The report is presented depicting the links between SWOT, PESTLE, risk and priority programmes. It has been used to review the Trust's strategy, development of the five year plan and the Trusts financial sustainability plan. It has been used as part of the mid-year review of priority programmes and capacity review. It will continue to be used in identifying and setting priority programmes on an annual basis in line with our business planning cycle.</p> <p>Key updates in the PESTLE summary report include:</p> <ul style="list-style-type: none"> ➤ NHS England and NHS Improvement (NHSE/I) have published a revised set of legislative proposals for a targeted NHS bill, developed over the course of 2019 and through NHS Providers' engagement. The proposals suggest a significant change to how

the NHS operates in the future supporting system working and collaboration. **The Trust CEO on behalf of the West Yorkshire and Harrogate Integrated Care System was invited to contribute to the development of these proposals.**

- **Digital technologies** are a key enabler for and driver of change within the Trust and externally. The West Yorkshire and Harrogate Integrated Care System has supported the Yorkshire and Humber Digital Charter that has been endorsed by the Local Health and Care Record Exemplar (LHCRE) which is chaired by the Trust's CEO. The ICS has also supported the draft Digital Strategy for West Yorkshire and Harrogate and this is aligned to the Trust Strategy.
- **Brexit uncertainty** remains although the threat of no deal Brexit appears to have reduced, with the second reading of the Brexit bill being approved.
- There is potential for a **general election** in the near future which could impact on health and care policy, funding, and current legislative review led by NHSE/I.
- A number of the local authorities across the Trust's footprint have **declared a climate emergency** and have prioritised environmental sustainability. The Trust is a partner in these activities and is developing a revised strategy and taking action too support local improvements to be more environmentally sustainable including reducing the use of plastics and carbon footprint.

Key updates in the **SWOT** summary report include:

Strengths

- **'Centres of excellence' within services have been recognised internally and externally** – e.g. Five of our early interventions in psychosis (EIP) teams have been named as some of the best performing in the country. All of our teams achieved the National Clinical Audit of Psychosis (NCAP) standard, with four of the five teams rated as 'Top performing'. Only 11 teams (7%) in the whole country were rated as 'Top performing'. Our Wakefield health integration team were shortlisted for the Community and General Practice Nursing Award of the prestigious RCNi Nurse Awards. The team were one of just five finalists in their category.
- The Trust has made significant investments in developing **modern facilities and hubs** including the recent official opening of the **new Unity centre**, and also **developing digital capability** through investment in infrastructure, agile working and safe transition to the new clinical record SystemOne.
- Our **Care Quality Commission report (2019)** highlights that more than 87% of the individual ratings are good or outstanding and 12 of our 14 core services are rated Good. The **overall rating for the Trust improved to GOOD**. CQC rated effective, caring, responsive and well-led as good.

Weaknesses

- We need to **better recruit and retain staff**. In common with other trusts we experience difficulties in ensuring that we have the right workforce in some hot spots.
- The newly implemented **clinical record system**, SystmOne, requires further focused work through an **optimisation work programme to ensure the system is used consistently** to support reduction in clinical variation and the full benefits are realised across the Trust.
- Our most recent **Care Quality Commission (CQC) Report from August 2019** highlights that there is a **requirement to improve our adult acute inpatient and Psychiatric Intensive Care Unit (PICU) services and Child and Adolescent Mental Health Service (CAMHS)**. Overall we need to improve our 'Safety' from 'requires improvement'.
- The **CQC report 2019 identified that Children and young people were waiting over 18 weeks to receive treatment in some areas**. Across the Wakefield and Barnsley service referral to treatment times exceeded 18 weeks. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service.

Opportunities

- Opportunity to **capitalise on additional investment to deliver the ambitions of the Long Term Plan** can support the improvement of services. South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) is in a strong position to influence this at a placed based level and across the Integrated Care Service (ICS) footprints, for example, as host and lead for the Operational Delivery Network for Learning Disability and Autism across Yorkshire and Humber and lead provider for the Forensic new models of care.
- **Collaborative partnership working by the Trust with third sector organisations** such as 'Live Well Wakefield', provides opportunities to strengthen engagement with external stakeholders, maximises the Trusts role and 'offer' within newly forming primary care networks and enhanced primary/ community care services.
- **The result of our CQC inspection provides opportunities to improve from 'good' to 'outstanding'**.
- **Opportunity to build capability to enhance capacity for change within the organisation** to meet strategic objectives through programmes including the Quality Improvement and Safety certificate provided by the Institute for Healthcare Improvement and the NHSI Board development programme.
- The Trust has the **opportunity to be an exemplar for being a 'great place to work' building on improvements** including award winning communications team and #allofus campaign, improved

	<p>Workforce Race Equality Standard results, a diverse Trust Board and strong staff networks.</p> <p><u>Threats</u></p> <ul style="list-style-type: none"> ➤ The development of integrated care and services, and the development of Primary Care Networks aligned to neighbourhoods, will require the Trust to realign its services in each place. The capacity to change and deliver services will also need be considered. We will need to continue to clarify and strengthen the Trust’s role within primary care networks and partnerships. ➤ Financial position – the Trust is currently operating with a deficit. Reductions in cash, unidentified CIPs, and regulator intervention could impact on our ability to improve services and meet our objectives. <p>This report suggests that the Trust’s strategy addresses the key points raised in it and there is a strong alignment between the Trust’s strategy, Board Assurance Framework, and priority programmes. Where there are gaps, the Trust is now examining the business capacity and capabilities for change that is required to successfully undertake the identified priority programmes of work for the Trust in 19/20.</p>
<p>Recommendation:</p>	<p>Trust Board is asked to:</p> <ul style="list-style-type: none"> ➤ NOTE the content of the report and the links to our strategy. ➤ NOTE the opportunity to ensure that the Five Year Plan and the Financial Sustainability Plan are tested against and reflect this analysis appropriately.
<p>Private session:</p>	<p>Not applicable.</p>

Strategic Overview of Business and Associated Risks

Salma Yasmeen
Director of Strategy

Our Aim

IMPROVE
HEALTH



IMPROVE
CARE



IMPROVE
RESOURCES



MAKE THIS A
GREAT PLACE
TO WORK



1. Purpose of the Report

This report updates on the last report to the Trust Board dated April 2019 based on a review of the PESTLE, SWOT, operational risk report, and the priority programmes in October 2019. It has been used to review the Trusts strategy and development of the 5 year plan and the Trusts financial sustainability plan. It has been used as part of the mid-year review of priority programmes and capacity. It will go on to be used in identifying and setting priority programmes on an annual basis and provides the opportunity to ensure that Trust strategy, the 5 year plan and the financial sustainability plan are responsive and aligned.

2. Information and Analysis

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

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

- **The date when the entry was first added to the register.**
Where this date is greater than one year this is referenced to help indicate where long term issues may require additional and specific attention.
- **The date the record was last updated.**
This is to ensure register entry currency and validity.
- **Cross-reference to the Trust organisational level risk register (ORR).**
This is to indicate alignment between the Trust risk register and external environment and highlight which issues are being managed through risk management action plans and resulting mitigation measures in the ORR. Cross reference between entries in the register and matching of risks is to the Trust Operational Risk Register dated 29th October 2019.
- **For SWOT analysis 'weaknesses' and 'threats' entries are also cross referenced with the Trust's strategy and priority programmes for 2019/20.**

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

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

3. PESTLE Analysis

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

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

The following summary relates to the Pestle Register from page 7 through page 16 in this report.

3.1 Frequency of Updating

- There are 60 current entries in the PESTLE record. This is an increase of 2 since the last update to Trust Board (as there were 2 removed as agreed).
- 2 of the 60 entries have been added this time.
- 8 of the total entries have been updated this time.
- 25 of the entries remain unchanged for more than a year.

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

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

3.2 Alignment to the Trust Risk Register

- 13 of the 60 entries are matched against current risks which are being managed on the Trust's organisational risk register. This matching indicates a degree of correlation between risks and PESTLE entries. The majority of those issues are being managed within the agreed risk tolerance. This cross referencing is a continual and ongoing exercise to determine alignment between the Trust risk register and the PESTLE analysis.

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

4. SWOT Analysis

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

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

The following summary relates to the SWOT register from page 17 through page 27 in this report.

4.1 Frequency of Updating

- There are 94 current entries in the SWOT register.
- 20 of the 94 entries have been added this time.
- 15 of the total entries have been updated this time
- 3 have been marked for suggested deletion next time as no longer relevant.
- 40 of the 94 entries remain unchanged for more than 1 year.
- All entries have been checked that they are still current, valid, and up to date.

5. Alignment to the Trust Risk Register, Five year plan, and financial sustainability planning

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

A comparison of 'weaknesses', 'opportunities' and 'threats' in the register indicates that 35 out of the 96 entries are matched against risks in the Trust operational risk register. This matching includes 8 'weaknesses', 10 'opportunities', and 17 'threats' that have been aligned. The report also shows that most risks are managed within the agreed risk tolerance.

This analysis has also been used to inform the development of Trust five year plan and financial sustainability plan, and specifically, the mid-year review of priority programmes.

The report also highlights where 'weaknesses' and 'threats' are being addressed through the priority programmes in the Trust's plan. Generally there is strong alignment. The Trust is now examining the business capacity and capabilities for change that is required to successfully undertake the identified priority programmes of work for the Trust in 19/20.

6. Summary of analysis

The PESTLE and SWOT analysis indicate that the Trust's strategy and strategic ambitions are both relevant and making significant progress. Some of the key areas are summarised below:

We continue to play a strong role through both Integrated Care Systems that we are partners in. The Trust is leading on a number of key programmes that will ensure that we are a recognised centre of excellence regionally for forensic, learning disability and specialist services, as we are now hosting and leading the Operational Delivery Network across Yorkshire and Humber and lead the Forensic new model of care across west Yorkshire in line with strategic ambition 1.

A number of our services have been recognised locally, regionally and nationally and our communications team have won several awards recognising the work that they have done to support improvements across the Trust. We continue to be a strong partner in each of the places that we provide services and continue to play a lead role in local integrated care partnerships. We have also had local, regional and national interest in the work that we are doing on co-production and asset based approaches delivered through our recovery colleges, creative minds and our partnership with the third sector and 'Live well service'.

Our Care Quality Commission report (2019) highlights that more than 87% of the individual ratings are good or outstanding and 12 of our 14 core services are rated Good. The overall rating for the Trust improved to GOOD. CQC rated effective, caring, responsive and well-led as good. The report also highlights our strong approach to system working and developing partnerships. However, the report highlights that there is a requirement to improve our adult acute inpatient and PICU services and CAMHS service and overall we need to improve our 'Safety' from requires improvement.

As a Trust we have prioritised making the Trust a great place to work as a fourth strategic objective and we have made considerable progress in ensuring that we provide modern digitally enabled environments for both staff and patients. We have some of the best estate across the region supported by significant investment over the recent years and agile working is also a strength across the Trust. The Trust has developed an award winning approach to supporting staff wellbeing and the #Allofus campaign has been recognised nationally. The Trust is making

progress in developing an inclusive workforce and has a diverse Board and strong staff networks including the BAME, LGBTQ+, Disability and Carers staff networks. This provides us with strong foundations to address the challenges we face due to national shortages for some professional groups and the changing nature of health and care delivery. We will need to continue to focus on ensuring that we are able to recruit, and retain our workforce to deliver services and respond to the changing context on integrated working in places.

We are well placed to capitalise on investments to support the delivery of the long term plan that will enable us to meet the needs of our diverse and changing populations. We will need to ensure that our services continue to be genuinely transformed so that they are fit for the 21st century in line with ambitions set out in the Long term plan. This will require focus on workforce, continued focus on developing new models of care, and accelerating the use of digital and creative opportunities to improve the health and well-being of the population that we serve.

7. PESTLE Register

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

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

Political	1.4	Nine integrated care systems (ICS's) were announced as the first wave and in May 2018 an additional number of ICS's were announced in the second wave of sustainability and transformation partnerships (STPs) to become ICSs. This included the West Yorkshire and Harrogate (WY&H) ICS. The long term plan (LTP) emphasises the stronger role of ICSs in system oversight and regulation. ICSs to be across the UK by April 2021. Work continues to ensure strong links between SWYPFT, the WY&H ICS, South Yorkshire ICS, and local elected members and Health and Wellbeing Boards. The Trust is actively involved in west and south Yorkshire integrated care systems place-based plans that impact on clinical services are governed and managed through trust-wide integrated change process at EMT and discussed at Trust Board.	Jan-17	Mar-19		695				
Political	1.5	Impact of continued austerity for local authorities coupled with perception of strong 'NHS' focus of integrated care system plans/partnerships guidance may make local political alliances with elected members more difficult which may manifest through Health and Wellbeing Boards and Overview and Scrutiny Committees.	Pre Apr 16	Mar-19						
Political	1.6	Continued emphasis on collaborative place based approaches to improvement and associated changes in organisational form such as integrated care systems and partnerships indicate a subtle shift away from market based drivers of improvement. The Trust is playing a key role in each of the partnerships that are emerging and developing for the places in which we provide services to mitigate the risk on quality and sustainability of services in the Trust.	Pre Apr 16	Apr-18		812				
Political	1.7	The continued uncertainty of the impact of the UK referendum decision on EU membership. Potential to alter previous assumptions regarding the quantum and focus of public spending, which underpin NHS budget projections. The potential to impact on workforce availability. Longer term potential to impact on public procurement and other public law. Initially has at least re-affirmed the importance of the NHS to the public but the continued uncertainty is a concern.	Pre Apr 16	Mar-19						
Political	1.8	Increased Treasury influence over the style and emphasis of Department of Health and Social Care (DoH) and NHS England (NHSE) communications, also impacting on regulatory regime.	Oct-16	Mar-19						
Political	1.9	The political stance on NHS employment contracts, e.g. Junior Doctors, emphasises the potential for continued discontent and disruption. Changes to IR35 and to NHSI expectations on limiting the use of agency highlight the changing political position and public affinity with healthcare professions acting as locums and agency workers.	Pre Apr 16	Mar-19						
Political	1.10	The impact of Yorkshire devolution /mayor plans and devolvement of major powers to the region could move key decision making on Government funds to the region.	Apr-18	Apr-18						

Political	1.11	Continued regulatory and commissioner scrutiny on people who are placed out of area. There is a risk that quality of care will be compromised if people continue to be sent out of area. We are working with partners and commissioners on a joint action plan in relation to monitoring and management of out of area cessation plans, including local plans of change activity to reduce admissions and plans to reduce length of stay.	Jul-18	Mar-19		1319				
Political	1.12	The appointment of Matt Hancock MP as SoS for Health and Social Care in July 2018 with top priorities of: workforce, technology and prevention and his support for the NHS Long Term Plan (also called the 10 year plan).	Sep-18	Mar-19						
Political	1.13	The future of agreements following Brexit, if it occurs, continue to be uncertain. If the UK does leave the EU and if a deal on the arrangements necessary post Brexit are made then the following will need to be included: <ul style="list-style-type: none"> • Legal and regulatory systems would carry on as they currently are until the end of the transition period (31 December 2020) • Eligible EU staff will be able to apply for settled status/work towards it in the UK If there is no deal made then there's the risk that 'no deal' Brexit could affect product, medicines and staffing availability: <ul style="list-style-type: none"> • EU medicines approvals would convert into UK approvals • Existing business continuity plans should include a reference to no deal • UK is expected to offer settled status unilaterally – but this is yet TBC. 	Sep-18	Mar-19		1369				
Political	1.14	As part of implementing the key role of ICSs at place level in accordance with LTP ambitions, commissioning arrangements will be streamlined to leaner Clinical Commissioning Groups (CCGs). The aim is typically to have 1 CCG per ICS area, although WY&H are developing a response that is consistent with its partnership approach and centrality of place within that.	Mar-19	Oct-19	√					
Political	1.15	There is potential for a general election in the near future which could impact on health and care policy, funding, and current legislative review led by NHSE/I. NHSE/I have recommended to the Secretary of State that Implementing the NHS Long Term Plan – Proposals for possible changes to legislation are included as an 'NHS integrated care bill' within the Queen's Speech. If there is a general election, we would expect an NHS bill to be included in party manifestos, and for any proposals for legislative change to be re-developed, potentially substantially depending on the makeup and majority of the government, as well as the degree to which the government supports NHSE/I taking a lead (as opposed to the Department of Health and Social Care).	Oct-19	Oct-19	√					

Economic	2.1	Gap between ideal of Five Year Forward View (FYFV) funding shift (prevention, primary care, mental health etc.) and the reality of 2017–2019 contracts enabled debate with commissioning partners. Collaboration re mental health investment standard helping establish shared intent. Changes in funding outlined in the NHS Long Term Plan supports collaboration and parity of esteem between Mental Health, Learning Disabilities, and Physical Health with a strong emphasis on tackling inequalities and prevention	Jan-17	Oct-19	√					
Economic	2.2	Increased impact on jobs, services and income related to public health prevention services. Pace of change increased significantly, linked to continued austerity in local authorities	Oct-16	Oct-17		1158				
Economic	2.3	Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices. NHS Improvement and HMRC interventions continue to impact	Oct-16	Mar-19						
Economic	2.4	The impact of NHS financial control measures on both commissioners and providers – particularly around control totals, agency caps, etc. There is stronger financial interdependence across health systems through integrated care systems-level control totals, as underlined in the FYFV and in the NHS long term plan.	Oct-16	Mar-19		812				
Economic	2.5	Impact of current employment market for clinical and IT staff, manifesting in buoyant agency market, driving cost growth for Trusts in excess of plans and 'cap'. Risk that wards are not adequately staffed, leading to increased temporary staffing and potential negative impact on quality of care provided. Safer staffing group meet on monthly basis and temporary staffing is monitored via OMG.	Oct-16	Oct-17		905				
Economic	2.6	Major Cost Improvement Programme requirements of financially challenged health and social care providers leading to sub-optimal approaches to pathways and partnerships within local health economies, and unintended consequences associated with services stopping/ failing and risk of deterioration in quality of care provided. Active involvement in both West and South Yorkshire integrated care systems and engagement in each place with partners through meetings and joint working.	Jul-16	Oct-17		275				
Economic	2.7	The planned increase in funding to support the LTP, particularly with a 'guarantee' that investment in primary, community and mental health care will grow faster than the level of growing overall NHS budget. 2019/20 planning guidance includes independent assessment of CCG MH investment through ICS. There is a risk that the Trusts financial viability will be affected as a result of changes to national funding which is being mitigated through the annual planning process and continued external engagement and communications with stakeholders.	Jul-16	Mar-19		522				

Economic	2.8	The Government has lifted the 1% pay cap and NHS chiefs and health unions in England have agreed a three-year pay deal pending membership agreement. The pay scales are set for 2019/20 and beyond giving us certainty on the values so will not increase financial risk. It is yet to be seen if this will provide relief on the recruitment and retention of staff that has been experienced.	Sep-17	Mar-19						
Economic	2.9	The strength, viability and maturity of the third sector to operate fully in the competitive market place impacts on the degree of flexibility that the Trust can partner to provide flexible and diverse services within health enabling us to reach into and benefiting communities.	Apr-18	Apr-18						
Economic	2.10	The Carter report published in May 2018 leading to increased discussions on unwarranted variations and productivity in mental health services and community health services. This provides increasing opportunities to address the issues raised in the report along with increased focus on efficiencies.	Jul-18	Mar-19						
Economic	2.11	The long-term funding of adult social care continues to be unclear with the publication of the Green Paper on social care for adults being further delayed.	Aug-18	Mar-19						
Economic	2.12	An increase in funding over the next 5 years to support the LTP (with a new guarantee that investment in primary, community and mental health care will grow faster than the level of growing overall NHS budget), builds on the progress of the Five year forward view for mental health.	Aug-18	Mar-19						
Economic	2.13	At present, demand and capacity issues across West Yorkshire and nationally have meant that children and young people requiring a CAMHs bed are temporarily located in a bed assigned for adults. Development of a new CAMHs inpatient facility in Leeds for West Yorkshire is scheduled for completion in 2020. Planned investment outlined in the Long Term Plan can support improvements to services. Transformation funding through the ICS's to support MH community services and children and young people's services have been secured for 2019/20	Mar-19	Oct-19	✓	1368				
Socio-Cultural	3.1	High profile campaigns, celebrity endorsement, local action and the aspirations of the NHS long term plan are all impacting on societal attitudes towards mental health increasing recognition of widespread prevalence and relevance in the lives of all and potentially removing the societal stigma of mental health conditions. Together with the NHS long term plan for services for young people, the likely uptake and demand for MH services and the whole system response has the potential to increase the likelihood of people seeking help, thereby increasing demand, but also potentially increases likelihood of people seeking help earlier increasing opportunities for effective early intervention.	Jan-17	Mar-19						
Socio-Cultural	3.2	Migration trends into the UK show increasingly diverse countries of origin, increasing complexity in service provision, and enriching local communities.	Jan-17	Jan-17						

		Future impact of Brexit on European migration trends not yet fully understood.								
Socio-Cultural	3.3	Impact of demographic change on the demand for services and also on workforce age profiles.	Pre Apr 16	Mar-19						
Socio-Cultural	3.4	Changing expectations of services, greater expectation of personalisation, higher standards of customer service and responsiveness, greater level of co-production. Policy makers and commissioners expect more self-care and emphasis on prevention all supported by the NHS long term plan. This requires changes in workforce requirements with new skills, new roles and new psychological contracts at work. Risk of not being able to recruit qualified clinical staff is being mitigated via safer staffing review and development of new roles such as Advanced Nurse Practitioner.	Pre Apr 16	Mar-19		1151				
Socio-Cultural	3.5	The national shortages of clinical staff is affecting the Trusts ability to recruit suitably qualified clinical staff which may have an effect on: the safety and quality of our services and the effective delivery of the Trust strategy, particularly in the ability for future development in services and increases our expenditure on bank and agency staff to fill the shortage gap.	Feb-18	Mar-19						
Socio-Cultural	3.6	The provision of effective health and wellbeing services are a significant contribution to the political ideology of social solidarity, initially proposed by Nye Bevan, which allows people to cope with life situations, have more choices, cope better with anxiety and depression and therefore improve confidence, motivation and wellbeing and sustain engagement in life of those people beyond the boundaries of illness.	Apr-18	Apr-18						
Socio-Cultural	3.7	The benefits of new health approaches – social prescribing, self-management, co-production, asset based approaches (placing people’s skills, networks and community resources alongside their needs to improve care and support) are helping to reduce dependency on health professionals and encourage sustainable development of a community’s health.	Apr-18	Apr-18						
Technological	4.1	Increased threat from cyber-crime impacting on NHS bodies – resulting in additional cost of defence and prevention, and heightened risk of disruption to service provision and/or theft of personal data. (mitigated by business continuity plans).	Jan-17	Jan-17		1080				

Technological	4.2	Digital technologies, and the continued direction of travel in public service towards “digital by default” are a key enabler for and driver of change within the Trust and externally. In addition, “political will”, individuals and communities drive demand for health and care providers to keep pace with their use of technology as in other aspects of their lives. This has been adopted by the Trust and is central to the digital strategy that has now been approved and initiatives like the ORCHA pilot in CAMHS are enabling that very strategy. The Trust has developed considerable infrastructure to support agile working. The use of NHS apps and digital technology is emphasised in the NHS LT Plan. The Trust is also working with partners as part of the WY&H ICS, SYB ICS. Both ICS’s have supported the Digital Charter that has been endorsed by the Local Health and Care Record Exemplar (LHCRE) Board, which is chaired by the Trust	Pre Apr 16	Oct-19	✓					
Technological	4.3	Inequalities in technology access, Literacy, and acceptance are slowly being eroded, but persist as a factor impacting on service design and access. In some ways technology inequalities mirror broader socio-economic inequalities, and as such are of relevance to deliver the Trust mission and objectives.	Jul-16	Jul-16						
Technological	4.4	Continued growth in use of social media by a wide range of demographic groups, changes the way in which customer experience and service quality is evaluated – becoming more open, faster, and comparable – e.g. Patient Opinion. Supports choice agenda, potentially links to commissioner decision making. Technology is also supporting the speed in which we receive friends and family feedback, as we use text messages and hand held devices.	Pre Apr 16	Oct-19	✓					
Technological	4.5	Technology enables improved access and use of data – telehealth monitoring of vital signs, self-reported well-being etc. Creates a different dialogue between service user and healthcare service provider – supports personal control, self-care, and movement towards coaching approaches. As supported in the LTP	Pre Apr 16	Mar-19						
Technological	4.6	Interoperability of clinical systems, and enhanced analytical functions (data warehouses, big data etc.) support evidence based care at system level and in relation to integrated care planning at an individual level. Creates demand for cross-organisational platforms for integrated working. The LTP accelerates opportunities to integrate and standardise health care information across care systems and actively supports collaborative digital opportunities across the regions.	Pre Apr 16	Mar-19						
Technological	4.7	Platform technology potentially allows Trust’s to widen the range of offers available to service users e.g. mobile apps, enables more peer to peer support, promotes innovation and provides data on choice. Also platforms have potential to disrupt traditional ‘supply chain’ based markets – e.g. Uber, Airbnb, eBay etc.	Jul-16	Jul-16						
Technological	4.8	Increased use of communications technology for consultation – engagement of carers/ Multi-Disciplinary Teams etc.	Pre Apr 16	Jul-16						

Technological	4.9	Technology opens up wider possibilities in terms of 'remote working', operating over a larger geography, and different option for provision of support services including more self-service, more collaboration and traded services between NHS partners and integrated care organisations.	Pre Apr 16	Mar-18						
Technological	4.10	The provision of agile working (using communications and information technologies to enable staff to work in ways which best suit their needs) offers the capacity to help the Trust become a more responsive, efficient and effective organisation, ultimately improving performance.	Apr-18	Apr-18						
Legal/Regulatory	5.1	Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions (e.g. Integrated Care System, Multi-specialty Community Provider), and for service line specific collaboration (e.g. mental health). Gap emerging between regulatory and legal frameworks and the intended future structures for integrated place based care provision	Jan-17	Mar-18						
Legal/Regulatory	5.2	The effects of the changing landscape of health regulation is developing with NHSE and NHSI establishing new working arrangements delivered through integrated teams with the devolution duties of financial oversight, provider configuration, regulation and special measures moved to these new regional directorates. The first appointments to the new unified NHS Executive Group will be in place from April 2019 and although it is still not yet clear what the effects of this closer working arrangement between NHSE and NHSI will be it will bring together a new CQC inspection and framework; NHS Improvement's Single Oversight Framework and alignment with Care Quality Commission; diminished emphasis on previous markers of independence such as Foundation Trust status and more focus on system-wide view of finance, quality and governance.	Pre Apr 16	Mar-19						
Legal/Regulatory	5.3	Care Quality Commission visit and subsequent publication of ratings of Trust services confirm regulatory position of the Trust overall and in relation to specific factors – this shapes future regulatory framework and frequency of review for the Trust.	Jul-16	Jul-16						
Legal/Regulatory	5.4	Some signals of changing commissioner alignment and relationships. In terms of commissioner to commissioner relationships, and also breaking down aspects of purchaser/ provider split. Committees in common in West Yorkshire and South Yorkshire, and provider to provider alliances starting to take shape.	Oct-16	Oct-16						

Legal/Regulatory	5.5	Mergers and Acquisitions regulation and guidance – legal and regulatory framework unchanged but the anticipated approach to the practical application of this regulatory framework is uncertain in light of shift towards system based solutions. Implementing the NHS Long Term Plan – Proposals for possible changes to legislation. The engagement documentation, NHS Legislation Survey issued by NHSE on 28 th Feb 2019, proposes possible changes – includes changes to primary legislation relating to the NHS. The legislation is designed to solve specific practical problems that the NHS faces and avoid creating operational distraction, with the intention of making the implementation of the NHS LTP easier and faster. These changes offer significant opportunity to further strengthen joint working across ICSs such as West Yorkshire and Harrogate. In September 2019, NHS England and NHS Improvement (NHSE/I) published a revised set of legislative proposals for a targeted NHS bill, developed over the course of 2019 and through NHS Providers’ engagement. The proposals put forward are deliberately targeted, and are not intended to completely restructure the NHS but could mark a significant change to how the NHS operates in the future supporting system working and collaboration.	Pre Apr 16	Oct-19	✓					
Legal/Regulatory	5.6	The NHS LTP places greater emphasis on choice and parity of esteem between mental health and physical health.	Mar-18	Mar-19						
Legal/Regulatory	5.7	The review of the Mental Health Act 1983 (2007), commenced in May 2017, is likely to bring changes to legislation to change the way that care to people under the Act is delivered. Sir Simon Wessley has now completed and published the findings of the review. The recommendations, if approved, will have implications for staff training and practice. There will also be increased scrutiny by the Tribunal service re decision making in certain areas. Final report due out December 2019	Mar-18	Oct-19	✓					
Legal/Regulatory	5.8	A draft bill following review of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) could potentially impact on Trust resources and the way in which we work with regards to administration of DoLS. Introduction of the draft bill could likely increase the Trusts resources required to implement and monitor the scheme, re-train the workforce, make changes to policies and procedures as well as incur additional costs for best interest assessors. The bill has now received Royal Assent and implementation date is now October 2020. The codes of practice and guidance are due out in December 2019 for consultation.	Apr-18	Oct-19	✓					
Legal/Regulatory	5.9	The review to develop a new NHS estates strategy to achieve best value from NHS estate; target the sale of surplus or inefficiently used NHS property; release land to build new homes on NHS land; support the realisation of the LTP and	Apr-18	Apr-18						

		enable clinical transformation to deliver world class care will brings changes to the Trusts estate strategy.								
Legal/Regulatory	5.10	Changes in law to data protection legislation with the introduction of the EU General Data Protection Regulation (GDPR) from 25 th May 2018 affect how the Trust governs the management and use of patient data and may attract financial penalties if these measures are not met. Internal audits and centralisation of function such as subject access requests have been put in place to mitigate this risk.	Mar-19	Mar-19		1216				
Legal/Regulatory	5.11	There is a legal regulatory framework provided through health and safety legislation for employers to provide employees with a safe and secure workplace in which to work. The legal remedies to provide appropriate management specifically on aggression and violence and on manual handling for the Trust are considerable.	Jan-17	Jan-17						
Environmental	6.1	Local Economic Partnership areas developing plans linked to local authority housebuilding and development control policy. Likely to increase density of population in some areas and change the environment.	Pre Apr 16	2 yrs +						
Environmental	6.2	Change in travel patterns as part of new service models and technological change – e.g. more home based care but fewer trips back to base. More support staff using video conferencing	Pre Apr 16	2 yrs +						
Environmental	6.3	Opportunities around renewal energy are emerging	Pre Apr 16	2 yrs +						
Environmental	6.4	Climate change is something that affects us all, both now and in the future. A number of the local authorities across the Trust footprint have declared a climate emergency and have prioritised environmental sustainability. The Trust is a partner in these activities and is developing a revised strategy to support local improvements to be more environmentally sustainable.	Oct-19	Oct-19	✓					

8. SWOT Register

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

Category	Ref.	Description	Date First Added	Date Last Updated	Updated This Time?	Cross Ref. with ORR	Current Risk Level	Risk Appetite	Target Risk level	Link to Strategic Priority Programmes
Strength	1.1	Compelling model for alternative capacity – Creative Minds, Recovery Colleges and Altogether Better is well aligned to LTP direction and offers opportunities for partnership in local place-based solutions such as ICS	Pre Apr 16	Mar-19						
Strength	1.2	Clarity of approach to management of partnerships and contractual relationships with other providers, and track record of integrated teams and multi-agency joint-delivery, is a strength in formation of integrated care systems.	Jul-16	Mar-18						
Strength	1.3	Partnership track record and place based delivery structure underpinned by clear FT governance arrangements including plans to fully engage and mobilise an active public membership – all key for system leadership in emerging ICS's and place based integrated care partnerships.	Oct-16	Mar-19						
Strength	1.4	Developing partnerships with neighbouring providers of mental health and learning disability services, aligned to achievement of ICS aims. For example, The Trust has worked with partners in West Yorkshire to agree lead provider collaborative for eating disorders, CAMHS and secure care.	Oct-16	Oct-19	✓					
Strength	1.5	'Centres of excellence' within services recognised internally and externally – e.g. Five of our early interventions in psychosis (EIP) teams have been named as some of the best performing in the country. All of our teams achieved the National Clinical Audit of Psychosis (NCAP) standard, with four of the five teams rated as 'Top performing'. Only 11 teams (7%) in the whole country were rated as 'Top performing'. Our Wakefield health integration team were shortlisted for the Community and General Practice Nursing Award of the prestigious RCNi Nurse Awards. The team were one of just five finalists in their category. Forensic services taking a lead role in developing a new model of care through the WY&H ICS; leading implementation of suicide prevention strategy for WY&H ICS; and leading on partnerships, e.g. Wakefield MH Alliance and the Kirklees MH and Wellbeing Alliance.	Jan-17	Oct-19	✓					

Strength	1.14	Our stakeholder survey indicates partners consider the Trust to be well led with an important role to play in the formation and delivery of local place based plans.	Jan-17	Jan-17						
Strength	1.15	Recognition of our services through local, regional and national awards raises the profile of the trust and celebrates outstanding achievements. In 2019 these included: Barnsley's intermediate care chosen as the winner in the 'Close Partnering and Collaboration Award' category of the 2019 Healthcare Financial Management Association (HFMA) Yorkshire and Humber awards, Wakefield College named our Trust as apprentice employer of the year in their apprenticeship awards 2019, and the long-standing collaborative relationship between Interserve and the Trust has been recognised by Constructing Excellence at its annual awards ceremony. Our insight-led campaign won 'Most innovative flu fighter campaign' at the NHS Employers Flu Fighter awards ceremony in Manchester on Monday 25 March, Our #allofus wellbeing campaign, which helps keep a focus on the wellbeing of staff so that we can provide the best possible care, was chosen as the winner in the 'Communications initiative' category of the HSJ Value Awards on Thursday 23 May.	May-18	Oct-19	✓					
Strength	1.16	Partnership working by the Trust with the 3 rd sector (voluntary and community sector) plays a significant role in strategic partnership working and in creating and maintaining local care network model. For example, partnership working with Nova and Living Well Service in Wakefield.	Jan-19	Jan-19						
Strength	1.17	The occupational health team has introduced a proactive process to support staff to manage distress caused by work and was noted as best practice in the recent CQC report	Aug-19	Oct-19	✓					
Strength	1.18	There are positive indicators that SWYPFT is a great place to work. WRES data indicates improvements in some areas; we have a diverse Trust board; staff networks established such as BME, LGBTQ+, Disability and Staff carers network; excellent staff side relations; agile and flexible working; and established leadership and management development framework in place.	Aug-19	Oct-19	✓					
Strength	1.19	The Trust has made significant investment in modern and high quality estates and digital infrastructure, evidenced by new hubs such as Drury Lane and the development of the Unity Centre; agile working; and the Trust-wide SystemOne implementation.	Aug-19	Oct-19	✓					
Strength	1.20	The Trust is taking active steps to support local improvements to be more environmentally sustainable. For example, to reduce waste and help the environment by reducing the use of single use plastics across all catering.	Aug-19	Oct-19	✓					
Strength	1.21	Intermediate Care Services are now delivered through an Alliance Contract .The service provides an integrated pathway for patients in Barnsley delivered by SWYPFT, Barnsley CCG, Barnsley Hospital NHS Foundation Trust, Barnsley Healthcare Federation and the Local Authority. Pulmonary Rehab pathways, and	Aug-19	Oct-19	✓					

		Stroke provision, are also both provided via integrated pathways.									
Strength	1.22	The Trust has supported a reduction in smoking prevalence e.g. Yorkshire Smoke Free Barnsley have supported a significant reduction in smoking prevalence (18.2% from 20.6%). We have worked in partnership to develop a proposal for implementation of QUIT across the ICS	Aug-19	Oct-19	✓						
Strength	1.23	SWYPFT have continued delivery of the schools flu programme in Barnsley with 2 additional year groups to be added year on year. This means approximately 6,000 children added to the eligible cohort over the next 2 years, and the vaccine being offered to all primary school children attending a Barnsley school.	Aug-19	Oct-19	✓						
Weakness	2.1	Some elements of data quality undersell the true quality and contribution made by the Trust. But examples of poor use of data that undermine stakeholder confidence and therefore impacts on Trust reputation and sustainability.	Pre Apr 16	Oct-18							
Weakness	2.2	There are some Trust services where access to help can be too slow and needs to improve and there is a risk that people will suffer as a result of waiting for treatment. This requires changes within services as well as improvements supported by commissioners to achieve the right level of capacity.	Pre Apr 16	Apr-18		1078					
Weakness	2.3	We need to better recruit, retain, motivate and value the health and wellbeing of our staff. In common with other Trusts we experience difficulties in ensuring that we have the right workforce in some hot spots. e.g. staff grade doctors, ward based nursing staff, Psychological Wellbeing Practitioners in Improving Access to Psychological Therapies. Opportunity to re-think models of care and roles and avoid negative impact upon quality of care provided.	Pre Apr 16	Oct-18		905					
Weakness	2.4	Our IT systems don't always support the desired agile style of working, particularly for those working in community services and non-SWYPFT locations, where connectivity or access to systems is not effective.	Pre Apr 16	Oct-17							
Weakness	2.5	Our most recent CQC Report from August 2019 highlights that there is a requirement to improve our adult acute inpatient and PICU services and CAMHS service. And overall we need to improve our 'Safety' from requires improvement.	Jul-16	Oct-19	✓						
Weakness	2.6	Sometimes we act in silos, with particular need to address gaps between operations and corporate support, and between strong local identities.	Jul-16	Sep-17							
Weakness	2.7	There is a gap between our brand and offer as we would like it to be – 'integrated holistic care' and the perceptions of many of our stakeholders, who often see us as focused on mental health alone.	Oct-16	Jan-17							
Weakness	2.8	Sometimes our approach is too bureaucratic, and colleagues and partners would like us to be faster in making decisions	Jul-16	Aug-17							

Weakness	2.9	Our approach to change takes too long, and is not always as engaging as it needs to be.	Jul-16	Oct-18		695				
Weakness	2.10	We have made improvements but we continue to make unnecessary and avoidable Information Governance breaches which undermine service user, commissioner, and regulator confidence and trust.	Jul-16	Sep-17		852				
Weakness	2.11	In some of our place based/integrated care system discussions with partners our broad geography can be portrayed as a lack of 'belonging' to each specific place and community	Apr-17	Mar-18						
Weakness	2.12	Our previous clinical record system (RiO) had not been reliable, resilient nor robust since November 2015, due in most part to how the system has been developed by the vendor, which impacts on effectiveness and the morale of staff using the system. The Trust selected a provider of a new CRS system (SystmOne) which has successfully gone live and is in the latter stages of implementation across inpatient and community MH and LD services. Recommended for closure as SystmOne has now been safety implemented	Oct-17	Mar-19	✓					
Weakness	2.13	The sustainability of the Trust relies on the level of contracted 'business' and the loss of any business could affect financial, operational and clinical sustainability	Feb-18	Feb-18		1077				
Weakness	2.14	A lack of engagement with external stakeholders and the resulting potential misalignment to commissioning intentions may result in non-achievement of the Trust's strategic ambition as set out in the Trust strategy	Feb-18	Feb-18		773				
Weakness	2.15	CQC overall rating reduced from good to requires improvement recommended for closure as no longer relevant	Jul-18	Jul-18	✓					
Weakness	2.16	High number of people continue to be placed out of area with the potential to compromise quality of care	Jul-18	Oct-18		1319				
Weakness	2.17	The CQC report 2019 identified that Children and young people were waiting over 18 weeks to receive treatment in some areas. Across the Wakefield and Barnsley service referral to treatment times exceeded 18 weeks. There were significant delays in accessing assessment for children and young people with autism spectrum disorder in all locations that offered this service.	Aug-19	Oct-19	✓	1078				
Weakness	2.18	The newly implemented clinical record system, SystmOne, requires further focused work, through an optimisation work programme, to ensure the system is used consistently to support reduction in clinical variation and the full benefits are enabled to be realised across the Trust.	Oct-19	Oct-19	✓					

Opportunity	3.1	Through the development of integrated care partnerships we have opportunities to provide integrated joined up care and engage local populations in their health. Integrated care developments in Barnsley, Alliance developments in Wakefield, Kirklees and Calderdale Cares have the opportunity to demonstrate this.	Jul-16	Mar-18								
Opportunity	3.2	We have an opportunity to become a national leader in shaping the future provision of low and medium secure forensic mental health, born out by the selection of SWYPFT as regional lead provider in forensics.	Jan-17	Mar-19								
Opportunity	3.3	The integrated nature of our organisation, with reach into several localities across many different services, means we are well placed to play a leading role in the changing shape of health and care provision, in which further integration is anticipated, of both a place based and a service-specific nature.	Pre Apr 16	Sep-17								
Opportunity	3.4	We can forge stronger collaboration and promote the delivery and growth of innovation through our connectivity to integrated care partnerships. In particular we have an opportunity to make a bigger contribution to the South Yorkshire ICS e.g. in the mental health workstream, to secure sustainable pathways and West Yorkshire and Harrogate Health and Care Partnership developments in new models of care.	Jul-16	Oct-18		1114						
Opportunity	3.5	By fully rolling out our devolved approach to leadership we can empower and inspire more people and continue becoming an employer of choice and delivering great results in partnership with our service users.	Jan-17	Mar-19		1151						
Opportunity	3.6	We can use the learning from our stakeholder engagement work on brand and strategy to forge excellent relationships with primary care as the bed rock of place based care systems.	Jan-17	Mar-18		1214						
Opportunity	3.7	The Trusts priority programme to make the Trust a great place to work provides us with the opportunity to respond to the key challenges faced by the services regarding workforce and the changes in workforce required to meet increasing service demands and acuity levels through maximising productivity and new ways of working. We can use our skills in health and wellbeing and health coaching to support our revised workforce strategy with a focus on retention and wellbeing.	Jan-17	Oct-19	✓	1151						
Opportunity	3.8	We can use the replacement of our clinical records IT system for mental health as an opportunity to improve quality, safety, and efficiency; and to create a system fit for the integrated place based systems of care envisaged in our integrated care partnerships and integrated care system plans.	Jan-17	Mar-18								

		to 32 days or fewer by 23/24.								
Opportunity	3.21	The Trust has submitted a proposal to NHSE to be lead provider for secure care in West Yorkshire and has been placed on the “further development track” to be a lead provider from April 2021.	Oct-19	Oct-19	✓					
Opportunity	3.22	Through the ICS’s digital strategies, there is the opportunity to actively support and participate in collaborative digital opportunities across the regions, places as appropriate, with the opportunity to be 100percent compliant with mandated cyber security standards by summer 2021.	Oct-19	Oct-19	✓	1080				
Opportunity	3.23	There is the opportunity to develop and deliver an integrated community services offer in Barnsley	Oct-19	Oct-19	✓					
Opportunity	3.24	There is an opportunity to explore the way we offer care and support to people living with mental health, learning disabilities and autism so we can identify opportunities to improve physical health and to increase the number of physical checks for people living with learning disabilities and autism.	Oct-19	Oct-19	✓					
Opportunity	3.25	There is the opportunity for greater involvement in regional networks and peer mentoring relationships in our local areas as they implement personal health budgets (PHBs)	Oct-19	Oct-19	✓					
Threat	4.1	Loss of autonomy arising from failure to achieve key financial and service delivery measures – resulting in increased regulatory attention, and diversion of effort away from progressive activities.	Jan-17	Jan-17		812				
Threat	4.2	If place based ‘integrated care’ systems are developed which result in significant loss of contracts for the Trust this would be a de-stabilising factor requiring a step change reduction in organisational cost base, and therefore a threat to viability.	Jan-17	Mar-18		522				
Threat	4.3	Focus on one or two particular issues could be a distraction to ensuring that all key performance metrics are given sufficient and appropriate focus and time.	Oct-16	Oct-17						
Threat	4.4	It is possible that well-developed infrastructure around service delivery and gaps between corporate support and operations may lead to a lack of agility to respond to changing priorities quickly enough.	Pre Apr 16	Sep-17						
Threat	4.5	Impact of continued austerity on public spending (particularly Local Authorities) leading to additional unplanned pressures on the Trust. This manifests in terms of additional demand for Trust mental health services (e.g. as a result of benefit restrictions).	Pre Apr 16	Oct-18		275				
Threat	4.6	Threat of decommissioning of services may result in loss of services and financial income.	Jan-17	Apr-18		1156				

Threat	4.7	Data quality and information governance issues may lead to regulatory action and reputational damage.	Pre Apr 16	Sep-17		852				
Threat	4.8	Threat that the under-delivery of cost improvements reduces funding available for investment in required capital schemes including IM&T	Jan-17	Sep-17		1076				
Threat	4.9.	Threat that the under-delivery of cost improvements impacts negatively on cash flow, necessitating undesirable urgent cost control measures, and negatively impacting on key operating measures that trigger regulatory action	Apr-17	Oct-17		1114				
Threat	4.10	Threat of cyber-attack impacting on operational continuity and stakeholder confidence	Apr-17	Sep-17		1080				
Threat	4.11	The development of an integrated care system for WY&H ICS may lead to the Trust sharing accountability for achievement of a system wide control total and performance The Trusts control total is set as part of the WY&H ICS. A change in system performance across the ICS may impact the shared control total which in turn may then have an impact on the Trust.	Apr-17	Oct-19	✓	812				
Threat	4.12	There is a threat of a sub-optimal implementation of the clinical record system (SystemOne), selected to replace our existing RiO system. Recommendation for closing as implementation phase is complete.	Oct-16	Oct-17	✓					
Threat	4.13	There is a threat that the Trusts reputation could be adversely affected by long waiting lists delaying treatment and recovery	Feb-18	Feb-18		1132				
Threat	4.14	Threat that the local tendering of services could increase, impacting on Trust financial viability.	Feb-18	Feb-18		1214				
Threat	4.15	Threat likely to the safety and quality of current services, ability for future development in services, and the effective delivery of the Trust strategy due to national shortages in clinical staff affecting ability to recruit suitably qualified clinical staff.	Feb-18	Feb-18		1151				
Threat	4.16	The constant level of tendering activity, natural in the provider sector, can have a negative impact on the moral of staff working in the 'tendered' services which could lead to sub-optimal performance and increased staff turnover.	Feb-18	Oct-18		1212				
Threat	4.17	Non, or late, submission of statutory returns could result in non-compliance with constitution and licence	Feb-18	Oct-18						
Threat	4.18	The ageing workforce who are able to retire in the next five years brings a potential loss of knowledge, skills and experience	Mar-18	Mar-18		1153				
Threat	4.19	The impact of universal credit and its roll out has the potential for some groups to lose out financially due to reduced benefits income or delays in claims for benefits may have an increased negative affect on people's mental health and therefore an increased pressure on Trust resources. This places greater emphasis on the need to continue to work with partners and Health and Wellbeing Boards to address the wider	Mar-18	Mar-19						

Threat	4.28	Failure to reduce CO2 emissions and use of single-use plastics results in the Trust not achieving its environment sustainability targets.	Oct-19	Oct-19	✓					
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Trust Board 29 October 2019 Agenda item 6.2

Title:	Board Assurance Framework (BAF) Quarter 2 2019/20
Paper prepared by:	Director of Finance & Resources
Purpose:	<p>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.</p> <p>This report provides the updated 2019/20 BAF for review and discussion at the Trust Board.</p>
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:	<p>Board Assurance Framework</p> <p>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:</p> <ul style="list-style-type: none"> ➤ 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. <p>A schematic of the BAF process is set out as an attachment.</p> <p>The BAF is used by the Trust Board in the formulation of the Trust Board agenda in the management of risk and by the Chief Executive to support his mid-year 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.</p>

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 course of the last 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 SWYPFT a great place to work':

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

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	
		Q3	Q4	Q1	Q2
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	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	Y	Y	Y
Improving resources	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to provide services effectively	A	Y	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	Y	Y	Y
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	G	G	G	Y
Making	4.1 Inability to recruit, retain, skill up,	Y	Y	Y	Y

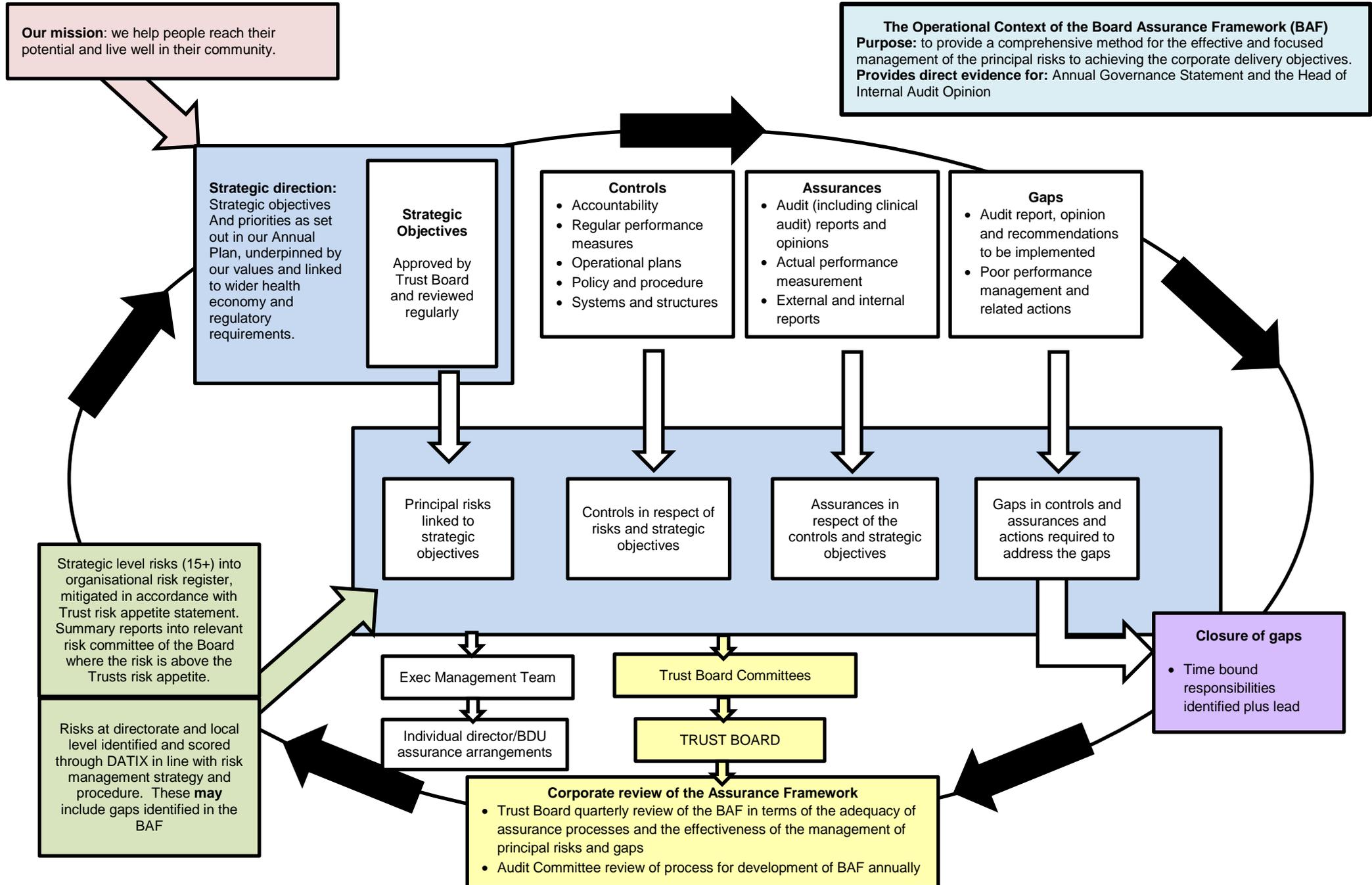
SWYPFT a great place to work	appropriately qualified, trained and engaged workforce leading to poor service user experience (2.2 in 2018/19)				
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The following changes have been made to the BAF since the last Board report in July 2019:

Strategic objective	Areas updated
Improving health	Strategic risk RAG ratings reviewed and remain unchanged.
	Rationale for current assurance level updated.
	Strategic risk 1.1 – Lead directors identified for gaps in control and assurance. Gaps in control and assurance updated, with one action in relation to gaps in assurance complete.
	Strategic risk 1.2 – Lead directors identified for gaps in controls and assurance. Gaps in assurance and control updated.
	Strategic risk 1.3 - Lead directors identified for gaps in control and assurance. One action in relation to gaps in control complete. Gaps in assurance updated.
	Strategic risk 1.4 - Lead directors identified for gaps in control and assurance. One assurance output removed (previous ref A45 in relation to monthly investment appraisal reports). One action in relation to gap in control and one action in relation to gap in assurance complete.
Improving care	Strategic risk RAG ratings reviewed and remain unchanged.
	Rationale for current assurance level updated.
	Strategic risk 2.1 – Lead directors identified for gaps in control and assurance. Gaps in control and assurance updated. Three actions in relation to gaps in assurance complete. One new action in relation to a gap in control identified.
	Strategic risk 2.2 – Lead directors identified for gaps in control and assurance. Two actions in relation to gaps in assurance complete.
	Strategic risk 2.3 - Lead directors identified for gaps in control and assurance. Control outputs updated (ref C50, C51, C56). New assurance output identified (ref A53). Gaps in assurance updated. One action in relation to gaps in assurance completed.
Improving resources	Strategic risk RAG ratings reviewed and change made to strategic risk 3.4.
	Strategic risk 3.1 - Lead directors identified for gaps in control and assurance. New control output identified (ref C84). Gaps in control updated. One action in relation to a gaps in control complete and one new action identified. One action in relation to a gaps in assurance complete and one new action identified.
	Strategic risk 3.2 - Lead directors identified for gaps in control and assurance. One action in relation to gaps in control complete. Gaps in assurance updated. One action in relation to gaps in assurance complete.
	Strategic risk 3.3 - Lead directors identified for gaps in control and assurance. New control output identified (ref C84). Gaps in control updated. One action in relation to gaps in control complete. Gaps in assurance updated.
	Strategic risk 3.4 - RAG rating updated. Lead directors identified for gaps in control and assurance. Gaps in assurance updated. One new action in relation to gaps in assurance identified.
	Strategic risk RAG ratings reviewed and remain unchanged.
Making SWYPFT a great	Rationale for current assurance level updated.
	Strategic risk 4.1 - Lead directors identified for gaps in control

	<p>place to work</p>	<p>and assurance. Gaps in controls updated. One action in relation to gaps in control complete. Gaps in assurance updated.</p>
<p>Recommendation:</p>	<p>The full detail for strategic risks is included in the attached BAF report.</p> <p>Within the Draft Head of Internal Audit Opinion for Stage 1 reported to the Audit Committee on 8 October 2019, the internal auditors provided some recommendations on the BAF for consideration. The first two have been actioned by the EMT, with the remaining three areas to be considered as part of the cyclical review in Quarter 3:</p> <ul style="list-style-type: none"> ➤ <i>Due dates should be identified against all gaps in control and gaps in assurance - complete.</i> ➤ <i>Consider whether a lead Director should be identified for the gaps in control and gaps in assurance - complete.</i> ➤ Consider whether the current RAG rating provides sufficient assessment to ensure that the BAF is reflective of the level of risk to achieving the organisation’s objectives, consideration of the risk appetite and the required target risk the Trust is aiming for. ➤ Benchmarking exercise against 19 provider BAFs top 10 risk issues noted two issues not explicitly covered: <ul style="list-style-type: none"> • Performance Targets • Estates (including H&S & Maintenance) ➤ Committees are noted as being aligned to strategic risks, however the BAF is not currently being presented at committee meetings. <p>Trust Board is asked to:</p> <ul style="list-style-type: none"> ➤ NOTE the controls and assurances against the Trust’s strategic objectives for Quarter 2 2019/20; and ➤ AGREE to an ongoing target for addressing gaps in control given the nature of the gaps and risks identified; and ➤ DISCUSS whether any action is needed in relation to the recommendations made in the Draft Head of Internal Audit Opinion for Stage 1. 	
<p>Private session:</p>	<p>Not applicable.</p>	

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS



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	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	Y		
	1.3 Differences in the services may result in inequitable services offers across the Trust	10	Y	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	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	Y		
	2.2 Failure to create learning environment leading to repeat incidents	17	Y	Y	Y		
	2.3 Increased demand for and acuity of service users leads to a negative impact on quality of care	19	Y	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	Y		
	3.2 Failure to develop commissioner relationships to develop services	25	Y	Y	Y		
	3.3 Failure to deliver efficiency improvements / CIPs	27	Y	Y	Y		
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	29	G	G	Y		
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	Y		

Strategic Objective: 1. Improving health - Working in partnership		Lead Director(s)	Key Board or Committee	Overall Assurance Level			
		As noted below	EMT, CGCS, MHA	Q1	Q2	Q3	Q4
				Y	Y		
Strategic Risks - that need to be controlled and consequence of non-controlling and current assessment							
Ref	Description						RAG Rating
1.1	Differences in published local priorities could lead to service inequalities across the footprint.						Y
1.2	Impact of or differences between a multiplicity of commissioners and place based plans, and those not being aligned with Trust plans						Y
1.3	Differences in the services provided due to unnecessary internal variation in practice, may result in inequitable service offers across the whole Trust.						Y
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.
- Care Quality Commission (CQC) visit overall rating of good including well-led review, Partnership working acknowledged to be strong.
- 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 Yorkshire & Harrogate and South Yorkshire & Bassetlaw Integrated Care Systems, especially on mental health is strong.
- 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.
- Mental health offer well regarded with the establishment of Mental Health Provider Alliance in Wakefield being copied in Kirklees and potential for this elsewhere.
- 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.
- Integrated Performance Report (IPR) summary metrics re improving people's health and reduce inequalities – IPR Month 5: out of area beds – amber, children and young people accommodated on an adult inpatient ward – red, 7 day follow up– to be confirmed (green for Months 1-4), physical health – green, LD referrals with completed assessment, care package and commenced delivery within 18 weeks – to be confirmed (red for Months 1-3), delayed transfers of care - 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
- NHS Long Term Plan requires Commissioners to grow investment in mental health services faster than the NHS budget overall, aligned to specific service requirements that will be common across all districts.

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	Director lead
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	DO
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	DS
Impact of not having a clear and well communicated value proposition (Note, expected completion date changed from September 2019 to January 2020 due to prioritisation of other areas including Care Quality Commission (CQC) improvement plan.)	January 2020	DS

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	Guidance/reports	Assurance Ref	Director lead	Strategic risk/s
Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board. (P,N) (I)	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee.(P) (I)	A02	DFR	All
Care Quality Commission (CQC) registration in place and assurance provided that Trust complies with its registration	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC. (P) (I)	A03	DNQ	1.1

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	Guidance/reports	Assurance Ref	Director lead	Strategic risk/s
Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives	Quarterly Board strategic meetings. (P) (I)	A04	CEO	1.1
Independent PLACE audits undertaken with results and actions to be taken reported to Executive Management Team (EMT), Members' Council and Trust Board	Service users and Directors involved in assessments. (P) (I, E)	A05	DHR	1.1, 1.2, 1.3
Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities	Clinical audit and practice effectiveness (CAPE) annual evaluation plan 2018/19 taken to CG&CS Committee June 2019 and 19/20 report scheduled for 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 2019 and 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. Trust engaging in development of Integrated Care System (ICS) 5 year plans (P, N) (I).	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4
Annual reports of Trust Board Committees to Audit Committee,	Audit Committee and Trust Board – April 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
attendance by Chairs of Committees and Director leads to provide assurance against annual plan				
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 held in May & June 2019, monthly engagement with stakeholders (the Focus), various service user & carer engagement events across the year plus Annual Members' Meeting September 2019. 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	Director lead
<i>Assessment of commissioning intentions. (Linked to ORR Risk ID 812). Complete - during 2019/20 contracting round.</i>			Complete	DFR
<i>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. This has changed further to November 2019 in line with planning timescale, work continues in each place as part of developing the Trust plan)</i>			Nov 2019	DS/DP D
<i>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. Complete - Engagement plan and prospectus in place.</i>			Complete	DS
Each integrated care system is required to develop a 5 year plan to implement the NHS long term plan			Nov 2019	DFR
Not a scheduled programme of board to board or exec to exec meeting in place with all partners <i>Ongoing - The requirement for Board to Board is diminishing due to whole system working across each ICS. Local board to board scheduled, CHFT exec to exec meetings in place, further meetings will be planned as required.</i>			Ongoing	DS

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	Director lead
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	DO

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 scheduled for 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 20/21 report included in 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. Trust engaging in development of Integrated Care System (ICS) 5 year plans (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. "Our Learning Journey Report" (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)	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
	and any action required identified. (P, N) (I, E)			
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	Director lead
<i>Assessment of commissioning intentions. (Linked to ORR Risk ID 812). Complete - during 2019/20 contracting round.</i>			Complete	DFR
Benchmarking data unavailable for some services and limited number of statistically similar organisations. <i>In progress - Programme of work agreed to accelerate availability of internal productivity information and effectively use the model hospital.</i>			Jan 2020	DFR
Assessment of place based plans in light of the impact of the NHS long term plan <i>(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. This has changed further to November 2019 in line with planning timescale, work continues in each place as part of developing the Trust plan)</i>			Nov 2019	DS
Each integrated care system is required to develop a 5 year plan to implement the NHS long term plan. An assessment of this against the Trust's strategy and plans will allow greater understanding of any risks and issues to be resolved.			Nov 2019	DFR
Not a scheduled programme of board to board or exec to exec meeting in place with all partners <i>Ongoing - The requirement for Board to Board is diminishing due to whole system working across each ICS. Local board to board scheduled, CHFT exec to exec meetings in place, further meetings will be planned as required.</i>			Ongoing	DS

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	Director lead
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, as well as using the LTP and relationships with groups of commissioners to ensure consistency. (Linked to ORR Risk ID 812).		Ongoing	DS

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 is scheduled for 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	Monthly update provided to Trust Board	A09	EMT	1.1, 1.2,

Assurance (Strategic Risk 1.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	Guidance/reports	Assurance Ref	Director lead	Strategic risk/s
programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Transformation Boards and IPR	via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)			1.3, 2.3, 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
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	Director lead
<i>Assessment of commissioning intentions. (Linked to ORR Risk ID 812). Complete - during 2019/20 contracting round.</i>			<i>Complete</i>	<i>DFR</i>
<i>Impact of medical workforce retention / turnover in certain specialities and assessment through recruitment and retention strategy. Complete - This is linked to the Trust Recruitment and Retention strategy with an ongoing action plan.</i>			<i>Complete</i>	<i>MD/DHR</i>
<i>Review of model hospital data and determine how this can best be used in the Trust In progress - Work has commenced on the review of the model hospital data with a presentation to EMT on 03/10/19 that identified initial areas for consideration.</i>			<i>Oct 2019</i>	<i>DHR</i>
<i>Each integrated care system is required to develop a 5 year plan to implement the NHS long term plan</i>			<i>Nov 2019</i>	<i>DFR</i>

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	Director lead
<i>Finalisation of an engagement plan and prospectus Complete - engagement plan and prospectus developed.</i>		<i>Complete</i>	<i>DS</i>

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
Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when			Date	Director lead
<i>Development of a clear value proposition linked to vision, mission and values Complete - prospectus developed.</i>			<i>Complete</i>	<i>DS</i>
Collate learning and insight from engagement surveys with feedback to identify themes			Dec 2019	DS

Strategic Objective: 2. Improving care - Safety first, quality counts and supporting our staff		Lead Director(s)	Key Board or Committee	Current Assurance Level			
		As noted below	EMT, WRC, CGCS	Q1	Q2	Q3	Q4
				Y	Y		
Strategic Risks - that need to be controlled and consequence of non-controlling and current assessment							
Ref	Description						RAG Rating
2.1	Lack of suitable and robust, performance and clinical information systems 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)

<ul style="list-style-type: none"> 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) assessment overall rating of good. 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. Development of trust wide arrangements for learning and improving standards, recognised by CQC Quality Improvement culture becoming embedded and good examples have emerged on safety huddles, reducing restricted practices and flu Data warehouse implementation taking place, but at slower pace than originally planned to ensure alignment with SystmOne implementation Capacity for routine analysis and focused work affected by 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 5 shows: Friends & Family Test MH green, F&F Test Community yellow, safer staff fill rates green, IG confidentiality breaches red, people dying in their place of choosing - green Effective initial implementation of SystmOne for mental health Programme of optimisation for SystmOne for mental health in place

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 SystemOne . (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	Director lead
Limited use of reports generated using the data warehouse tool with resource recently focused on SystemOne implementation.	2019	DFR
Limited data on caseload, real time waiting list issues, face to face time.	2019	DFR
Limited actual use of benchmarking information in the Trust. Review use of model hospital data (Note, change of due date from Oct 2019 to Jan 2020. Programme of work has commenced to accelerate availability of internal productivity information and effectively use the model hospital. Initial presentation made to EMT of areas for consideration following review of the model hospital)	Jan 2020	DFR

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	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 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
Executive Management Team (EMT) and reported to Trust Board through the Integrated Performance Report (IPR)	Annual review of impact of priority programmes received by EMT. (P) (I)			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
Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested	Included in monthly IPR to OMG, EMT and Trust Board. Regular reports to Audit Committee. (P) (I)	A24	DNQ	2.1
Progress against SystemOne 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	Director lead
<i>Implementation of actions identified in internal audit report on SystemOne implementation governance arrangements. Complete - Focus in Q3 & Q4 was on ensuring clinical record data for fit for migration to SystemOne for mental health services. System was implemented in February and March 2019 and moved into optimisation phase.</i>			Complete	DS
Development plan and implementation to more extensively generate and use management reports using the data warehouse. <i>(Note, expected date of completion changed from Quarter 3 to Jan 2020. Work has commenced and an initial presentation of model hospital benchmarking given to EMT)</i>			Jan 2020	DFR
<i>Completion of review of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee). Complete - Update approved by Trust Board in April 2019.</i>			Complete	DFR
<i>Data input for SystemOne implementation catch up is not yet complete. Complete - previous clinical records system closed.</i>			Complete	DS
SystemOne optimisation programme will take place over the course of the next twelve months.			Sept 2020	DS

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	Director lead
Monitoring of implementation of action plans linked to SI reports.		Ongoing	DNQ

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. "Our Learning Journey Report" (P), (N), (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	Director lead
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR Risk ID 852, 1216) <i>Largely complete - IG training achieved the target. Deep-dive conducted for Audit Committee. Updated comms plan taking effect from April 2019 following SysmOne go-live</i>			Jan 2019 <i>Largely complete</i>	<i>DFR</i>
<i>Impact of learning lessons process on all relevant practitioners</i> <i>Complete – now included in revised Patient Safety Strategy.</i>			<i>Complete</i>	<i>DNQ</i>
<i>Further assurance required to address similar repeated themes in relation to communication and risk assessment are identified through investigations</i> <i>Complete - "Our Learning Journey" Report and annual BDU Governance report published.</i>			<i>Complete</i>	<i>DNQ</i>
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	DO

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
Care Closer to Home Partnership Meeting and governance process. (I)	C50	DO	2.3
Care closer to home priority programme incorporating whole system actions with out of area bed reduction reported against trajectory. (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
Targeted improvement support in place to deliver waiting list management improvement plans 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	Director lead

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 20/21 report included in work plan. (E)	A12	DNQ	1.1, 1.2, 2.3
Annual reports of Trust Board	Audit Committee and Trust Board – April	A14	DFR	1.1, 1.3,

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
Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan	2019 (P) (I)			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) (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. "Our Learning Journey Report" (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
The Care Closer to Home Priority Programme incorporates the outcomes from the review of the community mental health transformation review	Reported through to Board as part of the priority programmes and to the Partnership Board with commissioners	A53	DO	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	Director lead
Impact upon patients and families of out of area placements. (Linked to ORR 1319) <i>In progress - Independent SSG report completed and recommendations being implemented during 19/20.</i>			Dec 2019	DO
<i>Outcomes of community mental health transformation programme review. Complete - findings have been incorporated into the Care Closer to Home priority programme.</i>			Complete	DO
Impact of waiting list in CAMHS services. <i>In progress - 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</i>			Oct 2019	DO

<i>retention. Significant progress noted in Calderdale and Kirklees across all pathways. Work ongoing to address the gap in assurance for Wakefield and Barnsley</i>		
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Strategic Objective: 3. Improving resources - Getting ready for tomorrow: operational excellence		Lead Director(s)	Key Board or Committee	Current Assurance Level			
		As noted	AC, EMT, WRC	Q1	Q2	Q3	Q4
				Y	Y		
Strategic Risks - that need to be controlled and consequence of non-controlling and current assessment							
Ref	Description						RAG Rating
3.1	Deterioration in financial performance leading to unsustainable organisation and insufficient cash to 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						Y

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
Financial Oversight Group (FOG) chaired by a non-executive director	C84	DFR	3.1, 3.3
Gaps in control - what do we need to do to address these and by when?		Date	Director lead
Risk of loss of business impacting on financial, operational and clinical sustainability (Linked to ORR Risk ID 1077, 1214).		Ongoing	DFR
Risk of inability to achieve transitions identified in our plan (Linked to ORR Risk ID 695, 1114).		Ongoing	DS
Trust has a history of not fully achieving its recurrent CIP targets (Linked to ORR Risk ID 1076). <i>In progress - Total CIP delivery to date in line with plan. £1.5m risk for the full year position</i>		March 2020	DFR/DO
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	DO
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). <i>Ongoing - Contractual growth for 2019/20 in line with mental health investment standard, recognises demographic growth and some specific service pressures</i>		Ongoing	DFR
<i>All financial risk for out of area bed costs currently sits with the Trust (Linked to ORR Risk ID 1335). Complete - 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.</i>		Complete for 18/19 and 19/20 contract	DFR
Increased risk of redundancy / lack of ability to redeploy if services are decommissioned at short notice (Linked to ORR Risk ID 1156, 1214).		Ongoing	DHR
Formal board committee covering finance, investment and performance will commence in November 2019.		Nov 2019	DFR

Assurance (Strategic Risk 3.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	Guidance/reports	Assurance Ref	Director lead	Strategic risk/s
Integrated Performance Report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	A02	DFR	All
Business cases for expansion/change of 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. Trust engaging in development of Integrated Care System (ICS) 5 year plans.(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	3.1
Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation,	Trust Constitution (including Standing Order) and Scheme of Delegation last reviewed by Audit Committee in April 2019 prior to approval by Trust Board	A46	DFR	3.1

Assurance (Strategic Risk 3.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	Guidance/reports	Assurance Ref	Director lead	Strategic risk/s
mitigation of risk, best use of resources	and Members' Council. (P) (I)			
Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG)	Standing agenda 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	Director lead
<i>Update of decision-making framework (Scheme of Delegation) to inform delegated authority at all levels (to Audit Committee). Will reduce some levels of approval. Complete - Update approved by Trust Board in April 2019.</i>			Complete	DFR
£1.6m of unidentified CIP for 2019/20 <i>In progress - Level of unidentified recurrent savings remains at a similar level. Options to address in-year and beyond continue to be assessed.</i>			October 2019 for 18/19	DFR
Internal audit reports with partial assurance management actions agreed by lead Director. Review of high and medium priority recommendations to be undertaken quarterly. <i>Ongoing - Completion of internal audit recommendations is largely in line with original timescales (92% implemented as at 31/3/19)</i>			As per Audit reports	DFR
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. <i>Ongoing - Actions identified as part of the SSG review are being implemented. Although a reduction in spend has been noted for 2019/20 the actions in place from the Care Closer to Home improvement priority programme are still to be embedded</i>			Ongoing	DO
Cash position is largely dependent on us delivering a surplus.			Ongoing	DFR
Balanced financial plan for 2019/20 not yet in place. <i>(Note, change of due date from April 2019 to April 2020. Regular forecast updates provided to Trust Board. Ongoing work to identify how unidentified CIP risk can be covered)</i>			April 2020	DFR
Recurrent position is a deficit in excess of £4m <i>Ongoing - Financial sustainability work is focusing on recurrent improvement opportunities.</i>			Ongoing	DFR
Level of board scrutiny to be increased by introduction of a Finance Committee <i>Ongoing - Terms of Reference for Finance, Investment and Performance Committee approved by Trust Board in September 2019, due to replace Finance Oversight Group from November 2019.</i>			Ongoing	DFR

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	Director lead
Risk of loss of business. (Linked to ORR Risk ID 1077). Being addressed as part of the work on the LTP in each place, SY&B and WY&H.		Ongoing	DFR
Level of tendering activity taking place. (Linked to ORR Risk ID 1214). Partnership and collaborative arrangements in each place being used to minimise this wherever possible.		Ongoing	DFR
Refresh of actions to support the stakeholder engagement plans. <i>Complete - prospectus and engagement plan complete.</i>		Complete	DS

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	Director lead
Refresh of actions to support the stakeholder engagement plans. <i>(Note, expected completion date changed from Oct 2018 to Dec 2018, work ongoing)</i>			Dec 2018	DS
Assessment of updated commissioning intentions. <i>(Note, expected completion date changed from Dec 2018 to Jan 2019 as publication of national guidance and long term plan has been delayed)</i> Completed - during planning process and contract negotiations). Further review taking place as part of the long term and 5 year plan intentions			Complete	DFR
Assessment of place based plans within the Integrated Care Systems. <i>(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 This has changed further to November 2019 in line with planning timescale, work continues in each place as part of developing the Trust plan)</i>			Nov 2019	DS/DPD

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
Financial Oversight Group (FOG) chaired by a non-executive director	C84	DFR	3.1, 3.3

Gaps in control - what do we need to do to address these and by when?	Date	Director lead
<i>Trust has a history of not fully achieving its recurrent CIP targets. Review of NHSI checklist to further strengthen CIP delivery process. Complete - review has been completed and recommendations form part of the financial sustainability plans.</i>	Complete	DFR
<i>Finance Oversight Group has not yet commenced Complete - Group meetings in place from June 2019. This will be replaced by a board committee – Finance, Investment & Performance from November 2019</i>	Complete	DFR

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	Operational plan for 2019/20 approved at Trust Board March 2019. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4

	reports. Trust engaging in development of Integrated Care System (ICS) 5 year plans.(P, N) (I)			
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) (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	Director lead
Currently £1.6m of unidentified CIP for 2019/20 <i>(Note, expected completion date changed from Sept 2019 to Jan 2020). Ongoing - Plans to bridge the gap continually reviewed and assessed. Main issue is that mitigations are typically non-recurrent.</i>			Jan 2020	DFR
Balanced financial plan for 2019/20 not yet in place. Financial sustainability partly developed with further opportunities for improvement required. <i>(Note, expected completion date changed from Sept 2019 to Jan 2020). Ongoing - Plans to bridge the gap continually reviewed and assessed</i>			Jan 2020	DFR
Level of Board scrutiny to be increased by introduction of a Finance Committee. <i>Ongoing - Terms of Reference for Finance, Investment and Performance Committee approved by Trust Board in September 2019, due to replace Finance Oversight Group from November 2019.</i>			Ongoing	DFR

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. (P, N), (I)	C71	DHR	3.4
Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	C72	CEO	3.4
Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (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. (P), (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. (P), (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. (P), (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. (P), (I)	C80	DS	3.4
Gaps in control - what do we need to do to address these and by when?		Date	Director lead

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

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 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. Trust engaging in development of Integrated Care System (ICS) 5 year plans.(P, N) (I)	A13	DFR	1.1, 1.2, 3.1, 3.3, 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	Director lead
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. . <i>(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. This has changed further to November 2019 in line with planning timescale, work continues in each place as part of developing the Trust plan)</i>			Nov 2019	DS
Additional demands being placed on Trust resource during the year over and above planning assumptions, particularly in respect of place based developments.			Nov 2019	DS

Strategic Objective: 4. Making SWYPFT a great place to work		Lead Director(s)	Key Board or Committee	Current Assurance Level			
		As noted	WRC	Q1	Q2	Q3	Q4
				Y	Y		
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, consistent feedback from regulators and partners.
- Award winning flu and #alofus staff wellbeing campaigns with strong impact.
- Vacancies in key areas – CAMHS consultants – and supply problems in LD nursing and PWP trainees.
- 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 average across the Trust, with some good areas and some hot spots.
- 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) visit overall rating of good. CQUIN targets largely achieved.
- Integrated Performance Report (IPR) summary
- "Hot spots" in terms of staff survey results and other workforce metrics reviewed and identified

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
Regular meetings established with Sheffield and Huddersfield University to discuss	C81	DHR	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
undergraduate and post graduate programmes			
Gaps in control - what do we need to do to address these and by when?		Date	Director lead
<i>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.</i>		Complete	DHR
<i>Support needed for a tailored medical leadership / talent development programme. Currently capacity issues exist to support this. Complete - Mentorship programme launched. Medical leadership programmes launched.</i>		Complete	MD/DHR
The recruitment group have membership including medical HR, medical directorate and are developing the offer further; the recruitment and retention strategy is in place. The offer is being finalised and once complete to be supported by the development of a comms plan		Dec 2019	MD/DHR

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	Director lead
<i>Report to Workforce and Remuneration Committee on reasons for leaving extracted from exit interviews. (Note, Reviewing & streamlining current processes which causes delay to meeting original plan. Next Committee meeting scheduled for Nov 2019)</i>			Nov 2019	DHR
<i>Sustainable workforce plan for CAMHS services.</i>			Complete	DO/DHR

<p><i>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.</i></p>		
<p>Impact of a no deal Brexit is currently uncertain. <i>(Note, Brexit coordination group established and Trust meeting national guidance. Timescale changed to be in line with latest withdrawal date)</i></p>	Oct 2019	DHR
<p>Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR ID 1151).</p>	Ongoing	DHR

Trust Board 29 October 2019 Agenda item 6.3

Title:	Corporate / Organisational Risk Register Quarter 2 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 and have controls and actions in place to mitigate those risks						
Mission / values:	The risk register 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. Standing agenda item at each board committee meeting. Triangulation of risk performance and governance report to Audit Committee in October 2019						
Executive summary:	<p>Corporate / Organisational Risk Register</p> <p>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 board committees for review and to ensure that the committee is assured the current risk level is appropriate.</p> <div data-bbox="683 1332 1300 1601" data-label="Diagram"> <table border="1"> <thead> <tr> <th colspan="2">Our four strategic objectives</th> </tr> </thead> <tbody> <tr> <td>Improving health</td> <td>Improving care</td> </tr> <tr> <td>Improving resources</td> <td>Making SWYPFT a great place to work</td> </tr> </tbody> </table> </div> <p>The risk register is reviewed at each board committee meeting and any recommendations made to the Executive Management Team (EMT) to consider as part of the cyclical 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.</p>	Our four strategic objectives		Improving health	Improving care	Improving resources	Making SWYPFT a great place to work
Our four strategic objectives							
Improving health	Improving care						
Improving resources	Making SWYPFT a great place to work						

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 July 2019:

Risks 15+

Risk ID	Description	Status	Update (what changed, why, assurance)
1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Controls and actions updated	Reviewed by lead Director and EMT. One complete action moved to controls, one complete action to be removed.

