Trust Board (business and risk)
Tuesday 28 July 2020 at 9.00
Microsoft Teams meeting

AGENDA

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
1.	**9.00**	**Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
2.	**9.01**	**Declarations of interest**	Chair	**Verbal item**	2	To receive
3.	**9.03**	**Minutes from previous Trust Board meeting held 30 June 2020**	Chair	**Paper**	2	To approve
4.	**9.05**	**Matters arising from previous Trust Board meeting held 30 June 2020 and board action log**	Chair	**Paper**	5	To approve
5.	**9.10**	**Service User Story**	Chief Executive	**Verbal item**	10	To receive
6.	**9.20**	**Chair's remarks**	Chair	**Verbal item**	3	To receive
7.	**9.23**	**Chief Executive's report**	Chief Executive	**Paper**	7	To receive
8.	**9.30**	**Risk and assurance**				
	9.30	8.1 Board Assurance Framework (BAF)	Director of Finance & Resources	**Paper**	10	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	9.40	8.2 Corporate / Organisational risk register (ORR)	Director of Finance & Resources	**Paper**	20	To receive
	10.00	8.3 Infection, Prevention and Control Board Assurance Framework	Director of Nursing & Quality	**Paper**	15	To approve
9.	**10.15**	**Business developments & collaborative partnership working**				
	10.15	9.1 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates / Director of Strategy	**Paper**	10	To receive
	10.25	9.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy / Director of Provider Development	**Paper**	10	To receive
	10.35	9.3 West Yorkshire Adult Secure Lead Provider Collaborative – update	Director of Provider Development	**Paper**	10	To receive
	10.45	9.4 Receipt of Partnership Board minutes	Chair	**Paper**	2	To receive
	10.47	*Break*			*13*	
10.	**11.00**	**Performance reports**				
	11.00	10.1 Update on arrangements in place for the management of Covid-19	Director of HR, OD and Estates / Director of Strategy	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.05	10.2 Integrated performance report (IPR) month 3 2020/21 • Update on race equality work	Director of Nursing & Quality / Director of Finance & Resources	**Paper**	45	To receive
11.	**11.50**	**Strategies and policies**				
	11.50	11.1 Digital Strategy	Director of Finance & Resources	**Paper**	5	To receive
12.	**11.55**	**Governance matters**				
	11.55	12.1 Interim governance arrangements – update	Director of Finance & Resources	**Paper**	5	To receive
	12.00	12.2 Board Development Proposal	Director of HR, OD and Estates / Director of Strategy	**Verbal**	5	To receive
13.	**12.05**	**Assurance and receipt of minutes from Trust Board committees** - Audit Committee 14 July 2020 - Finance, Investment & Performance Committee 27 July 2020 - West Yorkshire Mental Health Learning Disability and Autism Collaborative Committees in Common 23 July 2020 - Workforce and Remuneration Committee 21 July 2020	Chairs of committees	**Paper**	10	To receive
14.	**12.15**	**Trust Board work programme**	Chair	**Paper**	5	To note

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
15.	**12.20**	**Date of next meeting**	Chair	**Verbal item**	0	To note
16.	**12.20**	**Questions from the public** *(received in advance in writing)*	Chair	**Verbal item**	10	To receive
	12.30	*Close*				

Minutes of the Trust Board meeting held on 30 June 2020
Microsoft Teams Meeting

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

TB/20/29 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. No apologies were noted. It was noted that the meeting was quorate and could proceed.

AM outlined the virtual meeting protocols and etiquette and identified this was a performance and monitoring board. AM reported this meeting was being live streamed for the purpose of inclusivity, to enable members of the public to access to the meeting.

The Trust was not recording this meeting. Attendees of the meeting were advised they should not record the meeting unless they have been granted authority by the Trust prior to the meeting taking place.

AM reminded the members of the public that there would be an opportunity at the end of the meeting for questions and comments, received in writing.

TB/20/30 Declarations of interest (agenda item 2)

There were no further declarations over and above those made in the annual return in March 2020 or subsequently.

It was RESOLVED to NOTE no further declarations had been submitted.

TB/20/31 Minutes from previous Trust Board meeting held 28 April 2020 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 April 2020 as a true and accurate record.

TB/20/32 Matters arising from previous Trust Board meeting held 28 April 2020 (agenda item 4)

The following items from the action log were reviewed:

TB/20/17 – Carol Harris (CH) updated that the action relating to social distancing at Urban House (PS/20/11b) was being progressed as covered in the locality report and could now be closed. Salma Yasmeen (SYa) updated that the Involving People Strategy was progressing and this action (PS/20/13d) could also be closed.

TB/20/21b – Alan Davis (AGD) reported there was nothing further to raise in relation to the action regarding staff resilience and the impact of Covid-19 on black, Asian and minority ethnic (BAME) staff. The Integrated Performance Report (IPR) was being adjusted and the Workforce and Remuneration Committee was resuming on 21 July 2020. A deep dive would take place at this meeting and as such this action could now be closed.

TB/20/21c – Tim Breedon (TB) reported that the action in relation to reporting of safer staffing was complete and could now be closed.

TB/20/22b – TB updated that further work had taken place in relation to the controls for risk 1522. This referred to keeping staff, patients and service users safe and the action could now be closed.

TB/20/24b – The Chair reported that confirmation from the Committees in Common would be required as to when their first annual review would be completed following the impact of Covid-19.

TB/20/09a – AGD updated that the Estates Strategy was now to be submitted later in the year, for November Board.

TB/19/99a – TB reported that the complaints process was returning to normal arrangements as of 1 July 20 and targets were being revised.

TB/19/83a – It was reported that Mental Health Act Committee had conducted a review and had tightened up the work of the committee and adherence to the act. This had been reflected in the Care Quality Commission (CQC) report.

The Executive Management Team (EMT) had looked at the indicators that were in the IPR. Work still needed to be completed, but had been on hold due to Covid-19. This would be completed and included in the IPR when business was fully restored. It was agreed by the board that the action could be closed.

Rob Webster (RW) went on to explain that this fitted into a wider piece of work around what the board was taking as assurance. It was agreed that the Finance Investment and Performance (FIP) Committee should review the IPR against each phase of Covid-19 and make sure that the indicators were part of that work.

Action: FIP Committee

The Chair suggested that a new action was required and the current action could be closed. The action needed to be broader to confirm that the board had the right targets in the IPR to reflect performance in each phase of the Covid-19 response. The new action would need to be refreshed regularly and be current. It should be at the top of matters arising to maintain the right assurance for the board.

TB/20/22b Mark Brooks (MB) confirmed that the action about allocation of Covid-19 risks to committees had now been completed and the allocated risks by committee were attached to the action tracker. This allocation was agreed by the Board.

TB/20/33 Service User / Staff Member Story (agenda item 5)

Vicky Butterfield (VB) and Glenda Hartshorne (GH) from the learning disability community team in Calderdale presented the story of Sammy (changed identity). They explained how they as a team, had supported Sammy through Covid-19 and how they had adjusted their approach in response to Sammy's needs.

- Sammy had been deemed vulnerable by her multi-disciplinary team due to her Asian background, type 2 diabetes and being clinically obese.
- She had not received a formal shielding letter, however, it was felt necessary to support Sammy to discuss and consider whether she isolate for 12 weeks from March.
- Sammy was in agreement with this and expressed her worries about the virus.
- Covid-19 was a big change for Sammy and the team assisted Sammy to understand the need for shielding using a specialist Covid-19 social story.
- Additional telephone calls were put in place from her care coordinator.
- Calls focused on "talking about worries" during Covid-19.
- The team supported Sammy with establishing her daily routine and getting good sleep.
- Video-link was tried; however, Sammy did not take well to this so that was stopped.
- Urgent home visits were deemed necessary due to Sammy going into crisis and presenting as highly anxious about Covid-19.
- Her care coordinator and a social worker attended Sammy's home.
- As per Trust policy, Sammy was assessed by the intensive support team and assessed as high risk in terms of Covid-19.
- This meant, if required, Sammy would receive a face to face visit from the health team as it was deemed essential to health care delivery
- When visited for support, appropriate personal protective equipment (PPE) was used as could not assure two metre distance.
- Full Covid-19 care plan on SystmOne.
- VIP passport completed, uploaded to SystmOne and delivered to the acute hospital modern matron to ensure that any admission to the acute hospital would be informed by Sammy's needs.

AM thanked VB and GH for presenting Sammy's story.

Following the presentation the board asked if the team had yet had chance to reflect on whether they could have done anything differently, and how challenging the situation was in light of all the guidance being produced.

VH reported that the nature of Covid-19 was fast moving. There has been work that had to be done and then repeated, and the social story delivery had not been straight forward.

Guidance had changed regularly, and the team had to react quickly. Sammy was very in tune with day to day updates and had become fixated on the daily death toll, so the team

pulled figures together about the recovery rates to balance this. Staff were also anxious, especially in April and May.

VB noted that, clinically, the work with Sammy had not changed due to her BAME background but it was an added risk factor. The team spoke to her and her parents who were keen that she be shielded.

Sammy has a mild learning disability and staff wearing masks was daunting to Sammy, but she had been warned about this and soon became used to it.

When Sammy decided to re-enter the community the team looked at a further social story to help her understand this. Some service users had become very used to being at home, so when going out started again it became a new challenge. People need to be reintroduced to how they lived prior to Covid-19.

RW thanked VB and GH for their story showing the agility of their team in a fast-changing environment. There were generalised lessons for everyone from their story and Trust values were embedded within their actions.

It was RESOLVED to NOTE the Service User Story.

TB/20/34 Chair and Chief Executive's remarks (agenda item 6)

Chair's remarks

AM highlighted the items on the agenda for today's private board meeting:

- The board would be holding a discussion with a small number of representatives from the BAME staff network, but this was not part of the formal board meeting.
- Verbal updates on serious incident (SI) investigations, confidential as they are in progress, and business developments in each of our Integrated Care Systems (ICS) which are commercially confidential.
- Receipt of the final Trust annual report and accounts, which cannot be made public until it has been laid before parliament. It was confirmed during the meeting that these have now been laid before parliament and as such can become public documents.
- A procurement control approval that remains confidential until approved by the Board.

Chief Executive's report

RW reported:

- The Non-Executive Director's (NEDs) and Board members receive the brief which sets out the strategy and key issues within the organisation.
- Covid-19 briefings are now being provided weekly from this week onwards reflecting a reduction compared to the daily updates in operation at the onset of the pandemic and the subsequent months.
- Covid-19 remained a level 4 incident nationally and we are in phase 2 moving towards phase 3 of managing the incident.
- We would use this phase to plan for the future.
- Updates had been received since the Brief was published.

The main themes of the update were:

- The testing regime for staff has been increased, 8% of staff tested have tested positive for the virus.
- Testing would now focus on symptomatic staff, or an area where there had been an outbreak, and not on asymptomatic staff.

- Within the Trust, antibody testing has commenced and results to date show that 13% of staff tested had the antibody. This was a comparatively low figure compared to other trusts, which had up to 30%. The reason for this was unknown. It could be about effective use of PPE and Infection Prevention and Control but there was no evidence to support this.
- Testing is part of the test and trace arrangements which have been expanded nationally.
- A recent Kirklees outbreak had been managed well by local tracers. The Leicester outbreak required an intervention, hence no ease of restrictions. That is the kind of action that may happen if we experience significant local outbreaks.
- Currently, there are no areas in our footprint that would lead to this action. Media reports state Bradford is at risk of being similar to Leicester but this is not supported by the figures.
- Access to PPE has been better for the Trust in recent weeks, due to more consistency in national supply and use of regional mutual aid.
- Two metres social distancing should be carried out wherever possible. Guidelines around “one metre plus” means one metre social distance PLUS other protection or measures in place i.e. good ventilation, handwashing, etc. but in this Trust and across West Yorkshire we would aspire to two metres as the default.
- The Trust is yet to see any further information around finance arrangements beyond July. Nationally discussions are taking place with Treasury.
- Stress testing continues to take place with help from the military. New scenarios are being tested to support preparation and planning.
- There had been news in the media about the government issuing additional capital funding to support the removal of dormitory accommodation in mental health trusts. The Trust doesn’t have dormitories. We have engaged in a process to bid for national capital monies within the West Yorkshire & Harrogate ICS.
- Of our BAME staff, 99% have now received an individual risk assessment, with 100% completion expected imminently.

A discussion followed about why the testing strategy had changed and the concept of a Covid-19 secure environment.

It was explained that a “Covid-secure” environment is an area where there are safeguards in place that mean masks don’t need to be worn. All staff in community and hospital settings have to wear masks unless in a “Covid-secure” environment. Blocks within our hospitals and other buildings have been risk assessed to determine if they are “Covid-secure”.

Criteria for being “Covid-secure” include staff being able to stay two metres apart, maximum numbers in rooms, availability of hand washing facilities and hand sanitiser and appropriate PPE disposal.

Staff on Trust wards have to wear masks all of the time. As the rules develop the Trust will maintain focus on good infection prevention and control measures.

There was further discussion about the next stage of routine testing. There was potential that we would be required to run through a five / seven day routine basis for testing of staff. This would be coordinated through the Bronze testing group and overseen by Silver command.

The Trust was following national guidance and looking to be more proactive in spotting outbreaks.

Charlotte Dyson (CD) commented that the Leicester outbreak has highlighted the importance of making sure there is good communication that reaches across all communities.

RW explained that, on the broad point of managing outbreaks, all of the local councils had published outbreak management plans that week which include issues around communications. In Kirklees, people had been working with community leaders so that the right messages were being heard and positive messages were being relayed.

RW acknowledged that many of our Trust communications were visual to ensure that there was less of an issue with language or cognitive impairment. The question remained whether that was sufficient and we should continue to challenge ourselves to deliver easily understood material.

Salma Yasmeen (SYa) reported that communication and understanding was part of the Trust-wide Covid-19 Equality Impact Assessment (EIA). There had been a significant review of all information to ensure it was available in easy to understand form.

Nearly 800 people from across our communities had engaged with the refresh of the Involving People Strategy and we had been able to go back and check those messages through the relationships that had been developed.

A discussion in relation to personal protective equipment (PPE) followed. This identified that the Trust currently had approximately 30 days' supply of masks based on historical usage. This was now being reviewed in lieu of changes in guidance and therefore increased demand. There was no issue in terms of supply but the figures were being monitored and tested against what usage is being seen in practice.

One of the national stress testing scenarios was related to PPE and so it was an active consideration. PPE supplies were noted to now be more sustainable and less problematic than in previous phases of the pandemic, partly due to better coordination across the two Integrated Care Systems.

The BAME staff risk assessment was discussed and it was acknowledged that it had been developed to cover the specific risks identified in relation to those people from a BAME background. In doing so, broader underlying risks were included. The risk assessment was now also being used across the whole workforce and will address a wide range of identified Covid-19 risks, not just those specific to people from a BAME background.

As well as all BAME staff, all pregnant staff have been assessed. The next priority would be shielded staff, in line with a change in recent guidance and all shielded staff would have a risk assessment completed within the next two weeks. Home-based risk assessments would also start to take place, running alongside Trust-based environmental risks. All staff would receive a risk assessment but those deemed at higher risk were being prioritised.

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

TB/20/35 Performance reports (agenda item 7)

TB/20/35a Integrated performance report month 7 2019/20 (agenda item 7.1)

Tim Breedon (TB) highlighted the following from the quality section of the report:

- On page 5 of the IPR there was a substantial section on testing as already discussed. Testing for patients and service users had been managed well and quickly, there were no positive cases at present.

- A cohort ward had been used as part of our response when there were positive Covid-19 cases in forensic services. It is not currently in use as we have no service users with Covid-19. We have managed a number people with positive tests during the course of the pandemic to date.
- The patient testing numbers being discussed in the IPR did not include all the work in Barnsley in relation to care home testing. The outbreak support work to the care home sector continues to be considerable and our community visits have been in the region of 1700 a day. TB stated that in future reporting further clarity would be provided as to what the numbers included.

Action: Tim Breedon

- There had been two under 18 admissions to adult wards. There continue to be Tier 4 (inpatient children and adolescent mental health services (CAMHS)) bed pressures regionally. Both admissions had been for a short period.
- There has been an increase in information governance (IG) incidents. One area of enquiry about causation relates to changes in ways of working as a result of Covid-19 such as staff working from home and address information therefore not being double-checked and the impact of staff covering given increased sickness rates.
- The customer services team has been keeping up with turning around complaints in the required time. There had been a pause but 90% had been dealt with within the target 40-day timescale.
- Safer staffing on inpatient wards has been good despite the challenges presented by Covid-19. Work on developing community safer staffing metrics had been paused but will be resumed.
- There had been a positive response to managing staffing requirements through the use of students and retirees returning to work.
- The majority of moderate and severe harm incidents had been pressure ulcers, and slips trips and falls. Falls have gone up slightly.
- There has been an increase in incidents of self-harm when comparing year on year reporting, however a significant proportion are linked to five individuals with 40 incidents relating to one individual. The reducing restrictive physical interventions (RRPI) team is providing appropriate support to their care plans.
- There has been no significant change in the number of apparent suicides.
- Safeguarding is still a critical service, with a continued offer in relation to domestic violence, children and learning disability as a focus.
- RRPI work had seen a reduction in restraint figures from March, which was good as, anecdotally, anxiety had been noted to be up. This was testament to new collaborative working methods.
- The Covid-19 related incidents recorded on Datix are reducing and frequency is returning to levels reported in March.
- The infection, prevention and control (IPC) team has continued to deliver support, including bespoke training sessions with BAME staff in relation to PPE.
- CQC engagement has remained in place throughout the pandemic. A useful meeting had taken place recently, with a new emergency report framework to manage regulation, and the Trust is awaiting further details.
- The IPC Board Assurance Framework (BAF) was being worked through at the moment and further information will be provided as it develops.
- Quality metrics were being maintained but it was noted that acuity should not be underestimated in relation to the pandemic effect.

TB reported there had been no deaths as a result of Covid-19 in our inpatient services. There were people that were known to Trust services who had died but not whilst under our inpatient care.

There followed a discussion about the importance of clarity in these numbers and that they did not relate to Trust inpatient services.

These were people within our services who had been admitted to acute general hospital services having become unwell.

AM raised a query regarding the table on p26 of the IPR – 'Covid-19 incident reporting' – that showed 30 patient deaths to be suspected Covid-19 related. She was questioning the apparent discrepancy between these figures and the one death reported in the summary dashboard on p5. TB agreed to review and provide an explanation.

Action: Tim Breedon

It was noted that there was a negative trend in community service user risk assessment. TB explained that this tied in with the new FIRM (Formulation Informed Risk Management) risk assessment tool which had to be delayed. A planned restart for September had been identified and a pilot is being launched in CAMHS.

RW stated that TB had quite rightly said there was no evidence of increasing apparent suicides in our numbers. He also highlighted that high profile figures were claiming significant increases were apparent on social media, with subsequent round robins and RW asked if he could make a plea that when considering our own posts on social media that we should go back to the data and evidence and challenge misinformation wherever possible.

There followed a discussion about the rise in the level of self-harm and TB noted that the increase was linked to a number of individuals within the Trust and there was no current evidence that the increase was Covid-19 related.

It was also identified that there was specific work taking place through teams to monitor carers and the next step would be to monitor performance in relation to helping carers who were identified as particularly vulnerable through the task group.

Action: Tim Breedon

AM reported this needed to be a focus for the Equality and Inclusion Committee.

Action: Angela Monaghan

Information Governance (IG) breaches were then discussed. Breaches remain just within the levels of common cause variation. MB stated there appeared to instances in a couple of teams, where double-checking address details weren't taking place due to working from home. There had also been higher levels of absence and as such there have been occasions where staff hadn't been doing their regular jobs and may not be familiar with the process. As part of the investigation there would be a review as to what additional controls could be put in place.

Two IG incidents since the outbreak of the pandemic had been reported to the Information Commissioner's Office (ICO) but on receiving further information on one incident the ICO had downgraded it.

AGD highlighted the following from the workforce section of the report:

- Some of the normal workforce trends in terms of sickness, turnover and vacancies had been very positive.
- Positive trends had been identified in recruitment in terms of quality and numbers.
- These positives were good to see but it should be noted that staff had been working very hard. Rest and recuperation was very much a part of keeping staff well and resilient. This was still being monitored and it was possible other issues may arise after the initial few months of the pandemic.

- The understanding of staff health and wellbeing was very important and the wellbeing questionnaire would be going out to all staff shortly.

RW stated that the board needed to make sure they were role models for wellbeing including rest and breaks. There was a need to be assertive about this. RW reported that Claire Murdoch (NHS England's National Mental Health Director) had reinforced the need to take leave in a national discussion that morning. RW noted that the Trust was looking at the possibility of giving all employees an additional day of leave.

The impact of shielding was discussed and what the impact of staff shielding was on the sickness absence figures. AGD reported that approximately half of staff that were shielding were working from home and half weren't.

Staff anxiety about returning to the workplace has been acknowledged, as well as levels of dedication and commitment. It was reiterated that staff must not come to work if they are displaying any symptoms of Covid-19.

In relation to employees who were currently not working, the Trust was trying to make sure that people had meaningful work to do, to assist people through this time. AGD reported that the staff wellbeing questionnaire would be really useful in this respect and it was acknowledged that working from home could have benefits and reasonable adjustments could be made as a result.

The board noted the work that AGD and his team had done around staff risk assessments.

AGD reported that Barnsley teams had been in the centre of the pandemic. Community services had managed the discharge process from acute trusts and they had then been offering support into care homes. Carol Harris (CH) had been putting support around community services' teams in Barnsley as part of the wellbeing agenda.

It was noted that the Workforce and Remuneration Committee was starting again in July. It was also noted that staff were being listened to and being given opportunities for their voice to be heard, which was positive.

MB confirmed that the Trusts performance against national metrics was holding up well. National metrics are performance targets that all NHS Trusts have to achieve. It was noted there had not been any significant increase in referrals to Increasing Access to Psychological Therapy (IAPT).

RW asked that we follow up on whether the reductions in recovery rates for IAPT were an issue concerning the mode of delivery. Switching to a digital mode of delivery may not suit individuals.

Action: Carol Harris

CH highlighted the following from the locality section of the report:

- In Barnsley community services, work across the system remained excellent, and there was good support of hospital discharge, care homes and end of life care.
- Environmental risk assessments of workplaces had been taking place across the Trust.
- Child and adolescent mental health services' (CAMHS) performance had been the subject of a good discussion in the Finance, Investment and Performance Committee (FIP).
- Significant improvements had been noted in Barnsley and Wakefield regarding waiting times for treatment.

- The IPR data includes waits for ADHD / ASD (Attention Deficit and Hyperactivity Disorder / Autism Spectrum Disorders) assessments, which have been increasing specifically in Calderdale and Kirklees. This is in part due to the inability to carry out the observations of children in school and in part due to increased demand. Work is underway with the commissioners to develop increased capacity to meet the demand.
- In mental health acute inpatient areas across the Trust, a range of interventions had been used across the inpatient pathway to help maintain patient flow.
- There had been unusually high pressure in relation to Barnsley inpatient beds.
- Occupancy had been high on the inpatient wards across the Trust but no beds have been closed.
- There had been a spike in out of areas beds but this had been managed well, PICU (Psychiatric Intensive Care Unit) beds in particular.
- Positive engagement on the wards had continued. Pride, VE day, Black Lives Matter and messages of kindness has been supported and wards were still working in a creative way.
- Recent incidents in Calderdale / Kirklees community teams had led to the development of a working safely in the community group to ensure that all steps are taken to maintain staff safety.
- IAPT is working in different ways, including working to support intensive care units (ICUs) looking for signs of post-traumatic stress disorder (PTSD) after Covid-19 experiences.
- The forensic service had experienced high numbers of staff not being in work. The recent outbreak in one of our wards had resulted in a strong message going out about people with symptoms not coming into work, which has had an effect.
- A cohort ward had been successfully managed in forensic services with no cross contamination. This was managed very well locally and everyone was cared for safely.

It was acknowledged that the locality report showed how much work had been done by CH's team. It was explained that advocacy had been available to service users via iPads on the wards and further details on this would be provided to the Mental Health Act committee. Subha Thiyagesh (SThi) reported that this was being looked at with the engagement team.

Action: Subha Thiyagesh

Salma Yasmeen (SYa) highlighted the following from the priority programmes section of the report:

- The improvement work in CAMHS and forensic services had been resumed.
- Partnership development work was continuing in all of the Trust's places and across the two Integrated Care Systems (ICSs).

MB highlighted the following from the finance section of the report:

- The Trust was currently operating in an artificial financial environment with temporary arrangements in place, meaning the Trust will be enabled to break-even each month. Covid-19 related costs are separately identified and reclaimed. The Trust would not financially break even without additional top up. This is due to how the income calculation has been derived.
- The Trust was not incurring travel costs to the same degree it has done in previous years, but on a recurrent basis is incurring higher digital costs.
- Pay costs have increased month on month.

Things to be aware of:

- A reduction in the number of vacancies adds potential financial pressure.
- The Trust cash balance is healthy at this time.

A discussion followed in relation to the increase in pay costs. MB noted that some services stepped back up again in May and there had also been less staff turnover, staff redeployment and higher overtime, along with an increase in the number of student nurses.

It was queried what was included in healthcare contracts. MB reported that this not only included acute and PICU out of area beds but also locked rehabilitation services. There are high costs currently associated with the latter. Prior to the suspension of planning and contracting activity, negotiations had been taking place to receive additional income for this cost pressure.

Laurence Campbell (LC) asked why deferred income was so high. MB confirmed it was due to the fact that the Trust had received an extra month's income in advance, as have all provider organisations, to support cash availability and enable seven-day payments to suppliers.

AM thanked everyone for the work that had gone into producing the IPR.

It was RESOLVED to NOTE the integrated performance report and the comments made during its presentation.

TB/20/35b Incident Management Annual Report 2019/20 (agenda item 7.2)

TB highlighted the following:

- To remind the board that the national reporting system shows objective evidence of the Trust position.
- The internal audit report on patient safety from 360 Assurance is awaiting internal sign off. It shows significant assurance about the Trust's processes and taking learning from incidents.

It was RESOLVED to RECEIVE the Incident Management Annual report and NOTE the next steps identified.

TB/20/35c Covid Risks Update (agenda item 7.3)

MB highlighted the following:

- The Executive Management Team would update the full risk register in July; the paper presented today was a summary update of notable changes for the Covid-19 related risks.
- A legal risk was being added and would be reported in full in July.
- The full risk register and Board Assurance Framework would be presented to Board in July.
- It was noted that Non-Executive Directors have been regularly apprised of progress against Covid-19 risks at their weekly meeting.

It was RESOLVED to NOTE the updates to key risks since the last report to Board.

TB/20/35d Covid Trust-wide Equality Impact Assessment (agenda item 7.4)

TB highlighted the following:

- Covid-19 as a disease does not discriminate but there are disproportionate impacts on parts of the population.
- The focus remains on keeping people safe at this time.
- The Trust-wide equality impact assessment (EIA) needs to be continually updated as progress is made.

Action: Tim Breedon

- Staff are being reminded that this is to be used in conjunction with existing equality impact assessments and doesn't replace those already in existence.
- We will be monitoring the approach.
- Items raised at previous board meetings had been addressed.

Chris Jones (CJ) asked whether other protected characteristics were going to be risk assessed. For example, were any actions raised as a result of working-age men being identified as high risk. TB acknowledged that this had been identified as an action but work on this had not yet started.

Action: Tim Breedon

RW responded to say that suicide was acknowledged as the biggest killer of working age men. Pandemics were known to lead to economic recession, and there was evidence to suggest that suicide rates were higher during recessions. Professor Louis Appleby (National Suicide Prevention Strategy Lead) had recently referenced this in work with the Trust.

It was also identified that the document appeared staff centred, and there needed to be a greater focus on service users.

RW commented this was a good piece of work and noted it was ongoing. He reported that the work on this should be seen as mainstream. In reference to the carers' conversation that had taken place earlier, there was a big section in this document on carers and a "commitment to carers" specifically within the Trust. In questioning the content, Board assurance should be sought so that the line can be drawn between asking the questions.

TB reported that this document needs to be integrated into use with the other EIAs that were already in existence.

RW stated that the Business Intelligence Team would support the development of the Integrated Performance Report (IPR) to reflect equality impact, and this needed to be used as tool to seek assurance that we were managing our organisation accordingly. This was the lens that the IPR needed to be viewed through.

Action: Salma Yasmeen

It was RESOLVED to RECEIVE the second version of the Covid-19 Equality Impact Assessment as a Trust-wide assessment of impacts to date, AGREE it is a live document and that any emerging evidence or research to update the EIA is managed through a time-limited task force, and AGREE that the Equality and Inclusion Committee has delegated responsibility to oversee the Trust-wide Covid-19 EIA and monitor and enforce delivery of the action plan.

TB/20/36 Business developments (agenda item 8)

TB/20/36a South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 8.1)

AGD highlighted:

- In terms of the Integrated Care System, there is a transition back to normal business, with a focus on planning and the strategic agenda.
- The agenda will be more strategic than operational from now on.

In relation to Barnsley, SYa highlighted:

- The Barnsley Integrated Care Partnership Group (ICPG) has now fully resumed.
- Barnsley as a system would be taking part in an ICS-wide stress test tomorrow and the Trust had been fully involved in preparing for the meeting.

- In relation to the Barnsley Covid-19 outbreak management plan, it had been decided to establish an outbreak management board, in line with national requirements. This is council led, involves all local stakeholders and includes a representative for the health system appointed from the ICPG.

It was RESOLVED to NOTE the updates from the South Yorkshire and Bassetlaw Integrated Care System and Barnsley integrated care developments.

TB/20/36b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 8.2)

SYa highlighted:

- "Voluntary Action Calderdale" had been successful in receiving monies from The Health Inequalities Fund and Creative Minds would be involved.
- The bereavement support service had been launched that week.
- There was continued work with partners around Covid-19 and the recovery from the pandemic.
- A stress test workshop on future scenarios and our preparedness was taking place on 12 July.

AM reported that the work around developing a diverse workforce and leadership had received strong and positive involvement from the WYHHCP BAME staff network.

RW reported the national workforce race equality team, was offering support for organisations and systems. He also noted that Cherill Watterston, chair of the Trust's BAME staff network had been involved as part of that process and had made a good contribution.

As a system they were looking for external challenge for work with diverse communities and there was more work to be done. The Partnership has announced a Commission on this supported by Professor Dame Donna Kinnair, CEO of the Royal College of Nursing. Elsewhere, Owen Williams (Chief Executive, Calderdale and Huddersfield NHS Foundation Trust) is leading a wider piece of national work on inequalities in health and how the NHS can contribute to tackling them.

A conversation followed in relation to the Integrated Care System and devolution deals. RW reported that in West Yorkshire economic issues and health and care issues are considered together. The Local Industrial Strategy and the 5 year plan for health and care were both taken at the partnership board in December. In addition, RW sits on the Economic Recovery Board for the Leeds City Region. Although health is not part of the devolution deal the appropriate links are being made.

AGD added that the situation was very similar in South Yorkshire and Bassetlaw. Health was identified to be a large employer and research was a key part of what that brought to the economy.

It was RESOLVED to RECEIVE and NOTE the updates on the development of the West Yorkshire and Harrogate Health and Care Partnership and place-based arrangements in response to Covid-19 and recovery and reset planning.

TB/20/36c Covid Stabilisation and Recovery Update (agenda item 8.3)

SYa highlighted:

- Work has continued since the strategic Trust Board meeting in May.
- The next phase is the transition phase involving strategic longer term planning.
- The Covid-19 Trust-wide Equality Impact Assessment process will be central to work going forward.

- This has been strengthened by the variety of voices heard in relation to engagement work conducted with various communities.
- 400 pieces of information had been received from individuals and staff teams that contributed to the learning from Covid-19 and change work
- Planning processes are taking account of as many views as possible.
- Full strategic board discussion will take place around future planning.

AM referred to the emerging work plan and asked about the position of each of the Board Committees in the stabilisation and recovery process. It was noted that the Board was moving back towards more normal governance processes.

CD, chair of the Clinical Governance and Clinical Safety Committee, reported that they had continued to get assurance as much as possible during Covid-19 and a number of reports had continued to be received. From September the Committee would be returning back to its normal format and agenda.

LC, chair of the Audit Committee, stated that in general the Committee had been able to operate without too much impact during Covid-19. Triangulation of risk had been harder but the intention was now to move back to normal in July.

Sam Young (SYo), chair of the Workforce and Remuneration Committee, updated that the Committee had been on hold during Covid-19 with a restart to take place in July. There would initially be a reduced Covid-19 focussed agenda, but then returning to normal business at the meeting to follow. All topics that would have been taken to Committee had been discussed at Trust Board during Covid-19.

Kate Quail (KQ), chair of the Mental Health Act Committee, reported that the meeting had been reduced to an hour during Covid-19 and this now needed to be extended again. Valued input from the acute trusts had continued during Covid-19 with feedback received. The next meeting was to be held in August and would deal initially with items that had been delayed and deferred due to Covid-19.

Erfana Mahmood (EM), chair of the Charitable Funds Committee, updated that the Committee had continued normally during the pandemic and, although the work had been focussed on Covid-19, there were no items that had been missed during this time.

CJ, chair of the Finance Investment and Performance Committee, reported that the key issues to be addressed on return to normal business were financial stability, benchmarking and the productivity agenda.

AM, chair of the Equality and Inclusion Committee, reported that during Covid-19 the focus of the Committee had been on hearing the experience and voices of staff. Some standing items had been deferred and there were additional items to be considered for the performance dashboard as they returned to normal business.

SYa commented that while there was planning taking place for recovery, it still remained unknown whether a second wave of Covid-19 would occur and the organisation had to mindful of that.

A key message is that, as an organisation, we should not go back to old ways of working pre Covid-19, but go forward with changes from that had been learned during the pandemic. There were key messages emerging around governance and decision making and the thematic analysis was to be shared with Committee leads.

Action: Salma Yasmeen

AM reiterated this message and agreed that language should be of renewal, not going back to what we were before.

A conversation followed as to whether the voice of children and young people was being included in the work going forward. It was established that Healthwatch had been capturing the views of children and young people and SYa confirmed that the toolkit being used was flexible for these groups to be included.

RW commented that it was apparent that as a Trust we had good governance but that should not stop us from looking to streamline anything. Claire Murdoch (NHS England's National Mental Health Director) in her meeting with Trust Chief Executives had been looking at the demand on mental health services and there would be a community of practice sharing these models with which we are engaged.

It was RESOLVED to RECEIVE the progress and update on stabilisation and recovery, and NOTE the feedback on any additional aspects that should be considered prior to the detailed discussion in September.

TB/20/37 Governance Matters (agenda item 9)

TB/20/37a Internal Meetings Governance Arrangements (agenda item 9.1)

MB highlighted that the paper was there for noting and that in terms of governance structure the Trust had actually added more governance meetings in the last twelve months.

AM noted that that the Charitable Funds Committee, is a committee of the Corporate Trustee and not the Trust board, and this needs to be accurately reflected in the framework.

Action: Aimee Willett

It was RESOLVED to RECEIVE the internal meetings' governance framework and NOTE the comments made.

TB/20/37b Terms of Reference for the Executive Management Team (EMT) (agenda item 9.2)

MB highlighted the terms of reference for receipt and awareness for Board members.

It was RESOLVED to RECEIVE the terms of reference for EMT.

TB/20/37c Covid-19 Emergency Preparedness, Resilience & Response (EPRR) Arrangements (agenda item 9.3)

AGD highlighted that the transition back to "new normal" may be through the risk assessment process at various levels.

AM commented that it was positive there had been no Covid-19 related RIDDOR reportable (Health and Safety Executive reporting of injuries, diseases and dangerous occurrences regulations 2013) submissions.

It was RESOLVED to RECEIVE and NOTE the EPRR arrangements report.

TB/20/37d Trust Board self-certification (FT4) corporate governance statement 2019/20 (agenda item 9.4)

MB highlighted that it remains good practice to evidence that we comply with the NHS Improvement (NHSI) provider licence. He added that it is unlikely the document will require submission to the regulator this year.

AM commented that there is additional training and development for governors to that documented in the paper.

It was agreed that MB would send the self-certification to NHS England and NHS Improvement (NHSE&I) for completeness.

Action: Mark Brooks

It was RESOLVED to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to the Corporate Governance Statement 2019/20 and the training for governors 2019/20.

TB/20/37e Update on the annual report process following auditor's report and expected timescales for completion of the quality account (agenda item 9.5)

MB highlighted that the paper explained what the process had been for completion and approval of the annual report and accounts.

It was confirmed that the report had now been laid before parliament and could be published on the Trust website. It was duly noted that we had been the first NHS Trust in the country to submit its annual report and accounts and the Board thanked the finance team for their hard work in achieving this.

It was RESOLVED to NOTE the update on the process relating the annual report and accounts process and submissions and RECEIVE the external audit report relating to the annual accounts and comment accordingly.

TB/20/37f Update on policies and strategies delayed due to Covid-19 (agenda item 9.6)

MB highlighted that the paper could be taken as read. A six-month extension for a number of policies had been agreed by EMT given the impact of Covid-19.

SYa reported that the Involving People Strategy had been delayed. External stakeholder work was starting again that week. It was in the process of being updated and then it would be taken back to the stakeholder groups to test it. SYa reported the aim, at present, was to bring the final version back to board for approval in September and updated that some of the work and actions are being implemented already.

It was RESOLVED to NOTE the update in relation to policies and strategies delayed due to Covid-19.

TB/20/37g 2020/21 Planning Requirements (agenda item 9.7)

AM noted that this item was not commercial-in-confidence, as referenced in the paper.

MB updated that financial and planning arrangements beyond the end of July are not yet available. This clearly causes some level of uncertainty in terms of how much income the Trust will receive for the services being provided. He added that the Trust has been involved in discussions regarding what the arrangements could look like for the remainder of the year and specific issues with the current level of block income have been communicated to NHSE&I.

MB added that financial planning and horizon scanning are regularly discussed at FIP (Finance, Investment and Performance) Committee. MB reminded Trust Board members that currently a level of block income is received based on month 9 in 2019/20, with the

ability to reclaim reasonably incurred Covid-19 response costs and additional 'top-up' income to enable break even. This top-up income is required for the Trust as not all income previously provided is included in the block calculation.

MB stated that the costs incurred during the first two months of the financial year were not necessarily representative of the year as a whole. He gave a number of examples of why costs may change as the year progresses. These included:

- All the digital costs that had been added as a result of Covid-19 had not yet started to be paid.
- There is widely expected to be a surge in demand for our services.
- Staff would start to take more leave which in some cases would require backfill.
- Some staff had been redeployed in the first few weeks of the year. As they return to their core roles the positions they have been covering may need backfilling. This could impact on workforce requirements and the demand for inpatient beds.
- Some costs, e.g. training, have not been incurred yet and are likely to pick up as the year progresses.
- There will be costs associated with provision of testing for Covid-19.

MB explained that detailed planning work had already begun so as to understand our most likely cost requirements and to assess a number of scenarios. One scenario would be the impact of a second wave of Covid-19. MB added that there was likely to be more focus on financial control and governance with the next set of financial arrangements for the NHS.

CJ reported that the FIP (Finance Investment and Performance) Committee continued to gain assurance, and that MB and Rob Adamson (Deputy Director of Finance) had good processes in place to ensure the Covid-19 cost reclaim was appropriate. He added that they are receiving regular updates regarding the financial and planning environment and they were aware of the current uncertainty around future income streams, which had the potential to create financial tension.

It was RESOLVED to NOTE the update in terms of the planning process and potential changes to the financial arrangements after July, and the work the Trust is carrying out in terms of developing an operational plan for the remainder of the year.

TB/20/38 Assurance from Trust Board Committees (agenda item 10)

Audit Committee, 2 June 2020

LC highlighted that the annual accounts had been reviewed and recommended for approval.

Clinical Governance and Clinical Safety Committee 9 June 2020

CD highlighted the huge amount of work people had been doing to keep service users safe as referenced in the service user story earlier. The Committee wanted to recognise this, and in addition the work done by teams to get reports to Committee.

AM reported that there will be a focus on CAMHS (Child and Adolescent Mental Health Services), at the next meeting.

Equality and Inclusion Committee, 2 June 2020

AM highlighted that the Covid-19 Trust-wide Equality Impact Assessment had been discussed at Committee.

Reporting on equality standards and development of the performance dashboard had been suspended due to Covid-19, but were key pieces of work going forward. The work of this committee is especially important at the present time, given the concerns about race

equality, and the committee really values the input from staff networks, staff side and business delivery units across the Trust.

Finance, Investment and Performance Committee 23 June 202
CJ highlighted that in the meeting in June the Committee had been pleased to see that the Trust had paid 83% of suppliers within 7 days. Capital expenditure submissions in relation to Covid-19 had been made via the Integrated Care Systems and we would have to await the outcome of these. CJ stated that he would have a conversation about CAMHS with CD to clarify the work taking place in each committee on this subject.

Mental Health Act Committee 12 May 2020
KQ highlighted that due to Covid-19 the Committee had taken place in a reduced timescale and a number of items had been delayed.

It was RESOLVED to NOTE the updates from Trust Board committees and RECEIVE the approved minutes as noted.

TB/20/39 Use of Trust Seal (agenda item 11)

It was reported that the Trust seal had not been used since March 2020.

It was RESOLVED to NOTE that the Trust Seal had not been used since the last report in March 2020.

TB/20/40 Trust Board work programme (agenda item 12)

It was updated that the serious incident annual report had now been received by Trust Board.

It was clarified that Trust Board in December was a strategic meeting.

AGD updated that, in relation to the Estates, Sustainability, Organisational Development and Workforce strategies, November was achievable.

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

TB/20/41 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on 28 July, venue / arrangements to be confirmed.

TB/20/42 Questions from the public (agenda item 14)

No questions were received.

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 30 JUNE 2020 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 30 June 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/32	The Executive Management Team (EMT) had looked at the indicators that were in the IPR. Work still needed to be completed, but had been on hold due to Covid-19. This would be completed and included in the IPR when business was fully restored. It was agreed by the board that the action could be closed. Rob Webster (RW) went on to explain that this fitted into a wider piece of work around what the board was taking as assurance. It was agreed that the Finance Investment and Performance (FIP) Committee should review the IPR against each phase of Covid-19 and make sure that the indicators were part of that work.	FiP Committee	September 2020	The new action would need to be refreshed regularly and be current. It should be at the top of matters arising to maintain the right assurance for the board.

TB/20/35a	The patient testing numbers being discussed in the IPR did not include all the work in Barnsley in relation to care home testing. The outbreak support work to the care home sector continues to be considerable and our community visits have been in the region of 1700 a day. TB stated that in future reporting further clarity would be provided as to what the numbers included.	Tim Breedon	July 2020	
TB/20/35a	AM raised a query regarding the table on p26 of the IPR – 'Covid-19 incident reporting' – that showed 30 patient deaths to be suspected Covid-19 related. She was questioning the apparent discrepancy between these figures and the one death reported in the summary dashboard on p5. TB agreed to review and provide an explanation.	Tim Breedon	July 2020	
TB/20/35a	There followed a discussion about the rise in the level of self-harm and TB noted that the increase was linked to a number of individuals within the Trust and there was no current evidence that the increase was Covid-19 related. It was also identified that there was specific work taking place through teams to monitor carers and the next step would be to monitor performance in relation to helping carers who were identified as particularly vulnerable through the task group.	Tim Breedon	July 2020	

TB/20/35a	**See above action** : AM reported this needed to be a focus for the Equality and Inclusion Committee.	Angela Monaghan	September 2020	
TB/20/35a	MB confirmed that the Trusts performance against national metrics was holding up well. National metrics are performance targets that all NHS Trusts have to achieve. It was noted there had not been any significant increase in referrals to Increasing Access to Psychological Therapy (IAPT). RW asked that we follow up on whether the reductions in recovery rates for IAPT were an issue concerning the mode of delivery. Switching to a digital mode of delivery may not suit individuals.	Carol Harris	September 2020	
TB/20/35a	It was acknowledged that the locality report showed how much work had been done by CH's team. It was explained that advocacy had been available to service users via iPads on the wards and further details on this would be provided to the Mental Health Act committee. Subha Thiyagesh (SThi) reported that this was being looked at with the engagement team.	Subha Thiyagesh	August 2020	
TB/20/35d	The Trust-wide equality impact assessment (EIA) needs to be continually updated as progress is made.	Tim Breedon	September 2020	

TB/20/35d	Chris Jones (CJ) asked whether other protected characteristics were going to be risk assessed. For example, were any actions raised as a result of working-age men being identified as high risk. TB acknowledged that this had been identified as an action but work on this had not yet started.	Tim Breedon	September 2020	
TB/20/35d	RW stated that the Business Intelligence Team would support the development of the Integrated Performance Report (IPR) to reflect equality impact, and this needed to be used as tool to seek assurance that we were managing our organisation accordingly. This was the lens that the IPR needed to be viewed through.	Salma Yasmeen	September 2020	
TB/20/36c	A key message is that, as an organisation, we should not go back to old ways of working pre Covid-19, but go forward with changes from that had been learned during the pandemic. There were key messages emerging around governance and decision making and the thematic analysis was to be shared with Committee leads.	Salma Yasmeen	September 2020	
TB/20/37a	AM noted that that the Charitable Funds Committee, is a committee of the Corporate Trustee and not the Trust board, and this needs to be accurately reflected in the framework.	Aimee Willett	July 2020	
TB/20/37d	It was agreed that MB would send the self-certification to NHS England and NHS Improvement (NHSE&I) for completeness.	Mark Brooks	July 2020	

Actions from 28 April 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/17	PS/20/11b –CH advised that this [social distancing at Urban House] has stabilised and that an update will be provided at the next Clinical Governance & Clinical Safety (CG&CS) Committee.	CH	June 2020	Discussed in June Board. Complete
	PS/20/13d – Salma Yasmeen (SYa) updated regarding the timescale for the Involving People Strategy and advised that this will be June 2020.	SYa	June 2020	Discussed in June Board. Complete
TB/20/21b	Workforce support hub health and wellbeing services are in place to support staff and managers. A talent pool has been developed to allow the movement of staff to support where required in the organisation, alongside ongoing recruitment processes. Further areas being considered are staff resilience and the impact of Covid-19 on Black, Asian and Minority Ethnic (BAME) staff.	AGD	June 2020	Discussed in June Board. Complete
	The next version of the IPR will include a more detailed workforce dashboard which is currently in developments, with a focus on Covid-19 and reporting against new and aligned national priorities.	AGD	June 2020	Discussed in June Board. Complete

TB/20/21c	AM noted that the report [safer staffing] relates to inpatient services and not community services, TB confirmed this and added that this will be made clearer in future reports.	TB	July 2020	Discussed in June Board. Complete
TB/20/22b	Suggested that further work is required on the controls for risk ID 1522 to identify what is happening to keep staff, patients and service users safe.	TB	May 2020	Discussed in June Board. Complete
TB/20/24b	AM noted that there has been a delay in completing the first annual review for the West Yorkshire Committee-in-Common due to Covid-19. AM added that this would follow the same structure as other Committees, and that the review will be considered by the Audit Committee once finalised for completeness.	AM	TBC	Discussed in June Board. Needs confirmation from committee.

Actions from 28 January 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/09a	AGD noted that following an evaluation of the estates strategy, the Trust has done what was previously agreed, however it was noted to review if it worked out and achieved the goal. What is the learning and how do we feed back into the strategy.	AGD	September 2020	
TB/20/09a	Timetable: AGD stated that the strategy should be ready for Q1. Conversations required regarding how to review the strategy going forward. It was noted that further detail and engagement is required from Board before it is submitted for approval. The strategy will be discussed in March by EMT, and a draft brought back to the Board in April with a commitment to sign off the final version in September.	AGD	September 2020	

Actions from 26 November 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/111c	RW noted that the report considers safer staffing on inpatient wards but does not cover community services… RW queried how to get to a point where we report safer staffing for the organisation. TB advised that there is a pilot project with community teams, but it is too early to make recommendations. Timescales for introduction will be reported into the next CG&CS committee.	TB	September 2020	Plan to pilot nationally recognised staffing judgement across four community teams has been postponed due to Covid-19. Position will be reviewed by CG&CS September meeting. Noted in the report at agenda item 7.3.

Actions from 29 October 2019

Min reference	Action	Lead	Timescale	Progress
TB/19/97a	CD also noted that bullying has been picked up as a theme to tackle and that this is not really represented in the report. MB noted this issue should also be assessed for the Board Assurance Framework (BAF) and risk register.	AD	April 2020	This will be considered in the next versions of the Board Assurance Framework and risk register the Board receives. Delayed due to Covid-19. Discussed at May Strategic Board. BAF will be further reviewed in September Strategic Board..
TB/19/97c	Reflecting on the discussions relating to the Board Assurance Framework and Operational Risk Register RW suggested there could be another strategic risk for consideration in relation to external threats where people are aiming to do harm. Examples being cyber and the agenda around Prevent. This will be reviewed during the next update of the BAF for 2020/21.	MB	April 2020	This will be considered in readiness for the next versions of the Board Assurance Framework and risk register the Board receives. Delayed due to Covid-19. Discussed at May Strategic Board. BAF will be further reviewed in September Strategic Board.
TB/19/99a	EM stated that she had spent some time with the complaints team and recognised how complex some are to complete and bring to a conclusion. She wondered if the target completion date was always achievable and whether we should again review.	TB	July 2020	Proposal for revised target on hold due to Coivd-19, to consider post pandemic. Discussed in June Board. Going to normal arrangement as of 1 July 2020 and revising

Min reference	Action	Lead	Timescale	Progress
				targets.
Actions from 24 September 2019				
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	April 2020	Initial reporting on Mental Health Act indicators commenced in the September report. Given the impact of long-term sickness and additional sizeable priorities that have emerged in the year it is unlikely that much development work can take place meaning it is unlikely any new indicators will be reported on this year This has been further delayed by Covid 19. Discussed in June Board. RW – previously looked at MHA and tightened up the work of the committee and adherence to the act. Reflected in CQC report. EMT looked at indictors to go in IPR and that work needs to conclude but on hold due to Covid. Restoration stage will mean the work gets completed and included in IPR when restored. Action can be closed agreed by SYo and others. RW this fits in a wider piece of work but its also part of a bigger piece as what is the board taking as assurance. To make sure the FiP looks at the IPR against each phase and these indicators need to be part of that. New action – close this one. Make it broader the board has the right targets coming from

Min reference	Action	Lead	Timescale	Progress
				the IPR. AL to check with AM on this one. Need to keep this refreshed and current. To the top of matters arising. Right reassurance at the board. Superseded by action TB/20/32

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 7

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:	Effective communication during the Coronavirus outbreak has continued. The frequency of our communications has reduced with a weekly staff briefing and a fortnightly NEDs meeting now in place. The monthly Brief for all staff is attached at **[Annex 1]**. The progress of the pandemic has followed the national strategy with a move to local outbreak management and away from national restrictions. Since The Brief was issued we have seen: • **The implementation of outbreak management boards at regional and local levels.** These are local authority lead with NHS input. • **Publication of infection rates by post code and place** which has led to interest in which places are at risk of lockdown. • **Lockdown being maintained in Leicester which has significantly higher rates than other parts of the country.** However as Bradford had the next highest rate (which was around the third of that of Leicester) there has been significant interest in Bradford. This has also been the case in other Yorkshire areas for example Kirklees and Wakefield. • **There have been notable small outbreaks in the districts in which we work.** These have been of interest to the media and have been well managed by the outbreak management boards and local partners. The Board may wish to note that the official definition of an outbreak includes that it constitutes at least two people connected in space and time. This is somewhat removed from the common understanding of what an "outbreak" entails, which could be seen to constitute much larger numbers. • **This is all set within a context of reducing incidence,** falling numbers of deaths and substantial changes to the lockdown arrangements nationally as a result.

- **We have been working with partners and our ICS' on future planning.** This has included stress tests of our ability to respond to COVID-19 under different scenarios. All of this work is in lieu of national planning guidance and is part of local leaders' desire to ensure we have plans that work for each of our places. The process has been well supported by the central teams in each of our ICS' and we are engaged well in each system. If the national guidance is available prior to the Board we will give a verbal update of the contents and any issues.

- **The development of the financial arrangements for the rest of this year remains uncertain**. We have been contributing to the testing of potential financial arrangements which are anticipated to come in for the second half of the year. These are likely to include a greater role for ICS' as well as some guarantees around the Mental Health Investment Standard.

- **Public sector pay awards have been announced which include a 2.8% increase for doctors.** These awards are expected to be delivered within existing finances and do not include nurses who have an existing 3 year pay deal. We will consider the full financial impact when we receive more detail.

- **There is emerging evidence that immunity from COVID-19 may be short lived with antibodies disappearing after 3 months.** There is also evidence of different baskets of symptoms and an enduring degree of illness in some people infected. The latter has been dubbed 'long COVID' and is characterised by significant fatigue and organ damage.

- **The focus on prevention in the lead up to the winter will include work on flu vaccination.** We will be expected to deliver even higher levels of staff vaccinations and support vaccination of vulnerable people. COVID vaccines may be available before Christmas and we have groups in our ICS' considering how to ensure effective delivery at scale.

- **Away from Coronavirus, the LeDeR report was published last week** and makes for sobering reading. For example, only 37% of people with a learning disability live beyond the age of 65 compared to 85% of the wider population. As with many other measures people from BAME communities fair worse than their white counterparts and die at disproportionately younger ages. The Executive Management Team is considering the LeDeR report on 23 July 2020.

- **The WY&H ICS commission into inequalities chaired by Professor Dame Donna Kinnair has begun.** The papers are publicly available here. The report will be produced by September and will strengthen current actions and devise areas for further work for the biggest impact.

- **Staff continue to be well supported across the organisation.** Risk assessments for pregnant and BAME staff are at 100% and we are well on our way to supporting every member of staff to have a risk assessment. Feedback on the extra day of annual leave we have offered has been positive as have the wellbeing packs distributed through the EyUp! Charity. The Board will be pleased to hear that the Charity

	received an extra £50,000 from NHS charities for staff welfare. I have given my apologies for the Board meeting as I am taking some annual leave. It is important after a period of significant workload that all Board members role model the need for rest and recuperation. This is a message that is being promoted across the NHS. The Board papers today reflect that this is a period of great uncertainty and significant risk. The culture and infrastructure that we have in place have served us well to date and we will need to make sure that we continue to pay attention to the change in context in the ways which we work.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

2 July 2020

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

With **all of us** in mind.

Today's brief

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Welcome to the Brief being delivered through Microsoft Teams.

Please put your device on mute so that background noise is limited and turn your camera off unless you are speaking. You can ask questions throughout the presentation using the chat function. Questions will be collated and shared so if we don't get time to answer all of them online we will make sure a response is sent out to you.

Thank you for joining us for our Brief broadcast.

With **all of us** in mind.

Our mission and values

NHS
South West Yorkshire Partnership
NHS Foundation Trust

During challenging times is it important we focus on our 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

Despite celebrations being a bit different this year we joined our LGBT+ staff network for Pride Month and the online Virtual NHS Pride.

With **all of us** in mind.

Coronavirus

Keeping informed, acting responsibly

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We need to stay focused and keep up to date by reading the official guidance and information on the Public Health and NHS England websites.

We should also read our own guidance and helpful information on our Coronavirus intranet section.

We need to continue to follow the official guidance; and ensure good hygiene, social distancing and limiting unnecessary contact with other people are continued.

Keep doing what you are doing. It is saving lives.

Coronavirus
Our day to day approach

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Our approach in each area is still based on our **business continuity plans** which has helped us to maintain safe and effective services and be coronavirus free on our inpatient wards.

Our **silver and gold** command meetings are now meeting twice a week, and **bronze** meetings continue to take place in operational and corporate services.

Workplace risk assessments are taking place in all areas of the Trust, so we can make sure that where people work and receive our care is safe and secure.

All this is to make sure we can safely deliver services and that staff, service users and carers can stay protected.

With **all of us** in mind.

Our priorities for 2020 - 2021

Response to Covid-19

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Improve health

- Work with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield and West Yorkshire to develop a joint response to Covid-19
- Develop innovative offers to help people in their own homes through Creative Minds and recovery colleges

Improve care

- Patient Safety in response to Covid-19, testing and PPE to keep people safe
- Provide all care as close to home as possible and support discharges from hospital
- Deliver improvements particularly in CAMHS and forensic services

Improve resources

- Spend money wisely to support COVID response
- Accelerate the use of digital technology introducing new ways of virtual working to help support service users and staff

Make this a great place to work

- Support the wellbeing of #allofus through key conversations to help people cope & connect
- Develop a workforce hub

#allofusimprove and be outstanding

Underpinned by #allofusimprove to make sure that we learn from the organisational changes that have taken place

With all of us in mind.

Improving Health:
Joining up the response in every place

West Yorkshire and Harrogate Health and Care Partnership

South Yorkshire and Bassetlaw Integrated Care System

NHS South West Yorkshire Partnership NHS Foundation Trust

Integrated care systems continue to refocus their work to ensure system support for:

- Increased critical care
- Better discharge from hospital
- Protection for vulnerable people in communities
- The safety and wellbeing of staff
- Business continuity and mutual aid
- Moving to recovery and a new way of working

We actively work in both ICS'.

West Yorkshire Prepared brought organisations together to remind people to stick to the 2m social distancing rules where possible. "The virus has not changed – it is still infectious, still circulating and still killing people."

A new support and advice service was launched to help people across West Yorkshire and Harrogate through **grief and loss**. The free service will be available 7 days a week, from 8am to 8pm on 0800 196 3833 or griefandlosswyh.co.uk

South Yorkshire and Bassetlaw has its own 'listening ear' service providing emotional support for bereaved adults and children aged 11+. Tel: 0800 048 5224

We joined partners from across West Yorkshire and Harrogate to say thank you to all the workers and communities who came together in the 100 days since lockdown was announced.

With **all of us** in mind.

Improving Health:
Joining up the response in every place

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We continue to attend coronavirus response meetings in every place, as well as helping to develop services:

Barnsley
Our community teams continue to support care homes in their coronavirus response, including outbreak testing. Rightcare Barnsley has moved into the Lodge in Kendray to work as one team alongside the community nursing referral team – integration in practise.
Barnsley was identified by the World Health Organisation as a model of best practise for its smoking cessation work.

Calderdale
Calderdale have published their local outbreak prevention and control plan, which is available online. All councils are required to produce one.
Healthwatch Calderdale is carrying out their survey on the impact of coronavirus on local communities.

Kirklees
Partners worked together on a coronavirus outbreak response. Kirklees celebrated Safeguarding Week with a week of activity.

Wetherby
Our Focus forensic CAMHS team working at Adel Beck and Wetherby YOI have worked with partners on their coronavirus response.

Wakefield
A partnership called 'Wakefield Families Together' has been set up, to bring together all Wakefield based agencies working with children, young people and families. We are heavily involved.

Barnsley, Doncaster, Rotherham and Sheffield
Work on the QUIT programme in S Yorkshire includes all hospitals going smoke free.

Improving Care:
Safety and quality

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In May we had:

- 937 incidents - 784 rated green (no/low harm)
- 145 rated yellow or amber
- 8 rated as red
- There were 4 reported serious incidents this month. 2 apparent suicides, 1 accidental injury and 1 security issue.

We continue to monitor incidents where **coronavirus** is noted in the Datix entry. This is so we can identify of any themes and trends that require action, and so we can make changes.

There were **20 confidentiality breaches** in May, up from 15 in April. The Trust has a duty to assure the public that any information we hold is in safe hands. Everyone has a part to play to ensure information is handled, shared and secured properly – so every time you use a piece of information about someone – Think IG.

For help and advice contact the information governance team.

THINK IG
Information Governance

We have produced a suite of posters for use in inpatient units to explain what we are doing to keep people safe, and what service users can do themselves to help.

With **all of us** in mind.

Improving care:
Our performance in May

South West Yorkshire Partnership NHS Foundation Trust

- **3** inappropriate out of area bed days
- **100%** of people recommend our community services
- **86%** of people recommend our mental health services
- **1.7%** delayed transfers of care
- **40.1%** referral to treatment in CAMHS timescales
- **2** people under 18 admitted onto adult inpatient wards
- **91.5%** of prone restraint lasted less than 3 minutes
- **160** restraint incidents
- **91.5%** of people dying in a place of their choosing
- **49.2%** of people completing IAPT treatment and moving into recovery

There were **45** inpatient falls in May, up on the 39 we saw last month. All falls are reviewed to identify measures to prevent reoccurrence, and all serious falls are subject to investigation.

We had **46** attributable pressure ulcers, none of which were avoidable.

In the **Live Well Wakefield** annual report over **90%** of their clients say they had achieved their primary goal; and over **82%** reported improvements in their wellbeing.

With **all of us** in mind.

Improving care:
Our coronavirus related performance

NHS
South West Yorkshire Partnership
NHS Foundation Trust

As of 1 July:

- **There are currently 193 members of staff absent or working from home due to coronavirus.** This is **3.8%** of the Trust workforce.
- **94 members of staff are absent and 99 are working from home.** Of those absent, **63%** are shielding, **21%** are symptomatic, **11%** have household symptoms, and **3%** have been advised to isolate by occupational health
- **We've processed 1,738 swab test results for staff and household members**, with **146** of these testing positive and **1,592** testing negative.

As of 17 June:

- **103 service users have been tested** on the wards, **29** of which were positive. Of these, **28** have since recovered**.**
- **Occupational health** has received **796** calls to their coronavirus helpline.

Our learning disability services marked LD awareness week by posting films on social media advising service users and their families on how to stay healthy and well.

With **all of us** in mind.

Improving care
Electronic Prescribing & Administration of Medications (EPMA)

NHS
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NHS Foundation Trust

Delivery of the new system will enable the prescribing, supply and administration of medicines electronically and will bring with it a significant range of safety, quality and financial benefits.

We will be replacing the paper drug charts with electronic processes which will be completed in our current SystmOne Service User record. This will enable a complete record that can be accessed remotely from any Trust device.

It's a key development for the Trust, designed to improve patient safety, efficiency in service delivery, improve quality of data and deliver financial benefits. Initially we will be implementing EPMA within the inpatient wards across all BDUs.

'Computers on Wheels' in every ward will enable medication to be administered.

You'll have an opportunity to meet the EPMA team - your feedback is really important to us!

We need EPMA champions for each ward from the nursing team. Contact Allison.payne@swyt.nhs.uk

With **all of us** in mind.

Improving resources:

Our finances in 2020/21

South West Yorkshire Partnership NHS Foundation Trust

	Performance Indicator	Year to date
1	Surplus / Deficit	
	Covid-19 reimbursement	£0.9m
	Top Up	£0.5m
	Reported position	£0.0m
2	Agency Cap	£1m
3	Cash	£54.9m
5	Capital	£0.1m
6	Better Payment	
	30 days	97%
	7 days	83%

The Trust is reporting a breakeven position for April to July 2020. To achieve this additional national funding is required for both reimbursement of coronavirus costs incurred and additional top up. For May this equated to £482k and £242k respectively.

Whilst there is currently no NHS Improvement agency cap set for 2020/21 the Trust continues to monitor **agency spend** and action plans remain to ensure agency staffing usage and costs is appropriate. Spend in May was £0.5m.

Cash in the bank continues to be above expected levels. The main reason is the timing of block income payments, which are a month in advance. This is reduced partially by the earlier timing of invoice payments.

The Trust submitted a revised **capital** plan for 2020/21 of £6.6m. This continues to be reviewed in light of access, affordability and value for money driven by the implications of covid-19.

Our **Better Payment** results show that 83% of invoices have been paid within 7 days.

Coronavirus
Changes in service delivery

NHS
South West Yorkshire Partnership
NHS Foundation Trust

To celebrate carers week the **Dales Carers Group** in Calderdale Royal Hospital gave out over 100 wellbeing packs to their carers in Calderdale. The feedback from carers was phenomenal.

Our perinatal mental health team also gave out personalised **wellness packs** for their service users, all with a personal hand written message.

Our **Virtual Visitor** scheme has been rolled out across out inpatient areas. Despite rules on visiting being relaxed we will keep the Virtual Visitor scheme as an additional option.

Over 180 items of equipment have been taken out to domiciliary patients in Barnsley over the past 8 weeks by our physiotherapy assistants. This helps decrease the risk of falls, promotes mobility and keep patients active and independent in their homes.

With **all of us** in mind.

Coronavirus
Patient engagement and experience toolkit

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Gathering the views of service users, carers, friends, family, staff and communities will help the Trust understand the impact of coronavirus on people who work in and use our services. Each service is asked to gather feedback so we can understand our recovery approach. To support this work a toolkit has been developed to test out a systematic approach. Over the next 3 months services are asked to gather views using the toolkit. You can find the toolkit on the coronavirus section of the intranet.

By using a standard set of questions and it will;

- Enable the Trust to manage the use of surveys to prevent engagement fatigue
- Manage an approach that ensures data is collated centrally
- Allow the Trust to usefully use all data gathered for more than one purpose
- Ensure questions are appropriate and do not contain assumptions or appear as rhetorical
- Align the use of patient experience and engagement data
- Ensure that we ask a set of standard questions, in particular a requirement to gather equality data

Staff can use the toolkit to build a survey quickly and easily using a pick and mix approach. We are asking staff not to create their own surveys but to use the toolkit approach instead.

With **all of us** in mind.

Coronavirus
Looking after you

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Following a mandated government decision we have introduced face masks for all staff, visitors and outpatients.

This is to help restrict the spread of the virus through droplets that can be sprayed in to the air by coughing and sneezing.

This is another measure that will compliment what we are already doing through social distancing and regular hand washing.

We are carrying out workplace risk assessments in all our areas, so that we can safely reintroduce services into buildings where they were paused at the start of the pandemic. Once areas are risk assessed they can be designated 'COVID secure' which means we can then relax some of our measures.

Coronavirus update
Looking after you

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Staff testing
We are on target to provide coronavirus antibody tests to all staff by 10 July. This compliments the swab testing we are carrying out with people who show symptoms or need to be tested as part of outbreak management. We are no longer swab testing asymptomatic people as the antibody test is available instead. Email occupational health to either book a test or record an exemption.

BAME risk assessments
All BAME Staff, including Bank Staff, were offered a risk assessment and as of today 99% of those working have completed the assessment process.

We are supporting our staff who are still **shielding** and those who are due to leave shielding soon. We have minimum standards of contact to ensure staff are supported and in contact while shielding and risk assessments to take place before staff return to work.

Supplies of **personal protective equipment (PPE)** remain healthy and we are able to ensure all our services have what they need.

As the **weather** heats up for Summer we have reviewed our heatwave approach and put things in place to support staff who have to wear PPE. This includes hydration stations in our inpatient areas.

With **all of us** in mind.

#NHS72

Thank you for everything you do

South West Yorkshire Partnership NHS Foundation Trust

On 5 July the NHS celebrates it's 72nd birthday. It has been a challenging time and this is a good opportunity for us to reflect and celebrate what everyone has done to keep people safe and well.

As a thank you to everyone we are delighted to gift everyone with **one extra day of annual leave**. From 1 August everyone will be able to take this extra day to rest, refresh and recharge.

As a thank you we will also be distributing **health and wellbeing packs** to all our staff over the next few weeks. They will include a water bottle so people can stay hydrated, and advice to help you look after your personal and family wellbeing.

Everyone has contributed to our coronavirus response, helping us to maintain our services and keep people safe. Thank you to you all.

A great place to work
Wellbeing at work survey: Make your voice heard

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Our wellbeing at work survey returns from Tuesday 7 July.

All staff will be invited to take part in this either by email or through a paper copy for those colleagues who usually complete staff surveys this way.

The survey will be open for **three weeks** only.

Without your feedback we can't make changes to our health and wellbeing support. We need you to help us identify priorities for investment in workplace wellbeing support.

The Trust is committed to supporting your health and wellbeing before, during and after the pandemic.

To do that, we need to understand your current challenges and experiences to make sure we have the right support in place.

We need to hear from **all of us** to make sure we can make SWYPFT a great place to work for everyone.

The survey is completely confidential and anonymous.

With **all of us** in mind.

A great place to work
Support when you need it

#allofus
our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Remember that we have support available for all of us.

Our **occupational health** team have a dedicated phone line for managers and staff who require general advice around coronavirus. You can contact the team on **01924 316036** (Monday-Friday, 8am - 4pm)

Our HR **telephone helpline and email account** for managers and staff with Coronavirus enquiries is open Monday-Friday between 8.30am-5pm. The number is **07824 801649** and email is **COVID19-HR@swyt.nhs.uk**

Our **pastoral and spiritual care service** have set up a dedicated and confidential phone line for patients, carers and staff. It is called 'Talk Line'. It is available Monday to Friday between 9.30- 10.30am and 2-3pm. The number is **01924 316341**

If you want to speak to someone independent of the Trust then you can contact the national **#OurNHSPeople** phone line on 0300 131 7000 (7am – 11pm). There are also online resources available https://people.nhs.uk/

Our **website** includes advice on how everyone can look after their mental health and wellbeing and how to support others.

With **all of us** in mind.

Coronavirus update
What you can do to help

#allofusimprove and be outstanding

NHS South West Yorkshire Partnership NHS Foundation Trust

Support your own wellbeing by taking **annual leave** and **breaks** whenever you can. We have extended the annual leave year to allow staff to carry over 10 days into 2020-21. It is important that we look after ourselves by taking time whenever we can to recharge and refresh.

Follow our **Bare Below the Elbow** rules when in clinical areas and on community visits. This will help us to maintain good hygiene in clinical areas.

Continue to **wash your hands** as often as you can, making sure to follow the six step handwashing technique found on the intranet. .

Keep yourself **up to date** by visiting the coronavirus pages on the intranet and download our Staff App to get updates on your phone.

Keep all areas clean and germ free. This includes desks, workstations and equipment. We all have a part to play in keeping us safe.

With **all of us** in mind.

Coronavirus update

Remember we still need to practice 2m social distancing

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Stay at home

Where possible, work from home. If you do have to come into work, make sure you:

Keep your distance

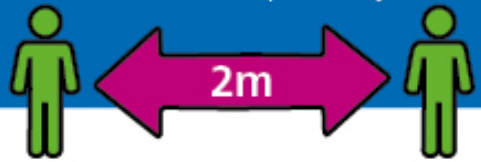
Keep a minimum of 2 metres distance at all times between you and the next person

Avoid close contact

Sit one to a desk, make use of empty office space and do not sit together in public areas

Stay away from counters

When using the pharmacy or restaurant stay 2 metres away from servers, cashiers and pharmacy staff



Avoid using public transport

Avoid non-essential use of public transport when possible

Use technology to stay in touch

Keep in touch using remote technology such as phones and internet

Limit contact with:

- People with underlying health conditions
- People over 70
- Pregnant women

Wash your hands

Remember to wash your hands with soap and water more often and for at least 20 seconds

With **all of us** in mind.

JOB NO 1532 MAR20

All of us improve
Stabilisation and recovery

We have spent time **understanding the impact of coronavirus** on **our services** and the **impact it has had on staff, service users and different groups.**

Over **400 staff and our governors** have **shared their views and experiences so far**. We are also **capturing the voices and feedback from service users, carers, and local communities**. We will be taking this learning forward as part of our move to a **'new normal'.**

We will **continue to build on the innovation and change** you **have all driven**, which has been **clinically led and supported by corporate teams.**

We have also **strengthened our approach to capturing feedback from service users, carers and communities** and will continue to work on this in the coming year**.**

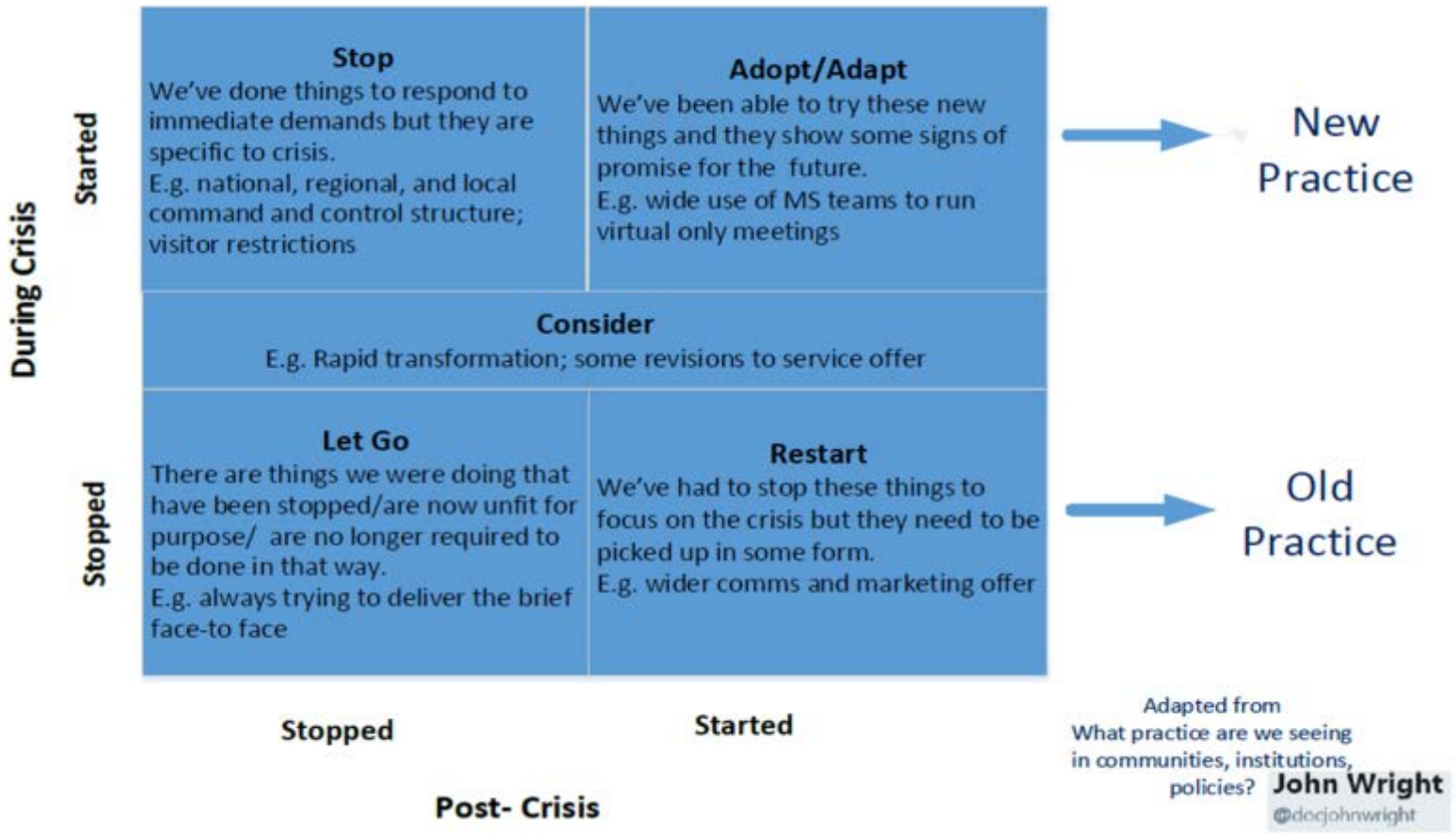
All changes will be made using **quality improvement approaches underpinned by our 'All of us Improve' approach.**

With **all of us** in mind.

All of us improve
Our approach

We are using this framework to measure the responses received so far

Response Measures



All of us improve

Learning and insight themes

We have collated the responses received so far into key themes:

Ranked Key theme	Comments
Connecting with colleagues virtually	MS Teams, Skype: Majority of responses are positive for both clinical and support services outcomes
Connecting with colleagues	Phone, WhatsApp, Facetime: Majority of responses are positive and focus on improved awareness and connectivity
Connecting with service users virtually	E.g. AccuRx. Majority of responses are positive but only about the outcomes for professionals (will need to triangulate with service user/carer feedback)
Connecting with service users through other mediums	Phone, texting, e-mailing, WhatsApp: Majority of responses focus on positive aspects of speed and freeing up of professional time (will need to triangulate with service user/carer feedback)
Agile working	Overall positive responses but with concerns about the need to implement and resource properly - developing a considered change plan
Change in service provision (service delivery)	Mixed responses on changes to service delivery and whether to adopt/adapt or stop for future delivery.
Change in service provision (support services)	Mixed responses to changes in support services and whether to adopt/adapt or stop for future delivery
Prioritisation	Overall positivity about using tools to prioritise and flexibility of staffing
Communication and sharing information	Positive feedback on structured approach to coronavius communication. Some feedback that wider communication could have been more streamlined

All of us improve
Applying the learning to support recovery and stabilisation

#allofusimprove and be outstanding

NHS South West Yorkshire Partnership NHS Foundation Trust

We have developed an approach to service planning and prioritisation for stabilisation and recovery phases. This includes:

Working to consolidate the learning into areas and feed this into the work that is happening in:

- Reviewing governance systems
- Estate
- Evaluating clinical approaches
- Evaluating digital interventions
- Evaluating use of digital
- Staff wellbeing

Test the framework and approach out in areas of the Trust, using the model for improvement.

Keeping a check that it is the right approach by continuing to collect service user, carer and staff feedback, using a toolkit developed to support engagement and triangulate this with information that is already available.

We are developing a framework for testing new and blended ways of clinical (and non-clinical) working that we have tried and are considering adopting or adapting.

Put into practice the new and blended ways of working in a safe, sustainable and equitable way.

With **all of us** in mind.

Take home messages

NHS
South West
kshire Partnership

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

Help to slow the spread of the virus. Practise good hygiene, wear a face mask where you need to and practise social distancing.

Be careful when dealing with data and information. And stay alert against potential fraud.

Get involved in our EPMA project and volunteer to become an EPMA champion

If you are invited to take a coronavirus test please do so. It helps us monitor the disease and keep you and your loved ones safe.

Look after your health and wellbeing. Take annual leave and breaks from work whenever you can.

Use our patient engagement and experience toolkit

Visit the intranet regularly to keep up to date and informed.

What do you think about The Brief? comms@swyt.nhs.uk

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Thank you to everyone for your response so far.

Keep doing the right thing.

With **all of us** in mind.

Cascading the Brief

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Thank you for joining us for the Brief broadcast.

Cascade of the Brief face to face is not possible in your teams at this time. Please use the technology available and be creative.

Thankyou!

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 8.1

Title:	**Board Assurance Framework (BAF) Quarter 1 2020/21**
Paper prepared by:	Director of Finance & Resources
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of its strategic objectives, this document also highlights the impact of the Covid-19 pandemic on delivery of strategic objectives, which should be considered for setting the 2020/21 strategic risks at the September Strategic Board. This report provides the updated BAF for review and discussion at the Trust Board. Given the impact of Covid-19 the Trust Board has agreed the reporting on the BAF will cover the same strategic risks as 2019/20 until any revisions to priorities are agreed at the Board strategy meeting in September.
Mission / values:	The assurance framework is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.
Any background papers / previously considered by:	Previous quarterly reports to Trust Board.
Executive summary:	**Board Assurance Framework** The Board Assurance Framework (BAF) provides the Trust Board with a simple but comprehensive method for the effective and focused management of the risks to meeting the Trust's strategic objectives. In respect of the current BAF, the high level risks to delivery of the Trust's strategic objectives have been identified and, for each of these, the framework sets out: • key controls and / or systems the Trust has in place to support the delivery of the objectives. • assurance on controls (where the Trust Board will obtain assurance). • positive assurances received by Trust Board, its committees or the Executive Management Team (EMT) confirming that controls are in place to manage the identified risks and these are working effectively to enable objectives to be met. • gaps in control (if the assurance is found not to be effective or in place). • gaps in assurance (if the assurance does not specifically control the specified risks or no form of assurance has yet been received or identified), which are reflected on the risk register.

A schematic of the BAF process is set out as an attachment.

The BAF is used by the Trust Board in the formulation of the Trust Board agenda 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.

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

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. No changes to assurance levels since Q4 2019/20 are recommended.

Strategic objective	Strategic risk	Assurance levels				
		19/20				20/21
		Q1	Q2	Q3	Q4	Q1
Improving health	1.1 Differences in published local priorities could lead to service inequalities across the footprint	Y	Y	G	G	G
	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	Y
	1.3 Differences in the services may result in inequitable services offers across the Trust	Y	Y	G	G	G
	1.4 Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services	A	A	Y	Y	Y
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	Y
	2.2 Failure to create learning environment leading to repeat incidents	Y	Y	Y	Y	Y
	2.3 Increased demand for and acuity of service users leads to a negative impact on quality of care	Y	Y	A	A	A

Improving resources	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to provide services effectively	**Y**	**Y**	**Y**	**G**	**G**
	3.2 Failure to develop commissioner relationships to develop services	**Y**	**Y**	**Y**	**Y**	**Y**
	3.3 Failure to deliver efficiency improvements / CIPs	**Y**	**Y**	**Y**	**Y**	**Y**
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives	**G**	**Y**	**Y**	**Y**	**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	**Y**	**Y**	**Y**	**Y**	**Y**

The Trust Board considered the BAF at their strategic session in May 2020 and agreed to keep the current format of the report during the Covid-19 pandemic, with a further review planned for the strategic Board session in September 2020. This will allow the Board to consider the impact and influence of Covid-19 on the Trust's strategic objectives for 2020/21 and 2021/22, the risks to meeting those objectives and the approach to mitigating those risks. Following this review, an updated BAF will be developed.

There are a number of potential implications arising from the Covid-19 pandemic that may have an impact on the Trust's strategic risks. These include but are not limited to:

- Recognition of the disproportionate impact of Covid-19 on BAME, other vulnerable groups and / or those with protected characteristics in our communities and workforce. The pandemic has further highlighted inequalities that need considering as part of the further development of our strategic risks.
- Financial arrangements have changed temporarily for 2020/21. It is not yet clear what the financial arrangements will be for 2021/22.
- The pandemic has highlighted the benefits of system working and the temporary financial arrangements in place have meant different roles for commissioners of our services. Whilst it is not clear what the position will be next year this is something that should be considered when updating our strategic risks.
- There has been significant uptake and reliance on the use of digital technology during the past few months.
- The pandemic has resulted in changes to ways of working, and it is not necessarily clear if all of these have any unintended consequences or are appropriate for the longer term.
- From a workforce perspective there has been good publicity for the NHS as an employer and there maybe changes to the nature of some roles and therefore skills required.
- The health & wellbeing and resilience of our workforce remains vitally important.
- How we use our estate e.g. impact of social distancing, use of Covid-secure buildings, use of digital technology.

- There may be a requirement for new or increased or different service provision such as Covid-19 aftercare, testing, surge in demand, impact of the pandemic on mental health.
- How we communicate and engage with our communities, service users, workforce and carers.
- Understanding the nature and volume of incidents.

It should also be noted that the focus on the Covid-19 response has had an impact upon the ability to complete some actions, with a number of actions now deferred until Q2 2020/21.

The following changes have been made to the BAF since the last Board report in April 2020.

	Strategic risk	Q1 update
	Rationale for current assurance level updated.	
	1.1	Assurance outputs updated.
	1.2	Controls and assurance outputs updated.
	1.3	Assurance outputs and gaps in assurance updated.
	1.4	Gaps in assurance and timescales updated.
	Rationale for current assurance level updated.	
	2.1	Assurance outputs and gaps in assurance updated.
	2.2	Controls, assurance outputs, gaps in assurance and timescales updated.
	2.3	Assurance outputs, gaps in assurance and timescales updated.
	Rationale for current assurance level updated.	
	3.1	Gaps in control and timescales, gaps in assurance and timescales, and assurance outputs updated.
	3.2	Assurance outputs, gaps in assurance and timescales updated.
	3.3	Assurance outputs updated.
	3.4	Assurance outputs and gaps in assurance timescales updated.
	Rationale for current assurance level updated.	
	4.1	Assurance outputs updated.

The full detail for strategic risks is included in the attached BAF report.

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 were completed in Quarter 2, with the remaining three areas considered as part of the cyclical review in Quarter 3:

- *Due dates should be identified against all gaps in control and gaps in assurance – complete Q2.*
- *Consider whether a lead Director should be identified for the gaps in control and gaps in assurance – complete Q2.*
- *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 –*

	complete Q3. • Benchmarking exercise against 19 provider BAFs top 10 risk issues noted two issues not explicitly covered: o Performance Targets o Estates (including H&S & Maintenance) o Ongoing, to be included as part of committee annual planning o process. o Committees are noted as being aligned to strategic risks, however the BAF is not currently being presented at committee meetings – it was agreed at Trust Board to retain review and oversight of the BAF at the Trust Board and not to present at committees at this stage.
Recommendation:	**Trust Board is asked to:** ➢ **NOTE the controls, assurances and progress to mitigate gaps against the Trust's strategic objectives for Quarter 1 2020/21.**
Private session:	Not applicable.