Risks below 15 (outside risk appetite):

Risk ID	Description	Status	Update (what changed, why, assurance)
905	Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls, new action identified.
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	Risk description and actions updated	Reviewed by lead Director and EMT. Description of risk updated. New action identified.
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	Controls and actions updated	Reviewed by lead Director and EMT. New action identified.
1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.	Controls and actions updated	Reviewed by lead Director and EMT. New control and action identified.
1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: <ul style="list-style-type: none"> ➤ 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. New action identified.
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls.

		current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.		
	1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls.
	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.
	1158	Risk of over reliance on agency staff which could impact on quality and finances.	Controls and actions updated	Reviewed by lead Director and EMT. Two new controls and one new action identified.
	1216	Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements places on the Trust that are not met or result in a financial penalty.	Controls and actions updated	Reviewed by lead Director and EMT. Complete action moved to controls.
	1368	Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a CAMHS bed. This could result in serious harm.	Risk 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'. Controls and actions updated.
	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.	Priority alignment and actions updated	Reviewed by lead Director and EMT. Risk aligned to new Trust priority – 'make this a great place to work'. New action identified.
	1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	Priority alignment and actions updated	Reviewed by lead Director and EMT. Risk aligned to new Trust priority – 'make this a great place to work'. New actions identified.
	1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	Priority alignment and controls updated	Reviewed by lead Director and EMT. Risk aligned to new Trust priority – 'make this a great place to work'. New control identified.

Risks below 15 (managed within risk appetite):

Risk ID	Description	Status	Update (what changed, why, assurance)
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	Controls and actions updated	Reviewed by lead Director and EMT. New control and new action identified.
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. Controls updated and two new actions identified.

Risks recommended for closure:

Risk ID	Description	Status	Update (what changed, why, assurance)
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 recommended for closure	Risk recommended for closure from the organisational level risk register following successful transition to SystmOne. EMT will continue to monitor system performance / optimisation.

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 2 review, EMT reviewed the triangulation of risk performance and governance report (Audit Committee 8 October 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 target of 17.7% in M1, M2 and M5 2019/20.
- Maximum six-week wait for diagnostic procedures – below target of 99% in M4 and M5.
- Data Quality Maturity Index – below target of 95% in M5.
- IAPT – treatment within six weeks of referral – below target of 95% in M5.
- % of learning disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks – Q1 below target, Q2 results due.

EMT agreed that none of these areas considered above required further escalation at this stage and requested assurance from the Operational Management Group (OMG) that they were included on local level risk registers.

	<p>Risk appetite</p> <p>The ORR supports the Trust in providing safe, high quality services within available resources, in line with the Trust's Risk Appetite Statement.</p>
Recommendation:	<p>Trust Board is asked to:</p> <ul style="list-style-type: none"> ➤ NOTE the key risks for the organisation subject to any changes / additions arising from papers discussed at the Board meeting around performance, compliance and governance; ➤ DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review; and ➤ AGREE the risk recommended for closure.
Private session:	Not applicable.

ORGANISATIONAL LEVEL RISK REPORT

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.

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

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

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

Risk appetite	Application
Minimal / low - Cautious / moderate (1-6)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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.

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) – 29 October 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.	<ul style="list-style-type: none"> 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. <p>(continued over)</p>	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> 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) <ul style="list-style-type: none"> Replacement of core equipment Application availability Implement Forcepoint email filtering solution (DFR) (March 2020) Work towards full cyber essentials certification (DFR) (December 2020) Implement recommendations from NHS IT health check report (DFR) (complete) 	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 – October 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
		<ul style="list-style-type: none"> ➤ 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. ➤ Windows defender advanced threat protection in place. ➤ Strengthened password requirements in place. 											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	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
275	Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding.	<ul style="list-style-type: none"> ➢ Agreed joint arrangements for management and monitoring delivery of integrated teams. ➢ Weekly risk scan by Director of Nursing & Quality and Medical Director. ➢ BDU / commissioner forums – monitoring of performance. ➢ Monthly review through performance monitoring governance structure via 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 meetings. ➢ Attendance and monitoring at contract forums. ➢ Annual planning process. 	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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 influence outside our control	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at EMT and Trust Board	6 Yellow / Moderate (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 – October 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.	<ul style="list-style-type: none"> ➢ 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 to Board and OMG with appropriate escalation arrangements in place. ➢ Biannual safer staffing report to Board and Commissioners. ➢ Review of establishment for adult inpatient areas completed and implementation plan developed. 	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ Implementation plan monitored through OMG & EMT. (DNQ) ➢ Agency and bank staffing action plan is monitored through OMG. (DO) ➢ Safer staffing group meets on a monthly basis to review exception reporting. (DNQ) ➢ Further review of forensics and older peoples services to take place (DNQ / DO) (March 2020) 	DO / DNQ	Ongoing	EMT (monthly)	6 Yellow / moderate (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 – October 2019
1078	Risk that young people will suffer serious harm as a result of waiting for treatment	<ul style="list-style-type: none"> ➢ 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 	4 Major	2 Unlikely	8 Amber / High risk (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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 	DO	Review every three months	Performance reporting to EMT - monthly Assurance report to	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2	Every three months prior to business and risk Trust

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
		<ul style="list-style-type: none"> place to start to address backlog for ASD. ➢ Future in Mind investments are in place to support the whole CAMHS system. ➢ Healthwatch Barnsley and Wakefield have carried out monitoring visits and are supporting local teams with the action plans. ➢ CAMHS performance dashboard for each district. ➢ Work has taken place to implement care pathways and consistent recording of activity and outcome data. ➢ Kirklees has a new ASD pathway in place. ➢ System wide work was undertaken in Wakefield to improve access to assessment for ASD. ➢ There is ongoing dialogue with people on the waiting list to keep in touch and to carry out well-being checks. ➢ Active participation in ICS 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. 					<ul style="list-style-type: none"> 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 Clinical Governance & Clinical Safety Committee. (DO) ➢ System being developed to review young people on the waiting list every three months. (DO) 			<ul style="list-style-type: none"> Clinical Governance Committee Individual district performance reports reviewed by BDU 			<ul style="list-style-type: none"> An additional £150k was made available by Kirklees CCG to support reduction of the ASC waiting list. The strengthened pathway ensured waiting times were reduced to less than 12 months by September 2018. 	Board – October 2019
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	<ul style="list-style-type: none"> ➢ 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. ➢ Review of impact and ongoing risk presented to CG&CS Committee. ➢ Bespoke arrangements are in place in BDUs where waiting times have an impact on carers. 	4 Major	3 Possible	12 Amber / high risk (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ Waiting list information being developed with P&I and reported to EMT on the IPR. (DPD / DO / DFR) (April 2020) ➢ Reports developed, further work is still required to ensure they are comprehensive. Additional reporting will be developed as part of SystemOne optimisation. (DPD / DO / DFR) (April 2020) ➢ Detailed evidence of demand growth in neighbourhood nursing and MSK has been developed for discussion with commissioners. (DO / DFR) (October 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) 	DO	April 2020	<ul style="list-style-type: none"> Performance reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performance reports reviewed by BDU. 	6 Yellow / moderate (4-6)	CG&CS	<ul style="list-style-type: none"> Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 	Every three months prior to business and risk Trust Board – October 2019

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1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	<ul style="list-style-type: none"> ➤ Fire Safety Advisor produces monthly / quarterly Fire Report and Operational Fire / Unwanted Fire Activation for review / action by EFM Senior Managers. ➤ Quarterly review undertaken by Estates TAG. ➤ Weekly risk scan are completed by the Trust's Fire Safety Advisor and any issues or concerns raised directly with the Head of Estates and Facilities and Head of Estates Operations with the Director of HR, OD and Estates been briefed and action undertaken accordingly. ➤ Trust smoking policies with the use of e-cigarettes agreed for a trial period. ➤ Compliance with the following regulations: <ul style="list-style-type: none"> ○ 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; ○ The identification of standards for the control of combustible, flammable or explosive materials; ○ 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; ○ The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures; ○ The development and delivery of suitable staff training in fire safety awareness; ○ 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. 	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ 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 / moderate (4-6)	CG&CS	<p>Risk appetite: Clinical risk target 1 – 6</p> <p>Links to BAF, SO2 & 3</p> <p>Note - A failure to effectively manage compliance with the Trust Fire/Smoking policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings.</p>	Every three months prior to business and risk Trust Board – October 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
1369	Risk that a “no-deal” Brexit has implications for the Trust including product availability, medicines availability and staffing.	<ul style="list-style-type: none"> ➢ 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. ➢ Local risk register in place. ➢ Engagement with local CCGs. ➢ Regular completion of sit rep to Brexit lead. 	4 Major	3 Possible	12 Amber / high risk (8 - 12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ Receive national guidance and instruction and feedback. (MD) ➢ Drugs & Therapeutics Committee to identify unlicensed medicines not covered by the national centralised stockpile. (MD) ➢ Brexit group constituted and meets weekly. ➢ Continued engagement with national groups on Brexit planning. ➢ Desktop exercises on drugs availability have been undertaken. 	MD	Ongoing	EMT (monthly) CG&CS (regular)	4 Yellow /Moderate (1-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board – October 2019
1424	Risk of serious harm occurring from known patient safety risks, with a specific focus on: <ul style="list-style-type: none"> ➢ Inpatient ligature risks ➢ Learning from deaths & complaints ➢ Clinical risk assessment ➢ Suicide prevention 	<p>Clear policy & procedure in place providing framework for the identification and mitigation of risks in respect of:</p> <ul style="list-style-type: none"> ➢ Ligature assessment. ➢ Blue light alerts and learning library introduced immediate lessons learnt are shared and prompt action taken to prevent recurrence of incidents. (DNQ) ➢ Learning from deaths. ➢ Complaints reviews. ➢ Clinical risk assessment process. ➢ Suicide prevention training. ➢ 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 job description. ➢ Updated clinical risk report that captures a wider range of risk information for OMG. ➢ Mental health safety improvement partnership in place with NHS I / CQC. ➢ Clinical risk assessment training 	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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 with SWYPT plans (DNQ) (Q2 2019/20) ➢ Q1 approach to be adopted on CQC areas for improvement. Detailed plan to be provided to CG&CS Committee. Risk assessment improvement is a key domain. (DNQ) (November 2019) ➢ CQC action plans performance managed through OMG and 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) 	DNQ MD	On going	Performance & monitoring via EMT, OMG & TB reports e.g. quarterly Patient Safety report & incident report	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to business and risk Trust Board October 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
		programme. ➤ Our Learning Journey report disseminated across all teams and discussed at team level (DNQ) (2017/18 report complete, 2018/19 report complete and being utilised).												
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	<ul style="list-style-type: none"> ➤ Participation in system transformation programmes. ➤ 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. ➤ 5 year funding arrangements increases income allocated to mental health services ➤ Mental health investment standard 	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ 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) ➤ 2020/21 contract negotiation process (DFR) (March 2020) 	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – October 2019
852	Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	<ul style="list-style-type: none"> ➤ 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 – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ 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 – October 2019
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its capital programme, leading to an inability to pay staff and	<ul style="list-style-type: none"> ➤ 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 	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ 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) 	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 – October 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
	suppliers without DH support.	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. ➢ Non-Executive Director led Financial Oversight Group (FOG). (Committee from November 2019).												
1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	<ul style="list-style-type: none"> ➢ 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. ➢ Non-Executive Director led Financial Oversight Group (FOG) (Committee from November 2019). 	3 Moderate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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) ➢ Implementation of longer term financial sustainability plan. (DFR) (ongoing over three years period 2019 - 2022) ➢ Development of targeted programme of business growth focused on specific services and markets and aligned to strategy. (DPD / DO) ➢ Scenario planning in operational plan and strategy regarding place based developments, where this could result in step-changes in income in either direction. (DS / DPD / DO) (Ongoing – delivery dates specific to each priority programme) ➢ Ongoing response to the rapidly changing operating environment and the role the Trust plays in each place (DS). (Ongoing – delivery dates specific to each priority programme) 	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moderate (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 – October 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.	<ul style="list-style-type: none"> ➢ 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. ➢ Non-Executive Director led Financial Oversight Group (FOG) (Committee from November 2019). 	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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) 	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	4 Yellow / Moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Every three months prior to business and risk Trust Board – October 2019
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce	<ul style="list-style-type: none"> ➢ Monitoring turnover rates monthly. ➢ Exit interviews. ➢ Flexible working guidance. ➢ Flexible working arrangements promoted. ➢ Investment in health and well-being 	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate	➢ Refresh of workforce plans as part of operational planning process. (DHR) (March 2020)	DHR	Ongoing	EMT and Trust Board reporting through IPR	6 Yellow / moderate	WRC	Risk appetite: Financial / commercial risk target 1 – 6	Every three months prior to business

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
	able to retire in the next five years.	<ul style="list-style-type: none"> services. ➢ Retire and return options. ➢ Apprenticeship scheme balancing the age profile. ➢ Recruitment and Retention action plan agreed. ➢ Workforce planning includes age profile. 				ate (1 – 6)				(monthly) RTSC exception reports	ate (4-6)		Links to BAF, SO2 & 3	and risk Trust Board – October 2019
1158	Risk of over reliance on agency staff which could impact on quality and finances.	<ul style="list-style-type: none"> ➢ Board self-assessment. ➢ Reporting through IPR. ➢ Safer Staffing Reports. ➢ Agency induction policy. ➢ Authorisation levels for approval of agency staff now at a senior level. ➢ Restrictions on Administration and Clerical Staff. ➢ Extension of the Staff Bank. ➢ Development of Medical Bank. ➢ OMG to Overview. ➢ Director of Delivery supporting reduction in agency usage. ➢ Retention plan developed. ➢ Agency project group. 	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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, as part of the workforce plans. (DNQ / DHR) (January 2020) ➢ Recruitment to Consultant roles (DHR / MD). ➢ Business case for potential use of NHS Professionals underway. (DHR) ➢ Direct engagement with medical locum master vendor contracting underway. (MD) 	DHR	Ongoing through agency project group and workforce planning – workshop October 2019	EMT (monthly) Board (monthly)	6 Yellow / moderate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – October 2019
1169	Risk that improvements in performance against the metrics covering open referrals, unvalidated progress notes and un-outcome appointments are not made leading to clinical risk and poor outcomes for service users.	<ul style="list-style-type: none"> ➢ Information is available daily at HCP, team, BDU and Trust level. ➢ A regular summary is reviewed at Operational Management Group (OMG) to track progress. 	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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 – October 2019
1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	<ul style="list-style-type: none"> ➢ 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. <ul style="list-style-type: none"> - 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 	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ Development of a value proposition. (DS) (March 2020) ➢ The Trust leadership is developing productive partnerships with other organisations to develop joint bids and shared services in preparation for integration of services. (DFR / DS / DPD / DO) ➢ The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) ➢ Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR) 	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – October 2019

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		place. ➢ Commercial strategy.												
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.	<ul style="list-style-type: none"> ➢ 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. ➢ Centralisation of Subject Access Request, staffing and consistent process. 	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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	November 2019	<ul style="list-style-type: none"> Regular reports to ICIG group Reports to Audit Committee 	6 Yellow / moderate (4-6)	AC	<ul style="list-style-type: none"> Risk appetite: Compliance risk 1 – 6 Links to BAF, SO3 This has been delayed given the impact of the SystemOne implementation on capacity 	Every three months prior to business and risk Trust Board – October 2019
1319	Risk that quality of care will be compromised if people continue to be sent out of area.	<ul style="list-style-type: none"> ➢ 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. ➢ Workstreams in place to address specific areas as agreed following the SSG review. 	3 Moderate	4 Likely	12 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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) ➢ 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 / Moderate (4-6)	CG&CS	<ul style="list-style-type: none"> Risk appetite: Clinical risk target 1 – 6 	Every three months prior to business and risk Trust Board – October 2019
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	<ul style="list-style-type: none"> ➢ 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 Moderate	4 Likely	12 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ 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	<ul style="list-style-type: none"> OMG monthly EMT monthly Trust Board monthly 	4 Yellow / moderate (4-6)	Trust Board	<ul style="list-style-type: none"> Risk appetite: Financial risk 1 – 6 	Every three months prior to business and risk Trust Board – October 2019
1368	Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a	<ul style="list-style-type: none"> ➢ Bed management processes are in place as part of the new care model for Tier 4. These include exhausting out of area provision. ➢ All community options are explored. ➢ Where no age appropriate bed or community option is available then a bed on an adult ward is considered as the least worst option to maintain safety. ➢ Protocol in place for admission of children 	4 Major	2 Unlikely	8 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➢ Development of new CAMHS inpatient facility in Leeds for West Yorkshire. (DO) (2020) ➢ Recruitment is well underway into all age liaison / home treatment teams from local CCG investments in 2019/20 in order to increase opportunities for alternatives to admission with full implementation planned by January 2020 in Wakefield and Barnsley. (January 2020) 	DO	Ongoing risk given external influence outside our control	<ul style="list-style-type: none"> EMT (monthly) CG&CS (regular) Trust Board (each meeting through 	4 Yellow / Moderate (4-6)	CG&CS	<ul style="list-style-type: none"> Risk appetite: Clinical risk target 1 – 6 The Trust ensures children and young people are only admitted to an 	Every three months prior to business and risk Trust Board – October 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
	CAMHS bed. This could result in serious harm.	<ul style="list-style-type: none"> 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. ➤ 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. 								integrated performance report)			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.	
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.	<ul style="list-style-type: none"> ➤ Safer staffing levels for inpatient services agreed and monitored. ➤ Agreed turnover and stability rates part of IPR. ➤ Weekly risk scan by DNQ and MD to identify any emerging issues, reported weekly to EMT. ➤ Reporting to the Board through IPR. ➤ Datix reporting on staffing levels. ➤ Strong links with universities. ➤ New students supported whilst on placement. ➤ Regular advertising. ➤ Development of Associate Practitioner. ➤ Workforce plans incorporated into new business cases. ➤ Workforce strategy implementation of action plan. ➤ Retention plan developed. ➤ Workforce plans linked to annual business plans. ➤ Working in partnership across West Yorkshire on international recruitment. 	3 Moderate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ Proposal for On Boarding System to include recruitment Microsite. (DHR) (October 2019) ➤ Marketing of the Trust as an employer of choice. (DHR) ➤ Develop new roles e.g. Advanced Nurse Practitioner. (DNQ / DHR / MD) ➤ Safer staffing reviewing establishment levels. (DNQ) ➤ Development of Physician Associate role. (DHR / MD) ➤ Inpatient ward workforce review with revised skill mix. Major recruitment drive underway to implement nursing associates via Trainee Nurse Associate recruitment. (DHR) 	DHR	Ongoing given external influence outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performance report)	6 Yellow / moderate (4-6)	CG&CS	<p>Risk appetite: Financial / commercial risk target 1 – 6</p> <p>Links to BAF, SO 2 & 3</p> <p>34 TNA posts recruited to (October – November 2019) both internal and external to a total establishment of 52 WTE.</p>	Every three months prior to business and risk Trust Board – October 2019
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	<ul style="list-style-type: none"> ➤ 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 	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ Each BDU is identifying wellbeing groups and champions. (DHR) (December 2019) ➤ HR and service managers ensuring consistent application of sickness policy. (DHR) (January 2020) 	DHR	January 2020	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	WRC	<p>Risk appetite: Financial / commercial risk target 1 – 6</p> <p>Links to BAF, SO2 & 3</p>	Every three months prior to business and risk Trust Board – October

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
		management. ➤ Extend use of e-rostering. ➤ Retention plan developed.												2019
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	<ul style="list-style-type: none"> ➤ 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. ➤ Framework for bullying and harassment between colleagues. 	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> ➤ Development of action plan to tackle harassment and bullying from services users and families. (DNQ) (Q2 2019/20) ➤ Delivery of WRES and EDS2 action plans. (DNQ) 	DHR	Ongoing	EMT (quarterly) E&I Committee (quarterly)	6 Yellow / moderate (4-6)	WRC E&IC	<p>Risk appetite: Financial / commercial risk target 1 – 6</p> <p>Links to BAF, SO2 & 3</p>	Every three months prior to business and risk Trust Board – October 2019

Organisational level risks within the risk appetite

Risk ID	Description of risk	Risk level (current / pre-mitigation)	Risk appetite	Risk level (target)
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
812	Risk the creation of local place based solutions which change clinical pathways and financial flows could impact adversely on the quality and sustainability of other services.	Amber / High risk (8 - 12)	Open / High (8 - 12)	Amber / High risk (8 - 12)
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	Amber / High risk (8 - 12)	Open / High (8 - 12)	Yellow / Moderate (4-6)
1362	Risk the Trust is unable to fully implement the falsified medicines directive following the change in legislation which would lead to non-compliance with the law, litigation and the risk that our service users are not protected from falsified medicines.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
279	Risk that trust may not be competitive in its offer to secure Any Qualifies Provider status for services selected by Cluster Commissioners.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
1212	Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Amber / High risk (8 - 12)
1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Amber / High risk (8 - 12)
1432	Risk of problems with succession planning / talent management.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Yellow / Moderate (4-6)

Risks recommended for closure

Risk ID	Description of risk	Current control measures	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
1213	Risk that sub-optimal transition from RiO to SystemOne will result in significant loss or ineffective use of data resulting in the inability capture information, share information and produce reports.	<ul style="list-style-type: none"> Established Programme Steering Group including nonexecutive Directors, Nursing and Clinical Leads. Monthly Reporting into EMT and the Board via the IPR reviewed by Transformation Board. Risks reported through Clinical Safety and Clinical Governance Committee and Audit Committee. Periodic gateway reviews and internal audits in place. Additional resources agreed to support staff on the group up to 31 August 2019 to cover full data catch up period, provide additional training where required and implement early optimisation plans. Communications and engagement plans in place. Completion and checking of data catch-up activities. Post implementation review and end of phase 1 project report. 	3 Moderate	2 Unlikely	4 Yellow / moderate (4-6)	Minimal / low – Cautious / moderate (1 – 6)	<ul style="list-style-type: none"> Learning from other mental health SystemOne implementations (DS) (May 2019). Complete for implementation. Ongoing for optimisation (March 2020) (DS) Develop optimisation plan and phase two of programme (DS) (May 2019). Optimisation proposal approved at EMT. Full optimisation plan being developed (Sept 2020) (DS) Ongoing monitoring of resources (DS) Continue clinical / non-clinical engagement via change network (including change reference groups and design reference group). (DS) Maintain relationship with the supplier (TPP) 	DS	31 May 2019	<ul style="list-style-type: none"> Monthly reports to PSG, Transformation Board, and Trust Board. Weekly status reports to EMT. Weekly cutover meetings with operational leads. Quarterly reports to CG&CS Committee and Audit Committee 	6 Yellow / moderate (4-6)	AC	<ul style="list-style-type: none"> Risk appetite: Strategic risk 8 – 12 Links to BAF, SO3 	Every three months prior to business and risk Trust Board – July 2019

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

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 young people will suffer serious harm as a result of waiting for 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 that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a CAMHS bed. This could result in serious harm. (1368) = 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 confidence in services 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 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)					

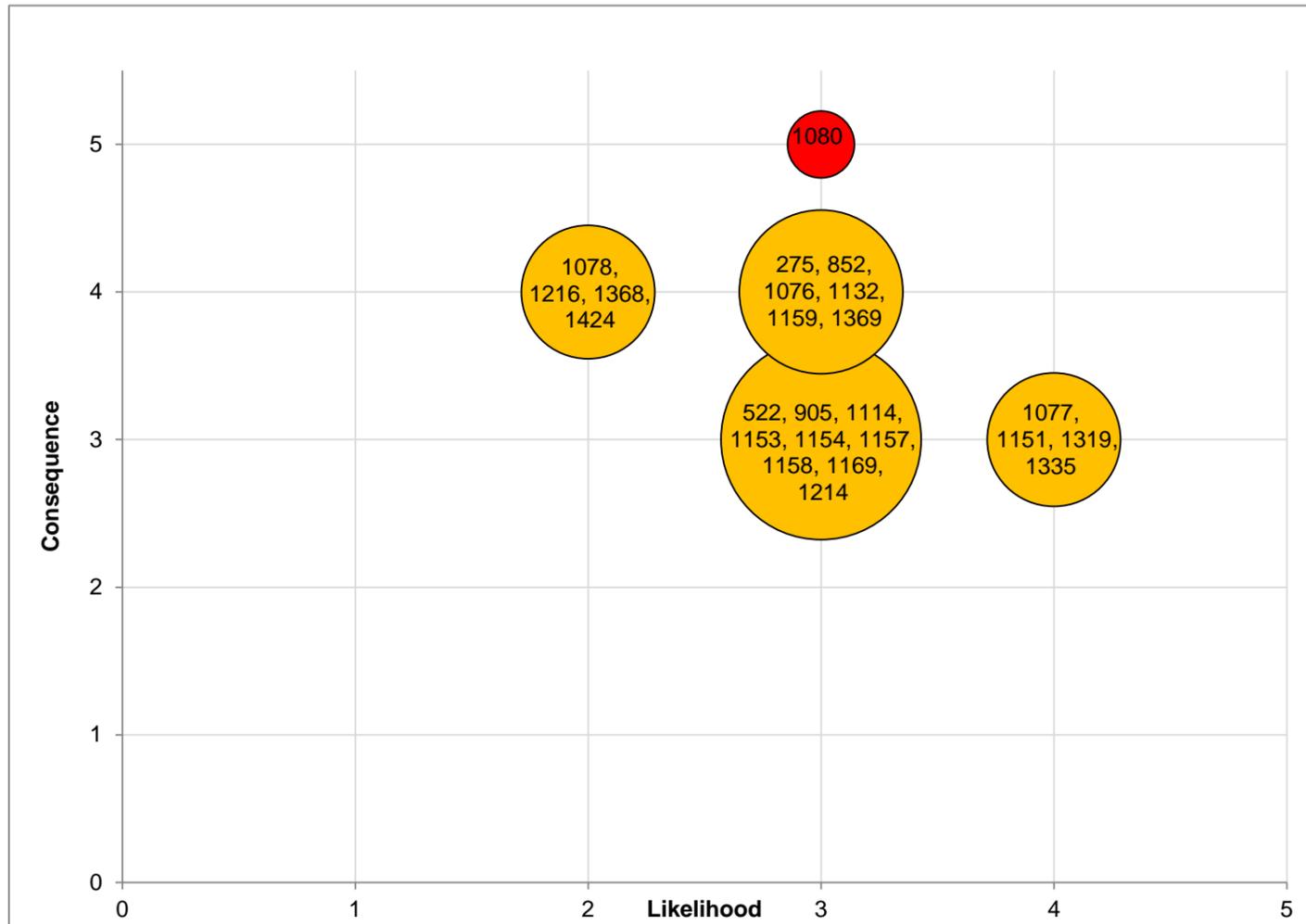
= same risk rating as last quarter
! new risk since last quarter

< decreased risk rating since last quarter
> increased risk rating since last quarter

RA risk appetite

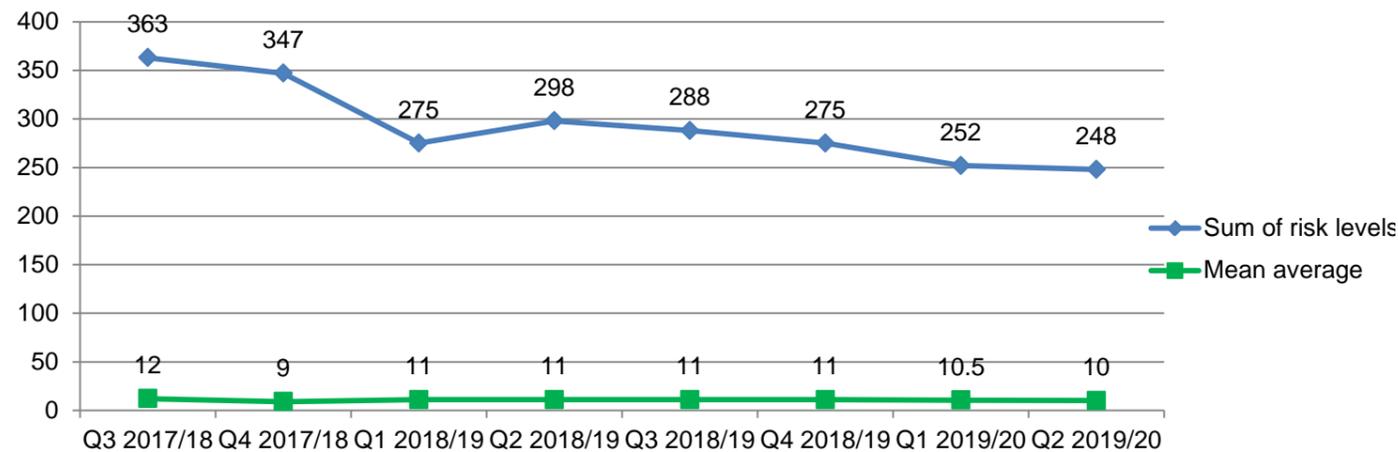


Risk profile (risks outside risk appetite) – Trust Board 29 October 2019



Score	ID	Description
12	275	Risk of deterioration in quality of care and financial resources available to commission services due to reduction in LA funding.
9	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.
12	852	Risk of information governance breach leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.
9	905	Risk that wards are not adequately staffed leading to increased temporary staffing which may impact upon quality of care and have financial implications.
12	1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support.
12	1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.
8	1078	Risk that young people will suffer serious harm as a result of waiting for 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.
8	1368	Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a CAMHS bed. This could result in serious harm.
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.

2017/18		2018/19				2019/20	
Q3 (33 risks)	Q4 (35 risks)	Q1 (23 risks)	Q2 (27 risks)	Q3 (26 risks)	Q4 (25 risks)	Q1 (24 risks)	Q2 (24 risks)
12	9	11	11	11	11	10.5	10



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 breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches 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

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)

Trust Board 29 October 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: <ol style="list-style-type: none"> 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 Trust's 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 September Trust Board.
Executive summary:	The Trust's Strategy 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): West Yorkshire and Harrogate Health and Care Partnership: <ul style="list-style-type: none"> ➤ WY&H HCP has evolved in to a maturing Integrated Care System (ICS) that is now playing a stronger role in system performance and transformation including developing the 5 year plan in response to the NHS Long Term Plan. The plan builds on the programmes and work initiated and developed over the last few years across each of the places that make up the ICS. Engagement with partners has shaped the draft plan that is being further developed and is available to view in full. https://www.wyhpartnership.co.uk/meetings/partnershipboard ➤ Significant transformation funding has been made available through the ICS to support key programmes and initiatives including the mental health, learning disabilities and autism programme. The paper will provide an update on transformation funding that will enable service development in each of the places that we provide services.

	<ul style="list-style-type: none"> ➤ The ICS has supported the Digital Charter that has been formally endorsed by the Local Health and Care Record Exemplar Board (LHCRE). A draft Digital Strategy has also been supported by the ICS and this is currently being discussed through boards and governing bodies. A separate paper providing details of the Digital Strategy will be presented at this Board meeting. ➤ The ICS was selected as one of the nine pilot sites to test a new Workforce Readiness Tool. Findings from all the test sites will be used to develop the Full People Plan which aims to deliver a number of objectives, including: making the NHS the best place to work; improving the leadership culture; taking action in 2019/20 to tackle the nursing challenge; delivering 21st century care; and developing a new operating model for workforce. The WY&H report has been finalised and was considered at the System Leadership Executive Group. <p>We continue to work with partners to develop and deliver joined up care and transform services and support. The paper provides an update that includes notable developments in the following places:</p> <ul style="list-style-type: none"> ➤ Kirklees ➤ Calderdale ➤ Wakefield <p>Risk Appetite</p> <p>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's 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.</p>
<p>Recommendation:</p>	<p>Trust Board is asked to RECEIVE and NOTE the updates on the development of Integrated Care Partnerships and collaborations including:</p> <ul style="list-style-type: none"> ➤ West Yorkshire and Harrogate Health and Care Partnership ➤ Wakefield ➤ Calderdale ➤ Kirklees ➤ Receive the minutes of relevant partnership boards.
<p>Private session:</p>	<p>Not applicable.</p>

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

Trust Board 29 October 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 was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). 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 West Yorkshire and Harrogate (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 September meeting include the following:

- The WYH **approach to commissioning arrangements** is being developed; the changes will ensure that commissioning continues to be delivered at place through Clinical Commissioning Groups (CCGs), joint arrangements with local authorities and increasingly through provider alliances. There is also work to understand what can be commissioned once across the ICS.

- Contingency **planning for EU Exit preparations** has continued at pace. The partnership has benefited from Robin Tuddenham and Tom Riordan's key regional leadership roles on this issue, supporting an integrated health and social care response. **The Director of human resources, organisational development and estates is the Trust's lead director contributing to regional and local planning forums.**
- The recent change in national policy on the availability of NHS capital funding was noted and it was recognised that this may reverse some of the previously required reduction in spending plans.
- The Strategic Outline Case for the reconfiguration of services in Calderdale and Huddersfield has now completed regional assurance and was noted to have been recommended to progress through the national approval processes. **The Trust is a partner in developing integrated joined up care in both Kirklees and Calderdale to support care as close to home as possible as part of the plans.**

3.2 ICS Five Year strategy and plan

Significant engagement informed the initial submission of the strategic narrative document to NHSE/I and positive feedback has been provided to the partnership (The draft strategy has previously been discussed at Trust Board and the ICS Partnership Board and is available for Trust Board members to review through the link in appendix 1). The document incorporates the updated priorities from each programme and builds on the existing work of the partnership. The plan will be developed further to be submitted to NHSE/I in November 2019 and published in December. A draft summary document has been developed and is currently being reviewed by partners. **The Trust continues working with partners in place and contributing to the development of the ICS plan as a key partner. The Trust's contribution to the plan was discussed at the last Trust Board meeting and there is also a separate paper as part of this Board meeting.**

3.3 Key programme updates from the ICS - received at the September SOAG meeting, Particularly of note for the Trust Board include:

Mental Health Programme

- Continues to secure funding through national bidding processes – including crisis and liaison; community mental health and children's mental health. **The Trust has benefited from this transformation funding and an update is provided in section 7.1 below.**
- Commissioning developments are being explored in both specialised commissioning (lead provider arrangement) and CCG services (developing alliance models). **The Trust is engaged in these developments both across the ICS and at place level and further details are outlined in sections 7.1 and 8.**
- A new 20-minute training programme had been developed by the Zero Suicide Alliance. All systems and organisations within the Partnership were encouraged to promote this to their own employees and contractors. **The Trust is leading the suicide prevention programme on behalf of the Integrated Care System (ICS).**
- Main risks on performance relate to Improving Access to Psychological Therapies (IAPT) access and out of area placements. A workshop focusing on IAPT is planned to share good practice.
- Out of area placements, work continues between providers to develop more coordinated bed management arrangements and working with commissioners to ensure there is a standard improved offer for crisis/Intensive Home Base Treatment (IHBT) services and alternatives to admission. **The Trust is key partner in this programme.**

Primary and Community Care

- Networking event for all PCN Clinical Directors was held on 11 October. This will be used to co-produce support offer and working arrangements. Primary care strategy document is being finalised following engagement. **The Trust is working with partners in Primary Care in each of the places that it provides services to develop joined up care.**

Improving Population Health

- The prevention at scale programme has been closed and replaced with an improving population health programme, which covers prevention, health inequalities, and social determinants of good health, environmental sustainability and population health management.
- The programme board will be chaired by Robin Tuddenham and James Thomas, and met for the first time in September. **The Trust continues to work with partners through the Health and Wellbeing Boards and Integrated Care Partnerships to address health and care inequalities.**

3.4 Review of System Performance and Delivery

Finance

- The overall financial position at month five showed that the ICS was in a positive position, with several providers who formed part of the single control total reporting being ahead of plan. All NHS organisations were forecasting full delivery of their plans. However, a number of risks continue to be managed.

Performance Dashboard

- Key headlines on system performance were noted.
- Since the introduction of the system dashboard there have been numerous discussions in terms of how Local Authorities could input into the dashboard so that there is a true reflection of health and social care measures. Conversations have been taking place across the West Yorkshire Local Authority network and it was agreed that measures reported at Health and Wellbeing Board (HWB) level could be fed into this process, especially for those relating to homelessness and life skills and how this manifested into demand on mental health services. Conversations will continue to develop an agreed set of metrics to obtain consistency across the six HWBs.

Moving towards integrated, whole system assurance

- In 2020/21 the CCG Improvement and Assessment Framework and the Single Oversight Framework for NHS Trusts and NHSFTs will be replaced by a new **NHS Oversight Framework**.
- NHSE/I colleagues joined the September SOAG meeting to present a framework of approaches which they were testing to develop a small number of outcome metrics that moved beyond current performance measures to demonstrate the progress made by STPs/ICS. It was likely that this would be incorporated into the 2020/21 NHS Oversight Framework.
- SOAG discussed proposals for a transition from routine assurance processes which focus on individual organisations to an approach which focuses on whole places, involving NHSE/I and the partnership working more closely together. It is anticipated that this change will be underpinned by the new NHS Single Oversight Framework.
- **Trust Boards and CCG governing bodies retain full statutory duties and responsibilities for their own plans and performance.**

4. Draft WYH Digital Charter and Digital Strategy

The strategy was shared at the System Leadership Executive meeting in October 2019. The strategy is underpinned by a digital charter. The digital charter has been formally endorsed by the Local Health and Care Record Exemplar and now supported by the West Yorkshire and Harrogate Integrated Care System and the South Yorkshire and Bassetlaw Integrated Care System. The strategy sets out the approach and standards to be achieved across the region, and places a strong emphasis on ensuring that the basics are prioritised across the partnership to ensure that digital health and care solutions are developed on firm foundations with the required infrastructure in place. The strategy will be further developed to include how digital literacy and competency will be considered as well as the role and of the voluntary and community sector. Cyber security needs to be considered as a critical priority. A more detailed implementation and resource plan will need to be developed and the resources required to deliver the strategy will be considered through the Director of Finance Group. **A more detailed update is included in the agenda item Digital strategy and Information Management and Technology update.**

5. Workforce Readiness Tool report

Following the publication of the [Interim NHS People Plan](#), a Workforce Readiness and Development tool has been developed in order to understand the emerging Integrated Care Systems (ICSs) and processes that are in place to support and develop the NHS element of their local workforce. The aim of the tool is to develop a joint view of what needs to be true within systems to enable the delivery of the People Plan.

West Yorkshire & Harrogate ICS was selected as one of the nine pilot sites and the full report has been published. This document outlines the overarching observations, summarises the main findings and outlines the next steps and actions which should be taken by the healthcare partnership in order to move from developing/maturing to a truly thriving ICS.

Key findings from the report

The key findings from the report are as follows:

- WY&H ICS has the architecture in place to manage workforce development on a system footprint, including ICS leadership, governance groups, a comprehensive ICS workforce strategy and nominated programme leads.
- More progress can be seen in the places that have comparable system architecture to the WY&H arrangements.
- Place level arrangements and activity varies significantly.
- The current resource available is not sufficient to deliver the WY&H workforce strategy. This is significantly limiting progress and would need to be resolved if the WY&H Health and Care Partnership is going to take on greater responsibilities in this area.

Findings from all the test sites will be used to develop the Full People Plan which aims to deliver a number of objectives, including: making the NHS the best place to work; improving the leadership culture; diverse workforce; taking action in 2019/20 to tackle the nursing challenge; delivering 21st century care; and developing a new operating model for workforce. **The Trust is a key partner in this programme and the Director of HR, OD and Estates is directly involved in this work.**

6. WY&H Leadership Takeover – WYH Talent and Inclusion workshop

The ICS wide Leadership team were involved in a discussion focusing on Inclusion and diversity in the workforce. This workshop formed part of the Black History Month celebrations to acknowledge the contribution of existing BAME talent across our system. The main aims of Black History Month are to celebrate the achievements and contributions of black people not

just in the UK, but throughout the world and to educate all on black history. The workshop was led by Owen Williams, CEO for Calderdale and Huddersfield NHS Foundation Trust. He was recently named amongst the country's top 100 in a list of BAME Business Leaders, and other colleagues including Richard Stubbs, CEO for the Academic Health Science Network and Fatima Khan-Shah, programme lead for unpaid carers. A series of videos were produced to stimulate conversations on a range of issues. **The Trust CEO, Director of strategy and Chair of the BAME staff network were also involved in contributing to the workshop.**

7. West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative 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 NHS Long Term Plan.

7.1 West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Update

Non-Executive Directors (NEDs) and Governors from mental health providers came together to hear about the overall work of the West Yorkshire and Harrogate Health and Care Partnership and its role in mental health, learning disability and autism. They also heard updates from those leading some of the significant transformation work that is being delivered by the provider collaborative, including the assessment treatment units for people with learning disabilities and children, forensic services and young people mental health care. All of which is reflected in the draft Mental Health, Learning Disability and Autism Collaborative Strategy, due to be finalised in November. NEDs and Governors spent some focused time considering what they have read in the strategy document, provided feedback and considered the role of co-production in communication and engagement and the expertise they bring.

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:

- **Transformation funding (Wave 1) for community mental health:** As indicated in the Trust Board paper in September, NHS England had now confirmed funding for a proportion of the WY&H ICS bid that we submitted for 2019/20, but not for 2020/21 at this stage. This has enabled the priorities in the bid to be 'pump primed'. The original bid was for £3m for this year, and NHSE is allocating £2.5m to take account of the delayed start. Work is underway to mobilise the priorities for each place.
- **Transformation funding for community crisis care:** The following amounts of funding over a two year period has been agreed by NHS England to fund crisis support, including enhancing intensive home based treatment services and development of West Yorkshire wide mental health crisis helpline:
 - Calderdale £140,246 in 19/20 and £191,358 in 20/21
 - Kirklees £322,842 for 19/20 and £425,697 for 20/21
 - Wakefield £268,729 for 19/20 and £355,906 for 20/21

Work is underway in each place to mobilise the services being funded by this additional income.

- **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. A Provider Collaborative is a collective of providers led by a Lead Provider working in partnership to provide specialised mental health, learning disability and autism services for a given population, to improve and standardise services. The nature of the system responsibilities being transferred to Provider Collaborative, and the complexity of the services delivered, mean that Lead Providers will be NHS organisations who deliver specialised mental health and/or learning disability services.

NHSE invited 'Applications' from the ICS in 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 services in July 2019. The Trust received confirmation on 16 August 2019 that the application had been considered as a *Further Development Track* submission i.e. on track to become a Lead Provider from April 2021. Should the work be able to be completed in a shorter timeframe, the Trust will be able to re-submit the application in the *Fast Track or Development Track* timeframe (November 2019 or April 2020). The West Yorkshire Forensic Provider Collaborative has begun to take this work forward, and has secured £96,000 from the WY&H ICS to fund clinical and project support (currently being advertised) to undertake the next phase of the work.

The inaugural meeting of the WY Forensics Providers Partnership Board took place on 8 October 2019. The work plan and new governance arrangements for the Collaborative are now being implemented.

The Leeds and York Partnership Foundation Trust, Lead Provider Application for the West Yorkshire Adult Eating Disorder Provider Collaborative, was considered to be a *Fast Track* submission i.e. on track to become a Lead Provider from April 2020. The Leeds Community Healthcare Trust Lead Provider Application for the West Yorkshire Child, Adolescent and Mental Health Service (CAMHS) Provider Collaborative was considered to be a *Development Track* submission i.e. on track to become a Lead Provider from October 2020.

- **Specialist Community Forensic Team Pilot Wave 2 Selection:** The Trust submitted a bid on behalf of the West Yorkshire Forensic Provider Collaborative for Wave 2 selection. Following feedback on the bid, further work has been undertaken with partners to add more detail to the bid, particularly in respect of details on the patient cohort that the service will focus on and how the service will work innovatively with different agencies (for example, housing providers). This revised bid was submitted on 6 September 2019, feedback from NHS England was expected on 11 October 2019, but this is now expected towards the end of week commencing 14 October 2019.

8. 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:

8.1 Calderdale

Calderdale partners are working together to deliver integrated, joined up care. Calderdale Cares is being progressed and five Locality Networks (PCNs) have been established across Calderdale. **The Trust has been working with partners to enhance the cultural, arts, health and wellbeing offer in Calderdale.** A partnership report that sets out current best practice as well as what more needs to be done to become an exemplar in this area has been developed and was discussed and shared at the October Health and Wellbeing Board (the report is available for Trust Board members and included in the Calderdale HWBB papers that can be accessed through the link in appendix 4). **The Trust continues to be a partner in the Calderdale Active programme that is led by the Local Authority, funding has been received to support additional peer support workers placed in the Recovery Colleges (RC) as part of this programme, with the aim of building on the work that the RC already do to support people's wellbeing. A further proposal is being developed to identify additional capacity to accelerate system change across all Trust services in Calderdale.**

8.2 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 ICP has approved a new governance framework for drawing together all the work currently being undertaken in respect of creating and developing sustainable places and communities for Wakefield District. The November ICP meeting will largely focus on further organisational development work.

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 approved against the WY&H ICS bid for transformation funding for community crisis care highlighted above) were approved at the ICP Board and the Wakefield CCG Governing Body meetings in July. All the approved priorities are now being mobilised. Following a national recruitment process, the Alliance has appointed to the post of Mental Health Transformation Lead. **This post, funded by Wakefield CCG, will be employed by the Trust, and accountable to the Alliance Chair. The successful applicant will commence in post on 9 December 2019.**

Wakefield Primary Care Networks - The Trust's director of provider development is the SRO for this programme (on behalf of the ICP Board). There are 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.** All seven PCHs have supported and implemented the approach whereby their social prescribing link workers are employed through Live Well Wakefield, via a memorandum of understanding.

8.3 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 through the development of an Alliance. Further engagement continues to take place with key strategic leads across the system to clarify and develop the engagement plan, governance arrangements and scope. A wider partnership engagement event was held to engage partners in shaping the development of a mental health alliance. Over 50 people attended the event from different parts of the system, and fully supported the development of an alliance. It is anticipated that the Alliance will operate in shadow form by January 2020. 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. An ICS peer review of the Kirklees system will take place in November.

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**

- **Receive the minutes of relevant partnership boards.**

Appendix- Links to relevant partnership meetings and papers

1. West Yorkshire & Harrogate Health & Care Partnership Board -
2. West Yorkshire & Harrogate Health & Care Partnership System Leadership Executive - <https://www.wyhpartnership.co.uk/blog>
3. West Yorkshire & Harrogate Health & Care Partnership System Oversight and Assurance Group - <https://www.wyhpartnership.co.uk/blog>
4. Calderdale Health and Wellbeing Board - <https://www.calderdale.gov.uk/council/councillors/councilmeetings/index.jsp>
5. Kirklees Health and Wellbeing Board - <https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0>
6. Wakefield Health and Wellbeing Board - <http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board>

**Trust Board 29 October 2019
Agenda item 7.2.1**

Title:	West Yorkshire & Harrogate Health and Care Partnership Digital Charter and Draft Digital strategy
Paper prepared by:	Director of finance and resources Director of strategy
Purpose:	The purpose of this paper is to: <ul style="list-style-type: none"> ➤ Share the Yorkshire and Humber Digital Charter, endorsed by the Local Health and Care Record Exemplar (LHCRE) and the two local Integrated Care Systems. ➤ Seek the Trust Board's support for the West Yorkshire and Harrogate Health and Care Partnership Draft Digital Strategy.
Mission/values:	This draft strategy is consistent with the Trust's own digital strategy and the priorities set out are aligned to the Trust's strategy and associated digital direction of travel. The plan enables the Trust to strengthen its role as one of the key Mental Health, Learning Disability and Community Service providers in the area whilst providing the ability to explore wider collaborative opportunities further, both in support of the delivery against this strategy's priorities and those of the Trust. The way in which the draft strategy has been developed is through partnership and collaboration. This approach supports our values.
Any background papers previously considered by:	Updates on collaborative developments are provided in the Trust Board updates on West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) and the Trust's digital strategy updates. The LHCRE reports are received through the West Yorkshire and Harrogate (WY&H) arrangements.
Executive summary:	The covering paper summarises the Yorkshire and Humber Digital Charter that has been endorsed by the LHRCE Board and the draft WY&H HCP Digital Strategy highlighting the key priorities and implications for the Trust. The West Yorkshire & Harrogate Health and Care Partnership draft digital strategy sets out the strategic direction and outlines an initial 10 key priorities, developed through engagement, for the Partnership to deliver over the next 5 years. Once delivered, this will enable the Partnership to fulfil its digital obligations as stated within the NHS Long Term Plan as well as supporting the broader care transformation aims and objectives that the Partnership is seeking to provide.

	<p>In line with the principles of subsidiarity, each Integrated Care System/Sustainability Transformation Plan (ICS/STP) will drive engagement and implementation through their places. The Trust's strategy is aligned to the Partnership strategy.</p> <p>Risk Appetite</p> <p>Supporting the development of strategic partnerships and place-based plans that promote the development of integrated and joined up care and services is within the Trust's risk appetite. Risks to the Trust services and own digital priority areas will need to be constantly reviewed and managed as the detailed plans and initiatives develop across the Partnership.</p>
<p>Recommendation:</p>	<p>Trust Board is asked to:</p> <ul style="list-style-type: none"> ➤ DISCUSS and COMMENT on the West Yorkshire & Harrogate Health and Care Partnership Draft Digital Strategy; and ➤ ENDORSE and provide organisational support for the Strategy.
<p>Private session:</p>	<p>Not applicable.</p>

South West Yorkshire Partnership NHS Foundation Trust Trust Board – 29 October 2019

West Yorkshire and Harrogate Health and Care Partnership Digital Charter and Draft Digital Strategy

1. Introduction

The purpose of this paper is to:

- Share the Yorkshire and Humber Digital Charter, endorsed by the Local Health and Care Record Exemplar (LHCRE) and two local Integrated Care Systems.
- Seek the Trust Board's support for the West Yorkshire and Harrogate Health and Care Partnership Draft Digital Strategy. The strategy was shared at the System Leadership Executive meeting in October 2019 and represents a working draft of this strategy.

2. Background

The West Yorkshire and Harrogate (WY&H) Digital and Interoperability programme recognised a need to set an overall **digital strategy** for the WY&H Health and Care Partnership Digital Programme ("the Partnership"). The strategy sets out the approach and standards to be achieved across the region.

This strategy is underpinned by the **Yorkshire and Humber Digital Charter** that has been endorsed by the Local Health and Care Record Exemplar (LHRCE) and two Integrated Care Systems including West Yorkshire and Harrogate Health and Care Partnership and South Yorkshire and Bassetlaw Integrated Care System.

In line with the principles of subsidiarity, the Partnership will drive engagement and implementation through each place that makes up the Integrated Care System.

3. The Digital Strategy and Priorities

This strategy outlines the approach the Partnership will take to delivering this transformation. It clarifies the vision and principles for digital across the Partnership, summarises the priority areas for future work, and proposes a model for delivery. While this is the strategy for the Digital Programme in the Partnership, it recognises that to deliver the strategy effectively and efficiently, digital work must be undertaken in collaboration whilst recognising and encompassing places, other programmes and organisations priorities in the wider collective.

The Strategy outlines an initial 10 key priorities, developed through engagement, for the Partnership to deliver over the next five years. Once delivered, this will enable the Partnership to fulfil its digital obligations as stated within the NHS Long Term Plan as well as supporting the broader care transformation aims and objectives that the Partnership is seeking to provide.

The 10 initial key priorities are:

1. Sharing of information between all health and care partners in the six places, including Yorkshire and Humber Care Record as a platform, for ambulances, care homes, community pharmacies, hospices and appropriate information with social care.
2. Staff digital literacy.
3. Patient self-management of health at home, including tackling digital inclusion.
4. Optimising “infrastructure” we already have – connectivity, voice, data, telecare etc.
5. Mechanisms for resource sharing, procurement, standards application, blueprinting etc.
6. Digital Maturity in organisations, e.g. Electronic Patients Records.
7. Supporting the Shift Left, initially with an integrated Urgent & Emergency Care.
8. Architecture/Storage/Eco-footprint opportunity.
9. Patient held record.
10. Replicating and scaling initiatives from ‘place’ within the Partnership.

This Strategy does not seek to define and prescribe how these priorities and the associated inherent projects and initiatives will be delivered, but the Strategy serves to describe the approach and model in which the Partnership will take in deciding where these priorities are best achieved, with the Partnership monitoring and overseeing the delivery through appropriate new governance structures that underpin the operating model.

4. Digital Health and Wellbeing Charter for Yorkshire and Humber

The Digital Health and Wellbeing Charter for Yorkshire and Humber is included in Appendix 1. The Charter sets out principles that underpin the Partnership strategy. The charter has been approved by the LHCRE Board, and from a South West Yorkshire Partnership NHS Foundation Trust’s perspective, this supports both our digital approach and strategy.

5. What it means for South West Yorkshire Partnership NHS Foundation Trust

By supporting the West Yorkshire and Harrogate Health and Care Partnership Digital Strategy, the Trust commits to continue to play our full role as an active member of the Partnership.

The priorities set out in the plan are aligned to the Trust’s own Digital Strategy and associated digital direction of travel. The plan enables the Trust to strengthen its role as one of the key Mental Health, Learning Disability and Community Service providers in the area.

Whilst providing the ability from which to explore and benefit from wider collaborative opportunities further, both in support of the delivery against this strategy's priorities and those of the Trust.

The current digital programmes of work that the Trust has in progress in support of delivering against its own Digital Strategy, serves to drive up our own levels of digital maturity as an organisation. This also lays down the foundations and positions from which the Trust actively contribute to and exploit collaborative opportunities across the Partnership more readily in support of the identified 10 key digital priority areas.

We will continue to develop our digital roadmap, services and organisational digital maturity whilst ensuring that our planned and future programmes of work are fully aligned with this Digital Strategy and that opportunities for accelerating digital improvements through the Partnership are fully utilised.

It is recognised that a number of the 10 key priority areas will best be delivered through the Partnership and via a collaborative model at scale that provides standardisation and commonality in approach, such as further developing digital literacy for staff and citizens; and digital inclusion. This is a key benefit for the Trust and it will be important to ensure that staff, patients and carers are able to access opportunities to enhance their digital literacy to ensure that they can fully engage in the development of digital solutions as well as use digital solutions to improve health and wellbeing. This will also ensure that the Trust as part of the wider system fully exploits opportunities for sustainability, through effective and efficient use of scarce resources and economies of scale.

Achievement against the Digital Strategy and the initial 10 key priority areas will clearly require significant collaborative and partnership working in the delivery approach. Cyber security will be an ever-increasing important factor that will need to be fully considered. To date cyber security assessments have not been done universally across the Partnership and have been conducted on a voluntary basis. However, cyber security is extremely important especially in the current climate, as a lack of effective security controls/measures, potentially exposes organisations to threats, unplanned downtimes for digital services which ultimately impact care delivery and our service-users. For this strategy to be delivered effectively, this requires organisations (including the Trust) to be increasingly connected, to enable appropriate access and sharing of data. Therefore, the risk of potential exposure to a single organisation increases through wider integration and interoperability.

It is expected that cyber security assessments will become ever more formal and a mandated requirement as the 2021 deadline for compliance to cyber security standards approaches. The Trust is well positioned currently in support of this but this cannot be considered purely by organisations in isolation.

The delivery against the priorities in the Digital Strategy will be determined by the funding and resources available to support the necessary initiatives and will also need to recognise there is variation in the degree of digital maturity of organisations, places and people across the Partnership.

There is an expectation that full advantage of all funding sources opportunities available will need to be explored in close collaboration with NHS England, NHS Improvement and others.

Whilst also recognising that the availability of workforce will be critical in supporting digital initiatives, effective delivery must be built upon a combination of People-Process-Technology. Successful delivery of initiatives will come from working together across disciplines and consistent adoption of the principles of co-design and ensuring inclusion of patients, carers and citizens in the design and delivery of digital services.

As this Digital Strategy is currently in draft format, it is expected that there will be further revisions to be made taking account of any feedback received. Also given the scale of the digital agenda and potential scope of the priority areas, there will need to be planned annual review and refinement of agreed plans considering digital advancements and progress.

6. Recommendations

- **DISCUSS and COMMENT on the West Yorkshire & Harrogate Health and Care Partnership Draft Digital Strategy; and**
- **ENDORSE and provide organisational support for the Strategy.**

Digital Health and Wellbeing Charter for Yorkshire & Humber

1. We will commit to our key clinical, business and professional leaders being developed and mentored to understand how digital, technology and data can be applied to enable new models of care;
2. We will support the ambition for our workforce being able to effectively use technology and data to do their jobs better;
3. We will support the implementation of the 100% Digital Inclusion Yorkshire & Humber Programme with the ambition that all our citizens will be digitally included;
4. The LHCRE program will seek to establish and gain funding for a permanent Yorkshire and Humber Digital Service and associated team to maintain, develop and assure the shared, regional capabilities. If established this team will provide support to progress the aims of this charter. Further we will commit as a region to look for opportunities to create centres of excellence and shared services that can be utilised across the region.
5. We will commit to integrate with, build upon and exploit the Yorkshire and Humber Care Record (LHCRE) integration capability and approach for all system to system integrations, both locally and regionally;
6. We will adopt the design principles noted in 5.3 and ensure our technologists adhere to the supporting nationally set Digital Design Principles (Appendix 1) for all Digital, Technology and Data developments and investments. This will ensure that future integration of data is seamless;
7. In line with the principles of subsidiarity, each ICS/STP will drive engagement and implementation in their areas, with support from the YHDT;
8. We will consistently incorporate the key parts of this strategy into our NHS long term plan submissions by October 2019;
9. The YHAHSN, working closely with the YHDT, will take a lead role to determine how the Best Place for HealthTech and Best Place for Health Data and Research strategies will be progressed.

As well as delivering digitally enabled change across the Health and Care system, by doing these things we have the opportunity to differentiate Y&H from other regions by enabling the creation of a new healthtech ecosystem of suppliers and innovators based on open platforms, improving outcomes for our population and delivering exportable solutions that can be used in other places.

West Yorkshire and Harrogate
Health and Care Partnership



WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP

WORKING DRAFT 5 YEAR DIGITAL STRATEGY

v0.13 - September 2019

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1. CONTEXT

Digital will be integral to delivering the transformation we need in health and care services.

This strategy outlines the approach the West Yorkshire and Harrogate Health and Care Partnership Digital Programme (“the Partnership”) will take to delivering this transformation.

It clarifies the vision and principles for digital across the Partnership, summarises the priority areas for future work, and proposes a model for delivery.

While this is the strategy for the Digital Programme in the Partnership, it articulates work that will need to be completed by in collaboration across the partnership in digital, encompassing places, other programmes and organisations.

BACKGROUND TO THE WEST YORKSHIRE AND HARROGATE HEALTH CARE PARTNERSHIP

West Yorkshire and Harrogate Health and Care Partnership is also known as an ‘Integrated Care System’ (ICS). An ICS is given flexibility and freedoms from government in return for taking responsibility, for the delivery of high quality local services. Throughout this Strategy we will refer to ourselves as “the Partnership” because we believe this describes what we do more clearly.

Since the creation of the Partnership in March 2016, there has been a shared commitment across its organisations and Programmes to deliver the best care and outcomes possible for the 2.6million people living across the area.



The Partnership has a simple goal - everyone in West Yorkshire and Harrogate should have a great start in life, and receive the support they need to stay healthy and live longer. The Partnership is committed to tackling health inequalities and to improving the lives of the poorest, the fastest.

This is being done with the help of staff and communities, alongside their representatives, including Healthwatch, voluntary, community organisations and local councilors. A bottom-up approach means that this is happening at both a local place and a Partnership level.

The Partnership wants to further develop services to help people stay well, whilst delivering more care in the community, freeing up specialist hospital care to concentrate on what only they can do. It aims to strengthen community care in partnership with our communities, redesign services for people in a way that better meet their needs and improves the health and wellbeing of those we serve.

Considerable effort and commitment from many partners has helped the Partnership get to this point and it is now in an even stronger position to move forward together as one health care system.

The Partnerships overall strategy can be found here - <https://www.wyhppartnership.co.uk/publications/next-steps>

The Partnership's Digital Programme, working together with places, organisations and other Programmes will seek to enable the transformational change West Yorkshire is looking to deliver by enhancing and improving the use of digital across the system.

In particular the Partnership's Digital Programme is working together with other Partnerships' Digital Programmes. The Digital Health and Wellbeing Charter has been developed for Yorkshire and the Humber that outlines a commitment to become an exemplar region for Health and Care digital delivery, data and research. The Charter includes delivery of the following outcomes across Yorkshire and Humber:

1. Develop our health and care, business and professional leaders to understand how digital enables transformation.
2. Work together to address digital inclusion across the region so all can benefit from digital innovations in their health and wellbeing.
3. Enable our workforce to effectively use digital services to do their jobs.
4. Integrate with, use and leverage maximum benefit from the Yorkshire and Humber Care Record.
5. Adhere to a common set of digital principles and standards.