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

South West Yorkshire Partnership NHS Foundation Trust

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

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

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

Strategic Objectives

Approved by Trust Board and reviewed regularly

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

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

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

Principal risks linked to strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

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

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

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

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

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

Board Assurance Framework (BAF) 2020/21

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

Committees: AC = Audit Committee, CGCS = Clinical Governance & Clinical Safety Committee, EIC = Equality & Inclusion Committee, FIP = Finance, Investment & Performance Committee, MHA = Mental Health Act Committee, WRC = Workforce & Remuneration Committee

EMT = Executive Management Team, OMG = Operational Management Group, MC = Members Council, ORR = Organisational Risk Register

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

RAG ratings:

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

Overview of current assurance level:

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

Strategic objective	Strategic risk	Page Ref	Assurance levels				
			2019/20				2020/21
			Q1	Q2	Q3	Q4	Q1
Improving health - Working in partnership	1.1 Differences in published local priorities could lead to service inequalities across the footprint.	4	Y	Y	G	G	G
	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	Y	Y
	1.3 Differences in the services may result in inequitable services offers across the Trust.	10	Y	Y	G	G	G
	1.4 Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services.	12	A	A	Y	Y	Y
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	Y	Y
	2.2 Failure to create learning environment leading to repeat incidents.	18	Y	Y	Y	Y	Y
	2.3 Increased demand for and acuity of service users leads to a negative impact on quality of care.	20	Y	Y	A	A	A
Improving resources - Getting ready for tomorrow: operational excellence	3.1 Deterioration in financial performance leading to unsustainable organisation and inability to provide services effectively.	24	Y	Y	Y	G	G
	3.2 Failure to develop commissioner relationships to develop services.	27	Y	Y	Y	Y	Y
	3.3 Failure to deliver efficiency improvements / CIPs	29	Y	Y	Y	Y	Y
	3.4 Capacity / resource not prioritised leading to failure to meet strategic objectives.	31	G	Y	Y	Y	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.	34	Y	Y	Y	Y	Y

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

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

Ref	Description	RAG Rating
1.1	**Differences in published local priorities could lead to service inequalities across the footprint.**	G
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.**	G
1.4	**Impact of the Trust not having a robust and compelling value proposition leading to under-investment in services.**	Y

Rationale for current assurance level (Strategic Objective 1)

- Health & Wellbeing Board place based plans – contributed to through board discussions and commented on.
- Active and full membership of Health & Wellbeing Boards.
- 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, through integrated partnerships in Calderdale, Kirklees Wakefield and Barnsley.
- Trust executive director is SRO on behalf of Integrated Care Partnership for implementation of Primary Care Networks (PCHs) in Wakefield.
- A range of executive and board arrangements with trusts, commissioner and other stakeholders in each of the place we operate.
- 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 engagement plans in place.
- Integrated Performance Report (IPR) summary metrics re improving people's health and reduce inequalities – IPR Month 2: out of area beds – green, children and young people accommodated on an adult inpatient ward – two service users for a total of five days, 7 day follow up– green, physical health – not reported, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – not reported, 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 & Risk, Patient Safety 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.
- Joint working arrangements in response to Covid-19 pandemic.

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) (E)	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 / West 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. *In progress - developed service and offer prospectus and engagement plan complete further work to develop value proposition to be concluded by April 2020.* *Impact of the Covid-19 response is to leave this action as part complete and re-visit at a later stage in 2020/21.*	July 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	The Trust is registered with the CQC and assurance processes are in place	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**
provided that Trust complies with its registration.	through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC. (P) (I)			
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 2019/20 report scheduled for 2020/21 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 Change and partnership Board, OMG and EMT 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. Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P,N) (I) 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 2018/19 was received by the CG&CS Committee in June 2019 and 2019/20 report included in 2020/21 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	Draft operational plan for 2020/21 agreed at Trust Strategy Board February 2020. Monthly financial reports to	A13	DFR	1.1, 1.2, 3.1, 3.3, 3.4

Assurance (Strategic Risk 1.1)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance / reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
challenged by NHS Improvement.	Finance, Investment & performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) 5 year plans (P, N) (I). 2020/21 planning process suspended due to required focus on the Covid-19 pandemic (E)			
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 – annually to April Trust Board (last report April 2020). (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 – currently under review as part of Involving People Strategy (reviewed at March 2020 Trust Board. Further engagement taking place, for completion October 2020). Weekly and monthly engagement with staff (the Headlines, the View and the Brief), 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 2020/21 were factored into our draft operating plan.	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**
Assessment of place based plans in each Integrated Care System (ICS). (Linked to ORR Risk ID 812). *(Note, expected completion date changed from June 2019 to September 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 February 2020 in line with planning timescale, affected by pre-election period work continues in each place as part of developing the Trust plan).* *Place based plans were reviewed as part of the planning process which has now been suspended due to the Covid-19 pandemic.*	July 2020	DS / DPD
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.*	*Complete*	*DS*
Not a scheduled programme of board to board or exec to exec meeting in place with all partners *Ongoing - The requirement for Board to Board is diminishing due to whole system working across each ICS and the development of Integrated Care partnerships in each place.*	Ongoing	DS
The expectation is that when Covid-19 pandemic is over we will return to previous plans and arrangements. It is unclear at this stage if this will be the case or if different approaches and requirements will emerge.	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 change programmes and work streams established, with appropriate membership skills and competencies, project initiation documents (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. (Under review as part of Involving People Strategy). (I,E)	C16	DS	1.2, 1.4, 4.1
New operational leadership structure has been implemented to reflect the ICS boundaries (West and South) and focus on reducing unwarranted variation service wide.	C85	DO	1.2

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.	*Complete*	*DO*
Clinical networks to be embedded across each pathway as part of the new operational leadership structure. *On hold due to the focus on the Covid-19 response.*	July 2020	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

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**
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 2019/20 taken to CG&CS Committee June 2019 and 2019/20 report scheduled for 2020/21 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. (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 Change and partnership Board, OMG and EMT 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) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee (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 2019/20 and 2020/21 report included in work plan. (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	Draft operational plan for 2020/21 agreed at Trust Strategy Board February 2020. Monthly financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) 5 year plans (P, N) (I) 2020/21 planning process was in the latter stages of completion prior to being suspended to enable focus on the Covid-19 response.	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,	Update reports into EMT and Workforce & Remuneration Committee. (P) (I)	A16	DHR	1.2

Assurance (Strategic Risk 1.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance / reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
deviations identified and remedial plans requested.				
Update reports on WY and SY ICS progress.	Routine report into EMT and Board. (P) (I)	A17	DS	1.2
Reports from 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 Finance, Investment & Performance Committee, Executive Management Team (EMT) and any action required identified. (P, N) (I, E)	A20	DFR	1.2, 3.1, 3.2, 3.3
Monthly Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business 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, Finance, Investment & Performance Committee and Trust Board. (P, N) (I)	A22	DO	1.2, 1.4, 3.1, 3.3
Commissioning intentions for 2020/21 were factored into draft operating plans prior to the planning process being suspended to enable focus on the Covid-19 response.	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**
Benchmarking data unavailable for some services and limited number of statistically similar organisations. *In progress - Programme of work agreed to accelerate availability of internal productivity information and effectively use the model hospital. Updated dashboards now available to teams. Presentations have taken place to EMT and Finance, Investment & Performance Committee. Plans to effectively roll out the use of the dashboard being developed.* *A further roll-out of dashboards covering additional services and metrics was completed in March 2020.*	*Complete* *DFR*	*DFR* *DFR*
Assessment of place based plans in light of the impact of the NHS long term plan *(Note, expected completion date changed from June 2019 to September 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 February 2020 in line with planning timescale, affected by pre-election period work continues in each place as part of developing the Trust plan). Place based plans were reviewed as part of the planning process which has now been suspended due to the Covid-19 pandemic.*	July 2020	DS
Not a scheduled programme of board to board or exec to exec meeting in place with all partners. *Ongoing - The requirement for Board to Board is diminishing due to whole system working across each ICS. Locala board to board scheduled, CHFT exec to exec meetings in place, further meetings will be planned as required.*	Ongoing	DS
The expectation is that when Covid-19 pandemic is over we will return to previous plans and arrangements. It is unclear at this stage if this will be the case or if different approaches and requirements will emerge.		

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 change programmes and 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, Finance, Investment & Performance Committee 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 2019/20 taken to CG&CS Committee June 2019 and 19/20 report is scheduled for June 2020. (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	NHS mental health service user survey	A08	DNQ	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**
annually to Trust Board and action plans produced as applicable.	results are reported to Trust Board when available with associated plans. (I, E)			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 Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)	A09	EMT	1.1, 1.2, 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 – annually to April Trust Board (last report April 2020). (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 – currently under review as part of Involving People Strategy (reviewed at March 2020 Trust Board. Further engagement taking place, for completion October 2020). Engagement with staff (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 2019. (P, N) (I, E)	A15	DHR, DS,	1.1, 1.3, 2.3
Reports from Calderdale, Kirklees and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	A18	DFR	1.2, 1.3
Commissioning intentions for 2020/21 were factored into draft operating plans prior to the planning process being suspended to enable focus on the Covid-19 response.	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**
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.*	*Complete*	*MD / DHR*
Review of model hospital data and determine how this can best be used in the Trust *In progress - Work had commenced on the review of the model hospital data with a presentation to EMT on 03/10/2019 that identified initial areas for consideration. Work is now paused due to the focus on the response to Covid-19 and will be revisited with Q2 data.*	July 2020 October 2020	DO
It is unclear at this stage if the focus on responding to Covid-19 will have any unintended consequences on variation of service offering due the period of the pandemic. Discussions are underway with commissioners in each place to ensure that we maximise learning from changes in service offers (e.g. increase in digital solutions). However, any variations will be based on best practice and in line with local need.		DO

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. (Under review as part of Involving People Strategy). (I,E)	C16	DS	1.2, 1.4, 4.1
Engagement and representation on South Yorkshire and Bassetlaw / West Yorkshire and Harrogate integrated care systems 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**
Finalisation of an engagement plan and prospectus *Complete - engagement plan and prospectus developed.*	*Complete*	*DS*

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) Reported regularly with deep dives on specific issues at Finance, Investment & Performance Committee.	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 – currently under review as part of Involving People Strategy (reviewed at March 2020 Trust Board. Further engagement taking place, for completion October 2020).	A15	DHR, DS,	1.1, 1.3, 2.3

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**
	Engagement with staff (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 2019. (P, N) (I, E)			
Reports from Calderdale, Kirklees and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	A18	DFR	1.2, 1.3
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) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (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. Regular reports to the Finance, Investment & Performance Committee. (P, N) (I)	A22	DO	1.2, 1.4, 3.1, 3.3
Commissioning intentions for 2020/21 were factored into draft operating plans prior to the planning process being suspended to enable focus on the Covid-19 response.	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 Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P, N) (I)	A27	DNQ	2.1 2.2 2.3
Quality strategy implementation plan reports into CG&CS Committee.	Routine reports into CG&CS via IPR and annual report scheduled in 2020/21 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**
Development of a clear value proposition linked to vision, mission and values *Complete - prospectus developed.*	*Complete*	*DS*
Collate learning and insight from engagement surveys with feedback to identify themes. *In progress - The Involving people strategy refresh complete by April 2020 will include significant stakeholder engagement and feedback. (Note, expected completion date changed from December 2019 to March 2020).* *The refreshed Involving People strategy was presented to the Trust Board in March 2020. Further engagement and development is taking place, with a view to the final version being presented at Trust Board in September 2020 and publication in October 2020.*	October 2020	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			

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	**Failure to create a learning environment leading to repeat incidents impacting on service delivery and reputation.**	Y
2.3	**Increased demand for and acuity of service users leads to a negative impact on quality of care.**	A

Rationale for current assurance level (Strategic Objective 2)

- 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.
- CQC have conducted a well-led review during recent inspections which has contributed to the overall rating provided.
- Internal audit reports – Governance & Risk, Patient Safety, General Data Protection Requirements– 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 vaccination programme.
- Data warehouse implementation largely complete.
- Some residual data quality issues with regard to how SystmOne is used.
- 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 2 shows: Friends & Family Test MH green, F&F Test Community green, 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.
- Testing and support for service users and staff in response to Covid-19.

Strategic Risk 2.1
Lack of suitable and robust, performance and clinical information systems backed by strong analysis leading to lack of timely high quality management and clinical information to enable improved decision-making

Controls (Strategic Risk 2.1)			
Systems and processes - what are we currently doing about the Strategic Risks?)	**Control Ref**	**Director lead**	**Strategic risk/s**
Access to the model hospital to enable effective national benchmarking and support decision-making.	C20	DFR	2.1
Development of data warehouse and business intelligence tool supporting improved decision making. (I)	C22	DFR	2.1
Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report to Trust Board. (I)	C23	DFR	2.1
Programme established for optimising the use of SystmOne. (I)	C24	DS	2.1
Risk assessment and action plan for data quality assurance in place. (I)	C25	DFR	2.1
Customer services reporting includes learning from complaints and concerns. (I)	C26	DNQ	2.1, 2.2, 4.1
Datix incident reporting system supports review of all incidents for learning and action. (I)	C27	DNQ	2.1, 2.2, 4.1
Integrated change management arrangements focus on co-design. (I)	C28	DS	2.1, 2.3
Patient Safety Strategy developed to reduce harm through listening and learning. (I)	C29	DNQ	2.1, 2.2, 4.1
Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	C30	DNQ/MD	2.1, 2.3, 4.1
Quality Improvement network established to provide Trustwide learning platform. (I)	C31	DNQ	2.1, 2.2, 4.1
Quality Strategy achieving balance between assurance and improvement. (I)	C32	DNQ	2.1, 2.2, 2.3
Performance management system in place with Key Performance Indicators (KPIs) covering national and local priorities reviewed by EMT and Trust Board. (I)	C33	DFR	2.1, 2.2, 3.1, 3.2, 4.1

Gaps in control - what do we need to do to address these and by when?	**Date**	**Director lead**
Limited use of reports generated using the data warehouse tool with resource recently focused on SystmOne implementation. *In progress - Initial presentations on model hospital benchmarking made to EMT and the Finance, Investment & Performance Committee. Updated team dashboards now available. A further roll-out of dashboards covering additional services and metrics was completed in March 2020.*	2020	DFR
Limited data on caseload, real time waiting list issues, face to face time. *In progress - Work is taking place as part of data warehouse and dashboard development. Further development expected during Q1 of 2020/21. (Note, expected completion date changed from 2019 to June 2020).* *Work on this will be delayed for at least three months given the focus on the Covid-19 response.*	Septemb er 2020	DFR
Limited actual use of benchmarking information in the Trust. Review use of model hospital data *(Note, change of due date from October 2019 to January 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).* *Mental health benchmarking data has been reviewed at the Finance, Investment & Performance committee and the use of the model hospital continues to develop. Our benchmarking work is currently being paused due to the focus on responding to Covid-19.*	July 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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	A01	DFR	All
Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	A02	DFR	All
Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through the Integrated Performance Report (IPR).	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Annual review of impact of priority programmes received by EMT. (P) (I)	A07	DS	1.1, 1.2, 1.3, 2.1, 3.4
Business cases for expansion / change of services approved by Executive 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) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (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 SystmOne optimisation plan reviewed by Programme Board, EMT and Trust Board.	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board. (P) (I)	A25	DS	2.1
Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly 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 Trust Board and CG&CS Committee	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P, N)	A27	DNQ	2.1 2.2 2.3
Quality strategy implementation plan reports into CG&CS Committee.	Routine reports into CG&CS (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) Currently suspended due to Covid-19.	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**
Implementation of actions identified in internal audit report on SystmOne implementation governance arrangements. *Complete - Focus in Q3 & Q4 was on ensuring clinical record data for fit for migration to SystmOne for mental health services. System was implemented in February and March 2019 and moved into optimisation phase.*	*Complete*	*DS*
Development plan and implementation to more extensively generate and use management reports using the data warehouse. *(Note, expected date of completion changed from Quarter 3 to January 2020).* *In progress - Work has commenced and an initial presentation of model hospital benchmarking*	January 2020	DFR

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
given to EMT. Use of benchmarking reports is evolving and will continue to do so over the next twelve months. A further roll-out of dashboards covering additional services and metrics was completed in March 2020.	*Complete*	
SystmOne optimisation programme will take place over the course of the next twelve months. Work on SystmOne optimisation has been paused to enable focus to be applied to the Covid-19 response.	September 2020	DS
Reporting for Covid-19 continues to evolve through the different stages of the pandemic.	Ongoing	DFR

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 Finance, Investment & Performance Committee 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 serious incident (SI) reports.	Ongoing	DNQ
Reducing the level of engagement and testing for system deployments during the Covid-19 outbreak may lead to an increase in information governance breaches.	July 2020	DFR
Delay in embedding of quality improvement culture during Covid-19 response. Action to review all Q1 programmes and maintain where possible or prepare for reinstatement on pandemic closure.	July 2020	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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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	NHS mental health service user survey	A08	DNQ	1.1, 1.2,

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**
annually to Trust Board and action plans produced as applicable.	results are reported to Trust Board when available with associated plans. (I, E)			1.3, 1.4, 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
Customer service reports to Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (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 CG&CS. (P) (I)	A28	DS	2.2, 4.1
Quality strategy implementation plan reports into CG&CS.	Routine reports into CG&CS via IPR and annual quality account report scheduled in 2020/21 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 CG&CS 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
New inpatient structure provides assurance of operational grip in relation to record keeping.	Routine matron checks reported through BDU governance groups and in governance report to CG&CS.	A54	DO	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**
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR Risk ID 852) *Largely complete - Deep-dive conducted for Audit Committee. Updated communications plan taking effect from April 2019 following SysmOne go-live. Current level of training is below the required amount and focus being placed on this during Q4. The final training figure for the year was 98% which was above the 95% target. Letters sent to team managers following confidentiality breaches asking for action plans to address.* Increase in IG breaches since the onset of Covid-19 and associated ways of working. Review taking place to identify how improvements can be made (October 2020).	January 2020 *Largely complete* *Complete* October 2020	DFR
Impact of learning lessons process on all relevant practitioners *Complete – now included in revised Patient Safety Strategy.*	*Complete*	*DNQ*
Further assurance required to address similar repeated themes in relation to communication and risk assessment are identified through investigations *Complete - "Our Learning Journey" Report and annual BDU Governance report published.*	*Complete*	*DNQ*
Inpatient strategy improvement plan evaluation data to be finalised prior to end of financial year. *On hold given the work required to manage the Covid-19 response.*	*Partially complete December 2019* November 2020	DO
It is unclear if there will be a loss of traction during and following the Covid-19 pandemic.		ALL

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**
N/A		

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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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 Change and partnership Board, OMG and EMT 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 2019/20 and 2020/21 report included in work plan. (E)	A12	DNQ	1.1, 1.2, 2.3

Assurance (Strategic Risk 2.3)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance / reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
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 – annually to April Trust Board (last report April 2020). (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 – currently under review as part of Involving People Strategy (reviewed at March 2020 Trust Board. Further engagement taking place, for completion October 2020). Engagement with staff (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 2019. (P) (I)	A15	DHR, DS	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 CG&CS 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. (I)	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) *In progress - Independent SSG report completed and recommendations being implemented during 2019/20.* *In progress - Progress against out of area has been noted and the actions from the independent report are well underway. Risk reduced but still present. (Note, expected*	*Complete*	*DO*

completion date changed from December 2019 to April 2020). The position with PICU out of area beds deteriorated in Q4 although the full year position remains improved compared to last year.		
The Care Closer to Home work continues, with progress notes across the pathways. Spikes in demand still present and these are closely managed and patients are quickly repatriated to their local areas. Complaints and incidents are monitored by the service line which is Trustwide. Reporting continues through Priority Programmes. The Trust will form part of ICS wide work on PICU to improve access across West Yorkshire. The impact on SWYPFT service users is hoped to be positive but will be reviewed and considered when the work commences.	Ongoing October 2020	DO
Outcomes of community mental health transformation programme review. *Complete - findings have been incorporated into the Care Closer to Home priority programme.*	*Complete*	*DO*
Impact of waiting list in CAMHS services. *In progress - Improvements noted but not yet sustained in Barnsley and Wakefield. CAMHS improvement group established with additional resources in place for change leadership. Further review required in April 2020 (Note, expected completion date changed from October 2019 to April 2020).Work in Q4 has been in line with our trajectory.* Improvements have been sustained throughout Covid-19 phase. Agreed in the CAMHS Improvement Group to review the impact of the improvement work in like with the Priority Programmes in September 2020. Additional waiting list pressures have been noted due to increased demand and reduced opportunity for observational work in ADHD / ASD pathways.	April 2020 September 2020	DO
Demand for services could increase during and after the Covid-19 pandemic. The impact of this is still to be fully understood. Noted increased in acuity and further exploratory work is underway to understand whether this relates to mode of service delivery during Covid-19 phase. This should be reviewed in September 2020.	September 2020	ALL

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

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

Ref	Description	RAG Rating
3.1	**Deterioration in financial performance leading to unsustainable organisation and insufficient cash to provide services effectively.**	G
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.**	Y
3.4	**Capacity and resources not prioritised leading to failure to meet strategic objectives.**	Y

Rationale for current assurance level (Strategic Objective 3)

- NHS Improvement Single Oversight Framework rating of 2 – targeted support.
- 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 – CIP, Quality and Integrity of general ledger and financial reporting, financial system (accounts payable) – 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.
- 2018/19 deficit recorded and 2019/20 small surplus.
- Current cash balance and cash management processes.
- Positive well-led results following Care Quality Commission (CQC) review.
- Capital investment prioritisation process.
- Priority programmes for 2019/20 are aligned to strategic objectives.
- 2019/20 surplus of £0.1m delivered compared to a deficit plan of £0.2m.
- CIP delivery of £10.7m, slightly higher than plan, 48% was non-recurrent.
- Interim financial arrangements in place for the first four months of 2020/21.
- Current uncertainty with regard to the financial and contracting arrangements beyond July 2020.

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). (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
Finance Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	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). *In progress - Total CIP delivery £0.5m below plan. £1.2m risk for the full year position* *Final position was that £10.7m of CIPs delivered, of which £5.6m (52%) was recurrent*	Annual target	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
Historical 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 over recent years. (Linked to ORR Risk ID 275). *Ongoing - Contractual growth for 2019/20 in line with mental health investment standard, recognises demographic growth and some specific service pressures. 2020/21 contract negotiations were well developed with investment in line with the mental health investment standard expected. The process has been suspended due to the Covid-19 pandemic. Temporary arrangements are being put in place.*	Ongoing	DFR
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. Improved position in 2019/20 with actual costs expected to be £2m lower than last year. Some non-recurrent income from commissioners made available in-year to support the position.	*Complete for 2018/19 and 2019/20 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). *Current environment means this is less likely.*	Ongoing	DHR
Development of financial arrangements including covering Covid-19 costs and top-up for lost income to be clarified for April – July 2020. *Complete for the first four months of the year. Arrangements are currently unclear beyond the end of July.*	July 2020	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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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. Standing agenda item at the Finance, Investment & performance Committee. (P, N) (I)	A10	DS DFR 3.1	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
Annual plan and budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	Draft operational plan for 2020/21agreed at Trust Strategy Board February 2020. Monthly financial reports to Trust Board, Finance, Investment & Performance Committee and NHS Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) 5 year plans.(P, N) (I) 20/21 planning process was in the latter stages of completion prior to being suspended to enable focus on the Covid-19 response.	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) Review of benchmarking reports is included in the annual work plan for the Finance, Investment & Performance Committee.	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) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (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. Reported regularly to Finance, Investment & Performance Committee (P, N) (I) Use of CQUIN currently paused as part of interim financial arrangements.	A22	DO	1.2, 1.4, 3.1, 3.3
Attendance of NHS England & Improvement at Executive Management Team (EMT) and feedback on performance against targets.	NHS England & Improvement hold Quarterly Review Meetings with EMT. (P) (E) Currently suspended due to the Covid-	A30	DFR	2.1, 3.1, 3.3

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**
	19 pandemic.			
Annual Governance Statement reviewed and approved by Audit Committee and Trust Board and externally audited.	Annual Governance Statement 2019/20 reviewed by Audit Committee and approved by Trust Board in May 2020. (P) (I)	A43	DFR	3.1
Half-yearly strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats.	Strategic business and risk analysis reviewed by Trust Board in the first half and second half of 2019. (P) (I)	A44	DS	3.1, 3.2
Audit Committee review evidence for compliance with policies, process, standing orders, standing financial instructions, scheme of delegation, mitigation of risk, best use of resources.	Trust Constitution (including Standing Order) and Scheme of Delegation last reviewed by Audit Committee in April 2019 prior to approval by Trust Board and Members' Council. (P) (I)	A46	DFR	3.1
Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG.(P, N) (I)	A47	DO	3.1, 3.3

Gaps in assurance, are the assurances effective and what additional assurances should we seek to address and close the gaps and by when	**Date**	**Director lead**
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.*	*Complete*	*DFR*
Internal audit reports with limited assurance management actions agreed by lead Director. Review of high and medium priority recommendations to be undertaken quarterly. *Ongoing - Completion of internal audit recommendations in line with original timescales (74% implemented within original timescales as at 31/03/20 and 96% fully implemented).*	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. *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. Use of out of area bed placements for PICU increased in the fourth quarter, but the total out of area bed placements in 2019/20 were significantly lower than 2018/19.*	Ongoing	DO
Cash position is largely dependent on us delivering a surplus. Cash balance of circa £36m at the year-end.	Ongoing	DFR
Balanced financial plan for 2019/20 not yet in place. *(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). The Trust delivered a small surplus of £0.1m in 2019/20 which is £0.3m better than plan. Temporary financial arrangements in place for the first four months of 2020/21 which enable trusts to break-even.*	July2020	DFR
Recurrent position is a deficit in excess of £4m *Ongoing - Financial sustainability work is focusing on recurrent improvement opportunities. Focus on the financial sustainability plan is being temporarily reduced to ensure there is clear focus on the Trust response to Covid-19.*	Ongoing	DFR
Impact of temporary financial arrangements including recovery of Covid-19 specific costs and top up income needs to work in practice to ensure the Trust is not financially disadvantaged.	July 2020	DFR
Financial arrangements and cost base post the end of July are not yet known.	July 2020	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. *Reduced level of tendering in 2019/20 and to enable focus on the Covid-19 response the NHS tendering of services is currently paused.*	Ongoing	DFR
Refresh of actions to support the stakeholder engagement plans. Complete - prospectus and engagement plan complete.	*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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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) Review of benchmarking reports is included in the annual work plan for the Finance, Investment & Performance Committee.	A20	DFR	1.2, 3.1, 3.2, 3.3
Monthly Investment Appraisal report – covers bids and tenders activity,	Monthly bids and tenders report to Executive Management Team (EMT)	A21	DFR	1.2, 1.4, 3.1, 3.2,

Assurance (Strategic Risk 3.2)				
Assurance outputs - how do we know if the things we are doing are having an impact internal and external	**Guidance / reports**	**Assurance Ref**	**Director lead**	**Strategic risk/s**
contract risks, and proactive business development activity.	and twice yearly to Trust Board (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P,N) (I)			3.3
2019/20 contracts reflect growth in line with mental health investment standard as well as some specific service pressures.	Contract plans for 2020/21 were for investment in line with the mental health investment standard. Contracting and planning processes suspended to enable focus on response to Covid-19. Temporary arrangements being implemented.	A33	DFR	1.1, 1.2, 1.3, 3.1, 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 and second 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. (Under review as part of Involving People 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. *The refreshed Involving People strategy was presented to the Trust Board in March 2020. Further engagement and development is taking place, with a view to the final version being presented at Trust Board in September 2020 and publication in October 2020.*	October 2020	DS
Assessment of updated commissioning intentions. *(Note, expected completion date changed from December 2018 to January 2019 as publication of national guidance and long term plan has been delayed).* *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. *(Note, expected completion date changed from June 2019 to September 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 February 2020 in line with planning timescale, affected by pre-election work continues in each place as part of developing the Trust plan). Place based plans were reviewed as part of the planning process which has now been suspended due to the Covid-19 pandemic.*	July 2020	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 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) (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 Investment & Performance Committee (FIP) chaired by a non-executive director. (I) (P)	C83	DFR	3.3

Gaps in control - what do we need to do to address these and by when?	**Date**	**Director lead**
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.*	*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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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.	Draft operational plan for 2020/21 agreed at Trust Strategy Board February 2020. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) 5 year plans.(P, N) (I) 20/21 planning process was in the latter stages of completion prior to being suspended to enable focus on the Covid-19 response.	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) Review of benchmarking reports is included in the annual work plan for the Finance, Investment & Performance Committee.	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) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (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. Reported regularly to Finance, Investment & Performance Committee. (P, N) (I)	A22	DO	1.2, 1.4, 3.1, 3.3
Attendance of NHS England & Improvement at Executive Management Team (EMT) and feedback on performance against targets.	NHS England & 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 £1.2m of unidentified CIP for 2019/20 *(Note, expected completion date changed from September 2019 to January 2020).* *Ongoing - Plans to bridge the gap continually reviewed and assessed. Main issue is that mitigations are typically non-recurrent. (Note, expected completion date changed from January 2020 to March 2020).* *Total CIP delivery of £10.7m in 2019/20, which was slightly higher than plan. Recurrent savings amounted to 52% of the total. Complete for 2019/20*	*Complete for 2019/20*	*DFR*
Balanced financial plan for 2019/20 not yet in place. Financial sustainability partly developed with further opportunities for improvement required. *(Note, expected completion date changed from Sept 2019 to Jan 2020).* *Ongoing - Plans to bridge the gap continually reviewed and assessed. Control total likely to be delivered in 2019/20 with a higher reliance on non-recurrent measures than what was assumed in the plan.* *The Trust delivered a small surplus of £0.1m in 2019/20 which is £0.3m better than plan. Complete for 2019/20*	*Complete for 2019/20*	*DFR*
Focus on the financial sustainability plan is being temporarily reduced to ensure there is clear focus on the Trust response to Covid-19. Efficiency savings are not expected between April – July.	July 2020	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 2019/20 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**
N/A		

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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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 Change and partnership Board, OMG and EMT 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.	Draft operational plan for 2020/21 approved at Trust Strategy Board February 2020. Monthly financial reports to Trust Board and NHS Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) 5 year plans.(P, N) (I) 20/21 planning process was in the latter stages of completion prior to being suspended to enable focus on the Covid-19 response.	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. *(Note, expected completion date changed from June 2019 to September 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 February 2020 in line with planning timescale, affected by pre-election period work continues in each place as part of developing the Trust plan). Place based plans were reviewed as part of the planning process which has now been suspended due to the Covid-19 pandemic.*	July 2020	DS
Additional demands being placed on Trust resource during the year over and above planning assumptions, particularly in respect of place based developments. Ongoing - Engagement through place based Integrated Care Partnerships to agree capacity and resources to deliver on agreed change programmes. *Priorities being assessed to focus on how staff and programmes of work can support the response to Covid-19.*	Ongoing	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 Y	Q2	Q3	Q4

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

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

Rationale for current assurance level (Strategic Objective 4)

- Staff 'living the values' as evidenced through values into excellence awards, consistent feedback from regulators and partners.
- Award winning flu and #allofus 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.
- Support to staff during pandemic, including testing, health and wellbeing offer and BAME taskforce.

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. (I)	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 undergraduate and post graduate programmes. (E)	C81	DHR	4.1

Gaps in control - what do we need to do to address these and by when?	Date	Director lead
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.*	*Complete*	DHR
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.*	*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 communications plan. *Additional activity during Q4 in the form of attendance at recruitment fairs and additional marketing of the Trust.* *Complete – there remains a regional WYICS recruitment initiative with support from MD and DHR.*	Decembe r 2019 *Complete*	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**	**Assura nce 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) Reported regularly with deep dives on specific issues to Finance, Investment & Performance Committee.	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 Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (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 CG&CS. (P) (I)	A28	DS	2.2, 4.1
Quality strategy implementation plan reports into CG&CS.	Routine reports into CG&CS via IPR and annual report, scheduled in 2020/21 work plan. (I)	A29	DNQ	1.4, 2.1, 2.2, 4.1
Annual Mandatory Training report goes to CG&CS Committee.	CG&CS 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 CG&CS 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 WRC 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
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 November 2019). WRC now receives a regular report on recruitment & retention including exit interviews*	Novembe r 2019	DHR
Sustainable workforce plan for CAMHS services. *Complete - Developed an action plan with consultants to increase their leadership role*	*Complete*	*DO / DHR*

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.		
Impact of a no deal Brexit is currently uncertain. *(Note, Brexit coordination group established and Trust meeting national guidance. Timescale changed to be in line with latest withdrawal date, now January 2020). Brexit process now in transitionary stage which lasts until the end of 2020. Internal work has been paused until the details of the withdrawal agreement are clearer.*	*Complete*	*DHR*
Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR ID 1151).	Ongoing	DHR

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 8.2

Title:	**Corporate / Organisational Risk Register Quarter 1 2020/21**
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, and monthly updates during the Covid-19 pandemic. Standing agenda item at each board Committee meeting.
Executive summary:	**Corporate / Organisational Risk Register** The Corporate / Organisational Risk Register (ORR) records high level risks in the organisation and the controls in place to manage and mitigate the risks. The organisational level risks are aligned to the Trust's strategic objectives and to one of the board Committees for review and to ensure that the Committee is assured the current risk level is appropriate. **Our four strategic objectives** **Improving health** / **Improving care** **Improving resources** / **Making SWYPFT a great place to work** The risks aligned to each Committee are reviewed at each 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. The Covid-19 pandemic has resulted in a change in emphasis in some risks and the addition of 14 (two of which are now within risk appetite) Covid-19 related risks. The full organisational risk register, including the Covid-19 related risks, are reviewed on a weekly basis by EMT

and updates are reported monthly to Board. The risks were discussed at the strategic Board session in May 2020, and an overview update provided at the public Board meeting in June 2020.

This report provides a full update on the organisational risk register since the previous quarterly report in April 2020.

The ORR contains the following **15+ risks**:

	Risk ID	Description
	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.
	1530	Risk that Covid-19 leads to a significant increase in demand for our services as anxiety and mental health issues increases in our populations.

The following changes have been made to the ORR since the last Board report in April 2020:

Risks 15+

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Actions updated	Reviewed by lead Director and EMT. Action plan timescales updated in relation to Covid-19, and specific Covid-19 related issues included. Good progress made on completion of Windows 10 roll out.
	1530	Risk that Covid-19 leads to a significant increase in demand for our services as anxiety and mental health issues increases in our populations.	Actions and expected completion date updated	Reviewed by lead Director and EMT. Action plan updated, and expected date of completion extended to allow for stress testing and planning. Risk score reviewed and agreed remains relevant until the next review in September 2020. Continued focus on reset and recovery.

Risks below 15 (outside risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	Actions updated	Reviewed by lead Director and EMT. Action plan updated to reference work with partners on Covid-19 recovery and reset plans. Recognition of financial pressures in local authorities.
	1511	Risk that carrying out the role of lead provider for	Controls and	Reviewed by lead Director and EMT.

		forensics across West Yorkshire will result in financial, clinical and other risk to the Trust.	actions updated	Controls and actions updated to reflect the delays caused by Covid-19. Work re-starting in July with a go-live date still planned for April 2021.
	905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	Controls and actions updated	Reviewed by lead Director and EMT. Controls, actions and timescales updated to reflect the impact of Covid-19.
	1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	Actions updated.	Reviewed by lead Director and EMT. Action timescales updated to reflect the delays caused by Covid-19. Progress being made on waiting list initiatives in Barnsley and Wakefield.
	1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	Actions updated.	Reviewed by lead Director and EMT. Actions timescales updated to reflect impact of Covid-19 on waiting lists.
	1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	Controls and actions updated.	Reviewed by lead Director and EMT. Controls and actions updated to reflect the temporary smoking arrangements and impact on review of e-cigarettes impacted by Covid-19.
	1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention • Restraint reduction • Covid-19	Controls and actions updated.	Reviewed by lead Director and EMT. Controls and actions updated to reflect the impact of and change in timescales relating to Covid-19 on implementation of clinical trio refresh, risk assessments and risk scans, pharmacy and IPC team offer.
	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	Score and actions updated	Reviewed by lead Director and EMT. Risk score increased to reflect uncertainty over funding arrangements beyond the end of August. Verbal update will be provided at Trust Board if available.
	852	Risk of information governance breach and / or non-compliance with	Actions updated.	Reviewed by lead Director and EMT. Actions updated to

		General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.		reflect Trustwide working across systems and increase in IG incidents as a consequence of Covid-19. Incidents reported since March being reviewed in more detail to identify if any trends or further mitigations required.
	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 suppliers without DH support.	Actions updated.	Reviewed by lead Director and EMT. Actions updated to reflect the impact of Covid-19 on temporary financial arrangements and Trust in bids for national Covid-19 capital funding via the ICS.
	1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	Actions updated.	Reviewed by lead Director and EMT. Actions updated to reflect the impact of Covid-19 on temporary financial and contracting arrangements.
	1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	Actions updated.	Reviewed by lead Director and EMT. Actions updated to reflect the impact of Covid-19 on financial arrangements.
	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.	Controls and actions updated.	Reviewed by lead Director and EMT. Controls and actions updated to reflect options for retirees and impact of Covid-19 on workforce planning process.
	1158	Risk of over reliance on agency staff which could impact on quality and finances.	Controls updated.	Reviewed by lead Director and EMT. Controls updated to reflect Bring Back Staff scheme.
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	Actions updated	Reviewed by lead Director and EMT. Actions updated to reflect the impact of Covid-19 on financial and contracting arrangements.
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	Actions updated	Reviewed by lead Director and EMT. Actions updated to reflect the impact of Covid-19 on financial arrangements. The impact of any potential surge in demand is

				considered to be included within the risk controls and actions as they currently stand.
	1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated to reflect the temporary NMC and HCPC register and retiree return, plus the impact of Covid-19 on the safer staffing review.

Covid-19 related risks below 15 (outside risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated to reflect establishment of Covid-19 testing, availability and use of masks and Covid-19 secure risk assessments.
	1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.	Actions updated.	Reviewed by lead Director and EMT. Actions updated to reflect work underway to make services safe in line with Covid-19 restrictions.
	1524	Risk that staff do not have access to necessary personal protective equipment (PPE) during the Covid-19 outbreak leading to issues with personal safety and weak staff morale.	Controls updated.	Reviewed by lead Director and EMT. Controls updated to reflect ICS mutual aid process.
	1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated – completed action changed to control.
	1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves.	Controls and actions updated	Reviewed by lead Director and EMT. Controls and actions updated to reflect support available to staff.
	1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	Actions updated	Reviewed by lead Director and EMT. Actions updated to include progress of Clinical Ethical Advisory Group.

	1531	Risk that Covid-19 response disproportionately affects people with protected characteristics leading to poorer quality of care.	Actions updated	Reviewed by lead Director and EMT. Actions updated to include reference to a specific taskforce centred on reviewing the impact of Covid-19 on the BAME community and what support is required by staff and service users.
	1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	New risk.	New ways of working introduced to enhance contact and review caseload. Will be considered as part of restoration and reset.
	1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**	New risk.	Consideration of possible legal action following Covid-19 pandemic.
	1533	Risk that as a number of key workforce activities have been suspended they could cause future problems around burnout and resilience, professional and personal development, staff and service safety.	New risk.	Support available to staff, including national health and wellbeing offer and Bring Back Staff as additional support.
	1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	New risk.	Taskforce in place to monitor, guidance and support available for staff and service users. Risk assessments completed for BAME staff.

<u>Covid-19 related risks within risk appetite:</u>

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1521	Risk that staff do not have appropriate IT equipment and access to facilitate home-working during the Covid-19 pandemic meaning staff unable to work effectively or provide appropriate clinical contact and key activities not delivered.	Risk score reduced and actions updated	Reviewed by lead Director and EMT. Actions updated to include implementation of AccuRx. Score reduced based on the provision of kit to staff and increases in licences following the onset of the pandemic and work that has taken place to increase the band-width available.
	1527	Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of	Risk score reduced and	Reviewed by lead Director and EMT. Controls updated to reflect establishment of

		staff and sub-optimal care.	controls updated	Covid-19 testing regime and risk scored reduced in line with this.

With the exception of the new risk relating to legal action, Covid-19 risks have been allocated to board Committees for review.

Further consideration is being given by the BAME taskforce for development of a new risk relating specifically to BAME service users, and discussions are taking place regarding risks to other vulnerable groups.

The full detail for all current organisational level risks is included in the attached risk report. Further detail regarding the status of risks is also provided in the attached risk profile.

Risk appetite

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

Recommendation:	**Trust Board is asked to:** • **NOTE the key risks for the organisation subject to any changes / additions arising from papers discussed at the Board meeting around performance, compliance and governance.** • **DISCUSS if the target risk levels that fall outside of the risk appetite are acceptable or whether they require review.** • **DISCUSS the draft risks added and actions identified in relation to the Covid-19 pandemic**
Private session:	Not applicable.

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

Risk appetite:
Clinical risks (1-6): Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.
Commercial risks (8-12): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as inability to recruit or retain an appropriately skilled workforce, damage to the Trust's public reputation which could impact on commissioners' decisions to place contracts with the organisation.
Compliance risks (1-6): Failure to comply with its licence, CQC registration standards or failure to meet statutory duties, such as compliance with health and safety legislation.
Financial risks (1-6): Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.
Strategic risks (8-12): Risks generated by the national and political context in which the Trust operates that could affect the ability of the Trust to deliver its plans.

Risk appetite	Application
Minimal / low - Cautious / moderate (1-6)	• Risks to service user/public safety. • Risks to staff safety • Risks to meeting statutory and mandatory training requirements, within limits set by the Board. • Risk of failing to comply with Monitor requirements impacting on license • Risk of failing to comply with CQC standards and potential of compliance action • Risk of failing to comply with health and safety legislation • Meeting its statutory duties of maintain expenditure within limits agreed by the Board. • Financial risk associated with plans for existing/new services as the benefits for patient care may justify the investment • Risk of breakdown in financial controls, loss of assets with significant financial value.
Open / high (8-12)	• Reputational risks, negative impact on perceptions of service users, staff, commissioners. • Risks to recruiting and retaining the best staff. • Delivering transformational change whilst ensuring a safe place to receive services and a safe place to work. • Developing partnerships that enhance Trusts current and future services.

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

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

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

KEY:
CEO = Chief Executive Officer
DFR = Director of Finance and Resources
DHR = Director of HR, OD and Estates
DNQ = Director of Nursing and Quality
MD = Medical Director
DS = Director of Strategy
DO = Director of Operations
DPD = Director of Provider Development

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

Actions in green are ongoing by their nature.

Trust Board (business and risk) – 28 July 2020

NEW COVID-19 RELATED RISK

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic.	➢ Process to receive and implement national guidance. ➢ Command structure for decision-making. ➢ Existing policies and procedures. ➢ Decision logs. ➢ Use of internal professional expertise. ➢ Use of risk assessments. ➢ Engagement and communications processes.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Consent letters and verbal contact being made with all service users in respect of sharing out of data. (September 2020) ➢ Ongoing review of leave entitlement for inpatient service users. ➢ Ongoing review and implementation of national guidance. ➢ Regular reinforcement of key messages to staff. ➢ Ongoing review of visitor policy. ➢ Reset and recovery of services. ➢ Review of estates requirements. (DHR) ➢ Regular consideration of staff wellbeing offers. (DHR)	DFR		EMT (monthly)	6 Yellow / moder ate (4-6)	TBC		Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk level 15+

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	➢ McAfee anti-virus software in place including additional email security and data loss prevention. ➢ The Trust's Windows 10 estate relies on Microsoft technologies, including Windows Defender and BitLocker, whereas the remaining Windows 7 estate (circa 250 devices) utilise 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. ➢ Microsoft software licensing strategic roadmap in place. ➢ Cyber security has been incorporated into mandatory Information Governance training. The Trust achieved the compliance requirement for level 2. ➢ Annual cyber exercise. ➢ Windows defender advanced threat protection in place. ➢ Strengthened password requirements in place. ➢ Annual cyber table top exercise completed in January 2020. ➢ Third year of IT infrastructure improvements has been completed ➢ Data Security & Protection Toolkit compliance	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	➢ Ongoing capital programme to upgrade IT infrastructure ➢ Work towards full cyber essentials certification (DFR) (June 2021) – timescales extended due to impact of Covid-19 and remain subject to confirmation - activities progressing to support this. ➢ Successful registration to be a pilot site for NHS Digital secure boundary service. Secured £240k NHSE funding via ICS at the end of 19/20 (DFR) (July 2020) ➢ Annual cyber survey currently being rescheduled and planned. (DFR) (September 2020) ➢ Feedback and evaluation from phishing exercise being incorporated into training needs, communications and guidance to staff. ➢ Cyber SAL campaign revamped which is aimed at improving cyber awareness across the Trust. ➢ Reinforcement and additional key messages relating to cyber security are being issued to staff as part of the Trust's COVID-19 communications. ➢ Improving Clinical Information & Information Governance Group (ICIG) partly re-purposed to review additional risks and identify practical mitigations to decisions taken during the pandemic. ➢ Cyber security issues have been identified specifically relating to Zoom. An NHS Digital CareCert alert has been issued and the Trust has implemented the necessary controls and measures meaning that Zoom is blocked from being downloaded onto Trust issued devices. ➢ The upgrade / replacement of the remaining 5% of Windows 7 devices to Windows 10 is complete other than for 4 machines (DFR) (Jul y 2020)	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. The COVID-19 situation is presenting highly challenging circumstances which means the potential threat of cyber-attack remains potent and possibly heightened. The measures that the Trust has established remain in place and all associated activities are continuing. Whilst there is a need to ensure rapid access to digital solutions and technologies which requires a less comprehensive testing approach in the short-term, security considerations remain at the forefront so as to ensure services remain safe.	Every three months prior to business and risk Trust Board – July 2020 & weekly Covid-19 review.

Risk level <15 - risks outside the risk appetite

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	➢ 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 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Involved with partners in the co-development of integrated care partnerships in each place as Trust priority programmes of work. (DS) ➢ 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) ➢ Working on a plan through command structures in each place. (DPD / DS) ➢ Contributing to the development of recovery plans in each place with partners. (DS / DPD / DO)	DS	Ongoing risk given external influenc e outside our control	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performanc e report) Annual review of contracts and annual plan at EMT and Trust Board	6 Yellow /Moder ate (4-6)	CG&CS FIP	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to busi- ness and risk Trust Board – July 2020 & weekly Covid-19 review
1511	Risk that carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical and other risk to the Trust.	➢ Partnership Board. ➢ Individual work streams. ➢ Given the impact of Covid-19, the majority of the work on the LPC project was paused from April to July.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Due diligence being carried out. (DPD) ➢ Development of appropriate financial risk and gain share with other providers in the collaborative. (DPD) ➢ Development of quality assurance processes and monitoring across the Collaborative. (DPD) ➢ Share learning from other lead providers and early implementers across the country. (DPD) ➢ Confirm and engage resource requirements. (DPD) Work referred to in this risk has paused due to Covid-19. Work is expected to commence from July 2020 and an update on timescales will be reported to Board in July 2020. Timescales for completion remain in line with previous meaning a planned go-live in April 2021	DPD	Februar y 2021	EMT (monthly)	4 Yellow / moder ate (4-6)	FIP		Every three months prior to busi- ness and risk Trust Board – July 2020 & weekly Covid-19 review
905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	➢ 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. ➢ Monthly safer staffing reports to Board and OMG with appropriate escalation	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Safecare implementation timescale to be reviewed in light of Covid-19. (DNQ) ➢ Additional funding requests with commissioners will be maintained throughout contract negotiations for 2020/21. (DO / DFR) ➢ Staff redeployment plan (DHR) ➢ Further review of forensics and older peoples services to take place. (DNQ / DO) (review delayed and revised date under review in line with Covid-19 response)	DO / DNQ	Ongoing	EMT (monthly)	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to busi- ness and risk Trust

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		arrangements in place. ➢ Biannual safer staffing report to Board and Commissioners. ➢ Review of establishment for adult inpatient areas completed and implementation plan developed. Progress monitored through OMG & EMT. ➢ Care hours per patient day (CHPPD) data now included in revised safer staffing six monthly board report. ➢ Ability to move staff between wards/teams ➢ Daily staff absence report. ➢ Covid-19 measures involve the review of staffing in each daily Bronze command meeting.					(September 2020) ➢ Safecare tool to be introduced during 2020/21 with pilot during Q4 2019/20. (DNQ) (Pilot delayed and revised implementation plan under review in line with Covid-19 response) ➢ Relaunch pilot of safer staffing judgement tool within community teams. (relaunch delayed and revised implementation plan under review in line with Covid-19 response) ➢ Embed MHOST following pilot in forensic services. (revised implementation plan under review in line with Covid-19 response) ➢ Implementation of agreed inpatient workforce model plan is underway across acute wards – reported to OMG monthly. (DO) ➢ During Covid-19 pandemic, Bronze command meetings review safer staffing and take action to prioritise redeployment of staff to maintain safe staffing levels.							Board – July 2020 & weekly Covid-19 review
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	➢ Emergency response process in place for those on the waiting list. ➢ Demand management process with commissioners to manage ASD waiting list within available resource. ➢ Commissioners have established an ASD Board and local commissioning plans are in place to start to address backlog for ASD. ➢ Future in Mind investments are in place to support the whole CAMHS system. ➢ Healthwatch Barnsley and Wakefield have carried out monitoring visits and are 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	4 Major	2 Unlikely	8 Amber / High risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ CAMHS Improvement Group established with identified change leadership for Barnsley and Wakefield – this focuses on improvements required to reduce waits. (DO) This was reviewed in July 2020 (review date delayed due to Covid-19). Significant progress noted, further embedding to be monitored and reviewed in September 2020. ➢ Recruitment to vacant positions is underway and showing successes in increasing capacity. This includes the consideration of new roles to improve opportunities to recruit. (DO) ➢ Calderdale CCG has led on development of a new diagnostic assessment pathway and is currently considering options for investment in a waiting list initiative. (DO) (Date to be confirmed by CCG). ➢ 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) ➢ Learning from the business continuity plans is being captured to support working differently in the future. This includes using technology to provide contacts. (DO) ➢ Improvement noted from waiting list initiatives in Wakefield and Barnsley. Reported to FIP and CG&CS	DO	Review every three months	Performanc e reporting to EMT - monthly Assurance report to Clinical Governanc e Committee Individual district performanc e reports reviewed by BDU	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 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. C&K waiting list initiatives (recovery plans) relate to ASC diagnostic assessment	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		Wakefield CCG oversees the delivery of young people's mental health and associated action plans. ➢ First point of contact is in place in all areas. ➢ Waiting list initiatives have been agreed in all areas.											and W&B initiatives focus on reducing waits from referral to treatment. Improving position in all areas with exception of K where increase in referrals outstrips the additional capacity. Position understood by CCG but potentially increases again the broader reputational and clinical risk.	
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	➢ Waiting lists are reported through the BDU business meetings. ➢ Alternative services are offered as appropriate. ➢ People waiting are offered contact information if they need to contact someone urgently. ➢ Individual bespoke arrangements are in place within services and reported through the BDU business meetings. ➢ Bespoke arrangements to review pathways in individual services. ➢ Additional investment secured waiting list initiatives as part of the 2019/20 contract negotiations to flex capacity across the IAPT pathway. ➢ 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. ➢ Waiting list initiatives have been agreed in all areas. ➢ Work has taken place with commissioners to agree additional capacity in specific services.	4 Major	3 Possible	12 Amber / high risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Waiting list reports developed, further work required to ensure they are comprehensive. Additional reporting will be developed as part of SystmOne optimisation. (DPD / DO / DFR) (September 2020) ➢ Waiting list initiatives agreed with Barnsley and Calderdale CCGs. Demand will be reported via contract meetings during 2020/21. (DFR) ➢ Waiting lists and associated actions are monitored through the clinical governance and clinical safety committee. (DO)	DO	April 2020	Performanc e reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performanc e reports reviewed by BDU.	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 C&K waiting list initiatives (recovery plans) relate to ASC diagnostic assessment and W&B initiatives focus on reducing waits from referral to treatment. Improving position in all areas with exception of K where increase in referrals	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
													outstrips the additional capacity. Position understood by CCG but potentially increases again the broader reputational and clinical risk.	
1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	➢ Fire Safety Advisor produces monthly / quarterly Fire Report and Operational Fire / Unwanted Fire Activation for review / action by EFM Senior Managers. ➢ Quarterly review undertaken by Estates TAG. ➢ Weekly risk scan are completed by the Trust's Fire Safety Advisor and any issues or concerns raised directly with the Head of Estates and Facilities and Head of Estates Operations with the Director of HR, OD and Estates been briefed and action undertaken accordingly. ➢ Trust smoking policies with the use of e-cigarettes agreed for a trial period. ➢ Compliance with the following regulations: o The allocation and definition of responsibilities and standards for the provision, installation, testing and planned maintenance of fire safety equipment, devices, alarm and extinguishing systems; o The identification of standards for the control of combustible, flammable or explosive materials; o The allocation of responsibilities for the implementation of fire emergency plans including evacuation procedures, first-aid firefighting, contacting the emergency services, emergency co-ordination and staff training; o The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures; o The development and delivery of suitable staff training in fire safety awareness; o Fire safety training compliance measured monthly at OMG with time	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Smoking group established to review the smoking policy including the trial period for the use of e-cigarettes. (DO) An update report will be provided to the Clinical Governance and Clinical Safety Committee in February 2020. (deferred due to the impact of Covid-19)	DHR	Ongoing	EFM (weekly and monthly) Estates TAG (quarterly) OMG (monthly)	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 Note - A failure to effectively manage compliance with the Trust Fire/Smoking policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings.	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		constrained action plans required for non-compliant areas. o The development and implementation of emergency procedures to ensure early recovery from unforeseen incident involving fire in order to maximise safety, minimise problems and enable the core business structure to continue. ➢ Use of sprinklers across all Trust buildings reviewed as part of the capital programme. ➢ New inpatient builds and major developments fitted with sprinklers. ➢ Reinforcement of rules and fire safety message in locations where additional oxygen could be used. ➢ Temporary smoking arrangements introduced in response to Covid-19.												
1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: ➢ Inpatient ligature risks ➢ Learning from deaths & complaints ➢ Clinical risk assessment ➢ Suicide prevention ➢ Restraint reduction ➢ Covid-19.	Clear policy & procedure in place providing framework for the identification and mitigation of risks in respect of: ➢Ligature assessment. ➢Blue light alerts and learning library introduced immediate lessons learnt are shared and prompt action taken to prevent recurrence of incidents. ➢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	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Quality improvement network focus on patient safety improvement. (DNQ) – to commence in Q1 2020/21 in line with clinical TRIO refresh. (Implementation plan to be reviewed in line with Covid-19 restoration and reset) ➢ Formulation of informed risk assessment training plan scheduled for Q4 2019/20 / Q1 2020/21 to introduce enhanced risk assessment process and outcome. (Implementation plan now scheduled for September 2020 following review in line with Covid-19 response) ➢ Cohorting plan in place to mitigate an impact of Covid-19 and any outbreak. ➢ Enhanced risk scan initiated to ensure incidents referencing Covid-19 are reviewed for trends and themes that may require mitigations. (DNQ) ➢ Enhanced IPC team offer to services as part of Covid-19 response. (DNQ) ➢ Pandemic flu plan response including BCP stress testing. (DNQ) ➢ Additional support from legal team to provide timely response to clinicians in relation to MHA / MCA matters. (MD) ➢ Internal and external regional work to ensure ECT offer remains in place. (MD) ➢ Additional pharmacy team support to clinicians to manage Covid-19 related matters. (MD)	DNQ MD	On going	Performanc e & monitoring via EMT, OMG & TB reports e.g. quarterly Patient Safety report & incident report	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

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
		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 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). ➢ Agency and bank staffing action plan is monitored through OMG. ➢ Safer staffing group meets on a monthly basis to review exception reporting. ➢ Alignment of WY&H ICS suicide prevention strategy with SWYPFT plans. ➢ QI approach adopted on CQC areas for improvement. Detailed plan approved by CG&CS Committee. Risk assessment improvement is a key domain. ➢ Suicide prevention strategy action plan. ➢ CQC improvement action plans performance managed through OMG and Clinical Governance Group with escalation arrangements in place where action behind schedule. ➢ Reducing restrictive practice and intervention (RRPI) improvement plan implementation. ➢ Covid-19 pathway including cohortying protocol developed and implemented. ➢ Enhanced risk scan initiated to ensure incidents referencing Covid-19 are reviewed for trends and themes that may require mitigation. ➢ Enhanced IPC team offer to services as part of Covid-19 response. ➢ Agreed pathway with acute providers to access clinically appropriate support for Covid-19. ➢ Additional training and support plan for staff to respond to needs of suspected and positive Covid-19 patients. ➢ Development of step-up and step-down guidance in partnership with acute trust colleagues. ➢ Development of a plan if impact of Covid-19 is such that service users need to be transferred on to different co-horted wards. ➢ Agreed pathway with acute providers to access clinically appropriate support for Covid-19.											

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	➢Participation in system transformation programmes. ➢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 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢The Trust is developing external engagement and communications to explain the benefits of mental health transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) ➢Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR) ➢2020/21 contract negotiation process (DFR) (March 2020). *Temporary contracting arrangements in place for April –August 2020. (DFR)* ➢Awaiting confirmation of financial arrangements from September onwards (DFR) (August 2020) ➢Information provided to NHSE&I in respect of potential funding requirements and issues from September onwards. (DFR) (August 2020)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3 Trust has written to NHSE&I with details of income not currently included in the base block payment	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	➢Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target of 95%. ➢Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. ➢Trust has appropriate policies and procedures that are compliant with GDPR. ➢Trust has good track record for recording incidents and all incidents are reviewed weekly with investigations carried out where needed and action plans put in place. ➢Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues. ➢Monthly report of IG issues to EMT. ➢Internal audit perform annual review of IG as part of IG Toolkit. ➢Internal Audit programme of work.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢Targeted approach to advice and support from IG Manager through proactive monitoring of incidents and 'hot-spot- areas. Individual letters asking for action plans from services where there has been a recurrence of incidents. (DFR) ➢Use of blue light system to highlight specific breaches. (DNQ) ➢Corporate and Clinical Governance leads working together to deliver focussed improvement work. (DFR / DNQ) ➢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) ➢Formal decision logs for any temporary changes to policies as a result of wider incidents. (DFR) ➢Ensuring that the data protection impact assessment is reviewed, updated and published as required. (DFR) ➢Part re-purposing of ICIG during the Covid-19 outbreak to identify IG concerns arising from rapid systems deployment and changes in policy & procedure. (DFR) ➢Review of incidents that have taken place during the Covid-19 outbreak to identify if additional mitigations required (DFR) (September 2020)	DFR	ICO external monitori ng of progres s by external evidenc e / desk based reviews	Progress monitored through EMT and weekly risk scans	4 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current	➢Financial planning process includes detailed two year projection of cash flows. ➢Working capital management process including credit control and creditor payments to ensure income is collected on	4 Major	2 Unlikel y	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-	➢ Investigate additional sources of capital funding should they be required. (DFR) (December 2020). *Current plan for 20/21 does not require additional funding. Trust has participated in prioritising bids for national Covid-19 related capital funding across each*	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF,	Every three months prior to busi-

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
	operating environment, and its capital programme, leading to an inability to pay staff and suppliers without DH support.	time and creditors paid appropriately. ➢ Capital prioritisation process to ensure capital is funded where the organisation most needs it. ➢ Stated aim of development of financial plans that achieve at least a small surplus position. ➢ Existing estates strategy in place. ➢ CIP identification and review process. ➢ Treasury Management policy. ➢ Non-Executive Director led Finance, Investment & Performance Committee. ➢ Cash management procedures				ate (1 – 6)	*ICS.* ➢ Focus on benchmarking and internal productivity. (DFR) (July 2020) ➢ Compare CIP ideas with similar trusts in the region. (DFR) (September 2020). *Delayed to due impact of Covid-19 and temporary financial arrangements.* ➢ Revised estates strategy being developed. (DHR) (July 2020) ➢ 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) ➢ Temporary contracting arrangements in place for April – August 2020. Awaiting confirmation of financial arrangements from September onwards. (DFR) (August 2020)				ate (4-6)		SO3	ness and risk Trust Board – July 2020 & weekly Covid-19 review
1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	➢ Systematic and integrated monitoring of contract performance, changes in specification and commissioning intentions to identify and quantify contract risks. ➢ Regular reporting of contract risks to EMT and Trust Board. ➢ Play full role in ICSs in both West and South Yorkshire. ➢ Communication, engagement and involvement strategy. ➢ Updated Trust strategy in place. ➢ Liaison with regulators. ➢ Approved commercial strategy. ➢ Non-Executive Director led Finance, Investment & Performance Committee. ➢ Prospectus and Board stakeholder engagement plan. ➢ Annual contracting process	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. (DPD / DO) ➢ Implement actions from stakeholder survey. (DS) (December 2019) ➢ 2020/21 contract negotiations. (DFR) (March 2020) *Temporary contracting & financial arrangements in place for April – August 2020.* ➢ External stakeholder engagement plans will be refreshed as part of the involving people strategy refresh. (DS) (September 2020) ➢ 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) ➢ *In light of Covid-19 outbreak there is no current tendering of services.*	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 1 & 3	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving	➢ Board and EMT oversight of progress made against transformation schemes. ➢ Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the	3 Moder ate	3 Possib le	9 Amber / high	Minimal / low – Cauti-ous /	➢ Focus on benchmarking and internal productivity. (DFR) (July 2020) ➢ Implementation of longer term financial sustainability plan. (DFR)	DFR	Annual review	EMT (monthly) Trust Board	4 Yellow /Moder	FIP	Risk appetite: Financial risk target 1 – 6	Every three months prior to

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
	requirements and ensure income received is sufficient to pay for the services provided.	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 Finance, Investment & Performance Committee.			(8-12)	moder-ate (1 – 6)	➢ 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) ➢ Temporary contracting arrangements in place for April – August 2020. Awaiting confirmation of financial arrangements from September onwards. (DFR) (August 2020)			(quarterly)	ate (4-6)		Links to BAF, SO 3	busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.	➢ Monitoring turnover rates monthly. ➢ Exit interviews. ➢ Flexible working guidance. ➢ Flexible working arrangements promoted. ➢ Investment in health and well-being services. ➢ Retire and return options. ➢ Apprenticeship scheme balancing the age profile. ➢ Recruitment and Retention action plan agreed. ➢ Workforce planning includes age profile. ➢ Bring back staff programme at national and local level. ➢ New pension arrangements allow for easier retire and return. ➢ All potential retirees have a discussion on options.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Refresh of workforce plans as part of operational planning process. (DHR) (December 2020)	DHR	Ongoing	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1158	Risk of over reliance on agency staff which could impact on quality and finances.	➢ Board self-assessment. ➢ Reporting through IPR. ➢ Safer Staffing Reports. ➢ Agency induction policy. ➢ Authorisation levels for approval of agency staff now at a senior level. ➢ Restrictions on administration and clerical agency staff usage ➢ Extension of the Staff Bank. ➢ Development of Medical Bank. ➢ OMG to Overview. ➢ Retention plan developed. ➢ Recruitment to Consultant roles. ➢ Direct engagement vendor is in place and meeting are almost complete with individual agency locums to support move to DE, with a few remaining. ➢ Agency project group has joined with the R&R group to focus on actions to address staffing shortfalls that then lead to agency use. ➢ Support through Bring Back Staff	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ A dedicated recruitment resource has been sourced until May 2020 to target areas with the greatest recruitment issues / highest agency use. (DHR / DO) (May 2020) ➢ Exit strategy for all agency locums has been requested from all clinical leads who refresh this on an ongoing basis. (MD) (March 2020) ➢ Business case for potential use of NHS Professionals underway. (DHR) (awaiting NHSP proposal) ➢ Implementation of new roles across 2020 including Nursing Associates and Advanced Clinical Practitioners. (DHR / MD)	DHR	Ongoing through agency project group and workforce planning – worksho p	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		Programme.												
1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	➢Clear service strategy to engage commissioners and service users on the value of services delivered. ➢Participation in system transformation programmes. ➢Robust process of stakeholder engagement and management in place through EMT. - Progress on transformation reviewed by Trust Board and EMT. ➢Robust CIP planning and implementation process. ➢Trust is proactive in engaging leadership across the service footprint. ➢Active role in ICSs. ➢Skilled business development resource in place. ➢Commercial strategy. ➢Trust prospectus.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢2020/21 contract negotiations. (DFR) (March 2020) – process currently suspended ➢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) – planning process currently suspended ➢Development of Alliances in Calderdale, Kirklees and Wakefield will ensure local priorities and impact are considered. (DS) ➢Temporary contracting arrangements in place for April – August 2020. (DFR) ➢*No current tendering of services in light of Covid-19 outbreak. (DFR)*	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.	➢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. ➢Routine reviews of care whilst out of area are in place. ➢Pathway for people with trauma informed emotionally unstable personality disorder is in place with a programme of training ongoing.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢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) ➢Identify barriers to discharge in light of impact of Covid-19 such as availability and capacity of care homes. Identify possible mitigations. (DO) ➢Implementation of actions identified through independent review of our bed management processes remain a priority throughout the Covid-19 phase. (DO)	DO	April 2020	OMG	4 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	➢Bed management process. ➢Joint action plan with commissioners. ➢Internal bed management programme board. ➢Weekly oversight at EMT and OMG. ➢In-depth financial reviews at OMG, EMT and Trust Board. ➢2019/20 contracts agreed and in place. ➢Contract arrangements for the first four months for 2020/21 enable trusts to break even.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢2020/21 contract negotiations. (DFR) (March 2020) – process currently suspended ➢Ongoing review with commissioners to prioritise areas of expenditure. (DFR) ➢Implementation of actions identified through independent review of our bed management processes. Remains a priority throughout the Covid-19 outbreak. (DO) ➢Review recommendations made by Niche regarding PICU bed management across West Yorkshire. (DO)	DO / DFR	Ongoing	OMG monthly EMT monthly Trust Board monthly	4 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk 1 – 6	Every three months prior to busi-ness and risk Trust Board – July

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
							(September 2020)							2020 & weekly Covid-19 review
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.	➢ 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 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.	4 Major	2 Unlikely	8 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Development of new CAMHS inpatient facility in Leeds for West Yorkshire. (DO) (2021) ➢ Further recruitment underway. ➢ All age liaison plans are being revised for Covid-19 with local solutions in place in Wakefield and Barnsley and a Trustwide solution available through the 24/7 helpline. Work will continue towards a substantive solution. (DO) (September 2020)	DO	Ongoing risk given external influenc e outside our control	EMT (monthly) CG&CS (regular) Trust Board (each meeting through integrated performanc e report)	4 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 The Trust ensures children and young people are only admitted to an adult bed as least worst option and ensure full safeguarding is in place when the need arises. This is in line with our “safety first” approach.	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	➢ Safer staffing levels for inpatient services agreed and monitored. ➢ Agreed turnover and stability rates part of IPR. ➢ Weekly risk scan by DNQ and MD to identify any emerging issues, reported weekly to EMT. ➢ Reporting to the Board through IPR. ➢ Datix reporting on staffing levels. ➢ Strong links with universities. ➢ New students supported whilst on placement. ➢ Regular advertising. ➢ Development of Associate Practitioner. ➢ Workforce plans incorporated into new business cases. ➢ Workforce strategy implementation of	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Proposal for On Boarding System to include recruitment Microsite. (DHR) ➢ 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) (Review delayed and revised implementation plan under review in line with Covid-19 response)	DHR	Ongoing given external 13nfluen ce outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performanc e report)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3 34 TNA posts recruited to (October – November 2019) both internal and external to a total	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		action plan. ➢ Retention plan developed. ➢ Workforce plans linked to annual business plans. ➢ Working in partnership across West Yorkshire on international recruitment. ➢ Inpatient ward workforce review with revised skill mix. Major recruitment drive to implement nursing associates via Trainee Nurse Associate recruitment. ➢ Introduction of new temporary register by NMC and HCPC plus retirees return national initiative is in place and being utilised to support staffing during Covid-19 response.											establishment of 52 WTE.	
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	➢ Absence management policy. ➢ Occupational Health service. ➢ Trust Board reporting. ➢ Health and well-being survey. ➢ Each BDU identified wellbeing groups and champions. ➢ Enhanced occupational health service. ➢ Well-being at Work Partnership Group. ➢ Health trainers. ➢ Well-being action plans. ➢ Core skills training on absence management. ➢ Extend use of e-rostering. ➢ Retention plan developed. ➢ HR and service managers ensuring consistent application of sickness policy.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)		DHR	Ongoing	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi- ness and risk Trust Board – July 2020 & weekly Covid-19 review
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	➢ Annual Equality Report. ➢ Equality and Inclusion Form. ➢ Equality Impact Assessment. ➢ Staff Partnership Forum. ➢ Development and delivery of joint WRES and EDS2 action plan. ➢ Targeted career promotion in Schools. ➢ Focus development programmes. ➢ Review of recruitment with staff networks complete. ➢ Actions identified in the equality and diversity annual report 2017/18. ➢ Establishment of staff disability network and LGBT network. ➢ Links with Universities on widening access. ➢ Framework for bullying and harassment between colleagues. ➢ Action plan to tackle harassment and bullying from service users and families.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Delivery of WRES and EDS2 action plans. (DHR)	DHR	Ongoing	EMT (quarterly) EIC Committee (quarterly)	6 Yellow / moder ate (4-6)	EIC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi- ness and risk Trust Board – July 2020 & weekly Covid-19 review

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.	Yellow / Moderate (4-6)	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.	Yellow / Moderate (4-6)	Open / High (8 - 12)	Yellow / Moderate (4-6)
1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	Yellow / Moderate (4-6)	Minimal / low – cautious / Moderate (1-6)	Yellow / Moderate (4-6)
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.	Yellow / Moderate (4-6)	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.	Yellow / Moderate (4-6)	Open / high (8 - 12)	Yellow / Moderate (4-6)

COVID-19 RISKS

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
1530	Risk that Covid-19 leads to a significant increase in demand for our services as anxiety and mental health issues increases in our populations.	➢ Planning process. ➢ Working as a key partner in each of the Integrated Care Systems, recovery and reset planning and learning from Covid-19 workstreams. ➢ Members of the place based partnerships and integrated care boards MH alliance in Wakefield, IPCG in Barnsley and ICHLB in Kirklees. ➢ Health and wellbeing boards.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ New ways of working e.g. digital. (DFR) ➢ Learning from Covid-19 is being captured as it becomes available. This will support working in a different way in the future. (DO) ➢ Learning from national mental health, learning disability and autism Covid-19 response cell. (DO) ➢ Work with partners in each place to understand emerging impact of Covid-19, need and demand. (DS / DPD) ➢ Contribute to stress testing exercises through the ICS and use learning internally. ➢ Prioritisation of service planning based on what is known of impact during stabilisation phase. (DO) (August 2020) ➢ Service delivery is prioritised to meet need, manage risk and promote safety. (DO) ➢ Detailed activity, workforce and finance planning for remaining 2020/21 (DPD) ➢ Contribute to place based planning including recovery and reset. (DS / DPD) ➢ Business continuity plans to remain responsive to difference phases and impact of the pandemic. (DO)	DO	Septem ber 2020	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&C S	Risk score reviewed and remains the same, whilst findings of stress testing and internal planning are considered. Review in September 2020.	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk level <15 - risks outside the risk appetite

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	➢ Policies and procedures revised to take account of Covid-19. ➢ Publication of guidance on the intranet. ➢ Regular communication to all staff. ➢ Application of social distancing guidance. ➢ Provision of appropriate personal protective equipment in line with national guidance. ➢ Bronze, silver and gold command incident processes established. ➢ Self-isolation guidance. ➢ Process for testing all staff established: symptomatic, asymptomatic and antibody. ➢ Covid-19 pathway including cohorting protocol developed and implemented. ➢ Enhanced IPC team offer to services as part of Covid-19 response. ➢ Agreed pathway with acute providers to access clinically appropriate support for Covid-19. ➢ Additional training and support plan for staff to respond to needs of suspected and positive Covid-19 patients. ➢ Development of step-up and step-down guidance in partnership with acute trust colleagues. ➢ Face masks available across the Trust for staff in line with government guidance.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Daily follow up of actions identified. (DNQ) ➢ Routine scan of national guidance as part of horizon scanning in command structure. (DNQ) ➢ Membership of clinical and professional regional and national networks. (DNQ) ➢ Risk assessments taking place across the Trust to determine if areas are Covid-19 secure. (DHR) (June / July 2020)	DNQ	Ongoing during Covid-19 pandemic	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.	➢ Business continuity plans. ➢ Performance management processes. ➢ Risk panel review process. ➢ There is clear escalation structure. through bronze / silver / gold meetings in place.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Bronze command meetings meet regularly to manage the demand in the local service and review the needs of the service users on the caseload. (DO) ➢ Bronze / management huddles are also being used to ensure safe return of services in line with Covid-19 restrictions. (DO) ➢ A 24/7 helpline is available to service users and members of the public who can raise concern and ask for help. (DO) ➢ OMG continues to monitor performance and take appropriate actions to address areas of concern, with appropriate escalation to EMT. (DO) ➢ The Datix reporting system has been simplified to support staff to report incidents which are then reviewed at the risk panel. (DNQ) ➢ Safe working practices in community services group established to ensure people are working safely. The group reports to OMG. (DHR / DO)	DO	Ongoing through Covid-19 phase	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS	Risk score reviewed. Currently score not reduced as the focus on Covid-19 remains during the work underway to return services in line with Covid-19 restrictions.	Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1524	Risk that staff do not have access to necessary personal	➢ Bronze PPE group. ➢ Trust guidance on application and use of PPE in line with national guidance.	4 Major	3 Possible	12 Amber	Minimal / low – Cauti-	➢ Collaboration with ICSs to better plan what stock is needed and where. (DNQ) ➢ Development of basic demand forecasting and stock	DNQ	Ongoing	EMT (monthly)	4 Yellow /	CG&CS	Currently good level of deliveries and	Every three months

Risk ID	Description of risk	Current control measures	Consequen-ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
	protective equipment (PPE) during the Covid-19 outbreak leading to issues with personal safety and weak staff morale.	➢ Part of national delivery process for PPE. ➢ Process in place for delivering to Trust services. ➢ Confirmed delivery process with the supplier, ➢ Mutual aid process within each ICS			/ high (8-12)	ous / moder-ate (1 – 6)	usage information. (DFR / DNQ) ➢ Routine scan of national guidance as part of horizon scanning in command structure. (DNQ)				moder ate (4-6)		provision. Likelihood of risk subject of ongoing review.	prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.	➢ Safer staffing policies. ➢ Increased supply of temporary labour through staff bank recruitment. ➢ Ability to move staff between wards / teams. ➢ Daily access to staff absent report by service. ➢ Business continuity plans in place that relate to the deployment of staff towards critical (24/7) services. ➢ Talent pool for the redeployment of staff from non-critical to critical roles. ➢ Staff health and wellbeing offer. ➢ Testing programme. ➢ Retirees return and 'bring back' NHS staff programme. ➢ New temporary register for NMC and HCPC. ➢ Fast track recruitment process for essential roles in line with national guidance. ➢ Staff testing arrangements in place. ➢ Staff and managers advice line operating 7 days a week. ➢ Integrated Health and Wellbeing support. ➢ Reduction in mandatory refresher training to release headroom. ➢ Student nurses deployed in line with guidance. ➢ Staff Portability Agreement with West Yorkshire MH / LD Trusts. ➢ Management guidance on supporting staff attendance. ➢ PPE guidance. ➢ New working from home guidance. ➢ Process for testing all staff. ➢ Revised equality / quality impact assessment process introduced during Covid-19 pandemic.	4 Major	3 Possibl e	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Training and support readily available for staff who are needed to work in a different service or a different way. ➢ Staff portability arrangements within each place. ➢ PPE availability processes being further developed. ➢ Link to national wellbeing offer to keep staff resilient. ➢ Staff testing arrangements available to all staff. ➢ Safe working practices in community services group established to ensure people are working safely. The group reports to OMG. (DHR / DO)	DHR / DO		Command structure	8 Amber / high (8-12)	CG&CS		Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves.	➢ Pastoral care 'talk-line'. ➢ Access to wellbeing apps. ➢ National mental health hotline. ➢ Occupational Health Service operating extended hours. ➢ Coronavirus psychological support line for staff operative 7 days a week. ➢ Support arrangements for shielded staff introduced. ➢ Health and wellbeing support centre as part of Workforce Support Hub. ➢ Support and advice on childcare and caring. ➢ Staff and managers advice line operating 7 days a week. ➢ Self help guide for managers and teams ➢ Coaching offer to managers, team leaders and teams to support wellbeing and resilience. ➢ Staff counselling availability. ➢ Link to the national Health and Wellbeing offer. ➢ Staff food provision for frontline staff. ➢ Health lifestyle support on stop smoking and weight management. ➢ Staff testing arrangements available to staff.	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Financial support guidance. (DHR / DFR) ➢ Strengthen bereavement support. (DHR)	DHR		Command structure	8 Amber / high (8-12)	WRC		Every three months prior to busi- ness and risk Trust Board – July 2020 & weekly Covid-19 review
1528	Risk that new models of care arising from Covid19 are not adequately tested, leading to a deterioration in the quality of care.	➢ Business continuity plans. ➢ Performance management processes. ➢ Risk panel review process. ➢ There is clear escalation structure through bronze / silver / gold meetings in place. ➢ Use of local clinical expertise in development of models. ➢ Log of all changes made during the outbreak. ➢ QIA process for clinical pathway changes.	3 Moder ate	3 Possibl e	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Introduction of an interim clinical ethical advisory group (CEAG). The group will provide urgent ethical advice to clinical teams and propose a framework for governance of the group with the intention of reporting into CG&CS on 9 June 2020 following support from the Board on 28 April 2020. (DNQ) ➢ Interim CEAG has provided advice and guidance to teams on cohorting issues and framework has been provided to CQC for review. (DNQ / MD)	MD / DNQ	May 2020	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Every three months prior to busi- ness and risk Trust Board – July 2020 & weekly Covid-19 review
1531	Risk that Covid-19 response disproportionately affects people with protected characteristics leading to poorer quality of care.	➢ Enhanced clinical risk scanning. ➢ Engagement with staff equality networks.	4 Major	3 Possibl e	12 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	➢ Risk scan report into EIC committee and escalation to EMT and OMG by exception. (DNQ) ➢ Working with commissioners and partners in both the West Yorkshire and South Yorkshire & Bassetlaw integrated care systems. (DPD / DS) ➢ Introduction of task group to understand the impact of Covid-19 on our protected user groups. ➢ Task group initial meeting on 10 June 2020. Risk entry reviewed, risk description final proposal to be	DNQ	Ongoing during Covid-19 pandemi c	EMT (monthly)	4 Yellow / moder ate (4-6)	EIC		Every three months prior to busi- ness and risk Trust

Risk ID	Description of risk	Current control measures	Consequen-ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
							taken to the next meeting. (DNQ)							Board – July 2020 & weekly Covid-19 review
1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	➢ New ways of working introduced to enhance clinical contact. ➢ Routine caseload risk scan by responsible clinician and local trio. ➢ Complaint and concern monitoring. ➢ 24 hour helpline available for service users and general public.	3 Moder ate	3 Possibl e	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ CAMHS "we are still here" campaign. ➢ Risk to be considered as part of restoration and reset workstream. ➢ Review of new benchmarking data. ➢ ICS system wide working to improve awareness of secondary services being open for routine referral.	DNQ / MD		EMT (monthly)	4 Yellow / moder ate (4-6)	CG&C S		Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1533	Risk that as a number of key workforce activities have stopped they could cause future problems around burnout and resilience, professional and personal development, staff and service safety.	➢ Workforce support to remain operational. ➢ Additional bereavement support to be kept in place. ➢ Great place to work to be re-focused. ➢ Workforce planning arrangements to continue with Learning Needs Analysis. ➢ Staff and Mangers advice line operating extended hours. ➢ Self help guide for managers and teams. ➢ Managers and team leaders coaching support. ➢ Healthy teams self-help guidance. ➢ Team coaching to support wellbeing and resilience. ➢ Staff counselling availability. ➢ National Health and Wellbeing offer to be maintained for at least 12 months. ➢ Bring Back Staff support to be reviewed to support staff leave and training.	3 Moder ate	3 Possibl e	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)		DHR		EMT (monthly)	4 Yellow / moder ate (4-6)	WRC		Every three months prior to busi-ness and risk Trust Board – July 2020 & weekly Covid-19 review
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	➢ Occupational health service operating extended hours. ➢ Coronavirus psychological support line for staff operating 7 days a week. ➢ Support arrangements for shielded staff introduced. ➢ Health and wellbeing support centre as part of the Workforce Support Hub. ➢ Staff and managers advice line operating	4 Major	3 Possibl e	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	➢ Health lifestyle support including review of vitamin D3. (DHR) (June 2020) ➢ Equality Impact Assessment of staff health and wellbeing offer and occupational health. (DHR) (June 2020)	DHR	Ongoing	Command structure of Gold, Silver, Bronze (daily) Trust Board through	8 Amber / high (8-12)	EIC	It has been agreed to ensure that workforce information is provided to the Trust Board and that the WRC will meet on an	Every three months prior to busi-ness and risk Trust

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		7 days a week. ➢ Self help guide for manager on their own and teams wellbeing and resilience. ➢ Managers and team leaders coaching to support wellbeing and resilience. ➢ Healthy teams self-help guidance. ➢ Team coaching to support wellbeing and resilience. ➢ Staff counselling availability. ➢ Link to the national health and wellbeing offer. ➢ BAME staff health and wellbeing taskforce established. ➢ Staff and BAME staff review meeting. ➢ BAME health and wellbeing project manager appointed. ➢ Ongoing review of national and international evidence and research. ➢ Health lifestyle support on Stop Smoking and weight management. ➢ Increased monitoring of Covid-19 BAME staff absence. ➢ Staff testing arrangements available to all staff. ➢ Support and engagement from the BAME Staff Equality Network. ➢ Management guidance on support and risk assessment for BAME staff. ➢ BAME staff Covid-19 risk assessment. ➢ BAME health and wellbeing videos.								IPR (monthly) Safer staffing reports (monthly) WRC (as appropriate)			exception basis as directed by the Board. Aim is to reduce the risk level to 8 which remains outside the current risk appetite. Further reductions may require revision on the Business Continuity Plans.	Board – July 2020 & weekly Covid-19 review

Risks within the risk appetite

Risk ID	Description of risk	Risk level (current / pre-mitigation)	Risk appetite	Risk level (target)
1527	Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
1521	Risk that staff do not have appropriate IT equipment and access to facilitate home-working during the Covid-19 pandemic meaning staff unable to work effectively or provide appropriate clinical contact and key activities not delivered.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)

Risk profile (risks outside the risk appetite) **– Trust Board 28 July 2020**

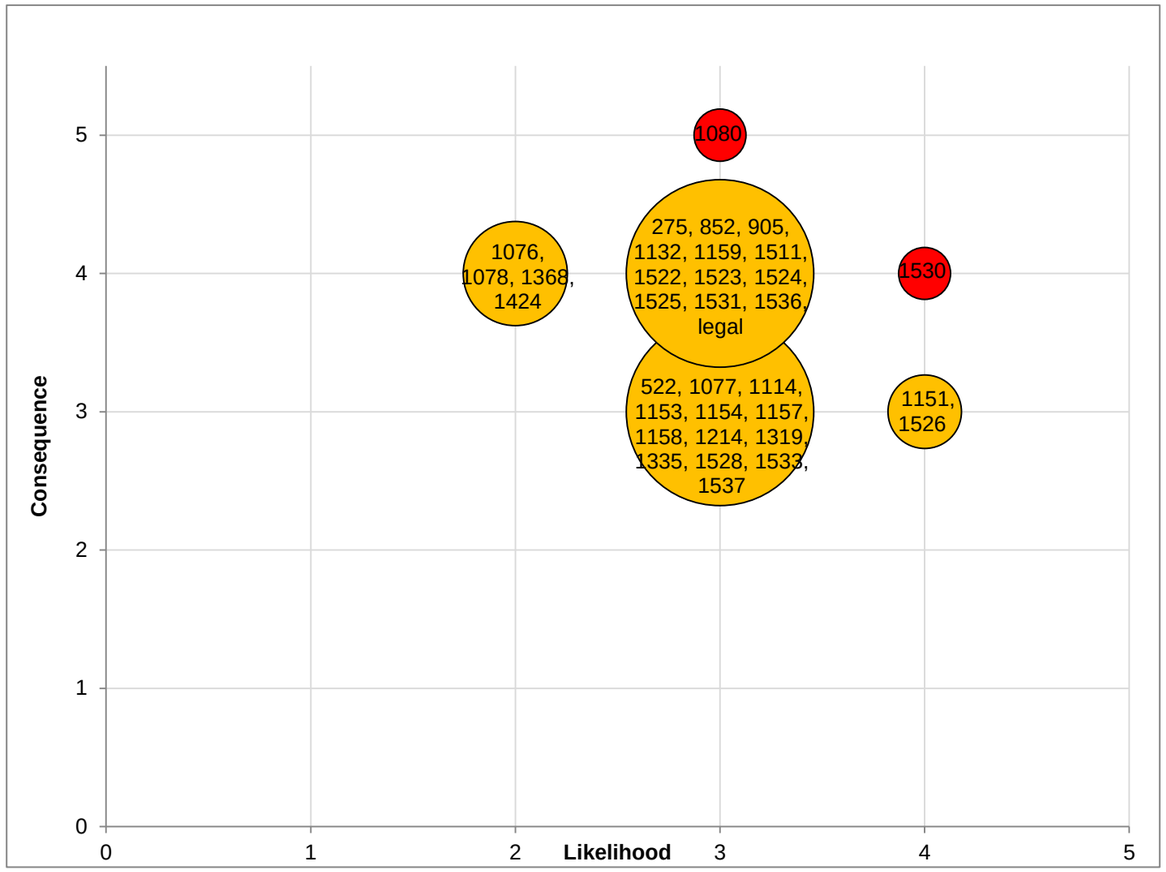
South West Yorkshire Partnership NHS Foundation Trust

Consequence (impact / severity)	Likelihood (frequency)				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Catastrophic (5)			= Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data. (1080)		
Major (4)		= Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its high capital programme committed to, leading to an inability to pay staff and suppliers without DH support. (1076) = Risk that young people will suffer serious harm as a result of waiting for treatment. (1078) = 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, with a specific focus on: inpatient ligature risks, learning from deaths & complaints, clinical risk assessment, suicide prevention, restraint reduction, Covid-19. (1424)	= Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners. (275) = Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk. (852) > Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care. (905) = 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 carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical and other risk to the Trust. (1511) C ! Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19. (1522) C ! Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak. (1523) C ! Risk that staff do not have access to necessary personal protective equipment (PPE) during the Covid-1 outbreak leading to issues with personal safety and weak staff morale. (1524) C ! Risk that the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services. (1525) C ! Risk that Covid-19 response disproportionately affects people with protected characteristics leading to poorer quality of care. (1531) C ! BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus. (1536) C ! Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic. (545)	C ! Risk that Covid-19 leads to a significant increase in demand for our services as anxiety and mental health issues increases in our population. (1530)	
Moderate (3)		> Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements. (522) = 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 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 WDES. (1157) = Risk of over reliance on agency staff which could impact on quality and finances. (1158) = Risk that local tendering of services will increase, impacting on Trust financial viability. (1214) = Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised. (1319) = Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total. (1335) C ! Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care. (1528) C ! Risk that as a number of key workforce activities have stopped the could cause future problems around burnout and resilience, professional and personal development, staff and service safety. (1533) C ! Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation. (1537)	= 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) C ! Risk that staff health and wellbeing is adversely affected by the impact of the Coronavirus on service users, their families and themselves. (1526)	
Minor (2)			RA (275), (522), (852), (905), (1076), (1077), (1078), (1080), (1114), (1132), (1151), (1153), (1154), (1157), (1158), (1159), (1214), (1319), (1335), (1368), (1424), (1511), (1522), (1523), (1524), (1525), (1526), (1528), (1530), (1531), (1533), (1536), (1537), (1545)		
Negligible (1)					

=	same risk rating as last quarter	<	decreased risk rating since last quarter	RA	risk appetite
!	new risk since last quarter	>	increased risk rating since last quarter	C	Covid-19 risk

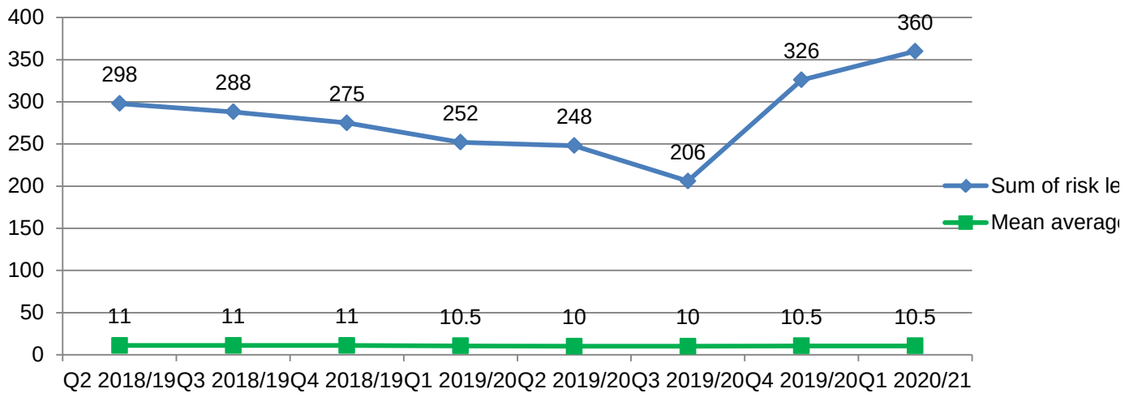
With **all of us** in mind.