NATIONAL PRIORITIES FOR DIGITAL

As well as enabling the transformational priorities of the Partnership, there are also a range of digital development areas that need to be addressed which are nationally mandated in the new NHS Long Term Plan (LTP).

The [LTP implementation framework](#) outlines that local systems need to develop the comprehensive digital strategies that describe how digital technology will enable each system's wider transformation plans over the next five years. It also outlines some specific requirements the plans need to include for regarding digital maturity, interoperability, data platforms and outpatient services, with each system needing to:

- Ensure all secondary care providers are fully digitised and are integrated with other parts of the health and care system, for example through a local shared health and care record platform.

- Adopt Global Digital Exemplar (GDE) Blueprints and an approach based on IT system convergence to reduce unnecessary duplication and costs.
- Ensure organisations will achieve a defined minimum level of digital maturity.
- Use approved commercial vehicles to ensure technology vendors and platforms comply with National standards for the capture, storage and sharing of data.
- Plan how they will increase the use of digital tools to transform how outpatient services are offered and provide more options for virtual outpatient appointments and identify which specialties they intend to prioritise.

The LTP framework also set out a large range of other digital priorities for the NHS as a whole (i.e. without specifying they must be contained within system plans). These priorities include:

- Significantly improving the provision of services and information through digital routes aligned to National standards and requirements.
- Driving forward digitisation focussed on the user need and engaging staff and patients in its development.
- Achieving 100% compliance with mandated cyber security standards across all NHS organisations.
- All staff working in the community will have access to mobile digital services to help them perform their role.
- Every patient with a long-term condition having access to their care plan via the NHS App, enabled by the Summary Care Record (SCR), with functionality eventually added
- so that local shared health and care record systems are able to send alerts directly to the patient.
- Rapid expansion of patients being able to access their digital maternity record and all parents having a choice of a paper or digital Redbook for their new babies.

The Digital Programme in the Partnership, working together with places, organisations and other Programmes is committed to developing the best operating model to achieve these nationally mandated aims. Digital also needs to support the aim of transformational change in models of care the Partnership is working on.

To achieve these two complimentary aims, this strategy has developed 10 key priority areas for delivery (see next section)

These priorities (and initiatives within priorities) will need to be delivered within the Partnership at a number of different levels. Some will best be delivered as a central digital programme or as part of an existing central priority Partnership programme. Others will be best led by the one of the six Places within the Partnership, or be the responsibility of the organisations within the Places. Many may be a combination of these levels.

This strategy does not define how every one of these priorities will be delivered (a full list of all the digital initiatives being undertaken by within the Partnership can be found in Appendix 1). Rather it describes the model the Partnership will take to deciding where these priorities are best delivered from, and how the Partnership will then monitor and oversee the delivery of these priorities through the governance that underpins the operating model.

2. KEY TENETS

To ensure the digital strategy has a clear purpose, it is important that there is a clear, simple vision that articulates what the Digital Programme in the Partnership is ultimately trying to achieve. Underpinning principles for the digital strategy have been collated. These will guide all aspects of the decision making during the delivery of the strategy and ensure the vision is realised.

The vision and principles (see Appendix 1) were developed through engagement with various stakeholders. Initially a workshop was held in April 2019, which was attended by approximately 40 Chief Information Officers (CIOs) and Chief Clinical Information Officers (CCIOs). This created a long list of principles (which can be found in Appendix 2). This long list of principles was then themed and categorised into 5 overall high level principles, which was further reviewed and ratified by CCIOs and CIOs at a further workshop. The Principles have also been presented to a number of key stakeholders such as Programme leads and groups such as the Programme Oversight Group and the Clinical Forum.

THE VISION AND PRINCIPLES FOR DIGITAL IN THE PARTNERSHIP

The vision for the Partnerships Digital Strategy is:

“Harnessing digital - working together - to promote health and wellness and ensure high quality care”

The Principles that underpin this vision reiterate the overall Partnerships Principles, define Working Mechanisms, and provide the basis by which to define opportunities and can be summarised into the following 5 areas:



A description of each of the principles is outlined as:

Effective working mechanisms

In the full long list of Principles there are 14 that relate to ensuring The Partnership has the right working mechanisms for the delivery of digital initiatives. The Working Mechanisms lay out the need to be transformational for our citizens, patients and staff. Opportunities will be agreed across the stakeholder spectrum and deployment of these opportunities will continue to engage all stakeholders and firstly using existing forums like the Clinical Forum.

Smart use of resources

The Digital Programme will apply best practice – from selection of technology, through design and deployment in its initiatives. The long list of principles recognise the need for subsidiarity to be balanced at times, by the opportunities that emerge from working as a Partnership, with ten principles outlining how we can be smarter with our existing resources by, leveraging them across the Partnership.

Digitally literate staff and citizens

Being aware of the need to develop digitally-literate staff and digital citizens is key to our success in delivering the strategy and its initiatives and formed several of the long list of principles.

Sustainability and business continuity

Ensuring the Partnership focuses on Sustainable solutions that improve business resilience and continuity will be fundamental to ensuring the digital initiatives in this strategy are successful.

Progressing digital maturity

The full set of Principles outline the importance of ensuring the digital initiatives within the Partnership maintain a strong focus on progressing digital maturity at pace (across places and organisations).

10 PRIORTIES

The Partnership has a huge range of digital initiatives that are being carried out or could be potentially in the pipeline. This strategy has sought to prioritise these for delivery so that the Partnership can focus (across programmes, organisations and places) its resources and tailor its decision making as required.

It is anticipated if the Partnership delivers on these 10 high level digital priorities, it will ensure it fulfils the requirements for digital as outlined in the long term plan, as well as enabling the transformation of care based on its own internal strategy. As noted, the level these are delivered at - ICS, place or organisation - will vary based on each digital initiative (with some using a combination of approaches).

These priorities were created in the same CCIO and CIO workshops which created the principles for the strategy, using a similar process. The groups compiled a full long list of all the digital initiatives in the Partnership (these can be found in Appendix 1), and then voted on them – bearing in mind the priorities of the LTP and the wider Partnership - to create a prioritised top 10. These are listed below, and detailed within each is the rational of why it matters to staff, the Partnership and to service users.

1. **Sharing of information between all health and care partners** in the six Places, including **Yorkshire & Humber Care Record (YHCR)** as a platform, for ambulances, care homes, community pharmacies, hospices & appropriate information with social care.

Our citizens and patients expect, with reasonable safeguards, that health and social care services communicate and share appropriate and relevant information. In a digital enabled system, secure 'frictionless' flow of data between organisations is key. This means that patients, citizens and health and social care staff will be able to access,

where appropriate, secure up to date information relating to individuals to make timely, informed and safe decisions to deliver person centred health and care efficiently.

The YHCR is being developed across the wider Partnership. The Partnership is working closely with the YHCR team to ensure that the health and care organisations within the Partnership are contributing to and will benefit our population from the benefits of the shared record.

What is the impact on citizens, patients and staff?

- Sharing of data across organisational boundaries and between professional groups means that care givers can see information relating to the individual as a whole, rather than held in separate organisations - supporting genuine partnerships to enable a systems level approach to work with citizens and patients in decisions about their health and wellbeing. Preventing unnecessary admissions to hospital by giving health and care professionals more real-time whole patient information about the individual when making their professional decisions;
- Sharing core information will improve safety and experience by making comprehensive and reliable allergy, medication, diagnosis and where appropriate and social circumstance information readily available across all health and care settings, for example in A&E or when an ambulance is called or individuals access community pharmacists.
- Individuals rightly give their story once, rather than repeating the same information to different health and care professionals time and time again – sharing of information will reduce duplication as well as gaps in traditional organisational information silos. Information sharing will support safeguarding by the use of alerts across multiple care settings for both adults and children.
- Only by sharing data between organisations can we support the NHS Plan of delivering on the ambition of person-centred care – choice and sharing control – by enabler patients and citizens to access and contribute to their shared data and enable coordination of care between services.

As we work collaboratively as a health and social care system, timely, person centred care can only be delivered if information is shared across the system. Benefits to the Partnership include:

- Improve safety and efficiency by reducing the need for unnecessary repeated tests or delays in transferring information between organisations, saving time to reducing the need to manually request information; this may impact on litigation costs and NHSLA premiums.
- Visibility of individuals, for example delivery of a system level care home bed state will support flow between acute and social care sectors. Better information sharing between schools, parents and councils will help manage and respond to demand for specialist child and adolescent mental health services.
- Sharing of de-personalised information supports more accurate understanding of local populations, allowing services to be designed more effectively around individuals' needs.
- This needs to be aligned with best practise to ensure secure, robust and transparent sharing, (based on the principles of 'no surprises'. Recognising and contributing where appropriate.

- Aggregated, de-personalised information can be used to support population health management, public health and integrated commissioning, helping understand how people interact with services, and supporting a shift towards prevention and early intervention.

2. **Staff digital literacy**

Digital literacy is about the ability for everyone working in health and social care to be able to learn, work and develop effectively in a digital workplace and society, making available an education programme to promote the adoption of strategies that will enable the spread of new technologies for the whole workforce.

The evidence suggests that people who have better digital literacy tend to have more positive attitudes and behaviours to adopting new technologies. It is important that staff feel positive about adopting new technologies and processes, to ensure they are able to deliver the best quality care for the people living within our region.

The Partnership needs to ensure that services are transformed to ensure they are gaining the best value for money and quality for patients. Utilising new digital solutions is a key enabler for many service transformations to be successful. Having digitally literate staff will ensure the transformations are implemented smoothly.

3. **Patient self-management of health at home, including tackling digital inclusion**

In order to improve the quality of life for people, better manage long term conditions and prevent deterioration it is vital people are supported to better manage their conditions themselves. Professionals must work in partnership with patients while realising that the vast majority of management is done by patients away from health care setting. There are a wide number of ways digital solutions can support this, through encouraging more active lifestyles, reminding about medication through to facilitating better timely communication with health professionals. In order for this to benefit all people it is vital we help those in society who may be less able or willing to use digital solutions, working with partners through health, social and voluntary sectors to improve the digital literacy of our populations. We must work to ensure that digital innovations and enhancements do not widen the deprivation gap.

What is the impact on citizens, carers, patients, and staff?

By helping people to have the tools to better manage their own health we will enable them to live healthier lives and be more in control of their own conditions. It will empower them to be leaders in the management of their own health working with health and care professionals. Better self-management will lead to a reduction in avoidable complications and reduce this area of demand on the health and care system. Improving digital literacy to support this can also provide wider benefits for people improving their general wellbeing.

There are a wide range of tools which will be adopted and suitable in this area and lots of work done to identify which solutions work for which groups; doing this and sharing the learning across the Partnership will allow more efficient and faster developments for the benefit of people. Where appropriate many tools to help self-management will integrate with the patients' health and care records and this will significantly benefit by being done on a wider footprint.

4. **Optimising existing “infrastructure” we already have – connectivity, voice, data, telecare**

Today within each of our organisations we run a number of digital services. To some extent these services vary by organisation. For example the Yorkshire Ambulance Service has recently installed a highly resilient communications network that is likely more resilient than others. These variances are opportunities for our Partnership to leverage and achieve additional benefit from either the existing investment or with marginal additional investment.

These variances will be explored and assessed for leveraging. They may take the form of patient-facing or staff-facing opportunities or may be infrastructure that is behind the scenes.

This is an important for the Partnership as only as a collective can we draw from the greatest breadth of technology that already exists to leverage between us.

5. **Mechanisms for - resource sharing, procurement, standards application, blueprinting**

To deliver our vision we need to make best use of our resources, both financial and the skills of our staff. When individual organisations plan for new systems or processes we will consider how these might benefit our partners and patients. This will require that we all adhere to best practice in terms of procurement, though sharing lessons learnt and including other interested parties to reduce the need for multiple procurements; to developing and purchasing systems based on standard architecture, in line with current NHS Digital guidance, and ensuring an Open Standards approach to make interoperability achievable; to agreeing to share and jointly blueprint or develop systems to the benefit of partners.

There are not sufficient resources across the region to allow each organisation to develop on its own digital journey. This approach will ensure that costs are contained and benefits of developing and implementing digital solutions at scale can be maximised. By involving our staff in wider projects we will ensure that the region develops a diverse and resilient skill base.

By taking this approach we will be able to develop systems that support our staff in working across organisations, increasing the flexibility of the workforce and reducing the requirement for reskilling.

6. **Digital Maturity in organisations**

Digital maturity of organisations, and increasingly Places, is the bedrock of digital opportunity and ability to enable transformation. A basic level of digital maturity is needed for all organisations. This maturity includes for example, modern infrastructure that is able to keep pace with cyber security, clinical and corporate information systems that use software to enable basic care and work processes, and using smart technology. Basic smart technology for example means ensuring all our organisations can take advantage of medication auto-alerting and digitised sending of clinical data when transferring care. For citizens, carers, and patients this basic level of digital maturity provides online access to people’s records.

Getting these basics accomplished reduces the paper burden on our staff while providing timely and accurate access to common/shared information where and when needed. This bedrock level of maturity is required in order for then more advanced

opportunities to be explored. For example, to achieve the National objective of choice of where pregnancy care is to be received there must be patient records in place that are secure and shared. These basics provide the bedrock by which the Partnership can transform the way in which we interact with people and deliver our services. This means that changing how we deliver health and care in each Place requires basic digital maturity of all our organisations.

7. Supporting the Shift Left initially in integrated Urgent & Emergency Care

The NHS Long Term Plan places ambulance services at the heart of the UEC system responses so patients can be treated by skilled clinicians at home or in the most appropriate setting outside hospital whenever it is safe to do so. Ambulance services cannot achieve these improvements in isolation. Safe reduction in avoidable conveyance requires a whole system approach to transformation, delivering the improvements needed to provide alternatives for patients when hospital is not the optimal pathway.

This initiative will initially see the inclusion of key data sets sent from ambulance to A&E departments using the Y&H Care Record and/or local shared care records. Further work is to be defined with the Urgent and Emergency Care Programme to – using digital - streamline the pathway, assist ambulance staff in reducing conveyances, improving on the scene clinical support, supporting integration of emergency services, effective pathways for patients experience mental health and development of differential responses.

For patients this initiative will see people treated and cared in the right place, improving the patient experience.

This is an important programme of work for the Partnership as it truly supports a new model of care that can only be done at system level.

8. Architecture/Storage/ Eco footprint opportunity

Architecture and digital storage in our organisations or across the Partnership is are topics that are not staff or patient facing yet impact both along with impacting the finances of health and care. For example across the Partnership our organisations runs likely 60 or more data centres, which cost many millions of pounds every year. A key component of cost is storage, especially as it increases every year from both use and advanced digital services like radiology and other imaging. In particular the YHCR, the Yorkshire Imaging Collaborative and the WYAAT Digital Pathology initiatives are all actively advancing exploration of storage solutions. Architecture and storage decisions are made years in advance of implementation and take many years to change. This Strategy commits to exploring our collective architectures, upcoming plans and pressures and future need to ensure that as we move forward we move forward in the most cost effective and resilient way.

Architecture/storage has little direct impact on citizens, patients and staff although a smart architecture will enable clinicians to access what they need quicker. This is an important initiative for the Partnership primarily due to long term financial value.

9. **Patient held record**

Providing access for patients to the information held about them by health and care professionals, and the ability for them to contribute to this data. This is provided in a way that is easy to access, safe, secure and easy for people to understand and use.

This may be through a single app such as Helm which is being developed as part of our LHCRE programme but also includes a variety of other offers available including numerous GP online apps and the NHS app.

A person held record supports a patient to be better informed about their health, and be more actively involved and in control of their care. By giving them direct access to their records they can recall information provided to them they may have forgotten, more effectively use health services, and it provides a way for them to feed into their care planning. By allowing them to contribute their own data they can provide useful information for professionals looking after them and richer information about their health. By appropriately sharing this information with carers they can be supported to work in partnership with patients and staff to provide care wrapped around the person at the centre.

People access services across our Partnership and do not want separate records or apps for separate organisations. By working together we can develop our solutions more widely at a greater scale and share with all the appropriate clinicians. This means more effective safe care and a better experience for patients.

10. **Replicating/scaling initiatives from within the Partnership**

All organisations within the Partnership have their own strategies to increase their digital maturity, which will resolve any gaps that apply to them personally. There are many similarities across the region, so an initiative that is important to one organisation is highly likely to be important to another. Partner organisations will consider whether a new initiative is relevant to other organisations prior to embarking on any procurement, so solutions can be procured once and implemented across multiple organisations. Learning lessons from one organisation to another to streamline the process and benefit from previous experience. This in turn reduces the cost of procurement exercises and likely to shorten implementation timelines.

Staff can share their experiences/lessons learnt with colleagues from other organisations. In some instances, staff will actually deliver digital solutions at sites other than their host organisation, to make the best use of the resources we have in place within the region.

There is insufficient capacity within the region, for every organisation to deliver the full range of digital solutions singularly. Working this way isn't cost effective and the Partnership needs to look at the best opportunities to gain value for money.

3. WHERE WE ARE NOW

The Principles and Priorities for the strategy are based on an assessment of the current state of digital in the Partnership. A breakdown of the current state is provided in more detail in the section below. It gives an overview of the digital maturity, Partnership digital programmes carried out to date, the digital strengths and weaknesses of the Partnership, as well as the service users' views on digital.

Understand the current picture, in detail allows the strategy is to articulate in full what it is seeking to do in the future, which is covered in the next section.

SUCCESSFUL PARTNERSHIP WIDE PROGRAMMES TO DATE

Our lives are being transformed by digital every single day. Digital is also transforming the Partnership – the way we interact with people, the way we deliver our services, and the way in which we work together as six health and care systems.

The Partnership's Digital Programme has seen many successes in the past year.

- Over 870,000 people can now **book and cancel their GP appointments online**. This work will continue this year where we expect **950,000 people to have access by the end of the year**. These people are also now able to seek medical help virtually using the online triage tools.
- **100% of first-time referrals for patients from GPs to medical specialists** are now electronic, making the process to receive an appointment faster.
- In 70% of our GP practices there is now **free Wi-Fi** for people to use. We are **targeting 100% by the end of the year**.
- In all unplanned care settings we have provided **access for health care workers to information about vulnerable children** to ensure these children are cared for.
- Working with the **Cancer Alliance** and the **Yorkshire and Humber Care Record Exemplar**, the Partnership is now **sharing key data to expedite cancer care**. The first wave included Leeds Teaching Hospitals Trust, Harrogate Foundation Trust and Yorkshire Ambulance Service. The second wave will be completed this year and include Bradford Teaching Hospitals.
- We are supporting easier working for our staff by putting in the 'GovRoam' Wi-Fi and 'federated' email allowing staff to access a single email address book for everyone and work digitally from any of our sites. Over 50% of organisations have installed **GovRoam with 100% planned by this year**.
- A **new, secure health and social care communications network** is being put in to replace the old, separate networks for 64+ organisations. Implementation is taking place now and **will complete by the end of the year**.
- Working with the **Yorkshire Imaging Collaborative**, across the Partnership and the Humber Coast and Vale Partnership, it is expected that this year **all hospitals will have access to all radiology images**. This has already been successfully tested between Mid Yorkshire Hospitals and Bradford Teaching Hospitals.

- Work is progressing to increase the level of data captured electronically at the point of care across our hospitals through individual **electronic patient records**. This will enable a wide range of data sharing in the future.
- Providing visibility of available **care home beds** across the region has ensured that patients are discharged from hospital in a timely manner when they are ready to leave hospital but aren't able to go home.
- Work is continuing to move organisations to a secure **email platform**, ensuring safety of clinical data being sent via email. This will also offer an opportunity in the future to provide visibility of **calendar and availability** data to health and care workers across the region.
- A pilot is underway to enable community optometrists to be able to refer patients directly to a hospital where more advanced care is required for **eye services**. This speeds up the process of patients receiving their first appointment for assessment.
- Patients in some areas are now able to **correspond with their GP practice digitally** and in most cases their whole consultation is dealt with digitally, reducing the requirement to visit the practice and reducing the number of unnecessary face to face appointments. This technology will be available to all patients by the end of the year.
- Patients can now access digital tools through **111 online** to support diagnosis of minor ailments and advise of the most appropriate treatment routes.
- Patients can now view their **medical record, request appointments and order repeat prescriptions** online via the **patient online** system at their GP practice or via the **NHS App**.

THE DIGITAL MATURITY OF THE PARTNERSHIP

Improving digital maturity across the partnership will be a key success factor for this strategy. However, in order to do this it is important to understand in detail current digital maturity, broken down by different sectors and specifying the key areas of weakness and strength. Improving digital maturity, while a priority in its own right (number 6) it also acts as a key enabler for all of the top 5 priorities in this strategy.

Digital Maturity – Trusts

The digital maturity “landscape” for the trusts in the Partnership has been provided by the 2017/18 national Digital Maturity Index self-assessment. It presents a high level picture that indicates the more traditional areas of informatics such as Information Governance, Leadership and Strategic Alignment all appear to be relatively “mature” whereas (perhaps unsurprising) the more complex or newer initiatives such as Remote and Assistive Care or Digital Transfers of Care score more poorly.

Whilst these represent improvement on the results 2016/17, progress appears incremental in most areas with the exception of transfers of care which has shown strong improvement (although the score still remains below the 60% mark). The new scores for Business Intelligence and Digital Channels introduced in 2017 provide an opening statement but few overall conclusions are possible from a single reference point. The fact that the exercise has not been repeated in 2018/19 is discernible.

The graphic below is a visual representation of the 2017 self-assessments done by each the acute, mental health, community and ambulance trusts, aggregated by category. The self-assessments were a suite of questions by category. For each category the number of trusts scoring well in that category is noted in the dark green section, those approaching full maturity in light green, those with more work to do in amber and those with low maturity in the category in red. To note when the results are scaled up to a Regional level, caution must be exercised as pockets of good and poor performance of individual organisations will be masked and therefore areas of extreme “need” may be hidden.



Digital Maturity – Local Authorities

Generally the Councils are doing well in terms of digital maturity. The supporting functions of Resourcing, Information Governance, Governance, Strategic Alignment and Leadership are all assessed as mature with Infrastructure well on the way to maturity. Areas that are approaching digital maturity include the use of Business Intelligence; Records, Assessments & Plans; Transfers of Care, Decision Support and Remote & Assistive Care. Digital Channels for delivery of services is an area for maturity.

The graphic below is a visual representation of the 2017 self-assessments done by each the Councils, again aggregated by category. The self-assessments were a suite of questions for each category. Councils scoring well in a category are noted in the dark green section, those approaching full maturity in light green and those with more work to do in amber.

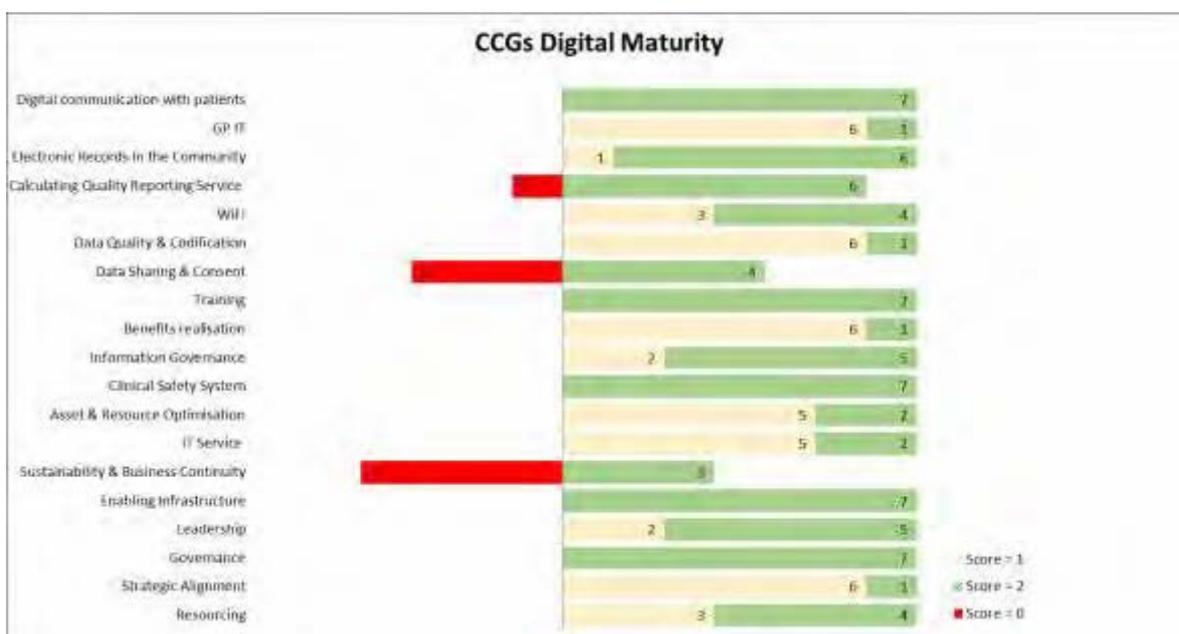


Digital Maturity – Primary Care

The NHS England Digital Maturity assessment for Primary Care contains over a hundred indicators which can support General Practice in improving by utilising digital technology enablers. It supports local commissioners (CCGs) and NHS England in meeting expectations to improve digital services in Primary Care.

Whilst there is a large range of indications together with a small range of values it is difficult to show clear performance across the Partnership as a whole. In general the use of clinical systems, EPRs, and Information Governance are mature across all the CCGs. Enabling Infrastructure is maturing along with Patient Facing Digital Strategies being slightly less mature. Areas for development, to varying degrees across CCGs, include Cyber Security, Supporting 7 day working (e.g., IT service desk and desktop support), Sharing Health and Care Information, Clinical and Population Health Intelligence and Leadership.

The graphic below is a visual representation of the 2018 self-assessments done by each the CCGs aggregated by category. The self-assessments were a suite of questions for each category. CCGs scoring well in a category are noted in the dark green section, those approaching full maturity in light green, those with more work to do in amber and those with low maturity in the category in red. Again, when the results are scaled up to a Regional level, caution must be exercised as pockets of good and poor performance of individual organisations will be masked and therefore areas of extreme “need” may be hidden.



Digital Maturity – Third Sector Organisations

There is currently no maturity assessment undertaken collectively across all 3rd Sector organisations. From the limited engagement to date with care homes and community optometry practices, it shows a low level of digital maturity and there are limited arrangements in place for IT support across these organisations. These limitations need to be factored in to any future work programmes involved these types of organisations.

Digital Maturity – Cyber Security

Cyber security assessments to date have not been done universally across the Partnership and have been done on a voluntary basis. Cyber security is important as lack of security exposes the organisations to threats and unplanned downtimes. As our organisations are increasingly connected with shared data, the risk of exposure to a single organisation multiplies through connections. Cyber maturity can also be used a proxy for age of equipment. It is expected assessments will become more formal and required as the 2021 deadline for compliance to cyber security standards approaches. Across the Trusts roughly half have taken the opportunity to become a cyber member with NHS Digital, have completed the recommended Board-level Training, have completed the external assessment called Cyber Essentials Plus and IT Health Check. Only two Trusts have mature technical remediation in place.

The graphic below is a visual representation of voluntary assessments done to date by each of the acute, mental health, community and ambulance Trusts. For each category the number of Trusts scoring well in that category is noted in the dark green section, those approaching full maturity in light green, those with more work to do in amber and those with low maturity in red. When the results are scaled up to a Regional level, caution must be exercised as pockets of good and poor performance of individual organisations will be masked and therefore areas of extreme “need” may be hidden.



Digital Maturity – Health and Care Systems

The above digital maturity assessments collectively represent a foundational maturity for each organisation. For the Partnership and its six Places to truly function digitally as health and care systems the digital maturity of the six Places needs to be considered in addition to each organisation. To date there has been no national assessment of digital maturity at a Place level. Oxford University, together with NHS Scotland, has developed a digital maturity assessment for Places for which NHS England have shared with our Partnership and agreed to trial with us.

The assessment outlines the digital requirements to enable system-level new models of care. It is in two parts, the first considers essentially an elevated organisation-based digital maturity assessment to a Place level set out in a suite of questions under four Enablers and questions to answer three Value Statements; both outlined below

The questions include, for example:

- Shared care records at a Place level
- Patient access to records for the whole Place

- Citizen wellness tools across the Place
- Specific functionality called out - Video consults, Joined-up care coordination and Use of digital tools in the home.

The assessment also focusses on the digital requirements specific for the functioning of a Place as a system. These include, for example:

- Digitally supporting workflow across a Place and realising whole-system benefits of Place-wide workflows
- Analytics for each Place for Population Health Management.

In addition the assessment considers:

- Collaboration with the AHSN, industry & research
- Agreed place-based digital investment for 2-3 years.

Enablers

1. Strategic alignment and focus (7 questions)
2. Leadership and skills development (7 questions)
3. Resources (5 questions)
4. Information governance (6 questions)

Value statements

Is your Place meeting the needs of-

1. Patients, carers and service users? (26 questions)
2. Staff? (30 questions)
3. Industry, researchers and commissioners? (10 questions)

The model has been reviewed and known gaps included in the Partnership's digital plans. However, the digital leads have agreed to complete the assessments for each of the Places. With six Places and given the nature of a new trial assessment, this exercise is expected to take six months. These assessments will then be used to update the existing plans and inform future plans.

SERVICE USER VIEWS

Considering the views and capabilities of service users is integral to the delivery of digital for the Partnership. This will ensure that digital initiatives will deliver according actual needs of the population it serves.

In order to find our service user views of some of the key elements of the LTP, the Partnership's six Healthwatch organisations were commissioned by Healthwatch England to find out local people's views. They received feedback from nearly 2000 people using a variety of surveys and 15 focus groups over a two month period in the summer of 2019, and a large element of this engagement focused on their views on digital.

Some of the key findings are outlined below:

- **People are happy to use digital technology**, and would consider using it – e.g. video appointments with their GP or health professional. **But they still hugely value face to face contact with clinicians.** People stated that a preference for personal, one-to-one contact might make them or others less likely to access digital services.

There was an aversion to “impersonal” services and “machine contact”. Respondents sometimes felt digital services could lead to lower quality care. Some felt that health professionals accessed digitally would be able to offer a less holistic service, and potentially miss symptoms which may be more apparent through face-to-face contact.

- **Some people are happy to access certain services online, but not others.** Some respondents said their level of comfort with digital services depended on what they wanted to do (for example, simply book an appointment rather than have a consultation) or on the type of condition they wanted care for.
- **People were generally supportive of their health care records being shared** with other professionals, and generally happy for anonymous information being used to help improve services and also identify people at risk of disease. But **some people said that data safety concerns would deter them from accessing digital services.** While most respondents cited hacking as their main worry, fears were occasionally expressed about personal information being released accidentally or shared with bodies, or about digital services making service users more vulnerable to scammers.
- **Respondents expressed worries that digitalisation would leave certain sections of the population behind, including some vulnerable groups** such as older or homeless people. People who gave this response sometimes commented that digital services should be just one option out of many, rather than being imposed on service users.
- **Most people said they used technology** such as a telephone, smart phones and the internet. But it was clear people said **it should not be assumed everyone can access the internet at home.** Some people said their disability was a barrier to accessing digital services, citing, among other conditions, visual and hearing impairments, arthritis, dyslexia, autism and the effects of stroke and brain damage as limiting factor.

In the delivery and oversight of this strategy and digital initiatives across the Partnership, these key findings will be born in mind at all times. They will guide decision making processes for digital in the same way as the overall Principles for this strategy.

THE PARTNERSHIP SWOT

The Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis was developed in a similar manner to the principles and priorities of this strategy. A collective view of the common strengths, weakness, opportunities and threats was developed which was then proposed to a wider group of CIOs and CCIO's for reflection, debate and subsequently additional content was added, resulting in the version included in this document (see Appendix 3).

The SWOT combined with the full digital maturity assessments provides the fully rounded view of the Partnership's current position in relation to digital.

A number of Key Themes emerged from this process which includes:

Strengths

- A shared sense of leadership and track record of collaboration e.g. LHCRE across the region.

- Members of the CIO community are in the process of achieving NHS Digital Academy certification – providing expert CIO leadership to the Partnership.
- Use made of regional infrastructure specifically GovRoam to improve connectivity and enable flexibility of working.

Opportunities

- A view that better leverage can be made from the collective investments made in regional infrastructure such as the Leeds Care Record or better collaboration in areas such as joint procurements.
- Greater exploitation of University resources and expertise to support the Partnership ambitions.
- To rollout out the HELM patient held record / NHS App across the region for benefit of patient care.

Weaknesses

- Recognition that there is a lack of capacity for subject matter experts (e.g. Cyber-Security) to work at both a Regional and Local level to support change.
- A capability deficit across the general workforce exists which will slow the overall pace of digital delivery.
- A lack of change management expertise to support or compliment the delivery of digital change across West Yorkshire and Harrogate.
- Lack of interoperability standards preventing system integration across organisations or silo'd information systems such as pathology.

Threats

- Consequences of not meeting Cyber Security Essential (plus) standard will have an impact on the delivery of the Partnerships programme.
- Inability to attract and retain subject matter experts due to the high competition for skilled digital resources from major private and public sector organisations located in the region.
- Requirement for a transition to revenue funding (as opposed to a capital funding model) to support e.g. Software as a Service, Infrastructure as a Service, challenging historic NHS financial processes.
- Ending of National NHS software licencing arrangements (e.g. Microsoft Office 2010) introducing new cost pressures.

4. WHERE WE ARE GOING

Based on the priorities for the Partnership, and the assessment of the current state, the Digital Team have defined what steps they will take to deliver the strategy. This includes how they will enable the transformation delivered by the Partnerships Programmes, enabling the plans already outlined by the different Places, and creating a model that defines at what level within the Partnership digital initiatives are delivered from.

DIGITAL SUPPORTING TRANSFORMATION - PARTNERSHIP PROGRAMMES

The Partnership delivers its transformation of care through a number of central priority programmes. They drive this transformation through delivery of their own strategies and plans, overseen by their own governance. The Digital Programme, as a Partnership enabling work stream, will look for opportunities to support the work of the programmes. There are a range of priority areas that have programmes associated with them in the Partnership. These are listed in the diagram below.



In constructing this strategy interviews were held with the Programme leads for these areas, where they were asked what their digital ambitions were for their programmes.

These conversations demonstrated these programmes are at different stages in their development and progression in terms of engagement with digital and how it relates to the delivery of their strategies. Some are already developing advanced technical solutions that are integral to the delivery of the core aims of the programme, while others are in the position of working through what support digital and technology can provide. Some examples of the digital initiatives that are already transforming care or will in the future are detailed below.

- **Mental health and learning disabilities.** There are a range of key, high level digital requirements that the programme will need to respond to that have been specified in the LTP implementation framework for Mental Health. For example the LTP outlines

that 100% of mental health providers will be fully digitised and integrated with other parts of the health and care system by 2024. It also requires that local mental health systems offer a range of self-management apps, digital consultations and digitally-enabled models of therapy, as well as utilising digital clinical decision-making tool. The mental health programme will aim to deliver these with the support of the wider partnership including the central Digital Team.

- **Cancer.** The Cancer Alliance has undertaken work to identify what digital solutions could potentially help address their key aims. It commissioned a project initiated by NHS Digital to discover what digital support was required for cancer care pathways across the West Yorkshire and Harrogate region as well as improved patient experience and cost reductions and improved staff utilisation.
- **Planned care.** Two main areas of clinical improvement work are currently underway are in Musculoskeletal and Ophthalmology. Ophthalmology is the area that has focussed on technology solutions to date, piloting the National Electronic Referral Service that enables community optometrists to refer directly into hospital eye services where required. The scheme minimises potential delays for patients in the time taken for their referral to reach hospital.
- **Harnessing the power of our communities.** The Programme is in the early stages in developing its approach to how digital will support the programme and what support and resource will be needed. There has been work undertaken to provide citizens with a digital view of the full range of community activities that are available within each Place. This library of services ensures citizens have information to know what services are available to them and how to access them.
- **Hospitals working together.** Delivered by the West Yorkshire Association of Acute Trusts, the Programme has a number of workstreams already progressing, some of which include digital tools to support clinicians, such as a single Picture Archive and Communication System (PACS) for sharing radiology images, implementation of secure email solutions for organisations to share patient identifiable information, a single inventory management solution for managing stock and an increase in capabilities of Electronic Prescribing and Medicines Administration (EPMA) solutions. There are a number of requirements that the Programme will need to respond to that have been specified in the LTP Implementation Framework, including decision support and AI to help clinicians in applying best practice and by summer 2021, there will be 100% compliance with mandated cyber security standards across all acute providers.
- **Primary and community care.** Digital First Primary Care is one of the five, major, practical changes to the NHS service model, detailed in the LTP, to meet the challenges facing the health systems. It commits that every patient will have the right to be offered digital-first primary care by 2023/24. This will include digital
- opportunities for patients to easily access advice, support and treatment from primary care; seamlessly integrated to provide a streamlined experience.

The Partnership priority programmes leads also provided views on how digital needs to be delivered across the Partnership, and what areas of support the programmes need in their delivery of digital initiatives. This provided the following common themes:

- **Capacity and specifying delivery leads.** These programmes have a huge range of aims and initiatives they wish to deliver and will often need support and capacity in order to enable any digital elements of these. The Digital Team will work with Programmes to see how they can support these initiatives. In particular when these initiatives align with the overall digital priorities of the Partnership (see section 2) or with key aims digital aims as outlined in LTP, the Digital Team will work with the

Programmes to create the optimum delivery models to achieve these aims. There are numerous digital initiatives that need to be delivered as part of the LTP and other National strategies. While some of these will naturally sit within a specific programme, others will be less clearly defined. Programmes said it would be useful if the Digital Team can work with Programmes to help define who should lead in the delivery of mandated digital initiatives or provide extra capacity and supporting where possible.

- **Scalability.** Programmes noted that the Partnership should seek to use its scale to enable the delivery of digital solutions. This includes using leverage to engage with suppliers in procurement as a single West Yorkshire and Harrogate level voice as well as looking across Programmes and Places to identify opportunities for sharing best practice or identifying where solutions could be expanded. This aligns with the key Principles of this strategy, to use resources effectively.
- **Digital literacy.** In many of the areas the Programmes are addressing, the digital literacy of staff is a significant challenge to implementing digital solutions. There is a requirement across Programmes to improve the digital literacy of current and future staff in order to enable the transformation of health and care services. This appears to be a common challenge that cuts across all Places and sectors and is therefore a clear area that could be driven or consolidated at a centralised Partnership level.
- **Benefits of digital approaches /stakeholder engagement.** The programmes will often need to carry out considerable stakeholder engagement and relationship building within the Partnership Places and organisations to persuade them of the benefits of proposed new digital approaches. They identified this as a clear area where the Digital Team could help provide additional capacity and expertise to improve this function.
- **Identifying innovation.** Programmes often identified a need for a centralised function to help identify new and emerging technologies for trial and early adoption to help increase the pace of transformation. This function will be overseen by the AHSN for the Partnership (see section 4)

Population health management and addressing health inequalities

Enabling better approaches to Population health management (PHM) and addressing health inequalities (HI) will be a key part of what the Digital Programme needs to deliver for the Partnership.

PHM and addressing HI is an enabling programme in the Partnership in its own right. It will work to introduce system level rigour so that other programmes ensure, when they are implementing transformation, that they consider PHM/HI. This will ensure the PHM/HI requirements of the LTP are met by the Partnership through being embedded in all of the transformation work the Partnership seeks to do.

The Programme is in the early stages of development, but is in the process of establishing a Programme Board that will create the governance that will oversee this new approach - Partnership digital representation will be present on this Board to ensure that digital is embedded in PHM/HI decision making and oversight. The Digital Programme will help develop the strategic PHM/HI approaches that are applicable across Places and organisations such as improving staff and service user digital literacy as mentioned above.

The Programme is also carrying out work within Places, particularly within Primary Care to introduce best practice in information governance and data sharing to enable more joined approaches to PHM/HI. The Digital Team will support with this stakeholder engagement to promote the benefits of these approaches.

DIGITAL SUPPORTING TRANSFORMATION – PLACE LEVEL STRATEGIES

A significant amount of the priorities outlined in this strategy will also need to be delivered at a Place based level. Many of the six Places that form part the Partnership have already developed their own detailed strategies or plans that outline what they are seeking to achieve (. Other localities are earlier in their journey in articulating what will be delivered digitally at place.

The priorities in these plans and strategies are very strongly aligned with those that have been defined for the whole Partnership in this document. Regardless of the development made to date in each of the Places, there are several common areas of agreement across the places about what digital priorities will be delivered, at least part, a local place based level:

- **Supporting the development of regional endeavours, for example shared care records.** There is a recognition in Places that in some areas Places will be best positioned to support rather than lead work that is being managed at a regional level, for example the YHCR and progressing the roll out of the NHS App, while other shared records will be best delivered at Place (such as creating interoperability between local organisations' EPRs).
- **Improving primary care digital maturity.** As referenced earlier in this document, improving primary care digital maturity is a key area of improvement for the Partnership, particularly in areas such as cyber security and enabling 7 day working. It would be expected (as articulated in their strategies) that Places will be ideally positioned to deliver many of these improvements as they are closest to the delivery of this care, and will be in a prime position to develop the close working relationships needed with Primary Care Networks as they mature.
- **Assessing population health management needs.** Similar to the primary care improvement, much of the delivery of improved approaches to population health management are ideally positioned for Places to lead. Places will have the local insight required to assess population health management needs and manage elements of data-based interventions, care coordination, applied health research and use of local business intelligence. This will tie in closely with the work of the population health management and addressing health inequalities programmes within the Partnership.
- **Leading work with local partners.** Places will often be in the best position to make the links with the system partners that are integral to the development of digital and data solutions at a localised level - for example in education, housing and police services.
- **Outpatient transformation.** There is clear requirement in the LTP to transform the delivery of outpatient services using technology. Given the nature of this service the frontline delivery of this will likely fall into each of the places. However, it will need to be joined up and coordinated across the Partnership using the planned care programme to ensure solutions align.

ENGAGING WITH FUTURE INNOVATIONS

As well as proposing of defined priorities, this strategy also outlines the approach that will be taken to ensure future or emerging digital innovations that could benefit West Yorkshire are identified and exploited.

The approach taken is a series of collaborative partnerships with organisations, forums or groups that have expertise in this area. These are detailed below.

Our Partnership with the Academic Health Science Network

Innovation is already transforming health and care across the Partnership. The system has a track record for innovation and a wealth of assets, including a thriving university sector and over 250 HealthTech businesses.

In line with mature system working, the Partnership has an established working relationship with its local Academic Health Science Network (AHSN). The AHSN helps lead the Innovation Programme for the Partnership and will be at the forefront of identifying new and emerging technologies that can benefit West Yorkshire and Harrogate.

There are two key areas in the approach the Innovation Programme will take that will have direct applicability to digital in the Partnership:

Spread and adoption of innovation

The AHSN will work to spread both nationally and locally identified good practice that fit with Partnership and digital priorities. The AHSN will be the bridge between the National Accelerated Access Collaborative support programme and the local system to capitalise on regional test bed clusters from 2020/21. The commitment to National funding for the AHSN until April 2023 enables the Partnership to collaborate to deliver a programme of system wide adoption of innovation. This programme is derived from:

- AHSN's portfolio of nationally funded technologies and innovations.
- Innovations with significant opportunity to improve care identified by the AHSN and partners through programmes such as the Propel@YH digital accelerator.
- Innovations identified by the Leeds Academic Health Partnership and the Centre for Personalised Health and Medicine.
- Real-world evaluations of innovation in practice supported in part by the AHSN as part of the nationally funded Innovation Exchange and the Leeds Academic Health Partnership.

Closer partnership working with the industry

Supported by the AHSN's Innovation Exchange needs identification and Signposting events, it will work to identify NHS and care-sector system needs and generate innovative responses including HealthTech and new processes, pathways and techniques.

The AHSN has a clear ambition to foster innovation in health and care services. Developing a closer and mutually beneficial working relationship with the HealthTech sector is an important part of this ambition. As well as improving health services and outcomes, it also has the potential to attract inward investment into our region, drive productivity and promote inclusive growth.

Over the past 12 months, The AHSN have been working with the Leeds Academic Health Partnership to develop a new way of working with the HealthTech 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 HealthTech sector, universities, and health and care organisations.

Our Partnership with the Yorkshire and Humber Data Architecture Design Authority

The Yorkshire and Humber Data Architecture Design Authority (DADA) has been established as part of the delivery of the YHCR and is aligned to the Clinical Technical Design Authority (CDTA). The role of DADA is to ensure organisations are sharing data

using Open Standards and specifically FHIR standards resources; curate YHCR FHIR profiles; facilitate regional standardisation; own and develop the YHCR maturity model and align YHCR FHIR profiles with National standards.

Our Partnership with the National Patient Safety Centre

Yorkshire and Humber is home to one of three National Patient Safety Centres funded by the National Institute for Health Research supported by the Universities of Bradford, Leeds and York. The Centre's research includes a Digital Innovation Theme which is examining how digital technologies such as social media can help make the NHS a safer place for patients. Our research also works with NHS partners and health IT companies examining the potential safety issues that new technologies such as Artificial Intelligence (AI) can introduce so that we can advise healthcare providers how best to make effective and safe use of digital health.

Our Partnership with the Northern, Yorkshire and Humberside NHS Directors of Informatics Forum

In addition, the Partnership benefits from very close collaboration across its CIO community with The Northern, Yorkshire and Humberside NHS Directors of Informatics Forum (NYHDIF). Established for over 25 years with a remit to share best practice, provide updates from National bodies and spread technology innovation across the region. NYHDIF membership extends to every NHS organization within Yorkshire and Humber, meets every two months and holds a yearly conference with keynote speakers from global industry and National NHS leaders.

NYHDIF is used as a forum to engage with our key supplier stakeholders to keep informed on the latest technologies, to test out long term innovation adoption capability across Yorkshire and Humber, assist in avoiding duplication and ensure innovations can be shared at scale. Another key theme from membership with NYHDIF is the opportunity to share experiences from other organisations within Yorkshire and Humber and learn from the lessons learned, to streamline future implementations.

DECIDING WHO DOES WHAT WHERE

Given the number of different digital initiatives that will need to take place within the Partnership to deliver the full set of 10 priorities, there needs to be a framework that helps define who should be delivering an initiative and at what level in the Partnership - organisation, Place or Partnership or even Region. This will also help achieve priority number 10 – Replicating/scaling initiatives from within the Partnership. Below is the proposed method for doing this. It is based on the overall delivery model of the Partnership: this specifies the principle of subsidiarity, but with the principle of using the scale and standardisation across the Partnership where appropriate.

The method is “decision tree” that can be applied to any digital initiatives to see if could or should be scaled up and delivered at a wider level than originally intended.

There are two prime drivers to consider if an initiative should be extended beyond its initial scope:

Test #1 To take advantage of the **benefit** of the initiative.

Test #2 To take advantage of **efficiencies** of scale.

Appendix 4 shows the two decision trees. These tests can be applied, one or the other or both tests, to determine if an initiative should be organisation, Place, Partnership or Region-based.

WHAT WILL BE DELIVERED – DEFINING SUCCESS

Success of the Strategy is when all organisations are digitally mature and when Place digital maturity and digital-enablement of new models of care are progressed.

This Strategy outlines its 10 digital priorities for the Partnership in order to achieve this. But within each of these principles there are series of initiatives that need to be completed.

As time progresses this long list of initiatives will be refined and adjusted every year to update them against the ongoing changing nature of digital ability and potentially Partnership priorities. Annual or interim adjustments will be done through a mini-review exercise overseen by the Digital governance (see section 5) with substantial changes brought back for approval to the System Leadership Executive Group. With each update a refreshed set of success statements will be outlined.

This Strategy will:

- 1. Implement the list of agreed Partnership priorities for sharing of clinical information between all health and care partners in the six Places. There are 31 pieces of work already identified for sharing clinically. The prioritised list is expected to be delivered at a minimum. This is sharing of:*
 - Alerts and safeguarding*
 - Scheduled appointments**
 - End of Life data.*
- 2. Staff digital literacy is and will be an ongoing maturity of staff. The Strategy will deliver, in conjunction with others:*
 - Technological skill set associated with digital maturity for all staff*
 - A progression of analytical skill set for all staff, exact deliverable to be defined in conjunction with the Workforce Programmes*
 - Agreement with schools and universities on digital needs and plan defined to realise them.*
- 3. Patient self-management of health at home, including tackling digital inclusion. This is both an area where availability of digital tools will change rapidly and where we need to in parallel ensure we are not creating a digital divide. At a minimum we will:*
 - Deploy available apps for health and care, instilling a mechanism to ensure ongoing management by services*
 - Continue to deliver a Patient Held Record through the Yorkshire & Humber Care Record, including integration with NHS App*
 - Advance digital tools to support social prescribing**
 - Work with our partners to develop a comprehensive plan to ensure a digital divide is not escalated and progress those plans, exact deliverable to be defined.*
- 4. Optimising existing “infrastructure” we already have, in particular where there is no additional cost outlay, could achieve early wins for the Partnership. We will:*
 - Review existing opportunities from within our IT estates and propose initiatives to the Digital Care Board for approval*
- 5. Effective Working Mechanisms is a priority that will support other priorities and work of organisations and Trusts. In this priority we will develop and put in routine use mechanisms to:*

- *Share resources between us*
 - *Share procurement exercises*
 - *Ensure application of standards*
 - *Ensure use of blueprints both from Global Digital Exemplar sites and from within our Partnership and others.*
6. *Bring the digital maturity of each organisation to a mature level. This specifically means:*
- *Complete the implementation of Electronic Patient Records to transform day-to-day delivery of care through the use of intelligent EPRs*
 - *Bring all organisations to a cyber-compliant position**
 - *Transform services traditionally offered on site by offering them off site using remote and assistive care**
 - *Implement the technical standard to exchange data when transferring care and removing the current technical workarounds and digitally exchanging key datasets through shared care records, supporting the delivery of shared business intelligence/ population health management*
 - *Providing seven day IT support services**
 - *Realising Board-level digital leadership across organisations*
 - *Further implement digital channels for Council services*
 - *Complete assessment, define gaps and define plans and options for Place-based maturity of our six Places.*
7. *Supporting the Shift Left for an integrated Urgent & Emergency Care. Supporting the shift left is a key objective and is embedded throughout this Strategy. This initiative specifically prioritises the left shift in urgent and emergency care. This Strategy will:*
- *Implement digital transfer of data from ambulance to A&E Departments using the Yorkshire & Humber Care Record and/or through existing shared care records*
 - *Further initiatives to be defined with the Urgent and Emergency Care Programme.*
8. *Ensuring we effectively plan Architecture/Storage and further develop an Eco- friendly footprint is defined by the following objectives:*
- *Review, assess and agree a plan for an efficient, eco-friendly architecture, including storage, across the Partnership and potentially across Yorkshire and Humber where it makes sense to do so.**
9. *Implementing a Patient Held Record across the Partnership is important to the Partnership and is a national priority. In this priority we will:*
- *Implement a Patient Held Record through the Yorkshire and Humber Care Record Programme, ensuring integration with the NHS App.***
10. *Replicating/scaling initiatives from within the Partnership will see the Partnership:*
- Removal of faxes*
- *A number of upgrades, as per list**
 - *Completing a number of initiatives in progress, including GPConnect** and eReferral***
 - *Implement eRostering and Medical Bank information systems**
 - *Implement a Regional Laboratory Information Management System***
 - *Implement the Yorkshire Imaging Collaborative sharing solution***
 - *Defining further initiatives that can be scaled or replicated within the Partnership and implementing each initiative in line with its project plan.*

* Denotes where targeted investment is a pre-requisite for success.

** Denotes initiatives where targeted investment is a pre-requisite for success but where funding has been identified, albeit not always fully covering the expected costs.

5. HOW WE TAKE THE STRATEGY FORWARD

MONITORING PROGRESS AND OPERATING MODEL

The operating model for digital initiatives will follow the principles of the operating model for the Partnership, with delivery segmented by region, Partnership, Place and organisational level.

Regional

There are a variety of programmes that are already being carried out at a regional level that impact on the Partnership including the LHCRE programme. The Partnership will continue to engage and support these programmes, as well as acting as a clear, unified representative voice for the Partnership into these programmes where required.

Partnership

There are programmes that are best managed and monitored by the central Partnership Digital Team. These programmes are those that have applicability or presence across more than one place within the Partnership, across numerous organisations and potentially sectors, and are targeted at delivering the priorities as outlined in this strategy. While they will be centrally overseen, they will in many cases rely on local delivery and resource.

The central Digital Team will also take the lead in ensuring that programmes within Places and organisations that have the potential to be aligned are, and support them to do so. It will ensure that digital programmes that take place at an organisational level or a Place level follow the Principles and Working Mechanisms as outlined in this strategy. This will be performed through the West Yorkshire and Harrogate Digital Health and Care Board. This Board will also oversee the progress of the key areas of National policy that have to be delivered in digital as outlined in the NHS LTP, but delivery may be in many cases led by Partnership priority programmes, programmes based in the Places in individual organisations.

Places

The six Places will lead the development of strategies and programmes that have applicability within each of their localities. They will deliver the programmes that are most appropriate on this scale. These programmes will involve creating greater digital interoperability between organisations within Places, better population health management at a Place based level. Place based digital initiatives will use the existing governance mechanisms that have been developed within the Places where they exist, including the development of Primary Care Networks to ensure digital programmes deliver in line with the requirements of neighbourhoods.

Places will update on the delivery of their work through the West Yorkshire and Harrogate Digital Health and Care Board which will have a responsibility for monitoring the progress and direction of these Place level programmes to ensure they deliver the overall principles of the Partnership strategy.

Organisational level

Organisations will have the autonomy to develop their own digital innovations and initiatives. Driven by the operational and quality requirements of the individual organisations, these innovations will not affect the progress of digital interoperability at a Place or regional level.

Scaling up initiatives

All levels within this model will have a responsibility for assessing whether their initiatives could be applied to the next level up within the model to achieve benefits associated with

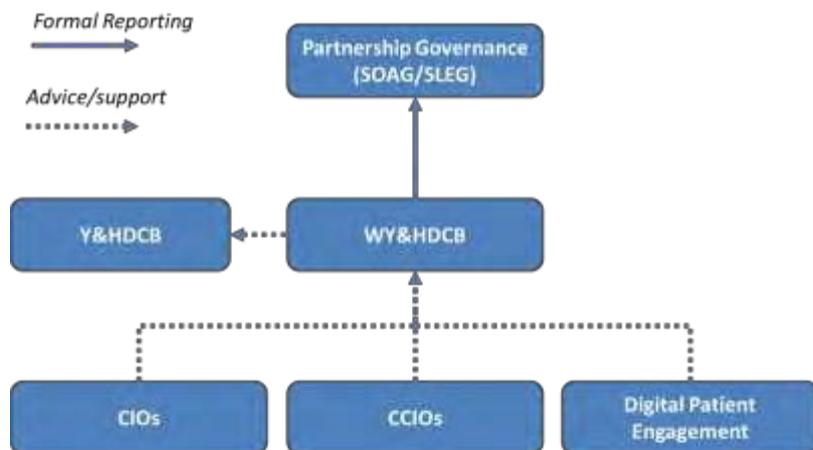
scale. The framework they should use for this is the decision tree system as described in section 4.

Oversight and governance

The execution of the digital strategy will be governed by a new West Yorkshire and Harrogate Digital Health and Care Board (WY&HDCB). The Board will have responsibility for:

- **Setting strategic direction** - set detailed direction of the Programme in line with the this strategy as well as the overall strategy for the Partnership as approved by the Partnership’s governance , Take responsibility to ensure ongoing alignment with the national and regional needs, including LHCRE, prioritise work and advise on opportunities, and ensure the work of programmes, places and organisations aligns with the digital strategy
- **Ensuring inclusion, cohesion and engagement** – ensure deliverables are in line with expectations of users; co-designed and co-delivered, receive agreements from the CIO Council and CCIO Council, and support innovation.
- **Oversee the delivery of the programme** – monitor delivery, in line with this strategy, approving changes and overseeing risk plans and mitigate identified risks (see below), and **provide assurance** on all aspects of the programme,

The members will be representative of our stakeholder community and include those delivering the Programme, finance representative, and those receiving health and care services. Each of the six Places will be represented on the Board in addition to their roles described above, as will key members of the key Partnership Programmes, Programme assurance, project management, and our partners NHS England/Improvement/Digital and The AHSN. The supporting Councils, CIOs and CCIOs, will each include every CIO or CCIO for any and all health and care organisations within the Partnership. Existing groups, including the CCIO and CIOs forum will feed into this group, as well as any future digital patient engagement forums



The Board should report and advise into the current Partnership governance structure in a similar manner to other enabling workstream boards (i.e. the Capital and Estates Board). It should also provide the central place for the Partnership to regional level digital oversight via the Yorkshire & Humber Digital Care Board (Y&HDCB), providing the clear link to the work of regional initiatives such as YHCR.

For delivery programmes, each programme will follow Managing Successful Programmes (MSP) principles and convene a programme board that will report into the WY&HDCB. In some cases there will be existing programme boards that can be leveraged to report progress on the digital elements to the WY&HDCB.

RISKS

There exists a set of key risks which threatens the future delivery of the Digital Programme which includes:

- A lack of (and the right type of) funding, requiring changes to funding processes and funding streams before developments can proceed, risking a slow-down of developments or preventing them entirely.
- Not enough suitably qualified staff and limited means to attract them into the NHS, slowing the pace of any delivery
- Interoperability between internal and external systems due to a lack of standardisation or the age of legacy systems, leading to silos of data which cannot be shared to support patient care.
- Poor planning, competing demands and shifts of National policy leading to a conflict and divergence from the delivery of the digital strategy.

RESOURCES

As discussed earlier in the Strategy there is a mixed level of digital maturity of organisations, Places and people. To deliver our Strategy successfully we must progress maturity of all elements at the same time.

Firstly there will be a need for some investment to progress initiatives where, in particular, purchases are required with both capital and annual costs. It is expected that we will take advantage of all funding opportunities available to us and seek out further opportunities in collaboration with NHS England/Improvement and others. We must also recognise that a number of the initiatives require people resources predominantly. Where we can initiatives will be resources from within our teams.

To deliver all of the initiatives, regardless of funding needs, we must work with others. Digital initiatives are always a combination of People-Process-Technology and as such our initiatives need to be co-led with clinical and operational colleagues and other Partnership programmes. Successful delivery of initiatives will come from working together across disciplines. We must remember the principles of co-design and ensure inclusion of patients, carers and citizens in the design and delivery of initiatives.

For adoption there is a need to rapidly increase the digital capability of all staff while continuing to deliver transformation. Digital skill set of our teams is outlined as a key priority for the Partnership. This programme will need to be delivered in parallel to other priorities.

Some of our priorities will seek to work specifically with other Partnership programmes, for example, the Workforce Programme, to deliver our aims.

For other priorities procurement mechanisms will be needed to support the leveraging and current and future assets between us.

To sustain digital maturity and advancements there is a need to reposition the underlying digital services to agree with industry standards. This means that there needs to be:

- IT budgets of 4-5% of revenue ongoing for digitally mature organisations
- Investment in digital teams to provide 24 hours by 7 day support services to recognise the health and care digital services provided around the clock
- Strong Information Asset Management ongoing extended to Places and regions to not only ensure good information governance but to support emergency and troubleshooting and planned improvements
- Ongoing capital investment to keep the IT estates modern and to continually take advantage of digital opportunities.

CONCLUSION

Content TBC

APPENDICES

APPENDIX 1 – DIGITAL PRIORITIES

1.Continue supporting & enabling other WY&HP programmes & local/Place/National work	2.Supporting staff working/mobility across the Partnership	3.Leveraging the Y&H Care Record for direct care, person held records & population health management where it makes sense to do so	4. Enabling health & care system working in the six Places	5.Developing digital citizens to ensure uptake of digital advancements, keeping in mind accessibility in all forms
<p>Connecting care homes Interoperability between health & care partners Supporting avoidable ED convergence (#7) Supported Integrated Urgent & Emergency Care (#7)</p> <p>Telemedicine Virtual Care - diagnostic tests etc. EPR Maturity (#6)</p> <p>Records scanning Cyber certification</p>	<p>Mobility of applications</p> <p>Active Directory for WY&HP Provide access to frontline staff to care record Shared car parking permits/systems Shared workspace /connectivity</p> <p>Virtual clinician-to-clinician & to-patient consult Access to data Messaging/presence visibility Secure messaging across organisations including</p> <p>Signal strength</p>	<p>Booking appointments by whomever, wherever Linking clinical & genomic data for new treatment Self-care data exchange including wearables, Internet of Things Developing interoperability standards Developing data quality standards/templates Report outcomes from hospital to ambulance Patient held record (#3) Enabling wellness & health eg Droha</p> <p>Expanding local system care records Population Health Management Connecting ancillary data to Y&H Care Record, e.g. imaging, pathology results, etc. Single longitudinal patient record available to anyone Sharing/Adding letters to Y&H Care Record Adding blood results into Y&H Care Record Providing access for community pharmacists to Key maturity data to enable patient choice Sharing allergy data Sharing frailty scores Sharing ambulance record across the region Access to care plans, end of life, mental health for Information Governance Sharing health & social care data within Y&H Care Record & ambulance (#1) Using Y&H Care Record for alerts & safeguarding (#1) Sharing scheduled appointments (#1-3)</p> <p>End of Life Care - data visibility (#1-2) Admit/discharge notifications Care referrals Death notice sharing Consent Timely visibility of red drugs Child Protection</p>	<p>Reducing unwarranted variation System-level medication reconciliation & information sharing with police, fire & rescue Information sharing with prisons Maternity record mothers' access Key data management in ICS Integration of ambulance & acute data NHS Mail- Social care / Local authority Patient flow through the system</p> <p>System-level operational management System-level care plans Inter-sector task exchange Record sharing with hospices Record sharing with care homes Record sharing with community optometrists Information sharing with third sector Care access to data All my clinicians have all records Places support people connections Discharge instruction communication for health & Place-based population health management - to be defined</p> <p>Enabling multi-method communications for all Unified comms for urgent & emergent care (#4) System-level interventions/preventions (#7)</p> <p>Network coverage in community Remove faes</p>	<p>"Alexa" provided to clients at home Monitoring people/patients at home</p> <p>Use of Virtual Reality for the app Adopting initiatives from other sectors e.g banking Enabling patient to manage health in own</p> <p>Tackling the digital divide Getting people online & digitally literate Vetted health & wellness apps Reliable online resource Social prescribing</p> <p>Patient view of records - primary & secondary care Leverage the NHS App</p>
<p>Key for information only, not to be included Advanced features Working as a system Bringing up to current standards Fixing legacy position</p>				

6. Replicating/scaling initiatives from within the Partnership	7. Further developing digitally-literate staff, both technology & analytics, to prepare for digital advancements	8. Ensuring digital sustainability & business continuity across the Partnership	9. Leveraging/sharing resources - people, infrastructure, software, knowledge, data - to make efficient use of our investments & enable use of collective data	10. Foundations
<p>Virtual robots- Automation of processes Command Centre blueprint</p> <p>Single electronic expenses system Care home out of a box - Alexa, Hive, Virtual Influencing suppliers - standards, price Clinical system convergence Leeds health pathways - Could it be wider? eRostering regional solution (#10) VY&HP Medical Bank (#10)</p> <p>Implement GPCconnect e-Referral - external & patient pass Non-clinical integration, e.g., Finance/ESF Digitalising paper forms clinical/corporate</p> <p>Fax removal Maternity patient record replacement Mammography upgrade Cardiology replacement Continually deploy EPRs Shared patient administration systems software Data Centre sharing (#5) Optimising connectivity, voice/data & telecare</p>	<p>Mandatory training IT "Skills", information Enhancing analytical skill set among staff</p> <p>Mandatory training/baseline testing Improving digital literacy across staff base (#2)</p>	<p>Internet first</p> <p>"Single" telephony network / voice over IP System-level business continuity planning CCGs Transition from EmBED Smartcard replacement - gov identity Servers virtualisation in primary care & Cloud first</p> <p>Establishing resilience standards/criteria Cyber essentials / ISO accreditation Upgrade/replacement of legacy technology Resilience of data centres</p>	<p>Artificial intelligence to support decision making What technology / digital web we use in 'everyday' lives which we could adapt for health care? Ethical use of data Digital first primary care</p> <p>Logistics / Transport Systems Single Sign On/Active Directory Federated secure email Virtual step-up wards Data presentation Analytics at scale Health & wellness apps Robotic process automation Regional pathology information systems (LIMS) Care home capacity tracker Digital Pathology Scan4Safety Public Secure Network Enterprise master patient index Scale what we already have (#4) Yorkshire Imaging Collaboration - Video storage etc.</p> <p>GovRoom National Pathology Exchange Office 365 or like deployment Wider use of EPRs for other sections in Places Windows 10 deployment</p>	<p>Evolving citizen-driven tools Intuitive tools</p> <p>Communication inside organisations, inside the Engagement with VYHP programmes Taking full advantage of all available funds Evolving the plans Logs for maintaining professional registration & Reduction in visits from Artificial Intelligence NHS & councils sharing oost "burden" of living Blueprinting mechanism (#5) Resource sharing mechanism (#5) Shared procurement method (#5)</p> <p>Clinical leadership Public engagement Standards - interoperability, data, codification, Exploiting existing GDEs Governance - alignment & monitoring Industry lead/leader relationship Enabling system learning from clinical audit Working with the AHSN, universities, LEP, etc.</p>

APPENDIX 2 – PRINCIPLES

ID	Principle	Expected Outcome
Our Partnership Principles		
We will be ambitious for the populations we serve and the staff we employ		
The partnership belongs to commissioners, providers, local government, NHS and communities		
We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict		
We will undertake shared analysis of problems and issues as the basis of taking action		
We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level		
Our working mechanisms		
WM1	We will be transformational - user experience, user value, efficiency (financial and non-financial), quality, safety, outcomes	Plan will include initiatives that are endorsed by stakeholders and meet the emerging needs of staff and citizens.
WM2	We will sometimes work as individual organisations, organisation types, Places or as an integrated care system	Agreed decision-tree to assess and confirm where (organisation, Place, Partnership, etc.) an initiative will be done.
WM3	We will agree priorities & objectives; what we will deliver and with what resource	Agreed plan in place including collective prioritisation
WM4	We will take our citizens, teams and organisations along with us	More opt ins than opt outs for initiatives where there is benefit to working together
WM5	We will engage to form directions, reach agreement and co-design	Programme and project boards have well-rounded stakeholder representations. Designs are inclusive of disciplines. All forums are utilised as and when needed for input as part of routine project design stage.
WM6	We will engage across disciplines and stakeholders	Programme and project boards have well-rounded stakeholder representations. Designs are inclusive of disciplines. All forums are utilised as and when needed for input as part of routine project design stage.
WM7	We will represent each other to enable efficient discussion and decision-making, relying on working mechanisms	Digital Board Terms of Reference
WM8	We will ensure all digital initiatives are based in best practice, standards and open principles	Sustainable solutions and 'good' implementations
WM9	We will use existing structures for engagement (e.g., Clinical Forum)	Programme and project boards have well-rounded stakeholder representations. Designs are inclusive of disciplines. All forums are utilised as and

		when needed for input as part of routine project design stage.
WM10	We will use a design authority, based on good digital design principles, to ensure citizen-centric, agree a set of architecture standards that all organisations/programmes will follow	Digital Board Terms of Reference
WM11	We will set degree of governance/central overhead dependent on initiative determined through a set of agreed criteria, using the lightest structure needed.	Digital Board Terms of Reference
WM12	We will speak with one, agreed voice	Agreed plan in place including collective prioritisation
WM13	We will determine geography of initiatives (at Place) by benefit	Digital Board Terms of Reference
WM14	We will iterate and develop further plans as opportunities are explored and needs evolve	Annual update of plan
Our initiatives		
Supporting existing initiatives		
E11	We will continue to support the initiatives to which we have already made a commitment	Completion of our commitments
Progressing digital maturity		
DM1	We will progress the digital maturity of each organisation	Maturity of each organisation advances every year
DM2	We will progress the digital maturity of each Place	Maturity of each Place advances every year
DM3	We will support each organisation or Place progressing at their pace	Agreed plan in place including collective prioritisation
DM4	We will be interoperable including the ability to share patient records/transfer patients between We will organisations is seen as a priority	Prioritisation of shared care records on the plan.
DM5	We will work together to achieve end-to-end data quality	Clinical work flows in use across patient pathway
Being smarter with our resources		
SwR1	We will assume all organisations are included in an initiative, i.e., must opt out	On review of initiatives, fewer and fewer initiatives that should have been done together
SwR2	We will consider all projects for wider collaboration in the first instance	On review of initiatives, fewer and fewer initiatives that should have been done together
SwR3	We will consolidate and share products at the level to which it is used	Forward-looking consolidation plan in place. Increasing number of shared products

SwR4	We will procure once on behalf of all organisations, listing all as optional	No IT procurements that have not been considered by others. Increasing number of joint procurements
SwR5	We will consider if completed procurements can be used for other organisations within WYHP	Action to be taken
SwR6	We will negotiate with suppliers through one voice	All main suppliers recognise the single voice of WYHP
SwR7	We will learn from each other and other integrated care systems	Plan in place to leverage existing investments across institutions in some form. Blueprints in place for completed initiatives that can be leveraged for others. Increasing number of initiatives leveraged across organisations.
SwR8	We will leverage local expertise for the collective benefit, running initiatives or services for each other where appropriate	Shared initiatives are run by one team or one virtual team.
SwR9	We will plan for seamless workforce transfer across organisations	Digital teams can work on any initiative in any organisation.
SwR10	We will exploit funding to enhance digital maturity within the region	Plan in place to advance digital maturity at all levels. Digital maturity is advanced year on year.
Further developing digitally-literate staff		
DLS1	We will enable a digital skillset among staff	Staff can demonstrate technological literacy. Staff can demonstrate analytics literacy.
DLS2	We will leverage existing learning and training opportunities to further digital skillset learning	Opportunities realised.
DLS3	We will work with the Workforce Programme and academic institutions to develop future workforce digital skills	Joint initiative has realised benefit.
Developing digital citizens		
DLC1	We will enable a digital skillset among citizens	Citizens can demonstrate technological literacy. Citizens can demonstrate analytics literacy.
DLC2	We will enable a digital inclusions among our citizens	Previously excluded citizens are now included.
Ensuring digital sustainability and business continuity		
S&BC1	We will implement and support each other for sustainability at all levels	Services may be sustainable by leveraging across organisation boundaries
S&BC2	We will plan for business continuity at all levels	Business continuity plans in place for organisation, Place, multi-organisation or multi-Place unplanned downtimes, e.g., Regional Pathology.
S&BC3	We will have sustainable services at all levels	Sustainable services at all levels of sustainability
S&BC4	We will plan for future proofing sustainability, including storage & computing	Plan in place an being enacted to future-proof WYHP storage and computing needs across WYHP

APPENDIX 3 – SWOT ANALYSIS

<p>Strengths</p> <p>Leadership & collaboration</p> <ul style="list-style-type: none"> • Leadership and information governance maturity • Increasingly closer co-operation & joint working • Long-standing CIO network • University partnerships • Success in bidding for national funds • Integration of some services, e.g., Service Desk <p>Implementation & adoption</p> <ul style="list-style-type: none"> • Track record of development & adoption • Deployment, e.g., GovRoam <p>Skill set</p> <ul style="list-style-type: none"> • Coverage of specialist IT knowledge • Digital Skills academy • Business Intelligence skills across the region <p>Health Tech</p> <ul style="list-style-type: none"> • Growing emerging <u>MedTech</u> sector in Leeds 	<p>Weaknesses</p> <p>Capacity & capability</p> <ul style="list-style-type: none"> • Lack of the sufficient, skilled change management capability • Variable levels of digital literacy across the workforce • Technical IT skills deficit in key areas, e.g., FHIR • Digital workforce strategy , workforce plan missing <p>Legacy</p> <ul style="list-style-type: none"> • Lack of interoperability standard preventing system integration • Silo, fragmented Information Systems • Lack of ubiquitous high speed internet connectivity (city v rural) <p>Leadership & collaboration</p> <ul style="list-style-type: none"> • Multiple data centres not been fully utilised • Belief of “keeping it local is the best way forward” when strategic solutions should be considered • Understanding horizon scanning. • Multiple relationships with providers/suppliers • Inclusion of all of primary care <p>Business Cases</p> <ul style="list-style-type: none"> • Not all in the same financial footing • Use cases / evidence base / benefits realisation evidence is weak, limited proven exemplars • Overall pace change is slow • Risk averse –organisations’ appetite
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Opportunities

Efficiencies of scale/funding

- Regional E-Rostering / logistics / transport
- Integrated use of a single messaging app
- Sharing of data centres

Standardisation

- Standardisation of the clinical dataset e.g. SNOMED, NEWS 2
- Expansion of the Leeds Health Pathways for any referral

Transformation

- Person Held Record/ NHS App
- Patient wearable technology & Online tool for self diagnosis
- Patient portal to access patient records
- Care pathway- different ways
- Internet/Digital First

Leveraging existing infrastructure

- Better use of GovRoam for agile working.
- Opportunity for single sign on across the Region
- Exploit relationships with National bodies such as NHSE/D/X
- Sharing digital skills/training
- Shared procurement
- Increase working with local authority and Public health
- Linking with all universities
- Primary care networks and community health services
- Commercial partnerships for new technology
- Resiliency planning at ICS level rather than locally e.g. infrastructure, SME & Cyber Security SMEs
- Deploy GP Connect to facilitate access to GP's record

Threats

Resources

- Attract and retain SME due to high competition
- Lack of resiliency planning and business continuity
- Revenue funding as opposed to traditional capital
- Ending of NHS software licensing agreement
- Digital literacy of patients / staff / organisations slowing down the overall pace of change
- Divergent national strategies, e.g., Internet First versus new secure network
- Consequences of not meeting Cyber Essential Plus standard
- GPIT Futures programme could distract from other improvements
- Ability to standardise clinically across organisations

Suppliers

- Duopoly of GP EPR providers and limited (albeit

APPENDIX 4 – DECISION TREES

Test #1 BENEFIT

Is the benefit of the initiative extendable to other organisations or Places in the Partnership or to the region, irrespective of approved budget or timing?

Yes. Then if initiative is extended beyond initial organisation(s) would extension negatively impact on or impair the current initiative in terms of approved budget or schedule?

Yes. Then if the initiative is extended is the impact on schedule?

Yes. Then if the initiative is extended and impacts schedule can the schedule be adjusted, realigned or lengthened?

Yes. Then if the initiative is extended and the impact on schedule can be remedied is there an impact on approved budget?

Yes. Then this initiative should seek further funding and the extension decision made based on funding availability.

No. Then this initiative should be extended to the extent to which the benefit applies.

No. Then this initiative should not be extended but its team will implement across other organisations or Places that directly follow, subject to funding extension.

No. Then if the initiative is extended and there is no impact on schedule is there an impact on approved budget?

Yes. Then this initiative should seek further funding and the extension decision made based on funding availability.

No. Then this initiative should be extended to the extent to which the benefit applies.

No. Then this initiative should be extended to the extent to which the benefit applies.

No. Then this is a local initiative.

Test #2 EFFICIENCIES

Could efficiencies of scale, with a savings to people's time or to total cost (including purchasing power and irrespective of approved budget), be achieved if the initiative was extended to other organisations or Places in the Partnership or to the region? A central team either seconded from an organisation or otherwise, should be used for initiatives where there is an efficiency benefit.

- Yes.** Then if initiative is extended beyond initial organisation(s) would extension negatively impact on or impair the current initiative in terms of approved budget or schedule?
 - Yes.** Then if the initiative is extended is the impact on schedule?
 - Yes.** Then if the initiative is extended and impacts schedule can the schedule be adjusted, realigned or lengthened?
 - Yes.** Then if the initiative is extended and the impact on schedule can be remedied is there an impact on approved budget?
 - Yes.** Then this initiative should seek further funding and extend the initiative.
 - No.** Then this initiative should be extended to the extent to which the efficiency applies without detriment.
 - No.** Then this initiative needs to undergo an options appraisal to determine if the potential efficiencies outweigh a schedule delay. The options appraisal will be reviewed and agreed by the Partnership Digital Care Board.
 - No.** Then if the initiative is extended and there is no impact on schedule is there an impact on approved budget?
 - Yes.** Then this initiative should seek further funding and extend the initiative.
 - No.** Then this initiative should be extended to the extent to which the efficiency applies without detriment.
 - No.** Then this initiative should be extended to the extent to which the efficiency applies without detriment.
- No.** Then this is a local initiative.

Trust Board 29 October 2019 Agenda item 8.1

Title:	Integrated Performance Report Month 6 2019-20
Paper prepared by:	Director of Finance & Resources Director of Nursing & Quality
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for September 2019.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	<ul style="list-style-type: none"> ➤ IPR is reviewed at Trust Board each month ➤ IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis
Executive summary:	<p>Quality</p> <ul style="list-style-type: none"> ➤ Positive progress on prone restraint continues ➤ Supervision, medicine omissions and risk assessment require further attention ➤ Complaints work remains positive, closure time improvement remains a focus ➤ Moderate/severe harm incident trend under review ➤ No under 18 admissions to adult wards <p>NHSI Indicators</p> <ul style="list-style-type: none"> ➤ There were no admissions of children and young people to adult wards during September which is the first month this has occurred this year ➤ Treatment within 6 weeks of referral for improving access to psychological therapies (IAPT) has been confirmed as being above threshold for August ➤ For September data quality warnings cover metrics relating to employment and accommodation where there are a number of records showing as “unknown” <p>Locality</p> <ul style="list-style-type: none"> ➤ Engagement and recruitment processes are commencing for the new stroke service including early supported discharge ➤ Mobilisation of work streams for Barnsley integrated community care is commencing ➤ Demand, complexity of care and bed occupancy for adult acute and older people’s services remain high and challenging across all places ➤ The Calderdale Dales Unit electroconvulsive (ECT) team has

received royal college of psychiatry accreditation along with very positive findings on care and safety

- Transition plans for forensic bed use have been implemented following agreement with the specialist commissioner
- The management of forensic Child & Adolescent Mental Health Services (CAMHS) has transferred to the Specialist BDU as part of the CAMHS service line
- Waiting times from referral to treatment for CAMHS remain a key area of focus with robust action plans being developed
- Action and improvement plans for ward 18 are being delivered with safer staffing and professional support

Priority Programmes

- Plans being developed to re-launch Future in Mind as a whole system in Wakefield
- New specification for Barnsley integrated community neighbourhood teams now published and work has commenced on mobilisation activities
- Suicide postvention service has been officially launched with staff recruited
- Bed pressures remain high and a number of changes are required to provide a sustainable system. Focused work and effort has resulted in recent improved performance
- SystemOne change reference groups have transitioned to SystemOne improvement groups

Finance

- Pre Provider Sustainability Funding (PSF) surplus in month 6 of £207k. Cumulative deficit is £1.1m which is £0.6m favourable to plan.
- Cumulative income is £0.6m lower than plan due to the recognition of a number of risks relating to CQUIN and requirements for spending on waiting list initiatives
- Out of area bed costs were £17k in month and £855k year-to-date, which is 60% lower than the spend incurred of the first half of last year.
- Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 45% above the cap and 25% higher than the same period last year.
- Net underlying savings on pay amounted to £0.6 in-month with mobilisation to mental health investment a key factor as well as ongoing vacancies
- CIP delivery of £4.4m is £0.1m lower than plan. Currently £1.1m CIPs remain unidentified for the full year.
- Cash balance of £32.4m at the end of September
- Capital expenditure of £1.7m is lower than plan, partly as a result

	<p>of delays whilst the final capital plan was agreed</p> <ul style="list-style-type: none"> ➤ The financial risk rating remains at 2 <p>Workforce</p> <ul style="list-style-type: none"> ➤ Cumulative sickness absence up to the end of September is 5%, which is higher than the same period last year. ➤ Staff turnover increased to 11.8% month on month which is 1% lower than prior year ➤ Appraisal completion for band 6 and above is 83.3% compared to a target of 95% ➤ Overall performance against mandatory training targets remains good ➤ 4 RIDDOR incidents reported in Q2 relating to incidents of violence & aggression and slips, trips & falls
Recommendation:	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable.

Integrated Performance Report Strategic Overview



September 2019

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for September 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. 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 health and safety metrics; NHS access standards. These will be updated where appropriate and when confirmed. The Trust Executive Management Team (EMT) has identified a number of metrics currently without targets and is assessing whether targets for these metrics should be added. These will be updated where appropriate for the October Trust Board. The provider oversight framework for 2019/20 has recently been published and there will be a requirement to report against a number of measures in relation to leadership and workforce based on the staff survey. It is also expected there will be further development of the oversight framework for 2020/21 onwards to include measures identified in the long term plan.

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.

Summary Quality National Metrics Locality Priority Programmes Finance/Contracts Workforce

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	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast
Single Oversight Framework metric	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green
Improve people's health and reduce inequalities	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast
% service users followed up within 7 days of discharge	95%	96.2%	97.2%	100%	97.7%	95.7%	98.0%	1
% Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 weeks 1	90%	77.5%			Due end Oct 19			3
Out of area beds 2	19/20 - Q1 576, Q2 494, Q3 411, Q4 329	207	303	195	178	146	21	3
Physical Health - Cardiometabolic Assessment (CMA) - Proportion of clients with a CMA	Community 75%	88.0%	87.6%	87.1%	86.7%	86.8%	86.2%	1
Community Inpatient 90%	Inpatient 90%	92.6%	91.5%	92.1%	93.3%	92.0%	92.5%	1
IAPT - proportion of people completing treatment who move to recovery 5	50%	54.4%	55.4%	51.9%	52.2%	54.6%	Due Nov 19	1
Number of suicides (per 100,000) population 6	tbc	0.67%			Due Oct 19			N/A
Delayed Transfers of Care	3.50%	1.4%	0.4%	0.6%	1.2%	1.6%	1.4%	4
Improve the quality and experience of care	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast
Friends and Family Test - Mental Health	85%	95%	86%	86%	91%	86%	86%	85%
Friends and Family Test - Community	98%	98%	99%	97%	97%	96%	98%	98%
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) 4	trend monitor	23	36	32	34	43	45	
IG confidentiality breaches	<=8 Green, 9-10 Amber, 11+ Red	3	11	12	5	11	10	
Proportion of people detained under the MHA who are Black, Asian & Minority Ethnic 7	trend monitor	14.5%			Due Oct 19			N/A
Total number of Children and Younger People under 18 in adult inpatient wards	TBC	1	5	3	1	1	0	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 3	trend monitor	32.0%	36.0%	37.4%	39.2%	37.0%	36.3%	
Psychology waiting times 12	tbc	Reporting to commence in 19/20 - likely Q4						
Access within one hour of referral to liaison psychiatry services and children and young peoples' equivalent in A&E departments 13		Reporting to commence in 19/20 - Dec19						
Improve the use of resources	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Position
Surplus/(Deficit)	In line with Plan	(£728k)	(£457k)	(£145k)	(£149k)	£188k	£207k	(£240k)
Agency spend	In line with Plan	£613k	£641k	£691k	£722k	£629k	£628k	£7.3m
CIP delivery	£1074k	£670k	£1.4m	£2m	£2.8m	£3.5m	£4.2m	£10.7m
Staffing costs compared to plan 10	tbc	(£367k)	(£124k)	(£268k)	(£448k)	(£450k)	(£624k)	tbc
Completion of milestones assumed in the optimisation of SystemOne for mental health 11	on plan	Reporting to commence in 19/20 - Nov19						
Financial risk in forecast	0	£1.5m	£1.5m	£2.8m	£3.1m	£3.3m	£1.1m	-
Making SWYPFT a great place to work	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Position
Sickness absence	4.5%	4.7%	4.6%	4.8%	5.0%	5.0%	5.0%	5.0%
Staff Turnover 6	10%	11.9%	10.4%	12.0%	12.6%	11.1%	11.8%	
Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	80%	N/A	N/A	75%	N/A	N/A	88%	
Staff FFT survey - % staff recommending the Trust as a place to work	65%	N/A	N/A	66%	N/A	N/A	72%	N/A
Actual level of vacancies	tbc	10.4%	10.3%	10.7%	11.9%	13.2%	12.8%	
% leavers providing feedback	tbc	25.0%			18.4%			

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 KPI counts first contact with service post referral. Under performance is generally due to waiting list issues. Q1 data has been impacted by some data quality issues as a result of transition to SystmOne and continuing challenges in recruiting specialist practitioners timely due shortage of LD specialists/applicants, this is a national issue - currently impacting on psychologists in Wakefield & Barnsley and LD nurses / speech & language therapists across all localities.
- 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 19 each month. Excludes ASD waits. Treatment waiting lists are currently impacted by data quality issues following the migration to SystmOne. Data cleansing work is ongoing within service to ensure that waiting list data is reported accurately.
- 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. Appropriate range to be established for Q2 20/21 Q2
- 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 in quarter 3 once the optimisation plan is agreed in quarter 2. Further detail related to this priority programme can be seen in the priority programmes section of the report.
- 12 - Psychology waiting times - waiting time functionality in SystmOne is being tested. Once this process has been signed off, work can commence on the set up for services. This needs to be in place before reporting can flow. It is anticipated this data may be available during quarter 4.
- 13 - The trust is involved in the urgent and emergency care pilot in conjunction with Mid Yorkshire Hospitals NHS Foundation trust. As part of this pilot, a dataset is being delivered with reporting set to commence from December 19.

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.

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Quality

- Positive progress on prone restraint continues
- Supervision, medicine omissions and risk assessment require further attention
- Complaints work remains positive, closure time improvement remains a focus
- Moderate/severe harm incident trend under review
- No under 18 admissions to adult wards

NHSI Indicators

- There were no admissions of children and young people to adult wards during September which is the first month this has occurred this year
- Treatment within 6 weeks of referral for improving access to psychological therapies (IAPT) has been confirmed as being above threshold for August
- For September data quality warnings cover metrics relating to employment and accommodation where there are a number of records showing as "unknown"

Locality

- Engagement and recruitment processes are commencing for the new stroke service including early supported discharge
- Mobilisation of work streams for Barnsley integrated community care is commencing
- Demand, complexity of care and bed occupancy for adult acute and older people's services remain high and challenging across all places
- The Calderdale Dales Unit electroconvulsive (ECT) team has received royal college of psychiatry accreditation along with very positive findings on care and safety
- Transition plans for forensic bed use have been implemented following agreement with the specialist commissioner
- The management of forensic CAMHS has transferred to the Specialist BDU as part of the CAMHS service line
- Waiting times from referral to treatment for CAMHS remain a key area of focus with robust action plans being developed
- Action and improvement plans for ward 18 are being delivered with safer staffing and professional support

Priority Programmes

- Plans being developed to re-launch Future in Mind as a whole system in Wakefield
- New specification for Barnsley integrated community neighbourhood teams now published and work has commenced on mobilisation activities
- Suicide postvention service has been officially launched with staff recruited
- Bed pressures remain high and a number of changes are required to provide a sustainable system. Focused work and effort has resulted in recent improved performance
- SystmOne change reference groups have transitioned to SystmOne improvement groups

Finance

- Pre Provider Sustainability Funding (PSF) surplus in month 6 of £207k. Cumulative deficit is £1.1m which is £0.6m favourable to plan.
- Cumulative income is £0.6m lower than plan due to the recognition of a number of risks relating to CQUIN and requirements for spending on waiting list initiatives
- Out of area bed costs were £17k in month and £855k year-to-date, which is 60% lower than the spend incurred of the first half of last year.
- Agency staffing costs continue to be higher than plan and the cap at £0.6m in month. Cumulative agency spend is 45% above the cap and 25% higher than the same period last year.
- Net underlying savings on pay amounted to £0.6 in-month with mobilisation to mental health investment a key factor as well as ongoing vacancies
- CIP delivery of £4.4m is £0.1m lower than plan. Currently £1.1m CIPs remain unidentified for the full year.
- Cash balance of £32.4m at the end of September
- Capital expenditure of £1.7m is lower than plan, partly as a result of delays whilst the final capital plan was agreed
- The financial risk rating remains at 2

Workforce

- Cumulative sickness absence up to the end of September is 5%, which is higher than the same period last year.
- Staff turnover increased to 11.8% month on month which is 1% lower than prior year
- Appraisal completion for band 6 and above is 83.3% compared to a target of 95%
- Overall performance against mandatory training targets remains good
- 4 RIDDOR incidents reported in Q2 relating to incidents of violence & aggression and slips, trips & falls

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Section	KPI	Objective	CQC Domain	Owner	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast	
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks ⁵	Improving Health	Responsive	CH	TBC	31.8%	35.8%	36.9%	38.7%	36.0%	36.3%	N/A	
Complaints	Complaints closed within 40 days	Improving Health	Responsive	TB	80%	31% 4/13	44% 4/9	26% 4/15	40.0%	53.0%	45.0%	4	
	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	36% 4/11	28% 5/18	17% 12/71	20% 4/20	12% 2/17	33% 3/9	1	
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	95%	86%	86%	91%	86%	86%	1	
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	98%	99%	97%	97%	96%	98%	1	
Quality	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Improving Health	Caring	AD	80%	N/A	N/A	75%	N/A	N/A	88%	N/A	
	Staff FFT survey - % staff recommending the Trust as a place to work ¹³	Improving Health	Caring	AD	65%	N/A	N/A	66%	N/A	N/A	72%	N/A	
	Number of compliments received	Improving Health	Caring	TB	N/A	15	64	14	10	34	32	N/A	
	Number of Duty of Candour applicable incidents ⁴	Improving Health	Caring	TB	trend monitor	21	39	30	34	Due Nov 19	Due Dec 19		
	Duty of Candour - Number of Stage One exceptions ⁴	Improving Health	Caring	TB	trend monitor	1	4	7	5				
	Duty of Candour - Number of Stage One breaches ⁴	Improving Health	Caring	TB	0	0	0	0	0			1	
	% Service users on CPA given or offered a copy of their care plan	Improving Care	Caring	CH	80%								1
	Number of Information Governance breaches ³	Improving Health	Effective	MB	<=9	3	11	12	5	11	10		
	Delayed Transfers of Care ¹⁰	Improving Care	Effective	CH	3.5%	1.4%	1.4%	0.5%	1.2%	1.6%	1.4%		1
	Number of records with up to date risk assessment - Inpatient ¹¹	Improving Care	Effective	CH	95%	86.8%	86.3%	89.8%	90.5%	89.2%	90.1%		N/A
	Number of records with up to date risk assessment - Community ¹¹	Improving Care	Effective	CH	95%	65.3%	64.4%	67.1%	70.9%	74.4%	73.5%		N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1158	1268	1084	1189	1209	1068		
	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	19	27	25	21	27	24		
	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	5	1	2	4	8		
	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	3	4	6	11	2	13		
	MH Safety thermometer - Medicine Omissions	Improving Care	Safety Domain	TB	17.7%	24.5%	27.0%	15.8%	17.1%	24.7%	23.4%		2
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	118%	117%	116%	116%	116%	116%		1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	96.6%	94.9%	92.1%	91.8%	91.8%	89.4%		1
	Number of pressure ulcers (attributable) ¹	Improving Care	Safety Domain	TB	trend monitor	41	46	34	41	42	44		
	Number of pressure ulcers (avoidable) ²	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0		1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0		1
	% of prone restraint with duration of 3 minutes or less ⁸	Improving Care	Safety Domain	CH	80%	75.8%	87.5%	90.6%	94.4%	92.5%	85.2%		1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	52	37	41	56	54	33		
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	287	303	193	190	262	168		
	No of staff receiving supervision within policy guidance ⁷	Improving Care	Well Led	CH	80%	73.4%			62.6%				1
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	82.6%	86.1%	100.0%	96.6%	85.7%	88.5%		1
	Smoking Cessation - 4 week quit rate ¹²	Improving Care	Effective	CH	tbc	Due end Oct 19			Due Jan 20				N/A
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	1	
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	1	

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* 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 SWYPFT 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 SWYPFT 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
- 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. Target only applicable to breaches.
- 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.
- 8 - The threshold has been locally identified and it is recognised that this is a challenge. 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. Trend reviewed in risk panel and clinical governance and clinical safety group.
- 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. Criteria used is - Older people and working age adult 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 October 19.
13. The national benchmark (65%) for this indictaor has been used to monitor Trust performance against.

Quality Headlines

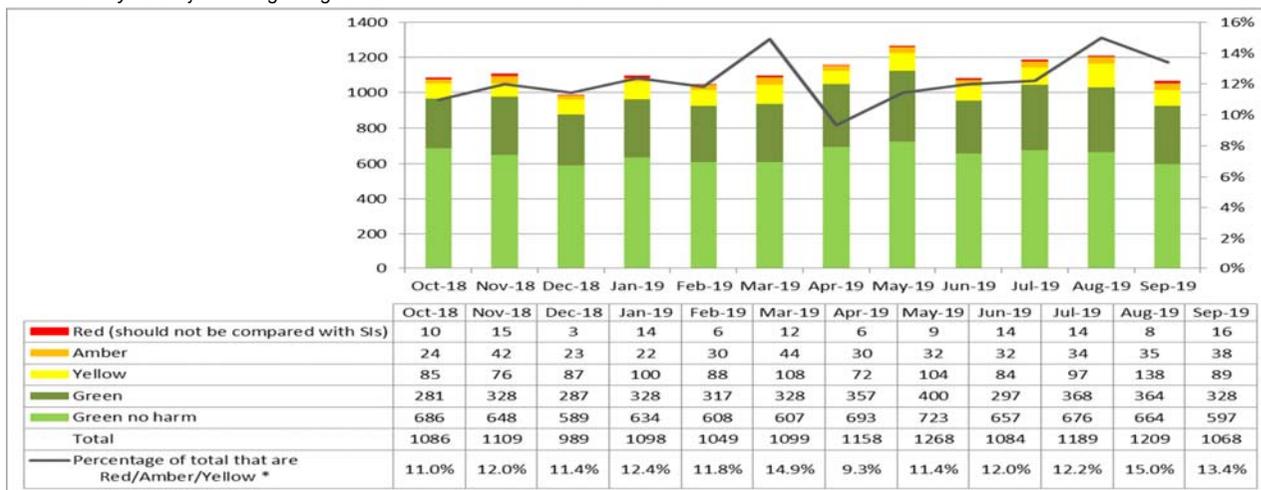
Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

- Number of restraint incidents - the number of restraint incidents during September has decreased (168) compared to the previous months (262) Further detail can be seen in the managing violence and aggression section of this report.
- NHS Safety Thermometer - medicines omissions – performance has improved slightly this month but continues to remain below threshold. Work continues across services to improve performance. The wards are self-monitoring weekly using the safety cross quality improvement tool and QIAT and pharmacy are doing some advisory visits to wards which are identified as hotspots from these. A review of omissions for the month has been undertaken and identified that a large proportion were clinically relevant or refused which then impacts on the performance. Further internal work to be undertaken over the next month so anticipate further update on the outcome of this will be included in next months report.
- Number of falls (inpatients) - September 19 has seen a reduction in the number of reported falls during the month. The level of incidents continues to mostly relate to Wakefield BDU and predominantly due to an increase in service users with high acuity high and as such increased levels of observations are 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.
- In recognition of the continued over achievement on fill rates an establishment review has been conducted and the implementation plan is now underway. The establishment changes will result in a change in our fill rate achievement levels and this is being assessed through the safer staffing group. Reporting arrangements against the new establishment levels are being finalised.
- Risk Assessments - Risk assessment performance, both completed assessments and quality of assessments continues to be managed through team action plans by quality governance leads/ matrons on a routine basis. A quality improvement group to review the wider issues impacting on risk assessment practice has been established, with the aim of ensuring risk assessments are completed in line with practice standards, are comprehensive, reviewed in a timely manner and risks are reflected in a risk management plan/ care plan. The goal is to achieve this target Trust wide by 31st May 2020. This project is aligned to the new risk assessment tool and developments with SystmOne. It has been identified that there may be a data quality issue where risk assessments have not been migrated successfully in the transition between electronic systems – this is being explored.
- Complaints - There is a slight decline in the complaints closed within 40 days in September. However, the overall trend remains positive. There is work in progress to improve our complaints pathway, with the aim to improve performance against this Trust target. Initial findings from the pathway review has identified several blockages in the system that we will need to address to improve performance, for example, allocation of a complaint to an investigator and complexity of the complaints. A report on the pathway review findings and recommendations is being prepared for the Director on Nursing & Quality & Director of Operations. Work to address the concerns raised by 360 - Internal Audit is on track and due to complete by 31st October 2019. We are in the process of agreeing a date, in January 2020, for internal audit to review that the changes we have made to our system and pathways meets their recommendations.

Safety First

Summary of Incidents since October 2018

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



* 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 19/20	Q3 18/19	Q4 18/19	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Total
Suicide (incl apparent) - community team care - current episode	4	7	4	11	0	2	1	1	5	3	3	1	1	2	5	2	26
Death - cause of death unknown/ unexplained/ awaiting confirmation	3	0	0	1	0	0	0	0	0	1	0	1	2	0	0	0	4
Suicide (incl apparent) - community team care - discharged	1	1	0	2	0	0	0	0	2	0	0	0	0	1	1	0	4
Self harm (actual harm) with suicidal intent	2	0	1	0	0	1	0	0	0	0	0	0	1	1	0	0	3
Homicide by patient	2	1	0	0	0	0	0	0	0	0	0	1	0	1	1	0	3
Pressure Ulcer - Category 3	1	0	0	2	0	0	0	0	0	0	2	0	1	0	0	0	3
Suicide (incl apparent) - inpatient care - current episode	0	0	1	1	0	1	0	0	0	0	1	0	0	0	0	0	2
Physical violence (contact made) against staff by patient	1	0	1	0	0	1	0	0	0	0	0	0	0	1	0	0	2
Information disclosed in error	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Lost or stolen paperwork	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Unwell/Illness	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Total	14	9	10	17	0	6	2	2	7	4	6	3	5	6	7	2	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://www.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 Sept 2019
- Patient safety alerts not completed by deadline of August 2019 - None

Mortality

The clinical mortality review group was held on 02/08/19 which focussed on learning and action from outcomes from learning from deaths reviews, including serious incidents, structured judgement reviews and other investigations. The group discussed low level self-harm and the EUPD pathway, incidents of Violence and Aggression and focused on the theme 'Threat Assessment Investigation' and produced four learning library templates which will be shared with comms and promoted across the Trust.

Regional work: The Trust has completed a SJRR case study which will be published as part of the Regional Mortality work.

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).

-Structured Judgement Reviews – There are currently 0 SJRRs to be allocated, all reviews are currently being completed within the allocated timescale. There are 2 cases awaiting second review.

Safer Staffing

Overall Fill Rates: 116%

Registered fill rate: (day + night) 89.4%

Non Registered fill rate: (day + night) 140.6%

BDU Fill rates - July 19 - September 19

Overall Fill Rate	Month-Year		
	Jul-19	Aug-19	Sep-19
Specialist Services	117%	117%	117%
Barnsley	115%	115%	111%
C & K	112%	110%	114%
Forensic	109%	108%	107%
Wakefield	134%	141%	142%
Overall Shift Fill Rate	116%	116%	116%

The figures (%) for September 2019:

Registered Staff - Days 82.7% (an increase of 2.5 on the previous month); Nights 96.1% (an increase of 2.4 on the previous month)

Registered average fill rate - Days and nights 89.4% (an increase of 2.5% on the previous month)

Non Registered Staff - Days 138.5% (an increase of 0.6% on the previous month); Nights 142.7% (a decrease of 4.1% on the previous month)

Non Registered average fill rate:

Days and nights 140.6% (a decrease of 1.7% on the previous month)

Overall average fill rate all staff: 115.0% (an increase of 0.4% on the previous month)

No wards, an improvement of two on the previous month, fell below the overall fill rates of 90% or above.

Summary

As above no ward has fallen below the 90% overall fill rate. Of the 31 inpatient areas 24, an increase of three wards on the previous month, (76.8%) achieved greater than 100%. Indeed of those 24 areas, 9 (28.8 of 31 wards) achieved greater than 120% fill rate.

Registered on days (Trust Total 82.7%)

The number of wards that have failed to achieve 80% decreased by four to 13 (41.6%) on the previous month. These were spread throughout all BDUs. There were various factors cited including vacancies, sickness and supporting acuity across the BDU. This is traditionally also a High Holiday point in the beginning of the month where there is less availability of bank and agency staff to provide any back fills. All measures to ensure that the wards were safely staffed were followed and the areas continued mutually supporting one another.

Registered On Nights (Trust Total 96.1%)

Two wards (6.2%), a decrease of two, has fallen below the 80% threshold. These were Elmdale within the C&K BDU and Hepworth within the Forensic BDU. Similar reasons as above were sighted for this. The number of wards which are achieving 100% and above fill rate on nights reduced by 1 ward to 16 (51.2%) this month. Two wards utilised in excess of 120%.

Specialist services remained consistent on 117% with Barnsley reducing by 4% to 111%. Calderdale and Kirklees BDU increased by 4% to 114%. Forensic BDU were 107% a decrease of 1%. Wakefield BDU increased by 1% to 142%. Overall fill rate for the trust remained consistent on 116%.

Significant pressures remain on inpatient wards due various influences including demands arising from acuity of service user population, vacancies and sickness. This is also a high annual leave period for all substantive, bank and agency staff. We are expecting a continued improvement in the RN figures with September being a month where traditionally a significant number of newly qualified staff join the Trust. We are also looking at uplifting the available numbers of HCAs in line with the establishment/skill mix review including the reintroduction of an increase in peripatetic staff.

Information Governance

During September 19, there has been a slight decrease increase in the number of confidentiality information governance breaches reported compared to the decreased number reported in September. 10 breaches during the month - 6 counts of information disclosed in error and 4 patient healthcare record issues.

No incidents were reported to the ICO.

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

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Commissioning for Quality and Innovation (CQUIN)

The Trust continues to work on the 19/20 CQUIN requirements, some of which come into effect mid year. Preparations are taking place for the Q2 submissions which are due to be submitted at the end of the month - the forecast for all applicable Q2 indicators is full achievement. Overall value of the scheme has reduced to 1.25% of contract value. The indicators for 19/20 are as follows:

- Staff flu vaccinations (Barnsley, Calderdale, Kirklees, Wakefield)
- 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 measures 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 monitor action plans to ensure maximum achievement for the year. Forecast for year end at end of September is currently 86% achievement with the following indicators being identified as areas of potential risk:

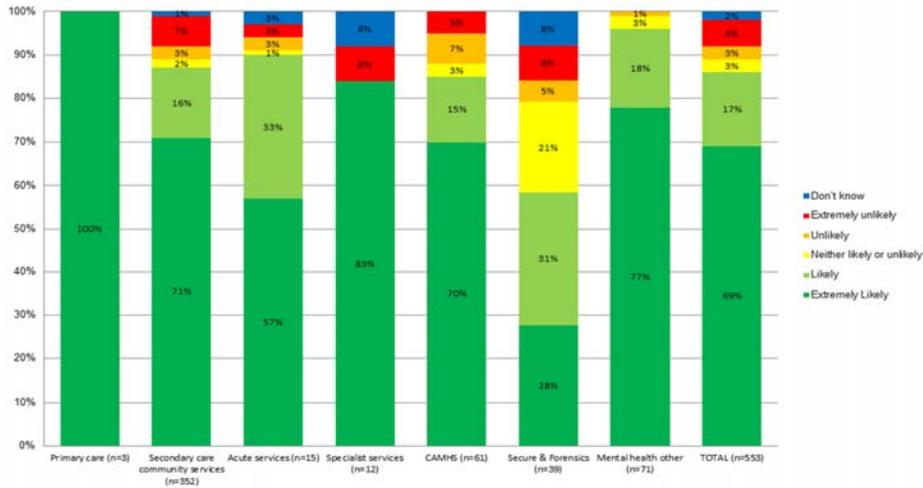
- Staff flu vaccines - risk identified with current performance compared to performance for same time last year. This is linked to staggered supply of vaccines and is a national issue.
- Mental Health Data Quality - focussed work taking place to concentrate on hotspot areas. Initial July performance was forecast to be 87% which falls short of payment threshold (>90%). July refresh position is now forecast at 96.1% - the improvement is related to a focussed piece of work to ensure all relevant data items were flowing and were mapped to the valid national codes. Regular reporting to monitor data quality being established. Work is now to commence on part b of the indicator which looks at the recording of interventions with reporting commencing from Q3 and as baseline is currently unknown, some risk has been identified in achievement.
- IAPT - anxiety specific disorders - monitoring comes into effect from quarter 2, with final performance measured at year end using an average of July - March data taken from the IAPT minimum dataset. Low numbers included in the measure have a significant impact on reported performance. Local reported performance differs slightly to nationally published data due to rounding approach taken by NHS Digital where there are small numbers. Local position shows higher performance.

Patient Experience

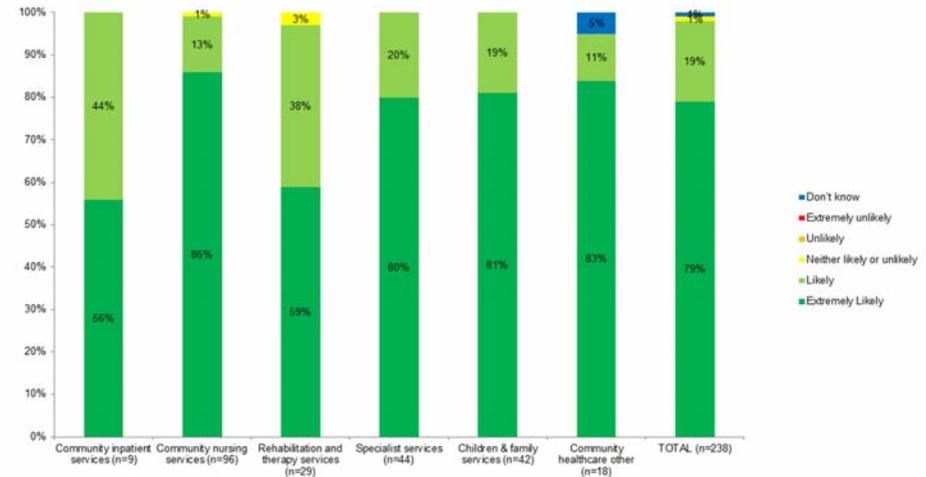
Friends and family test shows

- 86% of respondents would recommend Trust mental health services
- 98% of respondents would recommend Trust community health services
- The September results show an improvement in the number of people that would recommend community services compared to last month, the position for mental health services remains the same. On review of the results and the comments of those who would not recommend, we have not identified any trends or issues within the comments.

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.

Care Quality Commission (CQC)

CQC action plan

CQC asked us to respond to our 'must' and 'should' do actions by 20th September. These documents were submitted to the CQC within the required timescale.

Meetings have been held with key staff across core services to discuss our CQC 'must' and 'should' do actions. This year we are proposing a different approach in response to some of the actions we are taking. For example, CQC identified some similar themes across a number of core services around the need to improve the quality of risk assessment information. This also applied to care planning, record keeping and safe medicines management. Where these common themes were identified, we have established Trust wide quality improvement projects. It is intended that this approach will lead to sustainable improvement. Progress will be monitored via clinical governance group, learning shared via the quality improvement group and reported to clinical governance and clinical safety committee as part of the regular CQC reports.

Currently the CQC action plan is in draft format and is being taken to the Operational Management Group (OMG) on 30th October before going to EMT and the Clinical Governance and Clinical Safety Committee in November for sign off.

CQC Relationship Owner

In November our CQC relationship owner will change. Hamza Aslam is going to be taking over this role from Catherine Beynon-Pindar. The Trust has worked closely with Catherine to develop a good working relationship. A number of systems and processes had also been set up to promote effective engagement between Catherine and the Trust. When we held our CQC engagement meeting on 25th September, Catherine explained that she would be sharing the value of continuing this way of working with Hamza who will be attending the next CQC engagement meeting which is planned for November.

Safeguarding

Safeguarding Adults

- Safeguarding team audit of documentation from Kirklees to review triangulation of information, safeguarding referrals and actions – linked work to a mental health homicide review.
- Calderdale thematic review of street based lives – this was an opportunity for sharing information regarding current processes in service delivery across all partner agencies for individuals living street based lives.
- Domestic abuse training delivered to the enhanced team Wakefield x2 and psychiatric liaison team x1 as part of lessons learnt from a domestic homicide review.
- Team have attended the root cause analysis systems training.
- Multi agency audit findings meeting Barnsley which indicated good practice by community district nursing team in relation to a specific safeguarding case in South Yorkshire.
- The safeguarding team attended a professionals meeting to support the team with complex safeguarding issues that involved alleged Hari Krishna representatives – additionally an information sheet to support staff has been created.

Safeguarding Children

- Safeguarding team offered support to a staff member regarding a potential a child safeguarding practice review (CSPR), completion of two initial information gathering exercises for two potential CSPR and completion of a chronology for a cross border children safeguarding practice review.
- Attended launch of the domestic abuse strategy 2019/20 Kirklees
- Safeguarding team involvement with Kirklees improving access to psychological therapies (IAPT) service in relation to the appropriateness of the use of private facilities whereby concerns have been raised about the proprietor.

Infection Prevention Control (IPC)

- Annual infection prevention control plan 2019-20 (including quality improvement progress) is progressing well. No area at risk of non-completion. Quarter 2 has been fully completed.
- Surveillance: there has been no cases of MRSA Bacteraemia, MSSA bacteraemia, or clostridium difficile. There has been 1 ecoli bacteraemia case (SRU- date of case September 2019) upto date for 2019-20 data set which has been presented at post incident review panel (no set trajectory for these cases).
- Incident breakdown – 2 bite/scratch/spit, 2 incontinent of urine, 2 contact with needlestick injury (1 dirty needle / 1 clean needle), 2 faeces, 1 pathogen (infestation) and 1 ward /unit cleanliness.
- Severity rating – 8 incidents were risk rated green and 2 yellow.
- All incidents are investigated and supported by the infection prevention and control team
- Mandatory training figures are healthy - hand hygiene-trust wide total – 95%; infection prevention and control - trust wide total – 91%;
- Policies and procedures are up to date.

Reducing Restrictive Physical Intervention

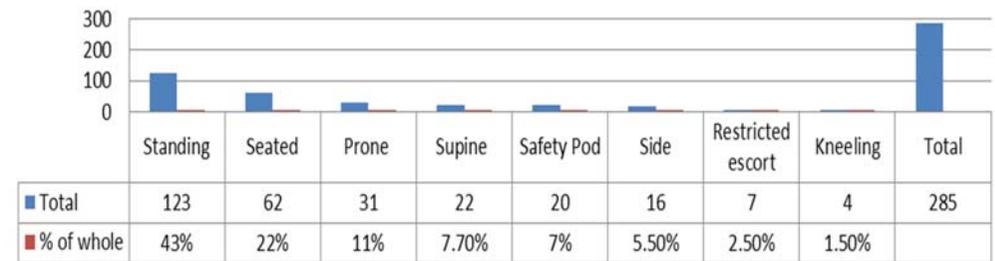
IPR data – September 2019 – Reducing Restrictive Physical Intervention (RRPI)

There were 168 reported incidents of restrictive physical interventions use in September this being a 36% reduction on the August figures that stood at 262. The highest proportion of all restraints again was in the standing position (123) which equates to 38% of all positions used, 178 a marked reduction from August that stood at 702. Seated restraints stood at 62 that equates to 22% of all positions used. In relation to incidents of that would be deemed prone restraint 27 this is a 32.5% reduction in the use of prone restraint from August 40. Wakefield BDU had the highest number of prone restraints 18 but it must be noted this is a 33% reduction in use from August that stood at 27. Only 3 BDUs reported the use of prone restraint in September these being Wakefield 18, Barnsley MH 6 and Forensics 3.

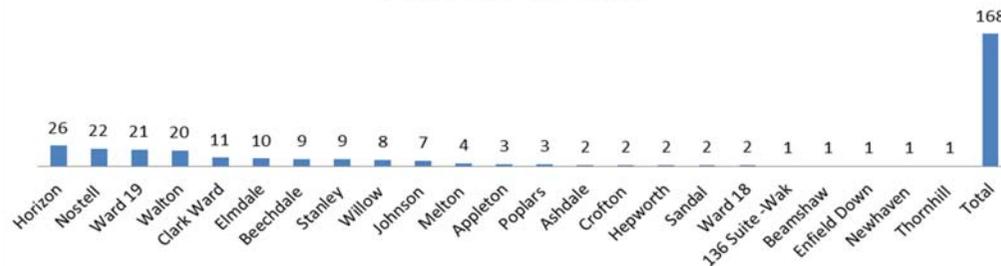
All Incidents Requiring Restrictive Physical Interventions
Sept 2019 by BDU



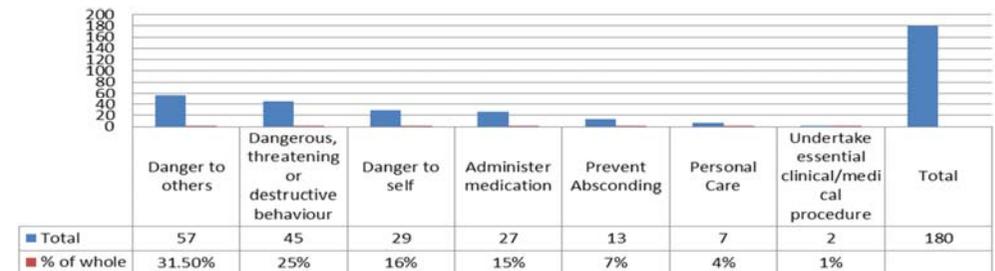
All Restraint Positions used in Incidents Requiring Restrictive Interventions Used Sept 2019



All Incidents Requiring Restrictive Physical Interventions
Sept 2019 by Team



All Incidents Requiring Restrictive Physical Interventions
Sept 2019 by Reason Given



Mental Health Act

From this month (September 2019), we will be including some key metrics related to performance against the Mental Health Act (MHA) requirements. Development of these have been taking place over the last few months. This month, we are able to commence reporting performance against Section 17 leave. Future developments will include reporting relating to Section 132 patients rights. Progress to date on this is as follows:

- The Trust section 132 policy and additional document amendments have been completed and agreed with the practice governance coach and the matrons.
- The Mental Health Act administrators have started attending the wards and meeting with registered staff to show them the new process, where to record on SystemOne and where to access the SystemOne white board (dashboard) so that the registered staff can at a glance and in real-time see what the activity is and what needs addressing / where the hotspots are.
- The MHA administrators will be developing a process to keep this under review and send reminders where needed to registered staff alerting that a patients' rights are due. We anticipate that we will be in a position to commence reporting on this data in the December 19 report (November data). We will in the first instance use the data from the SystemOne white board.

Section 17 leave

The Care Quality Commission have repeatedly raised as an issue the non completion of page 2 of the Section 17 leave form. This relates to the recording of who has been informed of the leave and the involvement of the service users and is a requirement of the MHA Code of Practice. Previous initiatives have not proven successful, so in light of this, the Trust has put a new monitoring process into place and now each form that is completed and submitted to the local MHA office is reviewed to ensure that it has been fully completed. If the form is not completed, it is sent back to the matrons/practice governance coach for action. The new process has been in place for approximately 2 months and has proven effective in most areas. There continues to be some hot spots and this is being addressed at ward level.

The numbers below are separated into :

numbers of forms received in total

of those forms, the number of forms that need to be returned for completion

the target for completion is 100% following action by MHA administration staff process of 'view and return' where not completed. The 100% compliance target is what is expected by the MHA Code of Practice.

	Sep-19		
	Section 117 form application		
Service	Forms Received	Forms complete	% complete
Older people services Trustwide	67	62	92.5%
Working age adult - Trustwide	275	245	89.1%
Specialist Forensic services	219	160	73.1%
Rehabilitation services - trustwide	21	21	100.0%

Please note, data will be refreshed each month as completed forms are received.

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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 table below lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold. This table has been revised to reflect the changes to the framework introduced during 2017/18.
- Mental Health Five Year Forward View programme – a number of metrics were identified by the Mental Health Taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
- NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.

The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

NHS Improvement - Single Oversight Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q1 19/20	Q2 19/20	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast	Data quality rating ^s	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	98.7%	98.8%	99.2%	98.7%	98.7%	98.9%	98.7%	98.8%	1		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100.0%	100.0%	98.7%	100.0%	100.0%	96.3%	95.4%	100.0%	1		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	99.7%	99.7%	99.2%	100.0%	100.0%	99.2%	100%	100%	1		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	97.4%	97.2%	96.2%	97.2%	100%	97.7%	95.7%	98.0%	1		
Data Quality Maturity Index ⁴	Improving Health	Responsive	CH	95%	Due Nov 19	Due Nov 19	96.8%	96.9%	100.0%	96.1%	97.0%	Due Nov 19	1		
Out of area bed days ^s	Improving Care	Responsive	CH	19/20 - Q1 576, Q2 494, Q3 411, Q4 329	703	318	207	303	193	151	146	21	3		
IAPT - proportion of people completing treatment who move to recovery ¹	Improving Health	Responsive	CH	50%	Due Nov 19	Due Nov 19	54.4%	55.4%	51.9%	52.2%	52.5%	Due Nov 19	2		
IAPT - Treatment within 6 Weeks of referral ¹	Improving Health	Responsive	CH	75%	Due Nov 19	Due Nov 19	83.1%	86.3%	81.4%	78.2%	76.1%	Due Nov 19	1		
IAPT - Treatment within 18 weeks of referral ¹	Improving Health	Responsive	CH	95%	Due Nov 19	Due Nov 19	98.6%	99.1%	98.4%	98.3%	98.6%	Due Nov 19	1		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	56%	83.1%	84.0%	92.0%	72.7%	88.0%	92.0%	85.7%	76.5%	1		
% clients in settled accommodation	Improving Health	Responsive	CH	60%	87.8%	89.4%	87.3%	88.0%	88.3%	88.8%	89.4%	89.9%	1		
% clients in employment ^s	Improving Health	Responsive	CH	10%	11.4%	11.6%	11.3%	11.4%	11.5%	11.7%	11.6%	11.6%	1		
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Improving Care	Responsive	CH		Due June 20							2			
Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast	Data quality rating ^s	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	90	28	5	29	56	7	21	0	2		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	9	2	1	5	3	1	1	0	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	Trend Monitor	214	183	214		183		N/A				
Proportion of people detained under the MHA who are BAME ²	Improving Care	Safe	CH	Trend Monitor	14.5%	13.1%	14.5%		13.1%		N/A				
NHS Standard Contract	Objective	CQC Domain	Owner	Target			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Year End Forecast	Data quality rating ^s	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%	99.1%	99.2%	98.7%	99.4%	99.0%	98.8%	99.7%	100.0%	1		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.8%	99.9%	99.7%	99.8%	99.8%	99.8%	99.9%	99.9%	1		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	90.2%	98.6%	84.1%	90.7%	89.5%	98.5%	98.6%	98.6%	1		

* 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 Oversight Framework operational metrics and changed from April 19 to extend the number of valid and complete data items from the MHSDS (now includes 36 data items).

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'

8 - Data quality rating - added for reporting from August 19. This indicates where data quality issues may be affecting the reporting indicators. A warning triangle identifies any issues and detailed response provided below in the data quality rating section.

Areas of concern/to note:

- A couple of metrics have not been finalised at the time of the report. Work continues with operational services on additional data quality checking which has been required as a result of transfer to a new clinical information system, this however, continues to be an improving position.
- The Trust continues to perform well against the majority of NHS Improvement metrics
- Maximum 6-week wait for diagnostic procedures - previous issues with a small number of waiters over 6 weeks have been resolved and the Trust is now achieving the threshold. A number of actions have been put in place to reduce risk of further under performance of this metric.
- Inappropriate out of area bed placements amounted to 21 days in September which is a further decrease compared to 146 days reported in August. The Trust has achieved its quarter 2 trajectory which is the first time the quarterly trajectory has been achieved since the indicator was introduced.
- % 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. A South Yorkshire & Bassetlaw partnership bid for individual placement support wave 2 funding has been successful which will see the creation of additional employment workers to support secondary care mental health services in Barnsley. There are some data completeness issues that may be impacting on the reported position of this indicator.
- The IAPT 6 week wait figure for August has now been finalised and this is now above threshold. September figures will be available in the November report.
- The scope of the data quality maturity index has changed in July 2019 as part of a national CQUIN, though the target has remained the same. The July and August figures are provisional, with July being published in October and August being published in November.

Data quality:

An additional column has been added to the above table to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

For the month of September the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for August shows a number of records with an unknown employment or accommodation status. This has therefore been flagged as a data quality issue.

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Barnsley BDU

General community services

Key Issues

- Yorkshire smoke free (YSF) managers working with partners on proposed QUIT programme across South Yorkshire.
- Health improvement team (Urban House) are seeing an increased number of clients with complex needs and the turnover of clients coming through the service has increased – a business case for additional required resource is being developed.
- Neighbourhood team mobilisation of integrated specification - task and finish groups established for estates and IT, SystmOne configuration, single point of access (SPA), E rostering etc.
- Integrated stroke service – the hyper-acute stroke unit commences formally in Barnsley 1st October. Recruitment processes commencing for early supported discharge service.
- Early Supported discharge (ESD) model reviewed independently and approved by CCG.

Strengths

- Childrens therapy services delivered twilight sessions information sessions to parents/carers/partners they received excellent feedback and we have noted the positive impact on waiting times into the service.
- Consistently positive friends and family test feedback for all services.
- Tissue viability team developed and launched a number of new pathways including leg ulcer pathway, self-harm pathway and moisture associated skin damage pathway
- Secretary of state for Scotland contacting BICES manager to look at replicating the re-cycling model across Scotland
- New out of area patient flow procedure to neuro rehabilitation unit at Kendray now completed and fully implemented

Challenges

- Audiology service level agreement with acute trust remains outstanding – both parties meeting late October to discuss further.
- Neighbourhood team specification - mobilisation of a new model and changes regarding integrated leadership and management, some agile bases and formation of neighbourhood teams and new ways of working.
- Workforce issues neighbourhood nursing service (NNS) – Level of increased demand alongside reduced capacity/ vacancies continues to be monitored very closely.
- NNS paper to support increased investment prepared.
- Epilepsy business case compiled due to increased demand and service pressures
- Stroke - Early supported discharge mobilisation

Areas of Focus

- Management of predicated staffing shortages in children's speech and language therapy due to maternity leaves and inability to obtain agency cover to date.

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Barnsley BDU:

Barnsley Mental Health

Key Issues

- The acute service lines including intensive home based treatment (IHBT) continues to experience high demand, staffing pressures and acuity leading to pressures on the wards and on-going bank expenditure. Bed occupancy levels remain high. Resources are being utilised across the wards and effective skill-mixing deployed to minimise expenditure.
- Average length of stay remains in excess of target and is rising and has been identified as part of the trust wide programme of improvement in addressing demand and capacity in acute services, in particular the work around Criteria Lead Discharge.
- 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 some improvement in the core pathway due to extra clinics. The waiting list reduction plan in core continues on track.
- We are working with the CCG and primary care partners to scope and plan integrated services at neighbourhood and primary care network level.

Strengths

- As part of mobilisation plan recruitment into all age liaison psychiatry posts is proceeding well
- Continued success in recruitment to medical posts has meant there are currently no agency medical staff in the BDU
- Ongoing management of patient flow despite growing pressures

Challenges

- Demand and capacity in acute and community services continues to be a challenge.
- The action plan and training around care programme approach (CPA) reviews and SystemOne is leading to some positive impact, and is being closely monitored and supported at trust level.
- Barnsley BDU monthly sickness rates are in excess of trust target with a hotspot in acute services. General managers continue to work with 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, including safer staffing, in community services.
- Sickness management.

Calderdale & Kirklees BDU:

Key Issues

- Older adult wards remain under pressure with very high acuity and need levels. The number of delayed transfers of care remain higher than normal and intensive work with clinical commissioning group (CCG) and social care commissioners is continuing to try to identify and secure specialist long term accommodation.
- The improvement to out of area adult acute beds non-use has been sustained whilst the system and our acute medical and accident and emergency systems are under intense pressures.
- The Calderdale, Dales Unit electroconvulsive therapy (ECT) team received royal college of psychiatry accreditation, along with very positive findings on care and safety.

Strengths

- High performance on mandatory training continues.
- Improving access to psychological therapies performance is above local trajectory agreed with the CCG. Positive discussions are underway with the CCGs about next year's investment priorities and psychological wellbeing practitioner (PWP) training places.
- Discussions have commenced with the 3 CCGS about next years investment and business plans.

Challenges

- Adult capacity levels remain managed in intensive home based treatment teams and on community caseloads.
- Calderdale psychological therapies remain under pressure with support from the CCG to commission some additional wider community capacity in third sector and also moving forward to recruit additional therapists.

Areas of focus

- See above

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 were de-commissioned and agreement was reached with commissioners for us to increase our mental illness beds. Transition plans have been implemented and ongoing monitoring with commissioners is in place.
- Occupancy has increased above target. Medium secure at 94%. Bretton Centre occupancy now at 97%; Newhaven at 75% (with 2 admissions planned in November on completion of call button works.)
- Work with the West Yorkshire provider collaborative continues with the new care model expected to go live in April 2021.
- Bid for a forensic community service has been re submitted to NHSE, with improved partner engagement and involvement.
- Forensic outreach service for learning disabilities (FOLs) is offering a consultancy and advisory service across the core week. Recruitment continues and we have successfully appointed to several key posts, including the consultant psychiatrist, a consultant psychologist and speech and language therapist
- Programme of organisational development in place with good engagement across the BDU looking at culture, well-being, reducing sickness, improving engagement and communication.
- Improving our volunteer opportunities to be a focus.

Strengths

- Strong performance on mandatory training.
- Good track record delivering CQUINs.
- Progress being made on CQC action plans. Significant planning is underway to ensure the call system can be installed and implemented safely..
- Service review of psychology service has led to improved performance with positive progress on recruitment to psychology posts.
- Excellent service user engagement at service and regional level.
- Carer Involvement plans are in place.

Challenges

- Recruitment of registered staff in all disciplines. A significant resource is being utilised to optimise recruitment activity.
- High turnover.
- Reducing sickness.

Areas of Focus

- The BDU will undertake a large piece of work supported by human resources and will focus on the following areas:

- *Leadership
- *Sickness/absence
- *Turnover
- *Staff wellbeing
- *Bullying and harassment
- Ensuring the culture remains positive and reflect the values of the organisation.
- Concentrated effort to reach appraisal targets.

Specialist BDU:

Key Issues

- Vacancy levels in learning disability services are adversely impacting on the ability to complete assessments/care planning within 18 weeks of referral. Data quality is now assured through routine performance clinics and each case breaching 18 weeks is tracked to ensure the reason for breaching is understood/recorded.
- Barnsley clinical commissioning group has confirmed the intention to re-procure child and adolescent mental health services (CAMHs) and bids must be submitted by 14 November 2019. The scope of the procurement includes lower level emotional/mental health services (as currently provided by Mindspace) and a partnership-based approach is expected. The new service model is expected to be implemented from 1 April 2020.
- Waiting times from referral to treatment in Wakefield and Barnsley CAMHs remain a concern. However, the number waiting in both areas has reduced. Further investment has been secured in Wakefield and Barnsley to implement waiting list initiatives.

Areas for focus

- The management of Forensic CAMHS (Wetherby young offenders institute and Adel Beck) has now transferred to specialist services business delivery unit as part of the CAMHs service line. This is designed to ensure the service benefits from alignment with childrens services governance arrangements and represents a key component of the improvement notice actions.
- The risk regarding the on-going delivery of harmful sexual behaviour was considered by the service and EMT. The risk was initially rated at 16 and mitigated to 9 with controls. It therefore remains on the local risk register.
- Robust action plans are being developed with regard to CAMHs waiting times within an improvement programme support/governance framework.
- Development of robust service response to Barnsley CAMHs procurement
- Proactively addressing vacancy levels in CAMHs and learning disability services (specifically consultant posts).

Summary

Quality

National Metrics

Locality

Priority Programmes

Finance/ Contracts

Workforce

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

Wakefield and acute inpatients trustwide

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.
- Good progress is being made on Ward 18 which has been experiencing particular challenges with staffing levels and retention. Action and improvement plans are being delivered with safer staffing and professions support. Bespoke recruitment has commenced and a new leadership team is in place.
- 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 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, drawing on the work around Criteria Lead Discharge.

Strengths

- Management of patient flow and for Wakefield nil OOA acute bed usage
- Official opening of Unity Centre took place on 10th October – really positive event led by a national journalist with lived experience and attended by external stakeholders and service users and carers.

Challenges

- Adult acute occupancy and acuity levels remain high.
- E-discharge performance is inconsistent and an improvement action plan in place led by the matrons across the wards.
- 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 reviews performance which has been subject to action planning lead by the Quality and Governance Lead has made significant progress and is nearly on target.
- 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.
- Improvements to staffing levels and support for staff wellbeing on Ward 18.
- 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

- Unity Centre opening attended by Horatio Clare, Ashley Jackson, and Andrea Jenkyns MP. This included films showing the build progress. Development of a roadmap of estates investment across all our BDUs. Promotion through social media and online.
- Promotion of the i-hub environmental challenge and follow up work. Now promoting next challenge around reducing waste
- Support to EyUp! team Challenge 2019. EyUp! comms plan produced – to be shared and discussed at the next operational group. Christmas campaign and merchandising in development. Website updated to support external awareness raising.
- Creative Minds comms principles shared through the charitable funds committee and then to be actioned. Creative Minds communications toolkit also produced to support Creative Minds staff in their roles.
- Support to Barnsley BDU regarding integrated care proposals.
- Support to the information resource project group advising on how to make information more accessible. Central intranet resource being developed with the Trust library.
- Support for Smokefree service for Stoptober – promoting success of service and support available to internal and external audiences.
- Support for nursing associate recruitment campaign
- Pharmacy waste communications plan drafted with Kate Dewhirst – this is focusing on cost effective prescribing
- SystmOne for mental health – comms support for phase 2 – optimisation. Comms manager now dedicated to the project and is producing a comms plan, which will be linked to the project plan. Comms activity will be planned for each milestone.
- Comms and key messages for campaign to reduce the number of data breaches. Focus on laptop security and checking email and letter distribution details.
- Co-developing a partnership communication campaign with Barnsley Hospital, the CCG and GP Federation to promote alliance working and partnership working successes. Film on the learning from the Dearne pilot has been produced. Second phase being developed.
- Co-developing a Wakefield-district wide communications and engagement group, with action plan, for children and young people's mental health and wellbeing –working with NHS Wakefield CCG to co-produce the plan which will be reviewed, signed-off and actioned by all partners involved
- Developing comms and engagement approach for integrated care in Kirklees. Partnership forum established. Lead role in developing a comms and engagement strategy for the group.
- #Allofusimprove – promoting i-hub challenges and continued support promoting the IHI training across the Trust. #Allofusimprove case studies continue to be developed and rolled out.
- Supported flu campaign, including developing materials and communication plan
- Promotions linked to Mental Health Awareness Day and Suicide Prevention Awareness day
- Wellbeing marketing campaign plan has been developed, focused on staff wellbeing offer on stress, anxiety and mental wellbeing. The plan is for this to be delivered in phases throughout the autumn, with staff engagement starting.
- Internal bullying and harassment campaign in development.
- Freedom to speak up guardian campaign in development
- Meeting with regional communications colleagues to plan for Brexit
- Excellence awards 2019 judging has taken place. We received 227 applications (70 more than last year). Shortlists have been announced and photographs and films are currently being developed for the presentation. Kim Leadbeater is our guest speaker.
- Ongoing support to recruitment and retention, to attract new staff and help retain those already employed in the Trust. Transfer Talk campaign developed and will be launched in the next quarter.
- Support for all staff networks, including the BAME and LGBT+ network
- Began promotion for the NHS staff survey launch in early October – communications action plan created and will be actioned.
- Co-ordinating engagement briefings for EMT colleagues in advance of Overview and Scrutiny and Health and Wellbeing Board meetings and meetings with local MPs.