Risk profile (risks outside risk appetite) **– Trust Board 28 July 2020**



2018/19			2019/20				2020/21
Q2 (27 risks)	**Q3** (26 risks)	**Q4** (25 risks)	**Q1** (24 risks)	**Q2** (24 risks)	**Q3** (21 risks)	**Q4** (31 risks)*	**Q1** (34 risks)*
11	**11**	**11**	**10.5**	**10**	**10**	**10.5**	**10.5**

*includes Covid-19 related risks



Score	ID	Description
12	275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.
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 and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.
12	905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.
8	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.
9	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, WRES and WDES.
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	1214	Risk that local tendering of services will increase, impacting on Trust financial viability
9	1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.
9	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.
8	1424	Risk of serious harm occurring from known patient safety risks, with a specific focus on: inpatient ligature risks, learning from deaths & complaints, clinical risk assessment, suicide prevention, restraint reduction, Covid-19.
12	1511	Risk that carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical and other risk to the Trust.
12	1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.
12	1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.
12	1524	Risk that staff do not have access to necessary personal protective equipment (PPE) during the Covid-19 outbreak leading to issues with personal safety and weak staff morale.
12	1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.
12	1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves.
9	1528	Risk that new models of care arising from Covid19 are not adequately tested, leading to a deterioration in the quality of care.
16	1530	Risk that Covid-19 leads to a significant increase in demand for our services as anxiety and mental health issues increases in our populations.
12	1531	Risk that Covid-19 response disproportionately affects people with protected characteristics leading to poorer quality of care.
9	1533	Risk that as a number of key workforce activities have stopped they could cause future problems around burnout and resilience, professional and personal development, staff and service safety.
12	1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.
12	1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.
12	1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 8.3

Title:	**Infection Prevention & Control Board Assurance Framework**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To appraise and provide assurance to the Trust Board in relation to the Infection Prevention & Control Board Assurance Framework (IPC BAF).
Mission / values:	Providing safe care for people who use our services and our staff. Maintaining assurance processes to ensure we work to achieve all our Trusts values.
Any background papers / previously considered by:	Regular IPC updates provided to Clinical Governance & Clinical Safety Committee, IPC BAF process update provided to Clinical Governance & Clinical Safety Committee 9 June 2020.
Executive summary:	NHS England developed the IPC BAF framework to help providers assess themselves against Public Health England national guidance that has been produced during the COVID 19 pandemic. The intention is that the framework is used as a source of internal assurance that quality standards are being maintained. The IPC legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. The IPC BAF has been structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **In SWYPFT we have used the tool to:** • Provide assurance to trust board that organisational compliance has been systematically reviewed. • Identify areas of risk and highlight the mitigating actions we have in place **Approach** • Key individuals (IPC specialists, estates staff, operational staff, professional advisors) have reviewed Trust evidence against the framework to provide high level assurance, assess immediate risks and consider mitigating actions • A summary table of evidence, risk and mitigation has been completed • The CQC have subsequently reviewed our plan **Findings** • Initial findings are that all relevant PHE guidance, published up to 20th July 2020, has been adopted in the Trust and is being followed or mitigated. • The emergency response framework has provided a robust structure for the organisation to follow during the COVID pandemic all appropriate central and regional guidance has been scanned and actioned through command structure with a robust log of decisions and actions noted. • No gaps in assurance were identified other than in domain 3. 'Ensure

	appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance'. Mitigation plans are in place. • The CQC have reviewed our plan in the knowledge that it will be received at this Board meeting (28.07.2020). Their conclusion is "***We have found that the board is assured that the trust has effective infection prevention and control measures in place".*** • The overall summary outlines key findings from their assessment, including any innovative practice or areas for improvement. **Next steps** • NHSE will update this framework as PHE guidance is being refreshed. The IPC TAG will provide the governance framework for monitoring our compliance with this document. • The SWYPFT Infection Prevention & Control Board Assurance Framework document will be reviewed on a 3 monthly basis (or sooner as required) and submitted to the Clinical Governance & Clinical Safety Committee at relevant points. **Risk Appetite** • This report provides assurance to the Trust Board in relation to the Infection Prevention & Control Board Assurance Framework. • This meets the clinical risk appetite – low and the risk target score 1-6.
Recommendation:	**Trust Board is asked to RECEIVE the IPC Board Assurance Framework as assurance that the appropriate standards are in place.**

SWYPFT Infection prevention and control board assurance framework

Final Version 20th July 2020

SWYPFT Infection prevention and control board assurance framework

SWYPFT's strategic approach to management of COVID 19 pandemic:

- We adopted the Emergency Planning Response Framework, including the BRONZE, SILVER AND GOLD command structure to ensure board to ward connectivity.
- Silver command led by the Deputy Director of Nursing & Quality, which has enabled a IPC focused approach
- This emergency planning structure was used to check for guidance, place it appropriately, interpret and apply to practice. Communication was through daily brief and operational structures
- Infection, Prevention & Control (IPC) policies, procedures and guidance and training updated or developed in line with national guidance.
- Developed a Standard Operating Procedure - The management of a patient/ patients with possible or confirmed COVID to a person centred approach, underpinned by evidence based practice
- Developed a COVID-19 Equality Impact Assessment
- Environmental Cleaning processes are in place
- Decontamination procedure in place in line with National NHS England guidance and the Trust Cleaning Policy
- IPC has inspected all cohort areas to ensure compliance with environmental requirements set out in the current PHE national guidance for COVID 19
- Provided assurance reports to Clinical Governance and Clinical Safety Committee.
- Provided our NED's a regular governance update
- Developed a COVID section in our Integrated Performance Report
- COVID risks section added to risk register

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure: • Infection risk is assessed at the front door and this is documented in patient notes • Patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • Compliance with the national guidance around discharge or transfer of COVID- 19 positive patients • All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE	SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19 includes: o Pre admission screen o SWYPFT COVID-19 Infection Prevention and Control SOP for Inpatient areas immediately a case of COVID 19 is possible/ confirmed o Admission principles o Pathway for admission o Action to take to reduce the risk of COVID 19 getting into the wards o Minimizing the impact of risk factors for serious COVID 19 disease in our patients o Process for symptomatic patients (protocols for testing pts on admission and leave, AWOL etc.) o Supporting people on Oxygen o Care planning and risk	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

that protects them for the appropriate setting and context as per national guidance • National IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way. • Changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • Risks are reflected in risk registers and the board assurance framework where appropriate • Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	assessments o Mental health act/ mental capacity act o Management of acute distress and disturbance o Transfer of care o Discharge process o Care of the deceased o Training for staff (including PPE) o Staff wellbeing and support The Trust has followed Public Health England (PHE) guidance on PPE use IPC have provided training and guidance on putting on and removing PPE Active participant question and answer sessions and Q&A on intranet Bronze PPE cell - system for monitoring usage and stock of PEE Poster campaign on use of PPE Coronavirus dedicated Intranet information pages The emergency planning structure was used to check for guidance, place it appropriately, interpret and apply to practice. Communication was through daily brief and operational structures		

	Infection, Prevention & Control (IPC) policies, procedures and guidance and training updated or developed in line with national guidance. IPC supported the implementation of changes to policy and practice by floor walking exercises on clinical areas Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens (MRSA, C-Diff, E-Coli, MSSA, CPE) Electronic reporting systems in place are DATIX, Sharepoint, SystmOne, COVID-19 email account. Reporting to PHE as per responsibilities on infections and outbreaks and RCA outbreak reports are reported into the clinical risk panel review. The learning from outbreak reviews are being fed into SOP's and guidance for staff.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • Designated cleaning teams with appropriate training in required techniques and use of PPE are assigned to COVID-19 isolation or cohort areas • Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19 provides the evidence based to care for and treat patients in COVID 19 isolation and cohort areas Housekeepers working on the inpatient areas were fully briefed regarding required cleaning requirements and were supplied with PPE The evidence to support cleaning of premises and equipment can be found in the following documents, which include cleaning schedules, products to use and general guidance for staff: o Environmental Cleaning process; which includes process following a	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

• Attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas • Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine • Alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacture s' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance • Frequently touched' surfaces , e.g. door/toilet handles, patient call bells, over-bed tables and bed rails, should be	possible or confirmed case o Decontamination procedure is in place in line with National NHS England guidance and the Trust Cleaning Policy o Evidence is included in the COVID-19 Infection Prevention and Control SOP for Inpatient o Laundry and Infection Prevention and Control Policy o Medical Devices Policy Monitoring environmental cleanliness: o Environmental audit, including cleaning, nursing and estates remits, are undertaken by the in house monitoring team along with IPC, with frequencies determined by risk area o IPC reviews of cohort areas o Environment monitoring due in Quarter 3 alongside PLACE visit o A deep clean team works to an annual plan, with frequencies determined by		

decontaminated at least twice contaminated with secretions, excretions or bodily fluid • Electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily • Rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • Linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • Single use items are used where possible and according to single use policy • Reusable equipment is appropriately decontaminated in line with	use of area as per National Standards of Healthcare Cleanliness (awaiting final confirmation of agreed standards) o A full review of cleaning services, including frequencies, methodologies, functional risk areas is in progress We only use single use items of equipment. We have reviewed and ensured good ventilation in admission and waiting areas to minimise opportunistic airborne transmission		

local and PHE and other national guidance • Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission			

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Arrangements around antimicrobial stewardship are maintained	• Pharmacists clinically checking every prescription • Use of refine data to look at hotspots • Data from community nursing analysed	• Currently have no mechanism to link prescribing data to individuals	• Introduction of EPMA being rolled out
• Mandatory reporting requirements are adhered to and boards continue to maintain oversight	• Reporting through Drug and Therapeutics Committee (D&T) and IPC meetings	• D&T meeting for less time so time spent on individual issues not significant	• Exception reports would be brought to the meeting • Oversight from IPC meeting

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Implementation of national guidance on visiting patients in a care setting • Areas in which suspected or confirmed COVID-19 patients are being treated are clearly marked with appropriate signage and have restricted access • Information and guidance on COVID-19 is available on all trust websites with easy read versions • Infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Visiting guidance (currently by appointment only), poster and leaflet available on intranet and internet with easy to read versions available Service user leaflets and guidance available in poster format on the wards and on SWYPFT website. Easy read information available Medical/nursing staff communicate with service user(s) and/or their carer's as appropriate Staff updates communicated timely via Trustwide Communications – Headlines, CE Brief, CE Update (was daily now weekly) Social media campaigns Infection status is on the intra-	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

	health care transfer form held within the IPC Risk Assessment Policy for Admission, discharge and transfer		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection, as per national guidance. • Mask usage is emphasized for suspected individuals • Ideally segregation should be with separate spaces, but there is potential to use screens,	The evidence for this domain can be found in 1. SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19 includes: o Pre admission screen o SWYPFT COVID-19 Infection Prevention and Control SOP for Inpatient areas immediately a case of COVID 19 is possible/ confirmed o Admission principles o Pathway for admission o Action to take to reduce the risk of COVID 19 getting into the wards o Minimizing the impact of	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

e.g. to protect reception staff • For patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible • Patients with suspected COVID-19 are tested promptly • Patients who test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced • Patients who attend for routine appointments and who display symptoms of COVID-19 are managed appropriately	risk factors for serious COVID 19 disease in our patients o Process for symptomatic patients (protocols for testing pts on admission and leave, AWOL etc.) o Supporting people on Oxygen o Care planning and risk assessments o Mental health act/ mental capacity act o Management of acute distress and disturbance o Transfer of care o Discharge process o Care of the deceased o Training for staff (including PPE) o Staff wellbeing and support 2. COVID-19 Essential Community Visits Standard Operating Procedure		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• All staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe • All staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it • A record of staff training is maintained • Appropriate arrangements are in place so that any reuse of PPE in line with the CAS alert is properly monitored and managed	All staff (clinical and non-clinical including bank/agency, contractors and volunteers) have appropriate training, as per guidance, to ensure their personal safety and working environment is safe; IPC training, training needs analysis for the cohort wards, additional training for medical staff, IPC walk arounds, Q&A's, Policy and Procedures on intranet, Control of Contractors document, signed by the contractor All staff (clinical and non-clinical including bank/agency) providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it; SOPs, Q&A on intranet, video films, posters	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

• Any incidents relating to the re-use of PPE are monitored and appropriate action taken • Adherence to PHE national guidance on the use of PPE is regularly audited • Staff regularly undertake hand hygiene and observe standard infection control precautions • Hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	ESR has records of donning & doffing, FFP3 mask fit testing and swabbing Hand hygiene is mandated training. Hand hygiene and bare below the elbows audit is scheduled to run Trustwide from September 2020 which will include the use of PPE Guidance available in poster format on the wards and on SWYPFT website PPE is not reused in the Trust Incidents related to PPE are recorded on DATIX, incident management system. A weekly report is produced for risk panel The IPC team review every incident and offer specialist advise We have the bronze PPE meeting which is a stock audit and any concerns raised are dealt with in a timely manner. Audit of staff adherence to IPC precautions is noted visually in walk arounds by IPC and		

• Staff understand the requirements for uniform laundering where this is not provided on site • All staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance, if they or a member of their household displays any of the symptoms	matrons– 'check and challenge'. IPC floor walkers, messages in the comms from CEO re: hand hygiene and IPC link professionals continually reinforce IPC precaution messages. Hand dryers are in situ in Folly Hall however hand towels are also available Scrubs are being introduced in MH services where laundering facilities are used. Staff understand the requirements of action to take , if they or a member of their household displays any of the symptoms. Evidence (contacts with OH, managers, HR) suggests staff are following this guidance. P&I have information recorded that supports this standard.		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • Areas used to cohort patients with possible or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • Patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPC Policies and procedures in place to supplement decisions made e.g. Outbreak Management, Isolation Policy Service users with possible or confirmed COVID-19 are isolated appropriately in designated areas as detailed in Cohort plan and Inpatient SOP IPC has inspected all cohort areas to ensure compliance with environmental requirements set out in the current PHE national guidance SWYPFT Coronavirus dedicated information pages via Intranet There has been a review of facilities for appropriate, effective isolation. This has been raised for estate capital programme to consider upgrading existing en-suite facilties.eg Sandal	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Testing is undertaken by competent and trained individuals • Patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • Screening for other potential infections takes place	SWYPFT has a service level agreement in place with BHNFT and Mid Yorkshire Hospitals for laboratory support o There is adequate lab capacity for admission, discharges and symptomatic patients. o There is adequate lab capacity for outbreaks or hotspot. o There are also options for staff testing through pillar 1 and Pillar 2. IPC are undertaking a review of the turnaround time of results. These laboratory's operate according to relevant national accreditation bodies standards IT Surveillance system operational in Barnsley, an electronic weekly surveillance system with Mid Yorks (has been daily during COVID-19)	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

	microbiology for any alert organisms and additionally support system for Calderdale and Kirklees with IPC team for any alert organisms Staff Swabbing SOP and Inpatient SOP		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Staff are supported in adhering to all IPC policies, including those for other alert organisms • Any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • All clinical waste related to confirmed or	Policies are in line with Assurance framework in the Health and Social Care Act (2008) and all IPC Policies are in date (20/7/2020) Information received via the COVID-19 email account and communicated via Silver command and comms and SOP's updated accordingly. IPC Policies and Guidance available on the Intranet	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

possible COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	IPC Quality Improvement Programme in place; policies are routinely audited to seek assurance on compliance, to identify gaps, enable robust action plans to be determined and put in place to rectify any identified issues. Action Plan outcomes are sought to collate lessons learned and improvements made Localised SOPs and Guidance created in response to COVID-19 SOP- management of MH/LD patients during COVID -19, including cohort plan and physical health management SOP - Laundering of staff clothing and scrubs The Trust waste management Policy and the IPC Community and Inpatient SOP's PPE stock is held by procurement and process managed by operational staff.		

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• Staff in 'at-risk' groups are identified and managed appropriately, including ensuring their physical and psychological wellbeing is supported • Staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained • Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	All staff have access to Occupational Health services Policies, procedures, guidance, dedicated support provided along with information on how to access services, self-support on the staff Intranet Risk assessment for vulnerable groups, pregnant staff, shielded staff etc. within OH guidance and National directive – intranet well-being pages, support contact numbers Work health assessments in place Staff health and well-being offer Antigen testing and antibody testing for staff Sign up to the national SIREN study	No gaps noted in this domain from our internal assessment. This has been validated by an external review by the CQC.	Not applicable.

All staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical area Consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas Staff absence and wellbeing are monitored and staff who are self- isolating are supported and able to access testing Staff who test positive have adequate information and support to aid their recovery and return to work	Monitoring of social distancing rules by operational staff and IPC – check and challenge. We have posters displayed across the trust, regular messages are posted in chief exec bulleting. A range of information is available to staff. Q&A's are on Trust website Occupational Health Policy and Track and Trace – information on the intranet of how to access testing Information on the intranet, IPC specialist advice and Occupational health support – all documented on sharepoint		

Infection Prevention and Control Assessment

Engagement call

Summary Record

South West Yorkshire Partnership NHS Foundation Trust

Provider address	Date
Trust Headquarters Fieldhead, Ouchthorpe Lane, Wakefield WF1 3SP	15/07/2020

Dear South West Yorkshire Partnership NHS Foundation Trust

The Care Quality Commission is not routinely inspecting services during the pandemic period and recovery phase, although we will be carrying out some focused inspections. We are maintaining contact with providers through our usual engagement calls and by monitoring arrangements such as those for infection prevention and control.

This Summary Record outlines what we found during an engagement call to discuss infection prevention and control arrangements, using standard sentences and explanatory paragraphs.

We have found that the board is assured that the trust has effective infection prevention and control measures in place. The overall summary outlines key findings from our assessment, including any innovative practice or areas for improvement.

This assessment and other monitoring activity are not inspections. Summary Records are not inspection reports. Summary Records are not published on our website.

Infection Prevention and Control – Assessment areas

1. *Has the trust board received / undertaken an assessment of infection prevention and control procedures and measures in place across all services since the pandemic of COVID 19 was declared. Does this include an assessment of the estate / isolation facilities?*	
Yes	The Board had received/undertaken a clear and comprehensive assessment of Infection Prevention and Control across all services including an assessment of the estate and isolation facilities.

2. *Are there systems in place to manage and monitor the prevention and control of infection? Do these systems use risk assessments and consider the susceptibility of service users, and any risks that their environment and other users may pose to them?*	
Yes	There are systems in place in manage and monitor the prevention and control of infection.

3. *Are there systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections?*	
Yes	There are systems in place to provide and maintain a clean and appropriate environment in managed premises, facilitating the prevention and control of infections.

4. *Is there appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance?*	
Yes	There is appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

5. *Does the trust provide suitable accurate information on infections, in a timely fashion, to service users, their visitors and any person concerned with providing further support or nursing/ medical care?*	
Yes	The trust provides suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

6. *Is there a system in place that ensures prompt identification of people who have or are at risk of developing an infection, so that they receive timely and appropriate treatment, to reduce the risk of transmitting infection to other people?*	
Yes	The trust has systems to identify promptly people who have an infection, or who are at risk of developing an infection so that they receive timely and appropriate treatment.

7. *Are there systems in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection?*	
Yes	There are systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process or preventing and controlling infection.

8. *Are there secure or adequate isolation facilities?*	
Yes	The trust has effective process in place to manage the isolation of patients appropriately.

9. Is there adequate access to laboratory support?	
Yes	There is adequate and responsive access to laboratory support.

10. *Is there evidence that the trust has policies designed for the individual's care which will help prevent and control infections?*	
Yes	The trust has effective policies designed for the individual's care which will help prevent and control infections.

11. ***Does the trust have a system to manage the occupational health needs of staff, regarding infection?***	
Yes	The trust has a system to manage the occupational health needs of staff regarding infection.

Overall summary record

From our discussion on the 15/07/2020 as well as other information about this service we assess that you are managing the impact of the Covid19 pandemic.

You said you had adequate systems and processes in place to identify and manage risks within the service. You told us about the trusts escalation processes which enabled oversight at different levels.

The trust told us they updated their policies inline with current guidance to ensure they were meeting best practice.

You provided us with examples of how you have taken steps to provide both staff, patients and carers with support during this time utilising a range of resources such as technology.

The trust felt confident they had enough PPE resource available to them and felt they had access further supplies should they require more. You provided us with examples of how you had dedicated teams working across the trust to ensure premises were safe and inline with guidance.

You provided us with examples of how you were able to isolate/cohort patients who were symptomatic or had tested positive for Covid19. The trust recognised the balance of not limiting the service provision but enabling safe spaces where they could isolate patients.

The trust felt they had appropriate laboratory support.

In addition to the current work taking place, you told us you were undertaking a survey to gather feedback from patients to help the trust understand what they could do differently and drive improvement.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 9.1

Title:	**South Yorkshire update including the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates and Director of Strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the SYB ICS and Barnsley integrated care developments.
Mission /values / objectives:	The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnerships working across the different health economies. It is, therefore, important that the Trust plays an active role in the SYB ICS.
Any background papers / previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYB ICS, including Barnsley Integrated Care Developments.
Executive summary:	**1. SYB ICS Update** The monthly Health Executive Group was re-established in June and the latest meeting was held on the 14th July 2020. The meeting started with a workshop on Equality, Diversity and Inclusion led by Richard Stubbs, Chief Executive, Yorkshire and Humber Academic Health and Science Network and Fatima Khan-Shah from West Yorkshire and Harrogate (WYH) ICS. The aim of the workshop was to start the development of a SYB ICS approach to Equality and Diversity and use the experience in WYH ICS to help shape it. **Coronavirus Update** The update on the position across SYB was that the trends were all going in the right direction with a reduction in new cases. The position on Personal Protective Equipment continues to improve and work is on-going to support primary care and ensure they have the necessary stock levels. The testing programmes are working well and there is capacity in the testing laboratories for NHS and Social Care Staff. As at the end of June 50% of SYB have had an antibody test.

Robust local outbreak management plans are in place in each of the local authorities across SYB.

Acute Trusts are continuing to work in partnership on the management and care of COVID-19 patients across the ICS.

NHS Reset

The ICS as part of the reset programme is looking to focus on resuming some clinical services stopped or reduced due to the COVID response. Cancer care continues to be one of the main priorities in SYB's system recovery plans and partners are working to review and reprioritise patients.

Service and Financial Planning

Further NHS planning guidance and a financial framework are expected in mid-July. A first draft SYB System Plan, which is an amalgamation of all five Place Plans, is currently in development. It takes into account constraints such as workforce, estates management, infection control and PPE while also incorporating examples of best practice in SYB and nationally. There will be a final submission at the end of July.

To support the planning process, a workshop to stress test the restoration of broader health and sustainment of care services in a COVID environment with partners took place on 1st June. Feedback from the session was very positive, with the learning now being built into local plans.

Identifying and embedding transformational change across SYB and capturing learning from the Covid-19 crisis

The ICS Programme Management Office is working with the Yorkshire and Humber Academic Health Science Network to capture views of senior leaders and colleagues from across SYB's health and social care organisations to feed into the joint project: 'Identifying and embedding transformational change across SYB and capturing learning from the Covid-19 crisis'. To accurately capture and understand the innovation that is emerging, views are being gathered from those directly involved in the implementation of the rapid changes through an extensive consultation exercise.

2. SYB ICS Mental Health, Learning Disabilities and Autism programme

The ICS Mental Health Executive steering group has a number of programmes of work, below is an update on some of these

	programmes. The Programme group has now reconvened meeting monthly and the CEOs from the mental health provider trusts continue to meet virtually bi-weekly to share information and explore mutual aid arrangements. The Programme team have held a workshop to support recovery planning and reprioritisation of the programmes. Members from this group have also contributed to the ICS recovery planning workshop and stress test workshop for scenario planning. **Individual Placement and Support (IPS)** - The SY&B IPS wave 2 roll out is progressing well with South Yorkshire Housing (SYHA) as the lead provider and coordinating the mobilisation process. The two SWYPFT roles recruited to cover Barnsley and their SYHA colleagues are now well embedded within the secondary care teams which is vital in promoting their work and generating referrals. The partnership agreement, data sharing agreement and collaboration agreement between SYHA and the Trust have been agreed and signed. **Mental Health Liaison and Crisis Care** - The Trust in partnership with Barnsley Clinical Commissioning Group (CCG), secured transformation funding from NHS England as part of the SYB ICS. One bid (circa £500,000) was to enable the all-age mental health liaison service to achieve 'Core 24' status and the second bid (circa £231,000) was to enable Barnsley to enhance alternatives to crisis support to be delivered through an extension to its current IHBT provision; in terms of resources and skill mix and in accordance with Fidelity to the Model. Prior to Covid-19 recruitment and mobilisation was underway in relation to all the new investment and in terms of the additional Core 24 resources. All posts have been advertised with the exception of the consultant roles and although initially delayed by Covid-19 recruitment is now being progressed. **NHS England specialised commissioning Lead Provider Collaborative** - The Specialist Forensic providers across the ICS are working together to develop a Lead provider model for Forensic services. The bid submitted to NHSE by the partners was on the development track with a gateway review / sign off by April 2020, with the intention of going live from October 2020. However, due to Covid-19, the timescales will not continue as planned and a review of the appropriate timeline for implementing development track collaboratives is underway by NHS England. The Trust is not a partner in the delivery of the model in South Yorkshire (Lead for the equivalent model in the West Yorkshire Health

	and Care Partnership) however will continue to work with providers in South Yorkshire to ensure that pathways in to care and the impact on community services is considered as part of the development phase. Providers of Eating Disorder Services across the ICS are working together to develop a Lead provider model. The bid submitted to NHSE by the partners was also on the development track with a gateway review / sign off by April 2020, with the intention of going live from October 2020. However, as above, due to Covid-19, the timescales to be reviewed for implementing development track collaboratives is underway by NHS England. The Trust is not a partner in the delivery of the model in South Yorkshire however is actively involved in meetings to ensure alignment of the model to our services. Workshops have now been arranged for August with colleagues from SWYPFT participating to develop and agree the clinical pathway. The **Quit programme** A band 8a lead – two year fixed term and working 15 hours per week - has been recruited. Other planned recruitment i.e. band 6 post working 15 hours per week and three band 3 support posts (2.5 wte) and a band 3 admin was postponed as Yorkshire Cancer Research was unable to release funding due to Covid-19 restrictions. The Trust is now exploring options to progress at risk. The band 8a has focused on setting up internal QUIT systems, processes, IT, training, data collection etc. and has also developed a pathway for ward staff to access free NRT. A development positively received by staff. An internal QUIT steering group is in place which is strongly linked in to the wider local and ICS wide systems. **Bereavement support** A Bereavement and trauma support service for the wider public and health care professionals has been set up across the ICS footprint and will be reviewed to assess impact. The service is commissioned until 31 December 2020 and is being closely monitored by the SYB suicide prevention steering group. Barnsley has now had 14 residents utilise the service. **3. Barnsley Integrated Care update** All partners across Barnsley continue to work together to develop a joined up response to Covid-19. Partnership arrangements are in place to support decision making as close to the front line as possible. Community services continue to provide care as close to home as possible working with primary care, social care and the wider CVS.

	The integrated Care Partnership has resumed and is overseeing the development of the place based stabilisation and recovery plan, the key priorities for the partnership have been agreed through the partnership. The system priorities build on the work that the partnership progressed over the last two years and that has been accelerated through the Covid-19 response phase. The 5 priorities include sustain joined up response to Covid-19, continue to support vulnerable, complex, shielded people, data and intelligence to continue to understand the impact of Covid, recovery and reset of priority services (lock in transformation and change), and system financial sustainability. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYBICS and Barnsley integrated care developments.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 9.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships update**
Paper prepared by:	Director of Strategy & Director of Provider Development.
Purpose:	The purpose of this paper is to provide the Trust Board: 1. With an update on the development of the West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) response to Covid-19; and recovery and reset 2. Local Integrated Care Partnership developments in response to Covid-19 and recovery and reset.
Mission/values:	The development of **joined up care and response to Covid-19** through **place-based arrangements** is central to the Trusts delivery of responsive services and support in places at this time. 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 strategic and operational developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**.
Any background papers/ previously considered by:	Strategic discussions and updates on place based plans and developments have taken place regularly at Trust Board including an update to June 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): The Trust has continued to work as a member of the partnership. **WYH HCP recovery and reset planning:** The Partnership has continued to progress recovery and reset planning. A series of world café sessions have been held to support place based plans to be developed and a workshop to stress test plans for a range of scenarios has also been held. **WYH Independent Review Impact of Covid-19 on our communities and workforce.** An Independent review chaired by Professor Dame Donna Kinnair has been commissioned by the chair of the Partnership Board Councillor Tim Swift. The review will focus on the partnership plans and work being progressed as well as identifying any gaps. The review will be conducted over four meetings commencing mid-July and concluding

	with a report setting out the outcomes of the review and recommendations for the partnership to take forward. **Mental Health, Learning Disabilities and Autism programme** The Programme Board has reviewed the Programme's 8 core work streams in the context of the impact of Covid-19. The Trust Board was appraised at the June meeting on the work that the Programme Board is now progressing. Additional issues discussed at the July Programme Board meeting are summarised in the report. **Adult Secure Lead Provider Collaborative (LPC)** There is a separate agenda item on the Board agenda in respect of this. **Place based response to Covid-19** We continue to work with partners to develop and deliver joined up Covid-19 response and support in each of the places that we provide services. The place based work is largely directed through the multi-agency Command structure, within which the Trust is either represented directly or through the CCG representing the whole health community (as in Wakefield Gold Command). We also continue to contribute to placed based recovery and reset planning. **Risk Appetite** The development of the partnerships response to Covid-19 and the development and delivery of place-based arrangements and response is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the updates on the development of the West Yorkshire and Harrogate Health and Care Partnership and place based arrangements in response to Covid-19 and recovery and reset planning.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - update
Trust Board 28 July 2020

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.

2. Background

Led by the Trust's Chief Executive, Rob Webster, West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) 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.

3. WYH HCP recovery and reset planning

The Partnership has developed a framework to support places to develop their local recovery and reset plans. The framework was shared with Trust Board at the last meeting. Significant work has been undertaken to ensure that there is a joined up response to the pandemic and recovery planning in each of our places and across the partnership. A series of World Café workshops have been held in each place and a stress testing and planning workshop based on a number of scenarios was also held in July. During the Partnership workshop that was supported by senior military personnel that have been supporting the NHS, each local area presented their plans for colleagues to ask questions and test the validity of the response. Common themes that emerged, including addressing health inequalities, supporting families and carers, children and young people with mental health concerns, the need to maintain agility and capacity to respond to a surge in activity, innovation, need and demand were all discussed, for example long-term health management. **The Trust contributed to the planning in each of the places both for the place based recovery and reset priorities as well as the stress test planning. The outcomes of both of these pieces of work will be considered within the Trust recovery and reset planning that is also continuing.**

4. WYH HCP Health Inequalities and Covid-19

The partnership five year plan sets out ambitions to reduce the gap in life expectancy by five percent in the most deprived communities by 2024; reduce inequalities in life expectancy for people living with mental health conditions, learning disabilities and autism; reducing health inequalities for children living in households with the lowest incomes, and reducing suicide by 10 per cent, whilst strengthening local economic growth and improving skills. In response to Covid-19 the Partnership will continue to build on these ambitions, to target efforts towards

those who need support the most. A preventative approach will be embedded across the partnership priority programmes. **The Trust is leading on the Suicide prevention programme on behalf of the partnership and as a partner in the mental health, learning disability and autism programme has contributed to the development of a bereavement support service as well as a mental health and well-being support line for the wider public.**

The ICS has made £503,000 health inequality funds available to voluntary and community organisations to help tackle the impact on people's health affected by Covid-19, including towards supporting Black, Asian and ethnic minority communities (BAME). From over 80 applications, thirteen groups will receive this funding with further support being identified by WY&H HCP to help those not successful in this round, move forward. **The Trust is a partner in the successful health inequalities bid that was led by Voluntary Action Calderdale.**

5. Independent Review- Impact of Covid-19 on BAME communities and workforce

National evidence has highlighted the differential impact of Covid-19 on staff and communities from black and minority ethnic communities (BAME). The Partnership has developed a programme of work to increase the diversity of the workforce and leadership across the region. This work is supported by the partnership network made up of chairs of organisational BAME networks. Health Inequalities is also a priority for the Partnership.

An Independent review chaired by Professor Dame Donna Kinnair has been commissioned by the chair of the Partnership Board Cllr Tim Swift. The review will focus on the partnership plans and work being progressed as well as identifying any gaps. The review will be conducted over four meetings commencing mid-July and concluding with a report setting out the outcomes of the review and recommendations for the partnership to take forward.

The Trust is key partner in this programme of work and the Chair of the Trust BAME staff network is a member of the partnership network. The Trust has made some progress on this agenda with a more diverse Board, established networks and improvements in some of the Workforce Race Equality (WRES) standards. In response to the differential impact Covid has on BAME communities the Trust has carried out significant work to develop a Trust wide Equality Impact assessment and approach as well as completed risk assessments for all BAME staff. A more detailed programme of work has commenced to accelerate our plans to develop a diverse workforce as well as deliver equitable culturally sensitive services to our BAME communities.

6. WYH Ethical Frame work

The Clinical Forum has worked with clinical leads across the partnership to develop an ethical framework that can support decision making and a consistent response across the region to manging Covid-19 as well as prioritisation during the recovery and reset phase. This ethical framework builds on exiting best practice in organisations as well as more recent guidance from professional and national bodies. **The Trust has also established an internal Ethics committee and the WYH framework has been considered at this committee and is aligned to the Trust approach.**

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

The Trust Board was appraised at the June meeting on the work that the programme board is now progressing. The programme board meets monthly, and the additional issues to highlight to the Trust Board discussed at the July meeting comprised:

- Agreement to the proposed allocation of approximately £450k of carry forward Transformation Funding in 2020/21. This includes a non-recurrent allocation of £180k to support the provider development capacity for the 3 Provider Collaboratives.

- West Yorkshire CCG Commissioners developing a proposal for a Children and Young Person 24/7 crisis helpline.

- WY Learning Disabilities Steering Group established and met for the first time in July. Its purpose: To expose and address the inequalities faced by our learning disabled population, reduce variation, and improve outcomes and experience of services across the partnership in line with the NHS Long Term Plan (and the foundations set out in the Five Year Forward View).

- Provider Collaboratives: Adult Eating Disorder Provider Collaborative has received confirmation that it will 'go live' on 1 October 2020. Adult Secure Provider Collaborative is the subject of a separate agenda item on the Trust Board agenda.

8. Local Integrated Care Partnerships - key developments

We continue to work with partners to develop and deliver joined up Covid-19 response and stabilisation and recovery approach in each of the places that we provide services. The place based work is largely directed through the multi-agency Command structure, within which the Trust is either represented directly or through the CCG representing the whole health community (as in Wakefield & Kirklees Gold Command).

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**
    - **Local integrated Care partnerships - Calderdale, Wakefield and 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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 9.3

Title:	**West Yorkshire Adult Secure Lead Provider Collaborative (LPC) - Update**
Paper prepared by:	Director – Provider Development
Purpose:	To provide an update on the West Yorkshire Adult Secure LPC, including the updated national timescale for *Main Track* Provider Collaboratives. The next steps in the context of the national timescale are summarised, within which the LPC needs to submit a business case in October 2020.
Mission/values:	The development of joined up care through place-based and service plans are 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 development of operational partnerships can support the achievement of the Trust's strategic objectives – to improve health and wellbeing through an enhanced focus on prevention and early intervention; improve quality and experience through more integrated ways of working; and improve the use of resources across the whole care system, in this case those service users accessing Adult Secure services. The way in which the Trust approaches service change must be in accordance with our values. The approach is in line with our values – being relevant today and ready for tomorrow. The subject area of this paper is consistent specifically with the Trust's strategic ambitions of: a regional centre of excellence for learning disability, specialist, and forensic mental health services; a strong partner in mental health service provision across West Yorkshire and South Yorkshire.
Any background papers/ previously considered by:	The Trust Board received and approved the initial 'Application for Lead Provider Selection' at its meeting on 25 June 2019. Regular updates on the Adult Secure LPC have been received by the Board, notably at the following meetings: 29 October 2019; 26 November 2019; 28 January 2020; 31 March 2020; 30 June 2020.
Executive summary:	In 2019, the Trust applied to lead a Provider Collaborative for adult secure services in West Yorkshire. Provider Collaboratives are a partnership of mental health, learning disability and autism providers led by an NHS Lead provider working to provide specialised mental health, learning disability and autism services for a given population.