This is the October 2019 priority programme progress update for the integrated performance report. It is a summary of the activity conducted in the period for September 2019. The priority programme areas of work providing an update in this report are:

- Wakefield Projects
- Barnsley Projects
- South Yorkshire Projects
- West Yorkshire Projects
- SystmOne Optimisation
- 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	<p>1. To develop and deliver partnership structures and relationships that underpins integrated working</p> <p>2. To deliver integrated networks in the neighbourhoods of Wakefield which meet the requirements of primary care home objectives whilst fully engaging the communities</p> <p>3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us</p> <p>4. To deliver improvement programmes in key areas determined as priorities by the Wakefield ICP. These include (but not limited to):</p> <ul style="list-style-type: none"> • Elderly and Frailty • Mental Health (via the MH Alliance) • Dementia (via the MH Alliance) <p>5. SWYPFT to take a lead partnership role in the development and delivery of a MH Alliance for Wakefield that oversees</p> <ul style="list-style-type: none"> • the delivery of priority work streams: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - Peri-natal mental health investment - Psychiatric Liaison Core 24 - CYP Eating Disorders - IAPT-LTC (in partnership with Turning Point). • the development and delivery of the Wakefield response to the NHS Long Term Plan for Mental Health. <p>6. Working with partners, develop and implement the operational requirements of the District's response to the agreed strategy for the Children and Young Peoples' Plan priority of emotional wellbeing and mental health.</p>	Sean Rayner	Sharon Carter	Transformation Board	<p>By 31/03/20 All primary care home neighbourhoods will have:</p> <ul style="list-style-type: none"> - 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 <p>• Each programme area will have delivered on key improvement aims as set out at the beginning of the year.</p>	Monthly on IPR	<p>Plans are on-going to re-launch Future in Mind as a whole system with a clear transformation plan in Wakefield. The local transformation plan would form a key component of the emotional health and mental wellbeing section of the Children and Young People Partnership Plan to be completed by November. 16-25 C&YP Transformation. A WY ICS bid (of which this was Wakefield's suggested component) against the national Community Mental Health Transformation Fund had initially been unsuccessful. However, NHS England have now reconsidered and funding has been offered for the remainder of this financial year, to March 31 2020, focusing on earlier intervention based on local needs. Next steps are data analysis; identify greatest need; identify three PCHs; develop a framework and mobilisation. Service priorities mobilisation update:</p> <ul style="list-style-type: none"> 1 – Increased capacity in IHBT (adults) - posts have gone out to advert. 2 – MH Helpline (all ages) across WY - currently working on specification which will be circulated. 3 – Increased capacity in Police Liaison (all ages) – one member in post, two more will commence in January. 4 – VCS Grant Fund (all age) – Management and process for grant funding is in final process of sign off by the W MH Alliance. The first meeting of the grants panel is scheduled for November, following launch in October. 5 – Expansion of the Children and Young People's Primary intervention team – implementation plan is in place and there are no key issues. Recruitment to vacancies is going well. 6 – Expansion of the crisis response for Children and Young People's Mental Health – currently going through organisational change process; recruited to two band 5 posts and clinical lead commences 17 October. 7 – "Autism review" of crisis services – all age services, expectation is that this research and review will provide support to better understanding of how to use the tool. 8a – Provision of a new Safe Space – agreed an approach. Local organisations are being requested that they identify what roles they would be willing to play in respect of safe space and/or support workers. 8b – Development of the Peer Support Network - already have individual organisations doing this – recruit of project manager to commence, SWYPFT hosting, to provide clarity and capacity to take forward. 9 – New capacity to offer Dialectic Behavioural Therapy (DBT) within Community Mental Health Teams, and 10 – Dialectic Behavioural Therapy Training, - Proposal drafted and to be circulated. Recruitment to backfill 2 posts will take place in November. 11 – Increased capacity to develop Multi-Agency Care Plans to support the Serenity Integrated Model and membership of the network - agreed that SWYPFT will employ, possibly by secondment, and two roles to be advertised. 12 – Increased capacity within the suicide postvention service - Currently having mobilisation challenges in recruitment, this is being managed by Wakefield Public Health team 13 – Grant funding for the Samaritans – a draft MOU has been developed. 14 – Roll out of the suicide prevention train the trainer model – Public Health working with Young Lives to set up a programme. Dates booked to pilot the ASK training (Assessing Suicide in Kids). 15 – IAPT-LTC and expansion to 22% - changing the model completely – clinical team leaders will take on more clinical capacity with the opportunity to use more therapists. The take up of services by people over 65 is being particularly looked as it is currently low. <p>Risks are managed by each programme of work, led by Transformation Manager, reporting to MH Alliance Board on a monthly basis. Areas of risk to report include: individual schemes in the plan will not be measured effectively in terms of their respective impact. The Alliance is working on an outcomes and benefits framework as part of risk mitigation. Programme manager commences post in December, and recruitment for band 6 project manager will commence in October. Both posts will be hosted at SWYPFT.</p> <p>By 31/03/20 Each scheme in the plan will have delivered to the outcomes framework developed. It is envisaged that the schemes will commence reporting against the outcomes measures from January 2020 onwards.</p>	Progress Against Plan	
								Management of Risk	

Summary	Quality	NHS Improvement		Locality	Priority Programmes	Finance/Contracts	Workforce		
Work with our partners to join up care in Barnsley	<p>1. To develop and deliver partnership structures and relationships that underpin integrated working</p> <p>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</p> <p>3. To develop population health management so that decisions are underpinned by a sound understanding of what the information tells us</p> <p>4. To deliver improvement programmes in key areas as identified by the partnership groups. These include:</p> <p>a. Frailty</p> <p>b. CVD</p> <p>c. Stroke</p> <p>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.</p> <p>To underpin this work with a clear plan for SWYPFT in via the Barnsley and SY internal integration group.</p>	Salma Yasmeen	Sue Barton	Transformation Board	<p>By 31/03/20 All six neighbourhoods will have</p> <ul style="list-style-type: none"> 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	<p>Barnsley has been successful in receiving transformation funding for MH crisis care and all age liaison services. SWYPFT are in the process of agreeing contract variations with the CCG and recruitment to posts has commenced. A business case to support the investment in and delivery of digital capabilities as part of an initiative of the Barnsley Integrated Partnership Group has been circulated for comments this month. This case focuses on the priority of a Barnsley Shared Care Record, including a supporting programme of transformation activity.</p> <p>The new specification for Barnsley Integrated community neighbourhood teams was published this month. It sets out the requirement to shift from the current position where services are aligned to neighbourhood to truly integrated neighbourhood teams, common pathways of care, informed and activated service users, asset-based community development and population health management. Mobilisation will start from October with a request from Barnsley CCG that the new service model in place and ready to go for April 2020. An internal project team has commenced work on mobilisation plans and activities. This includes scoping the work required for operational as well as non-operational support services such as IM&T and P&I as significant restructuring of clinical record system, SystmOne, and performance reporting is required to deliver the requirements of the service specification.</p> <p>Barnsley Commissioners provided authorisation to proceed with Stroke Early Supported Discharge (ESD) service this month and will be writing to SWYPFT and BHNFT to confirm BCCGs intentions. A mobilisation plan has commenced development to undertake the operational change and recruitment required prior to ESD service being implemented.</p>	Progress Against Plan	
							<p>Risks remain as follows for Stroke services:</p> <p>Recruitment and retention</p> <p>Contracting arrangements and Key Performance Indicators, particularly in light of recent Neighbourhood Team Specification discussions (Stroke in Phase 2)</p> <p>Consultation period required once new model agreed</p> <p>Timescale of 1 October to go live – new model will not be in place, therefore existing arrangements & provision will need to continue.</p> <p>HASU start date of 1st October may still be impacted in terms of patient flow as ESD service will not be in place although SWYPFT have not been asked to reduce SRU beds at this stage.</p> <p>Transition period to new model being fully running</p> <p>Double running costs during implementation</p> <p>Single specification for neighbourhood teams - Identified risks so far:</p> <p>Inadequate resources to deliver core hours beyond current service offers and resource envelope</p> <p>Mobilisation of a 24/7 SPA admin and clinical triage, not currently resourced Out of Hours</p> <p>Merger of SystmOne units will be required as a rapid programme</p> <p>Delivering management of change in a short period of time</p> <p>Estates challenges to move to a hub model in the 6 neighbourhood networks</p> <p>Possibility of Memory assessment service being aligned away from core MH</p> <p>Impact on staff owing to changes in working arrangements and we are keeping our staff informed with regular briefing sessions and information updates.</p> <p>Implementation plan/key milestones:</p> <p>By 31/07/19 Programme areas have identified key improvement aims for 19/20</p> <p>By 30/09/19 New specification for integrated community teams will be published</p>	Management of Risk	
Work with our partners to join up care in South Yorkshire	<p>Work with our South Yorkshire(SY) partners to deliver shared objectives as described through the integrated care systems plans. As the programmes of work develop, we aim to underpin this work with a clear plan for SWYPFT via the Barnsley and SY internal integration group.</p>	Alan Davis & Salma Yasmeen	Sue Barton	Transformation Board	<p>By 31/03/20 Each programme area will have delivered on key improvement aims as set out at the beginning of the year.</p>	Bi-monthly on IPR	<p>The SYB ICS 5 year response to the NHS Long Term Plan has been drafted and is currently being discussed through boards and governing bodies as part of the engagement process and the final plan will be submitted to NHSE/I by the end of November in line with the national timeframe. The plan focuses on the needs of the SYB population to improve population health, reduce health inequalities and improve outcomes, quality and experience for people through more integrated care approaches and transforming care. South Yorkshire Housing Association were awarded the contract for IPS provision in South Yorkshire following a competitive procurement. SWYPFT will provide two IPS posts in Barnsley as part of this service and recruitment is underway.</p>	Progress Against Plan	
								Management of Risk	

Summary	Quality	NHS Improvement		Locality	Priority Programmes	Finance/Contracts	Workforce		
Working with our partners to join up care in West Yorkshire	<p>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, Learning Disabilities & Autism Service Collaborative, to deliver shared objectives with our partners in the areas of:</p> <ul style="list-style-type: none"> • Forensic services including adult, children and LD project. SWYPFT is the Lead Provider for the WY&H Adult Secure Provider Collaborative. • Adult Mental Health Services • LD transforming care partnerships • Children and Adolescent Mental Health services whole system pathway development • Suicide Prevention • Autism and ADHD <p>We aim to underpin this work with a clear plan for SWYPFT via the WY internal integration group.</p>	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, and/or reshaped (rescoped) as determined by the ICS Programme Board in Autumn 2019.	Monthly on IPR	<p>Transformation funding (Wave 1) for community mental health, the ICS have now reached agreement with NHSE to fund the bids during 19/20 (circa £2.5M). After a lot of collaboration, it was felt that the risk in the system around the lack of second year funding could be managed.</p> <p>WY&H HCP MH, LD and Autism Programme Board are working on a number of projects within the workstreams identified. Workstream configuration is being reduced to 8 workstreams + 3 enablers. UEC and adult acute care pathway is to join under the leadership of Patrick Scott, BDCFT. SWYPFT internal team are looking to align SWYPFT resources to support and influence workstreams.</p> <p>The West Yorkshire Forensic Provider Collaborative has secured £96,000 from the WY&H ICS to fund clinical and project support to undertake the next phase of the work. An Adult Secure Lead Provider Partnership Board has been established and is implementing an updated governance and assurance arrangements, commencing October 2019. Recruitment to part-time, fixed term project leadership & support capacity is underway.</p> <p>Specialist Community Forensic Team Pilot Wave 2 Selection: outcome of bid is expected mid October 2019.</p> <p>Every mind matters metal health campaign will soon be launched and ICS members are encouraged to be ambassadors of the campaign and go back to their organisations to promote the campaign and resources to staff and beyond.</p> <p>The Learning Disabilities ATU Project has secured confidential approval in principle to an agreed service model. The next phase involves public engagement and undertaking further clarification of the financial and contracting deliverability of the service model.</p> <p>This month saw the official launch and go live date planned for the suicide postvention service now all staff have been appointed. Social media profiles and project website have gone live and continue to be developed. A half day conference took place at Halifax Town Hall for World Suicide Prevention Day. 4 new members of staff have been recruited this month to work across the ICS on two key initiatives – Suicide Prevention work with men and a WY wide Suicide bereavement support project working in partnership with Leeds Mind. These projects relate to key areas within the Suicide Prevention strategy, of which SWYPFT is the lead for the WY&H Suicide Prevention strategy. Plans for a suicide prevention campaign across WY&H building continue, meetings ongoing with ICS Communications team leading on this.</p>	Progress Against Plan	
							<p>Risks are managed by each programme of work. Areas of risk to report include:</p> <ul style="list-style-type: none"> 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 deliverable in the context of the financial & contracting due diligence that will need to be undertaken over the following months. 	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 our mental health offer for older people	To deliver the agreed community model within each BDU. To review progress in October 2019 and reassess the support from commissioners and decide if we can commence work on the inpatient proposals	Subha Thiyaresh	work managed within BDU s	OMG	To implement the community model in each BDU as far as the existing resources allow. For this to be evidenced by self-assessment	at key milestones	Progress review will take place in October and report on in November.		
							<p>Review of progress in implementing the community aspects of the model 31st October 2019</p> <p>Review of the context/environment that impact on this work 30th November 2019</p> <p>Document presented to OMG containing a recommendation from the OPS steering group regarding future direction 31st January 2020</p>		

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	<ul style="list-style-type: none"> • Appropriate Inpatient Stays: Work to refresh criteria led discharge has now commenced. High level process map, new protocol and roles and responsibilities (RACI) model have been produced. The pilot will commence in late October in Ward 18 and early November at the Dales, the project team has visited the wards in advance to prepare for the refresh. • The patient flow service is now operating on a business as usual basis. New sitrep report is now in place and meetings are being held with IHBT managers to confirm how joint working with the patient flow team will happen. We are still awaiting confirmation of a new office space for team. Feedback from patient flow service is that there are still high pressures in the system. • There is evidence of the community strand continuing to have an impact, with continued reductions in numbers of people waiting to be stepped down from IHBT to community teams across Calderdale and Kirklees and some reductions in weekend handovers from enhanced to IHBT. A new framework for core is in draft and a meeting to focus medics caseloads is planned for October. Priority work remains to get the community caseloads to more manageable levels to enable recovery focussed work. • The work in community should help enable new ways of working in IHBT, in particular establishing more joint out of hours mental health act assessments with AMHPs, but resourcing issues in the IHBT continue to limit opportunities to develop this, though plans are in place to resolve recruitment issues. Barnsley IHBT are visiting the Kirklees IHBT team in October and learning from this will help inform a workshop to be held late Oct / early Nov. • Triage tool testing and SBAR use has taken place in SPA in early October – early feedback is very positive from the team and work is now taking place to establish resource implications of implementing the tool. Joint work with Calderdale GP lead continues, with plans to test e-referral by Christmas. 111 meeting to finalise changes required is being organised. Service user engagement events planned for November. • The Trauma Informed Personality Disorder (TIPD) pathway activity continues to make good progress. Teams are now establishing collaborative care plans and aiming to implement new ways of working. The new pathways have been drafted and PD champions are being identified. A training programme is being established and rolled out in late 2019. • Work continues to ensure that the right level of information is available across all levels of management and governance in the organisation. <p>The programme remains at yellow as there are still parts of the plan that have taken longer to implement than expected, there are still very high bed pressures, and we are still some way off from having a sustainable system.</p>	Progress Against Plan	
							<p>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 highlight report to EMT.</p> <ol style="list-style-type: none"> 1) Failure to deliver timely improvement due to lack of resource, other work priorities and skills - this has been flagged to steering group given some slippage - although plans are being rebased and progress is being made across all strands. Activity across the programme is likely to run well into 2020. CLD refresh to run until approximately March 2020. SPA set to refresh in early 2020. 2) Lack of relevant information and poor data quality could lead to poor decision making and / or poor assessment of changes, leading to: <ul style="list-style-type: none"> - being unable to quantify impact of some changes - changes having a negative impact - changes leading to other unintended consequences <p>Dashboards now developed but not fully in use. Trajectories need to be agreed based on the dashboards and then tracked via new performance management processes. Further development of dashboards into Power BI was put forward as critical to success by SSG in recent challenge review.</p> <ol style="list-style-type: none"> 3) Activity required to reduce admissions to beds may not be sustainable in the long term, either due to resources or external pressures. 4) Differing cultures across the trust and varying levels of engagement could lead to failure to deliver the proposed changes. The programme continues to work with key stakeholders including staff to develop and implement the required changes. <p>Regular communication is to include thanks and appreciation.</p> <p>To have ever more people into the programme including staff, service users/parents.</p>	Management of Risk	

Summary Quality NHS Improvement Locality Priority Programmes Finance/Contracts Workforce

<p>Embed #allofusimprove to enhance quality</p>		<p>Tim Breedon & Salma Yasmeen</p>	<p>Vicki Whyte</p>	<p>EMT</p>	<p>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</p>	<p>at key milestones</p> <p>Trust priority conversation on iHub 'Spending wisely and reducing waste' launched in October and has generated 11 ideas to date. 250 staff across the Trust currently completing the IHI Certificate of Quality & Safety. 82 staff completed IHI Certificate and are now Trust Improvement Facilitators 4 members of staff have completed QSIR practitioner training with ACT Academy. Trust Board commenced 'Leading for Improvement Board Development Programme' with first session on measurement, the next session is scheduled for December 2019. The QSIR framework has been mapped across to the 3 phase Trust change framework and the tools identified. The toolkit is currently being prepared as a webpage with hyperlinks to the tools and guidance documents in order than staff can easily access this resource to undertake their own QI projects. It is anticipated this will be completed and "live" by mid-November. SPC measurement for improvement tools used in Care Closer to Home programme. Case studies published on intranet demonstrating impact. Learning Library established to share learning from experience. Knowledge Café on Change and Innovation scheduled for 30th October</p> <p>no key risks identified</p> <p>By 1/05/19 I Hub Relunched. 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.</p>

IMPROVE RESOURCES									
Make the most of our clinical information	Delivering SystmOne optimisation plan	Saima Yasmeen	Jules Williams & Sharon Carter	Transformation Board	<p>Completion of phase 1: implementation of clinical record system, SystmOne for MH, project closure report.</p> <p>Completion of phase 1: SystmOne for MH post implementation review. Build on from lessons learnt into phase 2: optimisation</p> <p>Co create and co deliver all priority areas of Optimisation plan (areas tbc)</p>	Monthly on IPR	<p>The SystmOne Change Reference groups have now transitioned to SystmOne Improvement Groups. Updates on optimisation have been made through these groups and local issues/ideas discussed. Outputs from engagement events together with concerns highlighted through help-desk have informed the development of an Optimisation Project Delivery Plan, and work stream leads have met to review the initial action plan, consider resources required to deliver the change, and to assign a lead. Findings of the Care Plan clinical testing were presented to CSDG on 9th September for sign off and there was agreement that organisational roll out can commence. This is 2 months behind the original schedule owing to the delay in Phase 2 (SystmOne Optimisation) commencement and required need for supplier to make secondary changes to the new Care Plan design based on initial feedback received nationally. The agreed implementation of the new Mental Health Care Plans is being piloted in Forensic services in October. Communications and drop-in demo / Q&A sessions have been set up in Forensics Services ahead of go-live to support implementation, respond to questions and identify any clinical concerns or training gaps that can be included in an updated training guide. Further engagement and testing will take place across services via the Service Improvement Groups. Roll out/cut over and training approach to be agreed in October following engagement with services. Aim is by the end of October the MH Care Plan will be signed off and ready for co delivery and roll out. A plan is being devised for risk assessment optimisation activity to be rolled out at the same time as clinical training on risk formulation FIRM. Further testing and engagement is required as part of codesign/co create phases aligned to programme governance. The level of training and support for the technical systmone aspects is being determined and a detailed project plan for the Risk Assessment optimisation activity on systmone, with engagement and training and cut over/roll out approach is in development. Following engagement and co-design with SPA and IHBT services, event templates to support improvement in data quality have been tested in demo, and are now built in live systmone environment ready for implementation. The scale and scope of the programme of work is being reconsidered owing to demands from other priority programmes for clinical services input, IM&T, ICT, and P&I resources.</p>	Progress Against Plan	
						<p>Optimisation Risk assessment will be undertaken as part of workstream planning, coordinated by workstream leads meeting. Preliminary risks have been identified as:</p> <p>There is a risk insufficient time/resources being made available by external stakeholders, or lack of commitment to the changes from external stakeholders impacting on the success of pilots or on wider roll-out of major optimisation activities such as tasks</p> <p>Insufficient resources to be able to configure the clinical system as required.</p> <p>Insufficient resources to be able to train and support clinicians</p> <p>External pressures such as changes to the Barnsley Community Services specification might place pressure to divert resources.</p> <p>In the event of end-user staff not engaging in optimisation there will be a risk of not capturing all processes/ways of working which will result in configuration of SystmOne having not made any improvement or being unsafe.</p> <p>There is a risk that without sufficient resources, and a consistent approach and guidance that clinicians will continue to record data incorrectly or use their own individual 'work-around'</p> <p>Inadequate number of staff attending the training and demonstrating competency will result in the organisation not getting the best use out of the clinical records system and no improvements identified</p> <p>Due to the volume of optimisation activities required there is a risk that significant optimisation opportunities might be overlooked</p>	Management of Risk		
						<p>The High Level Optimisation plan signed off by EMT in July 2019 suggested preliminary milestones for the project. Owing to extending the period of stabilisation, sign off of the plan being delayed until July, CQC inspection and project management not commencing until August, the initial phase of engagement and prioritising has been rescheduled. A robust plan for ongoing engagement and involvement throughout further stages of the project is in development, and delivery of the project remains on target as 31st May 2020.</p> <p>Owing to the above, Optimisation programme plan rescheduled and to be in place by end of October 2019 (following sign off by PSG)</p> <p>As agreed by EMT in July, Post implementation Review rescheduled to be completed by October 2020.</p> <p>Secondary changes made by the supplier to the new Care Plan design based on initial feedback delayed roll out of the care plans for testing. Roll out (subject to sign-off by CSDG) has been rescheduled to commence in October.</p>			
MAKE THIS A GREAT PLACE TO WORK									

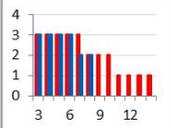
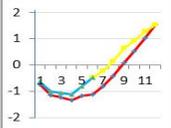
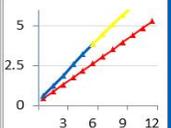
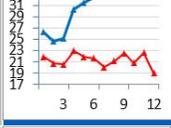
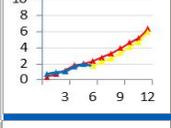
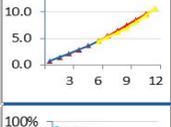
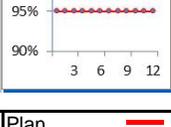
Progress against plan rating	Risk Rating	Likelihood			
On target to deliver within agreed timescales / project tolerances	Consequence	1 Rare	2 Unlikely	3 Possible	5 Almost certain
ability/confidence to deliver actions within agreed timescales / project tolerances		5 Catastrophic	5	10	15
ability/capacity to deliver actions within agreed timescales / project tolerances	4 Major	4	8	12	20
Actions will not be delivered within agreed timescales / project tolerances	3 Moderate	3	6	9	15
Action complete	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

Glossary:	
C&YP Children and Young People	ATU Assessment and Treatment Unit
ICS Integrated Care System	HASU Hyper acute stroke unit
WY West Yorkshire	SPA single point of access
SYB South Yorkshire and Bassetlaw	NHSE/1 National Health Service England/ NHS Improvement
NHS National Health Service	IPS individual placement support
PCH Primary Care Hub (also referred to as Primary Care Network)	NMOC new model of care
PCN Primary Care Network (also referred to as Primary Care Hub)	OMG organisational management group
IHBT – Intensive Home Based Treatment	OPS older peoples services
MH mental health	SRU stroke rehabilitation unit
VCS voluntary and community sector	FIRM Formulation informed risk assessment
DBT Dialectic Behavioural Therapy	CSDG clinical safety design group
MOU memorandum of understanding	QI quality improvement
IAPT Improving Access to Psychological Therapies	SPC statistical process control
LTC long term conditions	IHI Institute for Health Improvement
CCG Clinical Commissioning Group	QSIR Quality, Service Improvement and Redesign)
IM&T Information management and technology	SSG an external consultancy company
P&I performance and information	EMT executive management team
ESD Early Supported Discharge	GP General practitioner
WY&H West Yorkshire and Harrogate	TIPD Trauma Informed Personality Disorder
HCP Health Care partnership	SBAR Situation - Background - Assessment – Recommendation – quality improvement tool
LD Learning Disabilities	AMHP Approved mental health professional
UEC Urgent and Emergency Care	RACI roles and responsibilities indicator
BDCFT Bradford District Care Trust	LTP long term plan
SWYPFT South West Yorkshire Partnership Foundation Trust	ICT Integrated change team

Overall Financial Performance 2019/20

Executive Summary / Key Performance Indicators

Performance Indicator		Year to date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The NHS Improvement risk rating has remained at 2 in September 2019. The biggest risk to this rating is the agency performance against capped levels.	
2	Normalised Deficit (excl PSF)	(£1.1m)	(£0.2m)	September financial performance is a surplus of £207k excluding Provider Sustainability Fund (PSF). This reduces the year to date cumulative deficit to £1.1m. The year end deficit of £0.2m is still considered achievable through continued financial control and increased cost improvements.	
3	Agency Cap	£3.9m	£7.4m	Agency expenditure is higher than plan with £0.6m spent in September, £0.2m above the agency cap set by NHS Improvement. This is a similar level to August. Current projection is that our agency cap will be exceeded by £2m. Any further investment in waiting list initiatives or other specific pressures could lead to additional agency staffing requirements.	
4	Cash	£32.4m	£31.3m	Cash in the bank continues to be above planned levels; partly due to opening balances being higher than plan but also due to continued actions in year.	
5	Capital	£1.7m	£6m	Capital spend is below plan at the end of September. Forecast is being amended to £6m to reflect the current most likely position.	
6	Delivery of CIP	£4.4m	£10.6m	Year to date £4.4m cost reductions have been secured. Any unidentified CIPs will need to be managed within the overall financial position, currently £1.1m is rated as red with a high risk on delivery.	
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	

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Contracting - Trust Board

Contracting Issues - General

SWYPFT successful in a bid to become the lead provider for the West Yorkshire collaborative for adult secure services on the further development track workstream to commence from April 2021.

CQUIN

Work is ongoing to prepare the Q2 CQUIN submissions for the end of October 2019.

Contracting Issues - Barnsley

Work continues in relation to the implementation of the 2019/20 mental health investment plan including Improving access to psychological therapies (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. Implementation of work related to children's therapies expansion and waiting list reduction is ongoing. Mobilisation continues for implementation of the new Barnsley smoke free service model for commencement 1 November 2019.

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. Work is ongoing to implement Individual Placement Support and to implement additional crisis investment gained through bids to NHSE.

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. Work is ongoing to implement additional crisis investment gained through bids to NHSE.

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. Work continues in implementation of the additional mental health investment streams related to increasing capacity within the intensive home based treatment team, expanding capacity for police liaison and providing new capacity to offer dialectic behavioural therapy within community mental health teams.

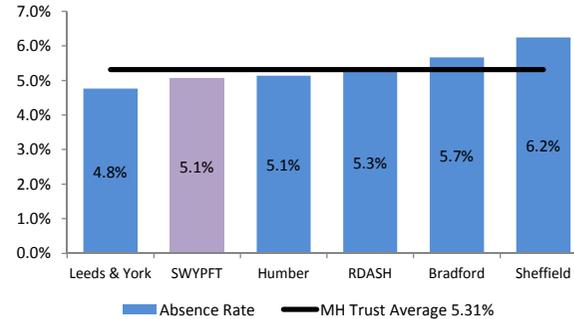
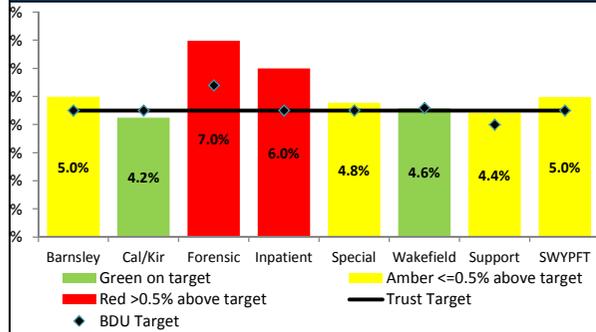
Contracting Issues - Forensics

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. SWYPFT successful in a bid to become the Lead Provider for the West Yorkshire collaborative for adult secure services on the further development track workstream to commence from April 2021.

Workforce

Human Resources Performance Dashboard - September 2019

Sickness Absence



Current Absence Position and Change from Previous Month - Sept 2019

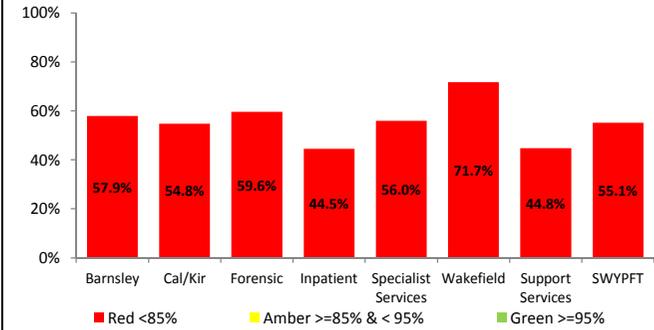
	Barn	Cal/Kir	Fore	Inpat	Spec	Wake	Supp	SWYPFT
Rate	4.6%	4.4%	8.0%	6.9%	3.6%	4.4%	4.3%	5.0%
Change	↑	↑	↑	↓	↓	↑	↔	↔

The Trust YTD absence levels in September 2019 (chart above) were above the target at 5%.

The YTD cost of sickness absence is £3,005,912. If the Trust had met its target this would have been £2,716,186, saving £289,726.

The above chart shows the YTD absence levels in MH/LD Trusts in our region for 2018-19 financial year. During this time the Trust's absence rate was 5.05% which is below the regional average of 5.31%.

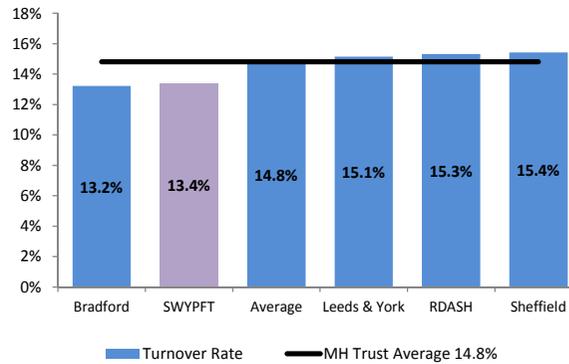
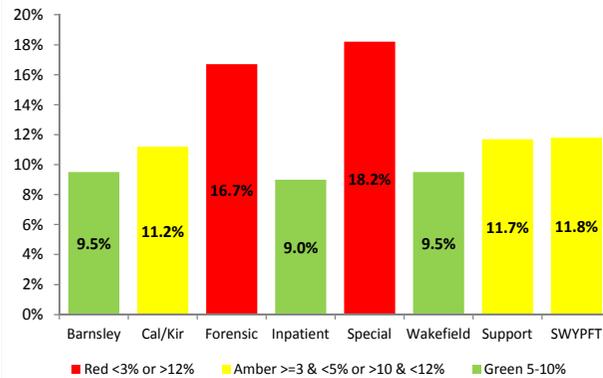
Appraisals - All Staff



The above chart shows the appraisal rates for the Trust to the end of September 2019.

Until August, the figures only included staff on Band 6 and above. From September's report onwards, they 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 and, for all staff, to reach 95% by the end of September.

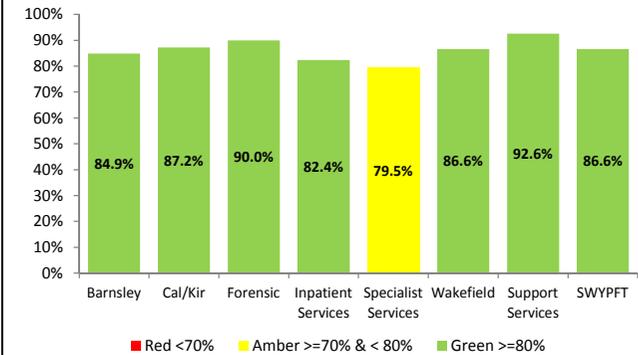
Turnover and Stability Rate Benchmark



This chart shows the YTD turnover levels up to the end of September 2019. The turnover data excludes decommissioned services.

This chart shows turnover rates in MH Trusts in the region 2018-19. This is calculated as: leavers/average headcount. These figures include temporary staff who are usually excluded from the Trust's local reports and so these figures are higher than ours. Decommissioned services are included in this benchmark data.

Fire Training Attendance



The chart shows the 12 month rolling year figure for fire lectures to the end of September 2019. Specialist Services are still slightly below the target but all other areas and the Trust continue to achieve the 80% target.

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Workforce - Performance Wall

Trust Performance Wall																	
Month	Objective	CQC Domain	Owner	Threshold	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.6%	4.8%	4.9%	5.0%	5.1%	5.1%	5.0%	4.7%	4.7%	4.9%	5.0%	5.0%	5.0%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.1%	5.7%	5.8%	5.7%	5.8%	5.1%	4.6%	4.7%	4.7%	5.2%	5.3%	5.0%	5.0%
Appraisals (Band 6 and above) 1	Improving Resources	Well Led	AD	>=95%	95.0%	95.8%	98.1%	98.2%	99.1%	99.1%	99.1%	6.3%	19.8%	66.2%	76.2%	80.3%	83.8%
Appraisals (Band 5 and below)	Improving Resources	Well Led	AD	>=95%	78.6%	87.2%	94.3%	95.0%	96.5%	97.5%	97.5%	0.2%	1.5%	7.8%	26.4%	39.1%	69.7%
Aggression Management	Improving Care	Well Led	AD	>=80%	82.2%	81.3%	81.4%	82.5%	83.1%	82.9%	81.7%	81.6%	82.8%	84.0%	84.3%	84.0%	82.8%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	81.6%	80.1%	80.2%	81.2%	82.1%	81.4%	80.7%	80.2%	80.1%	81.3%	81.3%	82.8%	83.0%
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	85.8%	85.8%	86.1%	87.4%	87.8%	88.7%	88.4%	87.9%	88.7%	88.3%	86.8%	87.8%	88.7%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	89.8%	90.2%	90.7%	91.3%	90.9%	91.0%	90.3%	89.6%	89.8%	90.3%	91.2%	91.2%	91.5%
Fire Safety	Improving Care	Well Led	AD	>=80%	86.3%	86.8%	86.7%	88.1%	85.2%	84.9%	84.6%	84.6%	84.6%	85.7%	86.1%	85.5%	86.6%
Food Safety	Improving Care	Well Led	AD	>=80%	81.7%	81.9%	84.1%	82.2%	82.3%	83.7%	83.4%	83.6%	83.6%	83.3%	83.8%	83.0%	82.0%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	89.1%	89.3%	89.1%	89.7%	89.5%	90.4%	89.9%	90.5%	90.8%	91.1%	91.7%	91.7%	92.2%
Information Governance	Improving Care	Well Led	AD	>=95%	92.1%	92.3%	90.2%	90.8%	96.1%	97.6%	98.5%	97.2%	94.3%	94.5%	94.5%	94.0%	94.2%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	87.2%	87.3%	88.6%	89.0%	87.8%	88.9%	90.5%	90.4%	91.4%	91.8%	92.0%	91.9%	91.7%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	90.9%	91.4%	92.6%	92.3%	92.7%	92.5%	91.7%	91.2%	91.7%	91.6%	92.4%	92.7%	93.2%
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	85.9%	85.8%	87.7%	86.7%	86.7%	86.4%	84.5%	84.2%	85.2%	86.8%	88.2%	88.6%	88.8%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	83.8%	82.6%		86.8%			72.9%			61.3%			
Prevent	Improving Care	Well Led	AD	>=80%											80.8%	81.5%	83.5%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	91.5%	92.1%	93.0%	93.7%	93.2%	93.4%	92.9%	92.4%	92.5%	93.2%	93.5%	93.8%	94.2%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	90.0%	90.4%	89.4%	91.4%	91.3%	90.9%	91.1%	89.6%	91.0%	91.7%	92.2%	92.3%	91.5%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	94.6%	94.6%	94.1%	94.5%	93.9%	94.5%	94.9%	94.0%	94.8%	95.1%	95.2%	95.9%	96.0%
Bank Cost	Improving Resources	Well Led	AD	-	£845k	£615k	£674k	£678k	£752k	£1048k	£772k	£625k	£844k	£695k	£708k	£889k	£770k
Agency Cost	Improving Resources	Effective	AD	-	£522k	£537k	£536k	£530k	£596k	£545k	£634k	£613k	£641k	£619k	£772k	£629k	£628k
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£507k	£586k	£571k	£572k	£602k	£476k	£482k	£479k	£494k	£521k	£541k	£507k	£497k
Business Miles	Improving Resources	Effective	AD	-	279k	267k	299k	279k	286k	270k	289k	274k	240k	293k	281k	245k	284k
Health & Safety																	
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	Reporting commenced 19/20							7			4		

1 - this does not include data for medical staffing.

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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 83.8% however performance to the end of September is below expected levels and is below the level achieved for the same time last year. There is typically a time lag in terms of recording appraisals so an increase is expected by the end of October.

Sickness Absence

- Year to date sickness at the end of September is 5.0% which compares with 4.6% last year. The monthly rate of 5.0% is 0.1% lower than September last year.

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.
- Staff turnover at the end of September is 11.8% which whilst a slight increase compared to August is 1% lower than the corresponding period last year. Particular hotspots are in forensic and specialist services BDUs.
- The year to date turnover rate for registered nursing staff is 10.8%

Health & Safety

- 4 RIDDOR incidents reported during quarter 2. The incidents related to 2 as a result of violence & aggression, 2 related to slips trips & falls – 1 in a patient's home from a member of staff who tripped over a cable & 1 from someone walking back to

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Guardian of Safe Working Report - Q2 (July - Sept 2019)

High level data

Number of doctors in training (total):	55
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 but this has been much better on the S. Yorkshire and Leeds/Wakefield schemes recently with full recruitment for August 2019. On the Calderdale and Kirklees Core Training Scheme there are a number of vacancies, compounded by issues with trainees being on maternity leave or unable to take part in the rota for health reasons. Also, new doctors from overseas are not always ready to take part in the rota on arrival.

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.

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.

Rota gaps and cover arrangements

Gaps by rota July/August/September '19					
Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	3 (2%)	3 (100%)	0	0	0
Calderdale 1st	49 (27%)	48 (96%)	0	0	1 (2%)
Kirklees 1st	9 (10%)	9 (100%)	0	0	0
Wakefield 1st	17 (9%)	16 (94%)	0	0	1 (6%)
Total 1st	78 (12%)	76 (97%)	0	0	2 (3%)
Wakefield 2nd	19 (21%)	0	0	19 (100%)	0

Costs of Rota Cover July/August/September '19					
1 st 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	3 (28)	£980	0	0	£980
Calderdale	48 (463.25)	£16214.75	0	0	£16214.75
Kirklees	9 (122)	£4270.00	0	0	£4270.00
Wakefield	16 (193.5)	£6772.50	0	0	£6772.50
Total	76 (806.75)	£28237.25	0	0	£28237.25

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 very few shifts were unfilled. None have been filled by agency staff during this quarter.

Summary

Quality

National Metrics

Locality

Priority
Programmes

Finance/Contracts

Workforce

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). We currently have MTI (2) and WAST (2) doctors in the trust and we expect more to join us next year unless National Recruitment to Core Training improves. We were pleased to welcome 4 new core trainees to the Calderdale and Kirklees scheme in August 2019. 3 vacancies were advertised for the February 2020 rotation but only 1 was filled. For August 2019 all vacant slots were filled by MTI and WAST doctors but there has subsequently been 1 resignation. The Leeds-Wakefield rotation and the South Yorkshire Rotation are both fully recruited and no gaps are expected for February 2020. Local GP schemes have raised the possibility of sending more trainees for experience in psychiatry from August 2020 which would be positive for their training and might address some of the rota 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. Currently discussions are on-going about arrangements to allow Core Trainees to gain more emergency psychiatry experience. The forum has also been involved in deciding how money associated with the Fatigue and Facilities Charter should be spent.

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. We will also work to improve use of personalized work schedules for trainees.

Amendments to 2016 Contract – I have been working with colleagues in HR to ensure that rotas are updated to reflect the amendments to the Junior Doctor Contract. These will lead to a slight increase in costs for the trust. It is expected that most will be implemented in December but further changes are likely to be necessary prior to August 2020.

Responsible Officer Quarterly Report

MEDICAL APPRAISALS	Q1 1.4.19 – 30.6.19	Q2 1.7.19 – 30.9.19	Q3 1.10.19 – 31.12.19	Q4 1.1.20 – 31.3.20
Number expected to be undertaken in period	28	31		
Number undertaken in period	27	29		
Number not undertaken for which the RO accepts postponement is reasonable	1	2		
Percentage of appraisals taken place	96%	93%		
Percentage of appraisals signed off in period as satisfactory	100%	100%		

MEDICAL REVALIDATIONS	Q1 1.4.19 – 30.6.19	Q2 1.7.19 – 30.9.19	Q3 1.10.19 – 31.12.19	Q4 1.1.20 – 31.3.20
Number of revalidation recommendations due in period	14	8		
Number of positive recommendations	12	8		
Number of deferrals	2	0		
Number of non-engagements	0	0		
Percentage of revalidation recommendations made	100%	100%		

RESPONDING TO CONCERNS	Q1 1.4.19 – 30.6.19	Q2 1.7.19 – 30.9.19	Q3 1.10.19 – 31.12.19	Q4 1.1.20 – 31.3.20
Number of active cases under Maintaining High Professional Standards procedures	0	0		

Publication Summary

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

NHS England

Delivering same-sex accommodation

This guidance has been updated to reflect current patient pathways, including further definition of what is and is not a mixed-sex accommodation breach and circumstances in which mixing may be justified and therefore not constitute a breach.

[Click here for link to guidance](#)

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

NHS Improvement provider bulletin: 18 September 2019:

Changes to the patient safety alerts process

- New platform for public sector payments
- Time to get your free flu jab — new flu vaccination campaign
- Cancer patient experience survey — get your local results
- Develop your senior leadership skills with the Nye Bevan programme
- EU Exit readiness workshop

Diagnostic imaging dataset: May 2019

NHS sickness absence rates: May 2019, provisional statistics

NHS staff earnings estimates: June 2019, provisional statistics

NHS workforce statistics: June 2018, including supplementary analysis on pay by ethnicity

Childhood vaccination coverage statistics: England, 2018-19

NHS Improvement provider bulletin: 25 September 2019:

- Updated information on continuity of medicines supply in a no-deal EU exit
- Submit your board assessment framework for seven-day hospital services (7DS)
- Share your evidence for the review of pharmacy aseptic services in England
- Reducing single-use plastics in the NHS
- What does the NHS Long Term Plan mean for urgent and emergency care (UEC) delivery?

NHS Improvement provider bulletin: 2 October 2019:

Changes to the patient safety alerts process

- New platform for public sector payments
- Time to get your free flu jab — new flu vaccination campaign
- Cancer patient experience survey — get your local results
- Develop your senior leadership skills with the Nye Bevan programme
- EU Exit readiness workshop

NHS Improvement provider bulletin: 9 October 2019:

- Volunteers in NHS trusts survey
- ‘People’ not ‘beds’ — changing the language we use in health and social care
- Developing allied health professional (AHP) leaders
- Updates from our partners

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatient and accident and emergency data: April 2019 - August 2019

Psychological therapies: reports on the use of IAPT services, England July 2019; final including reports on the IAPT pilots

Out of area placements in mental health services: July 2019

Mental health services monthly statistics: final July, provisional August 2019

Delayed transfers of care: August 2019

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

Direct access audiology waiting times: August 2019

Estates Returns Information Collection (ERIC): summary page and dataset for ERIC, 2018/19



South West
Yorkshire Partnership
NHS Foundation Trust



Finance Report



Month 6
(2019 / 20)

Appendix 1

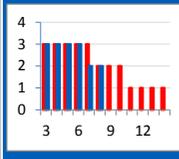
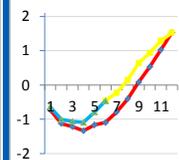
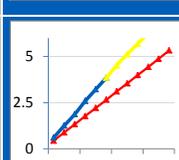
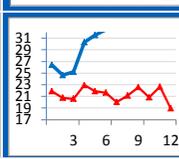
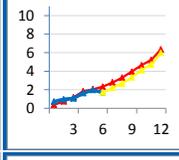
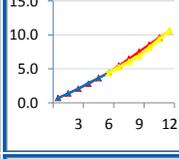
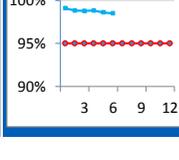


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With **all of us** in mind.

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1.0	Strategic Overview	1.0	Key Performance Indicators	3
		1.1	NHS Improvement Finance Rating	4
2.0	Statement of Comprehensive Income	2.0	Summary Statement of Income & Expenditure Position	5
		2.1	Cost Improvement Programme	12
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		4.2	Glossary of Terms & Definitions	19

Performance Indicator		Year To Date	Forecast	Narrative	Trend
1	NHS Improvement Finance Rating	2	2	The NHS Improvement risk rating has remained at 2 in September 2019. The biggest risk to this rating is the agency performance against capped levels.	
2	Normalised Deficit (excl PSF)	(£1.1m)	(£0.2m)	September financial performance is a surplus of £207k excluding Provider Sustainability Fund (PSF). This reduces the year to date cumulative deficit to £1.1m. The year end deficit of £0.2m is still considered achievable through continued financial control and increased cost improvements.	
3	Agency Cap	£3.9m	£7.4m	Agency expenditure is higher than plan with £0.6m spent in September, £0.2m above the agency cap set by NHS Improvement. This is a similar level to August. Current projection is that our agency cap will be exceeded by £2m. Any further investment in waiting list initiatives or other specific pressures could lead to additional agency staffing requirements.	
4	Cash	£32.4m	£31.3m	Cash in the bank continues to be above planned levels; partly due to opening balances being higher than plan but also due to continued actions in year.	
5	Capital	£1.7m	£6m	Capital spend is below plan at the end of September. Forecast is being amended to £6m to reflect the current most likely position.	
6	Delivery of CIP	£4.4m	£10.6m	Year to date £4.4m cost reductions have been secured. Any unidentified CIPs will need to be managed within the overall financial position, currently £1.1m is rated as red with a high risk on delivery.	
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	

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.

Area	Weight	Metric	Actual Performance		Plan - Month 6	
			Score	Risk Rating	Score	Risk Rating
Financial Sustainability	20%	Capital Service Capacity	2.7	1	2.1	2
	20%	Liquidity (Days)	25.2	1	17.4	1
Financial Efficiency	20%	I & E Margin	-0.4%	3	-1.0%	4
Financial Controls	20%	Distance from Financial Plan	0.6%	1	0.0%	1
	20%	Agency Spend	45%	3	17%	2
Weighted Average - Financial Sustainability Risk Rating					2	3

Impact

The rating remains at 2 for September 2019 although, due to the reducing deficit position, the I & E margin metric continues to improve within its threshold. This metric includes cash received as part of the Provider Sustainability Fund (PSF).

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.

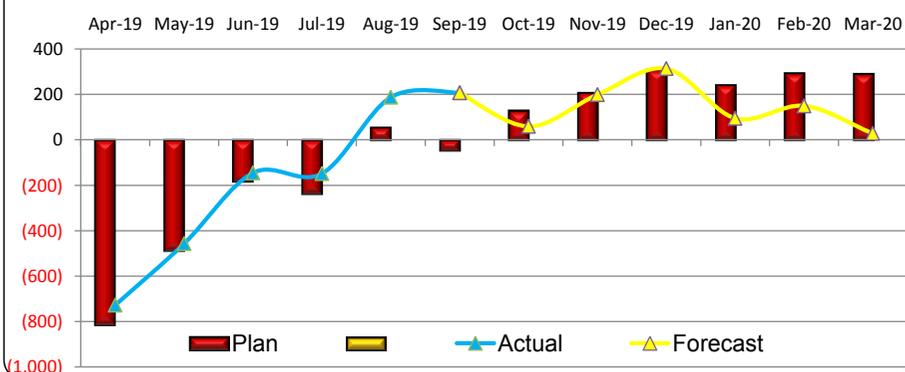
I & E Margin - the degree to which the organisation is operating at a surplus/deficit

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.

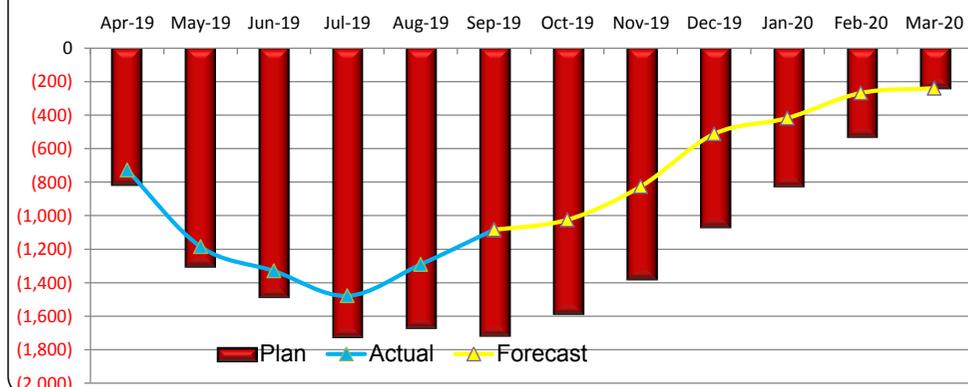
Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	WTE	WTE	%	£k	£k	£k		£k	£k	£k	£k	£k	£k
				17,768	17,628	(140)	Clinical Revenue	106,134	105,423	(711)	212,804	212,010	(794)
				17,768	17,628	(140)	Total Clinical Revenue	106,134	105,423	(711)	212,804	212,010	(794)
				1,312	1,252	(60)	Other Operating Revenue	7,124	7,234	110	14,003	14,400	397
				19,080	18,880	(200)	Total Revenue	113,258	112,657	(601)	226,806	226,410	(397)
4,254	4,069	(185)	4.3%	(15,087)	(14,463)	624	Pay Costs	(89,761)	(86,970)	2,791	(179,860)	(176,051)	3,809
				(3,689)	(3,554)	135	Non Pay Costs	(21,237)	(20,249)	987	(42,911)	(43,289)	(377)
				310	18	(292)	Provisions	(9)	(2,477)	(2,468)	3,653	846	(2,807)
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
4,254	4,069	(185)	4.3%	(18,466)	(17,999)	467	Total Operating Expenses	(111,007)	(109,697)	1,310	(219,118)	(218,493)	625
4,254	4,069	(185)	4.3%	614	880	267	EBITDA	2,251	2,960	709	7,688	7,917	229
				(442)	(467)	(25)	Depreciation	(2,651)	(2,788)	(137)	(5,302)	(5,586)	(284)
				(227)	(227)	0	PDC Paid	(1,363)	(1,363)	0	(2,726)	(2,726)	0
				8	21	12	Interest Received	50	108	58	100	156	56
4,254	4,069	(185)	4.3%	(47)	207	254	Normalised Surplus / (Deficit) Excl PSF	(1,713)	(1,084)	630	(240)	(240)	0
				117	117	0	PSF (Provider Sustainability Fund)	618	618	0	1,765	1,765	0
4,254	4,069	(185)	4.3%	70	324	254	Normalised Surplus / (Deficit) Incl PSF	(1,095)	(466)	630	1,525	1,525	0
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,254	4,069	(185)	4.3%	70	324	254	Surplus / (Deficit)	(1,095)	(466)	630	1,525	1,525	0

Trust Monthly I & E Profile (Excluding revaluation and PSF)



Produced by Performance & Information

Trust Cumulative I & E Profile (Excluding revaluation and PSF)



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September 2019 is the second consecutive month where a surplus run rate has been reported. This continues to be facilitated by reducing out of area placement costs.

Month 6

The September position is a pre PSF surplus of £207k and a post PSF surplus of £324k, this is £254k ahead of plan. The key headlines are below. This represents the second consecutive month where a surplus has been reported and is largely due to continued reductions in out of area placement costs and expenditure control.

Both pay and non pay categories have continued to underspend, however this has been offset by income being lower than plan and some income risks being recognised.

Income

The year to date clinical revenue position recognises risk around CQUIN delivery and other known risks. Additional income risks are recognised within the provisions position.

Pay Expenditure

Pay budgets have continued to underspend; £624k in September. Recruitment into both vacancies and new posts created by investment continues and therefore pay expenditure is forecast to increase over the remaining 6 months of the year. Additional analysis is included within the pay information report to highlight the different expenditure levels across the services.

Additional information is also highlighted within the report on agency spend. The NHSI maximum agency cap for 2019/20 has been set at £5.3m. In September agency costs are £628k. This is £185k (45%) higher than cap.

Non Pay Expenditure

Non pay is underspent by £135k in September and cumulatively is £1.3m less than the same period last year. The report highlights expenditure on out of area placements which, whilst still a major area of focus, is £1.3m lower than last year. More details are included within the out of area focus page.

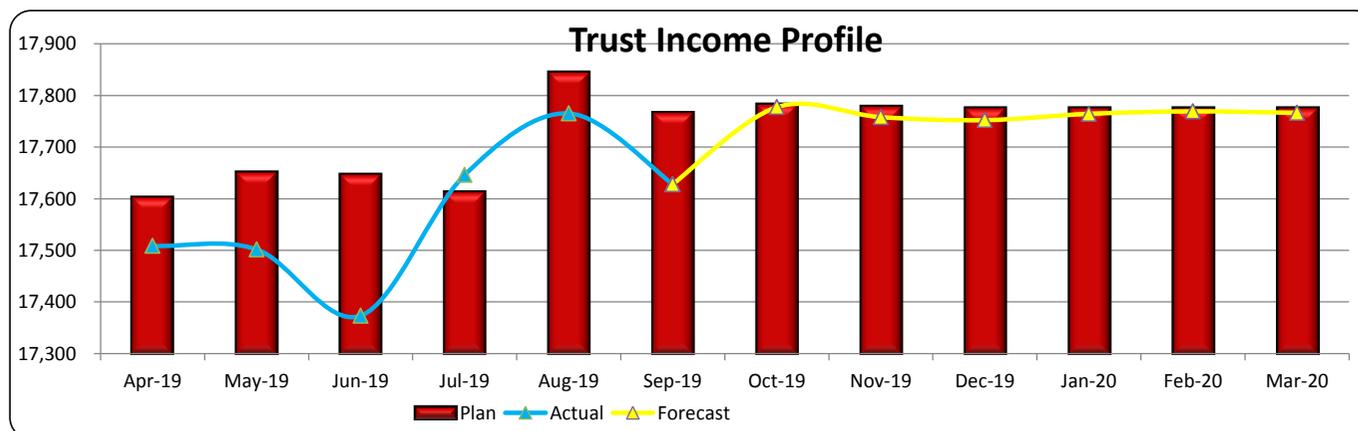
Forecast

The Trust is still forecasting to achieve its year-end control total of £240k deficit. Given a number of unidentified CIPs and other risks, particularly on income achievement, this is not assured at this point in time.

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	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total	Total 18/19
	£k	£k												
CCG	12,398	12,398	12,242	12,429	12,367	12,539	12,447	12,444	12,441	12,457	12,457	12,457	149,074	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	1,334	1,345	1,342	1,338	1,338	1,343	1,340	15,856	14,596
Local Authority	441	441	460	446	446	450	445	441	441	441	441	441	5,334	5,074
Partnerships	614	614	670	631	633	494	656	656	656	656	656	656	7,589	7,172
Other	737	730	681	821	1,001	786	860	851	851	848	848	848	9,861	6,708
Total	17,509	17,502	17,373	17,646	17,765	17,628	17,777	17,758	17,752	17,764	17,769	17,766	212,010	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	



Income is less than plan in month due to:

- * Estimates whilst actual costs incurred are verified for services recharged on an actual cost or activity basis. This includes estimate of activity for Barnsley neuro rehab beds.
- * This includes recharges of staffing costs for Youth Offenders and Barnsley additional mental health investment. Invoices will be raised as agreed and when charges are agreed with commissioners.

Year to date a CQUIN delivery risk of £82k has been recognised across all commissioners. The forecast continues to assume that this will be achieved in full.

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	13,082	12,768	12,819	12,959	13,014							78,290
Bank & Locum	663	906	752	747	934	821							4,824
Agency	613	641	624	722	628	628							3,856
Total	14,923	14,629	14,145	14,288	14,522	14,463	0	0	0	0	0	0	86,970
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%	6.2%	5.3%	5.2%	6.4%	5.7%							5.5%
Agency as %	4.1%	4.4%	4.4%	5.0%	4.3%	4.3%							4.4%

Year to Date Budget v Actuals - by staff group						
	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
Medical	11,781	9,250	278	2,016	11,544	237
Nursing Registered	32,433	26,423	1,666	271	28,361	4,072
Nursing Unregistered	9,874	8,821	2,310	905	12,035	(2,161)
Other	21,763	21,084	225	641	21,950	(187)
BDU Admin	6,406	5,578	246	10	5,834	571
Corporate Admin	7,505	7,133	99	14	7,245	260
Total	89,761	78,290	4,824	3,856	86,970	2,792

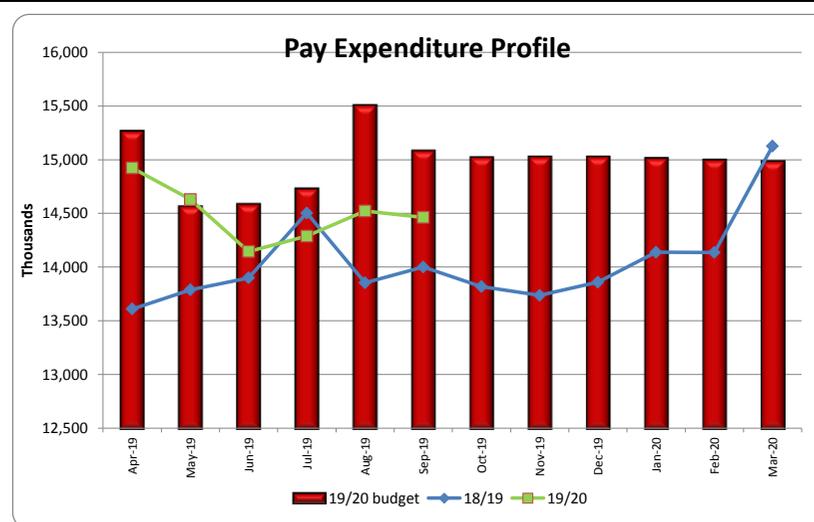
Year to date Budget v Actuals - by service						
	Budget £k	Substantive £k	Bank £k	Agency £k	Total £k	Variance £k
MH Community	38,984	33,184	877	2,419	36,479	2,505
Inpatient	23,047	18,649	3,436	1,277	23,362	(315)
BDU Support	3,626	3,521	101	10	3,632	(6)
Community	10,769	10,302	178	97	10,576	192
Corporate	13,336	12,635	232	54	12,921	416
Total	89,761	78,290	4,824	3,856	86,970	2,792

Key Messages

Overall pay expenditure is higher in 2019/20 than previous years. This is largely a result of the national pay awards and pay increments under Agenda For Change. In addition 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 September pay underspent by £624k. Year to date the underspend is £2.8m. Temporary staffing provided by both agency and bank staff totals £8.7m to date (10% 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. Mobilisation of the recurrent workforce strategy for adult acute inpatient continues following EMT approval. The financial effectiveness of this is being impacted by exceptional levels of sickness in recent months and cases of acuity above those normally expected. This plan replaces existing temporary staff with permanent employees and resets the rota's being utilised.



The NHS Improvement agency cap is £5.3m

Spend, for the year to date, is £1.2m more than cap.

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.

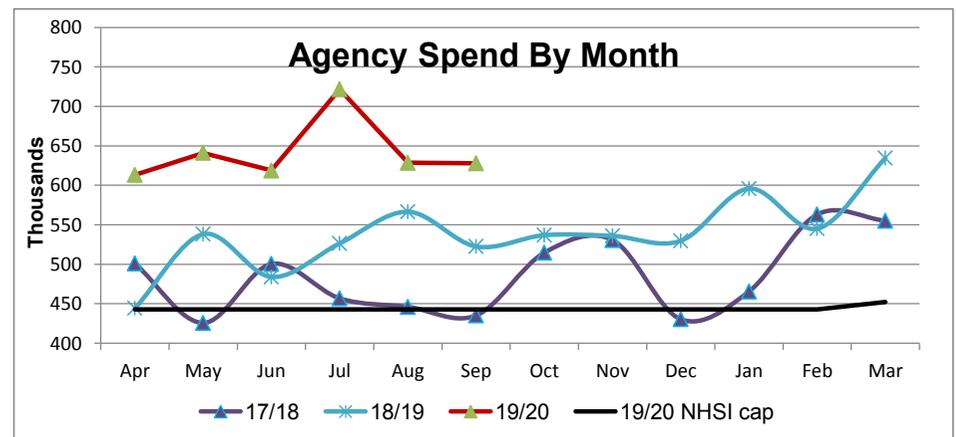
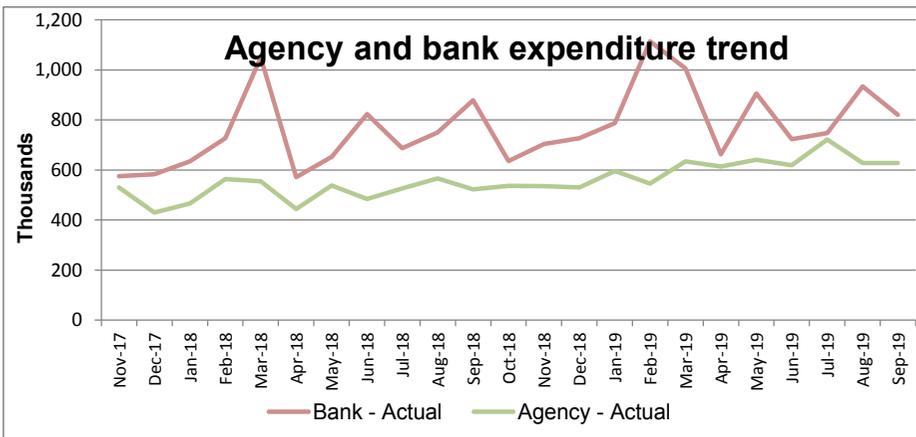
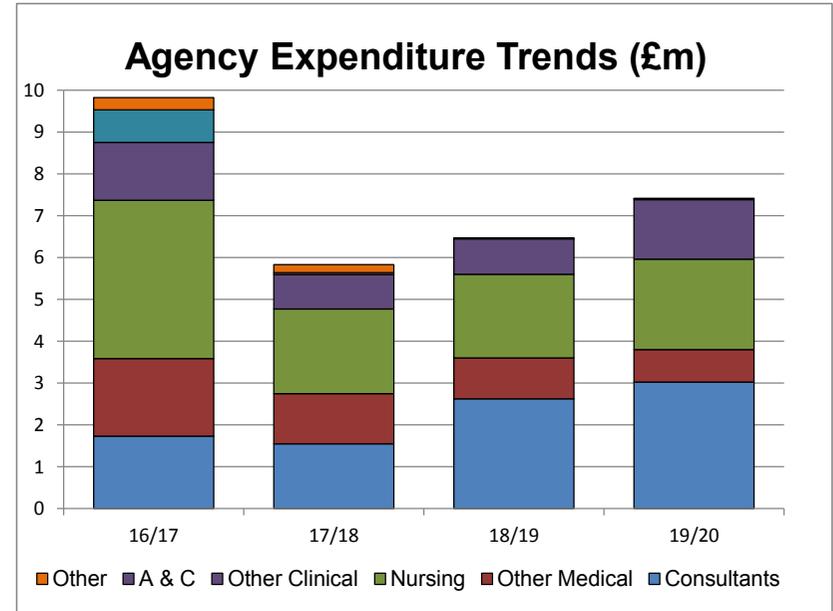
The maximum agency cap established by NHSI for 2019/20 is £5.3m which is £0.1m higher than the 2018/19 cap. In 2018/19 spend was £6.5m which breached the cap by £1.3m (24%). The NHSI agency cap has been profiled equally across the year with a maximum spend of £443k a month. The Trust plan assumed spend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

Actual agency usage continues to be reported to NHS Improvement on a weekly basis. From September 2019 this reporting included additional focus on admin agency. The Trust have 3 individuals in September 2019 with plans in place for these to end.

September agency spend is £628k, 42% above cap. This is similar to spend last month and continues to be a higher rate than incurred in 2018/19. Cumulatively agency spend is £3.9m which is 45% above cap and 25% higher than the same period last year. Actions within the Trust agency action group continue to progress reducing agency spend overall.

The current forecast, based upon these plans, is £7.4m. This is a £0.1m increase from last month. The Trust Direct Engagement programme has now gone live; the financial impact of this continues to be validated. Additional costs have been forecasted to support delivery of additional service requests within CAMHS.

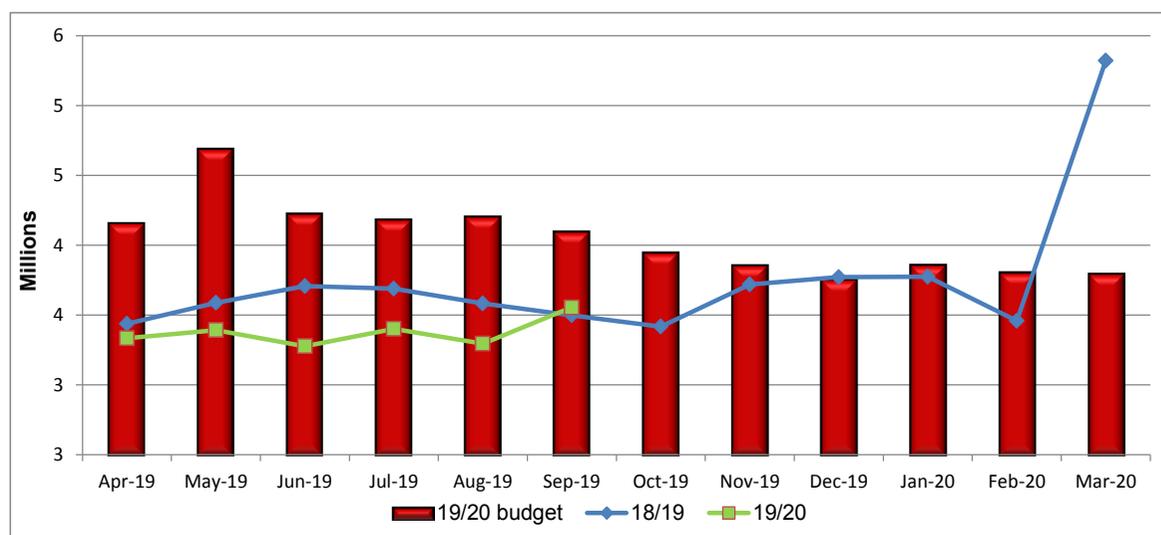
Bank and locum expenditure in September 2019 is £775k. This is lower than August 2019.



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	3,400	3,295	3,554							20,249
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

Non Pay Category	Budget	Actual	Variance
	Year to date £k	Year to date £k	£k
Clinical Supplies	1,360	1,356	4
Drugs	1,819	1,709	110
Healthcare subcontracting	2,633	2,313	321
Hotel Services	918	799	119
Office Supplies	2,388	2,389	(1)
Other Costs	2,467	2,129	338
Property Costs	3,415	3,563	(148)
Service Level Agreements	3,101	3,077	24
Training & Education	204	255	(52)
Travel & Subsistence	1,746	1,434	312
Utilities	523	616	(93)
Vehicle Costs	663	611	53
Total	21,237	20,249	987
Total Excl OOA and Drugs	16,784	16,227	557



Key Messages

Budgets and plans were reset during the 2019/20 annual planning round. The plan included resetting those categories which have historically overspent such as healthcare subcontracting (use of out of area placements) and drugs. Overall most categories are underspent against these reset budgets with the exception of Estates related lines (property costs, utilities). These have been subject to a detailed deep dive review and reported back to the Trust non pay expenditure group.

As illustrated by the graph, year to date non pay expenditure is £1.3m lower than in the previous year. Whilst there are a number of variances within these values the reduction in out of area placement costs is in itself £1.3m lower.

The largest single underspend is within other costs (£338k). This encompasses a range of varied spend areas not covered by the other headings. The second largest is in the travel and subsistence costs category which is currently £312k under plan. These are being reviewed for areas of recurrent CIP saving.

The non pay review group continues to focus on areas of wastage and inefficiency to ensure that all non pay expenditure offers 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 (£)

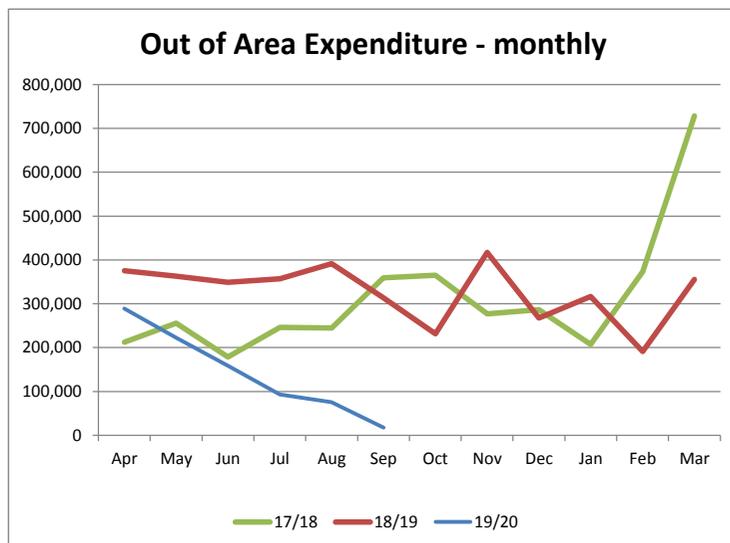
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	3,733
18/19	376	363	349	357	392	314	232	417	268	317	191	355	3,929
19/20	289	222	158	93	76	17							855

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	238	206	156	28							1,264

Bed Day Information 2019 / 2020 (by category)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
PICU	32	26	30	26	0	0							114
Acute	160	277	178	150	142	24							931
Appropriate	90	51	30	30	14	4							219
Total	282	354	238	206	156	28	0	0	0	0	0	0	1,264



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 2019 reducing to 5 placements by March 2020.

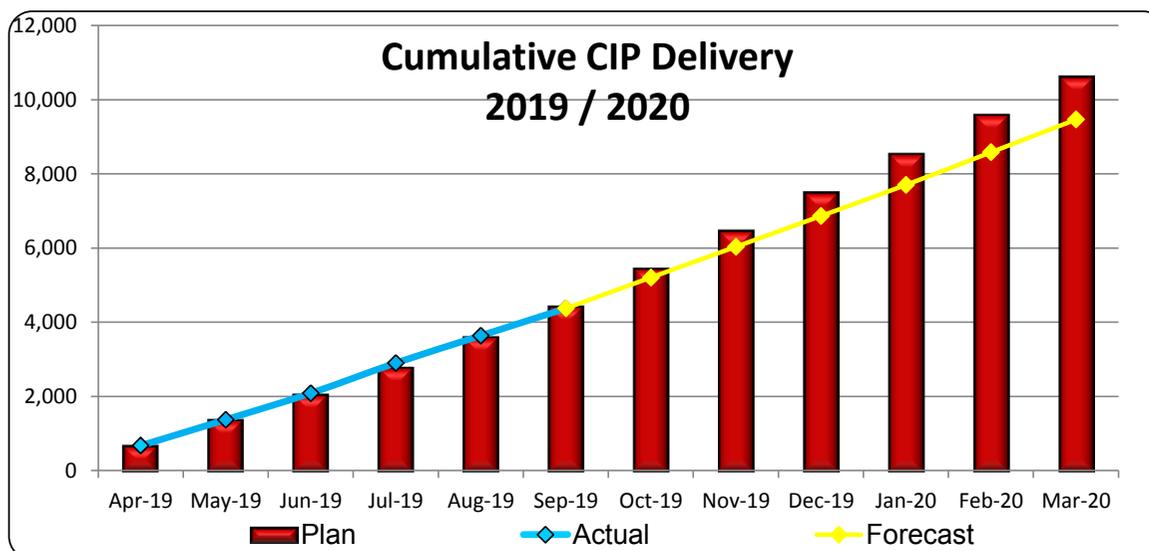
Demand for placements has reduced again in September 2019 with a second month of zero PICU placements. Overall the number of placements required has reduced compared to the same period last year, a year to date reduction of 1,783 days (59%).

Expenditure has reduced from £3,047k to £1,264k for the April to September period. This is a combination of reduced usage and reduced costs for specialist nursing and transport.

Whilst this is positive from an operational and financial perspective the impact on other areas (e.g. staffing on the inpatient wards) and general sustainability continue to be assessed. Workstreams will continue to ensure this is maintained and expand into a wider assessment of activity, commissioning requirements and ward sizes.

There continues to be huge focus on this issue across the Trust and the results achieved have been through significant effort by a large number of staff.

	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	4,439
Achieved - plan	669	1,353	2,018	2,788	3,487	4,191	4,922	5,653	6,384	7,124	7,906	8,690	4,191
Achieved - mitigation	4	19	69	113	151	181	283	381	480	578	676	774	181
Mitigations - Upside schemes										386	772	1,160	0
Shortfall / Unidentified	15	4	(21)	(111)	(23)	67	249	446	643	455	242	(0)	67



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.

Year to date performance is £67k behind plan with a shortfall (£153k) in recurrent offset by £86k over-delivery of non recurrent schemes. The majority of schemes continue to be delivered as originally planned.

Delivery of the full target requires mitigations for a further £1.1m. This work continues within the Trust financial sustainability workstream.

	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	2,844
Achieved - plan	378	772	1,186	1,693	2,127	2,561	3,024	3,486	3,949	4,426	4,925	5,427	2,561
Achieved - mitigation	3	17	66	86	109	130	152	174	195	217	239	260	130
Shortfall / Unidentified	38	50	7	(59)	47	153	423	692	962	1,227	1,468	1,681	153

	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	1,595
Achieved - plan	291	582	832	1,095	1,360	1,631	1,899	2,167	2,435	2,698	2,981	3,263	1,631
Achieved - mitigation	1	2	3	27	42	51	131	208	284	361	437	514	51
Shortfall / Unidentified	(23)	(46)	(28)	(52)	(70)	(86)	(173)	(246)	(319)	(386)	(454)	(521)	(86)

	2018 / 2019 Plan (YTD)		Actual (YTD)	Note
	£k	£k	£k	
Non-Current (Fixed) Assets	100,005	100,426	98,926	1
Current Assets				
Inventories & Work in Progress	259	232	259	
NHS Trade Receivables (Debtors)	3,019	3,258	1,943	2
Non NHS Trade Receivables (Debtors)	1,007	777	1,291	3
Prepayments, Bad Debt, VAT	1,559	2,663	2,876	
Accrued Income	5,138	3,212	2,278	4
Cash and Cash Equivalents	27,823	21,637	32,430	5
Total Current Assets	38,806	31,779	41,077	
Current Liabilities				
Trade Payables (Creditors)	(4,663)	(3,033)	(3,147)	6
Capital Payables (Creditors)	(1,070)	(397)	(405)	
Tax, NI, Pension Payables, PDC	(6,002)	(6,001)	(5,576)	
Accruals	(8,020)	(8,198)	(11,635)	7
Deferred Income	(276)	(375)	(1,034)	
Total Current Liabilities	(20,031)	(18,004)	(21,797)	
Net Current Assets/Liabilities	18,775	13,775	19,279	
Total Assets less Current Liabilities	118,780	114,201	118,205	
Provisions for Liabilities	(7,221)	(6,270)	(7,067)	
Total Net Assets/(Liabilities)	111,560	107,931	111,138	
Taxpayers' Equity				
Public Dividend Capital	44,221	44,221	44,265	
Revaluation Reserve	9,453	9,845	9,636	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,666	48,645	52,017	8
Total Taxpayers' Equity	111,560	107,931	111,138	

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 current position is less than originally planned partly due to VAT refunds received in September.

2. The team continue to focus on minimising the level of NHS trade debtors. The value outstanding has reduced again in September and continue to be lower than plan. A number of aged debts have been escalated to support recovery.

3. Non NHS debtors are higher than plan, all debts over 30 days are actively chased to identify issues early.

4. Accrued income remains lower than plan, all accrued income is reviewed monthly to ensure that all invoices are raised in a timely and appropriate manner.

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. Payments to creditors continue to be paid in line with the Better Payment Practice Code (page 17). At September these are slightly higher than plan.

7. Accruals are higher than plan as the Trust awaits invoices for goods and services received.

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

	REVISED						Note
	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,715	350	193	(157)	2,557	(159)	
Equipment Replacement	93	20	30	10	90	(3)	
IM&T	2,195	798	859	61	2,480	285	
Major Capital Schemes							
Fieldhead Non Secure	936	936	504	(432)	504	(432)	2
Nurse Call system	200	18	18	0	200	0	3
Clinical Record System	211	193	180	(13)	220	9	
VAT Refunds	0	0	(75)	(75)	(75)	(75)	1
TOTALS	6,350	2,315	1,709	(606)	5,975	(375)	

The capital programme has undertaken a number of revisions in year. The current plan is £6.35m.

Capital Expenditure 2019 / 2020

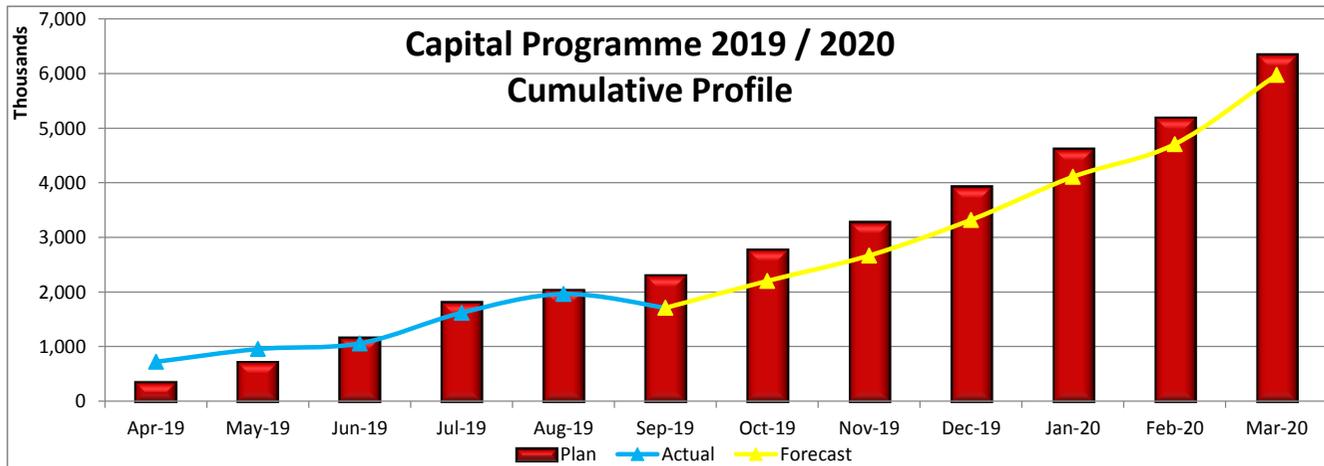
1. The originally agreed capital plan for 2019 / 20 was £7.0m and schemes are guided by the current estates and digital strategies.

Following various re-iterations given national guidance the capital plan for the year is now £6.35m. Based on the current most likely outcome the forecast is being amended to £6m.

Expenditure has reduced in month 6 as a number of historical VAT refunds have been processed by HMRC.

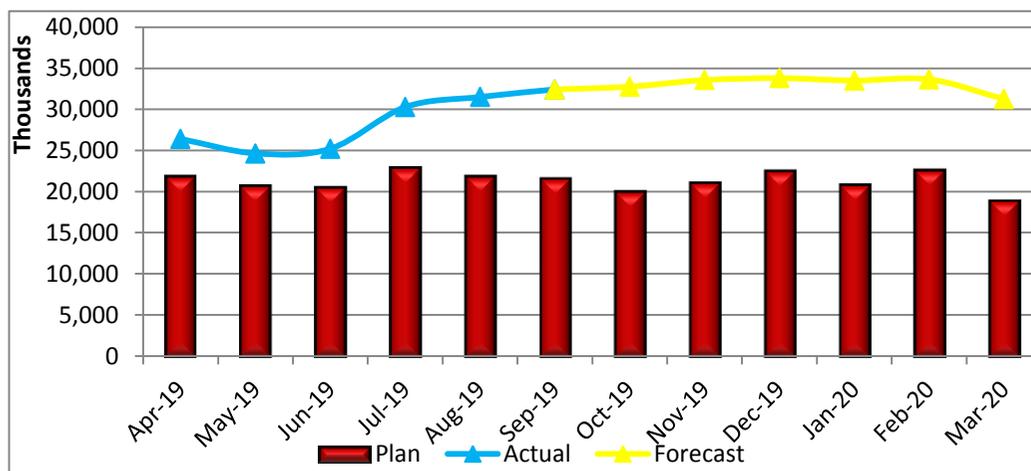
2. The final costs of the Fieldhead non-secure scheme are currently being agreed.

3. The nurse call system has commenced and is forecast to be complete early 2020.

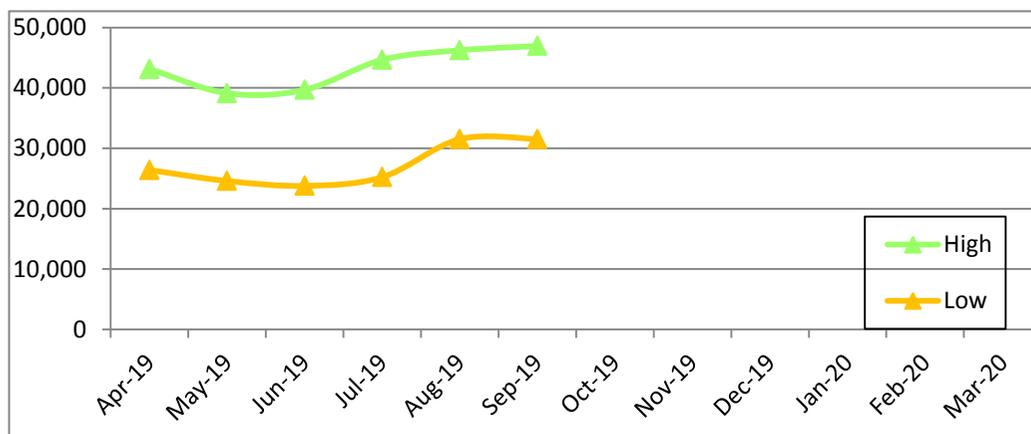


3.2

Cash Flow & Cash Flow Forecast 2019 / 2020



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	27,823	
Closing Balance	21,637	32,430	10,793



The Trust cash position remains healthy.

Although PDC (£1.3m) has been paid in September the overall cash position has increased. This is due to continued recovery of debtors, VAT refund and the generation of a surplus in the last two months.

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

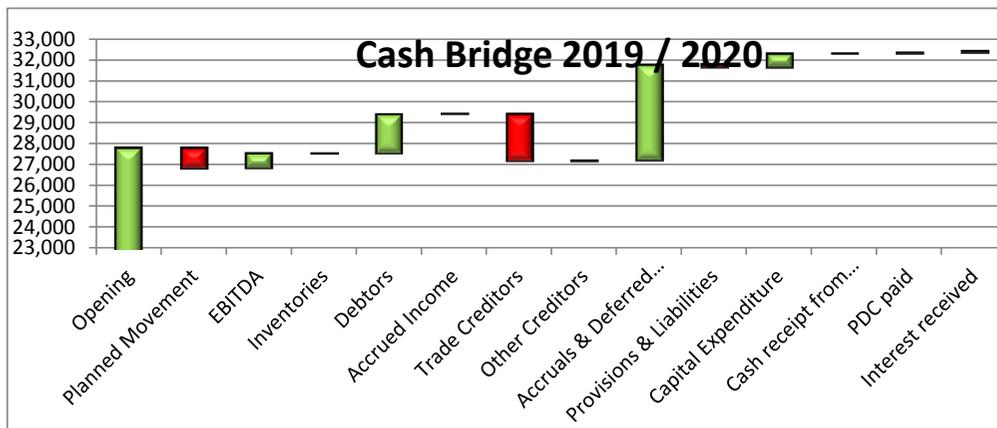
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £46.9m
The lowest balance is: £31.5m

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)	2,865	3,578	713	2
<i>Movement in working capital:</i>				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	464	2,335	1,871	3
Trade Payables (Creditors)	236	(2,005)	(2,241)	5
Other Payables (Creditors)	0	44	44	
Accruals & Deferred income	(184)	4,373	4,557	4
Provisions & Liabilities	(5)	(153)	(148)	
<i>Movement in LT Receivables:</i>				
Capital expenditure & capital creditors	(3,042)	(2,374)	669	
Cash receipts from asset sales	0	0	0	
PDC Dividends paid	(1,362)	(1,300)	62	
PDC Dividends received			0	
Interest (paid)/ received	48	108	60	
Closing Balances	21,637	32,430	10,793	



The plan value reflects the April 2019 submission to NHS Improvement.

Factors which increase the cash position 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.
3. Debtors, including accrued income, continue to be better than plan. Day to day management continues although a number of historical issues remain which are being pursued with other organisations for resolution.
4. Accruals are higher than plan whilst we await invoices. This improves cash as we have not yet paid for goods and services received. This is normal as we await the issuing of the end of quarter 2 invoices.

Factors which decrease the cash position against plan:

5. 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.

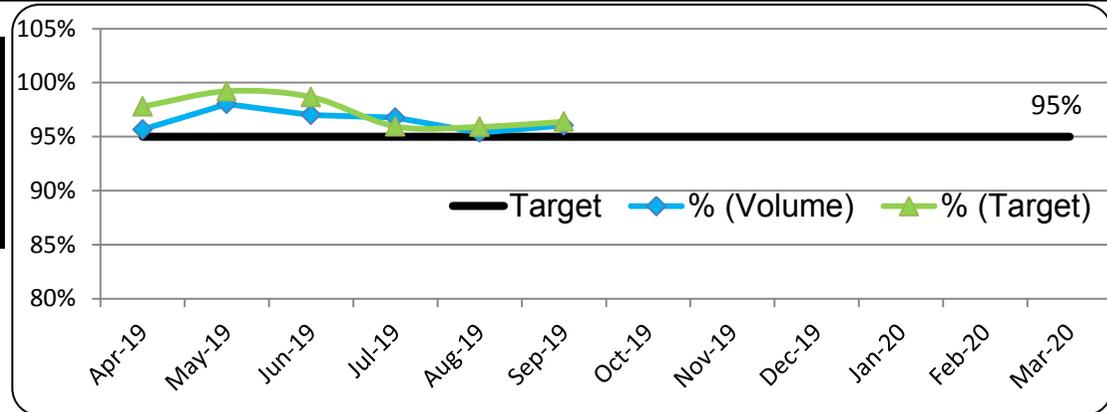
4.0

Better Payment Practice Code

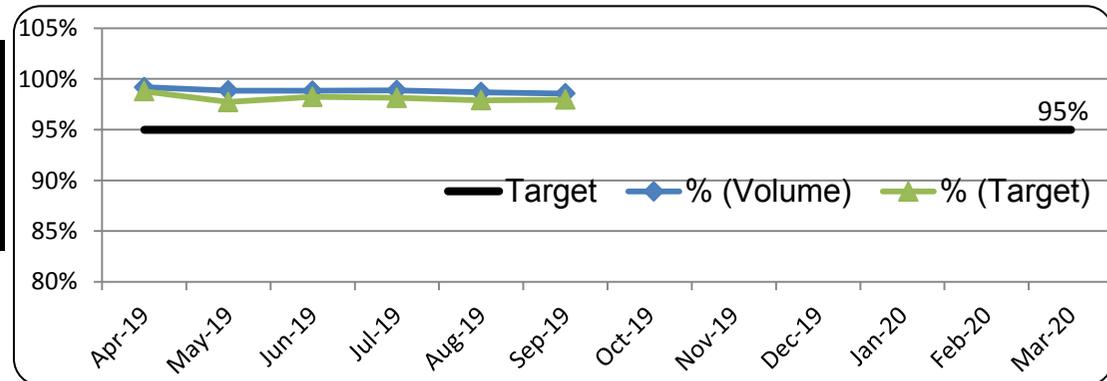
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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 August 2019	95%	96%
Year to September 2019	96%	96%



Non NHS		
	Number	Value
	%	%
Year to August 2019	99%	98%
Year to September 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 (£)
27-Sep-19	Property rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3119005	226,501
05-Sep-19	Property rental	Kirklees	Bradbury Investments Ltd	3117056	118,518
05-Sep-19	IT services	Trustwide	Daisy Corporate Services Trading Ltd	3117096	93,125
12-Sep-19	Property rental	Wakefield	Assura HC Ltd	3117800	90,000
16-Sep-19	CNST contributions	Trustwide	NHS Litigation Authority	3118024	64,044
16-Sep-19	Property rental	Barnsley	Apollo Court	3117965	35,612
06-Sep-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3117127	34,330
09-Sep-19	Purchase of Healthcare	Trustwide	Cygnat Health Care Ltd	3117255	33,881
10-Sep-19	Staff recharge	Trustwide	Leeds and York Partnership NHS FT	3117443	33,732
02-Sep-19	Purchase of Healthcare	Forensics	Cloverleaf Advocacy 2000 Ltd	3116372	31,416
05-Sep-19	Property rental	Kirklees	Bradbury Investments Ltd	3117108	27,108
26-Jul-19	Communications	Trustwide	British Telecommunications plc	3113093	27,004
17-Sep-19	Communications	Trustwide	Vodafone Corporate Ltd	3118135	26,056
27-Aug-19	Communications	Trustwide	Virgin Media Payments Ltd	3115874	25,832
24-Sep-19	Communications	Trustwide	Virgin Media Payments Ltd	3118757	25,431
06-Sep-19	Drugs	Trustwide	Lloyds Pharmacy Ltd	3117127	25,218

- * Recurrent - an action or decision that has a continuing financial effect
- * Non-Recurrent - an action or decision that has a one off or time limited effect
- * Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year
- * Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year
- * Surplus - Trust income is greater than costs
- * Deficit - Trust costs are greater than income
- * Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.
- * Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year
- * Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2018 / 2019 the Trust were set a control total deficit.
- * In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.
- * Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.
- * Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.
- * EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.
- * Provider Sustainability Fund (PSF) - is an income stream distributed by NHS Improvement to all providers who meet certain criteria (this was formally called STF - Sustainability and Transformation Fund)

Appendix 2 - Workforce - Performance Wall

Barnsley District										
Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.2%	4.8%	4.9%	5.2%	5.4%	5.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.4%	4.8%	4.9%	6.0%	6.0%	4.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.2%	8.1%	22.1%	68.2%	73.1%	78.8%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.2%	0.4%	2.7%	13.7%	30.9%	44.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.0%	77.8%	77.9%	80.0%	80.0%	80.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.0%	78.0%	80.0%	80.0%	80.0%	79.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	79.3%	79.4%	77.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Information Governance	Resources	Well Led	AD	>=95%	95.2%	96.2%	92.6%	92.9%	93.5%	92.9%
Moving and Handling	Resources	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	78.8%	75.6%	78.6%	80.0%	80.0%	80.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Agency Cost	Resources	Effective	AD		£37k	£28k	£57k	£46k	£56k	£53k
Overtime Costs	Resources	Effective	AD		£2k	£3k	£1k	£0k	£1k	
Additional Hours Costs	Resources	Effective	AD		£10k	£17k	£14k	£15k	£15k	
Sickness Cost (Monthly)	Resources	Effective	AD		£165k	£125k	£132k	£160k	£167k	£127k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		79.37	84.36	80.88	78.97	89.98	100.58
Business Miles	Resources	Effective	AD		97k	97k	99k	109k	104k	94k

Calderdale and Kirklees District										
Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.2%	9.7%	25.1%	66.9%	77.3%	81.6%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.2%	0.2%	1.7%	5.3%	18.0%	29.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	77.3%	76.3%	75.1%	75.9%	75.5%	79.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	78.9%	79.5%	78.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Information Governance	Resources	Well Led	AD	>=95%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Moving and Handling	Resources	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Agency Cost	Resources	Effective	AD		£135k	£146k	£157k	£120k	£159k	£125k
Overtime Costs	Resources	Effective	AD		£1k	£2k	£7k	£2k	£2k	
Additional Hours Costs	Resources	Effective	AD		£4k	£5k	£4k	£1k	£1k	
Sickness Cost (Monthly)	Resources	Effective	AD		£109k	£92k	£94k	£84k	£84k	£90k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		68.72	75.61	80.5	71.04	95.92	101.97
Business Miles	Resources	Effective	AD		82k	66k	45k	65k	£67k	53k

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

Forensic Services										
Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	7.5%	5.6%	5.9%	6.3%	6.5%	6.8%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	5.6%	5.6%	6.2%	7.1%	6.9%	7.5%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	94.4%	3.5%	15.5%	58.8%	80.3%	80.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.2%	0.7%	0.7%	3.6%	35.2%	53.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Information Governance	Resources	Well Led	AD	>=95%	95.2%	95.2%	95.2%	95.2%	93.9%	94.9%
Moving and Handling	Resources	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Agency Cost	Resources	Effective	AD		£69k	£50k	£59k	£65k	£65k	£75k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£0k	£0k	£1k	
Additional Hours Costs	Resources	Effective	AD		£1k	£1k	£2k	£3k	£1k	
Sickness Cost (Monthly)	Resources	Effective	AD		£55k	£52k	£59k	£67k	£69k	£74k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		64.52	78.25	84.96	88.64	86.39	90.11
Business Miles	Resources	Effective	AD		9k	5k	6k	8k	10k	5k

Specialist Services										
Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.9%	4.4%	4.8%	4.9%	5.2%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.9%	4.4%	5.1%	4.9%	6.0%	5.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.2%	2.8%	10.9%	53.7%	64.7%	69.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	92.7%	0.0%	2.4%	9.4%	26.1%	37.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.7%	78.6%	79.0%	78.1%	80.3%	80.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	79.8%	7.8%	79.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	71.0%	73.3%	70.0%	73.3%	71.0%	72.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Information Governance	Resources	Well Led	AD	>=95%	95.2%	95.2%	95.2%	95.2%	94.3%	94.3%
Moving and Handling	Resources	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.2%	95.2%
Agency Cost	Resources	Effective	AD		£275k	£283k	£268k	£258k	£296k	£229k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£2k	£2k	£1k	
Additional Hours Costs	Resources	Effective	AD		£3k	£10k	£5k	£5k	£3k	
Sickness Cost (Monthly)	Resources	Effective	AD		£32k	£48k	£59k	£53k	£64k	£49k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		61.42	55.85	63.99	0	81.8	81.77
Business Miles	Resources	Effective	AD		35k	34k	34k	45k	36k	37k

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

Support Services										
Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	4.30%	4.70%	4.50%	4.60%	4.40%	4.40%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	4.30%	4.60%	4.40%	4.70%	4.40%	4.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.00%	3.30%	12.90%	66.70%	77.00%	82.20%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.00%	0.00%	0.20%	2.50%	19.80%	29.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	68.00%	72.10%	80.00%	79.30%	79.70%	80.00%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.00%	76.90%	80.00%	80.00%	80.00%	80.00%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Information Governance	Resources	Well Led	AD	>=95%	95.00%	95.00%	94.20%	94.30%	95.00%	92.80%
Moving and Handling	Resources	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Agency Cost	Resources	Effective	AD		£12k	£14k	£15k	£6k	£5k	£5k
Overtime Costs	Resources	Effective	AD		£45k	£5k	£16k	£29k	£15k	
Additional Hours Costs	Resources	Effective	AD		£17k	£10k	£8k	£11k	£10k	
Sickness Cost (Monthly)	Resources	Effective	AD		£63k	£64k	£64k	£68k	£61k	£66k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		49.57	45.38	37.6	43.44	41.67	36.42
Business Miles	Resources	Effective	AD		29k	35k	22k	27k	29k	22k

Wakefield District										
Month	Objective	CQC Domain	Owner	Threshold	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	4.8%	5.7%	5.2%	4.8%	4.8%	4.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.7%	5.6%	4.7%	4.9%	4.9%	4.4%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	95.00%	4.3%	23.8%	80.7%	80.00%	80.00%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	95.00%	0.0%	0.8%	13.9%	27.0%	42.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	80.00%	79.0%	79.6%	80.00%	80.00%	80.00%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	79.5%	78.9%	80.00%
Equality and Diversity	Resources	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	74.0%	72.7%	79.3%	80.00%	80.00%	80.00%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Information Governance	Resources	Well Led	AD	>=95%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Moving and Handling	Resources	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%
Agency Cost	Resources	Effective	AD		£107k	£92k	£84k	£24k	£34k	£31k
Overtime Costs	Resources	Effective	AD		£0k	£1k	£2k	£1k	£2k	
Additional Hours Costs	Resources	Effective	AD		£3k	£4k	£5k	£3k	£3k	
Sickness Cost (Monthly)	Resources	Effective	AD		£58k	£58k	£48k	£40k	£48k	£36k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		39.69	39.49	37.44	31.39	32.68	38.98
Business Miles	Resources	Effective	AD		37k	38k	34k	39k	34k	32k

Glossary

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

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

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to align with the NHSI rating system.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures
Produced by Performance & Information

Trust Board 29 October 2019 Agenda item 9.1

Title:	Digital Strategy Progress Update
Paper prepared by:	Director of Finance & Resources Director of Strategy
Purpose:	To provide an update of the progress being made against the 2019/20 activities included in the Digital Strategy
Mission/values:	Supports all Trust objectives
Any background papers/ previously considered by:	Digital Strategy approved by the Trust Board in January 2018 Trust Board is provided with a twice yearly update of progress being made against the strategy.
Executive summary:	<ul style="list-style-type: none"> ➤ Progress against the activities agreed for 2019/20 is identified in this report. ➤ Work progresses on the final year of the three year IT infrastructure modernisation programme of works ➤ Following the successful implementation of SystmOne to replace RiO, focus is now shifting to optimisation activities after a period of system stabilisation. Optimisation will continue in order to develop the system to further support the provision of clinical care and delivery of business intelligence data ➤ A number of initiatives are being undertaken in support of paper digitisation, reducing the Trust's dependency on paper and associated processes, all of which will contribute to the developing sustainability agenda moving forward ➤ Greater emphasis is being placed on effective use of data intelligence Resource is focused on the development of a data warehouse to support the understanding of internal productivity by teams. Whilst the model hospital is still in relative infancy for mental health and community providers there is now sufficient information contained within it enabling some comparisons to be made. ➤ In relation to having a skilled and digitally able workforce the primary focus to date has been related to SystmOne operational training and attendance at team meetings to support staff in the use of it. ➤ The relatively new Digital Strategy Group is driving forward opportunities, such as the development of an e-voucher scheme within the Quit Manager system and also exploration of an eConsultation solution for a pilot project within the mental health perinatal service ➤ In respect of cyber security the Trust has taken up various services offered by NHS Digital relating to cyber security and a number of remedial activities have been completed during the reporting period which support the Trust's drive towards cyber maturity ➤ Work has concluded with Servelec regarding the decommissioning of the RiO clinical information system and the removal of RiO access for staff. ➤ The Trust staff app has now been launched.

	<p>➤ The ability to deliver on all of the 2019/20 priorities in line with the timescales identified later in this report remains very much dependent on availability of suitable resources and continuous balancing of competing priorities</p> <p>Risk appetite</p> <p>This paper needs to be considered in line with the Trust risk appetite statement which aims for clinical risk of 1-6 (subject to Board approval).</p>
Recommendation:	The Trust Board is asked to NOTE and COMMENT on the update of progress made against the Trust's Digital Strategy.
Private session:	Not applicable.

Digital Strategy

Progress Report

Head of IT Services & Systems Development

October 2019

Purpose of Report

The purpose of this report is to inform the Board of the progress and developments made during the last 6 months in respect of the Trust's Digital Strategy.

Executive Summary

This report focuses on the progress made during the first half of 2019/20 with regard to the priority areas in support of delivery against the aims and objectives of the Digital Strategy. Within the report there are a number of new and emerging themes which will continue to develop during the course of 2019/20 and beyond.

To support the delivery of the Digital Strategy, a milestone delivery plan has been developed which includes 8 cross-cutting domains. These domains map to the 6 key aims of the digital strategy. The cross-cutting delivery domains are:

1. Fit for Purpose IM&T Infrastructure

To ensure that the Trust has a strategically aligned, resilient and robust IT infrastructure (network/end user computing hardware and software) which enhances business continuity, disaster recovery capabilities and potential cyber security safeguards for wider organisational assurance. The primary focus during 2019/20, which is year 3 of the 3 year infrastructure modernisation programme of works, continues to build on the good progress made during 2018/19. Overall good progress is being made within the schemes in this domain and remains on track against the plan for 2019/20.

2. Integrated Electronic Care Record System

Use technology and information innovatively to make the most effective and efficient use of resources and as an enabler in redesigning services which supports making better use of clinical information systems and integration capabilities. This domain is focused on developing the Trust's electronic care record systems and the drive towards seamless integration and enhanced interoperability that supports the electronic exchange of information and messaging capabilities. Following the successful implementation of SystemOne to replace RiO, focus is now shifting to optimisation activities after a period of system stabilisation following the phased go live approach. Optimisation will continue in order to develop the system to further support the provision of clinical care and delivery of business intelligence data.

3. Digitisation & Information Sharing with our Partners

The focal point for this domain is to make inroads into the reduction of the paper estate and to increase the Trust's digital footprint as a result, thus enabling improved information sharing opportunities with our partners and key stakeholders. This supports the Trust in moving towards becoming paper free by 2020. A number of initiatives within this domain complement each other in support of reducing the Trust's dependency on paper and associated processes, all of which will contribute to the developing sustainability agenda moving forward.

4. Business Intelligence Systems

This domain is concerned with the advancement of the Trust's reporting capabilities through the development of business intelligence and improving data quality which in turn aids organisational and service line performance.

The use of business intelligence tools helps to deliver information in a more standardised and user-friendly way e.g. via dashboards. Such developments increase the use of forecasting, benchmarking and statistical techniques to deliver information rather than data and wider sharing information capabilities. They also support the delivery of care, improve data quality and information accuracy and ensure relevant information is shared in a timely and automated way. Resource is focused on the development of a data warehouse to support the understanding of internal productivity by teams. Whilst the model hospital is still in relative infancy for mental health and community providers there is now information contained within it enabling some comparisons to be made. The initial review has taken place and been discussed at EMT. The optimisation of SystemOne will also cover how effective our reporting is to ensure consistency of recording data and ability to report on what is important to us.

5. A Skilled & Digitally Enabled Workforce

This domain focuses on the development of digital skills and working practices across the Trust's workforce. Equipping Trust staff with the requisite digital skills is critical in the utilisation of digital technologies, systems and information. By improving capabilities within services, with all staff having access to or being provided with the appropriate digital skills to use current and future technologies serves to meet the changing demands of the organisation and the services we provide. The primary focus to date has been related to SystemOne operational training and attendance at team meetings to support staff in the use of SystemOne. Work is also ongoing during the remainder of the year to assess the potential of using Skype for Business for delivering mandatory training.

6. Engaging and Learning from Digital Best Practice

This domain focuses on exploiting opportunities for digitisation through wider awareness of the use and application of new and emerging digital capabilities. Central to this will be sharing and spreading our own digital best practice, learning from what others do nationally and internationally, working with our partners and adopting digital tools that have been tried and tested elsewhere. This is a developing domain which the Digital Strategy Group is instrumental in driving forward opportunities, such as the development of an e-voucher scheme within the Quit Manager system that serves to improve the service user experience, whilst reducing the associated operational costs and also exploration of an eConsultation solution for a pilot project within the mental health perinatal service.

7. Championing Digital Inclusion for People Accessing our Services

This is an emerging domain and enhancements within other domains will aid the Trust's overall digital maturity and support opportunities to improve the digital offer and experience for our patients, service users, carers and families.

8. Embedding Digital in our Culture

This is also a developing domain and enhancements elsewhere in support of delivering against this strategy will aid the Trust's overall digital maturity and opportunities to nurture and embed digital by default in everything that we do. This will be supported through hosting digital events, launching digital challenges on iHub to gather ideas, adopting a digital-by-design approach to service re-design and tenders, and piloting the use of digital innovations e.g. apps in clinical practice.

West Yorkshire & Harrogate Integrated Care System

It is also worth noting that the West Yorkshire & Harrogate Integrated Care System (ICS) has developed a digital strategy, which is the subject of a separate Board report. This strategy was shared at the System Leadership Executive meeting in October 2019. The strategy is underpinned by a digital charter and sets out the approach and standards to be achieved across the region. The strategy places a strong emphasis on ensuring that the basics are prioritised across the partnership to ensure that digital health and care solutions are developed on firm foundations with the required infrastructure in place. The strategy will be further developed to include how digital literacy and competency will be considered as well as the role and of the voluntary and community sector. Cyber security needs to be considered as a critical priority. A more detailed implementation and resource plan will need to be developed and the resources required to deliver the strategy will be considered.

Digital Strategy Progress

Detailed within this report is a summary of the activities and progress to date, particularly over the last six months, in respect of the agreed 2019/20 milestones. Below is a summary of the main achievements and items to note in this reporting period.

- **Infrastructure modernisation year 2 (2018/19) review:** An end of period review report covering 1 April 2018 to 31 March 2019 was produced that provided a summary of progress made during year 2 of this 3 year programme. Key improvements to note are: -
 - Replacement of end of life approaching core Kendray LAN (Local Area Network) and removal of single point of failures.
 - Replacement of the Fieldhead and Kendray firewalls which increased the bandwidth for general internet based systems including clinical systems.
 - Network enhancements that support the ability to failover from Fieldhead to Kendray data centre should a situation arise, thus maintaining internet facing services such as a VPN for remote connectivity and Skype for Business to connect to the Internet securely without opening up the entire Trust network.

- Fieldhead and Kendray wireless infrastructure expansion and proactive replacement of end of life approaching and end of capacity equipment.
 - Improvements to network storage and backup refresh which included replacing legacy hardware and upgrading operating systems to newer versions, whilst also increasing resiliency and capacity at the same time.
 - Active Directory (AD) upgrade – migrating from Windows 2008 AD to Windows 2016 AD, ahead of the end of life deadline for Windows 2008 AD, thus ensuring the environment continues to be supported. This introduced additional functionality and security enhancements has also enabled the centralised management of Windows 10 client machines.
 - ATP (Advanced Threat Protection) - As a result of the work on Windows 10 and the core infrastructure, the Trust has been able to adopt the centrally provided ATP service from NHS Digital
- **Microsoft licence costs:** A briefing paper was produced stating the proposed approach and Trust position ahead of the June 2019 licence renewal point with Microsoft. The annual cost of £348k represents a reduction of £46k against the original estimate of £394k that was initially put forward for the 2019/20 plan to cover the Trust's direct Microsoft licence requirements.
- **HSCN connectivity:** The options and associated costs for Health & Social Care Network (HSCN) connectivity to replace existing N3 wide area network (WAN) connections have been evaluated and a paper produced with recommendations approved by EMT, which included: -
- Replacing the existing N3 wide area network with dedicated HSCN links at the six larger hub sites only which served to reduce down annual revenue costs by 62% to £34k during the term of the 3 year contract based on existing costs.
- **Replacement of point of presence (POP) network connections:** The planned migration of the wide area network (point of presence) connections at Kendray Hospital, Laura Mitchell and Airedale Health Centre sites to new HSCN connections were completed ahead of the respective NHS Digital closure dates.
- **Email platform review:** An options appraisal has been completed evaluating NHS Mail and Microsoft Office365/Exchange which informed the development of a business case for EMT/Trust Board consideration and approval regarding the future strategic corporate email platform.
- **Cyber security & threat monitoring:** The Trust has taken up various services offered by NHS Digital relating to cyber security and a number of remedial activities completed during the reporting period which support the Trust's drive towards cyber maturity.

- **Mental Health Services clinical record system (SystemOne):** Data catch-up work on the inputting of all activity conducted during the cut-over period between staff stopping inputting into RiO and starting to use SystemOne was fully completed within planned timescales.
- **Mental Health Services clinical record system (RiO):** Work has concluded with Servelec regarding the decommissioning of the RiO clinical information system and the removal of RiO access for staff.
- **Paper digitisation:** The project team recruitment activities have been completed and a revised paperlight accreditation process produced, which has been approved by the Improving Clinical Information Group (ICIG).
- **MY SWYPFT:** The Trust staff app has now been launched.
- **ORCHA:** A capital bid identified through the annual planning process to secure further funding for ORCHA into 2019/20 and 2020/21 was approved by EMT to support the wider rollout of the app platform.

Risks

The priorities set out as summarised in this report continue to reduce the likelihood of risk of system failure. This includes the work activities which remain focused on: -

- Continuation of the infrastructure modernisation programme covering both the data centre enhancement and improvements to disaster recovery so as to improve resilience and application/systems availability. This programme of work also incorporates cyber security enhancements to establish further controls and measures to reduce the risk and likelihood associated with the threat of cyber-attacks.
- Delivery of paper digitisation changes that continues to introduce new working practices and ways of working across clinical services. This will require time and support from clinicians and administrative staff in order to deliver this efficiency agenda successfully. Changes to clinical and administrative processes will need to be agreed at both local and regional levels in order to reduce paper generation and consumption.

The ability to deliver on all of the 2019/20 priorities in line with the timescales identified later in this report remains very much dependent on availability of suitable resources and continuous balancing of competing priorities.

A particular point to note is the ever-increasing growing demand on digital technologies and solutions within available resources. This will require careful management of expectations of Trust staff. Horizon scanning and exploring opportunities to source and secure other avenues for external funding will be key to supporting wider organisational aspirations in line with digital strategy objectives. The Digital Strategy group plays a fundamental role in supporting this requirement.

The provision of digitally enabled services is vital in enabling Trust staff to deliver safe care. As such the risk appetite remains to be considered low with a target score of 1-6.

Summary

The information included in this update report clearly articulates the breadth and scale of the 2019/20 Digital Strategy work which is underway. A considerable amount of time has been afforded in the planning of activities to support progress being made. This has meant timescales for delivery of the initiatives in this document remain realistic and achievable, subject to allocated/available resources. Any additional priorities which arise in-year will need to be assessed on an individual basis to determine and further resources required or any re-prioritisation of projects required.

As this update report demonstrates good progress has been made against 2019/20 priorities in support of the Digital Strategy, with the majority of the key initiatives across the domains being on track as depicted in the summary dashboard on the page below and in the individual summaries provided for each initiative. Therefore, the October 2019 position has been rated as **GREEN** overall.

The Board is asked to note the progress in respect of the delivery against the 2019/20 milestones. The Board will continue to be updated in respect of progress against Digital Strategy delivery twice a year with the next update to be provided in April 2020.

Digital Strategy Summary Dashboard (September 2019)

Domain 1: Fit for purpose IM&T infrastructure	RAG Status	Progress Indicator	Domain 4: Business Intelligence Systems	RAG Status	Progress Indicator
Infrastructure Modernisation Programme	G	↗	Business Intelligence / Data Warehouse	G	↗
Health & Social Care Network	G	↗	Information Governance	G	↗
Migration to Windows 10	G	↗	National Data Opt-Out Programme	G	↗
Email Platform Review	G	↗	Domain 5: A Skilled & Digitally Enabled Workforce	RAG Status	Progress Indicator
Microsoft Licence Review	G	↗	Intranet Development	P	→
Cyber Security & Threat Monitoring	G	↗	Social Media Access for Staff	G	↗
Telephony Services Review	P	→	Succession & Workforce Planning (IM&T Staff)	G	↗
Domain 2: Integrated Electronic Care Record System	RAG Status	Progress Indicator	Development of Staff Training (IT/Digital Skills)	G	→
Physical Health Services Clinical Record Systems	G	↗	Domain 6: Engaging and Learning from Digital Best Practice	RAG Status	Progress Indicator
Mental Health Services Clinical Record System	A	↗	Digital Strategy Group	G	↗
Clinical Portal Development	G	↗	Domain 7: Championing Digital Inclusion for People Accessing our Services	RAG Status	Progress Indicator
eCorrespondence	G	↗	Patient Reminder System	G	↗
Domain 3: Digitisation & Information Sharing with Partners	RAG Status	Progress Indicator	Reporting Health Outcomes	P	↗
ICS Digital Work Streams	G	↗	Service User (Patient) Portal Development	P	→
Records Management	G	↗	Domain 8: Embedding Digital in our Culture	RAG Status	Progress Indicator
Paper Digitisation	G	↗	Apps for Service Users and Carers	G	↗
Multi-Function Device (MFD) Re-procurement	A	↗	i-Hub Digital Challenge	G	↗
eConsultation	P	→			

Key

	Completed		On track		Off track but in control
	Off track requires attention		Planned for the future		Improving position
	No progress		Deteriorating position		
	Completed activities		Ongoing activities		

Financial Investment

In order to meet the priorities outlined in this report, a capital allocation of £2.445m has been made available during 2019/20. The table below provides a summary of the year to date position against the capital allocation and associated expenditure against the IM&T schemes as at 30 September 2019.

Scheme		19/20 (£k)		
		Allocation	Expenditure/ Committed	Variance
IT Infrastructure	Data Centre/Disaster Recovery	400	400	0
	Infrastructure/WAN	250	250	0
	Server Hardware Refresh	150	150	0
	Network Switch Upgrades	300	300	0
	Cyber Security	200	200	0
	Email Upgrade	25	25	0
	WiFi (Corporate) Refresh	100	100	0
	IT Infrastructure Sub Total	1,425	1,425	0
Clinical Systems Development	Mental Health Clinical Records System	0	0	0
	Integration & Portals (Inc Interoperability)	100	10	(90)
	Electronic Prescribing & Medicines Administration	165	0	(165)
	Clinical Systems Development Sub Total	265	10	(255)
Business Intelligence	Business Intelligence, Data Warehousing and Reporting*	55	0	(55)
	Business Intelligence Sub Total	55	0	(55)
Corporate Development	Finance Ledger System	300	0	(300)
	Multifunction Device Contract Replacement	50	0	(50)
	Corporate Development Sub Total	350	0	(350)
Digital Innovation	Paper Digitisation (Paperlight/Paperless NHS)***	250	200	(50)
	Digital Innovation Opportunities (Digital Strategy Group)	100	52	(48)
	Digital Innovation Sub Total	350	252	(98)
Overall Capital Total		2,445	1,687	(758)

Due to national correspondence relating to reducing the total NHS capital programme, the 2019/20 schemes were profiled in two phases during the year. The schemes that are indicating a variance in terms of underspend to date remain work in progress. The electronic prescribing & medicines administration and paper digitisation schemes are awaiting confirmation of external funding being released to support these initiatives during 2019/20.

ONGOING MILESTONES FOR 2019/20 & BEYOND (September 2019 position):

Domain 1: Fit for Purpose IM&T Infrastructure	<i>Supports Digital Strategy Aims</i> 1. To enhance quality of care and patient safety 4. To develop an effective and digitally empowered workforce 5. To maximise efficiency and sustainability
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		Infrastructure Modernisation Programme Phase 3: Data Centre Improvements (Year 3 of 3)		
Summary update			Milestone	Achieved
<p>Purpose: This is a 3-year programme of work that focuses on the review and modernisation of the Trust's core IT infrastructure and the two existing data centre's located at Fieldhead and Kendray. The purpose is to provide a strategic, robust and secure IT environment, removing single points of failure, which therefore provides the Trust with the necessary assurances, business resilience and disaster recovery capabilities to support the digital future. The business case for this programme was approved in July 2017.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ Year 2 (2018/19) review: An end of period review report covering 1 April 2018 to 31 March 2019 provided a summary position of what progress had been made during year 2 of this 3 year programme and what this work has achieved/delivered in line with the business case previously approved. Key improvements to note are: - <ul style="list-style-type: none"> ▪ Replacement of end of life approaching core Kendray LAN (Local Area Network) and removal of single point of failures. ▪ Replacement of the Fieldhead and Kendray N3 to HSCN firewalls which increased the bandwidth for general internet based systems including clinical systems. ▪ Network enhancements that support the ability to failover from Fieldhead to Kendray data centre 			May 2019	July 2019

<ul style="list-style-type: none"> No requirement for major short term investment in event of a disaster. Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs). Proven disaster recovery position with confirmed recovery points and associated timelines. Enhanced cyber security position would bring about improved resilience and greatly reduce the risk from cyber-attack, malicious or otherwise. 		
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Status	Direction	Health & Social Care Network (HSCN) Implementation (N3 Replacement)		
				
<i>Summary update</i>		<i>Milestone</i>	<i>Achieved</i>	
<p>Purpose: Focuses on the replacement of the existing N3 (NHS-wide national network) with the new Health & Social Care Network (HSCN).</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ HSCN connectivity options appraisal: The Trust IT Service has evaluated the options and associated costs for HSCN connectivity to replace existing N3 wide area network (WAN) connections. Pricing schedules were reviewed and the contract awarded to Virgin Media, the existing provider. <ul style="list-style-type: none"> ▪ That the Trust replaces N3 with dedicated HSCN links at the six larger hub sites only which served to reduce down annual revenue costs by 62% to £34k during the term of the 3 year contract based on existing costs. ▪ That the Trust awards the contract and re-signs with Virgin Media Business for provision of YHPSN/WAN services. This option provided the most efficient and cost effective option and offers minimal disruption to Trust business operations, potentially generating recurrent revenue saving of £67k. ▪ That a small proportion (£7k) of the annual YHPSN/WAN service revenue savings identified above are to be re-invested back into the Trust network to upgrade some of the current legacy connections, addressing historic bandwidth restrictions and improving resiliency. ✓ Replacement of Point of Presence (POP) network connections: The planned migration of the wide area network (point of presence) connections at Kendray Hospital, Laura Mitchell and Airedale Health Centre sites to new HSCN connections have been completed ahead of the respective closure 		May 2019	Jun 2019	
		Jul 2019	Jul 2019	

<p>dates.</p> <p>➤ Implementation of HSCN circuits to replace N3: The replacement of N3 and implementation of HSCN circuits is anticipated to take approximately 2 years to complete commencing during quarter 2 2019/20.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Continuity of wide area network (WAN) connections that essentially provide inter-connectivity between Trust sites and the wider NHS/Social Care infrastructure. • Improved resilience of core IT infrastructure. 	<p>2019/20 & 2020/21</p>	
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<i>Status</i> 	<i>Direction</i> 	Migration to Microsoft Windows 10	
Summary update		Milestone	Achieved
<p>Purpose: A programme of work was initiated during 2018/19 to commence the upgrade/migration of the Trust's end user computing estate (desktops and laptops) from the existing Microsoft Windows 7 platform to Microsoft Windows 10 operating system ahead of the 14 January 2020 deadline. The approach taken is also aligned with the IT Services coordinated end user computing replacement programme across the Trust in support of this focused work.</p> <p>Key activities:</p> <p>➤ The deployment of Windows 10 focuses on the replacement of existing old desktops/laptops that are not capable of running the Windows 10 operating system as part of the centralised end user computing replacement programme and the aim is to complete this replacement programme by 31 March 2020.</p> <ul style="list-style-type: none"> ▪ Up to September 2019, this has been conducted as a 'business as usual' operational activity so that additional project/professional service Daisy costs are not incurred and to date approximately 1,000 machines have been migrated from Windows 7 to Windows 10 via this means. ▪ The Trust's IT Service and Daisy have developed an approach to automate the migration to 		<p>Mar 2020</p>	

Windows 10 with the aim being to have completed the Windows 10 rollout before the end of March 2020

- As part of this approach there will be a requirement for Daisy to conduct a manual mop-up exercise for devices that cannot be upgraded automatically.
- The cost for completing this work and replacing all remaining old desktops/laptops that are incompatible with Windows 10 during 2019/20 has been determined and outlines further investment of circa £350k. The Trust's IT Service constantly monitors the compatibility position of the existing desktop/laptop estate which is determined by the manufacturer as new Microsoft releases are issued.
- This NHS Digital annual review point will determine which organisations continue to be part of the national agreement with Microsoft. Any organisation that has licences revoked will also cease to qualify for the free extended support for Windows 7, since this free extended support is only available by being part of the NHS national agreement. Therefore by potentially delaying Windows 10 local organisations will not only risk losing the free Windows 10 licences but will also need to pay for their own extended support for their Windows 7 estate.
- The cost of replacing free national licences and purchasing extended support is currently £205 per user (Inc. VAT), so for an organisation of 5,000 devices this would be in the region of £1m. Providing the Trust continues with its plan and delivers the migration to Windows 10, this risk would be mitigated.

Expected outcomes:

- Enables the Trust to provision new and replacement end user computing devices in a strategic and planned manner, making better use of available resources.
- Centralised control of all end user computing assets, therefore optimising use across the Trust.
- Improves end user experience.
- Provides greater assurance and controls from which to minimise the risk of cyber threats through continuous availability to software security updates.

Status 	Direction 	Email Platform Review	
Summary update		Milestone	Achieved
<p>Purpose: To conduct a review of the options open to the Trust for the future provision of its corporate email platform (NHS Mail v Microsoft Exchange/Outlook) so as to inform the development of a business case for consideration and approval</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ An options appraisal has been conducted to inform the Trust's future strategic corporate email platform, evaluating Microsoft Office 2019, NHSmail and Microsoft Office365. ➤ The business case incorporating the above options appraisal of future strategic corporate email platforms has been produced and was presented to EMT in September 2019. It was originally planned to align this with the future Microsoft software licence requirements for the Trust due to co-dependencies, however, from the significant work undertaken, it was determined that this would be considered separately. Therefore, a separate business case for the future Microsoft licence requirements is being produced. <p>EMT has approved the recommendation that that the Trust selects Microsoft Office 365 hosted in the cloud (by Microsoft) as the preferred option. .</p> <ul style="list-style-type: none"> ➤ Detailed plans and implementation activities are being completed, to commence and complete the necessary work during 2019/20 and ahead of the 14 January 2020 deadline (when Microsoft Exchange 2010 goes out of support). <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources. • Potential for wider STP region standardisation of email platforms and closer partnership/collaborative working opportunities. 		<p>May 2019</p> <p>Aug 2019</p> <p>Dec 2019</p>	<p>Jun 2019</p> <p>Sep 2019</p>

<p>Digital having recently indicated that they will seek to negotiate a discount position, rather than a fully funded proposition as they do for Microsoft Windows 10. It is expected that an update will be released by NHS Digital towards the end of 2019.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Supports the infrastructure modernisation programme which will add resilience, improve performance for end-users, and build in contingency in the event of network failure. • The new NHS-wide agreement for Windows 10 software licences that was established in 2018/19 by NHS Digital reduced the Trust direct annual costs associated with Microsoft licence arrangements. 		
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Status	Direction	Cyber Security & Threat Monitoring		
				
Summary update		Milestone	Achieved	
<p>Purpose: The potential threat of cyber-attack is on the increase as witnessed by the WannaCry incident in May 2017 where a number of public sector/NHS organisations' business operations were impacted. The Trust continues to take such threats extremely seriously and has established a number of steps to safeguard against the likelihood of such threats.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ NHS IT Health Check: The Trust undertook a service offered by NHS Digital that was performed by Dionach in January 2019 that conducted an on-site assessment of the Trust's cyber controls. ▪ Password policy: Following a cyber-audit of the Trust's infrastructure a potential area of improvement was identified within SWYPFT's password policy. The subsequent required changes have now been fully enforced across all accounts. (EMT approved this change in May 2019) ▪ Health check report: The report included a total of 34 recommendations, of which only 1 medium recommendation item now remains outstanding. This relates to the patching of third party applications, where the IT Service and Daisy are engaged with a number of vendors to develop a 		Sep 2019	Sep 2019	

<p>proposal for the patching of these applications to enable closure. It is anticipated that this will require a business case outlining the need for the Trust to invest in additional solution(s) to support the patching of these 3rd party applications or to determine if the potential risk associated is acceptable for the Trust to carry.</p>		
<ul style="list-style-type: none"> ✓ Penetration testing: The Trust undertakes an independent regular infrastructure, server and client penetration (PEN) test, outside of the Daisy contract, with the purpose being to ensure and provide further assurances that the services being provided by Daisy are being proactively managed. 	<p>Sep 2019</p>	<p>Sep 2019</p>
<ul style="list-style-type: none"> ✓ Strategic cyber roadmap: The Trust has arranged a workshop with NHS Digital and the Trust's IT Services provider Daisy to review and assess wider strategic roadmap and plans for cyber security to aid Trust prioritisation activities. 	<p>Sep 2019</p>	<p>Sep 2019</p>
<ul style="list-style-type: none"> ➤ Cyber security survey: Conduct an annual cyber security survey to further gauge staff awareness and understanding and identify if this is improving. This has been revised from May to November 2019. 	<p>Nov 2019</p>	
<ul style="list-style-type: none"> ➤ Cyber essentials: The findings and recommendations from the review conducted during 2017/18 continue to inform strategic IT infrastructure roadmap planning and prioritisation of the detailed IT programme of works during 2019/20. This incorporates additional cyber capabilities through enhanced threat protection and detection which provides more proactive technologies and safeguards. A challenge in the capital available in 2019/20 and future years may mean the Cyber Essentials certification takes longer to attain. 	<p>Ongoing</p>	
<ul style="list-style-type: none"> ➤ Simulated phishing exercise: The Trust has registered an expression of interest to participate in conducting a simulated phishing training tool developed by NHS Digital. 	<p>Awaiting timescale</p>	
<ul style="list-style-type: none"> ➤ Cyber table top exercise: Following a recommendation from the cyber security audit conducted during 18/19, it is planned to conduct another annual table top exercise to ensure that processes, roles and responsibilities are clear in support of mobilising against a cyber-attack. 	<p>Jan 2020</p>	
<ul style="list-style-type: none"> ➤ Cyber threat monitoring: The monitoring against the potential threat of a cyber-attack continues to be an integral item of business for monthly service performance and review meetings with Daisy IT services. The Trust routinely reviews the actions taken or required to be taken to mitigate and 	<p>Ongoing</p>	

<p>establish safeguards against the threat of cyber-attacks. NHS Digital has confirmed that they have a number of initiatives ongoing that will deliver support in this area from Q3 2019/20 onwards which the Trust will consider.</p> <p>➤ Staff awareness: Staff vigilance remains an integral defence, regular communications are issued to staff and staff are advised to raise any questions or concerns with the IT service desk in the first instance at the earliest opportunity.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> Continued vigilance and awareness of the threat of cyber-attack. Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats Adoption of industry standard best practices, as appropriate. Improve the defences against a cyber-attack 	Ongoing	
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<i>Status</i> 	<i>Direction</i> 	Telephony Services Review	
<i>Summary update</i>		<i>Milestone</i>	<i>Achieved</i>
<p>Purpose: To conduct a review of the options and to explore the potential to consolidate both desk and mobile telephony contracts and to integrate service provision.</p> <p>Key activities:</p> <p>➤ Conduct an options appraisal for the future provision of both desk and mobile telephony services. The outcomes to inform a proposal/business case during Q3 2019/20.</p> <p>➤ Detailed implementation/transition plans and activities to be established following Trust approval of the proposed recommendations detailed within the business case.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources. Potential wider ICS standardisation of platforms and closer collaborative working opportunities. 		<p>Oct 2019</p> <p>TBD</p>	

Domain 2: Integrated Electronic Care Record System	Supports Digital Strategy Aims 1. To enhance quality of care and patient safety 3. To foster integration, partnership and working together 5. To maximise efficiency and sustainability 6. To support people and communities
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Status	Direction	Physical Health Services Clinical Records System (SystmOne)			
		Summary update		Milestone	Achieved
<p>Purpose: Development of SystmOne to support physical health community services development priorities, service re-design and new models of care agendas.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ Paediatric audiology: This Barnsley therapy service achieved SystmOne go live on 5 August 2019 as planned. ➤ Neuro-physiotherapy (Barnsley): Work commenced at the start of July 2019 and following a standard deployment timeline, this service is now scheduled to go live in October 2019. ➤ Neighbourhood teams (Barnsley) service re-design: A major programme of work has commenced in support of service re-design and enhancements to support new models of care for integrated neighbourhood teams in collaboration with partners, incorporating newly forming primary care networks. Two task and finish groups for Estates/IT and Performance & Information/Systems/IG/Records are being established to support the detailed planning activities for mobilisation. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. 		<p>Aug 2019</p> <p>Oct 2019</p> <p>May 2020</p>	<p>Aug 2019</p>		

<ul style="list-style-type: none"> To support the development of new integrated models of care. To ensure that all community services are fully optimised in their usage of SystemOne. 		
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Status	Direction	Mental Health Services Clinical Record System (CRS) (SystemOne)		
				
Summary update		Milestone	Achieved	
<p>Purpose: Following the successful implementation of the new mental health CRS (SystemOne) that replaced RiO we are moving to Phase 2 of the process, that of optimisation, to ensure SystemOne gives the Trust the opportunity to improve how we work now and in the future. The process will continue use the Trusts change approach of ‘co-design’, co-create’ and ‘co-deliver’ to deliver these improvements.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ Data catch-up: Work to catch up on the inputting of all activity conducted during the cut-over period between staff stopping inputting into RiO and starting to use SystemOne has been fully completed within planned timescales. ✓ RiO decommissioning: The work to decommission the RiO clinical information system has been completed. ➤ Care plans: The Trust has been actively working with TPP (SystemOne supplier) to make some changes to mental health act functionality and medics care plan. The medics care plan is currently undergoing testing by the Trust prior to deployment into the live system. This has been delayed slightly due to ongoing testing within Forensics and it is planned to be deployed in the live system in Forensics from 14 October 2019. ➤ Optimisation: A high-level optimisation approach paper was approved by EMT on 20 June 2019. Detailed planning activities are progressing and a series of workshops held to engage/consult on areas for consideration and prioritization, together with input from the established service improvement groups, which will inform the detailed optimisation plan and programme of works. The optimisation plan is undergoing review in light of progress made to date, significant service-redesign requirements in response to the Barnsley Integrated Care Community specification published in 		May 2019	May 2019	
		Jul 2019	Jul 2019	
		Oct 2019		
		May 2020		

<p>September 2019 and associated risks for overall programme delivery in successful of the Trusts objectives</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> • SystemOne will be used as consistently and as effectively as possible. • Processes and workflows will be developed that help staff and improve outcomes for our service users. • Improved service user care through more timely receipt and management of referral to services via electronic capabilities. • Support for development of new integrated models of care. • Contribute to the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs, further demonstrating our commitment in meeting commissioner intentions. 		
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<i>Status</i> 	<i>Direction</i> 	Clinical Portal Development (PORTIA)		
<i>Summary update</i>		<i>Milestone</i>	<i>Achieved</i>	
<p>Purpose: Enables the Trust to bring together information from different clinical information systems into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ PORTIA roll-out: The focus during 2019/20 remains on continuing the rollout of the Trust clinical portal (PORTIA) and promotion of its usage. ➤ PORTIA usage: To date approximately 20,500 patient record searches have been conducted. ➤ PORTIA development: Restart Consulting, the solution supplier and developer for PORTIA are re-designing the end user interface which improves the information displayed within the portal solution. A demonstration was provided to the Digital Strategy Group on 8 July 2019 which was well-received. It is planned to conduct further discussions on the front-end re-design with PORTIA users as part of 		<p>Ongoing</p> <p>Ongoing</p> <p>Mar 2020</p>		

<p>this solution upgrade.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Provision of a single integrated holistic patient record view. • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. 		
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<i>Status</i>	<i>Direction</i>	eCorrespondence	
			
Summary update		Milestone	Achieved
<p>Purpose: Enables the Trust to reduce the reliance and flow of paper both internally and with our partners in respect of delivering patient care. This also supports the digitisation agenda and the drive towards a paperlight/paperless NHS by 2020.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ eDischarge summaries: Changes have been made to the inpatient discharge summary letter following the implementation of SystmOne to replace RiO and usage is under review. ➤ eDischarge volumetrics: Over 2,215 eDischarge messages have been successfully sent to and received by GP practices to date as at the end of August 2019. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Supports the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of STPs. • Potential to improve ongoing client care through the provision of discharge information to GPs in a much improved timeframe. • Ability to send discharge letters etc. electronically rather than traditional printing/posting channels. 		<p>Apr 2019</p> <p>Ongoing</p>	<p>Apr 2019</p>

Domain 3: Digitisation & Information Sharing with our Partners

Supports Digital Strategy Aims

1. To enhance quality of care and patient safety
2. To enable prevention, wellbeing and recovery
3. To foster integration, partnership and working together
4. To develop an effective and digitally empowered workforce
5. To maximise efficiency and sustainability
6. To support people and communities

Status	Direction	Integrated Care System (ICS) Digital Work Streams		
				
Summary update		Milestone	Achieved	
<p>Purpose: Across the ICS regions (West Yorkshire & Harrogate and South Yorkshire & Bassetlaw) in which SWYPFT is a key stakeholder, work has been progressing on a variety of digital interventions through the work of place-based initiatives in support of wider digital maturity.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ WY&H and SY&B ICSs: Trust continues to participate in a number of external groups/forums in support of the ICS digital work stream initiatives in collaboration with health and social care partners. ➤ LHCRE: The Trust is engaged in the developments to support the local health and care integrated records exemplar (LHCRE) initiative and has representation on the Yorkshire & Humber Care Record Delivery Board. ➤ Kirklees digital transformation board: The digital transformation board is focusing on identifying key themes and potential priority areas for collaborative working in support of the emerging digital agenda across Kirklees, which SWYPFT is actively participating in. ➤ Barnsley shared care record: A business case is being created to consider the potential for the development of a Barnsley ‘place’ shared care record solution across all partners. The Barnsley IT Strategy Group led by the CCG is overseeing this work and reports into the Barnsley Integrated Care 		Ongoing		
		Ongoing		
		Ongoing		
		Ongoing		

<p>Partnership Group. From a SWYPFT perspective, it is expected that this solution will dovetail and integrate with the Trust's existing clinical portal PORTIA.</p> <p>➤ ePrescribing/EPMA: The Trust submitted a bid for external funding to support the implementation of ePrescribing and electronic prescription management administration (EPMA). The outcome from the bid is awaited.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> • The vision will lead to an integrated digital infrastructure across ICS regions, making more effective use of the technical expertise available and allowing our collective digital capabilities to develop in parallel with technological advancement. • Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Local systems will support digital pilots and wider delivery and the scaling up of successful interventions will be coordinated by digital work streams and the supporting key interventions. 	TBD	
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<i>Status</i> 	<i>Direction</i> 	Records Management (Scanning – Archive/Paper Records)	
Summary update		<i>Milestone</i>	<i>Achieved</i>
<p>Purpose: Continue to develop the onsite scanning bureau and work towards meeting the 2020 paper free target.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ The scanning bureau has transferred 'in-flight' Calderdale & Kirklees paper light work to the paper digitisation project team to enable focus on reducing offsite storage costs through destruction of records past retention date, with ad-hoc retrieval of records not being returned to offsite storage. ✓ The development of some Key Performance Indicators (KPIs) has been completed that can be used to monitor and track performance and progress against reducing paper records and off-site storage costs. The defined KPIs are summarised below. <ul style="list-style-type: none"> ▪ Staff productivity is broken down in to records prepared, scanned and quality assured per 		<p style="text-align: center;">May 2019</p> <p style="text-align: center;">Jun 2019</p>	<p style="text-align: center;">May 2019</p> <p style="text-align: center;">Jun 2019</p>

<p>member of staff per month</p> <ul style="list-style-type: none"> ▪ Records & pages are broken down daily, monthly & per service. <p>➤ Subject access requests (SARs) volumes continue to be high and Trust wide 76% of requests were responded to within the required timescales. A revised process has been implemented to improve this position and work is ongoing operationally to enhance procedures further.</p> <p>➤ The clinical coders continue to meet their 100% target for finished consultant episodes within 6 weeks of discharge or transfer. However, the transition to SystemOne is impacting the ability to code all episodes within the six-week target and this is being investigated further with TPP.</p> <p>➤ The scanning bureau is maintaining its average of scanning approximately 1,250 records every month, which includes performing quality assurance checks on every sheet. As at the end of August 2019, over 32,000 paper records which equates to over 5.7m pages have been scanned since the programme of work commenced in April 2017</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Reduced reliance on off-site storage (avoidance of increased costs). • Improved governance through having easy, electronic access to all records related to a Trust client, supporting the digitisation and paperless NHS agendas. 	<p>Mar 2020</p> <p>Ongoing</p> <p>Ongoing</p>	
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<p>Status</p> 	<p>Direction</p> 	<p>Paper Digitisation (Paperlight/Paperless NHS)</p>	
<p>Summary update</p>		<p>Milestone</p>	<p>Achieved</p>
<p>Purpose: Paperlight forms part of the wider care record digitisation agenda and aims for all clinical services (predominantly those services that currently use SystemOne as their main clinical information system) to work towards achieving paperlight accreditation.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ Paper digitisation project team: The paper digitisation project team recruitment activities have been completed. 		<p>May 2019</p>	<p>Apr 2019</p>

✓ **Paperlight accreditation:** The accreditation documentation has been revised and approved by the Improving Clinical Information Group (ICIG).

➤ **BDU Paper digitisation areas for prioritisation:** The project team met with BDU representatives to discuss BDU requirements, priority service areas for each BDU and to outline the approach and scope. The team have commenced activities with the follow service areas: -

Initial Stages	Working with	Completed workshops
Child Health, Barnsley	IAPT Barnsley	SPA Barnsley
ECT	Pharmacy, Wakefield	
Stroke Rehabilitation, Barnsley	SPA Wakefield	
Neuro Rehabilitation, Barnsley	Older Peoples Mental Health, Barnsley	

➤ **Facsimile machines:** This project is also focusing on the decommissioning of facsimile 'fax' machines in line with the national requirement and the team are working with services to consider alternative means of communication as appropriate.

Fax machines removed	Fax machines removal In progress	Total number of faxes remaining
10	4	40

Expected outcomes:

- Reduce/remove the creation of paper records/case files for new service users.
- Reduce/remove the usage/reliance on fax machines in use across the Trust in line with the national directive for decommissioning of fax machines by 31 March 2020
- Reduce the demand for paper records storage and space in the future.
- Support the Trust's drive towards achieving paperless services by 2020 as part of the wider national paperless agenda.

Jul 2019

Jul 2019

Ongoing

Mar 2020

Status	Direction	Multi-Function Device (MFD) Re-procurement		
				
Summary update		Milestone	Achieved	
<p>Purpose: To undertake a re-procurement exercise in respect of the Trust's multi-function device fully managed service provided by Xerox. This provides an opportunity to review the Trust's current and future requirements and to explore the prospects of securing service efficiencies, cost savings and improving the existing quality of service.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ✓ A revised specification of requirements to account for Trust operations and business needs together with compliancy for records scanning standards has been completed. ➤ The formal procurement exercise commenced towards the end of September/start of October 2019 ➤ Implementation of the preferred solution is currently planned to be completed by 1 April 2020 but this remains subject to the outcome of the procurement exercise. ➤ <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Improve the patient experience. • Improve access to services, engaging information users and further supporting the digitisation agendas in line with wider ICS/STP digital aspirations. 		<p>Aug 2019</p> <p>Dec 2019</p> <p>Mar 2020</p>	<p>Aug 2019</p>	

Status	Direction	eConsultation		
				
Summary update		Milestone	Achieved	
<p>Purpose: eConsultations are electronic means of establishing consultative communications between</p>				

<p>clinician-to-clinician at a provider-to-provider level or in collaboration with patients/service users/carers via an electronic health record (EHR) or web-based platform. eConsultations offer the potential to improve access to specialty expertise for patients and providers without the need for a face-to-face visit.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ The Trust's skype platform technical partner (Modality) is scheduled to attend the next meeting of the Digital Strategy Group in October to present/demonstrate wider capability and inform possible opportunities for use of skype in support of eConsultation and virtual clinics. The outcome of which is hoped will enable the Trust to conduct a pilot project to inform suitability of this technology and to assess the overall clinical fitness for purpose for scalability and wider rollout opportunities. A proposal has been put forward for Mental Health Perinatal Services as a pilot area. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Improve the patient experience. • Improve access to services, engaging information users and further supporting the digitisation agendas in line with wider ICS/STP digital aspirations. 	<p>Mar 2020</p>	
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<p>Domain 4: Business Intelligence Systems</p>	<p><i>Supports Digital Strategy Aims</i></p> <p>3. To foster integration, partnership and working together</p> <p>5. To maximise efficiency and sustainability</p>
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<p><i>Status</i></p> <div style="text-align: center; border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; background-color: green; color: white; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> G </div>	<p><i>Direction</i></p> <div style="text-align: center; border: 1px solid black; width: 40px; height: 40px; background-color: gray; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> ↗ </div>	<p>Business Intelligence/Data Warehouse (information hub & dashboards)</p>	
<p>Summary update</p>		<p><i>Milestone</i></p>	<p><i>Achieved</i></p>
<p>Purpose: The development of a business intelligence/data warehouse that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service improvements and delivery.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ Development of internal benchmarking dashboard to support understanding of productivity and 		<p>Oct 2019</p>	

<p>variation within the organisation. Development underway with initial publication planned for October 2019.</p> <p>Expected outcomes:</p> <ul style="list-style-type: none"> Continue to improve and make available the use of real time information to support operational services and transformation agendas. 		
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<i>Status</i>	<i>Direction</i>	Information Governance		
				
Summary update		Milestone	Achieved	
<p>Purpose: To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ General Data Protection Regulations (GDPR): Monitoring audits will be conducted during 2019/20 and appropriate action will be taken as and when new GDPR guidance is available. ➤ Information Governance training: Ensure that the mandated annual information governance training update is maintained and that classroom based IG training continues to be rolled out for staff groups who do not have ready access to a computer. ➤ Data Protection & Security Toolkit (IG Toolkit): Gather evidence and ensure compliance against the 2019/20 toolkit. <p>Expected outcomes:</p> <ul style="list-style-type: none"> Mandatory IG training target is achieved. The Data Protection & Security toolkit target of meeting all mandatory standards is maintained. Ongoing compliance with GDPR is assured and processes established which are reviewed regularly. 		<p>Ongoing</p> <p>Ongoing</p> <p>Mar 2020</p>		

Status 	Direction 	National Data Opt-Out Programme		
Summary update			Milestone	Achieved
<p>Purpose: The national data opt-out programme is a new service that allows individuals to opt out of their confidential patient data being used for research and planning. NHS Digital has been implementing this since May 2018 but all other organisations that use health and care information must fully comply with this by March 2020.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ Trust plans remain in early stages of development to support this and a new assertion has been added into this year's Data Security & Protection Toolkit (DSPT) to evidence compliance. The first actions will be to check the current state of readiness and as part of the work towards the DSPT compliance and GDPR audit review, an evaluation of the Trust's data flow maps will be conducted and will include a new check for application of the national data opt-out requirements, and where applicable, will determine what changes to systems, processes, staff training and the Trust's privacy information are required. ➤ NHS Digital's Information Standards Notice (ISN) and associated documentation is currently under review to inform Trust plans and to understand further what activities needs to happen. Consultation with relevant managers and a draft implementation plan will be produced for approval by the Caldicott Guardian and SIRO at the November 2019 ICIG meeting. ➤ Once approved, it is aimed that the plan will be implemented by the end of January 2020, with subsequent checks performed to ensure that the Trust has appropriate evidence for the final DSPT submission in March 2020. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Preparedness for the national data opt-out is assured and processes established to ensure compliance within prescribed timescales. 			<p>Ongoing</p> <p>Nov 2019</p> <p>Jan 2020</p>	

Domain 5: A Skilled & Digitally Enabled Workforce

Supports Digital Strategy Aims

4. To develop an effective and digitally empowered workforce

Status	Direction	Intranet Development		
				
Summary update		Milestone	Achieved	
<p>Purpose: To ensure that the Trust corporate intranet is developed, maintained and services/information is accessible across the workforce. This is being led by the marketing, communications & engagement team.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ Define and scope out requirements for the re-design/re-development of the Trust intranet to inform the production of a business case for Trust approval. ➤ Conclude procurement activities, subject to Trust approval, for the re-provisioning of the Trust intranet based on the agreed requirements. ➤ Implementation of proposed solution and for replacement to be live during Q1-Q2 2020/21. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • To improve access to corporate systems and information in a timely and responsive manner. 		<p>Nov 2019</p> <p>Mar 2020</p> <p>Q1-Q2 2020/21</p>		

Status	Direction	Social Media Access for Staff		
				
Summary update		Milestone	Achieved	
<p>Purpose: To enable more staff to access information online and join online networks/discussions forums.</p>				

<p>Key activities:</p> <ul style="list-style-type: none"> ✓ MY SWYPFT: Staff app launched. ➤ Social media guidance updates: Collaborate with staff side, IT HR and IG for comments. ➤ Social media savvy guides: Bitesized do's and don'ts guides for staff, working with staff side to review content. ➤ Social media drop-ins: Open workshops for troubleshooting, suggestions, hints and tips. A Twitter guide has been developed and is to be reviewed this with staff side ahead of the workshops/drop-ins that are to take place in December. ➤ Social media webinars: Themed webinars on how to get the most out of corporate webinars – using skype for business. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Improve staff access to social media to enhance digital capabilities. 	<p>Jun 2019</p> <p>TBD</p> <p>TBD</p> <p>Dec 2019</p> <p>Mar 2020</p>	<p>Jun 2019</p>
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<i>Status</i>	<i>Direction</i>	Succession & Workforce Planning (IM&T Staff)	
			
Summary update		<i>Milestone</i>	<i>Achieved</i>
<p>Purpose: To ensure that the IM&T Service has a suitability skilled workforce, including the required skills-mix balance and the requisite resources from which to deliver effective and efficient services to the organisation. This includes meeting both current and future needs of the organisation and will establish foundations for a robust succession plan which informs and supports wider staff development opportunities.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ A programme of work to aid continuous development and service improvements is being initiated from the timeout workshop outcomes and key themes identified. This is supported by Learning & Development. An internal steering group to consider service improvement opportunities has been 		Ongoing	

<p>established to drive this agenda forward with activities based on outputs from the time-out sessions held during October 2018 and the staff survey findings.</p> <ul style="list-style-type: none"> ➤ A workforce plan has been drafted in support of annual planning activities and this will also incorporate the develop succession plans. ➤ Working with Learning & Development to consider opportunities for wider eLearning training provision in line with staff appraisal development needs. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Improve staff retention. • Improve access and availability of training and development opportunities in support of identified needs. • Improves service resilience and delivery. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities. 	<p>Ongoing</p> <p>Q3-Q4 2019</p>	
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<i>Status</i> 	<i>Direction</i> 	Development of Staff Training (IT & Digital Skills)	
<i>Summary update</i>		<i>Milestone</i>	<i>Achieved</i>
<p>Purpose: To explore opportunities from which to support staff development (capacity/capability) in the use of IT/digital technologies and solutions in the workplace. Individual need will be based on employee capability on using new systems as well as general IT/digital skills in using applications such as Microsoft Office etc.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ IT trainers remain fully focused on SystmOne currently. In the absence of another internal IT training offer at present, IT skills development requests are being actively managed via the Trust study leave procedure and accessing alternative training routes available via Learning & Development. The future migration to Office 365 will be the catalyst for readying the broadening of the service offer. ➤ Calderdale College is looking to including digital in their existing curriculum for students entering the 		<p>Ongoing</p> <p>Ongoing</p>	

<p>health & care sector. Potential to explore opportunities to tailor their external offer to NHS providers in developing education packages in the same area for existing staff, which might align with the wider digitisation agendas.</p> <ul style="list-style-type: none"> ➤ The Digital Strategy Group will help support the development of a wider digital culture and digital champions within the workforce. ➤ The potential use of Skype for Business is under consideration in support of delivering mandatory training. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Improve staff retention. • Improve access and availability of training and development opportunities in support of identified needs. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities. 	<p>Ongoing</p> <p>Mar 2020</p>	
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<p>Domain 6: Engaging and Learning from Digital Best Practice</p>	<p><i>Supports Digital Strategy Aims:</i></p> <ol style="list-style-type: none"> 1. To enhance quality of care and patient safety 2. To enable prevention, wellbeing and recovery 3. To foster integration, partnership and working together 4. To develop an effective and digitally empowered workforce 5. To maximise efficiency and sustainability 6. To support people and communities
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<p>Status</p> 	<p>Direction</p> 	<p>Digital Strategy Group</p>	
<p>Summary update</p>		<p>Milestone</p>	<p>Achieved</p>
<p>Purpose: A Trust-wide group has been established to oversee and co-ordinate the initiatives and programmes of work included in the Trust's Digital Strategy. Focus will be on exploring new and emerging</p>			

<p>digital opportunities and solutions from which to bring about further digital evolution across the organisation and its constituent services, with a focus on clinical application and utilisation. This will also consider wider collaborative opportunities that will aid closer working across a variety of sectors including digital technology solution providers and partners and will act as a conduit for expansive Integrated Care System alignment.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ The Digital Strategy Group has enabled/approved the following initiatives to date <ul style="list-style-type: none"> ▪ Wider deployment opportunities for the use of the Orcha platform following approval in April 2019 ▪ Approval in July 2019 of a project proposal for the development of e-voucher scheme within the Quit Manager system that provides an opportunity to reduce operational costs. ▪ Exploration of an eConsultation solution by Modality (Trust Skype for Business technical partner) which is being reviewed further for consideration of a pilot project within the mental health perinatal service. The group supported this opportunity in principle at this stage, subject to further detail within the proposal being provided. ➤ Establishment of a Trust digital innovation register that contains potential digital solution providers and applicability to Trust services. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • To develop and maintain a register of digital innovation opportunities to support external bids for funding streams and also internal annual planning prioritisation. • To oversee and drive an effective digitisation of the Trust workforce plan and training programmes. • To demonstrate and evidence improvements through effective benefits identification, measurement, management and realisation. Accounting for return on investment in both financial and qualitative terms from approved pilot projects. • To explore wider learning opportunities, approaches and experiences externally. • To approve and advise on policies and standard operating procedures as required. 	<p>Mar 2020 Dec 2019</p> <p>Mar 2020</p> <p>Nov 2019</p>	
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Domain 7: Championing Digital Inclusion for People Accessing our Services

Supports Digital Strategy Aims:

1. To enhance quality of care and patient safety
2. To enable prevention, wellbeing and recovery
3. To foster integration, partnership and working together
4. To develop an effective and digitally empowered workforce
5. To maximise efficiency and sustainability
6. To support people and communities

Status	Direction	Patient Reminder System		
				
Summary update		Milestone	Achieved	
<p>Purpose: We have a patient appointment reminder system in operation which aims to reduce “did not attend” (DNA) levels across the Trust services.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ Due to the transition from RiO to SystemOne the appointment reminder service was temporarily suspended to allow clinicians to start using HCP/clinic rotas, with the appointment location and contact telephone number details updated. This work was completed on 15 April 2019. On recommencing the service, patient appointment reminders were sent for all clinic appointments. This means usage increased from around 200 clinic appointment reminders to approximately 350 per day. ➤ From the beginning of June 2019, the Trust recommenced collecting Friends and Family feedback using the appointment reminder service. As a consequence feedback has increased by 119% from the previous month. ➤ From Monday 14 July 2019 interactive voice messaging reminders are being introduced for service users without a mobile telephone recorded, and an agent call patient reminder for any person over 75 years old or with a learning disability appointment where there is no mobile telephone number recorded. ➤ Calderdale and Kirklees Single Point of Access are now using the reminder service to for all initial appointments 		Apr 2019	Apr 2019	
		Jun 2019	Jun 2019	
		Jul 2019	Jul 2019	
		Aug 2019	Aug 2019	

<ul style="list-style-type: none"> ➤ It is intended to start sending reminders for appointments from the HCP rota for core teams as soon as possible however initial scoping suggests clinicians in these teams are not using rotas consistently and this issue may need to be addressed first ➤ Barnsley MSK, Podiatry and Dietetic Community Service are hoping to start using the appointment reminder service to collect Friends and Family feedback by the end of the year. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Reduce DNAs, increase re-use of appointment slots ('fast-track' patients in need of urgent appointment) and in turn reduce costs and waiting times. The pilot teams have been able to demonstrate a 30% reduction in DNA rates. • Improve efficiency of services. • Improve quality of services. • Improve patient experience. 	<p>TBD</p> <p>Mar 2020</p>	
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<i>Status</i> 	<i>Direction</i> 	Collecting and Reporting Health Outcomes		
<i>Summary update</i>		<i>Milestone</i>	<i>Achieved</i>	
<p>Purpose: Outcomes are changes in health that result from an intervention/procedure. The measurement of these outcomes provides insight into not just whether the treatment has been successful but also into the patient experience as a whole.</p> <p>Clinical outcomes can be measured by data such as hospital re-admission rates, or by the 5 domains set out in The NHS Outcomes Framework indicators:</p> <ul style="list-style-type: none"> ▪ Preventing people from dying prematurely ▪ Enhancing quality of life for people with long-term conditions ▪ Helping people to recover from episodes of ill health or following injury ▪ Ensuring that people have a positive experience of care ▪ Treating and caring for people in a safe environment and protecting them from avoidable harm 				

Key activities:

- The Trust is exploring digital solutions to collection and reporting outcomes. Some services such as IAPT, CAMHS and early intervention are required to routinely collect outcome measures. However in other services there is no consistent approach to outcome measure collection. The manual collection and re-inputting into the electronic clinical record of patient reported outcome measures (PROMs) is also time consuming which adds to existing clinical burden, and there is little feedback to either clinician or service user as to the outcomes of intervention.
- A demonstration of a solution by Checkware was provided to the Trust on 23 September and a potential pilot project opportunity is to be put forward to the Digital Strategy Group in October 2019 for consideration.
- A digital solution would allow a quick way of sending out and collecting the volume and diversity of Patient Reported Outcome Measures (PROM) data required, without increasing the clinical burden. It would generate fast, measurable and significant benefits through: -
 - Self-reporting of outcomes where the patient completes health outcomes via the internet or smart phone at home, or at a clinic appointment before, during or after treatment.
 - Staff time preserved that allow for replacement of paper questionnaires with a streamlined electronic process, requiring no collation or management of questionnaires or re-inputting of data required.
 - Integration of data available via a single reporting dashboard would allow integration with other patient feedback and audit data.
 - Support future move to future outcomes based payment systems.