	They work in partnership to improve and standardise services, and have the flexibility to make savings and reinvest in community and step-down services to improve the whole pathway and reduce reliance on the most specialised services. The application was placed on the national "*further development track*" (now termed "*main track"*), with planned date to go live of 1 April 2021. This date remains the same post Covid-19. Originally, the application included West Yorkshire and Harrogate, but due to changes in CCG structures, the Trust has since been advised that the collaborative will not include the Harrogate population. This collaborative is one of three West Yorkshire Provider Collaboratives: Adult Secure, Tier 4 CAMHS (Led by LCH), and Eating Disorders (led by LYPFT). The Eating Disorders Collaborative will go live 1 October 2020, and CAMHS at the same time as Adult Secure. This paper summarises key points relating to: • The roles and responsibilities of the Lead Provider. • The principles relating to the clinical model. • The current governance arrangements. • The delineated commissioning function. • Finance and contracting, including mandated financial principles. • The requirements of Boards in relation to Provider Collaboratives. • Risks and benefits of being a Lead Provider. • Key Provider Collaborative milestones through to *Main Track* 'go live' on 1 April 2021. The appendix to the paper sets out two of the criteria that the final business case must meet. These two criteria relate to Board Assurance, and are brought to the Board's attention in advance of the final business case being presented for Board approval.
Recommendation:	**Trust Board is asked to** - **Receive and note the update on the Adult Secure Lead Provider Collaborative.** - **Note the current governance framework, which will be kept under review and the Board apprised of any changes.** - **Note the requirements for Board Assurance as part of the Provider Collaborative approval process, outlined in appendix 1.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

West Yorkshire Adult Secure Lead Provider Collaborative - Update

Trust Board 28th July 2020

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Adult Secure Lead Provider Collaborative (LPC), focusing specifically on developments that are of importance or relevance to the Trust.

2. Background

The NHS Long-Term Plan sets out a vision for greater local system integration and autonomy. Supporting this, specialised services will move towards more integrated commissioning with local systems. The long-term ambition is to fully join up commissioning pathways for mental health, learning disability and autism: so that coordinated decisions are made across ICSs and Provider Collaboratives and funding is used in the most effective way possible to improve outcomes for people.

Over the past two years (following the unsuccessful submission of a Wave 2 expression of interest to be a New Model of Care site), the Trust has, through the West Yorkshire and Harrogate Health and Care Partnership, developed the relationships across providers and commissioners (CCGs and specialised commissioning) with a shared vision of what we want to achieve for forensic provision in West Yorkshire.

In 2019, the Trust applied to lead a Provider Collaborative for adult secure services. Provider Collaboratives are a partnership of mental health, learning disability and autism providers led by an NHS Lead provider working to provide specialised mental health, learning disability and autism services for a given population. They work in partnership to improve and standardise services, and have the flexibility to make savings and reinvest in community and step-down services to improve the whole pathway and reduce reliance on the most specialised services.

Members of the WY adult secure LPC comprise:

- South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), as lead provider
- Bradford District Care NHS Foundation Trust (BDCFT)
- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- Cygnet Health Care (Bierley Hospital)
- In Mind Healthcare Group (Waterloo Manor, Garforth)

The application was placed on the national "*further development track*" with planned date to go live of 1st April 2021. Originally, the application included West Yorkshire and Harrogate, but due to changes in CCG structures, the Trust has since been advised that the collaborative will not include the Harrogate population.

This collaborative is one of three West Yorkshire Provider Collaboratives: Adult Secure, Tier 4 CAMHS (Led by LCH) and Eating Disorders (led by LYPFT). The Eating Disorders Collaborative will go live 1st October 2020, and CAMHS at the same time as Adult Secure.

3. Roles and responsibilities of the Lead Provider

As lead provider of the Adult Secure LPC, SWYPFT will have a number of key responsibilities as outlined below.

- **Contractual, financial and informational oversight**
    - To act as the lead provider in the Provider Collaborative and oversee the delivery of all services under the Contract with NHSE.
    - Manage the delivery of the services for the population within the available income.
    - Ensure all providers within the Provider Collaborative comply with their contractual obligations under their respective Sub-Contracts.
    - Ensure high-quality information submissions across the Provider Collaborative and submitting collated information to the Commissioner when required.
- **Strategic planning and service development**
    - Involve service users, carers, families and friends in service development and commissioning decisions.
    - Assess needs of local population and develop plans for specialist, community and step-down services, in partnership with local commissioners (Clinical Commissioning Groups / Sustainability and Transformation Partnerships (STPs) /Integrated Care Systems (ICSs), Transforming Care Partnerships (TCPs) and Local Authorities).
    - Develop and implement plans for service development and improvement including national policy recommendations and investing from savings in the overall population.
    - Work with other Provider Collaboratives and commissioners to manage pressures and capacity across the whole specialised mental health system.
    - Engage with local ICSs and other relevant stakeholders on mental health, learning disability and autism provision across pathways.
- **Clinical oversight and quality assurance**
    - Pathway management to improve experience and outcomes for service users and reduce unwarranted variation.
    - Case management for the population the Provider Collaborative is responsible for.
    - Quality assurance of all services within the Provider Collaborative, and continuously improving outcomes and experience for service users, carers and families.
    - Workforce planning and development across the Provider Collaborative, including a training strategy, covering all partners and agencies.
- **Populations with Learning Disabilities and/or Autism**
    - Ensure Long Term Plan inpatient targets are achieved.
    - Ensure spend for people with a learning disability and / or autism is spent on services for this population and is agreed with the proportionate and functional governance, which must include people with a learning disability, carers, and relevant Local Authorities.
    - Ensure reasonable adjustments are made across all services.

To support these responsibilities, the Trust will need to ensure that the Provider Collaborative has governance including agreements to support joint working and decision-making.

4. Clinical model

The overall vision for adult secure services in West Yorkshire is based on a number of fundamental principles which underpin high quality care, consistently ensuring safe, effective and efficient service user centred care.

Within these principles are specific issues relating to adult secure mental health provision to include providing care close to home, in the least restrictive setting and individualised to a person's needs. Through workshops to develop both an overall vision and incremental steps for the model a number of important themes emerged which will be critical to our approach including:

- Placing service users and carers at the centre of all we do.
- Developing a model of localised care but with specialised therapeutic input from regionally developed resource.
- Focusing on development of psychologically informed environments regardless of diagnostic category.
- Engagement as a key issue, which must include other mental health services, local authorities, a range of commissioners, third sector providers and most importantly service users and carers.
- Development of a therapeutic model which is applied consistently across West Yorkshire within inpatient and community services.
- Integration of care both within mental health services, particularly with general adult services and the criminal justice system, and with social care and third sector providers.
- Need to acknowledge areas of specific need and develop or renew strategies for future provision of care to women and those with personality disorder.

Through our close work with the Yorkshire and Humber involvement network, we have held a range of interactive workshops to engage service users and front-line staff in the development of new models, and clinical pathways.

5. Governance

As the Lead Provider, the Trust must ensure robust governance to enable the Provider Collaborative to work effectively, ensure independence of quality oversight, and transparency of decisions on investment.

This must include:

- Delineation of pathway and budget management and provider functions within the Provider organisation, with pathway and budget management functions being independent to be able to hold providers effectively to account. This must include a named Non-Executive Director and Executive Director who are accountable for the commissioning functions and separate to the Executive Leadership of the Operational provider functions.
- Appropriate governance processes, such as Board sub-committees.
- Robust procedures for management of conflict of interest.
- Agreed processes to ensure open dialogue with NHS regional teams on the quality and performance of services, and early notice of problems or issues.
- Agreed processes (for instance through involvement in Partnership Boards) for agreeing new services and investment with NHS regional teams.

- Agreed processes for dispute resolution within the Provider Collaborative.
- Experts by Experience part of governance frameworks for Provider Collaboratives and part of decision making for commissioning decisions.

It is expected all partners in the collaborative enter into a collaborative agreement (Partnership Agreement) that sets out:

- The vision and objectives of the Provider Collaborative.
- Way of working within the Provider Collaborative.
- Governance and decision-making arrangements to support joint working and collaboration.
- Risk share agreements and arrangements for the approval of reinvestment monies.
- Agreement on management costs of the Provider Collaborative.
- Specific mitigations to address informational or provider service issue risks for the Provider.

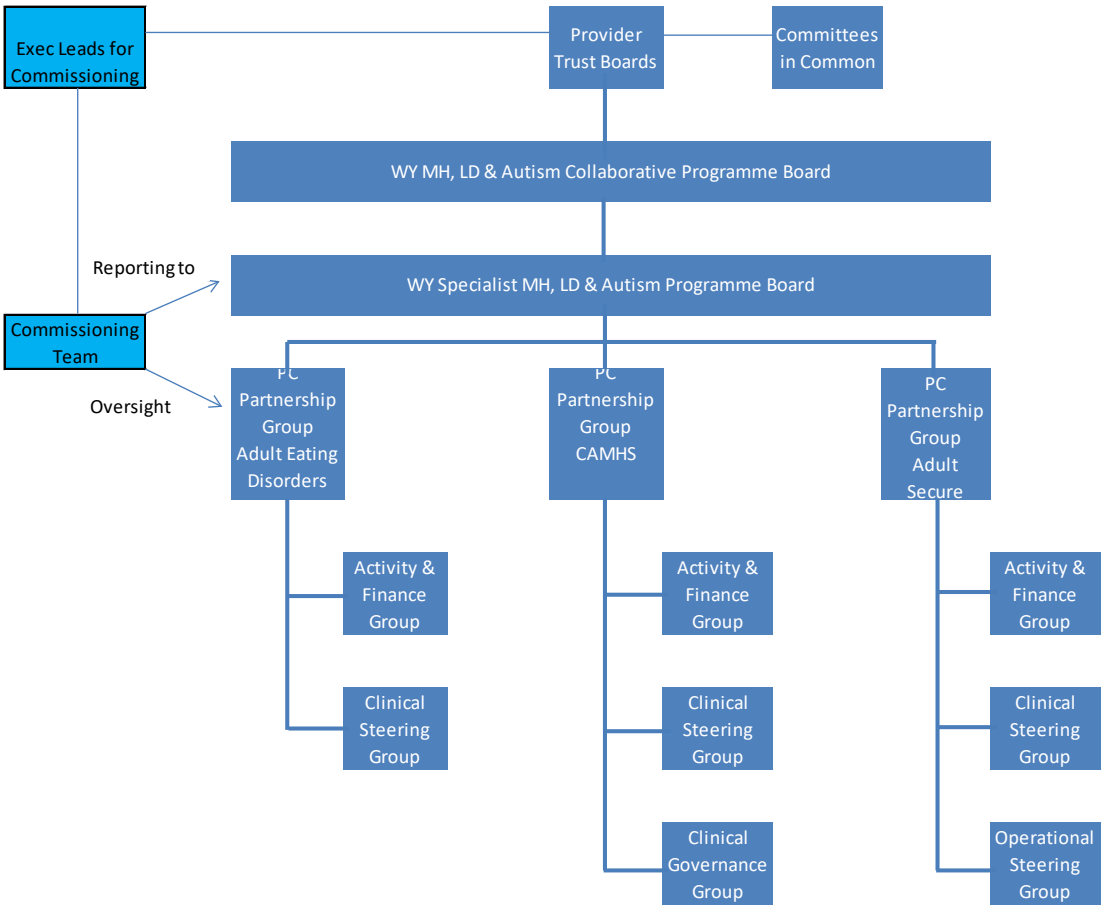
To date, the following governance structure has been established for the collaborative:

An Adult Secure Provider Collaborative Board, hosted by SWYPFT and with representation from all partners and the Involvement Network meets on a monthly basis, reporting on a monthly basis into the West Yorkshire Specialised Mental Health, Learning Disability and Autism Programme Board. The Adult Secure Board is supported by a range of sub-groups including Finance and Contracting, Operational Group, Clinical Group and Service User Involvement Forum.

The whole Specialised Mental Health, Learning Disability and Autism programme (including Adult Eating Disorders, Tier 4 CAMHS, and Adult Secure) also reports into the wider West Yorkshire and Harrogate Mental Health, Learning Disability & Autism Collaborative Programme Board and associated Committees in Common. Both forums are used to escalate issues and concerns, or to discuss alignment with local care pathways and other transformation. The Committees in Common, underpinned by a monthly face-to-face meeting between provider CEOs, is the formal place for any dispute to be resolved.

A partnership agreement which formalises these arrangements and details the roles and responsibilities of the governance groups was signed up to by all providers in draft in 2019 (see Appendix 2) and will be redrafted prior to final business case approval.

A schematic representation of the current governance structure is summarised as follows:



6. Delineated commissioning function

One of the key requirements of Provider Collaboratives (PCs) is that they must be able to demonstrate that they can clearly articulate how commissioning will be delineated from provision. There must be a clear plan for commissioning activities which includes the team responsible for commissioning activities, reporting structures and how disputes between provision and commissioning will be managed.

Representatives from the West Yorkshire NHS providers formed a working group to look specifically at the commissioning function for PCs. A discussion paper was prepared and approved by the Adult Secure Provider Collaborative Board and the West Yorkshire Specialised Mental Health, Learning Disability and Autism Programme Board.

The Trust's commissioning responsibilities as Lead Provider for the Forensics Lead Provider Collaborative (from April 2021) will be discharged through the Steady State Commissioning arrangements within West Yorkshire and Harrogate, and we are therefore proactively engaged in the work on ensuring that the Adult Secure LPC and the other two PCs have sufficient commissioning and lead provider staffing capacity to fulfil its functions.

An independent Commissioning Team (CT) will be established to discharge the commissioning responsibilities, which will report directly to the West Yorkshire Specialised Mental Health, Learning Disability and Autism Programme Board. How this will fit into the governance structure is summarised below:

The Commissioning Team will oversee commissioning for all three provider collaboratives

in West Yorkshire. It will report to the Director of Finance of SWYPFT as the Named Executive Director of the Lead Provider. Reporting ultimately goes through to provider Boards, ensuring Non-executive Director oversight.

A set of principles and values focussed around prioritising service user needs, transparency, independence and quality improvement will be established for the Commissioning Team to support the culture of the team and its interactions with operational services.

The key functions of the team will be:

- Quality assurance and improvement.
- Contractual oversight.
- Review and challenge investment decisions.
- Oversee the needs assessment and pathway reviews.
- Holding to account.
- Engagement and involvement.
- Arbitration/mediation between partners.

7. Management of Disputes Between Provision and Commissioning

There are a number of levels of conflict of interest and dispute which may arise, the key ones are outlined below.

- Service User Level

  If a service user expresses a desire to exercise their choice and access an out of area service, there is potential for conflict of interest to arise as the provider is incentivised to reduce out of area placements. The commissioner lead will fulfil the case manager role and advocate for what is best for the service user.

  There is a process in place which has been tested through the Adult Eating Disorders model that is robust and has received positive feedback from the service users who have experienced the process. Any service user wishing to seek inpatient treatment from an alternative provider (for whatever reason) is able to present their case to an independent panel for consideration. The membership of the panel includes an independent clinician, an independent commissioner, and an independent manager (drawn from partners from across the ICS). In addition, service users are encouraged to seek support from advocacy services and to bring a family member and/or carer along with their advocate to the appeal panel meeting should they wish.

- Lead Provider Level

  Disputes around investment and quality decisions may arise within the Lead Provider. The separation of a director lead for commissioning and a director lead for provision facilitates robust internal conversations.

- Provider Collaborative Level

  An escalation route is provided through the governance structure. The director of commissioning's position will have been influenced and supported by internal governance structures of the Lead Provider.

  Disputes between commissioning and provision will be managed through the WY Specialised Mental Health, Learning Disability & Autism (MHLDA) Programme Board. A scheme of delegation will be put in place to summarise this relationship, particularly

in relation to financial limits. If a dispute cannot be resolved in the WY Specialised MHLDA Programme Board it will be escalated to the WY&H MHLDA Collaborative Programme Board.

8. Finance and Contracting

The provider collaborative and lead provider will take on the financial and contracting responsibilities previously performed by the specialist commissioner. Key points for the Trust Board to be aware of are:

- The total contract value is in excess of £50m
- Financial risk is currently borne by the specialist commissioner including the cost of exceptional packages of care
- A finance and contracting work stream has been established with representation from all the five services providers identified in this paper
- Baseline activity and financial data for 2018/19 has been provided by the specialist commissioner and reviewed by each organisation
- It has been agreed in the work stream that more extensive financial and activity due diligence is required and work has commenced to provide this
- Updates for 2019/20 actual contract arrangements and financial performance should be available shortly as well as the financial history from 2016/17 onwards
- A financial risk and gain share will need to be in place to manage any variances in cost each year and this will need to be agreed by all boards of participating organisations
- Conversations are taking place with other lead provider collaboratives with regard to how these issues are being tackled

9. Requirements of Boards in relation to Provider Collaboratives

In order to gain approval to 'go live' in April 2021, the Provider Collaborative must submit a business case in October 2020, approved by each provider Board, which meets a series of criteria. Two of these requirements relate to Board Assurance and are set out in more detail in Appendix 1.

10. Mandated Financial Principles

As part of the assurance process, there is a requirement for Board sign up to mandatory financial principles. The implications of this are:

- Budgets will not be adjusted for the contract term.
- Cost improvement savings will be netted off future growth, so in effect budgets will be flat over the contract term. It will be necessary for the service to make a cost improvement programme (CIP) each year to offset inflationary cost pressures.
- Reinvestment decisions must be made through a partnership approach within the LPC. The process for this is set out in the LPC Partnership Agreement.
- Lead providers must hold contingency reserves.
- Arrangements around national programmes, such as Transforming Care, must be honoured.

These principles will be assessed through the financial due diligence process.

11. Risks and benefits of being a lead provider

The risks to SWYPFT of being lead provider are continuing to be identified, and a risk register will be included as part of the final business case. A summary of the key risks identified to date include:

- Being responsible for service delivery across all providers. This is a significant risk. In the case of Adult Secure Services, this will involve oversight of services provided by SWYPFT and four other providers. SWYPFT will be responsible for clinical oversight and quality assurance, so robust structures and processes will have to be put in place to delineate commissioning and provision functions to facilitate appropriate check and challenge.
- It is proposed that PCs would be responsible for quality assurance of independent sector inpatient units. This is a significant risk. We are working with NHSE to clarify the precise requirement of PCs in relation to independent sector providers.
- Current NHSE staff will transfer to PCs under the Transfer of Undertakings (Protection of Employment) (TUPE) Regulations (although the timescale of this is uncertain with NHSE indicating that TUPE processes may not take place until after PCs have gone live and that current employment arrangements may continue as an interim position). Early indications from NHSE are that supplier manager resources will not be transferred, but case managers will be. There is at present sufficient case management support to transfer for Adult Secure. There is a risk that SWYPFT will have to resource the integrated commissioning team (along with the other NHS Trusts) in the short term, and this risk is materialising with a need identified to support commissioning capacity with non-recurrent funding.
- There is a financial risk involved in being the Lead Provider for services with a significant commissioning budget. This is a significant risk. We will need to develop risk share arrangements for the PC, and potentially across the PCs in West Yorkshire. Demand increase, the availability of beds and the efficiency challenge could create cost pressures in the future, and an approach to how these will be managed needs to be agreed between the PC partners.
- Reputational risk to achieve objectives and service quality.

The benefits to SWYPFT of being lead provider include:

- Achievement of our strategic ambition to be regional lead provider for forensic services.
- Flexibility to lead, influence and improve pathway design and patient flows, working across the bed base and community pathways to improve patient care.
- Opportunity to shape the future of specialised service provision.
- Strengthen relationship with commissioners.

12. Timescales

Due to Covid-19, Provider Collaboratives on the *development* and *further development* tracks have been moved onto the *Main Track* aiming to go live in April 2021. This was confirmed in the NHSE/I paper – 'Provider Collaborative Selection Process: Development and Approval Phase for the Main Track', issued on 15 July 2020. The *Main Track* timescales identified in this paper are summarised below:

Key PC Milestones	Main Track PCs	Lead/Remarks
Details of Approval Panels to Lead Providers	From August 2020	Regional teams
Regional HR submissions to EHRSG	September 2020	NHSE/I Regions with National Team support. Followed by Trade Union scrutiny.
Issue refreshed financial allocations	September 2020 – TBC	National/regional team
Submissions to Approvals panels	Early November 2020	Lead Providers
HR Consultation launched	Early November 2020	Regional teams
Approvals panels held	November 2020	Regional teams/Lead Providers
ISAP/TR process (if required)	January 2021	Regional teams/Lead Providers
Contract negotiation	January 2021	Regional teams/Lead Providers.
Main track go live	**1 April 2021**	

13. Recommendations

The Trust Board is asked to **receive and note** the update on the development of the Adult Secure Provider Collaborative.

The Board is asked to **note** the current governance framework for the collaborative, and the relationship with the commissioning function. These governance structures will be kept under review, in the context of further national guidance and collaborative discussions, and the Board will be appraised of any changes. A final governance structure will be included as part of the business case submission due later this year. It is expected Board approval of the governance arrangements will be requested at September 2020 Board. To note are the requirements for:

- Risk share developed by all partners.
- Robust finance and contracting arrangements.
- Clarity on responsibility for the independent sector providers.
- Sign up to mandated financial principles.

The Board is asked to **note** the requirements for the Trust Board as part of the Provider Collaborative approval process outlined in Appendix 1.

A further update will be provided at September 2020 Board.

Appendix 1: Provider Collaborative Assurance Criteria in relation to Board Approval

Provider Criteria 1- Board assurance (commitment)

Domain	Criteria	Evidence base
Board Assurance (commitment)	The Lead Provider must demonstrate that there is Board level commitment.	The provider must demonstrate that there is Board level commitment for assuming the requisite accountabilities as detailed within the Lead Provider Roles and Responsibilities document, at minimum for the lifetime of the contract.
	Selection phase evidence	**Approval phase evidence**
	Letter from board setting out commitment and plans to put appropriate governance in place.	Board Papers within the last 3 months.
Threshold	**Compliant**	❑ Board papers demonstrate thorough discussion of the implications of being lead provider, with effective assessment of the risks and benefits to the organisation ❑ The Board have approved the business case for submission ❑ Risk share agreements have been reviewed by the Board ❑ Letter from the Board setting out commitments to lead provider ❑ Governance frameworks signed off by the Board ❑ Evidence of discussion with the Board from April 2019
	Partially compliant	•Letter from the Board supporting the commitment to be lead provider •Some evidence of discussion at Board meetings •The Board have approved the Business Case •Risk share discussions have taken place with Board
	Non-compliant	•Board supportive in principle/not supportive •Board require more time to review the implications •Board have not considered risks and benefits •Board have not approved the Business Case

Provider Criteria 2- Board assurance (clinical and operational leadership)

Domain	Criteria	Evidence base
Board Assurance (clinical and operational leadership)	The lead provider must have clinical leadership in place for all pathway(s). This must include learning disability and autism where relevant (for further information regarding expectations around pathways for learning disability and autism please see 4.12 in Annex B of the Guidance Note). The Lead Provider Board must have a named Executive Director that has overall leadership for planning and commissioning of services as part of the partnership. The named Executive Director must not be accountable for the delivery of the services under the partnership arrangements. Appropriate Non-Executive Oversight should be in place.	Executive Director accountable for Planning and Commission Services named in Board Papers and Job Description. Clinical leadership for all areas clearly set out in governance arrangements and partnership agreement. The board must have appropriate Non-Executive assurance and oversight of delivery for both provision and commissioning, which should be delineated.
	Selection phase evidence	**Approval phase evidence**
	Letter from board setting out commitment and plans to put appropriate governance in place.	Job Descriptions, Board Papers and organisational charts.
Threshold	**Compliant**	❑ Named Executive Director on lead provider board – evidenced in Board papers ❑ Final partnership agreement to name Executive Director accountable for delivery of services across the partnership ❑ Clinical Governance framework in draft, including named clinical lead for each pathway with evidence of commitment for co-production ❑ Final governance arrangements include Non-Executive Director oversight ❑ Job Description in place for Named Executive Director ❑ Clarity in governance regarding how commissioning activities will be overseen and the Board assured
	Partially compliant	•Named Executive Director and Clinical Leads •Governance articulated by framework not fully developed •Non-Executive and Board assurance of provider collaborative not yet ratified by Board •Commissioning activities included in framework but not fully developed
	Non-compliant	•Governance framework not developed •Clinical leadership not yet agreed •Named Executive not yet developed, no Job Description

Appendix 2: Draft partnership agreement

Annex 4- draft partnership agreemer

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020

Agenda item 9.4 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Meetings scheduled for 26 November 2019, 23 January 2020 and 23 April 2020 all cancelled. Next meeting scheduled for 6 August 2020.
Member	Chief Executive / Director of Strategy
Items discussed	• Barnsley Children & Young Peoples Plan 2019-2022. • Barnsley Safeguarding Children Board Annual Report. • Barnsley Safeguarding Adults Board Annual Report. • Health and Wellbeing Board Review. • Joint Strategic Needs Assessment. • Better Care Fund 2019/20 Submission. • Advancing our health: prevention in the 2020s – consultation document. • South Yorkshire and Bassetlaw Integrated Care System 5 Year Plan.
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	11 June 2020
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	• Summary of impact of Covid-19. • Approval of West Yorkshire and Harrogate Memorandum of Understanding. • Early years peer review. • Impact on producing the Pharmaceutical Needs Assessment (PNA) due to Covid-19. • Forward plan.
Minutes	Papers and draft minutes (when available): https://www.calderdale.gov.uk/council/councillors/councilmeetings/index.jsp

Kirklees Health and Wellbeing Board

Date	4 June 2020 and 16 July 2020
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Implications of Covid-19 for Kirklees. • Kirklees wide approach to inequalities. • Kirklees outbreak control plan. • Progress on establishment of Integrated Health and Care Leadership Board. • Stabilisation and reset across Kirklees Health and Social Care System. • Learning and evaluation – shaping the future of public services in Kirklees. • Pharmaceutical Needs Assessment update.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?XXR=0&Year=2020&CId=159&MD=ielistmeetings

Wakefield Health and Wellbeing Board

Date	Meeting scheduled for 11 June 2020 cancelled. 9 July 2020
Member	Chief Executive / Director of Provider Development
Items discussed	• Focussed discussion – Wakefield Health and Care System learning from Covid-19 and planning for the future state. • The impact of Covid-19 on Health and Wellbeing priorities. • The impact of Covid-19 on health inequalities in Wakefield. • The impact of Covid-19 on carers in Wakefield. • Tackling inequalities through employment.
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	11 October 2019 (meeting scheduled for 13 March 2020 cancelled)
Member	Chief Executive
Items discussed	➢ Public Health Update ➢ Priorities for joint working for local authorities: Complex Lives ➢ Developing the ICS focus on the Voluntary and Community Sector ➢ New arrangements for CPB ➢ Developing the South Yorkshire and Bassetlaw 5 Year Strategy 2019 – 2024 ➢ ICS Finance Update ➢ ICS Highlight Report ➢ Sheffield City Region team on the Health Led Employment Trial
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership Board

Date	2 June 2020
Member	Chief Executive
Items discussed	• Gathering people's experiences and feedback during the Covid-19 pandemic. • Understanding the direct and indirect impacts of Covid-19 on difference population groups. • Supporting system stabilisation and reset. • West Yorkshire devolution and economic recovery.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

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Trust Board 28 July 2020
Agenda item 10.1

Title:	**Covid-19 – Emergency Preparedness Resilience and Response (EPRR) Arrangements**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates and Director of Strategy
Purpose:	This paper updates the Board in respect of the Covid-19 EPRR arrangements in response to the coronavirus outbreak.
Mission / values:	The EPRR work stream is in place to ensure that the Trust can operate safely in a period of uncertainty and looks at key areas which could be affected. The work is part of wider planning at national level.
Any background papers / previously considered by:	Executive Management Team (EMT) and Operational Management Group (OMG) are receiving updates from the command groups.
Executive summary:	**Trust Command Arrangements** The Trust continues to operate a command structure, in accordance with its incident management plan, in response to the pandemic. These arrangements are continual reviewed in light of service needs and pressures and a decision has been taken to move to a weekly Gold Command. **Operational Pressure Escalation Level (OPEL)** The Trust continues to operate at OPEL 2 particularly given pressures on the Mental Health inpatient beds. **COVID Related Risk Assessments** The Trust has developed a roll out programme for the completion of COVID staff risk assessments, for the whole workforce, based on known risk factors. The highest risk group included BAME and Pregnant Staff and for these two staff groups a 100% of risk assessments have been completed. The Trust is currently at 98.3% for Shielded Staff. The aim is to have completed risk assessments for all staff by 31 July 2020. In support of this aim a self risk assessment tool has been developed by the Trust and to date over a 1500 staff have completed it. All COVID environment risk assessments have been completed. **Business Continuity Planning** The Trust continues to update its Business Continuity Plans in light of a potential second surge of the coronavirus. These plans will be supported by national and regional scenario planning that has taken place on a second surge over the winter period.

	The Director of HR, OD and Estates and the Director of Strategy are developing stress testing arrangements within the Trust in preparation for the winter and a possible second surge of the coronavirus. **Risk Appetite** This plan is in line with the Trust's risk appetite for both clinical services and emergency planning.
Recommendation:	**Trust Board is asked to NOTE the contents of the report.**
Private session:	Not applicable

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COVID-19: Emergency Preparedness Resilience and Response (EPRR) Arrangements Update

1. Introduction

This paper provides an update for the Trust Board on the ongoing arrangements within the Trust in response to COVID-19 and the key developments.

2. Command Arrangements

In line with the Trust's major incident plan a series of command arrangements were introduced. These arrangements are reviewed on a regular basis and since the last Board meeting, Gold Command has moved to once a week, on a Friday. Silver continues to meet twice a week (Monday and Thursday) and Bronze Command arrangements continue to be reviewed at an operational level.

The Gold arrangements within our local authorities at the present time are:

- Barnsley: 2 times a week with one meeting focusing on COVID and the second on recovery.
- Kirklees: Have re-established the gold command and it now meets weekly
- Calderdale: Fortnightly
- Wakefield: Weekly

3. Operational Pressure Escalation Level (OPEL)

The Trust reviews the overall OPEL level on a weekly basis using the individual service reviews of their OPEL level. The Trust's OPEL remains at 2 due to pressure in Mental Health Inpatient beds and staffing pressures in some areas. The breakdown of OPEL for Mental Health Inpatients are as follows:

- Acute Adult MH beds are 100% occupied; (Opel 3)
- Older Acute Adult MH beds are at 74% occupancy (additional 7% of beds are closed); (Opel 1)
- Psychiatric Intensive Care beds are at 81% occupancy; (Opel 1)
- Specialised Commissioning MH beds are at 93% occupancy. (Opel 2)

All other BDU's are at OPEL 2 and Support Services remain at OPEL 1

Attached is the Trust's OPEL framework.

The OPEL levels for partner organisations are:

- Barnsley Acute Trust: OPEL 2
- Mid Yorkshire Hospital Trust: OPEL 1 but under review
- Calderdale and Huddersfield Acute Trust: OPEL 2
- Bradford District Care Trust: OPEL 2
- Leeds and York Partnership FT: OPEL 3

4. Risk Assessments

4.1 Staff Risk Assessments

The Trust has an agreed a roll out plan for completing risk assessments for all Staff, including Bank Staff, prioritised using known risk factors. Risk stratification using the most up to date evidence on known on risk was used to prioritise staff groups for risk assessments as follows:

Group 1

- Pregnant Staff: 100% completed
- BAME Staff: 100% completed
- Shielded Staff: 98.3% completed

Group 2 (to be completed by 24 July 2020)

- Staff Over 70 years old: 20.8%
- Staff with known health conditions: subject to self-declaration
- Staff who have recently become pregnant: subject to self-declaration

The Trust does not hold records of members of staff underlying health conditions so this is subject to them declaring this to their manager. Also staff who have recently become pregnant will not be known unless they self-declare. Therefore the completion rates for these staff will be include in the final overall numbers of completed risk assessments.

Group 3 (to be completed by 31 July 2020)

- All Staff between 60 years old and 69 years old
- Male Staff between 50 years old and 59 years old

Staff in this group have been asked to complete a self-risk assessment.

Group 4 (to be completed by 31 July 2020)

- All staff not previous covered in groups 1,2 and 3

Staff in this group have been asked to complete a self risk assessment.

To date there have been over 1500 self risk assessments completed for Groups 3 and 4.

In line with national guidance staff that refuse a risk assessment and/or do not self-declare they have an underlying health condition are excluded for the national return.

4.2 Environment Risk Assessments

The Trust has now completed environment risk assessments for all its buildings.

5. Business Continuity Planning

5.1 Academy of Medical Science Report: Preparing for a challenging winter 2020/2021

The Government asked the Academy of Medical Science to look at and report on what might be a reasonable worst case scenario for this winter given the potential of a second surge of coronavirus and the normal seasonal flu.

A reasonable worst-case scenario for this winter is set out in the report, and includes a resurgence of COVID-19, which might be greater than that seen in the spring. The scenario worked through involved:

- A large resurgence nationally of COVID, with local and regional epidemics
- Disruption to the health and care system due to responding to COVID
- Backlog of non-COVID care
- A possible flu epidemic at the same time

In response to this possible worst case scenario the report recommends:

- Processes for minimising transmission needs to be in place and strengthen
- Rigorous infection control procedures in health and social care settings
- Improving public health surveillance
- Increased flu vaccinations

This report is being used as part of updating business continuity plans within the Trust. It will also be part of a workshop to stress test the Trust's response to a second surge of the coronavirus.

5.2 Stress Testing Plans for Second COVID Surge and Winter

The Trust was part of two stress testing exercises supported by the military across South and West Yorkshire. These workshops involved a number of different scenarios related to a second surge of the coronavirus.

The learning from these two workshops will also form part of the Trust's own stress test exercise in preparation of a second surge over the winter period.

Alan Davis
Director of HR, OD and Estates

South West Yorkshire Partnership NHS Foundation Trust

Operational Pressures Escalation Levels (OPEL) Framework

Purpose

The paper provides the background and rationale for the OPEL framework and considers how this is applied to SWYPT during the current COVID-19 pandemic.

Gold command is asked to note the report and the next steps and provide comments before the paper is shared with Silver and Bronze command groups.

Background

The OPEL framework was introduced by NHS England as a single, national system to bring consistency to local approaches, improve management of system-wide escalation and encourage wider co-operation in a more effective manner.[1]

The objectives of OPEL framework are to:

- Enable local systems to maintain quality and patient safety
- Provide a nationally consistent set of escalation levels, triggers and protocols
- Set clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at local level (providers, commissioners and local authorities), by Directors of Commissioning Operations (DCO) and NHS Improvement sub-regional team level, regional level and national level
- Set consistent terminology

OPEL shares common actions with the NHS England Emergency Preparedness, Resilience and Response (EPRR) framework. As an incident evolves its level may be described as identified in the table below.

This framework has been developed for operational pressures and is applicable all year round, not just in response to winter pressures, and has been used in the current COVID-19 pandemic.

[1] OPEL Framework, (V1.0) introduced 31st October 2016

Four phase approach

The 4-phased approach to OPEL levels is outlined in the table below,[2] where Level 1 is less serious and can be managed locally and Level 4 is very serious and requires a national response.

Alert	Activity	Action	NHS England Incident Levels	
Alert	Dynamic Risk Assessment	Declaration of Incident level	1	A health related incident that can be responded to and managed by local health provider organisations that requires co-ordination by the local CCG
			2	A health related incident that requires the response of a number of health provider organisations across an NHS England local area team boundary and will require the NHS England Local Area Team to co-ordinate the NHS local support
			3	A health related incident that requires the response of a number of health provider organisations across an NHS England region and requires NHS England Regional co-ordination to meet the demands of the incident
			4	A health related incident that requires national co-ordination to support the NHS and NHS England response

Implications for SWYPT

The OPEL framework has been used in SWYPT in response to the COVID-19 pandemic since the Gold, Silver and Bronze command structure was set up in March 2020.

Silver command, as the tactical-operational level forum, considers the Trust OPEL level at each meeting and reports this to strategic Gold command and OPEL level decisions are disseminated through Bronze command groups.

On the 24th April 2020, a meeting of Silver and Gold Command colleagues met to discuss the current and future implications of using the OPEL framework during the different stages of COVID-19 pandemic.

It was noted that healthcare partners across the West and South were at varying levels of OPEL due to variance in interpretation and implementation within their respective organisations. It is a further point of note that new national guidance is to be published in response to the variance of interpretation.

It was agreed that SWYPT needed to identify how OPEL levels are interpreted and subsequently embedded within the Trust, along with the associated trigger points; followed by reviewing the approach to recovery, business critical issues and next steps.

Work was already ongoing to engage operational staff in determining OPEL levels and this would continue to confirm local-level BDU criteria and trigger points (See appendix 2).

It was acknowledged that connectivity across partner systems as well as internal systems is vital for successful support programmes and OPEL implementation and agreed that we should identify overarching key principles to be able to take a systems view.

[2] NHS England EPRR Framework 2015

The OPEL levels would be key in the recovery and restoration of Trust services and this process would be in three stages:

1. Reflection on Incident Management
2. Stabilisation whilst plan for recovery and the new normal
3. Recovery

The OPEL framework for SWYPT is developed to reflect operational responsibilities and accountabilities to ensure it is fit for purpose beyond COVID-19.

Criteria and trigger points for the OPEL framework are based on the principle of safety first, with appraisal of health, safety and wellbeing risks for patients, carers and staff being at the forefront of decision making. This will be supported by consideration of the following key areas:

- Performance and patient experience
- Capacity and capability of resources
- External influences and pressures (e.g. new guidance, partners escalating OPEL levels)

Decisions on OPEL levels will be informed by evidence from key indicators (e.g. clinical cases, incidents, outcomes, staff health and wellbeing, sickness/absence, testing, complaints, bed occupancy, OH referrals) and a SWYPT-specific dashboard is being explored.

Using the above, a Trust wide 4-phase response has been developed (Appendix 1) and a service-specific 4-phase response has been prepared by respective BDUs (Appendix 2). These will be reviewed and updated as required as circumstances dictate.

Next steps

- Share with Recovery and Restoration group for comment
- Receive national guidance and review implications for SWYPT approach; ETA TBC
- Ongoing work to refine the Trust wide and Service-specific 4-phase criteria and trigger points
- Develop Corporate Services 4-phase criteria and trigger points
- Report against criteria and trigger points in Silver Command to inform judgements and decisions about retaining, escalating or de-escalating OPEL levels and responses
- Develop SWYPT specific COVID-19 dashboard to inform decision making
- The Emergency Preparedness, Resilience and Response (EPRR) Team, will learn from COVID-19 response to strengthen the BCP suite going forward by way of implementing an overarching BCP that encompasses the OPEL system and recovery process and will:
    - Write and implement a Trust wide Business Continuity Plan and Recovery Plan;
    - Consult with BDU and Operational leads with a view to implement an electronic Situation Report system via SharePoint to monitor local BDU OPEL levels, to inform daily Trust OPEL levels;
    - Local BDU trigger points to be reviewed to ensure generically focussed and not linked directly to COVID-19, for continuous use.

Recommendation
Gold command is asked to note the report and the next steps and comment before the paper is shared again with Silver and Bronze command groups.

Appendix 1 Trust wide 4-Phase Response

Steady State **OPEL One**

There may be the potential for emergency to arise, or an emergency may be unfolding, or have escalated in a small number of cases in the locality or nationally. SWYPFT is ensuring preparedness to respond and escalate appropriately.

- All service delivery is normal or manageable. Refine the planning and preparedness process.
- Develop the practical mechanisms of the plan.
- Implement the framework.
- Complete audit tools to assist the modelling and management of the emergency.
- Gap analysis of the plan and preparedness.
- Training, communicating and validation exercises.
- The Incident Control Team (ICT) assumes Tactical (Silver level) command and control
- Strategic Command (Gold level) will be consulted, and will make the decision to escalate the phases.

Moderate Pressure **OPEL Two**

The emergency may be affecting SWYPFT in a discreet number of activities or services, compromising the provision of service.

- Activation of service BCPs.
- At this level, affected services will remain manageable, in the main.
- Affected services will be supported and monitored by the Silver Command
- Gap analysis of the practical applications, training, communicating and validation exercises will be identified and continued during this phase.
- Strategic Command and Control (Gold level) may be activated at this level.
- Affected services will have to activate their Operational Command and Control structure (Bronze level), requiring the contingent use of BCPs.
- Clear communication mechanisms will be established.

Severe Pressure **OPEL Three**

The emergency is affecting a number of SWYPFT services, compromising the provision of critical services. Staff re-deployment may be required to critical service areas.

- Service BCPs under pressure
- Numerous services affected and some services will be under threat of ongoing viability without additional staff or continuity/contingency measures being deployed. Staff may be redeployed from non-essential services.
- Some services may change 'ways of working' to support the overarching NHS response (inter agency). The ICT will support and monitor the services on a daily basis.
- This phase includes the embedding of the Trust-Wide BCP across the majority of services and the introduction of daily communication systems. Decisions may include the suspension of meetings, training, reports, performance targets, activation of critical care wards and closure of services.
- Teleconferencing briefings for General Managers and Service Managers will be introduced. Trust Strategic Command (Gold level) will be in place.
- Affected services will activate their Operational Command and Control structure (Bronze level). Local BCPs and scenario specific plans will be activated by Operational command following negotiation on service changes with the ICT.

Extreme Pressure **OPEL Four**

Major disruption to services. Critical services become the focus of plan and resource allocation.

- BCPs at risk of not maintaining safe levels of care and treatment
- This phase will involve the majority of services at some level. There will be planned closures of non-critical services.
- Critical services may be struggling to maintain delivery. The ICT will support and monitor the services closely.
- There may be a requirement for enhanced care wards, should there be a shortage of beds in acute hospitals.
- The internal reporting system will inform the ICT in the decision making on services. This could include the suspension of meetings, training, reports, and performance targets.
- Memoranda of Understanding will be activated re access to staff and equipment from partner organisations.
- Mutual aid measures may be activated between agencies.
- Teleconferencing briefings for service managers will be frequent, possibly daily.
- Strategic command and control structures will be liaising daily with health economy and regional support systems.

Appendix 2 Service Specific 4- Phase Response

Operational Pressures Escalation Levels - OPEL Service Specific Warning Markers							
Barnsley Community Services		**Barnsley Community Mental Health and CAMHS**		**Trust wide MH inpatients and Calderdale, Kirklees and Wakefield Community Mental Health**		**Forensic & LD**	
Inpatient	**Community**	**Community MH**	**CAMHS**	**Inpatients**	**Community MH**	**Forensic**	**LD ****
OPEL 1 - The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources.							
• Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination • No DTOCs • Wards working within 85% occupancy • Good patient flow through whole system	• Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination • No DTOCs • Good patient flow through whole system • NRS – staff levels meet minimum requirements; demand no exceeding staffing capacity • NRS bed capacity is within range of care home beds 28 and home visiting beds between 50 & 70	Staff to call service users before carrying out visits deemed necessary and ask relevant questions to ascertain their current Covid 19 risks. Where contact with the service would be via clinic, notices need to be placed on all estate entry points asking Service Users who are symptomatic not to attend and contact via telephone number. Teams to appropriately allocate staff to visits based on staff health vulnerabilities e.g. Long Term Conditions Teams to utilise the RAG rating system to identify priority visits appropriate to service users' needs- Red = service users in an acute phase and contact to manage this is essential, Amber= service users with moderate risks who we may relapse if contact is not maintained, Green= service users with low risk who have only routine	**SPA** • Capacity to manage the volume of calls and referrals into the system • Skills to undertake the role safely (CAMHS experience, Local Knowledge, Skill mix of professional background and banding/roles) • Capacity within Admin functions to ensure the work can be processed in a timely manner **Core/Specialist** • Capacity to ensure all CYP open to the service are safely monitored and are receiving contact from the service. • Capacity to offer clinical intervention by virtual means where clinically appropriate • Capacity to ensure where required patients can be seen face to face (in clinic or at home) • Capacity within the Consultant group to ensure there is access to a medic for consultation, review and medication	• Capacity available to meet expected demand • Wards working within 85% occupancy • Good patient flow through whole system • DTOC within normal limits of 7.5% of ward capacity • Nursing activity meet staffing requirements	Staff to call service users before carrying out visits deemed necessary and ask relevant questions to ascertain their current Covid 19 risks. Where contact with the service would be via clinic, notices need to be placed on all estate entry points asking Service Users who are symptomatic not to attend and contact via telephone number. Teams to appropriately allocate staff to visits based on staff health vulnerabilities e.g. Long Term Conditions Teams to utilise the RAG rating system to identify priority visits appropriate to service users' needs- Red = service users in an acute phase and contact to manage this is essential, Amber= service users with moderate risks who we may relapse if contact is not maintained, Green= service users with low risk who have only	• Capacity available to meet expected demand. • Able to process referrals in accordance with national guidance re timescales. • Able to admit and discharge service users to meet the need for secure care. • Able to achieve 90% occupancy rate. • Ward rounds, CPA reviews and clinical team meetings taking place as scheduled • Court appearances are taking place as scheduled • Workforce is appropriately skilled and experienced to meet the	

		contact with services . Team to commence telephone triage and assessment/visits in relation to RAG ratings Staff to be aware of Management of a suspected case of coronavirus. http://nww.swyt.nhs.uk/ipc/Pages/Coronavirus.aspx **Escalation criteria from level 1-2:** Demand, guidance or internal/ external threats disrupt any teams ability to function as normal	should this be required. • Capacity within Admin functions to ensure work can be processed in a timely manner **Crisis/IHBT** • Capacity to ensure all CYP open to the service are safely monitored and are receiving contact from the service including multiple visits per day where clinically indicated. • Ability to triage, accept and assess all urgent cases • Skill mix to ensure there are sufficient senior staff (who can undertake assessments and generate care plans) • Ability to maintain the 4 hour KPI for assessment. • Admin capacity to ensure the work is processed timely. • Skill mix and role variation to ensure staff support and patient safety is prioritised. **Secure CAMHS Wetherby YOI & Adel Beck SCH** • Capacity available to meet expected demand • Can deliver pathways without undue increase in patients waiting for assessment / interventions and / or treatment and within appropriate		routine contact with services . Team to commence telephone triage and assessment/visits in relation to RAG ratings Staff to be aware of Management of a suspected case of coronavirus. http://nww.swyt.nhs.uk/ipc/Pages/Coronavirus.aspx **Escalation criteria from level 1-2:** Demand, guidance or internal/ external threats disrupt any teams ability to function as normal	demands of the service users across all disciplines. • Clinical need met by movement of resources around the BDU.	

			timescales • Ability to undertake CHAT assessment within national KPI • Ability to meet Prison Service Instructions in timescales • Ability to deliver Integrated Framework for Care (Secure Stairs) • Population size and mental health needs of the YOI and SCH remain stable • Able to facilitate attendance at training / study as per LNA • Able to engage in relevant meetings / structures				
Inpatient	**Community**	**Community MH**	**CAMHS**	**Inpatients**	**Community MH**	**Forensic**	**LD**
OPEL 2 - The local health and social care system is starting to show signs of pressure.							

• Patients in acute settings waiting for community care capacity
• Lack of medical cover for inpatient beds
• Infection control issues emerging
• Lower levels of staff available, but are sufficient to maintain services
• Wards working over 85% occupancy
• Patient flow becoming restricted
• Some unexpected reduced staffing numbers (e.g. sickness, weather
	• Patients in community and / or acute settings waiting for community care capacity
	• Lack of medical cover for community beds
	• Infection control issues emerging
	• Lower levels of staff available, but are sufficient to maintain services
	• Patient flow becoming restricted
	• Some unexpected reduced staffing numbers (e.g. sickness, weather conditions)
	• Increased activity
	• Loss of capacity e.g. infection
		In phase 2, the full delivery of all teams will be deemed not possible due to staff absence. Non critical services such as Psychological therapies, Out Patients, and Recovery College etc. will review their clinics and where possible move to telephone consultations to reduce face to face contact and further contamination of staff. The Guidance regarding clinic based interventions should be followed below.
		
		Scheduled meetings should continue via Skype where possible.
		
		The below link provides
			<u>SPA</u>
			• Capacity to manage the volume of calls is reduced and there is a delay to being able to triage calls and referrals into the system
			• Reduced skills to undertake the role safely (CAMHS experience, Local Knowledge, Skill mix of professional background and banding/roles)
			• Reduced capacity within Admin functions that cause a delay to processing the work undertaken in SPA
			<u>Core/Specialist</u>
			• Reduced capacity to ensure all CYP open to the service are safely monitored and
				• Capacity approaching concern
				• Wards working over 85% occupancy (including SUs on Leave/AWOL)
				• Good patient flow becoming restricted:
				  • Discharges below expected norm
				  • Requests still ongoing for IHBTT assessments
				  • DTOC beginning to exceed 7.5% normal limits
				• Increase in levels of observations
				• Some unexpected reduced staffing numbers (e.g.
					In phase 2, the full delivery of all teams will be deemed not possible due to staff absence. Non critical services such as Psychological therapies, Out Patients, and Recovery College etc. will review their clinics and where possible move to telephone consultations to reduce face to face contact and further contamination of staff. The Guidance regarding clinic based interventions should be followed below.
					
					Scheduled meetings should continue via Skype where possible.
						• Capacity either too high or too low.
						• Too high and the clinical needs of the services users e.g. use of s17 leave will be affected.
						• Inability to accept referrals leading to an increase in OOA spend.
						• Capacity drops below 90% where there is a threat of a financial penalty
						• Increase in observation levels and /or	

conditions) • Increased activity • Loss of capacity e.g. infection control, estate issues • Acuity of patients increasing e.g. number of 1 to 1 observation / specialing • DTOCs occurring due to lack of social care packages	control, estate issues • NRS – number of patients requiring double handling • DTOCs occurring due to lack of social care packages e.g. reablement unable to step down • NRS working above threshold of 70 patients.	guidance on Community visits http://nww.swyt.nhs.uk/news/Documents/Standard%20Operating%20Procedure%20Covid-19_Community%20Visits%2005042020.pdf **Escalation Criteria from Level 2 -3** 1 or more critical services become amber on the daily staffing and demand template and there is no local solution from non-critical services to support this. This is dictated by staffing levels and/or increase in demand exceeding resource.	are receiving contact from the service therefore increased risk that some cases may be missed or reduce engagement due to unknown practitioners. • Reduced Capacity to see patients face to face (in clinic or at home) unless in crisis. • Reduced capacity within the Consultant group to ensure there is access to a medic for consultation, review and medication should this be required. Therefore the potential for increased crisis/risk situations. • Reduced capacity within Admin functions to ensure work can be processed in a timely manner therefore communication with other services limited and the risk is less shared. **Crisis/IHBT** • Reduced capacity to ensure all CYP open to the service are safely monitored and are receiving contact from the service therefore only telephone support is available unless an emergency. • Less ability to triage, accept and assess all urgent cases in a timely manner • Reduction in ability to skill mix to ensure there are sufficient senior staff (who can	sickness, weather conditions) • Increased activity Loss of capacity e.g. infection control, estate issues	The below link provides guidance on Community visits http://nww.swyt.nhs.uk/news/Documents/Standard%20Operating%20Procedure%20Covid-19_Community%20Visits%2005042020.pdf **Escalation Criteria from Level 2 -3** 1 or more critical services become amber on the daily staffing and demand template and there is no local solution from non-critical services to support this. This is dictated by staffing levels and/or increase in demand exceeding resource.	excessive • Use of seclusion. • Recruitment issues leading to high number of vacancies. • High levels of staff sickness/absence. • Increased activated with a result in a loss of capacity. • Loss of capacity due to loss of estate through damage etc. • Reduced membership of MDTs • Disrupted or reduced ability to continue with full clinical pathways • Referrals admissions and discharges disrupted or affected • Safer staffing levels becoming difficult to maintain • Special observations on patients increasing due to acuity or need for isolation	

			undertake assessments and generate care plans) potentially leaving junior staff more vulnerable. • Inability to maintain the 4 hour KPI for assessment. • Reduced admin capacity to ensure the work is processed timely. **Secure CAMHS Wetherby YOI & Adel Beck SCH** • Capacity is not available to meet expected or existing demand and requires protracted use of additional staff to deliver service Clinical staffing is reduced to (>50%) as BCP • Inadequate staffing capacity or skill mix to deliver all pathways and / or inability to prioritise based on need and risk which is now impacting on patients waiting for assessment / interventions or treatment timescales • Required to mitigate any reduction in staffing levels in association with joint provider (LCH) via use of transferable skills / training/ and adaptation to service offer • Inability to undertake CHAT assessment within national timescales requiring negotiation to extend				

			or adapt process • Inability to meet Prison Service Instructions within national timescales requiring negotiation to extend this and or prioritise to which PSI's we respond • Inability to deliver core elements of the Integrated Framework for Care (Secure Stairs) • The population size and / or mental health needs of the YOI and SCH show sign s of potential increase / instability that requires increased CAMHS staffing levels / skills being sourced to meet demand on a short term basis and can be sourced with timely approval of DBS / vetted staff for the YOI • Safe reduction of core offer agreed with YOI / SCH and joint health provider • Introduction of suitable / alternative IT and patient contact systems can be negotiated with YOI / SCH • Increase in discharges that are unplanned and which CAMHS have not risk assessed however community liaison and follow up in place • Reduction / Closure of low / medium secure mental health beds = increased acuity and management of care				

			in YOI due to delayed transfer • YOI regime is in lockdown and CAMHS contact restricted however communication / liaison can be maintained • Command meetings are in operation and can negotiate solutions in line with BCP • Able to facilitate mandatory training within revised timescales • Meetings are stood down however able to engage in essential meetings / structures • Able to offer a remote / reduced clinical and managerial supervision offer • Staff induction is compromised  HMYOI Wetherby and Adel Beck SCH BC				
Inpatient	**Community**	**Community MH**	**CAMHS**	**Inpatients**	**Community MH**	**Forensic**	**LD**
OPEL 3 - The local health and social care system is experiencing major pressures in staffing, clinical activity, performance and safety compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1.							
• Inpatient capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather	• Community capacity full • Significant unexpected reduced staffing numbers (due to e.g. sickness, weather	In phase 3 we will break the service down into the critical functions which are: all Inpatients (including Enfield Down and Lyndhurst), Enhanced teams, treatment teams, IHBT, Mental Health	**SPA** • Capacity to manage the volume of calls is reduced and there is a delay to being able to triage calls and referrals into the system (1-2 people)	• Beds available, but over 100% bed occupancy in more than 1 main area • Below 2 useable beds • BDU DTOC above 7.5% normal limits	In phase 3 we will break the service down into the critical functions which are: all Inpatients (including Enfield Down and Lyndhurst), Enhanced teams, treatment teams, IHBT, Mental Health	• Demand for services at higher than expected levels either locally or nationally. • High levels of	

conditions) in areas where this causes increased pressure on patient flow • Beds full – no planned safe discharges • Unable to transfer patients due to lack of capacity in the wider system • Patients waiting to transfer from acute (DTOCs) • High acuity of patients • Infection Control issues - e.g. D&V • Staff sickness	conditions) in areas where this causes increased pressure on patient flow • No capacity in independent sector beds • Unable to transfer patients due to lack of capacity in the wider system • Patients waiting to transfer from acute (DTOCs) • High acuity of patients • Infection Control issues - e.g. D&V outbreak in independent sector beds • Staff sickness	Liaison , KOT and we use staff flexibly from the non-critical area, across the BDU. This will ensure the identified critical teams are able to continue to function for service users assessed as priority (red and some cases of amber). This will include the appropriate deployment of staff in non-critical teams moving into the critical functions. It does not however mean that the non- critical services will stop working completely and some staff will be required to remain and cover the service. All non-essential training should be cancelled. Any scheduled meetings should be cancelled. Further detail regarding non critical services with critical functions to be added.	• Reduced skills to undertake the role safely (CAMHS experience, Local Knowledge, Skill mix of professional background and banding/roles) • Reduced capacity within Admin functions that cause a delay to processing the work undertaken in SPA **<u>Core/Specialist</u>** • Reduced capacity to ensure all CYP open to the service are safely monitored and are receiving contact from the service therefore increased risk that some cases may be missed or reduce engagement due to unknown practitioners. • Reduced Capacity to see patients face to face (in clinic or at home) unless in crisis. • Reduced capacity within the Consultant group to ensure there is access to a medic for consultation, review and medication should this be required. Therefore the potential for increased crisis/risk situations. • Reduced capacity within Admin functions to ensure work can be processed in a timely manner therefore communication with other services limited and the risk is less shared. **<u>Crisis/IHBT</u>**	putting pressure on patient flow • Planned admission requests for Clozaril and ECT are unable to be admitted due to capacity levels and acute demand • Patients on acute wards assessed and accepted for Rehab within Trust but unable to transfer due to lack of capacity in the wider system • Anticipated pressure on maintaining IHBTT 4 hour assessment target • Loss of capacity e.g. infection control, estate issues • Continuing staff sickness • Patients having to be slept out of host ward i.e. WAA on OPS wards	Liaison , KOT and we use staff flexibly from the non-critical area, across the BDU. This will ensure the identified critical teams are able to continue to function for service users assessed as priority (red and some cases of amber). This will include the appropriate deployment of staff in non-critical teams moving into the critical functions. It does not however mean that the non- critical services will stop working completely and some staff will be required to remain and cover the service. All non-essential training should be cancelled. Any scheduled meetings should be cancelled. Further detail regarding non critical services with critical functions to be added.	occupancy. • Inability to admit to meet the local demands for secure care. • DTOC's • Significant and unexpected drop in workforce capacity either due to recruitment issues, sickness or that the level of acuity in service users means the demand on the workforce is higher than we are able to meet. • Over reliance on bank and agency to meet clinical needs. • Patient flow through secure services is impeded having a system wide effect. • Cessation of admission, transfer and discharge. • Clinical pathway stagnant • Limited MDT working • Court escorts are unable to proceed	

			• Reduced capacity to ensure all CYP open to the service are safely monitored and are receiving contact from the service therefore only telephone support is available unless an emergency. • Less ability to triage, accept and assess all urgent cases in a timely manner • Reduction in ability to skill mix to ensure there are sufficient senior staff (who can undertake assessments and generate care plans) potentially leaving junior staff more vulnerable. • Inability to maintain the 4 hour KPI for assessment. • Reduced admin capacity to ensure the work is **Secure CAMHS YOI & SCH** • Capacity is not available to meet expected or existing demand based on reduced offer and / or additional staff are not available/ cannot be recruited to deliver service • Inadequate staffing capacity or skill mix to deliver pathways and inability to prioritise based on need and risk which is impacting on safety / outcomes for patients • Waiting times for			• Staffing numbers below safer staffing requirements • Shortage of equipment or systems failures	

			assessment / interventions or treatment are continuing and increasing • Inability to undertake CHAT assessment and/ or timescales are significantly increased and risk is unassessed • Inability to meet Prison Service Instructions and negotiating which PSI's are responded to now on a regular basis increasing risk and or impacting on care of a significant number of children • Inability to the deliver Integrated Framework for Care (Secure Stairs) • The population size and / or mental health needs of the YOI and SCH is increased and there is instability that requires increased CAMHS staffing levels / skills being sourced to meet demand on a mid to longer term basis and cannot recruit and or ensure timely approval of DBS / vetted staff for the YOI • Integrated health care team / showing pressure and inability to share use transferable skills / training to deliver service • Reduction of service offer is to crisis response only • Suitable / alternative				

			IT and patient contact systems cannot be negotiated and or sustained with YOI / SCH • Ongoing increase in discharges that are unplanned for which CAMHS not risk assessed which requires a community YOT / Forensic Offer and community capacity is now challenged and cannot be assured • Reduction / Closure of low / medium secure mental health beds = increased acuity in YOI due to delayed transfer and risk of significant harm to patients • YOI regime is lockdown and CAMHS contact restricted • Command meetings are in operation and negotiating solutions which is a whole system challenge • All meetings are stood down and ability to engage in critical meetings is compromised • Adequate staff induction cannot be provided • Unable to offer a remote / reduced clinical and managerial supervision offer				

Inpatient	Community	Community MH	CAMHS	Inpatients	Community MH	Forensic	LD
OPEL 4 - Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised.							
• Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient f low is at a level that compromises service provision / patient safety • No beds available • Surrounding trusts in same position i.e. no OOA bed capacity • Predicated discharges less than expected admissions • Unable to secure extra staffing via Bank or Agency • Infection control determines bed closures • Environmental concerns determine room closures e.g. estates issues	• No capacity in community services • Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Care home capacity full • Surrounding trusts in same position i.e. no OOA bed capacity • Predicated discharges less than expected admissions • Unable to secure extra staffing via Bank or Agency • Infection control determines bed closures • Environmental concerns determine room closures e.g. estates issues	This Phase will be reached when services are hit with high numbers of staff loss due to illness/absence. The BDU will be broken into one critical service provision consisting of joint management structures and staffing to ensure all clinically critical work is undertaken. This will mean the sharing of all resources across the BDU. There is a potential for the whole local Health and Social care systems to amalgamate to meet urgent care needs for our communities. This would include Acute Trusts, Local Authorities, SWYPFT and partner organisations all working together to meet the primary needs of the locality. Should we approach this stage, a significant level of planning and communication will be required.	**SPA** • Only urgent calls are able to be accepted; only urgent referrals will be triaged. **Core/Specialist** • Only the higher risk cases will be reviewed, kept in contact with and only emergency cases will be seen face to face. **Crisis/IHBT** • Only cases where there is an emergency will be assessed, no IHBT will be offered or delivered. • Increased admissions likely • Increased demand on all partnership resources likely. **Secure CAMHS YOI & SCH** • Workforce capacity is so low patient safety is known to be compromised across the whole health system and within the secure estate • Access to high risk patients is significantly restricted • Service cannot respond to a significant number of PSI's. • Inability to undertake CHAT assessment and/ or timescales are significantly increased and risk is unassessed and a timescale to assess cannot be	• No beds in host BDU • Lack of useable beds across the Trust , and over 100% bed occupancy in more than 1 main area • Possible available OOA beds • BDU DTOC above 7.5% normal limits putting pressure on patient flow • Predicted discharges < expected admissions • Unexpected reduced staffing numbers (e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety • Inability to admit gate kept assessed patients from General Hospitals due to lack of beds or acute MH priority i.e. urgent MHA assessments • Patients having to be slept out of host ward i.e. WAA on OPS wards • Staffing deficit in IHBTT • Wards unable to	This Phase will be reached when services are hit with high numbers of staff loss due to illness/absence. The BDU will be broken into one critical service provision consisting of joint management structures and staffing to ensure all clinically critical work is undertaken. This will mean the sharing of all resources across the BDU. There is a potential for the whole local Health and Social care systems to amalgamate to meet urgent care needs for our communities. This would include Acute Trusts, Local Authorities, SWYPFT and partner organisations all working together to meet the primary needs of the locality. Should we approach this stage, a significant level of planning and communication will be required.	• Closed to admissions. • Use of OOA beds to meet all local demand. • Wards unable to accept admissions and requesting closure due to: • acuity, i.e. increased levels of observation • unable to secure extra staffing via Bank or Agency, • infection control determines ward closures • Loss of Estate due to damage, FIRE etc. • Workforce capacity is so low patient safety is potentially compromised. • Service closed to IPC issue. • No medical cover • Dangerously low levels of nursing staff • Integrated systems failure • No patient	

			assured • Service is at risk of imminent closure due to issues such as : IPC / closure of estate (YOI , SCH) & clinical staff cannot enter or agree / communicate a plan to manage the care of high risk patients • High demand and high vetting refusals and unable to transfer staff with skills to support service continuity • Sudden and significant increase in population of YOI and acuity due to transfers from another affected site and CAMHS capacity to assess risk in the cohort is not available (Note :YOI population is not at capacity) • Inability to the deliver Integrated Framework for Care (Secure Stairs) • Reduction of service offer is to crisis response only • Delivery / availability of clinical equipment and or medicines is delayed and stock is significantly depleted on sites • Suitable / alternative IT and patient contact systems are not sustainable with YOI / SCH • Regular discharges for patient which CAMHS have not risk assessed and a community YOT / Forensic	accept admissions and requesting closure due to: • acuity, i.e. increased levels of observation • unable to secure extra staffing via Bank or Agency, • infection control determines ward closures • Environmental concerns determines room closures. Wards over capacity with patients returning from leave to an unallocated bed		flow. Pathways ceased to be effective. • Situation escalated to NHSE • Regional BCP for secure services activated.	

			capacity is now significantly affected and cannot be assured • Reduction / Closure of unceasing number of low / medium secure mental health beds with increased and sustained care of acuity in YOI due to delayed transfer and risk of significant harm to patients identified • YOI regime is lockdown and CAMHS cannot have contact with high risk patients • All meetings are stood down and / or ability to engage in critical meetings • Staff induction cannot be provided • Unable to offer clinical and managerial supervision to staff				

** LD Information in Progress

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 10.2

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resources and Director of Nursing & Quality
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for June 2020.
Mission/values/objectives	All Trust objectives
Any background papers/ previously considered by:	• IPR is reviewed at Trust Board each month. • IPR is reviewed regularly at the Finance Investment & Performance Committee (FIP). • IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis.
Executive summary:	The IPR for June has been prepared in line with the framework discussed at the March Trust Board meeting so as to focus on: • Covid-19 response. • Other areas of performance we need to keep in focus and under control. • Locality reports that focus on business continuity. • Priority programmes report that focus on those programmes supporting the work on Covid-19. The Covid-19 response section has been updated to reflect the current phase of the pandemic. **Quality** • Majority of quality reporting metrics maintained during pandemic. • Safer staffing for inpatients overall during June shows a positive position, however all inpatient services are experiencing high acuity. • Testing arrangements remain mature and achieving desired position. • Incident levels remain within usual parameters whilst subject to regular review. • Enhanced clinical risk scan continues to monitor impact of Covid-19 on mental health, an increase in self-harm behaviour is emerging. • Covid-19 guidance regularly updated in response to emerging directives and advice. • Positive outcome from review of infection prevention control assurance framework by CQC, remote MHA visits feedback also positive. **NHSI Indicators** • One young person under the age of 18 were admitted to an adult

	ward in May for a total of three days. • The percentage of service users waiting less than 18 weeks from referral to treatment has dropped to 85.1%, largely as a consequence of Covid-19. • Inappropriate out of area bed usage amounted to 72 days in June. • Within IAPT the provisional figure for the proportion of people completing treatment who move to recovery decreased further to 42.8%. • The percentage of service users seen for a diagnostic appointment within 6 weeks has reduced to 29.0% as a direct consequence of Covid-19. • All other nationally reported targets are currently being achieved. • Increased number of detentions under the Mental Health Act in Q1. **Locality** • Currently operating speech & language services with reduced staffing in Barnsley. • There is an increasing demand for face to face visits for community nursing, neighbourhood rehab and crisis response in Barnsley. • Stoke early supported discharge service is now operational. • Considerable demand pressure coupled with increases in acuity within inpatient wards. • Building risk assessments in place for all community bases and are being tested against recovery plans. • Community mental health services are witnessing high levels of acuity and distress and relapse rates in service users on their caseloads. • IAPT referrals and access rates have typically decreased since the onset of the Covid-19 outbreak. • Data quality within learning disabilities for initial screening and access within 18 weeks is being reviewed. • A review of the forensics cohort ward implementation plan is taking place. • Positive survey results from remote appointments in ADHD have been received. • Recovery college prospectus for September has been completed. • CAMHS referrals have been lower than normal during the pandemic, but a small increase is now being seen. **Priority Programmes** • The Trust continues to work with partners across both integrated care systems particularly on the response to Covid-19 with a recent focus on restoration and reset. • West Yorkshire bereavement helpline established in June. • Increasing level of challenge in providing care closer to home with an increase in out of area bed placements.

- Staff consultation on the full implementation of the all age liaison service re-commended recently.
- Work continues to deliver the key actions in the forensic improvement plan. A communication approach has been developed for the BDU.
- Much increased use of video consultations in June.

Finance

- Interim financial arrangements in place for April through to July.
- £478k of costs identified as being reasonably incurred as part of the Covid-19 response.
- In month 3 there was a deficit recorded pre final top-up of £393k. It has been assumed this will be reimbursed to enable the Trust to break-even. The main issues continue to be a) the lack of CAMHS income for Barnsley due to the timing of the calculation of block income compared to planned changes in commissioning arrangements and b), forensic CAMHS income and income for the community forensics pilot from the specialist commissioner, again due to timing differences.
- Taking the above into account a break-even position has been reported (follows instructions in the national guidance).
- Agency staffing costs cam to £0.5m in June, a similar value to May.
- The cash balance has fell slightly to £54.1m.
- Out of area bed costs increased to £88k, with a higher run rate being seen at the end of the month, which continues to increase in July.
- Capital expenditure remains light at £0.1m. As part of a national process bids have been made for some further capital to support the Trust's response to Covid-19.
- 83% of all third party invoices were paid within seven days of receipt of goods or services, with 97% paid within 30 days.

Workforce

- As at 22 July 2020, 47 staff off work and not working as a result of Covid-19 diagnosis, symptoms, household symptoms or shielding, with a further 107 working from home.
- 2,238 staff tested for Covid-19 as at July 22nd with 146 returning a positive result.
- Non-Covid staff sickness at the end of June was 3.9%.
- Staff turnover has increased to 9.8% and the actual level of vacancies has fallen further to 6.3%.

Covid-19 response

In addition to the points identified in the sections above:

- Emergency planning command structure remains in place with a

	reduced number of weekly meetings reflecting the current phase of the pandemic. • 3,222 anti-body tests carried out with 11.2% returning a positive result. • Sufficient PPE remains available for staff. • Risk assessments for all staff are being rolled out on a phased risk based approach following completion of risk assessments for all BAME members of staff. • Work continues on reset and restoration of services. • Testing process remains in place for staff via the national testing route. • Significant support to care homes is being provided by the general community team in Barnsley. • The Trust has participated in stress testing workshops in both South and West Yorkshire. • Over 1,600 video consultations using AirMid or AccuRX taking place each week. • National guidance continues to be monitored, reviewed and adopted.
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview

June 2020

With **all of us** in mind.

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South West
Yorkshire Partnership
NHS Foundation Trust

Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for June 2020. As agreed at the March Trust Board interim reporting arrangements are in place during the course of the Covid-19 pandemic. The aim is to provide a report that provides information on:
• The Trust's response to Covid-19
• Other areas of performance we need to keep in focus and under control
• Priority programmes in so far as they contribute to the Trust response to Covid-19
• Locality sections in terms of how business continuity plans are operating

This approach has necessitated a review of the sections and metrics reported previously. Following that review a number of changes have been made to the executive dashboard to add in key metrics related to the Covid-19 response and suspend the appearance of some other metrics whilst the focus has moved to managing the Covid-19 outbreak.

A separate new section for the Covid-19 response has been added. The structure of this section has been updated this month to reflect the current phase of the pandemic and focuses on:
• Managing the clinical response
• Supporting our staff and staff availability
• Supporting the system
• Standing up services
• Restoration and reset

It must also be recognised that given the focus of all staff on responding to Covid-19 and the increased level of staff absence not all the normal information is readily available for the report.. The quality section remains largely unaltered given the need to ensure the Trust retains focus on the provision of its core services. The report on national metrics is again unaltered as national reporting requirements remain unchanged. Other sections remain in place with typically reduced content.

With reference to key information relating to Covid-19 where possible the most up-to-date information is provided as opposed to the June month-end data. This will ensure that Trust Board can have a discussion on the most current position available as opposed to the position four weeks earlier. Given the fact different staff provide different sections of the report there may be some references to data from slightly different dates.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These 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:
• Executive summary
• Covid-19 response
• Quality
• National metrics
• Priority programmes
• Finance & contracting
• Workforce

Our integrated performance strategic overview report is publicly available on the internet.

Given the fact that we are now three months into revised reporting arrangements it is opportune to review them during July to identify if any changes need to be made.

This dashboard represents a summary of the 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 in 2019/20. Any change in requirement for 2020/21 will be reviewed in the coming weeks. Given the outbreak of the Covid-19 pandemic, a number of additional metrics are included in this report. These relate to the actual data as at July 22nd as opposed to the end of June. A small number of metrics have been removed from the dashboard to enable greater focus on the Trust response to Covid-19. It should be noted that as well as these specific metrics many of the standard metrics used will be strongly influenced by the impact of Covid-19.

KPI	Target	Feb-20	As at 23rd April 2020	As at 19th May 2020	As at 17th June 2020	As at 22nd July 2020	Notes
Additional Metrics to Highlight Response to and Impact of Covid-19							
No of staff off sick - Covid-19 not working [7]	N/A	N/A	**154**	**204**	**112**	**48**	
Shielding			54	59	52	37	
Symptomatic			69	118	46	5	
House hold symptoms			26	24	13	4	
OH Advised Isolation			5	1	0	0	
Test & Trace Isolation			0	0	0	0	
Other Covid-19 related			0	2	1	2	
No of staff working from home - Covid-19 related [8]			**125**	**136**	**107**	**90**	
Shielding			76	78	72	71	
Symptomatic			13	28	13	5	
House hold symptoms			29	23	13	1	
OH Advised Isolation			7	6	7	3	
Test & Trace Isolation			0	0	0	7	
Other Covid-19 related			0	1	1	3	
Number of staff tested [9]			90	603	1762	2238	Cumulative
No of staff tested positive for Covid-19 [10]			24	93	130	134	Cumulative
No of staff returned to work (including those who were working from home)			683/962 = 71%	921/1246 = 73.9%	1183/1393 =84.9%	1310/1448 =90.5%	
No of staff returned to work (not working only) [13]			445/599 = 74%	609/807 =75%	800/908 =88.1%	872/928 =94.0%	
No of staff returned to work who were Covid-19 positive [12]			10	43	79	92	Cumulative
No of Service users tested (ward)			41	65	103	104	Symptomatic
No of service users tested positive (ward)			9	10	29	29	Cumulative
No of service users recovered			8	9	28	28	One patient died not in SWYFT care.
Additional number of staff enabled to work from home			900	900	937	1003	cumulative
Calls to occupational health healthline			311	316	796	884	Cumulative
Making SWYPFT a great place to work	**Target**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Forecast**
Sickness absence	4.5%	5.0%	3.8%	4.0%	3.5%	4.0%	
Staff Turnover	10%	11.3%	11.9%	8.5%	7.9%	9.8%	
Actual level of vacancies	tbc	12.2%		8.7%	6.9%	6.3%	
Improve people's health and reduce inequalities	**Target**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Forecast**
% service users followed up within 7 days of discharge	95%	81/85 =95.2%	105/107 =98.1%	90/92 =97.8%	102/102 = 100%	105/105 = 100%	1
Out of area beds [1]	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	175	137	23	8	72	2
IAPT - proportion of people completing treatment who move to recovery [4]	50%	52.4%	55.7%	*51.4%*	*49.2%*	*42.8%*	1
Delayed Transfers of Care	3.50%	1.8%	1.9%	2.0%	1.7%	1.4%	1
Improve the quality and experience of care	**Target**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Forecast**
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [3]	trend monitor	20	21	35	37	34	
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	12	6	15	20	14	
Total number of Children and Younger People under 18 in adult inpatient wards	*TBC*	0	2	1	2	1	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [2]	trend monitor	37.8%	40.0%	39.9%	44.9%	47.2%	
Improve the use of resources	**Target**	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Forecast**
Surplus/(Deficit)	In line with Plan	(£49k)	(£968k)	-	-	-	
Agency spend	In line with Plan	£581k	£613k	£469k	£507k	£518k	
Single Oversight Framework metric	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green

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 - 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.

2 - 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 and neurodevelopmental teams. 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.

3 - 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. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.

4 - 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.

5 - Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other

6 - Data taken from the Trusts Covid-19 sickness absence recording system as at 22nd July broken down by those staff that are reported as being absent from work and being either symptomatic, shielding or household symptoms

7 - Data taken from the Trusts Covid-19 sickness absence recording system as at 22nd July. Staff not working due to Covid-19 related issues.

8 - Trusts Covid-19 sickness absence recording system as at 22nd July. Staff working from home but recorded as having either symptomatic, shielding or household symptoms.

9 - Count of tests undertaken for staff and/or staff family member up to and including 22nd July.

10 - Number of staff and/or family member tested positive for Covid-19 out of those that have been tested.

11 - Number of staff that have returned to work who were reported as being off work due to Covid-19 related issues as at 22nd July.

12 - Number of staff that have returned to work who were tested positive for Covid-19 as at 22nd July.

13 - Number of staff who have returned to work who were unable to work during their absence.

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.

Quality
• Majority of quality reporting metrics maintained during pandemic
• Safer staffing for inpatients overall during June shows a positive position, however all inpatient services are experiencing high acuity.
• Testing arrangements remain mature and achieving desired position
• Incident levels remain within usual parameters whilst subject to regular review
• Enhanced clinical risk scan continues to monitor impact of Covid-19 on mental health, an increase in self-harm behaviour is emerging
• Covid-19 guidance regularly updated in response to emerging directives and advice.
• Positive outcome from review of infection prevention control assurance framework by CQC, remote MHA visits feedback also positive

NHSI Indicators
• One young person under the age of eighteen were admitted to an adult ward in May for a total of 3 days
• The percentage of service users waiting less than 18 weeks from referral to treatment has dropped to 85.1%, largely as a consequence of Covid-19
• Inappropriate out of area bed usage amounted to 72 days in June
• Within IAPT the provisional figure for the proportion of people completing treatment who move to recovery decreased further to 42.8%
• The percentage of service users seen for a diagnostic appointment within 6 weeks has reduced to 29.0% as a direct consequence of Covid-19
• All other nationally reported targets are currently being achieved
• Increased number of detentions under the Mental Health Act in Q1

Locality
• Currently operating speech & language services with reduced staffing in Barnsley
• There is an increasing demand for face to face visits for community nursing, neighbourhood rehab and crisis response in Barnsley
• Stoke early supported discharge service is now operational
• Considerable demand pressure coupled with increases in acuity within inpatient wards
• Building risk assessments in place for all community bases and are being tested against recovery plans
• Community mental health services are witnessing high levels of acuity and distress and relapse rates in service users on their caseloads
• IAPT referrals and access rates have typically decreased since the onset of the Covid-19 outbreak
• Data quality within learning disabilities for initial screening and access within 18 weeks is being reviewed
• A review of the forensics cohort ward implementation plan is taking place
• Positive survey results from remote appointments in ADHD have been received
• Recovery college prospectus for September has been completed
• CAMHS referrals have been lower than normal during the pandemic, but a small increase is now being seen

Priority Programmes

- The Trust continues to work with partners across both integrated care systems particularly on the response to Covid-19 with a recent focus on restoration and reset
- West Yorkshire bereavement helpline established in June
- Increasing level of challenge in providing care closer to home with an increase in out of area bed placements
- Staff consultation on the full implementation of the all age liaison service re-commended recently
- Work continues to deliver the key actions in the forensic improvement plan. A communication approach has been developed for the BDU
- Much increased use of video consultations in June

Finance

- Interim financial arrangements in place for April through to July.
- £478k of costs identified as being reasonably incurred as part of the Covid-19 response
- In month 3 there was a deficit recorded pre final top-up of £393k. It has been assumed this will be reimbursed to enable the Trust to break-even. The main issues continue to be a) the lack of CAMHS income for Barnsley due to the timing of the calculation of block income compared to planned changes in commissioning arrangements and b), forensic CAMHS income and income for the community forensics pilot from the specialist commissioner, again due to timing differences
- Taking the above into account a break-even position has been reported (follows instructions in the national guidance)
- Agency staffing costs cam to £0.5m in June, a similar value to May
- The cash balance has fell slightly to £54.1m
- Out of area bed costs increased to £88k, with a higher run rate being seen at the end of the month, which continues to increase in July
- Capital expenditure remains light at £0.1m. As part of a national process bids have been made for some further capital to support the Trust's response to Covid-19.
- 83% of all third party invoices were paid within 7 days of receipt of goods or services, with 97% paid within 30 days.

Workforce

- As at July 22nd 47 staff off work and not working as a result of Covid-19 diagnosis, symptoms, household symptoms or shielding, with a further 107 working from home
- 2,238 staff tested for Covid-19 as at July 22nd with 134 returning a positive result
- Non-Covid staff sickness at the end of June was 3.9%
- Staff turnover has increased to 9.8% and the actual level of vacancies has fallen further to 6.3%

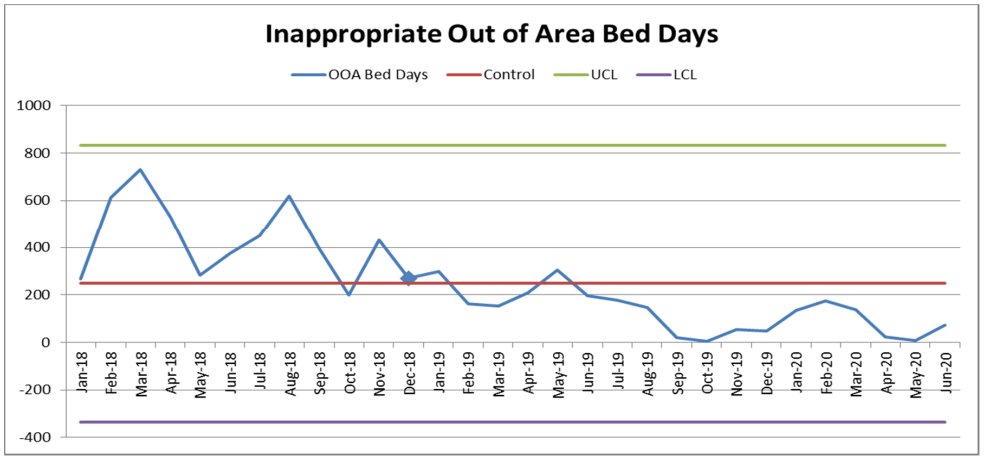
Covid-19

In addition to the points identified in the sections above:

- Emergency planning command structure remains in place awith a reduced number of weekly meetings reflecting the current phase of the pandemic
- 3,222 anti-body tests carried out with 11.2% returning a positive result
- Sufficient PPE remains available for staff.
- Risk assessments for all staff are being rolled out on a phased risk based approach following completion of risk assessments for all BAME members of staff
- Work continues on reset and restoration of services
- Testing process remains in place for staff via the national testing route
- Significant support to care homes is being provided by the general community team in Barnsley
- The Trust has participated in stress testing workshops in both South and West Yorkshire
- Over 1,600 video consultations using AirMid or AccuRX taking place each week
- National guidance continues to be monitored, reviewed and adopted

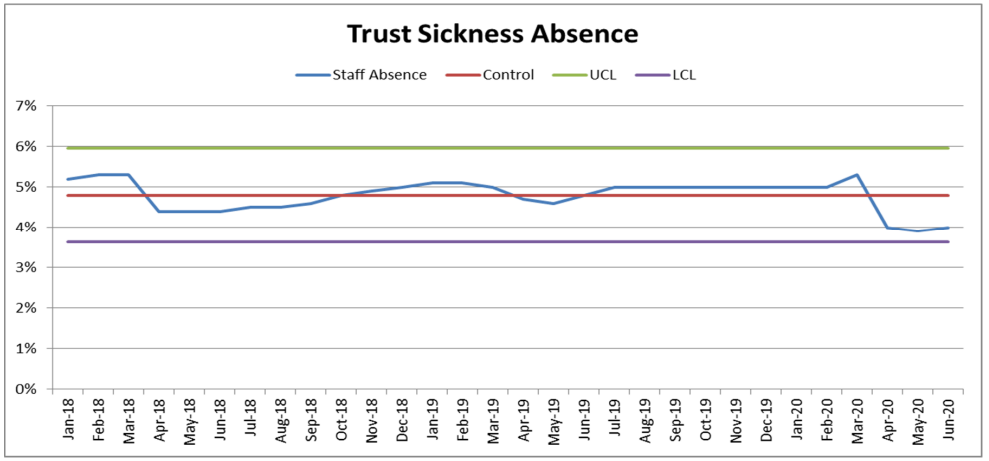
Statistical process control (SPC) is an analytical technique for plotting data over time. It helps understanding of variation and in so doing guides on the most appropriate action to take, as well as allowing tracking the impact of the changes made. The following four areas have been identified as key indicators to view using SPC. Further charts are in development.

Inappropriate Out of Area Bed Days



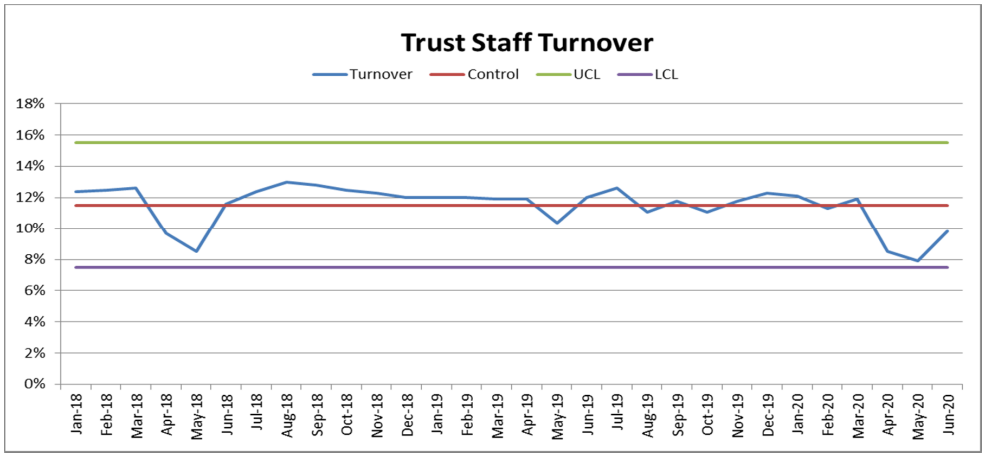
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in December 2018 has been highlighted for this reason.