Expected outcomes:

- Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient.
- Improved timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment.
- Automatic analysis, scoring and reporting in real time at clinical, service and organisational level.
- Better understanding of clinical need and effectiveness of services.

Status 	Direction 	Service User (Patient) Portal Development		
Summary update		Milestone	Achieved	
<p>Purpose: Development of a SWYPFT capability that provides service users (patients) with access to their own digital care record via a portal solution. Potentially providing opportunities to self-manage and engage more readily in the delivery of their care and that delivers alternative means from which to engage with care professionals offering greater flexibility.</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ Service user access to electronic care records: SWYPFT has registered interest with TPP in becoming a pilot organisation for the impending SystmOne App, which TPP are developing and planning to make available by the end of December 2019 in line with the national requirement to provide access to records electronically by 31 March 2020. ➤ Service user access to electronic care records: The Trust is monitoring developments within the Yorkshire & Humber Care Record programme (LHCRE) plans for a patient held record. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • Provision of a single integrated holistic patient record view that facilitates a patient's access to their own electronic care record. • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner. 		<p>Mar 2020</p> <p>Ongoing</p>		

<p>Domain 8: Embedding Digital in our Culture</p>	<p>Supports Digital Strategy Aims:</p> <ol style="list-style-type: none"> 1. To enhance quality of care and patient safety 2. To enable prevention, wellbeing and recovery 3. To foster integration, partnership and working together 4. To develop an effective and digitally empowered workforce 5. To maximise efficiency and sustainability 6. To support people and communities
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<i>Status</i> 	<i>Direction</i> 	Apps for Service Users and Carers		
Summary update		Milestone	Achieved	
<p>Purpose: As part of the wider digitisation agenda, the Trust is exploring opportunities from which to make information and services more accessible to our patients, service users and carers.</p>				
<p>Key activities:</p> <ul style="list-style-type: none"> ✓ A capital bid was submitted as part of the annual capital planning process to secure further funding for ORCHA into 2019/20 and 2020/21. EMT approved continuation of work with ORCHA through to 2021 and rollout plans have been established by the Integrated Change Team which will launch to a small number of services initially and complete evaluations ahead of rolling out to other relevant services using this learning. Phase 1 services are: Stop Smoking Services, CAMHS Services, IAPT Service and Suicide Prevention. ➤ Marketing, communications and engagement are assisting the services where necessary through regular social media, as well as regular updates in the internal communications routes to help promote ORCHA within the services. ➤ Services signed up to rolling out Orcha during phase 1 are: Stop Smoking Services, CAMHS Services, IAPT Service and Suicide Prevention. ➤ Each service will identify a number of success measures which will be regularly reviewed and as part of the project ORCHA continue to provide us with some hard data such as, site visits, numbers and details of apps searched for and downloaded by our patients and populations, search terms, numbers and details of apps searched for and apps recommended by your professionals and conversion rate post recommended app. ➤ As part of the Digital Innovation we will be re-launching our work with ORCHA with the current services with a view to roll out to more services across the Trust within the next 12 months. As part of the re-launch we have asked for an ORHCA champion from each service who will be the regular point of contact for ORCHA. 		<p>Jun 2019</p> <p>Mar 2020</p> <p>Mar 2020</p> <p>Mar 2020</p> <p>Mar 2020</p>	<p>Jun 2019</p>	

<p>Expected outcomes:</p> <ul style="list-style-type: none"> • Improves the overall patient experience. • Improves access to services, supportive information users and is part of the wider digitisation of the NHS, further supporting the LDR plans and aspirations of ICS/STPs. 		
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Status	Direction	i-Hub Digital Challenge		
				
Summary update		Milestone	Achieved	
<p>Purpose: i-Hub is a social innovation platform where the aim is to crowdsource ideas and experiences, to help develop and realise identified organisation priorities. i-Hub is centred on a number of ‘challenges’ that pose a key question, opportunity or area of development to engage our workforce about (including volunteers).</p> <p>Key activities:</p> <ul style="list-style-type: none"> ➤ i-Hub was re-launched in May 2019 following a staff survey as a place to put your ideas, a place to share good practice and a place where you can raise problems and ask others for help in solving them. Conversations are now centred on Trust priorities. The first conversation following the re-launch was ‘Going Green’ which received over 50 ideas, 142 comments and 79 new users join. The next conversation, launched in September 2019, is ‘Spending Wisely and Reducing Waste.’ ➤ During year 3, three main challenges will be focused on, Your Fab Stuff, My Idea and a rolling director sponsored challenge that will reflect our strategic priorities. <p>Expected outcomes:</p> <ul style="list-style-type: none"> • This online tool helps the Trust connect, share, discuss, develop and spread ideas. • Support staff to continuously innovate, improve and transform. • Improve efficiency of services. • Improve quality of services. • Improve patient experience. 		<p>May 2019</p> <p>Ongoing</p>	<p>May 2019</p>	

Trust Board 29 October 2019
Agenda item 10.1

Title:	Emergency Preparedness Resilience and Response (EPRR) Core Standards: Statement of Compliance
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper is to seek Board approval to declare substantial compliance against the NHS core standards for EPRR compliance.
Mission/values:	This ensures the Trust can continue to deliver its mission, even during a period where Emergency procedures are invoked.
Any background papers/ previously considered by:	The Clinical Governance and Clinical Safety Committee receive regular updates from the Safety and Resilience Trust Action Group and Sub-Groups. EPRR compliance is managed through these meetings. The Executive Management Team has received this report prior to it being received at Board.
Executive summary:	The Trust is required to measure itself against 54 core standards of the 68 in the NHS EPRR framework on an annual basis. The Trust is able to declare compliance against 52 of the 54 core standards, therefore, is substantially compliant. Whilst the declaration of substantial compliance is the same as the previous year, the Trust has made progress in complying with the final two requirements which are to have a site wide evacuation plan and loggists available for major incidents at all times. These two requirements are on schedule to be completed this year. It is a requirement of the reporting that Trust Board agrees to the declaration of substantial compliance.
Recommendation:	Trust Board is asked to AGREE to the Trust signing off that it is substantially compliant with the NHS EPRR core standards.
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust Compliance against the NHS England Core Standards for Emergency Preparedness, Resilience and Response

The NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) clearly set out the EPRR standards which NHS Organisations and providers of NHS funded care must meet. The new standards were published on 15 July 2019 with a request for compliance status by 31 October 2019. A self-assessment toolkit was provided which automatically creates an action plan for the following 12 months; this along with the self-assessment is to be submitted to NHS England. This Action Plan will form the core work streams for the 2019/20 action plan for EPRR and as such supersedes any previous EPRR work programmes.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) as a Healthcare provider of Mental Health, Learning Disability and Community services are mandated to provide assurances against 54 of the 68 standards.

These standards enable providers of healthcare to share a common purpose and to co-ordinate EPRR activities.

In addition to this, the Trust must also provide assurance against 20 “Deep Dive” standards; however, these do not form part of the final reporting position of the Trust. This year the Deep Dive has changed its overall focus from Command and Control to Severe Weather; these new standards revolve around the implementation of appropriate weather plans and long term adaptation planning. This has been tested by analysis of the Trust’s severe weather plans at Trust and BDU level, this exercise has uncovered some minor inconsistencies and omissions in plans which are in the process of being modified.

Out of the 54 areas requiring compliance, a rolling programme of works has enabled the Trust to achieve total compliance (green) in 52 areas and two areas of partial compliance (amber).

These works relate to the creation and implementation of a whole site evacuation plan, as required from the Shelter and Evacuation standard and also the provision of a suitably qualified bank of trained loggists that are available 24/7. Works to progress both standards are underway. These two outstanding standards are the same as last year and compliance is planned to be achieved in this year.

The risks around the non-compliance on the two core requirements will be confirmed as part of achieving compliance, the risks around not having loggists is very low as all incident managers make notes which can be turned into action logs after the event. The complexity of a site wide evacuation plan means that the risks will be understood when the plan is complete. At present individual evacuation plans are on risk registers.

Last year the Trust declared SUBSTANTIAL compliance; this year the Trust will again be declaring SUBSTANTIAL compliance.

The EPRR framework compliance is tested through ongoing engagement with Business Delivery Units (BDU's) and support services to ensure that the reporting is evidence based.

Recommendations

The Trust Board is asked to:

- Agree to the Trust declaring itself substantially compliant against the 54 core standards for emergency preparedness resilience and response to NHS England

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Alan Davis - Director of Human Resources, Organisational Development and Estates	Green (fully compliant) = Fully compliant with core standard.				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust Emergency Preparedness, Resilience and Response Policy (review due 2022 - reviewed 2019).	Green (fully compliant) = Fully compliant with core standard.				
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	The EPRR Report is combined into the Safety Services Annual Report which was presented to the Safety & Resilience TAG, the Clinical Governance and Clinical Safety Committee and Trust Board	Green (fully compliant) = Fully compliant with core standard.				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	EPRR Work Programme combines actions derived from lessons learned from exercises, incidents and actions from the Core Standards	Green (fully compliant) = Fully compliant with core standard.				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy in place along with supporting plans and processes. JD & PS of Emergency Planning Adviser - contains organisational chart showing discharge of responsibilities and management from Board to management/line management. All duties and responsibilities from Board down detailed in policies and procedures.	Green (fully compliant) = Fully compliant with core standard.				
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Incident Reporting Policy/EPRR Policy/ Major/critical Incident Plan/ Datix incident management system/ Attendance at partner exercises	Green (fully compliant) = Fully compliant with core standard.				
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR Risk Assessments reviewed 2019 and Risk Register added to EPRR Policy as an appendix. The risk assessments and subsequent register take into account the National Risk Register and Community Risk Register risks.	Green (fully compliant) = Fully compliant with core standard.				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR Policy Major Critical Incident Policy Risk Assessment Policy Bed Management Policy All EPRR risks are assessed and reviewed at the Safety & Resilience TAG and incorporated on an EPRR Risk Register, that is reviewed annually and forms part of the EPRR policy. The review of the register and risks will be increased as necessary.	Green (fully compliant) = Fully compliant with core standard.				
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Plans are consulted upon with partners when reviewed so to form part of wider planning arrangements	Green (fully compliant) = Fully compliant with core standard.				
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Major/Critical Incident Plan in place	Green (fully compliant) = Fully compliant with core standard.				

12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Major/Critical Incident Plan in place	Fully compliant				
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Heatwave plans in place, included in the Adverse Weather Policy. All weather alerts are cascaded to an annually reviewed staff group for onward distribution to respective teams for appropriate use/action.	Fully compliant				
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Cold Weather plans in place, included in the Adverse Weather Policy. All weather alerts are cascaded to an annually reviewed staff group for onward distribution to respective teams for appropriate use/action. Cold Weather plans in place, included in the Adverse Weather Policy. All weather alerts are cascaded to an annually reviewed staff group for onward distribution to respective teams for appropriate use/action.	Fully compliant				
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Pandemic Influenza Plan is in place, consulted upon with partners and tested at partner exercises. An internal exercise is planned for 2019.	Fully compliant				
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Viral Haemorrhagic Fever policy in place, Outbreak procedure for wards in place, TB Policy in place, Detailed as a supporting Trust in partner plans for outbreak as per outbreak agreements. Wakefield Outbreak agreement signed off at Board, Barnsley and Kirklees agreements still in progress, however the Trust have signed up to working in partnership.	Fully compliant				
17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	As a Trust we would not be lead provider in this instance, however offer support to BMBC as documented in their Mass Vaccination and Treatment Plan and Multi Agency Outbreak Plan. Action cards and responsibilities in Kirklees Council Outbreak Plan. The Trust have action cards in the following partner documents: <ul style="list-style-type: none"> BMBC Mass Vaccination and Treatment Plan and Multi-Agency Outbreak Plan. Draft Outbreak Matrix under consultation at the Health Protection Board which identifies all supporting agencies and resources for particular outbreaks across Barnsley. Kirklees Outbreak Plan Wakefield – Outbreak Incident Agreement. 	Fully compliant				
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Community and Mental Health organisations do not usually have any single agency plan in place for mass casualties. After consultation with NHS England EPRR specialists, they advise that if mass casualty plans are in place across the local health economy, and so long as our Trust is signed up to respond in support of that plan, then that is sufficient for compliance.	Fully compliant				
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Draft Evacuation Plan being consulted upon internally to strengthen whole site evacuation approach, in particular for inpatient settings. To be consulted upon further with local authority partners and wider health partners to identify support including rest centre facilities so to finalise the plan. Low and Medium Secure Evacuation Plan in place for Forensics Services which is scheduled to be tested by SWYPFT early 2020. Memorandum of Understanding for Acute Mental Health Services being discussed with Mental Health partners in Bradford, Doncaster, Hull, Leeds and Sheffield EPRR Advisers.	Partially compliant	Finalise Evacuation Plan by consulting internally and externally. Test Low and Medium Secure Evacuation Plan	EH	Aug-20	
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Lockdown Policy and procedures in place. Clinical plans in place which are tested/utilised on a regular basis. Non clinical hub procedures being tested throughout 2019.	Fully compliant				
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Media Policy references VIP management Internal and External security teams available to provide secure provision for protected individuals. Regular risk panels undertaken where such cases will be discussed.	Fully compliant				
23	Duty to maintain plans	Excess death planning	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: <ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Community and Mental Health organisations do not usually have any single agency plan in place for excess deaths. After consultation with NHS England EPRR specialists, they advise that if mass casualty plans are in place across the local health economy, and so long as our Trust is signed up to respond in support of that plan, then that is sufficient for compliance.	Fully compliant				

24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level. On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer.	Y	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy statement On call Standards and expectations are set out Include 24 hour arrangements for alerting managers and other key staff. 	Director on Call Packs, Manager on Call Packs, On Call Policy/Procedure, Intranet Rota Systems, ICC account to send notifications of incidents	Fully compliant				
25	Command and control	Trained on-call staff	The identified individual: <ul style="list-style-type: none"> Should be trained according to the NHS England EPRR competencies (National Occupational Standards) Can determine whether a critical, major or business continuity incident has occurred Has a specific process to adopt during the decision making Is aware who should be consulted and informed during decision making Should ensure appropriate records are maintained throughout. 	Y	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy statement 	Trained September 2017 for Media Training, On call training provided February and April 2017	Fully compliant				
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	<ul style="list-style-type: none"> Process explicitly described within the EPRR policy statement Evidence of a training needs analysis Training records for all staff on call and those performing a role within the ICC Training materials Evidence of personal training and exercising portfolios for key staff 	Training Needs Analysis in place - all identified training in place. EPRR training available online and also discussed at Trust Welcome Events. Training packages continue to be expanded.	Fully compliant				
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: <ul style="list-style-type: none"> a six-monthly communications test annual table top exercise live exercise at least once every three years command post exercise every three years. The exercising programme must: <ul style="list-style-type: none"> identify exercises relevant to local risks meet the needs of the organisation type and stakeholders ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	<ul style="list-style-type: none"> Exercising Schedule Evidence of post exercise reports and embedding learning 	Schedule of events attended and undertaken maintained to demonstrate exercise involvement. Live exercise was 19.07.17 (next exercise in development). Desktop exercise was April 2019 (loss of Mental Health Ward); Communications test to access contact to on call Director was January 2019 - test to contact on call managers to be undertaken August 2019	Fully compliant				
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	<ul style="list-style-type: none"> Training records Evidence of personal training and exercising portfolios for key staff 	Schedule of events attended and undertaken maintained to demonstrate exercise involvement.	Fully compliant				
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fail-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	<ul style="list-style-type: none"> Documented processes for establishing an ICC Maps and diagrams A testing schedule A training schedule Pre identified roles and responsibilities, with action cards Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards 	ICC in place at Kendray Hospital; back up room is in the Directors Block at Fieldhead. Major Critical Incident Plan provides details of requirements.	Fully compliant				
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	<ul style="list-style-type: none"> Planning arrangements are easily accessible - both electronically and hard copies 	All service BCPs are located within services and on L drive. Trustwide policies and plans are available on the Intranet and downloadable if needed	Fully compliant				
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	<ul style="list-style-type: none"> Business Continuity Response plans 	Business Continuity Plan procedure in place and departmental BCPs in place. Trust BCPs include Fuel Plan, Pan Flu, Heatwave, Cold Weather in place and on the Intranet.	Fully compliant				
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	Y	<ul style="list-style-type: none"> Documented processes for accessing and utilising loggists Training records 	2 loggists trained in the Trust to date. EP Adviser attended Working with Your Loggist training and is building training package to deliver to new volunteers. The 2 loggists live within suitable distances of both command rooms and have confirmed 24/7 availability.	Partially compliant	To write Loggist Training package and identify additional volunteers	EH	May-20	
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	<ul style="list-style-type: none"> Documented processes for completing, signing off and submitting SitReps Evidence of testing and exercising 	On call processes. EPRR policy. SITREP template available in the Trust. Requests for SITREP reporting are received via the icc@swyt.nhs.uk account along with EP Adviser and Senior Management email accounts. Processes in place to administer SITREP reports both in and out of hours. Carried out for incidents such as Industrial Action of Junior Doctors, Waste Management incident and Eu Exit.	Fully compliant				
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	<ul style="list-style-type: none"> Have emergency communications response arrangements in place Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response Using lessons identified from previous major incidents to inform the development of future incident response communications Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work 	Social Media Intranet pages providing advice and guidance as to when to and when not to use. Major/Critical Incident Plan EPRR Policy On-Call Policy Director and Manager On Call Packs updated to reflect partner contact details	Fully compliant				

38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	<ul style="list-style-type: none"> Have emergency communications response arrangements in place Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders Using lessons identified from previous major incidents to inform the development of future incident response communications Setting up protocols with the media for warning and informing 	Media Policy section 5.7	Fully compliant			
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokesperson able to represent the organisation to the media at all times.	Y	<ul style="list-style-type: none"> Have emergency communications response arrangements in place Using lessons identified from previous major incidents to inform the development of future incident response communications Setting up protocols with the media for warning and informing Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespersons and 'talking heads' 	<p>On Call Packs Media Management Policy quotes: "In the media management policy it states under 'responsibilities': "Directors on call will receive media queries via the Pinderfields switchboard."</p> <p>And under 'responding to media': "Any queries received out of hours must be referred to the director on-call." Provision of pre-determined comms lines to Directors for out of hours, along with contact for Head of Communications should assistance be required.</p>	Fully compliant			
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	Y	<ul style="list-style-type: none"> Minutes of meetings 	AEO and Head of Security, Safety and Risk (Deputy Chair of Safety & Resilience TAG)	Fully compliant			
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	<ul style="list-style-type: none"> Minutes of meetings Governance agreement if the organisation is represented 	NHSE attends LRF meetings for Health	Fully compliant			
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England	Y	<ul style="list-style-type: none"> Detailed documentation on the process for requesting, receiving and managing mutual aid requests Signed mutual aid agreements where appropriate 	Signed MOUs in place with numerous organisations	Fully compliant			
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	<ul style="list-style-type: none"> Documented and signed information sharing protocol Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public' 	Information Sharing Protocols and Inter-agency framework for sharing information in place	Fully compliant			
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301	Y	<ul style="list-style-type: none"> Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement 	Business Continuity Management Procedure	Fully compliant			
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	<ul style="list-style-type: none"> BCMS should detail: <ul style="list-style-type: none"> Scope e.g. key products and services within the scope and exclusions from the scope Objectives of the system The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties Specific roles within the BCMS including responsibilities, competencies and authorities. The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process Resource requirements Communications strategy with all staff to ensure they are aware of their roles Stakeholders 	Business Continuity Management Procedure	Fully compliant			
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	<ul style="list-style-type: none"> Documented process on how BIA will be conducted, including: <ul style="list-style-type: none"> the method to be used the frequency of review how the information will be used to inform planning how RA is used to support. 	Business Continuity Management Procedure	Fully compliant			
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<ul style="list-style-type: none"> Statement of compliance 	DPST assurance declared by the Trust within stipulated deadline. Board report in evidence file to support this.	Fully compliant			
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: <ul style="list-style-type: none"> people information and data premises suppliers and contractors IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises	Y	<ul style="list-style-type: none"> Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation 	All services complete their own BCP's taking into account the areas listed. All BCP's are saved on a central electronic drive, accessible by all staff and departments across the Trust	Fully compliant			
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	<ul style="list-style-type: none"> EPRR policy document or stand alone Business continuity policy Board papers 	Annual Board Report. Safety & Resilience TAG minutes	Fully compliant			
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	<ul style="list-style-type: none"> EPRR policy document or stand alone Business continuity policy Board papers Audit reports 	Each BC exercise is reported upon to Business Development Units and provided to the Safety and Resilience TAG - actions from reports are monitored by BDU Senior Management and the EP Team.	Fully compliant			
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	<ul style="list-style-type: none"> EPRR policy document or stand alone Business continuity policy Board papers Action plans 	Each BC exercise is reported upon to Business Development Units and provided to the Safety and Resilience TAG - actions from reports are monitored by BDU Senior Management and the EP Team. Lessons learned are shared in appropriate forums.	Fully compliant			
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	<ul style="list-style-type: none"> EPRR policy document or stand alone Business continuity policy Provider/supplier assurance framework Provider/supplier business continuity arrangements 	System in place to support the identification of business continuity plans from providers and suppliers. This system further supports the national procurement systems. All suppliers contacted to provide assurance of BCP's; works progressing to obtain copies of Business Continuity Plans	Fully compliant			
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	<ul style="list-style-type: none"> Staff are aware of the number / process to gain access to advice through appropriate planning arrangements 	Detailed in the HAZMAT procedure	Fully compliant			

57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: <ul style="list-style-type: none"> • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies 	Detailed in the HAZMAT procedure	Fully compliant				
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: <ul style="list-style-type: none"> • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste. 	Y	<ul style="list-style-type: none"> • Impact assessment of CBRN decontamination on other key facilities 	Detailed in the HAZMAT procedure	Fully compliant				
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. <ul style="list-style-type: none"> • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/epr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/epr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ 	Y	Completed equipment inventories; including completion date	Provided in HAZMAT boxes to reception in each Trust locality.	Fully compliant				
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: <ul style="list-style-type: none"> • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training 	Trained staff in place. Training programme rolling out 2019/20 for new starters and also refresher training for long term staff.	Fully compliant				
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: <ul style="list-style-type: none"> • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique 	As standard 66	Fully compliant				
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Patients with confirmed symptoms will have been directed to specialist staff and not community and mental health providers. Works underway to identify storage for FFP3 masks and also fit testing equipment following recent near miss incident with a potential TB patient.	Fully compliant				

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	<ul style="list-style-type: none"> current in line with current national guidance in line with risk assessment tested regularly signed off by the appropriate mechanism shared appropriately with those required to use them outline any equipment requirements outline any staff training required 	Draft Evacuation Plan being consulted upon internally to strengthen whole site evacuation approach, in particular for inpatient settings. To be consulted upon further with local authority partners and wider health partners to identify support including rest centre facilities so to finalise the plan. Low and Medium Secure Evacuation Plan in place for Forensics Services which is scheduled to be tested by SWYPFT early 2020. Memorandum of Understanding for Acute Mental Health Services being discussed with Mental Health partners in Bradford, Doncaster, Hull, Leeds and Sheffield EPRR Advisers.	Partially compliant	Finalise Evacuation Plan by consulting internally and externally. Test Low and Medium Secure Evacuation Plan	EH	Aug-20	
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	<ul style="list-style-type: none"> Documented processes for accessing and utilising loggists Training records 	2 loggists trained in the Trust to date. EP Adviser attended Working with Your Loggist training and is building training package to deliver to new volunteers. The 2 loggists live within suitable distances of both command rooms and have confirmed 24/7 availability.	Partially compliant	To write Loggist Training package and identify additional volunteers	EH	May-20	
1	Severe Weather response	Overheating	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	Contained within the Estates and Facilities Heatwave and Cold Weather Plan - review and incorporation into Trustwide Heatwave Plan required.	Partially compliant	Amalgamate all documents into one Trustwide Heatwave Plan	EH	May-20	
3	Severe Weather response	Staffing	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	The organisations arrangements outline: <ul style="list-style-type: none"> What staff should do if they cannot attend work Arrangements to maintain services, including how staff may be brought to site during disruption Arrangements for placing staff into accommodation should they be unable to return home 	Referenced within Heatwave Plan, Adverse Weather Plan and E&F Heatwave and Cold Weather plan	Partially compliant	Needs updating and adding to a central plan for use Trustwide. As per DD1	EH	May-20	
4	Severe Weather response	Service provision	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alternative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care		Partially compliant	Contacted Community services leads across all BDUs to obtain evidence to strengthen plan. Contacted Sarah Leason Hurley for Barnsley and Wakefield Community Mental Health for assurances. Liaise with Leads to ensure BCP's are updated to include required information.	EH	Nov-19	Confirmation from Barnsley Community that services prioritise patient treatment/services according to weather changes. Work Instructions saved in BCP files. Calderdale and Kirklees confirmed that some, not all BCP's contain details regarding prioritisation of clinical services in extreme weather. Confirmation required for Barnsley Mental Health and Wakefield services.
5	Severe Weather response	Discharge	The organisation has policies or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	Confirmation being sought from service leads across localities	non compliant	Contacting service leads across localities to provide evidence for this standard	EH	Nov-19	
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	The organisation has clearly demonstrable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner		Partially compliant	Identify providers to assist in an emergency response for clean up after flooding or similar incident as previous arrangements no longer in place.	Estates and Facilities	Dec-20	Liaise with Estates and Facilities managers, along with Fire Safety Advisers to plan a combined approach.
13	Severe Weather response	Supply chain	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Check with Gary Garvey	Partially compliant	Liaise with procurement	EH	Dec-19	Encompassed in BCP Assurances for Supplies Workstream. Discuss with Procurement Lead August 2019 to identify how this information is captured.
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Evidence that there is an entry in the organisations risk register detailing climate change risk and any mitigating actions	The Estates and Facilities Risk Register incorporates risks from the Climate Change Risk Assessment, including flood, heatwave and cold weather along with Carbon reduction	Partially compliant	Review CCRA and identify any other risks that need to be encompassed on risk registers	EH	May-20	
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	Identified programme of work for areas that need cooling management systems. Reviewing Sustainability programme.	Partially compliant	Review Work programmes and ensure up to date, taking into account all areas.	EH/MB	May-20	
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS		Non compliant		EH	Aug-19	Liaise with Estates representatives to source evidence to support assurances against this standard
20	Long term adaptation planning	New build	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	The organisation has relevant documentation that it is including adaptation plans for all new builds	Carbon footprint and sustainable development	Partially compliant		EH	Aug-19	As per DD19.

Trust Board 29 October 2019 Agenda item 10.2

Title:	Update to Trust Standing Financial Instructions
Paper prepared by:	Director of Finance & Resources
Purpose:	To enable Trust Board to consider and approve proposed updates to the Trust Standing Financial Instructions (SFIs)
Mission/values:	<ul style="list-style-type: none"> ➤ Open and transparent ➤ Improve and aim to be outstanding ➤ Relevant today and ready for tomorrow
Any background papers/ previously considered by:	<p>Previously approved by the Trust Board and reviewed by the Audit Committee in August 2016.</p> <p>Current updates reviewed by EMT and Audit Committee.</p>
Executive summary:	<p>The Trust's Standing Financial Instructions (SFIs) are a key governance tool for all staff to observe and adhere to. They are used in conjunction with the Scheme of Delegation to provide a framework of rules to ensure financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. SFIs are reviewed on a regular basis to allow for any changes in rules, changes in the operating environment and any improvements to be recognised.</p> <p>In the attached version track changes has been used to identify any amendments or additions from the previous version.</p> <p>It should be noted there is a separate tendering procedure which forms part of the SFI control environment, which is also included in the papers provided.</p> <p>Whilst carrying out a review of the SFIs it has been identified that there needs to be clear communication of them on a regular basis. With this in mind further consideration is being given to how they are communicated including the development of an "easy read" summary version which will include key highlights and point the reader in the direction of the main document. Use of the Trust induction to highlight SFIs will also be considered.</p> <p>There are a number of suggested changes in the document, which are typically recommended to reflect current practice, changes in the operating environment, changes in legislation and/or improved practice.</p> <p>It is noted the Director of Finance has significant responsibilities in relation to the administration of Trust charities. In practice the executive director lead is the Director of Strategy, who receives support from the Head of Financial Accounting. At this point in time it is suggested the SFIs remain as they are and to facilitate adherence to them the Director of Finance will meet with the Director of Strategy, Head of Financial Accounting and Fund Raising Manager on a regular basis. If a need becomes apparent to change the SFIs as a result this will form part of the next update.</p>

	<p>This document was an agenda item at the October Audit Committee, at which subject to a small number of clarifications which have been provided, the SFIs were recommended for approval by the Trust Board</p> <p>Risk appetite</p> <p>This paper needs to be considered in line with the Trust risk appetite statement which aims for clinical risk of 1-6 (subject to Board approval).</p>
Recommendation:	The Trust Board is asked to COMMENT on and APPROVE the updated Trust SFIs.
Private session:	Not applicable.

Standing Financial Instructions

October 2019

Foreword

The Code of Accountability requires NHS Foundation Trusts to adopt:

- Standing Financial Instructions (SFIs)
- Standing Orders (SOs)
- Reservation of Powers to the Board and Delegation of Powers

These documents provide a regulatory framework for the proceedings and the business of the Trust.

They fulfil the dual roles of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

All executive and non-executive directors and all members of staff, including staff seconded into the Trust and contractors working for the Trust, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These SFIs have been adopted by the Trust Board and are therefore mandatory for all directors and employees of the organisation. Non compliance will be reported to the Trust Audit Committee and could lead to disciplinary proceedings.

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Introduction

1.1 The Financial Framework

1.1.1 These Standing Financial Instructions (SFIs), together with the Trust's Standing Orders and Scheme of Delegation, provide a business and financial framework and set the rules that Directors and officers of the Trust, including employees of third parties contracted to the Trust, shall be expected to work within. Together, they cover all aspects of financial management and control, and set out the responsibilities of individuals, including the levels of responsibility clearly delegated to Executives and other senior officers.

1.1.2 These documents protect the interests of the Trust, explain financial responsibilities and regulate the conduct of the Trust, its Directors, officers and agents in relation to all financial matters, and provide the financial framework to enable staff to be confident they are acting properly.

1.2 Authority and Compliance

1.2.1 These SFIs shall have effect as if incorporated in the Trust Board Standing Orders and, as a result, are part of the Trust's Constitution. As the Trust Board approves SFIs, they may only be overridden with the express authority of Trust Board in accordance with **SO 4.13** (Suspension of Standing Orders)relating to suspension of Standing Orders.

1.2.2 These SFIs document the financial responsibilities and instructions adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and the requirements of the Independent Regulator to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation for the Trust, which includes a list of the Decisions Reserved to Trust Board.

1.2.3 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituency organisations, including trading units and any shared services centre. They do not provide any detailed procedural advice. These statements should, therefore, be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.2.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Director of Finance **must be sought before acting**. The user of the SFIs should also be familiar and comply with the provisions of the Trust's Standing Orders. Failure to comply with the Trust's Standing Orders or SFIs is a disciplinary matter, which could result ~~in dismissal~~in disciplinary action. Non-compliance must be reported to the Director of Finance.

2 Definitions and Terminology

2.1.1 Any expression, to which a meaning is given in Health Service Acts or in the Financial Directions made under the Acts or in the 2003 Act or regulations made under it, shall have the same meanings in these instructions. In particular:

- a) **“Board”** means Board of the Trust and is regarded as synonymous with “The Trust”;
- b) **“Trust”** means South West Yorkshire Partnership NHS Foundation Trust and is to be regarded as synonymous with Trust Board.
- c) **“Chair”** is the person appointed by the Members’ Council to lead [the](#) Trust Board and to ensure that it successfully discharges its overall responsibility to the Trust as a whole;
- d) **“Chief Executive”** means the chief officer of the Trust;
- e) **‘Accountable Officer’** means the NHS Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
- f) **“Director of Finance”** means the Chief Financial Officer of the Trust;
- g) **“Budget”** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specified period, any or all of the functions of the Trust;
- h) **“Budget Holder”** means the Director or employee with delegated authority to manage the finances (income and expenditure) for a specific area of the organisation;
- i) **“Constitution”** means the Constitution of the Trust
- j) **“Members’ Council”** means the Members’ Council of the Trust as constituted by the Constitution;

2.1.2 Wherever the title of Chief Executive, Director of Finance or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

2.1.3 Wherever the term “employee” is used and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

3 Responsibilities and Delegation

3.1 Responsibilities of the Trust Board

3.1.1 The Board exercises financial supervision and control by:

- a) formulating the financial strategy;
- b) requiring the submission and approval of budgets within approved allocations / overall income;
- c) setting limits on expenditure that may be committed without Board approval
- d) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and
- e) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document;

3.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

3.2 Responsibilities of the Chief Executive

3.2.1 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as accounting officer to Parliament for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

3.2.2 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

3.2.3 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

3.3 Responsibilities of the Director of Finance

3.3.1 The Director of Finance is responsible for:

- a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- d) the provision of financial advice to the Trust and its directors and employees;
- e) the design, implementation and supervision of systems of internal financial control;
- f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.
- g) leading the Trust Board in the development of the financial strategy of the Trust

3.4 Responsibilities of all Directors and employees

3.4.1 All directors and employees, severally and collectively, are responsible for:

- a) the security of the property of the Trust;
- b) avoiding loss;
- c) exercising economy and efficiency in the use of resources; and
- d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

- 3.4.2 Any agent, contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.
- 3.4.3 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

4 Audit

4.1 Audit Committee

- 4.1.1 In accordance with Standing Orders and the Audit Code for Foundation Trusts the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2011), which will provide an independent and objective view of internal control by:
- a) overseeing Internal and External Audit services;
 - b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements including the Trust's Annual Report and Accounts;
 - c) monitoring compliance with Standing Orders and Standing Financial Instructions;
 - d) reviewing schedules of losses and compensations and making recommendations to the Board;
 - e) reviewing the information prepared to support the assurance statements prepared on behalf of the Board and advising the Board accordingly; and
 - f) receive the annual report of the Local Counter Fraud Specialist (LCFS).
- 4.1.2 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

- 4.1.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. In exceptional circumstances the matter may need to be referred to the Independent Regulator. The Audit Committee should comply with Counter Fraud guidance on the reporting of potential or actual fraudulent actions.
- 4.1.4 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

4.2 Fraud and corruption

- 4.2.1 In line with prevailing requirements as to their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS [Counter Fraud Authority \(NHSCFA\)](#) ~~Protect~~ Standards for Providers and any relevant guidance or best practice advice issued by the Independent Regulator, or HM Government on fraud and corruption.
- 4.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified ~~within NHSCFA Standards for Providers by the Department of Health Fraud and Corruption manual and guidance.~~
- 4.2.3 The ~~LCFSocal Counter Fraud Specialist~~ shall report to the Trust Director of Finance on matters relating to fraud, [bribery](#) and corruption. ~~All work completed by the LCFS will be in line with the NHSCFA Standards for Providers. and shall work with staff in the NHS Protect, when required in accordance with the Department of Health Fraud and Corruption Manual.~~

4.2.4 The ~~Local Counter Fraud Specialist (LCFS)~~ will provide regular progress reports to the Director of Finance and Audit Committee detailing work undertaken against the Trust's counter fraud plan. ~~on counter fraud work which set out progress against annual counter fraud plans within the Trust and the national context.~~ In addition the LCFS will work with the Trust to ensure an annual submission is made to NHS Counter Fraud Authority ~~Protect via the the return of the Self Review Toolkit (SRT).~~ which includes an annual report and a completed Self Review Toolkit (SRT). The SRT ~~will~~ will detail work undertaken by the Trust and the LCFS in ensuring compliance against NHSCFA's Standards for Providers. ~~include a review of the NHS Protect Standards for Providers on Fraud and Corruption.~~ The LCFS will submit an annual report to the Audit Committee which will include the completed SRT. The Director of Finance will be responsible for determining when to report to the police matters of suspected fraud or corruption and will seek advice from the LCFS and where appropriate NHSCFA ~~Protect.~~

If it is considered appropriate that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the Director of Finance to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. criminal investigation.

The LCFS will ensure that measures to mitigate identified fraud risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of risks identified. Work will be monitored by the Director of Finance and outcomes fed back to the Audit Committee.

4.3 Bribery Act / Corruption

4.3.1 The Trust's Standards of Business Conduct and Bribery Act Policy defines the standards of conduct expected of employees, contractors etc. in the course of the Trust's business. The policies also instruct in what gifts, hospitality and other interests should be declared and how to report suspicions and bribery and other financial irregularities.

4.4 Role of the Director of Finance

4.4.1 The Director of Finance is responsible for:

- a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;
- b) ensuring that the internal audit is adequate and meets NHS mandatory audit standards;
- c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;
- d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- i) a clear statement on the effectiveness of internal control,
- ii) major internal control weaknesses discovered,
- iii) progress on the implementation of internal audit recommendations,
- iv) progress against plan over the previous year,
- v) strategic audit plan covering the coming three years,
- vi) a detailed plan for the coming year.

4.4.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

- a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- b) access at all reasonable times to any land, premises or employee of the Trust;
- c) the production of any cash, stores or other property of the Trust under an employee's control; and
- d) explanations concerning any matter under investigation.

4.5 Role of Internal Audit

4.5.1 Internal Audit will review, appraise and report upon:

- a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
- b) the adequacy and application of financial and other related management controls;
- c) the suitability of financial and other related management data;
- d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - i) fraud and other offences,
 - ii) waste, extravagance, inefficient administration,
 - iii) poor value for money or other causes.

- 4.5.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.
- 4.5.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.
- 4.5.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor.
- 4.5.5 The agreement shall be in writing and shall comply with the best practice guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

4.6 Role of External Audit

- 4.6.1 The external auditor is appointed by the Members' Council and paid for by the Trust. The auditor must fulfil the requirements as set out in the Local Audit and Accountability Act 2014.
- 4.6.2 The External Auditors are required to work in accordance with the Audit Code for NHS Foundation Trusts.
- 4.6.3 The Chief Internal Auditor shall work closely with External Audit and conduct joint planning audit coverage in order to minimise duplication of work and to provide the Trust with the best value for money.
- 4.6.4 The Audit Committee will be responsible for ensuring the External Auditor's work presents value for money.

5 Business Planning, Budgets, Budgetary Control and Monitoring

5.1 Preparation and approval of business plans and budgets

- 5.1.1 The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast available resources. The annual business plan will contain:
- a) a statement of the significant assumptions on which the plan is based; and
 - b) details of major changes in workload, delivery of services or resources required to achieve the plan.
- 5.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:
- a) be in accordance with the aims and objectives set out in the annual business plan;

- b) accord with workload and manpower plans;
- c) be produced following discussion with appropriate budget holders;
- d) be prepared within the limits of available funds; and
- e) identify potential risks.

5.1.3 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

5.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

5.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets effectively.

5.2 Budgetary delegation

5.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing, ~~and~~ accepted by the budget holder and be accompanied by a clear definition of:

- a) the amount of the budget;
- b) the purpose(s) of each budget heading;
- c) individual and group responsibilities;
- d) authority to exercise virement or transfer;
- e) services to be delivered through the delegated budget; and
- f) the provision of regular reports.

5.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement or transfer limits set by the Board. Any requirement to overspend must first be explained and agreed with the Director of Finance and formal approval must then be sought from EMT. The Director of Finance must then communicate any such changes to the Trust Board

5.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement or transfer. Non-recurrent sources of funding should not be used to finance recurring expenditure without Executive Management Team Trust Board approval.

5.3 Budgetary Control and Reporting

5.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

- a) monthly financial reports to the Board in a form approved by the Board containing:
 - i) income and expenditure to date showing trends and forecast year-end position;
 - ii) movements in working capital
 - iii) capital project spend and projected outturn against plan
 - iv) cash-flow and rolling cash-flow forecast
 - v) balance sheet
 - vi) explanations of any material variances from plan;
 - vii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
- b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- c) investigation and reporting of variances from financial and staff budgets
- d) monitoring of management action to correct variances; and
- e) arrangements for the authorisation of budget virements and transfers.

5.3.2 Each Budget Holder is responsible for ensuring that:

- a) any likely overspending or reduction of income which cannot be met by authorised virement is not incurred without the prior consent of the Executive Management Team (EMT) or if necessary the Board, or the Chief Executive within his delegated limits;
- b) any ~~significant~~ reduction in income in excess of £250,000 which cannot be met by corresponding cost saving should be reported to the Board;
 - (a) and (b) above may be replaced at the discretion of the Chief Executive with required contribution targets for defined business units;
- c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of

transfer and virement;

- d) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Executive Management Team~~Board~~;
- e) that the use of contractors, agency staff, locums, or non-contractual payments to employees, such as overtime, is not used to circumvent the budgeted establishment; and;
- f) they provide all information as requested by the Director of Finance to enable him discharge his duties.

5.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a budget which achieves the target surplus.

5.4 Capital Expenditure

5.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 16)

5.5 Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Independent Regulator.

6 Annual Accounts and Report

6.1.1 The Director of Finance, on behalf of the Trust, will:

- a) prepare financial returns in accordance with the accounting policies and guidance given by the Independent Regulator and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS) and/or generally accepted accounting practice;
- b) prepare and submit periodic and annual financial reports in accordance with prevailing guidelines and requirements;
- c) submit financial returns for each financial year in accordance with the guidelines and timetable prescribed by the Independent Regulator.
- d) Provide regular reports on the financial performance of the trust to the Members' Council

- 6.1.2 The Trust's audited (by an auditor appointed by the ~~Audit Committee~~ Members' Council) annual accounts and auditor's report must be presented to a general meeting of the Member's Council.
- 6.1.3 The Trust will publish an annual report, in accordance with the prevailing requirements of the Independent Regulator and present it at a public meeting.

7 Bank and Government Banking Service (GBS) Accounts

7.1 General

- 7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ directions issued from time to time by the Independent Regulator. The ~~Audit Committee~~ Board shall approve the banking arrangements on behalf of the Trust Board.

7.2 Bank and GBS Accounts

- 7.2.1 The Director of Finance is responsible for:
- bank accounts and Government Banking Service (GBS) accounts;
 - establishing separate bank accounts for the Trust's non-exchequer funds;
 - ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and
 - reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

7.3 Banking Procedures

- 7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:
- the conditions under which each bank and GBS account is to be operated;
 - the limit to be applied to any overdraft;
 - those authorised to sign cheques or other orders drawn on the Trust's accounts.
 - those authorised to approve electronic banking transfers.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated; the limits to be applied to any overdraft and the limitation on single signatory payments and any changes that may be required by resolution of the Board of Directors as may be necessary from time to time. In addition, the Director of Finance shall advise the bankers in writing, of the officer(s) and/ or Director(s) authorised to release money from, and draw cheques on, each bank account of the Trust and shall notify promptly the cancellation of any such authorisation.

7.4 Tendering and review of banking arrangements

7.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This exercise is not necessary for GBS accounts.

8 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

8.1 Income Systems

8.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. The Director of Finance is also responsible for the prompt banking of all monies received.

8.2 Fees and charges

8.2.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

8.2.2 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate / deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

8.2.3 Any income generated from the activities of staff working in their employment hours, and/or utilising any of the Trust's facilities shall be declared as Trust Exchequer Income and dealt with in line with the Trust's official income systems and controls and any relevant aspects of an employee's terms and conditions of employment.

8.2.4 All income generation activities shall be approved, before they are undertaken, by the appropriate budget holder / manager, and comprehensive and detailed records retained for audit. Such approval shall only be granted where the scheme generates a minimum of break even after taking account of all overheads and after further approval of prices by the Director of Finance. Any exceptions to this will be agreed by the Finance, Investment and Performance Committee. Income generation activities attracting an annual income of £500,000 or above require Board approval.

8.3 Debt Recovery

8.3.1 The Director of Finance is responsible for ensuring appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with the losses procedures. Overpayments should be detected (or preferably prevented) and recovery initiated.

8.4 Security of cash, cheques and other negotiable instruments

8.4.1 The Director of Finance is responsible for:

- a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- b) ordering and securely controlling any such stationery;
- c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and
- d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

8.4.2 Official money shall not under any circumstances be used for the encashment of neither private cheques nor IOU's.

8.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

9 Contracting for Provision of Services

9.1.1 The Chief Executive is responsible for negotiating contracts for the provision of healthcare services in accordance with the business plan, and for establishing the arrangements for extra-contractual services. In discharging this responsibility, the Chief Executive shall take into account:

- a) the standards of service quality expected;
- b) costing and pricing of services;
- c) payment terms and conditions;

- d) amendments to contracts and extra-contractual arrangements

Contracts should be so devised as to ensure a measured balance between risk and opportunity, and should be made with the long-term interests of the Trust in mind.

The Director of Finance shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of any variable elements of that income. This shall include any partnership arrangement the Trust enters into for the provision of healthcare related services.

10 Terms of Service and Payment to Directors and Employees

10.1 Workforce and Remuneration and Terms of Service Committee

10.1.1 In accordance with Standing Orders the Board shall establish a Workforce and Remuneration and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The duties of the Committee are outlined in the Scheme of Delegation and detailed in the terms of reference of the Committee.

10.1.3 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee. Remuneration and terms of services of the Chair and Non-executive Directors will be determined by the Members' Council, based on external advice and/or the remuneration offered to Non-executive Directors in comparable Foundation Trusts.

10.2 Funded establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The funded establishment of any department may not be materially varied without the approval of the Chief Executive who will establish and maintain schemes of transfer and virement, and the use of contractors, agency staff or locums will be counted against the funded establishment. Variations not considered material include minor skills mix changes as a result of recruitment to vacant positions, which will be agreed with the appropriate director.

10.3 Staff appointments

10.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

- a) unless authorised to do so by the Chief Executive; and
- b) within the limit of their approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

10.4 Processing of payroll

10.4.1 The Executive Director (Director of Human Resources) responsible for payroll is responsible for:

- a) specifying timetables for submission of properly authorised time records and other notifications;
- b) the final determination of pay and allowances;
- c) making payment on agreed dates; and
- d) agreeing method of payment.

10.4.2 The Executive Director responsible for payroll will issue instructions regarding:

- a) verification and documentation of data;
- b) the timetable for receipt and preparation of payroll data and the payment of employees;
- c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
- d) security and confidentiality of payroll information;
- e) checks to be applied to completed payroll before and after payment;
- f) authority to release payroll data under the provisions of the ~~Data Protection Act~~ General Data Protection Regulations (GDPR);
- g) methods of payment available to various categories of employee;
- h) procedures for payment by cheque, bank credit, or cash to employees;
- i) procedures for the recall of cheques and bank credits
- j) pay advances and their recovery;

- k) recovery of overpayments and the correction of underpayments;
- l) maintenance of regular and independent reconciliation of pay control accounts;
- m) separation of duties of preparing records and handling cash; and
- n) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

- a) submitting time records, and other notifications in accordance with agreed timetables;
- b) completing time records and other notifications in accordance with the Executive Director's instructions and in the form prescribed by the Executive Director ;
- c) completing documentation changing to employees terms and conditions of service, subject to compliance with the prevailing procedures and verification agreed by the Director of Finance, and the Director of Human Resources; and
- d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Executive Director must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Director of Human Resources shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to the Director of Human Resources for:

- a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and
- b) dealing with variations to, or termination of, contracts of employment.

11 Non Pay Expenditure

11.1 Delegation of authority

The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. The Trust Audit Committee ~~Board~~ will be responsible for agreeing the Trust's procurement strategy.

11.1.1 The Chief Executive will set out:

- a) the list of managers who are authorised to place requisitions for the supply of goods and services; and
- b) the maximum level of each requisition and the system for authorisation above that level. (as outlined within the Trust Scheme of Delegation)

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Choice, requisitioning, ordering, receipt and payment for goods and services

11.2.1 The Director of Finance will be responsible for ensuring staff operate within the approved procurement arrangements. The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the requisitioner must follow the prevailing procedures issued by the Director of Finance for the procurement of goods and services.

11.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance and as outlined in 11.2.3.

11.2.3 The Director of Finance will:

- a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved the thresholds will be incorporated into standing orders and any amendment will require approval of Trust Board, the Members' Council and Monitor.
- b) prepare and disseminate procedural instructions on the obtaining of goods, works and services incorporating the thresholds;
- c) be responsible for the prompt payment of all properly authorised accounts and claims;

- d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
- i) A list of directors/employees (including specimens of their signatures) authorised to certify invoices.
 - ii) Certification that:
 - goods have been duly received, examined and are in accordance with specification and the prices are correct;
 - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
 - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
 - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
 - the account is arithmetically correct;
 - the account is in order for payment.
 - i) A ~~timetable and~~ system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
 - ii) Instructions to employees regarding the handling and payment of accounts within the Finance Department.
- e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as stated below).

11.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV) and the intention is not to circumvent cash limits.

- b) the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
- c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and
- d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.5 Official Orders must:

- a) be consecutively numbered;
- b) be in a form approved by the Director of Finance;
- c) state the Trust's terms and conditions of trade; and
- d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

- a) all contracts [other than for a simple purchase permitted within the Scheme of Delegation or delegated budget], leases, tenancy agreements, service level agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;
- b) contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);
- c) contracts that commit the organisation to revenue consequences above £500,000 over three or less years are approved by the Trust Board
- e)d) all service level agreement which are provided by and for the Trust must be formally authorised by the Director of Finance. The Director of Finance must be notified of any intention to exit a service level agreement in advance of that exit being confirmed.
- d)e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;
- ii) conventional hospitality, such as lunches in the course of working visits;
- e)f) no requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;
- f)g) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
- g)h) _____ verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
- h)i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
- i)j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
- j)k) changes to the list of directors/employees authorised to certify invoices are notified to the Director of Finance;
- k)l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and
- l)m) _____ petty cash records are maintained in a form as determined by the Director of Finance.

11.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice, utilising the guidance contained within CONCODE and ESTATECODE where appropriate. The technical audit of these contracts shall be the responsibility of the relevant Director.

12 Tendering and Contract Procedures

12.1 Duty to comply with standing orders

12.1.1 The procedure for making all contracts for or on behalf of the Trust will comply with these standing orders except where **SO 4.13 (Suspension of Standing Orders)** is applied.

12.2 Directives Governing Public Procurement

12.2.1 Directives by the Council of the European Union promulgated by the Department of Health prescribing procedures for awarding all forms of contracts shall have the effect as if incorporated into these standing orders.

12.2.2 The Trust will comply as far as possible with relevant guidance issued by the Department of Health and the Independent Regulator (or other relevant regulatory body as appropriate)

12.3 Trust Procurement Framework

12.3.1 The Trust will look to ensure Value For Money by utilising existing Trust Procurement Framework arrangements. Should not this be the case then the Procurement team will explore Quotations (12.4) or Formal competitive tendering (12.5) as appropriate.

12.4 Quotations

12.4.1 Quotations are required where the formal tendering procedures are waived under 12.7 (Waiver of Tenders) and where the intended expenditure is between £~~105~~105,000 and £~~215~~215,000.

12.4.2 Where quotations are required they should be obtained from at least three firms or individuals based on specifications or terms of reference prepared by or on behalf of the Board.

12.4.3 Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so, in which case quotations may be obtained by telephone. Written quotations must be sought by post, email or an approved electronic trading system through the Trust Procurement department.

12.4.4 Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation should be obtained should be set out in a permanent record. All quotations should be treated as confidential and should be retained for inspection.

12.4.5 The Chief Executive or his nominated officer should evaluate the quotations and select the one that best meets the trust's requirements. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be a permanent record.

12.4.6 Non-competitive quotations in writing may be obtained for the following purposes:

- a) Supply of goods and services of a special character for which, in the opinion of the Chief executive or nominated officer, it is not possible or desirable to obtain competitive quotations.
- b) The goods and services are required urgently

12.5 Formal competitive tendering

12.5.1 The Trust will ensure that competitive tenders are invited for the supply of goods, materials, manufactured articles and services including all forms of management consultancy (other than specialised services sought from or provided by the [Department of Health](#)), for the design, construction and maintenance of buildings and engineering works (including construction and maintenance of grounds and gardens) and for disposals. Formal competitive tenders will be invited for all aforementioned procurement or disposals above £245,000 in value.

12.5.2 The Director of Finance will be responsible for the receipt, endorsement and safe custody of all tenders received either by post or via an approved electronic trading system and for maintaining a register showing each set of tender invitations dispatched by post or electronically.

12.5.3 Where only one tender is received, the Chief Executive and Director of Finance will be responsible for assessing whether it represents value for money.

12.6 Where tendering or quotation is not required

12.6.1 The Trust will use the procurement system for all goods and services under £105,000 in value unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

12.6.2 The Chief Executive is responsible for ensuring that best value for money can be demonstrated for all service provided under contract or in-house. The Trust Board may determine from time to time that in-house services should be market tested by competitive tendering.

12.7 Waiver of tenders

12.7.1 Formal tendering procedures may be waived by the Chief Executive or Director of Finance if:

- a) The supply is proposed under special arrangements negotiated by the Department of Health in which event the special arrangements must be complied with; or

- b) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for a single tender; or
- c) Specialist expertise is required and is available only from one source; or
- d) The task is essential to complete the project AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
- e) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or
- f) The circumstances are covered by provision in the ~~Capital Investment Manual for a single tender.~~ NHS Estate Code.

12.7.2 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

12.7.3 Where it is decided that competitive tendering is not applicable and should be waived by virtue of one or more of the above criteria, the fact of the waiver and the reasons should be documented and reported by the Director of Finance to the Audit Committee at the next formal meeting.

12.7.4 Except where the criteria agreed in SF12.7 (Waiver of Tenders) apply, the Board will ensure that invitations to tender are sent to sufficient number of firms or individuals to provide fair and adequate competition as appropriate and in no case less than three firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

12.7.5 ~~The Board will ensure that the companies or individuals invited to tender are among those on the Trust's e Tendering database, procurement system or a recognised public sector framework agreement. The Board will ensure that normally the firms or individuals invited to tender are among those on approved lists.~~ The Director of Finance is responsible for maintaining-ensuring that the approved supplier lists are; reviewed and have a documented process which allows for the addition and deletion of companies and organisations from the lists. ~~ing these regularly and documenting the process whereby firms or organisations are added or deleted from these lists.~~ Where, in the opinion of the Director of Finance, it is desirable to seek tenders from firms not on the approved list, the reason should be recorded in writing to the Chief Executive.

12.8 Contracts

12.8.1 The Trust may only enter into contracts within its statutory powers and within its Terms of Authorisation.

12.8.2 Where appropriate contracts will be in (or embody) the same terms and conditions of contract as was the basis on which the tender or quotation was obtained. In all contracts made by the Trust, the Board will endeavour to obtain best value for money. The Chief Executive will nominate an officer to oversee each contract on behalf of the trust.

12.9 Healthcare Services Contracts

12.9.1 The Chief Executive shall delegate power to negotiate for the provision of health services with commissioners to nominated officers.

12.10 Partnerships

12.11 Where the trust enters into partnership for the delivery of services or for obtaining goods and services where there is no exchange of monies or where the terms and conditions are negotiated by another body, and the value of the goods or services exceeds £~~500~~250,000, then the partnership must be approved by the Trust Board, who will set a timescale for its review and renewal. This includes, but is not limited to Procure 21 and Section 75 agreements. The Chief Executive shall ensure there are adequate systems for the management of such partnerships

12.12 Cancellation of contracts

12.13 Except where specific provision is made for contracts with NHS organisations, all written contracts will include a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor (or any person acting on his behalf with or without the knowledge of the contractor) has offered, given or agreed any gift, inducement or reward to any person for entering into the contract or any other contract with the Trust or if the contractor or any person acting on his behalf has committed any offence relating to corruption.

12.14 Determination of contracts for failure to deliver goods or materials

12.15 Every written contract for the supply of goods or materials will include a clause to allow the Trust to determine the contract if the contractor fails to deliver the goods or materials (or any portion of them) to purchase other goods to make good the default. The clause will secure that the Trust can recover the cost of making good the default from the contractor.

12.16 Contracts involving funds held on trust

- 12.17 Contracts involving funds held on ~~t~~Trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

13 External Borrowing

- 13.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by the Independent Regulator. The Director of Finance is also responsible for reporting periodically to the Board concerning the Public Dividend Capital (PDC) debt and all loans and overdrafts.
- 13.1.2 Any decision to undertake external borrowing must be made by Trust Board.
- 13.1.3 Any application for PDC, a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by him/her.
- 13.1.4 The Director of Finance must prepare detailed procedural instructions concerning applications for PDC, loans and overdrafts.
- 13.1.5 All borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance.
- 13.1.6 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

14 Investments

- 14.1.1 The Director of Finance shall produce a Treasury Management [strategy and](#) policy requiring ~~Audit Committee~~~~Trust Board~~ approval providing a comprehensive framework for the management and investment of cash balances.
- 14.1.2 The Treasury Management [strategy and](#) policy shall have a conservative approach to investments appropriate for a tax-funded public body, and shall comply with the prevailing guidance or instructions of the Independent Regulator.
- 14.1.3 The Director of Finance shall prepare and implement detailed procedural instructions for the implementation of the Treasury Management [strategy and](#) policy.

15 Financial Framework

15.1.1 The Director of Finance will ensure that the Trust Board are aware of the prevailing instructions and guidance of the Independent Regulator, and any statutory or regulatory requirements, regarding the financial management and financial duties of the Trust.

16 Capital Investment, Private Finance, Fixed Assets and Security of Assets

16.1 Capital investment

16.1.1 All decisions relating to capital investment above £500,000 will require approval by the Trust Board.

16.1.2 The Chief Executive

- a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and
- c) shall ensure that the capital investment is not undertaken without full consideration of the impact on the Trust's cash and working capital position and **Financial** Risk Rating.

16.1.3 For every capital expenditure proposal, [requiring Trust Board approval](#), the Chief Executive shall ensure:

- a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:
 - i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and
 - ii) appropriate project management and control arrangements; and
- b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

16.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of ESTATECODE or Procure 21+ or any other legally binding contractual process as appropriate.

16.1.5 The Director of Finance shall issue ~~procedures for the~~ regular reporting of expenditure and commitment against authorised expenditure.

16.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

- a) specific authority to commit expenditure;
- b) authority to proceed to tender;
- c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management broadly in line with ESTATECODE guidance, and in accordance with the Trust's Standing Orders.

16.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

16.2 Private finance

16.2.1 Any proposal to use private finance (PFI, LIFT or similar), or to enter into a contract that commits the Trust to long term (15 years or more) arrangements for capital assets with a lifetime value in excess of £500,000, require approval by the Trust Board.

16.2.2 The Director of Finance shall ensure that any such proposal is fully assessed against alternative routes for obtaining that capital asset applying prevailing guidance or instruction from the Independent Regulator or best practice guidance.

16.3 Asset registers

- 16.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical sample check of assets against the asset register to be conducted once a year.
- 16.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified by the Independent Regulator.
- 16.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:
- a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
 - b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and
 - c) lease agreements in respect of assets held under a finance lease and capitalised.
- 16.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 16.3.5 The Director of Finance shall ensure there is a regular process~~approve procedures~~ for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
- 16.3.6 The value of each asset shall be re-valued in line with accounting policies drawn up by the Director of Finance, reviewed by the audit committee, and which are in accordance with the accounting requirements of the Independent Regulator.
- 16.3.7 The value of each asset shall be depreciated using methods and rates in accordance with the accounting requirements of the Independent Regulator.

16.4 Security of assets

16.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

16.4.2 This is supported by Trust employed Local Security Management Specialists (LSMS) who, utilising the Trust security management strategy (as aligned to NHS Protects Strategy and Standards) and Safe and Secure Environment Policy to protect NHS staff and patients, security of premises, protection of property and assets and security resilience.

16.4.3 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

- a) recording managerial responsibility for each asset;
- b) identification of additions and disposals;
- c) identification of all repairs and maintenance expenses, where relevant and beneficial;
- d) physical security of assets;
- e) periodic verification of the existence of, condition of, and title to, assets recorded;
- f) identification and reporting of all costs associated with the retention of an asset; and
- g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

16.4.4 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

16.4.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

16.4.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

16.4.7 Where practical, equipment assets should be marked as Trust property.

17 Stores and Receipt of Goods

17.1 Stores

17.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

- a) kept to a minimum;
- b) subjected to annual stocktake;
- c) valued at the lower of cost and net realisable value.

17.1.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel oil and coal of a designated Estates Manager, the control of the equipment store to the designated Equipment Store Manager.

17.1.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

17.1.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

17.1.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

17.1.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

17.1.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 19, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.2 Receipt of goods

17.2.1 For goods purchased using the Trust's requisitioning/purchase order system, they will be delivered to the Trusts central receipt point before being delivered by Trust personnel to the end user. These goods will be checked and receipted on the purchase order system by the central receipt point staff in readiness for payment. An internal delivery note will accompany the goods and will be signed as acceptance of receipt of the goods by the end user (person/ward/department requesting the goods). Any discrepancies on the goods delivered must be reported to the [receipt and distributions](#) department within five working days, who will then take the most appropriate action.

18 Disposals and Condemnations, Losses and Special Payments

18.1 Disposals and condemnations

18.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

18.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate. All staff have a responsibility to report asset disposals and those determined as obsolete or missing.

18.1.3 Disposal of assets with a Net Book Value in excess of £50,000 require approval of the Board. Any proposed disposal requires a paper detailing options for disposal and expected net realisable value from such options. Any such proposal must include criteria for proceeding with the disposal (such as net receipt, or eradication of an associated liability), such that if the criteria is not achieved then the disposal is not completed.

18.1.4 All unserviceable articles shall be:

- a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and
- b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

18.1.5 It is the responsibility of all staff to ensure that obsolete / damaged / missing assets are reported to the Director of Finance.

18.2 Losses and special payments

- 18.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance must also prepare a ~~process~~ 'Fraud Response Plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.
- 18.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.
- 18.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:
- a) the Board, and
 - b) the External Auditor.
- 18.2.4 The Director of Finance shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidation. For any loss, the Director of Finance should consider whether any insurance claim can be made.
- 18.2.5 The Director of Finance shall maintain a Losses and Special Payments Register in which any write-off action is recorded and presented to the Audit Committee for approval. This includes the write off for bad debts and the report will include volumes, values and reasons for the write off. Authorisation for write off is by the Director of Finance.

19 Information Technology as regards Financial Systems

- 19.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:
- a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the ~~Data Protection Act 1984 and 1998~~ General Data Protection Regulations and Caldicott principles;
 - b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
 - c) ensure that adequate controls exist such that the production systems are separated from development, maintenance and amendment;
 - d) ensure that an adequate management (audit) trail exists through the computerised

system and that such computer audit reviews as he/she may consider necessary are being carried out.

19.1.2 The Director of Finance shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

19.1.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

19.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation. Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy him/herself that:

- a) systems acquisition, development and maintenance are in line with any relevant prevailing corporate policies such as an Information Technology Strategy;
- b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
- c) Directorate of Finance staff have access to such data; and
- d) Such computer audit reviews as are considered necessary are being carried out.

19.1.5 Where the Trust provides IT services to other health organisations, the Director responsible for information systems shall ensure that appropriate contracts are drafted and agreed.

20 Patients' Property

20.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival in the possession of patients who lack capacity to take care of it for themselves.

20.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,

- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.1.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20.1.4 Where statutory or regulatory instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

20.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

20.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

21 NHS Charitable Funds

21.1 Introduction

- 21.1.1 The discharge of the Trust's corporate trustee responsibilities for Charitable Funds are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each Charitable Fund is managed appropriately with regard to its purpose and to its requirements. The Charitable Funds are administered by the Board acting as corporate trustee. The Board may execute its responsibilities through a Committee established for that purpose, although it remains responsible for the proper management and administration of the Charitable Funds.
- 21.1.2 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of Charitable Funds it holds, and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on trust and to the Independent Regulator for all funds held on trust.
- 21.1.3 The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.
- 21.1.4 As management processes overlap most of the sections of these SFIs will also apply to the management of Charitable Funds. This section however covers those instructions which are specific to the management of Charitable Funds.
- 21.1.5 All other sections of the SFIs shall apply equally to Charitable Funds as to other funds except that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate Fund and made in accordance with approval limits set by the Trust Board, or a Committee established for the administration of the Charitable Funds.
- 21.1.6 The over-riding principle is that the integrity of each Charitable Fund must be maintained and Statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.
- 21.1.7 The Board hereby nominates the Director of Finance to have primary responsibility to the Board for ensuring that these SFIs are applied taking legal advice as required.

21.2 Existing Charitable Funds

21.2.1 The Director of Finance shall arrange for the administration of all existing Charitable Funds taking legal advice as required. He shall ensure that a governing instrument exists for every Fund and shall produce detailed codes of procedure covering every aspect of the financial management of the Charitable Fund, for the guidance of directors and employees. Such guidelines shall identify the restricted nature of certain Funds including Linked Charities.

21.2.2 The Director of Finance shall periodically review the Funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such Funds within statutory guidelines.

21.2.3 The Director of Finance may recommend an increase in the number of the Funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds e.g. designation for specific wards or departments.

21.3 New Charitable Funds

21.3.1 The Director of Finance shall, taking legal advice if necessary, arrange for the creation of a new Charitable Fund where funds and/or other assets, received in accordance with the Trust's policies, cannot be managed adequately as part of an existing Charitable Fund. The Director of Finance shall present the governing document to the Board for adoption for each new Charitable Fund. Such document shall clearly identify, inter alia, the objects of the new Charitable Fund, the capacity of the Trust to delegate powers to manage and the power to assign the residue of the Fund to another Fund contingent upon certain conditions, e.g. discharge of original objects. This same process applies to Linked Charities.

21.4 Sources of new funds

21.4.1 In respect of donations the Director of Finance shall provide guidelines to officers of the Trust as to how to proceed when offered funds. These to include:-

- a) the identification of the donor's intentions;
- b) where possible, the avoidance of new Charitable Funds;
- c) the avoidance of impossible, undesirable or administratively difficult objects;
- d) sources of immediate further advice; and
- e) treatment of offers for personal gifts.

- 21.4.2 The Director of Finance shall provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's Charitable Funds and that the donor's intentions have been noted and accepted.
- 21.4.3 All gifts accepted shall be received and held in the name of the Trust and administered in accordance with the Trust's policy, subject to the terms of specific trusts. As the Trust can accept gifts only for all or any purposes relating to the Health Service, officers shall, in cases of doubt, consult the Director of Finance before accepting any gifts.
- 21.4.4 In respect of legacies and bequests the Director of Finance shall provide guidelines to officers of the Trust covering any approach regarding the wording of wills and the receipt of funds/other assets from executors.
- 21.4.5 Where necessary the Director of Finance will obtain grant of probate or make application for grant of letters of administration where the Trust is the beneficiary.
- 21.4.6 The Director of Finance will be empowered on behalf of the Trust to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty and shall be directly responsible taking legal advice as necessary for the appropriate treatment of all legacies and bequests.
- 21.4.7 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Director of Finance who alone shall be empowered to give an executor a good discharge.
- 21.4.8 In respect of fund raising the Director of Finance shall after taking legal advice deal with the arrangements for fund raising by and on behalf of the Trust and ensure compliance with all statutes and regulations.
- 21.4.9 The Director of Finance shall be empowered to liaise with other organisations/persons raising funds for this Trust and provide them with adequate discharge. The Director of Finance shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board.
- 21.5 Taking legal advice, the Director of Finance shall be responsible for alerting the Board to any irregularities regarding the use of the Trust's name and its registration numbers and for the appropriate treatment of all funds raised.
- 21.5.1 In respect of trading income the Director of Finance shall be responsible, taking legal advice as required, along with other designated officers, for any trading undertaken by this Trust as a corporate trustee and for the appropriate treatment of funds from this source.

21.6 Investment management relating to charitable funds

- 21.6.1 In respect of investment income the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source, in accordance with the approved strategy and policy.
- 21.6.2 The Director of Finance shall be responsible for all aspects of the management of the investment of funds held on trust. He will, taking legal advice as required, formulate an investment policy for approval of the Board in its capacity as trustees. The policy will be within statutory powers and governing instruments to meet its requirements with regard to income generation and the enhancement of capital value.
- 21.6.3 The Director of Finance will be responsible for the appointment of advisors, brokers and where appropriate fund managers. Taking legal advice as necessary the Director of Finance shall agree the terms of such appointments and written agreements will be drawn up and signed by the Chief Executive.
- 21.6.4 The Director of Finance shall be responsible for pooling investment resources and for the preparation of a submission to the Charity Commission for them to make a scheme and for the participation of the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds.
- 21.6.5 The Director of Finance will ensure that the use of trust assets is appropriately authorised in writing and charges raised within policy guidelines.
- 21.6.6 The Director of Finance shall review the performance of brokers and fund managers and shall report on investment performance.
- 21.6.7 All share and stock certificates and property deeds shall be deposited either with the Trust's bankers or in a safe, or a compartment within a safe, to which only the Director of Finance will have access.

21.7 Disposition management relating to Charitable Funds

- 21.7.1 The Director of Finance shall manage the dispositive discretion of the Trust in respect of Charitable Funds in conjunction with the Board acting as trustees.
- 21.7.2 Account will be taken of:-
- a) the objects of various funds and the designated objectives;
 - b) the availability of liquid funds within each trust;
 - c) the powers of delegation available to commit resources;
 - d) the avoidance of the use of Exchequer funds to discharge trust fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Exchequer shall

be discharged by Charitable Funds at the earliest possible time;

- e) funds are to be spent rather than preserved, subject to the wishes of the donor and identified needs; and
- f) the definitions of “charitable purposes” as agreed by the NHS Executive with the Charity Commission.

21.8 Banking service for Charitable Funds

21.8.1 The Director of Finance shall advise the Board and with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. Those bank accounts should permit the separate identification of liquid funds to each trust fund where this is deemed necessary by the Charity Commission.

21.9 Asset management for Charitable Funds

21.9.1 Assets in the ownership of or used by the Trust as corporate trustee shall be maintained along with the general estate and inventory of assets. The Director of Finance shall ensure, taking legal advice as required that:-

- a) appropriate records of all assets owned by the Trust as corporate trustee are maintained and that all assets at agreed valuations are brought to account;
- b) appropriate measures are taken to protect and/or replace assets. These to include decisions regarding insurance, inventory control and the reporting of losses;
- c) donated assets received on trust rather into the ownership of the Secretary of State shall be accounted for appropriately; and
- d) all assets acquired from funds held on trust which are intended to be retained within Charitable Funds are appropriately accounted for and that all other assets so acquired are brought to account in the name of the Secretary of State.

21.10 Reporting

21.10.1 The Director of Finance shall ensure that regular reports are made to either the Charitable Funds Committee, the Terms of Reference of which are outlined in the Standing Orders and Scheme of Delegation.

21.10.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Trust Board within agreed timescales.

21.10.3 Taking legal advice as required, the Director of Finance shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Independent Regulator and to the Charity Commission for adoption by the Board.

21.11 Accounting and audit of Charitable Funds

21.12 The Director of Finance shall maintain all financial records including an Investments Register to enable the production of reports as above and to the satisfaction of internal and external audit.

21.13 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They will liaise with external audit and provide them with all necessary information. The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

21.14 The Board shall be advised by the Director of Finance on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

21.15 Administrative costs

21.16 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

21.17 Taxation and excise duty

21.18 The Director of Finance shall ensure that liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

22 Retention of Documents

- 22.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Information Governance requirements.
- 22.1.2 The documents held in archives shall be capable of retrieval by authorised persons.
- 22.1.3 Documents held under SFI 22 (Retention of Documents) shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.
- 22.1.4 The Chief Executive will ensure all records are stored securely with proper environmental controls and adequately protected against fire and flood.
- 22.1.5 The local records office should be consulted before records more than sixty years old are destroyed.
- 22.1.6 The method used for destruction of confidential records should ensure that their confidentiality is fully maintained. Normally destruction should be by incineration or shredding. Where this service is provided by a contractor, it is necessary to ensure that the methods used throughout all stages (including transport to the destruction site) provide satisfactory safeguards against accidental loss or disclosure.

23 Risk Management and Insurance

- 23.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.
- 23.1.2 The programme of risk management shall include:
- a) a process for identifying and quantifying risks and potential liabilities;
 - b) engendering among all levels of staff a positive attitude towards the control of risk;
 - c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
 - d) contingency plans to offset the impact of adverse events;
 - e) audit arrangements including; internal audit, clinical audit, health and safety review;
 - f) arrangements to review the risk management programme.
 - g) The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by Monitor.

23.1.3 The Chief Executive shall ensure that insurance arrangements exist in accordance with the risk management programme.

23.1.4 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority (NHSLA) or self-insure for some or all of the risks covered by the schemes. If the Board decides not to use the risk pooling schemes (clinical, property and non-clinical third party liability), this decision shall be reviewed annually. For insurable risks not covered by the NHSLA the Board shall decide whether to self-insure or seek third-party insurance.

23.1.5 All the risk-pooling schemes require members to make some contribution to the settlement of claims. The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Document name:	Annex A – Standing Financial Instructions Contracting and Purchasing
Document type:	Finance Department Guidance
Staff group to whom it applies:	All Trust staff
Distribution:	The whole of the Trust
How to access:	Intranet and internet
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Developed by:	Tony Cooper Head of Procurement
Director lead:	Director of Finance
Contact for advice:	Tony Cooper Head of Procurement or Senior Procurement Managers

ANNEX A
STANDING FINANCIAL INSTRUCTIONS
CONTRACTING AND PURCHASING

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1. INTRODUCTION
2. SCOPE OF THE PROCEDURE
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4. DEFINITIONS
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7. FORMAL CONTRACTS
8. APPENDICES

This financial procedure should be used in conjunction with the Trust's: -

- **Standing Orders;**
- **Standing Financial Instructions; and**
- **The Trust's Scheme of Delegation.**

Should any difficulties arise regarding the interpretation or application of any of these financial procedures, then the advice of the Director of Finance **MUST BE SOUGHT BEFORE ACTING.**

**FAILURE TO COMPLY WITH FINANCIAL PROCEDURES IS A
DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.**

Tendering Procedure

1. Introduction

- 1.1 All NHS Organisations are required to ensure that their tendering process is fair, transparent and produces value for money contracts. The procedure outlined ensures a set code of conduct for the bidding process in which all suitable suppliers are treated equally and fairly in accordance with the rules of procurement.
- 1.2 The procedure is written in line with the Trust's Standing Orders and Scheme of Delegation. It defines the action that must be taken by staff of the Trust when letting a contract for the purpose of procuring goods and services.
- 1.3 Every contract and sub contract made on behalf of the Trust shall comply with the following instructions, except that in an emergency the Chief Executive, or in his/her absence the Director of Finance or Deputy Chief Executive, may set aside such of these instructions as may be necessary. The Director of Finance shall report each such exception to the next meeting of the Trust Management Executive.
- 1.4 In order that the Trust's contractual position is sound all quotations and tenders should, wherever possible, be obtained on the official documents of the Trust.
- 1.5 Where a specification issued by the British Standards Institute or other recognised authority is current at the date of the tender or quotation and it is appropriate for goods and materials to be used in the execution of any contract, such goods or materials shall be at least in accordance with that specification.
- 1.6 Generally all tender requests for goods and services will be processed via the Trusts electronic tendering system which is approved by the Chief Executive or in its absence or unavailability they must be processed by the Chief Executive's Department.

2. Scope of the Procedure

- 2.1 In order to fulfil the requirements of the policy all contracts for goods and services must only be entered into by the Trust following a set procedure that ensures the interests of the Trust and the public are maintained. Such a procedure must ensure that risk is managed and that the Trust achieves the best possible contract.
- 2.2 The advice of a procurement department must always be sought before tendering for any contract, as there are exceptions and potential implications in ensuring compliance with Standing Orders. The procurement department may also call on other members of Trust staff, outside support i.e. Crown Commercial Services, NHS Supply Chain, NHS Shared Business Services, Department of Health and expertise from other Health organisations for advice and/or to become a member of a contract procurement panel.

2.3 Waivers

The Chief Executive, Deputy Chief Executive or Director of Finance may waive the requirements of the procedure except where the legislative rules of public procurement apply i.e. purchases made over the European Union threshold currently **£181,302** (this figure is dependant on £/Euro exchange rate and is subject to a bi-annual update) .

The formal tendering procedures may be waived in the following cases.

1. Where the supply is proposed under special arrangements negotiated by the DoH in which event the said special arrangements must be complied with; or
2. The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not justification for single tender; or
3. Specialist expertise is required and is available from only one source; or
4. The task is essential to complete the project, AND arises as a consequence of a recently completed assignment and engaging different consultants for the task would be inappropriate; or
5. There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential advantage to be gained by competitive tendering; or
6. Where provided for in the Capital Investment Manual.

Non-competitive quotations in writing may be obtained for the following purposes

1. Supply of goods and services of a special character for which, in the opinion of the Chief Executive or nominated officer, it is not possible or desirable to obtain competitive quotations.
2. The goods and services are required urgently.

The request to waive the Trusts Standing Orders / Standing Financial Instructions must be submitted on a Waiver of Tender Procedure / Waiver of Quotation Procedure Form (see appendix I). This form is available from the Procurement Department, who will provide advice and guidance on the legitimacy of each request for a single Tender / Quotation.

The Tender Waiver Request Form (Appendix I) should be fully completed and forwarded, with any supporting documentation, to the Procurement department for validation by the Head of Procurement. If the proposed purchase is IT related it should signed by an approved member of the IM&T department before being sent to Procurement.

If the reason for the waiver deemed to be satisfactory the Head of Procurement will sign and forward the waiver onto the Executive office for final authorisation by the Director of Finance, Deputy Chief Executive or the Chief Executive. The Director of Finance, Deputy Chief Executive and/or the Chief Executive may at this stage choose to seek the advice of the Head of Procurement on the legitimacy of the waiver application.

If in the opinion of the Authorised officer, (Director of Finance, Deputy Chief Executive, Chief Executive) and/or the Head of Procurement competition could be sought, then a formal tender process would commence after first ensuring that this action has been communicated to the originator of the waiver request.

If it is clear that there are no other supply alternatives or if the purchase falls under one of the six single source cases listed above; the approved Waiver Form should then be forwarded to the Procurement Department, along with the supporting documentation i.e. electronic requisition (RFQ - request for quotation) reference number from the procurement system. To confirm the legitimacy of the single source request the Tender Waiver form will be countersigned by the Head of Procurement.

The Waiver of Tender Procedure / Waiver of Quotation Procedure Form (Appendix I) is available from the Procurement Department, who will provide advice and guidance on the legitimacy of each request for single quotation. The form must be fully completed and authorised by the appropriate Trust officer. The form should then be forwarded to the Procurement Department along with any supporting documentation i.e. electronic requisition (RFQ - request for quotation) reference number from the procurement system. To confirm the legitimacy of the single source request the Quotation Waiver form will be countersigned by the Head of Procurement. Should the Head of Procurement deem that competitive bids ought to be obtained a formal quotation process will be conducted after first communicating this approach with the originator of the waiver document.

All Information Technology related waivers should also be countersigned by an appropriate IT Manager.

A register of all Tender and Quotation Waivers will be maintained by the Head of Procurement and made available for Audit inspection and, where applicable for the purpose of informing the Trust Board.

All Tender / Quotation waivers will be reported to the Audit Committee on a quarterly basis by the Head of Procurement.

2.4 Joint Procurement

The Trust may undertake joint procurements in conjunction with NHS or other bodies. One organisation will be the lead for the tendering process up to and including the evaluation of the tenders. Thereafter the adjudication for a contract to be awarded by the Trust for goods and/or services for its use will be undertaken in accordance with this procedure. Where the Trust is the lead organisation this procedure will be followed.

It is not necessary to follow the procedures where the following conditions apply:

- Goods and/or services are being ordered under an existing contract.
- Estates purchases made under other appropriate compliant contracts / procedures.
- Disposals of land and buildings governed by the NHS Handbook on Land Transactions.
- Where a waiver has been issued by the Director of Finance, Deputy Chief Executive and/or the Chief Executive
- Where a nationally agreed contract exists.

If the Director of Finance, Deputy Chief Executive or the Chief Executive decides to waive the Tendering Procedure, a Register of Waivers must be kept available for Audit inspection. It should include:

- The description of the tender
- The amount
- The reason for the Waiver
- The company involved
- The signature of the Director of Finance & Resources or the Chief Executive or their nominee

3. To Whom this Document Applies

This document applies to any member of staff involved in

- Requesting a substantial service/asset which is to be bought or leased by the Trust
- Managing the Tendering Process
- Reviewing Tenders

4. Definitions

- 4.1 Tender a strictly controlled process for inviting bids for goods and services in as wide and competitive a market as practical. This places the contract under the Trust's and/or the NHS terms and conditions of contract. The term tender is also used to describe the offers received from suppliers.
- 4.2 Quote a response to an approach by the Trust to a limited number of suppliers for a price for a specified requirement.
- 4.3 Contract a legally binding Agreement between the Trust and its supplier relating to the provision of goods and services. This can be in the form of a formal document which is duly signed by all interested parties and in some cases sealed by the Trust, a purchase order placed for the goods and services or very simply a verbal instruction given by a member of the Trust instructing a company to provide goods and services in exchange for payment. Clearly the latter should not be encouraged as it may compromise the Trust both in commitment and financial terms and the action may exceed the member of staff's financial authority and could therefore lead to disciplinary action.

5. The Stages of the Procedure for Tenders

5.1 Identify the need for goods and/or services

The end user or service manager will usually identify the need to procure goods for a variety of reasons such as increased capacity for equipment in use, replacement of existing goods, technology innovations.

Once identified a submission must be made to the Procurement Department for approval to proceed. At this stage it will be determined by the Head of Procurement, with input from the end user / service manager whether the procurement will require a procurement panel to oversee and evaluate the full tender process. If the panel is required it will consist of representatives of the procurement function, finance, the originating department and if the tender has a direct impact on the health care needs of the Trusts service users then a service user representative will be invited to join the panel.

The tender project will be assessed at the outset to determine the level of sensitivity of the contract and whether additional security measures should be put in place at the commencement of the project. Key individuals will be requested to formally declare that they do not have a vested interest in tender projects at the commencement of proceedings and the need for confidentiality will be communicated to these individuals either verbally at the tender meetings or through the signature of a confidentiality document (see appendix II). The number of people for intricate projects will be kept at an optimum level commensurate with the complexity of the project. Commercially sensitive information will be distributed on a need to know basis with access via the Trusts eTendering system on a temporary "selected project only" basis.

The Chief Executive's Office will be fully informed of the outcome of any formal tender exercises. Agreement to proceed with any procurement will only be given once the source of funding has been identified. There are a number of potential sources:

- The capital programme
- Revenue expenditure which may be through lease payments or an individual budget
- Other sources such as Trust or charitable funds.

If a procurement panel is required it will also agree to invite the minimum number of companies deemed applicable to the purchase value as detailed in the Trusts Standing Financial Instructions.

5.2 Determine the value of the requirements

There are different rules for different values of goods and/or services:

5.21 **£1,000-£10,000** – it is considered good practice for the end user to obtain at least one written quotation from the proposed supplier of the goods or services required. This should be forwarded to the Procurement

department after completing an electronic requisition (RFQ – Request for Quotation), which will be duly authorised in accordance with the Trust's hierarchical authorisation / signatory procedures. The end user should retain a copy of the quotation for their records. The Trusts procurement function *may* look to find an alternative supply source to the one specified by the end user through seeking offers via its electronic eTendering system, any such changes to the supplier identified will be agreed where necessary by the procurement department with the end user prior to placing the purchase order.

- 5.22 **£10,000-£25,000** - the Procurement department must look to obtain a minimum of three competitive quotations in writing. The Procurement department will ascertain whether or not a national contract exists. The end user should forward any informally received quotations obtained to the Procurement department after completing an electronic requisition (RFQ), which will be duly authorised in accordance with the Trust's hierarchical authorisation / signatory procedures. It is the Procurement department's role to obtain competitive quotations via its eTendering system as it ensures that the process is independent, fair and transparent and fully complies with the Trusts Standing Financial Instructions and all associated levels of scrutiny.
- 5.23 **£25,000** and above – the contract must be let by tender and the proposed procurement submitted to the Procurement department and/or if the contract is such that it requires a Procurement panel submitted to the panel for agreement to proceed. The tender specification should be signed off by the user department/procurement panel before commencement of the tender exercise. If the value of the contract is below the European Community [EC] threshold the next stage [see below] should be followed. Where the value of the contract is above or very close to the EC threshold, an advertisement will be placed in the European journal [known as the Official Journal of the European Union, or OJEU]. All advertisements will be placed on behalf of the Trust or where applicable on behalf of a collaborative of Trusts/Local Authority's in order to achieve economies of scale.
- 5.24 The format and requirements of the OJEU advertisement are pre-determined and should only be placed by the Procurement department except in special circumstances where an external body has been engaged to undertake a procurement process on behalf of the Trust. This may occur either for works to be managed by the Estates Department or where a joint procurement with NHS or other bodies is taking place.
- 5.25 When an OJEU advert is placed it is generally accepted that due to the specialist nature of the NHS business the Restricted Process is used. This process through its very structure restricts the number of tenderers by placing qualifying requests on prospective suppliers expressing an interest in the contract i.e. must provide three years financial accounts, must possess certain business recognised qualifications/standards etc. It allows potential tenderers up to 37 days to express their interest in the contract (this timescale is reduced by 7 days in cases where the advert is

electronically submitted); they are then given a further 30 days from the time of dispatch of the tender to return their offer (this timescale is reduced by 5 days in cases where there is full electronic access to tender documents).

The process can be accelerated to 15 days (this timescale can be reduced by 5 days in cases where the advert is electronically submitted) for expressions and 10 days for the tender return if the Trust has a valid reason for doing so i.e. a matter of extreme urgency such as major equipment failure. Poor planning cannot be used as a reason to reduce the OJEU tender process.

Criteria for the evaluation of the tenders should be contained in either the OJEU advert or in the actual tender documents.

5.3 Invitation to Tender

- 5.31 If an OJEU advertisement is not placed, as the procurement does not exceed the threshold, then in the case of the Estates and Facilities department an agreed number of companies from the Trusts approved list of suppliers (i.e. the Trusts own database of suppliers or those registered on Constructionline or other Public Sector framework agreements), will be invited to tender for the goods or services via the procurement departments eTendering system.
- 5.32 For non-facilities purchases, tenders will be sought via the Procurement department using where possible suppliers that are on the Trusts own eTendering database; national NHS / Crown Commercial Services; and Public Sector framework contracts for like products/services or whose details are captured on the trusts purchase order system having previously been an approved supplier to the Trust. This procedure also applies to all I.T. procurement where purchases are made from non-contract sources. Tender opportunities posted via the Trusts eTendering portal will also be advertised in "Contracts Finder" to encourage the participation of local and Small, Medium Enterprises (SME's).
- 5.34 New suppliers submitting tenders to the Trust that have successful bids will be subject to an approval process which will look at their economic, financial and technical capacity, major contracts won and customer references. The extent of the approval process for new suppliers to the Trust will be dependant on the value of the contract and any potential risk to the Trust in placing business with them.
- 5.35 Tender documents sent to potential suppliers should contain or make clear reference to the NHS Terms and Conditions or the Crown Commercial Services (CCS) Terms and Conditions of Contract if the tender is using a CCS Framework agreement. It should also have a specification [or operational requirement] of the goods or services required. Where the NHS Terms and Conditions are merely referred to it should be indicated that copies are available for those suppliers on request.

- 5.36 Invitations to tender shall be checked and sent out by officers authorised by the Chief Executive, as appropriate, and each shall state a specific date and time after which tenders will not be considered. Each invitation shall also include a warning against corruption, and in the case of consultancy or sole trader providers include an income tax and national insurance declaration form which asks for confirmation that the bidder is fully compliant with all HMRC regulations around the payment of national insurance and income tax. No tender will be considered unless submitted in the correct manner, in the case of the Trusts eTendering system through the method prescribed by the system and on the rare occasions where tenders may be invited by post in the plain sealed envelope provided which shall not bear any name or mark indicating the sender.
- 5.37 All tenders requested via the Trusts eTendering system shall be invited by the procurement department and the tenders opened by two member of the Trusts Procurement team and shall be deemed “open” on release of the data in the manner prescribed by the system. On the rare occasions where tenders are being sought by post they shall be addressed to the Chief Executive, and shall remain in the custody of a delegated officer until the time appointed for their opening. At the earliest convenient time after the latest time for the receipt of tenders they shall be opened in the presence of two officers. Officers should not participate in the opening of those tenders in which they are associated.
- 5.38 The specification should be generic and not contain any requirements or features that are specific to one supplier only thereby restricting competition. The specification should be signed off by the end user department, the procurement department and where appropriate members of the procurement evaluation panel prior to its issue to confirm its compliance with the above statement.
- 5.39 During the period that tenders are open site visits and trials may be undertaken. Reports or evaluation forms must be submitted to contribute to the overall analysis of the offers from suppliers.

It is important that the contract evaluation criteria is contained in the tender document and is used as part of any site visits or trials.

5.4 The receipt and safe custody of tender documents

- 5.41 The receipt and safe custody of tender documents is an important part of the process that governs whether or not offers from suppliers can be accepted and considered by the Trust for the supply of goods and services.
- 5.42 The Chief Executive’s nominee, the Receiving Officer is responsible for the safe custody of tenders until the time appointed for opening.
- 5.43 The date the Receiving Officer receives the tenders shall be noted on the Trusts eTendering system and on the rare occasions where tenders are requested by post must be endorsed on the unopened packages.

- 5.44 The Trusts eTendering system shall hold securely all bids until the specified time for release by the designated members of the Trusts Procurement Team.

On the rare occasions where tenders are invited by post a Register must be kept by the Receiving officer for each tender bid identifying:

- a) The name and reference of each supplier invited to tender
- b) The date of opening
- c) The price quoted for the contract
- d) The signatures of the delegates opening the documents

This Register must be held in safe custody by the Receiving Officer for a period of 5 years. The Procurement Dept must retain a full record of the tender, including selection criteria records for a period of 1 year to allow audit to take place. Individual departments may keep copies of documents as required.

5.5 The opening of tenders

Tender documents must be opened in accordance with rules that ensure probity and demonstrate that all tenders are treated equitably.

These rules are as follows:

- In terms of the Trusts eTendering system the offers shall be deemed “opened” on release by the designated members of the Trusts Procurement Team in the manner prescribed by the system.
- The offers received via the eTendering system should be anonymised until they are opened by the system after the receipt date/time has expired.
- All documents must be opened at the same time.
- Where tenders are sought by post the documents must be opened in the presence of the Director of Finance, Deputy Chief Executive [or his/her nominated deputy] and another Director [or their nominated deputy]. For tenders above **£1,000,000** one of those Directors should be a Non-Executive Director.
- After all documents are opened and recorded either via the Trusts eTendering system or the postal method, it is the responsibility of the Nominated Contracts Officer to arrange for a Panel to evaluate the tenders.

5.6 Acceptance and record of formal tenders

Tenders may only be accepted in accordance with the Rules of Acceptance and Record of Formal Tenders.

Rules

- 5.61 Tenders received after the due time and date *may* be considered only if the Chief Executive, Deputy Chief Executive or Director of Finance decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advances would accrue. In terms of tenders submitted by the Trusts eTendering system, late tenders can only be accepted

outside of the system as the system is locked down after the return date/time has expired and this is by ticking a late tender box after the lock down date. The Chief Executive, Deputy Chief Executive or Director of Finance must be satisfied that there is no reason to doubt the bona fides of the tenders concerned.

- 5.62 The Chief Executive, Deputy Chief Executive or Director of Finance shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. In the case the Trusts eTendering system the offers shall be deemed to be “unopened” until the officer responsible has conducted the correct procedure in accordance with the systems instructions.
- 5.63 Incomplete tenders [i.e. those from which information necessary for the adjudication of the tender is missing] and amended tenders [i.e. those amended by the tenderer upon his own initiative either orally or in writing] should be dealt with in the same way as late tenders.
- 5.64 Where examination of tenders reveals errors, which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.
- 5.65 Necessary discussions with a tenderer of the contents of his tender, in order to clarify technical points before the award of a contract, need not disqualify the tender.
- 5.66 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.
- 5.67 Where only one tender/quotation is received it will be considered void unless agreed otherwise by the Chief Executive, Deputy Chief Executive or Director of Finance.
- 5.68 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or nominated officer.
- 5.69 All tenders should be treated as confidential and should be retained for inspection for a minimum of six years or where contracts extend beyond six years at least one year beyond contract termination.

5.7 Evaluation of the Tender

Where appropriate or previously agreed a Panel shall be established to evaluate the tenders, in accordance with the following rules.

Rules

5.71 The constitution of the evaluation panel shall be the end user[s], a senior procurement manager, a senior accountant. The nominated Contracts Manager must ensure that the membership of the evaluation panel consists of people who have no vested interest in the award of contract, this may include seeking confirmation of that fact and panels members signing a document to that end. The individuals involved must complete an evaluation for all items of equipment or other goods and these must be kept as a permanent record with the tenders. The evaluation should consist of a financial and non-financial analysis. The Chief Executives Office will be duly informed of any formal tender awards.

Commercially sensitive information will be distributed on a need to know basis with access provided via the Trusts eTendering system on a temporary "selected project only" basis. Any information forwarded electronically should be via secure email connections, postal information should be sent securely and marked "Private and Confidential for the Addressee only".

5.72 The technical analysis will include whether or not the offers meet specification and will score each one in accordance with the pre-set criteria agreed at the start of the process.

5.73 The financial analysis will compare the core items and include any enhancements offered by the suppliers. It will also examine the financial stability of the prospective supplier using where necessary the suppliers financial account details or a comprehensive financial report from Dun & Bradstreet if deemed necessary for the procurement of the product/service.

5.74 As part of the evaluation it may be necessary to obtain written references from the potential supplier's client base. These will preferably be other NHS Trusts or Local Authority establishments.

5.75 It may be necessary to seek further clarification from suppliers. This must be done in writing if possible and where tenders are sought through the Trusts eTendering system via that system to ensure that such clarification is documented, has a full audit trail and is duly shared with all prospective bidders.

5.76 Where applicable the panel and/or the Procurement department will recommend the letting of a tender and the Chief Executive's representative will write to the successful tenderer. Ensuring that appropriate approval is sought, which may include Board approval if needed.

5.77 A tender other than the lowest (if payment is to be made by the Trust or highest tender if payment is to be received by the Trust), shall not be accepted unless for good and sufficient reason the Executive Management Team decides otherwise on the basis of a report submitted by the

procurement department and/or procurement panel which supports the decision.

5.78 In certain circumstances, it may be necessary to hold post tender discussions or negotiations. Post tender discussions are used to clarify aspects of an offer, whereas post tender negotiations are intended to deal with additional financial considerations. Post tender negotiation may be defined as: -

“Negotiation after the receipt of written offers and before the letting of contracts with suppliers having a reasonable opportunity of winning the contract, with a view to obtaining an improvement in price, delivery or content in any circumstances which do not put other suppliers submitting offers at a disadvantage or affect adversely their confidence or trust in the competitive offer system”.

5.79 The need for post tender negotiations should be minimal if pre tender discussions and negotiations have been carried out properly. Every effort should be made to make sure all requirements are clear at the pre tender stage and included in the invitation to tender package. If tenders fall within the EU limits, advice from the Procurement department must be sought as different rules apply.

5.80 Post tender negotiations should only take place when :-

- a) suppliers have been informed at the pre tender stage or tender stage that post tender negotiations may be held with those who submit the most competitive offers;
- b) after all the offers have been evaluated, there is no overwhelming evidence for choosing one supplier over another;
- c) terms and conditions of the contract or purchasing arrangement need to be clarified by mutual agreement, e.g.
 - when a fixed price offer period varies from one supplier to another
 - when the lowest offer is based on different terms and conditions to all the other offers (providing the differences are not great enough to warrant abandoning the existing offers and inviting new written offers)
- d) the award of business to one supplier provides the optimum purchasing solution and where such an outcome could not have been anticipated at the pre tender stage;
- e) an offer is not based on a detailed specification or where there has been a bona fide change in specification which is not significant enough as to warrant abandoning the existing offers and inviting new written offers.

- 5.81 Post tender negotiations must only be undertaken following the approval of the Director of Finance, who will ensure that they are conducted (where it is deemed appropriate i.e. the value of the contract dictates) before a witness, with the newly-negotiated prices being recorded.
- 5.82 Wherever possible post tender negotiations should be conducted face to face and include at least two authorised officers of the Trust. Clear notes are to be retained on the content and decision reached, which are to be signed by the officers concerned. If the task is to be carried out by telephone, faxed or hard copies which confirm the details must be obtained and become addenda to the tender documents.

6. Opening of quotations

Quotations must be opened in accordance with rules that ensure probity and demonstrate that all offers are treated equitably.

These rules are as follows:

- In terms of the Trusts eTendering system the quotations shall be deemed “opened” on release by the designated member of the Trusts Procurement Team in the manner prescribed by the system. This Procurement Team member should not be the person who has originated the request for quotation.
- The quotation offers received via the eTendering system should be anonymised until they are opened by the system after the receipt date/time has expired.
- All documents must be opened at the same time.

7. Official Orders

- 7.1 No goods, services or works other than works and services executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order and contractors shall be notified that they should not accept orders unless on an official form. Verbal orders shall be issued only by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued no later than the next working day and clearly marked "Confirmation Order".
- 7.2 Official orders shall be consecutively numbered, in a form approved by the Director of Finance and shall include such information concerning prices and costs as he/she may require. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations, etc.
- 7.3 Requisition forms and/or user access to the Trusts on-line purchase order requisitioning system shall only be issued / given to and signed

by/approval provided to officers so authorised by the Chief Executive. The authority given to officers to sign/electronically approve requisitions shall not exceed the delegated financial limits set out in the Trust's Schedule of Reservation of Powers to the Board and Delegation of Powers, which are :-

Requisitioning and approving of invoices

Approval Level	Approval Limit Up to:	Notes / indicative delegations
6	Greater than £75,000	Dual Director approval (normally Director and Director of Finance)
5	£75,000	Director
4	£50,000	Deputy Director
3	£5,000	Typically General Manager
2	£500	Typically budget holder
1	£100	Typically a senior requisitioner
0	0	Requisitioner

Lists of authorised officers and their specimen signatures shall be maintained by the Director of Finance and this list of approved signatories and their delegated financial limits will be held within the Trusts financial ledger / purchase order system. Amendments to authorised officers should be notified to finance so that the specimen signature lists and the system can be kept up to date. Such lists shall be available for inspection by any officers authorised by to do so.

- 7.4 Order forms shall only be issued to and signed by officers so authorised by the Chief Executive, Deputy Chief Executive or Director of Finance i.e. manager or supplies service, estates service, etc., for specific items. Details of authorised officers shall be maintained for management control purposes. The details will show for each authorised officer the type of items to be ordered and delegated financial limit which will be reflected in the Trusts hierarchical approval limit set on its Accounts Payable / Purchase Order system.
- 7.5 All orders placed must comply with the Trust's Standing Financial Instructions and with the regulations for the time being in force on National, Regional, Collaborative, and Trust contracts.
- 7.6 Details of all orders placed shall be available to the Director of Finance either in a hard copy form or accessible through a computerised purchase ledger system.
- 7.7 No order should be issued for any item for which there is no budget provision unless authorised by the Chief Executive, Deputy Chief Executive or Director of Finance.

- Orders shall not be placed in a manner devised to avoid the financial limits set out in the above.
- No order shall be issued for any item or items for which an offer of gifts (other than low cost items, e.g. calendars, diaries, pens, etc.) or hospitality has been received from the person interested in supplying goods and services. Any officer receiving such an offer shall notify his senior officer as soon as practicable, details of hospitality received shall be entered in a register maintained by the Chief Executive. Visits at supplier's expense to inspect equipment, etc., must not be undertaken without the prior approval of the Chief Executive. In general any such visits should be paid for by the Trust.

Further guidance is contained in "Standards of Business Conduct for NHS Staff".

8. Formal Contracts

- 8.1 In the case of works which exceed **£500,000** in value (excluding VAT) or any individual contracts of a capital or revenue nature where the annual value or value over a three-year period exceeds **£500,000** contracts shall be executed under the common seal of the Trust. These contracts must have Trust Board approval before they can be awarded. For contracts of a lower value, where the professional advice from the procurement evaluation panel is that the Trust would benefit from sealing, then such action should be taken.
- 8.2 The Trust may only enter into contracts within its statutory powers and shall comply with:
- (a) the Standing Orders;
 - (b) the Trust's SFIs;
 - (c) EU Directives and other statutory provisions;
 - (d) any relevant directions including the Capital Investment Manual and guidance on the Procurement and Management of Consultants;
 - (e) such of the NHS Standard Contract Conditions as are applicable.

Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

- 8.3 All other aspects of for dealing with formal contracts are as stated in the Trusts Standing Orders section 9.19 to 9.25.

Request to Waive Standing Financial Instructions

SECTION 1: SUMMARY OF REQUIREMENTS *(Full procedure available from Purchasing)*

1. This form is to be completed **in all** circumstances where the competitive quotation/tendering procedures required under the Trust's Standing Financial Instructions are to be waived.
2. The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through competitive procedure.
3. Sections 2-4 must be completed in full by the Requisitioner and authorised by their Service Manager and the IT Department for IT related purchases before submitting to Procurement for validation by the Head of Procurement.
4. If reason for waiver is satisfactory, the Head of Procurement will forward to the Executive Office for final authorisation from the Director of Finance, Deputy Chief Executive or Chief Executive.
5. Once final authorisation has been obtained Procurement will process the RFQ.
6. Failure to comply with the above will result in a breach of Standing Financial Instructions.

Value £ (Exclusive of VAT)	Procedure	Min. no. of quotations/tenders	Scheme of Delegation
Supplies and Services			
Over £10,000 – Less than £25,000	Official Quotation	3	DoF or CE
Over £25,000 – Less than £181,302	Official Tender	3	DoF or CE
Over £181,302 (EU threshold)	EU Tender	5	Cannot be waived

Note:

It is considered good practice to obtain at least one written quotation for purchases made between the values of £1,000 to £10,000. Any quotations received should be forwarded to the procurement department with a copy retained by the end user. The procurement department may still look to seek an alternative source or test the price(s) received, any such changes to the proposed supplier will be agreed with the end user before placing the purchase order.

SECTION 2 : DETAILS OF REQUEST

Department		Date	
Requisitioner(Name)		
Description of goods or services requested	<i>Please provide as much detail as possible.</i>		
Valid Period (where applicable)	[start and end date]	Initial Order Value (exc. VAT)	£
Proposed Supplier		Total Whole Life Cost Value (exc. VAT)	£

SECTION 3 : JUSTIFICATION FOR WAIVER

Select justification	Explanatory Notes (<u>must</u> be added)
<p><u>Quotations (13.4.6 of the Trusts SFI's) :</u></p> <p>a) Supply of goods and services of a special character for which, in the opinion of the Chief executive or nominated officer, it is not possible or desirable to obtain competitive quotations.</p>	
<p>b) The goods and services are required urgently</p>	
<p><u>Tenders (13.7.1 of the Trusts SFI's) :</u></p> <p>a) The supply is proposed under special arrangements negotiated by the Department of Health in which event the special arrangements must be complied with.</p>	
<p>b) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for a single tender</p>	
<p>c) Specialist expertise is required and is available only from one source</p>	
<p>d) The task is essential to complete the project AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate</p>	
<p>e) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering</p>	
<p>f) The circumstances are covered by provision in the Capital Investment Manual for a single tender</p>	

Please supply any supporting information on a separate sheet

SECTION 4 : RECOMMENDATION OF WAIVER REQUEST

Must be approved via email by the Budget Holder or Equivalent (*failure to provide authorised approval will result in your waiver being returned*)

Budget Holder/Equivalent:(Print) Finance Code:

SIGNATURE HERE:

DATE:

I confirm that the information contained within this form is true and correct. I can confirm that that I have complied with the Trust's Standing Financial Instructions and Standing Orders. I understand that if I have knowingly provided false information or made a false statement that I may be subject to disciplinary and/or criminal action.

Authorised in Budget Holder/Equivalent's absence due to *ANNUAL LEAVE / SICKNESS (**delete as appropriate*)

Delegated Signatory: (Print)

SIGNATURE HERE:

DATE:

I confirm that the information contained within this form is true and correct. I can confirm that that I have complied with the Trust's Standing Financial Instructions and Standing Orders. I understand that if I have knowingly provided false information or made a false statement that I may be subject to disciplinary and/or criminal action.

SECTION 5 : PROCUREMENT VETTING

(RFQ/Order Number):

Recommended by Head of Procurement:

OPTION A

Justification for waiving SFI's have been reviewed by the Purchasing Team and agreed as acceptable in this instance.

..... (PRINT NAME)

SIGNATURE HERE:

DATE:.....

OPTION B

This waiver has been declined by Purchasing for the following reason(s):

.....
.....
.....

..... (PRINT NAME)

SIGNATURE HERE:

DATE:

SECTION 6 : APPROVAL OF WAIVER

I M & T Purchases Authorisation

Job Title:

Name: (PLEASE PRINT)

SIGNATURE HERE:

DATE:

Director of Finance or Deputy Chief Executive(PRINT NAME)

SIGNATURE HERE:

Chief Executive(PRINT NAME)

SIGNATURE HERE:

DATE:

This document forms part of the Trusts Standing Financial Instructions for Contracting and Purchasing (Annex A); copies of the guidance document are available on request or via the Procurement department's intranet page.

Appendix II - Declaration Form

IN STRICT CONFIDENCE – CONFIDENTIALITY / PERSONAL INTERESTS DECLARATION FORM	
Name and Base	
Job Title	
Description of Area of Confidentiality and/or Personal Interest	
Relevant dates	From: _____ To: _____
<p>The information submitted will be held by South West Yorkshire NHS Foundation Trust ('the Trust') for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that South West Yorkshire NHS Foundation Trust holds.</p> <p>I confirm that the information provided above (confidentiality / personal interests) is complete and correct. I acknowledge that any changes in these declarations (personal interests) must be notified to South West Yorkshire NHS Foundation Trust as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, internal disciplinary or professional regulatory action may result.</p> <p>I do / do not give my consent for this information to be published on registers that South West Yorkshire NHS Foundation Trust holds. If consent is not given please give reasons.</p>	
Signed:	Date:
Comments of Procurement Manager and/or Head of Service (as appropriate)	
Signed:	Date:
Action required, if any:	
<ul style="list-style-type: none"> • Original to Tender File 	<ul style="list-style-type: none"> • Copy to Register of Interests File (if required)

COPY OF THIS FORM TO: Company Secretary, Block 7, Fieldhead, Wakefield (Interests Only)

Estates & Facilities Supplier Selection Process

The South West Yorkshire Partnership NHS Foundation Trust currently works with a Procure 21+ Principal Supply Chain Partner called Interserve Limited to deliver its capital programme and to assist with the minor works projects. In addition to this business relationship other Estates and Facilities projects are conducted by using locally approved suppliers either where there is a sole supplier arrangement for their equipment/service e.g. fire alarm system, intruder alarm system etc, or where suppliers have a formal contractual agreement with the Trust e.g. a day rate contract for the provision of professional tradesmen. Other projects are generally conducted on a “one off” basis as and when they arise where the supplier selection process is assisted by sourcing potential suppliers through a number of recognised databases/website i.e.

1. The Trusts own contract database / eTendering portal (inTend) <https://intendhost.co.uk/southwestyorkshire>
2. Constructionline <https://www.constructionline.co.uk/>
3. Suppliers that are on Crown Commercial Services contract for a similar product range.
<http://ccs.cabinetoffice.gov.uk/>
4. Suppliers that are on an NHS Collaborative Procurement Hub framework contract for a similar product range i.e. Shared Business Services, NHS Supply Chain
<http://www.sbs.nhs.uk/home>
<http://www.noecpc.nhs.uk/>
<http://www.lpp.nhs.uk/frameworks/>
<http://www.healthtrusteurope.com/>
<https://www.supplychain.nhs.uk/>
5. Suppliers who are on a Local Government contract for similar products i.e. YPO, ESPO, NEPO, YorHub.
<http://www.ypo.co.uk/>
<http://www.espo.org/> /
<https://www.nepo.org/>
<http://www.yorhub.com/>

The benefits of using the Constructionline supplier database are:

- Access to over 20,000 pre-qualified suppliers, from Sole Traders to Small Medium Enterprises (SME's) to major contractors through the database
- Supplier details managed and kept up-to-date in real time by Constructionline
- Over 1,000 work categories to choose from
- Standard pre-qualification data covering; company details, financials, health & safety, equalities and environmental information
- It is endorsed by the Crown Commercial Services organisation, the Welsh Assembly, the Northern Ireland Executive and the Scottish Executive

The benefits of using Crown Commercial Services, NHS and Local Government contracts

- Fully compliant EU level framework contracts
- Access to several thousand pre-qualified suppliers
- A full Public sector range of products and services
- Access to over pre-qualified suppliers, from Sole Traders to Small Medium Enterprises (SME's) to major contractors through the various databases.

Supplier Selection – Orders Below £10,000 Quotation Threshold

For services below the quotation threshold business placed for tradesmen activity, Estates & Facilities consultancy i.e. the provision of an electrician, the provision of a cost advisor, the Trusts EU tendered framework contracts should be used. Within the two framework contracts there remains the option of market testing these smaller projects of work through conducting a mini-competition via the Trusts eTendering system rather than going to direct award of business to one or more suppliers on the framework contract.

For Estates and Facilities work which sits outside of the departments two main framework contracts, suppliers will be sourced where applicable via Crown Commercial Services framework suppliers, local government contracts, and through mini-quotation exercises conducted through the Trusts inTend eTendering solution.

Supplier Selection – Orders Above £25,000 Quotation Threshold to EU Level

For services that are on the Trusts Estates & Facilities framework agreements for the Provision of Estates & Professional Consultancy and the Provision of Estates and Facilities Day Rate Tradesmen where the value of business is over £25K or the project exceeds 12 weeks continuous work, the procurement department will conduct a mini-tender for the work with all the suppliers on the framework contract for that particular category. Whilst it is not anticipated that these individual projects will exceed the EU threshold level the contracts have been advertised as such and allow for this level of expenditure.

For services above the quotation and tender level but below the EU level for Public Procurement, companies will be selected from the various supplier database websites listed above and the work tendered via the Trusts eTendering system.

Trust Board 29 October 2019

Agenda item 11 – Assurance from Trust Board committees

Audit Committee

Date	8 October 2019
Presented by	Laurence Campbell, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<ul style="list-style-type: none"> ➤ Complaints - internal audit recommendation implementation to be completed by end of October. ➤ SystemOne optimisation plus further projects planning by December. ➤ Standing Financial Instructions - need for easier access, communication and materiality judgement. ➤ IFRS 16 - material impact on balance sheet. ➤ BAF - internal audit points on actions re dates and accountability. ➤ Cyber risk - very good work on technical defences, question about need for further training. ➤ Internal audit recommendation implementation now up to 70% (target 75%); assignments now more back end loaded.
Approved Minutes of previous meeting/s for receiving	<ul style="list-style-type: none"> ➤ Minutes of the Committee meeting held on 9 July 2019 (attached).

Nominations Committee

Date	24 October 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	<ul style="list-style-type: none"> ➤ To be confirmed.
Approved Minutes of previous meeting/s for receiving	<ul style="list-style-type: none"> ➤ Minutes of the Committee meeting held on 15 July 2019 and 26 July 2019 (to follow)

West Yorkshire Mental Health, Learning Disabilities & Autism Collaborative Committees in Common (previously called the West Yorkshire Mental Health Services Collaborative Committees in Common)

Date	3 October 2019
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	<ul style="list-style-type: none"> ➤ Programme update. ➤ Assessment and Treatment Unit (ATU) Business Case ➤ Transforming Care Programme: Independent Sector Learning Disability Placements Memorandum of Understanding ➤ ICS & Programme Strategy and structure ➤ Governor/NED Event on 22nd October

Approved Minutes of previous meeting/s for receiving	➤ Minutes of the Committee meeting held on 28 June 2019 (to follow)
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Note, assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

Minutes of the Audit Committee held on 9 July 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
 Tony Cooper Head of Procurement
 Caroline Jamieson Senior Manager, Deloitte
 Emma Jones Company Secretary

In attendance: Rob Adamson Deputy Director of Finance
 Tabitha Arulampalam Insight Programme
 Karen Batty Assistant Director of Nursing and Quality [item 10]
 Mark Brooks Director of Finance (lead Director)
 Leanne Hawkes Deputy Director, 360 Assurance
 Olivia Townsend Assistant Anti-Crime Manager, Audit Yorkshire
 Salma Yasmeen Director of Strategy [items 7 & 12]
 Jane Wilson PA to the Director of Finance (author)

AC/19/59 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. Apologies are noted above.

AC/19/60 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/19/61 Minutes from the meeting held on 9 April 2019 & 21 May 2019 (agenda item 3)

It was **RESOLVED** to **APPROVE** the minutes of the meetings held on 9 April 2019 and 21 May 2019 as a true and accurate record with the amendment of 2 typographical errors in the 9 April minutes.

AC/19/62 Matters arising from the meeting held on 8 January 2019 (agenda item 4)

Action log

The responses in the action log was noted.

AC/19/63 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 9 April 2019. All risks from the trust-wide ORR graded 15 and above were reported to the Trust Board on 30 April 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.

In relation to risk 1080 relating to cyber crime MB acknowledged that the risk score is outside the Trust's risk appetite and this is recognised at EMT

MB asked the Committee if there were any risks they felt needed more focus on around actions being taken, and was there any further assurance needed from any of the other committees.

- Risk 1217- capacity to meet Trust and system-wide objectives. LC stated he felt this was a very key risk and not necessarily within risk appetite, although the scoring is currently in line with our risk appetite. MB agreed, stating it had previously been assessed as green but one that we definitely needed to keep a close eye on given the on-going demands on the Trust and number of priorities.
- Risk 812 – local place based solutions which change clinical pathways. EM raised the question of whether in relation to Out of Area (OOA) bed placements the Trust will be able to financially mitigate this issue. MB stated this particular risk does not just relate to OOA. It is focused on the fact we have a number of commissioners and they all can commission services slightly differently. As such we need to consider how we can provide a consistent service standard across our geography whilst meeting specific place based requirements. CAMHS is a classic example with different models of care commissioned in each place we provide the service. In regard to out of area bed placements MB reported people do not come into the service in a uniform manner and that May was a weaker month compared to previous 5 or 6 months, but he emphasised the need to look at longer term trends. When comparing quarter 1 2019/20 with quarters 1 and 4 in the previous year there has been lower usage and cost which is positive, but not necessarily reflecting a sustainable solution to the issue.
- MB confirmed Carol Harris is taking a more detailed Board paper on this subject to the 30 July Trust Board outlining what actions are taking place.
- Risk 1216 - GDPR. Erfana Mahmood (EF) suggested that given its score this risk be removed from the register. MB stated he wouldn't want to lose sight of this at this stage given the fact GDPR has only been in place for a little over one year. This is a question that can be taken to the Trust Board.

ACTION: Emma Jones

- SYo commented that a number of risks didn't reference the creation of the Finance Oversight Group (FOG) committee. MB stated the ORR had been produced prior to the creation of the FOG the updated version being taken to the July Trust Board would no doubt include the addition of the FOG in the appropriate sections of the risk register.

ACTION: Mark Brooks

- Sam Young (SYo) commented that having looked at the actions she was not convinced they were going to take us down to target score in every case, recognising that in some cases all the actions being taken are appropriate. She asked if there was a way in which Trust Board could be made aware of which risks the executive feel can meet the target risk score and which cannot.

ACTION: Emma Jones/Mark Brooks

- SYo noted that one risk seems to be owned by both the Workforce and Remuneration Committee and the Equality and Inclusion Committee and asked if the committee chairs could resolve where ownership of the risk belongs.

ACTION: Mark Brooks/Emma Jones

It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee.

AC/19/64 Triangulation of risk performance and governance report (agenda item 6)

MB presented the update stating the report followed the pattern of previous reports. He confirmed the report uses the version of the ORR submitted to the Business and Risk meeting of Trust Board on 30 April 2019. The risk areas are reviewed to identify where the issues have been escalated in terms of sub committees or other governance meetings; and identifies any performance indicators in the current IPR (Month 2 2019/20) which are not necessarily covered in the risk register or board assurance framework (BAF). MB stated the report also considers the strategic risks in the BAF as reported to Trust Board on 30 April 2019 and six monthly strategic overview of business and associated risks report to Trust Board on 30 April 2019.

LC asked if there were any gaps in assurance in the Board Assurance Framework (BAF) that were not picked up on the risk register. MB stated there were not. LC also asked how much focus the board assurance framework received MB explained that both the risk register and board assurance framework are regularly reviewed at EMT.

In relation to the detailed report the following comments were received:

- Page 4 - Fire Risk LC asked what the current status is with vaping. MB explained that this was for a trial period which is still running. Karen Batty (KB) commented it was for Clinical Safety Committee (CSCG) to update on this.
- Page 7 – Financial Sustainability LC recommended that the introduction of the FOG be added as a control.

LC stated this was a very useful document and was working 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/19/65 Approval of Charitable Funds annual report and accounts (agenda item 7)

Salma Yasmeen (SY) confirmed the Charity has had a significant year, and that continued efforts were going into building up the EyUp! brand with the fundraiser, who is now permanent, making

good progress. SY commented that there had been some really successful campaigns and that the plan for this year was ambitious and achievable.

Salma Yasmeen (SY) stated these were the draft annual report and accounts for EyUp! and its linked charities, Creative Minds, Mental Health Museum and Spirit in Mind. The draft version has not yet gone through the independent examination provided by Deloitte and all final comments are requested by the 31 July 2019. The final version is due to be presented to the corporate trustee at the end of September 2019.

LC commented that the report and accounts were much more readable and accessible than previous versions and were very well presented.

In relation to accounting closure SY asked the committee if everyone was happy to use the standard representation letter that was taken into the last Charitable Funds Committee. This was agreed.

The following additional comments were received;

- MB suggested that the sentence on page 8 “Our linked charity develops community partnerships to not only co-fund but also co-deliver projects for local people and all the projects are supported on a match-funded basis” could be incorrectly interpreted as salary costs are not match-funded. He asked that the wording be changed. LC agreed with this. SY to update the wording for the final draft.

ACTION: Salma Yasmeen

- LC asked if on page 47 the allocation of support costs and overheads have not been restated in the previous year to recognise salary costs for the linked charities. Rob Adamson (RA) confirmed this.
- MB felt it would be helpful if possible to ensure there is a clear distinction in all the financial tables between 2018 and 2019. LC agreed with this.
- SYo – suggested that with respect to page 17, we need to consider how we articulate the benefits of the investments being made. SY suggested the need for a Board conversation.
- SYo asked about the sustainability of the charity. MB stated that the report shows an improvement against the previous year and that this needs to be monitored regularly to ensure it continues to be sustainable.

LC stated that subject to the above points the Committee were happy to recommend the annual report and accounts for approval subject to the changes identified.

ACTION: Salma Yasmeen

It was RESOLVED to APPROVE the annual report and accounts for 2018/19 subject to amendments being made.

AC/19/66 External agencies policy register report (agenda item 8)

It was agreed that this item would be carried forward to the meeting on the 8 October 2019

AC/19/67 Declaration of interests for staff – risk assessment (agenda item 9)

MB 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.

MB stated there had been some very notable short staffing issues in that area. He confirmed that all declarations identifying critical people had been published on the Trust website before the end of March. He emphasised the need to chase those individuals who haven't made any form of declaration, including nil declarations, over the last 6 months.

ACTION: Emma Jones

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/19/69 Update on internal audit on complaints (agenda item 10)

Karen Batty (KB) confirmed that work was continuing to improve our customer service process to make sure that the Trust always responds in ways that ensure learning and to meet the needs of our service users, families and carers. KB stated that in November, Internal Audit undertook a review of complaints processes with the overall aim of providing an independent assurance opinion on the Trust's system and processes for managing concerns and complaints. The outcome was 'limited assurance', with concerns being raised about the quality of data used to underpin the customer service reports, an incomplete set of data measures to assess the performance of the customer services processes and the electronic system not being used efficiently, increasing the burden of reporting. KB stated that in response to the recommendations a management response was developed and continues to be implemented. KB emphasised that the quality of complaint responses was not compromised during the implementation of the agreed actions.

KB stated there had been lots of work done on recommendations and that this remained work in progress. Given notable staffing shortages a number of recommendation implementations have slipped beyond the original planned date. LC emphasised the need to hit dates in terms of completion stating that realistic dates need to be set. KB explained that resources had been very limited with only 1 member of staff currently having the necessary skills to make changes to the datix system, and that this member of staff was now off ill. KB confirmed that there would be some dedicated resource to specifically focus on this from August and they were still working through systems expertise. KB stated that whilst there has been limited resource the team have focussed on complainants not being affected. SYo stated she would rather see dates slip rather than quality deteriorate.

MB stated that when the report was first published in December 2018, actions were written with the best information available at that time and that some issues that have subsequently arisen were not expected and could not have been planned for. MB stated that we have to balance the need to achieve timescales to make improvements with the change in circumstances in the team and come up with an updated plan to ensure we can deliver the outstanding improvements in a reasonable timescale. This would need the approval of EMT. He also emphasised a number of actions have been completed and also the need to not lose sight of the most important thing, which was getting the complaints process right.

EM asked if there was any element of automisation that needed to be looked at, stating there were Case Management Systems available that could make life easier. EM agreed to liaise with KB.

ACTION: Erfana Mahmood/Karen Batty

Leanne Hawkes (LH) explained that when the plan was set for 19/20 it was agreed that 360 Assurance would carry out a follow up on the complaints audit and actions. She raised the question of when the best time to do this was for Audit Committee to receive best assurance. The Committee agreed the back end of Q3/beginning of Q4 would work best, MB confirmed the new dates would need to go back to EMT for approval.

ACTION: Karen Batty

It was RESOLVED to APPROVE the update

AC/19/70 Procurement report (agenda item 11)

MB presented the procurement update. Twelve contracts were let with a value of £1.1m including the £0.6m with Interserve for the Fieldhead re-development, SSG Health for consultancy and project management support, and purchase of mattresses. Seven major contracts are currently in progress including the provision of taxi services, the supply and support of a financial ledger system, a nurse call system, a managed print solution and plumbing and heating products. Fifteen orders were placed under the Crown Commercial Services Framework including fleet insurance and Microsoft licences.

LC raised the question of whether any funding was coming from the CCGs in relation to the SSG work. MB responded that there wasn't specifically as the commissioners have provided increased funding in the 19/20 contract in relation to demographic growth and out of area bed usage. In addition the work being completed is purely for the Trust in terms of enabling pace and providing expertise. LC asked if SSG were likely to be re-engaged for further work. MB stated he was not in favour of this as the Trust needs to ensure skills have been transferred internally and that we are able to own all of the work ourselves. The current work will be complete at the end of September and MB expected a review to take place of programme management and other support requirements at that time.

MB also added that NHS Improvement have been informed that the Trust has used SSG for further work

SYO asked if the potential change in direct engagement provision would impact on the locums we use. MB stated the proposal has the full backing of the Trust's Medical Director. LC asked if there is a risk around payroll and fraud. MB explained that advice has been sought on this which has been responded to satisfactorily. There is some further legal advice being sought that the Director of HR is progressing. It was also explained this form of direct engagement is used with a number of trusts nationally already.

LC asked which wards the alarm call system would be used on. MB stated it would be applied to all inpatient wards.

EM asked about legal services and our own internal team. MB explained that we have a legal services team which in effect focuses on mental health act and coroner cases. For other areas of legal guidance we use external lawyers and advisers.

MB confirmed that a total of £43k CIP (Cost Improvement Plan) savings with a further £8k cost avoidance savings had been recorded to date in the first quarter.

There are eighty three SLAs currently active, of which 56 are currently signed, 12 in negotiation, 15 at the sign off stage.

It was RESOLVED to NOTE the Procurement Report

AC/19/71 SystemOne implementation risks and milestone (agenda item 12)

SY confirmed that that catch up phase was now complete and that the risk associated with this has been fully mitigated and closed. We are now entering the optimisation phase.

LC asked if the care plan was now operative. SY stated this was imminent and that there was still some transitioning to end phase 1 along with support going into phase 2. SY reported the catch up phase was a credit to all operational teams including Julie Williams and her team stating the number of issues closed had been huge. LC reiterated they were all to be congratulated. EM raised the question of how to thank them. MB commented that thanks and recognition have been widespread. He would also like to see this be realised in the form of some nominations for staff excellence awards.

It was RESOLVED to NOTE the report

AC/19/72 Treasury management (agenda item 13)

RA confirmed that all funds remain within the Government 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. RA reported the rate had slightly increased from what was in the paper and that he would keep an eye on this.

Actual interest receivable in 18/19 was £161k (£65k 17/18). Forecast for 2019/20 is £113k with actual for April and May 2019 totalling £33k.

It was RESOLVED to RECEIVE the update.

AC/19/73 Internal audit (agenda item 14)

Leanne Hawkes (LH) presented the progress report, stating there had been two reports issued since the last Audit Committee meeting. Both of these formed part of the 18/19 plan and were included for completeness.

- Cost Improvement Programme - Significant Assurance provided
- Compliance with Legislation - Significant/Limited Assurance.

LC asked how progress will this be reviewed. LH confirmed it would be reviewed through follow up process. LC expressed his concerns over the limited assurance part of the report and will report on this as a matter arising to the Trust Board. LC also suggested that working in partnership with others may present some risks in this area that management needs to consider.

In relation to the 2019/20 plan LH confirmed the following terms of reference had also been issued:

- Policy Monitoring
- Payroll Data Analytics
- Governance and Risk Management
- GDPR
- Data Quality

LC raised the question of what effect matrons were having on data quality re adherence to quality and consistency, and was there any way in which this can be detected. LH confirmed she would follow this up with Julie Williams.

LH confirmed the terms of reference for the work which will also be used to support the 2019/20 Head of Audit Opinion had also been issued.

LH stated there was an issue around follow up percentages and that fact it works on the basis of hitting the original agreed action completion dates, she confirmed this was currently 66% with a target of 75%. LH agreed to monitor in between meetings and keep MB and EJ briefed. The variance was largely affected by the actions from the Complaints internal audit.

LH confirmed 360 Assurance had received a request to defer the GDPR review to late Q2/early Q3. EM suggested this could be late given the potential penalties associated with non compliance. MB explained that Internal Audit reviewed readiness for GDPR last year and the Trust Board and Audit Committee received regular detailed updates throughout the course of 18/19. This audit is to check on compliance with the GDPR. The Trust also benefited from having an expert in this field lead the Trust's implementation. The Governance and Risk Management work had also been requested for late Q2. LH stated there was a forthcoming review planned on Cyber. LH asked the committee if they would consider doing a phishing exercise. The Committee confirmed they were happy to support this as long as long as the right communications were in place. LC asked if staff side should be brought on side. MB stated yes they should be.

ACTION: Leanne Hawkes/Mark Brooks/Emma Jones

It was RESOLVED to RECEIVE the update.

AC/19/74 Counter fraud progress report (agenda item 15)

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 confirmed that 3 alerts had been issued since last Audit Committee meeting.

In relation to the passport investigation OT confirmed the Trust is liaising with the West Yorkshire police. There could be proceedings using the Proceeds of Crime Act.

OT stated there had been new referrals relating to agency timesheets and the patient's bank. The patient's bank investigation will not be progressed, but there are some areas of development for the Trust in terms of consistent use of controls.

ACTION: Rob Adamson

With regard to the timesheet investigation preliminary enquiries are being undertaken, which may then proceed to a criminal investigation.

It was RESOLVED to RECEIVE the update.

AC/19/75 External audit update (agenda item 16)

MB reported that the Audit of Charity accounts was complete and that Deloitte would be in a position to sign once an updated set of accounts were approved by the Corporate Trustee.

It was RESOLVED to RECEIVE the update.

AC/19/76 Losses and special payments (agenda item 17)

RA confirmed the report provided details of the payments made since the last report to the Committee on 9 April 2019 and covers payments made to 14 June 2019.

In total the Trust has made payments of £2,172 since the last report to the Audit Committee.

Of this amount the largest single transaction was:

- £1,700 recharges to service users for damage to ward environments. Invoices were only raised following review of clinical appropriateness. These are no longer recoverable.

The remaining payments are due to either damaged glasses or loss of e-cigarettes.

It was RESOLVED to NOTE the contents of the report.

AC/19/77 Any other business (agenda item 18)

No other business was raised.

AC/19/78 Consideration of any changes to from the organisational risk register relevant to the remit of the Audit Committee (agenda item 19)

No changes to the organisational risk register were requested other than those discussed under agenda item 5.

AC/19/79 Items to report to Trust Board (agenda item 20)

The following items were agreed as being reportable to the 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 regarding partnership working?;
- Outstanding actions arising from limited assurance internal audit of complaints;
- Charity Accounts - how do we fully demonstrate the 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.

AC/19/80 Work programme (agenda item 21)

- Delivering service change to be removed from the annual work programme
- There were no changes to the Standing Financial Instructions (SFI's). The Committee agreed to move this item to October.
- External policies agency plan, the Committee was unsure what this item related to. MB agreed to clarify this with EJ.

ACTION: Mark Brooks

It was RESOLVED to NOTE the Updates to work programme.

AC/19/81 Date of next meeting (agenda item 22)

The next meeting of the Committee will be held on Tuesday 8 October 2019 at 14:00 in Meeting Room 1, Block 7, Fieldhead, Wakefield.

Trust Board annual work programme 2019-20

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar
Standing items								
Declaration of interest	x	x	x	x	x	x	x	x
Minutes of previous meeting	x	x	x	x	x	x	x	x
Chair and Chief Executive's report	x	x	x	x	x	x	x	x
Business developments	x	x	x	x	x	x	x	x
STP / ICS developments	x	x	x	x	x	x	x	x
Integrated performance report (IPR)	x	x	x	x	x	x	x	x
Serious Incidents (private session)	x	x	x	x	x	x	x	x
Assurance from Trust Board committees	x	x	x	x	x	x	x	x
Receipt of minutes of partnership boards	x	x	x	x	x	x	x	x
Question from the public	x	x	x	x	x	x	x	x
Quarterly items								
Corporate/organisational risk register	x		x		x		x	
Board assurance framework	x		x		x		x	
Serious incidents quarterly report		x		x		x		x
Use of Trust Seal		x		x		x		x
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	x		x		x		x	
Half yearly items								
Strategic overview of business and associated risks	x				x			
Investment appraisal framework (private session)	x				x			
Safer staffing report	x				x			
Digital strategy (including IMT) update	x				x			
Estates strategy update			x				x	
Annual items								
Draft Annual Governance Statement	x							
Audit Committee annual report including committee annual reports	x							

Agenda item/issue	Apr	June	July	Sept	Oct	Nov	Jan	Mar
Compliance with NHS provider licence conditions and code of governance - self-certifications <i>(date to be confirmed by NHS Improvement)</i>	x	x						
Guardian of safe work hours	x							
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	x							
Review of Risk Appetite Statement	x							
Annual report, accounts and quality accounts - update on submission		x						
Health and safety annual report		x						
Patient experience annual report		x						
Serious incidents annual report		x						
Equality and diversity annual report			x					
Medical appraisal/revalidation annual report			x					
Sustainability annual report				x				
Workforce Equality Standards				x				
Assessment against NHS Constitution						x		
Eliminating mixed sex accommodation (EMSA) declaration								x
Data Security and Protection toolkit								x
Strategic objectives								x
Trust Board annual work programme								x
Operational plan	x					x <small>(draft / private)</small>	x <small>(draft / private)</small>	x <small>(draft / private)</small>
Five year plan				x				
Policies and strategies								
Constitution (including Standing Orders) and Scheme of Delegation					x			
Communication, Engagement and Involvement strategy		x <small>(update)</small>					x	
Organisational Development Strategy						x		
Risk Management Strategy	x							
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies)							x	
Treasury Management Policy							x	
Workforce Strategy								x

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)*
- Sustainability Strategy *(to be reviewed with the Estates Strategy)*

	Business and risk
	Performance and monitoring
Strategic sessions (including Board development work) are held in February, May, September and December 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.	