Staff Sickness Absence



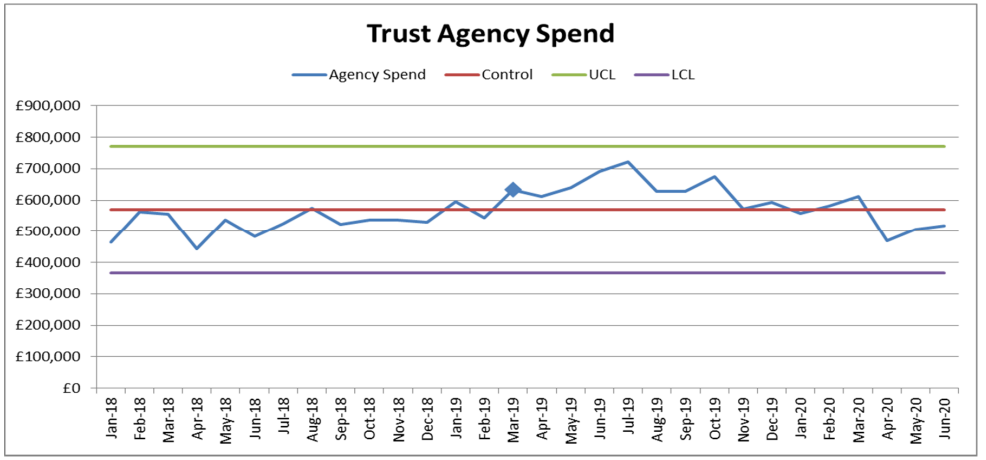
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that sickness levels are within the expected range.

Staff Turnover



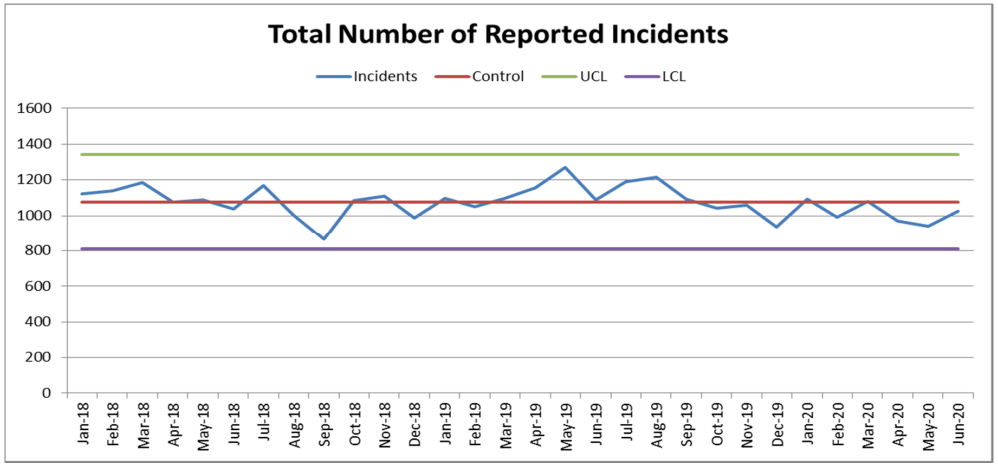
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that staff turnover levels are within the expected range.

Agency Spend



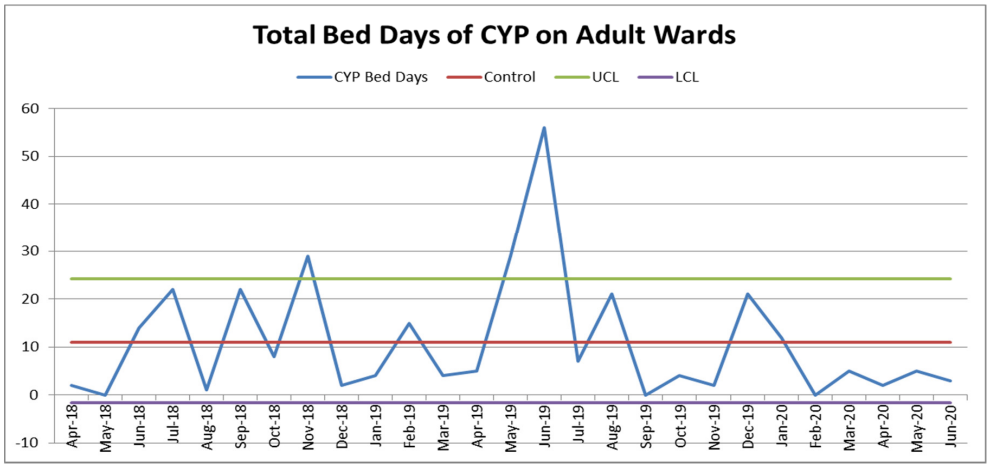
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in March 2019 has been highlighted for this reason.

Incidents



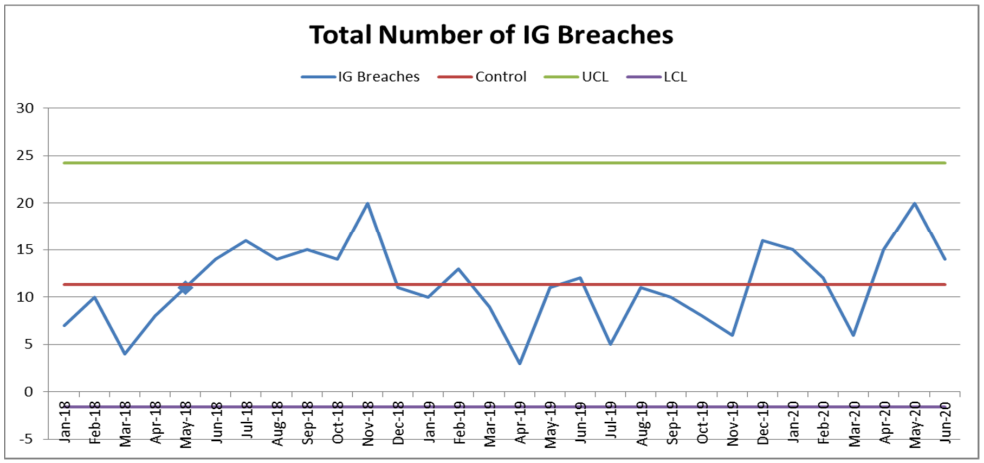
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Total bed days of CYP on adult wards



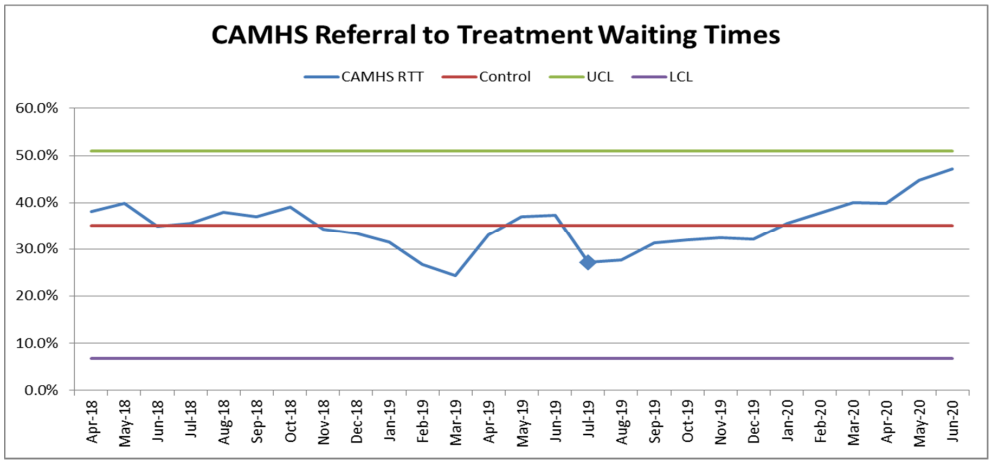
The majority of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported bed days are within the expected range with the exception of Nov-18 and Jun-19.

IG Breaches



All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported IG breaches are within the expected range. The data point in May 2018 has been highlighted to indicate the introduction on GDPR.

CAMHS Referral to treatment waiting times



All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that waiting times are within the expected range. The data point in July 2019 has been highlighted as the neurodevelopmental teams have been excluded from this point onwards following a change in June 2020.

Covid-19 response

This section of the report identifies the Trusts repose to the Covid-19 pandemic and in particular the 6 items identified by Simon Stevens that are critical to being able to work through the national crisis.

Managing the clinical response

IPC response – guidance

There have been two recent letters; COVID-19 care home outbreak and regular testing and the COVID-19 FAQ's Estates and Infrastructure which have been reviewed and interpreted by the IPC team. The IPC team have worked with the deputy director and general managers across Barnsley BDU to initiate the testing; starting the 27th July 2020. A flowchart has been devised to implement the programme with IPC oversight. Further consideration will be required if this is expected to be rolled out across the Trust. The IPC team reviewed the Estates and Infrastructure letter and as Trust we are compliant, no risks identified.

Patient testing & pathway/Outbreak response & management

We tested 8 symptomatic inpatients and had 3 confirmed positive cases in the whole of June. The 3 confirmed were part of the sandal outbreak.
We have performed no official test and trace on inpatients as all were positive prior to that guidance being released. We have had 9 positive staff members in June, only 2 test and trace were performed as we only commenced test and trace on 15/06/2020. No breaches were identified.

Covid-19 clinical risk scan

Please refer to the Covid-19 related incident reporting section in the quality report

PPE position

- More consistent provision of PPE in recent weeks
- The Trust participates in a mutual aid scheme within each ICS
- PPE is received centrally and then distributed across 8 hubs in the Trust
- Additional PPE has been sourced directly to supplement national deliveries when it has been required
- The size of some items e.g. gloves is key as some sizes are used far more frequently than others

PPE Levels as at 14/07/2020	Approx days stock	Stock items
Surgical masks	30	253,000
Respirator masks	80	4,300
Aprons	11	70,000
Gowns	95	3,900
Gloves	28	388,000
Visors	100	40,700

Covid-19 response

Supporting our staff and staff availability

Testing approach

Current position

Patients:

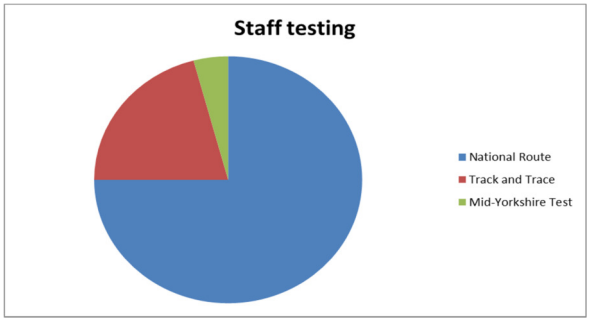
- Swabbing for symptomatic testing through Pillar 1 inpatient and through Pillar 2 if required for community setting.
- Asymptomatic takes place on admission, 5-7 day post admission and discharge testing is being undertaken. Also testing for service users prior to going for a planned operation/ treatment/ procedures testing being undertaken through Pillar 1.
- Outbreak and hotspot management testing is provided through an internal testing route, with adequate capacity from local labs.
- Testing some mental health and general health community patients if they require admission to adult care home, or admission to hospital.
- Swabbing for outbreaks in care homes - SOP produced and commencement date to be finalised.

Staff

- Swabbing for symptomatic testing - access via pillar 2 or through internal testing route. Testing staff per and post-operative and procedures
- Hotspot outbreak management testing is provided through internal testing route, with adequate capacity from local labs.
- Trust committed to the national SIREN study, which will include fortnightly swabbing and anti-body testing.

Staff testing report – current position

The Wakefield Fieldhead testing site officially closed on 5th July, since this date 23 members of staff have received a test via the national testing route or test and trace process.
All staff requiring a test continue have their details taken and are contacted to ensure a test has been sought and monitor when result received.



The reasons for absence from work for the staff members who were tested are included in the table below:

Reason for absence	Total Number
Household symptoms	7
Staff symptomatic	11
Test and Trace	5

Results

Most of the results have been returned within one day (70%) and the remainder barring one exception within two days. There is no apparent difference to date between the Fieldhead testing site and national testing site in terms of the time it takes to receive results..

Future plans for testing staff

- Remain with staff testing through the national route.
- For Trust infection prevention & control (IPC) staff PC to have oversight of the staff absence as a result of Covid-19 so they can monitor results and advise as necessary.
- Any member of staff who is unable access a national test will be considered for local testing via the nursing, quality and professions directorate.

Staff absence

- The Trust completed 100% of its risk assessments for BAME members of staff
- The risk assessment process is being rolled out to other staff using a phased risk-based approach

Please rtefer to the sickness reporting section in the workforce report

Covid-19 response

Supporting the system

Care home support offer
- Significant support to care homes is provided from the general community team in Barnsley.
- Support includes testing (for both staff and residents), training and advice. This requires significant capacity, especially where there have been clusters/outbreaks.
- Support also includes direct care from community staff including our specialist palliative care teams , District Nurses and matrons and our out of hours nurses.
- SWYPFT is part of the mutual aid response to care homes to ensure they have adequate PPE
- Mental Health and Learning Disability support has also been provided into care homes across the whole of the Trust footprint to support the residents

ICS stress test and outbreak support
- SWYPFT were part of ICS stress testing workshops in both South Yorkshire & West Yorkshire as part of the place based response
- We continue to work closely with partners in outbreak support response in each of our four places
- Strong leadership from the Infection Prevention & Control (IPC) team continues so we ensure appropriate IPC measures are in place
- We provide input and support in to the communication and engagement cells in each of our places to support the covid management and outbreak response.

Standing up services

Operational services delivery update
Please refer to the localities section of the report

Workplace risk assessments
- Environmental risk assessments are being carried out across the Trust, including the identification of Covid secure locations

EPRR update inc Opel levels
- The command structure remains in place with a reduced number of weekly meetings reflecting the current phase of the pandemic
- The Trust remains at Opel level 2

Covid-19 response

Restoration and reset

Key priorities

- Review and revise governance systems in light of learning from covid
- Progress the identified clinical priority areas for restoration and reset
- Evaluate estate requirements and capacity in light of health & safety restrictions
- Work with partners in each place as well as both ICS systems to support restoration and recovery in each place
- Evaluate the new clinical models and digital approaches that we have used during the pandemic
- Continue work to ensure this is great place to work
- Deliver the requirements in the phase three planning guidance
- Review the priority programmes for the next phase and develop scopes and key metrics

Race equality response

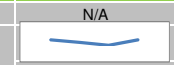
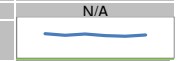
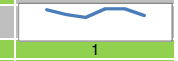
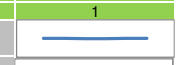
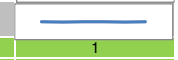
- Our refresh of the Equality, Inclusion and involvement strategy and Trust Approach is already underway - Integrated systematic approach underpinned by involvement since October 2019
- Leadership and Stronger governance /delivery structure
  - Board leadership
  - E&I committee and Task Force
  - BAME workforce Task Force
  - BAME Network participation in Task Force
- Strengthened our processes to capture insights, data, impact and informed decision making
  - WRES/WDES/EDS2 – Action Plans currently being updated based on NHSE/I requirement templates
  - Covid19 Trust wide EIA and action plan
  - Covid19 Trust wide intelligence tool
  - EIA quick decision tool to support decision making and change
  - EIA form and intelligence supported decision making in Silver command structure
  - Equality and Engagement team as advisors in silver command – Latter from July 2020
  - EIA and insight work from strategy refresh to inform Priority programmes and planning as part of stabilisation and recovery
  - Mapping representation in meetings (awaiting data)
- Targeted and accessible communications, messaging and materials
  - Translation services promoted – translated COVID19 materials
  - Use of easy read materials developed and promoted
  - Website and intranet tools
  - Targeted messages to communities

Digital response

- Calls to the service desk stabilising after the initial increase at the onset of the pandemic and increase in staff working from home
- Over 1,000 additional VPN licences provided to enable staff to work remotely
- Significant uptake in the use of Microsoft Teams
- On average circa 1,600 video consultations carried out each week in June
- Daily average of VPN connections is almost 2,000 higher than January this year.

Digital - Summary Metrics	Apr	May	Jun
Total numbers of tickets logged with service desk:	5,914	4,186	4,424
Total phone calls to service desk:	2,733	1,644	1,744
Number of SystmOne tickets (day to day system requests/amendments):	321	320	298
Number of smartcard related tickets:	367	308	296
Additional VPN licences since March	888	937	1,003
Average number of daily VPN connections	2,674	2,430	2,731
Microsoft Teams - meetings participated	10,535	7,201	15,450
Airmid video consultations (average/week)	316	593	858
AccuRX video consultations (average/week)	0	318	752

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	35.6%	37.8%	40.0%	39.9%	44.9%	47.2%	N/A
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	6% 1/17	18% 4/22	15.0%	10.0%	0% 0/14	17% 5/29	1
	Number of compliments received	Improving Health	Caring	TB	N/A	35	17	11	13	13	41	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	trend monitor	39	19	295 incidents during 19/20	39	33	Due Aug 20	
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	trend monitor		11		2	2		N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	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	15	12	6	15	20	14	2
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	0.7%	1.8%	1.9%	2.0%	1.7%	1.4%	1
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	89.2%	81.5%	82.7%	90.4%	91.5%	Due Aug 20	N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%	69.0%	69.8%	83.9%	71.2%	83.3%	Due Aug 20	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1093	993	1082	969	942	1026	
	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	27	16	20	34	32	32	
Quality	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	1	4	1	1	5	2	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	5	4	2	1	6	10	
	MH Safety thermometer - Medicine Omissions [15]	Improving Care	Safety Domain	TB	*17.7%*	10.3%	18.0%	11.6%	No longer available			2
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	112.9%	108.0%	109.9%	115.1%	119.4%	123.3%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	96.6%	89.4%	88.9%	95.7%	94.3%	93.9%	
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	trend monitor	44	36	31	46	46	34	
	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%	95.5%	94.5%	94.5%	93.0%	91.5%	90.0%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	48	47	44	38	45	46	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	218	139	189	173	160	177	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	86.5%	83.9%	90.0%	95.3%	91.5%	90.2%	1
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

** 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. Excludes ASD waits and neurodevelopmental teams.
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 e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available).
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.
14 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return and is monitored under the NHS oversight framework.
15 - The medicine omissions data was taken from the NHS Safety thermometer tool. This data collection ended at the end of March 20 and therefore data for this metric is no longer available.

Quality Headlines

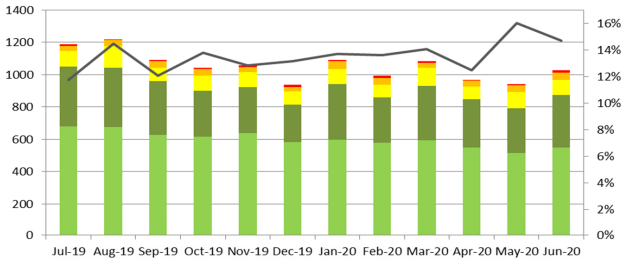
Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.
• Number of restraint incidents - the number of restraint incidents during June reduced from 160 to 177. Further detail can be seen in the managing violence and aggression section of this report.
• NHS Safety Thermometer - medicine omissions. It has been decided by NHS Improvement that the safety thermometers are to cease being used and they are currently working on a replacement. Therefore staff no longer need to collect monthly data or input onto the national site. Alternative patient safety measures are being explored.
• Number of falls (inpatients) – A slight increase in June from 45 to 46 - this appears to be in line with incidents reported in previous months. All falls are reviewed to identify measures required to prevent reoccurrence and more serious falls are subject to investigation.
• Staffing fill rates are provided for the last 2 months where new planned staffing in acute mental health wards is included and fill rates measured against these.
• Patient safety incidents involving moderate or severe harm or death fluctuated over recent months (see section below). Increases mainly due to increased number of unavoidable pressure ulcers and slips, trips and falls. Increase in number of deaths although important to note that deaths are often re-graded upon receipt of cause of death/clarification of circumstances.

NHS Improvement consultations and developments for the NHS patient safety strategy have been suspended.
Guidance has been received from NHS Improvement regarding changes to patient safety activity during Covid-19.
During Winter 2019/20, 360 Assurance undertook an internal audit of our incident reporting and associated processes. The Trust received significant assurance. A number of actions have been identified and an action plan is in development. The actions are summarised below and focus on clarifying:
• Responsibilities for completion of the degree of harm field and timeliness of reviewing incidents
• Policy terminology and definitions to ensure they align with Datix (e.g. closed date, near miss definition, Green1 (no harm) severity)
• Investigation timescales for incidents of all grades, and where relevant, how we manage investigation extensions.
• Level of performance information in clinical risk reports for Operational Management Group (OMG).

Safety First

Summary of Incidents July 2019 - June 2020

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



	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Red (should not be compared with SIs)	11	4	10	9	12	14	11	13	11	6	8	12
Amber	33	34	39	41	31	26	46	41	30	35	42	45
Yellow	96	138	83	94	93	83	93	81	111	80	101	94
Green	371	365	331	284	283	229	347	278	336	301	277	327
Green no harm	679	676	629	616	639	584	596	580	594	547	514	548
Total	1190	1217	1092	1044	1058	936	1093	993	1082	969	942	1026
Percentage of total that are Red/Amber/Yellow *	11.8%	14.5%	12.1%	13.8%	12.9%	13.1%	13.7%	13.6%	14.0%	12.5%	16.0%	14.7%

Degree of harm analysis:

Degree of harm will be updated when more information emerges. The patient safety support team add a provisional degree of harm at the point of an incident being reported based on information recorded at that point, and what the harm could potentially be. This is checked and revised when an incident is finally approved, after the manager has reviewed and added the outcome. This can be delayed due to length of time to review incidents, and volumes. This is a constantly changing position and the data was accurate at the time of extraction (14/7/20).
Deaths: of the 10 deaths reported, 4 Deaths are awaiting confirmation of cause of death for decision regarding level of review. The other 6 deaths are categorised as Slip/Trip/Fall (1), Suicide (incl apparent) - community team care - current episode (2) and Suicide (incl apparent) - community team care - discharged (3). Two of the deaths have been reported as serious incidents.
Severe harm: There were 2 severe harm incidents reported, 1 pressure ulcer incident reported by Neighbourhood Nursing Team Barnsley, 1 self harm incident reported by Assessment and IHBTT/ Crisis Team - Calderdale.
Moderate harm: Of the 32 incidents – these have been analysed and these are across a range of incidents, with no particular patterns or trends. Degree of harm will be updated when more information emerges and incidents are approved, so the position may change. Pressure ulcers continue to be the highest category of moderate harm incidents with 17 incidents (all Neighbourhood Nursing, Barnsley). There was 2 Tissue Viability other incidents recorded by Neighbourhood Nursing, Barnsley. The pressure ulcer and tissue viability incidents account for 41 % of all moderate harm incidents. There are no particular patterns or trend. One has been reported as a serious incident. There were 8 self-harm incidents (2 Enhanced Team, South Kirklees, 2 IHBTT Kirklees, 1 IHBTT Calderdale, 1 Enhanced Team East, Barnsley, 1 Enhanced Team East – Wakefield, 1 Stop Smoking Service – Doncaster. There was 1 unwell/illness incidents (1 Johnson Ward). There was 1 Safeguarding Adult incidents (Barnsley Enhanced Team West). There was 1 medication incident on Johnson Ward and 1 incident involving a patient absent without leave on Elmdale Ward. There was 1 slip/trip/fall on Beamshaw Ward.
Degree of harm will be updated when more information emerges and incidents

** 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

	20/21 Q1	19/20 Q2	19/20 Q3	19/20 Q4	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20
Death - cause of death unknown/ unexplained/ awaiting confirmation	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0
Death - confirmed from physical/natural causes	0	0	1	1	0	0	0	0	0	1	1	0	0	0	0	0
Security - Other	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Slip, trip or fall - patient	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0
Substance Misuse	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0
Suicide (incl apparent) - community team care - current episode	4	10	4	5	5	2	3	2	1	1	4	0	1	0	2	2
Suicide (incl apparent) - community team care - discharged	1	1	1	0	1	0	0	0	0	1	0	0	0	0	0	1
Suicide (incl apparent) - inpatient care - current episode	0	0	0	4	0	0	0	0	0	0	1	2	1	0	0	0
Unintended/Accidental injury	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Physical violence (contact made) against staff by patient	0	0	1	2	0	0	0	0	1	0	1	1	0	0	0	0
Pressure Ulcer - Category 3	2	1	1	0	0	0	1	0	0	1	0	0	0	0	0	2
Total	9	12	8	15	6	2	4	2	2	4	9	4	2	0	4	5

- Incident reporting levels have been checked and remain within the expected range.
- Degree of harm and severity are both subject to change as incidents are reviewed and outcomes are established.
- Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
- All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
- Risk panel meets weekly and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.

Mortality

Learning: Work paused during Covid 19, work is planned to recommence work to develop thematic learning summaries for sharing across the Trust.

Regional work: Regional meeting held 9/7/20, Acute focus, with discussion around medical examiners and use of SJR in Covid 19 deaths. Connections made with lead in RDASH. Next Northern Alliance meeting planned for September 2020.

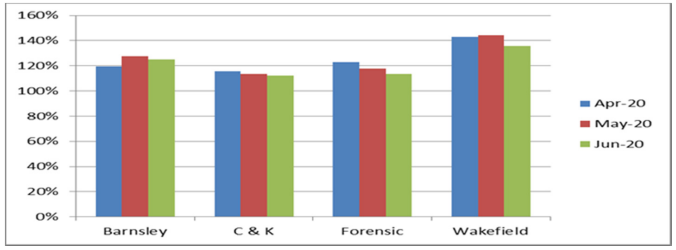
Reporting: A summary of mortality reporting has been prepared and included in the Incident annual report 2019/20. An update on Quarter 1 data will be included in the Q1 2020/21 Incident report. Further analysis will be carried out later in the year. Analysis of deaths occurring from 1/3/20 - 30/6/20 is being prepared for Clinical risk panel.

Structured judgement reviews: SJR training (via Teams) is planned for 30 July. New reviewers are always welcomed. Anyone wishing to complete reviews, to contact learningfromdeaths@swyt.nhs.uk and guidance and support will be given.

Safer Staffing Inpatients

The staffing fill rates for June 2020 included a reduced proportion of staff either self-isolating or shielding due to the COVID-19 virus as well as staff redeployed to core services. The influx of student nurses (78 in total) has had a positive impact on Services. At present, 11 of these students have opted to end their contract with the rest opting to extend to the 23rd August. This is an ever changing picture. There has also been some success in the Bring Back to Work project as well as retirees and returns. All the above was supported by an ongoing recruitment onto bank project with June's recruitment onto bank figures:
The trust is also continuing an extensive COVI-19 testing programme, anti-body testing and have embarked on its track and trace model.
No ward has fallen below the 90% overall fill rate threshold. Of the 31 inpatient areas, 28 (89.6%), a decrease of one ward on the previous month, achieved greater than 100%. Indeed of those 28 wards, 16 (an increase of six wards) achieved greater than 120% fill rate.
Registered On Days -Trust Total 89.3% (an increase of 1.0%). The number of wards that have failed to achieve 80% registered nurses decreased by one ward on the previous month to 12 (38.4%). Eight wards were within the Forensic BDU, two in Wakefield, one in Barnsley and one in Calderdale and Kirklees. All inpatient areas remain under pressure from a staffing perspective. COVID – 19 has had an impact on staffing as well as other contributory factors included high levels of acuity, high sickness/absence and existing vacancies. Forensic remains the focal point for the band 5 recruitment campaigns with some success which will have an impact moving forward. We are expecting an influx of new band 5 starters from September onwards.
Registered On Nights- Trust Total 98.4% (a decrease of 1.9%). Four wards (12.8%), an increase of one on the previous month, fell below the 80% fill rate in the month of January. Three were within the forensic BDU and the other within Barnsley BDU. This was due to a number of reasons reflective of the reasons in the section above. The number of wards who are achieving 100% and above fill rate on nights decreased by one to 21 (67.2%). One ward utilised in excess of 120%.
Overall fill rate for registered staff is 93.9%.

Ward Name	Apr-20 Average Fill Rate - All Staff (%)	May-20 Average Fill Rate - All Staff (%)	Jun-20 Average Fill Rate - All Staff (%)
Beamshaw	107.1%	121.6%	120.5%
Clark	95.5%	92.5%	99.3%
Melton Suite PICU	128.5%	133.9%	149.2%
Neuro Rehab Unit	121.1%	152.2%	142.9%
Stroke Rehab Unit	113.1%	118.7%	122.2%
Willow Ward	121.2%	114.9%	122.1%
Ashdale	96.0%	104.7%	102.1%
Beechdale	102.5%	116.4%	118.6%
Elmdale	97.6%	107.5%	105.9%
Enfield Down	102.5%	107.9%	100.7%
Lyndhurst	103.9%	111.1%	116.8%
Ward 18	107.3%	116.2%	130.4%
Ward 19 - Female	117.3%	105.4%	110.0%
Ward 19 - Male	103.8%	107.0%	116.2%
Appleton	110.0%	103.0%	98.0%
Bronte	133.4%	117.5%	136.2%
Chippendale	95.7%	97.0%	100.0%
Hepworth	110.0%	109.0%	168.2%
Johnson	173.1%	171.1%	170.4%
Newhaven	106.6%	105.0%	108.3%
Priestley	116.2%	102.6%	98.8%
Ryburn	117.3%	106.7%	109.5%
Sandal	131.0%	121.9%	136.9%
Thornhill	114.1%	106.9%	107.3%
Waterton	129.2%	133.9%	126.9%
Crofton	136.4%	119.8%	122.1%
Horizon	120.8%	119.6%	110.4%
Nostell	126.5%	141.1%	134.5%
Poplars	143.3%	154.8%	156.3%
Stanley	109.8%	137.0%	149.3%
Walton PICU	101.4%	124.2%	122.4%
All Wards	115.1%	119.4%	123.3%



BDU Overall Fill Rates

Forensic and LD BDU increased from 118% to 124%. Barnsley decreased from 128% to 125%. Calderdale and Kirklees BDU decreased from 114% to 112%. Wakefield BDU decreased from 144% to 136%.

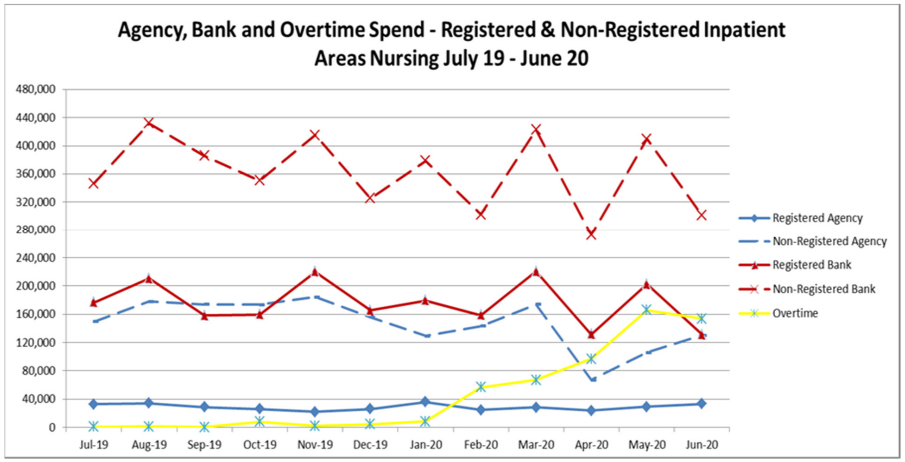
The overall spend, and usage of, bank and agency has fallen in June with several things impacting on this figure including less staff self-isolating due to COVID-19, substantive staff still not taking their full complement of planned leave and new starters within the HCA workforce.

Bank spend has decreased by just over £150K, Overtime decreased by around £12K whilst agency spend has increased by approximately £29K. This was as a result of a decrease in the overall temporary staffing requests, reduced by 405.53 hours, and a slight drop in bank staffs availability due to some staff taking a break from their bank role after a sustained period of engagement. This meant that there was a slight increase in the use of agency.

In June several wards had a fill rate exceeding expectations, which was due in the main to an increase in acuity and extra demand for staff but also due to the student nurses being counted in the fill rates (Table 2). In terms of increased demand, two wards stand out, 1) Hepworth ward had a Service User admitted to Pinderfields requiring a 3:1 escort resulting in a 60% average increase in staffing needs, and 2) Johnson Ward, which was used as a covid-19 cohort ward and the establishment template is due to be reviewed by the end of August.

Throughout the last month the main wards where staffing was a raised concern were Ward 18, Ashdale, Melton Suite, and Newton Lodge. Shifts were picked up quickly and the fill rate of requested flexible staffing shifts remained high . We are continuing to target the areas above within our recruitment campaigns, block booking and prioritization within bank booking. However, this does vary on a weekly basis dependent on acuity and clinical need as well as the impact of COVID-19 on particular wards.

Below shows the impact of an increase in the usage of bank/OT/excess hours on agency spend



Information Governance

June saw a slight decrease in confidentiality breaches down from 20 in May to 14 in June; in addition, the number of breaches caused by information being disclosed in error has reduced from 14 to 10, which is a significant improvement. In June, breaches of this type were due to correspondence being sent to the wrong recipient or email/ postal address and information about other parties being attached to or included with correspondence in error. It is likely that one of these will result in a complaint: the affected party has accepted there was an error and has not been harmed but has requested further information on raising a concern. The incident involved an intervention report for a child that had apparently been opened before being delivered to the intended recipient. The parent is concerned that the handwriting on the envelope is not clear and there is a spelling mistake, plus it wasn't sent by recorded delivery.

Three cases of lost paperwork were reported: one involved a prescription card that has not been located; the others involved personal data being found unsecured and being returned secure storage. There was also an incident involving inappropriate access to a record as a health professional viewed the record of a recently deceased patient who had been under their care: an informal warning has been issued by line management.

Commissioning for Quality and Innovation (CQUIN)

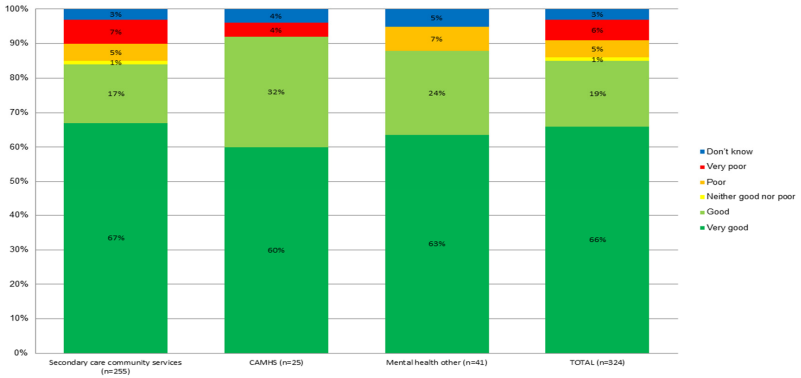
Schemes for 20/21 have been suspended during the Covid-19 pandemic period.

Patient Experience

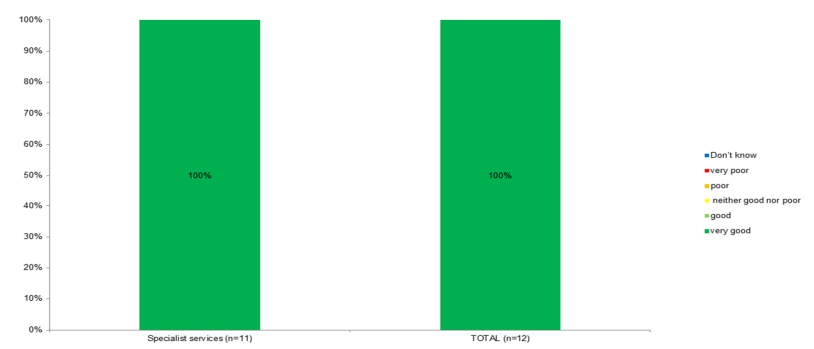
Friends and family test shows

- 100% of respondents would recommend community services.
- 85% would recommend mental health services.

Mental Health Services



Community Services



- 86% (n=321) of respondents would recommend Trust services.
- 100% (n=12) of respondents would recommend community services.
- 85% (n=333) of respondents would recommend mental health services.
- The new FFT was launched on the 15th June. All services have received new cards, literature and promotional items.
- Text messages provided 85% of the responses in June.

Care Quality Commission (CQC)

CQC inspection and MHA visits

While routine inspections have been paused, CQC say they have continued to inspect in response to risk and concerns raised, and services have remained subject to close monitoring using a range of intelligence sources. This includes an additional monitoring tool – the Emergency Support Framework (ESF). The ESF helps CQC better understand the impact of COVID-19 on staff and people using services and identify where they may need to inspect, or escalate concerns to partner organisations.
As the situation evolves and the impact on the health and social care system changes, CQC will be adapting the ESF tool to be used alongside their responsive visits and a managed return to routine inspection of lower risk services in the autumn. Inspectors are now scheduling inspections of higher risk services to take place over the summer.
CQC continue to undertake our MHA visits remotely. A number of our teams have been subject to this new way of working and the feedback about the process has been positive.
CQC improvement plan

In July core services will resume sending their monthly updates since this was paused due to the COVID-19 pandemic. There will be particular emphasis on five key 'must do' actions. These will focus on risk assessments, care planning, reduction of incidents of violence and aggression against staff, safe medicines and treating service users with dignity and respect. Due to the pandemic, extended timescales have been put in place for actions to be completed.

Closed cultures

CQC have issued updated guidance in relation to closed cultures and the measures that are being introduced. This is a follow-up from the guidance that was initially produced following the BBC Panorama documentary in May 2019 which exposed a culture of abuse and human rights breaches of people with a learning disability at Whorlton Hall, a privately run NHS funded unit. Following the programme CQC commissioned tow independent reviews into their regulation of Whorlton Hall that highlighted a number of shortfalls in the CQC regulation processes and reporting mechanisms. The new guidance will enable CQC to better identify and respond to services that might be at risk of developing closed cultures. In producing this guidance CQC worked with people who use services, Experts by Experience, families, Local Healthwatch and other stakeholders. All CQC inspectors and their regulatory colleagues will be required to undertake a series of training sessions throughout summer 2020 on the guidance and closed cultures more broadly. CQC are also looking to involve other people in this work through an Expert Advisory Group. The intention is that this group will consist of people with lived experience or through professional expertise in:

- Hospitals that care for autistic people or those with a learning disability
- Mental health hospitals, where people are detained under the Mental Health Act
- Services that use Deprivation of Liberty safeguards through the Mental Capacity Act including social care services.

CQC engagement meeting

We recently held our CQC engagement meeting via Microsoft Teams on 16 June. During this meeting CQC provided some positive verbal feedback on the actions we have taken to help maintain our care and services during the COVID-19 pandemic.

Safeguarding

Safeguarding Children and Adults
Safeguarding has remained a critical service throughout the Covid-19 pandemic, all statutory duties have been maintained, data flow has continued in a timely manner and the team have continued to provide supervision. Training has been accessed via e-learning and the training statistics have been monitored, any hotspot areas have been contacted and virtual training has taken place on the 10th July 2020.
External information gathering requests have been responded to and the team have continued to attend Safeguarding Practice Review panels, safeguarding Adult Review panels and Domestic Abuse panels. Additionally the team have received external information gathering requests from the Police for a Person in Position of Trust (PiPoT) concern and a potential DBS enquiry.
The team have supported clinical activity through attendance at multi-disciplinary meetings, section 42 enquiries and in child visiting arrangements.
The team contributed to the West Yorkshire Safeguarding week and presented a domestic abuse training session and have continued their own personal development by attendance at the NHSE Named Nurse event and safeguarding practitioner events. This learning has been shared with the wider safeguarding practitioners via the weekly newsletter and the link professional's forum.

Infection Prevention Control (IPC)

- Maintaining Substantial amount of work being undertaken in response to COVID19 Pandemic.
- Annual report 20/21 is yet to be completed, due September 2020
- Surveillance: there has been zero cases of C difficile, there has been zero cases of MRSA Bacteraemia, MSSA bacteraemia. and Ecoli bacteraemia.
- Mandatory training figures are healthy - Hand Hygiene-Trust wide Total –94%; Infection Prevention and Control- Trust wide Total –88%;
- Policies and procedures are up to date.

Complaints

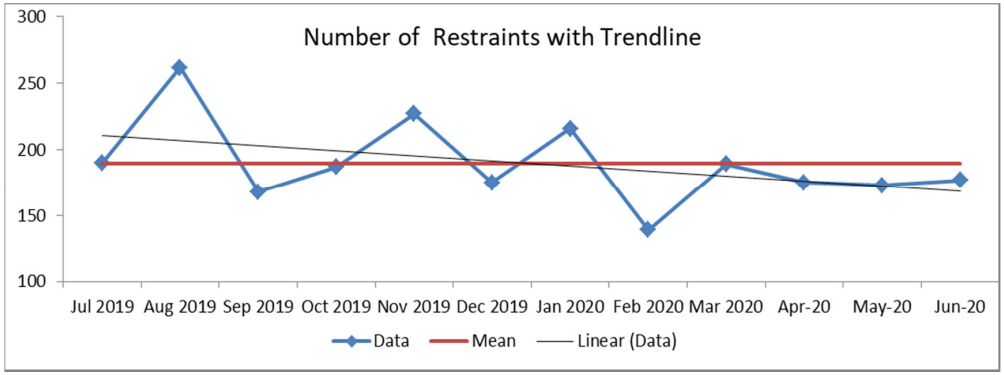
There were 29 new formal complaints, of these 8 have had timescales start, 4 have been closed as no consent/contact and 17 are awaiting consent/questions
17% of formal complaints (n=5) had staff attitude as a primary subject
41 compliments were received
10 formal complaints were closed in June 2020 plus 2 reopened complaints. Of the 10, 9 (90%) were closed within 40 working days .

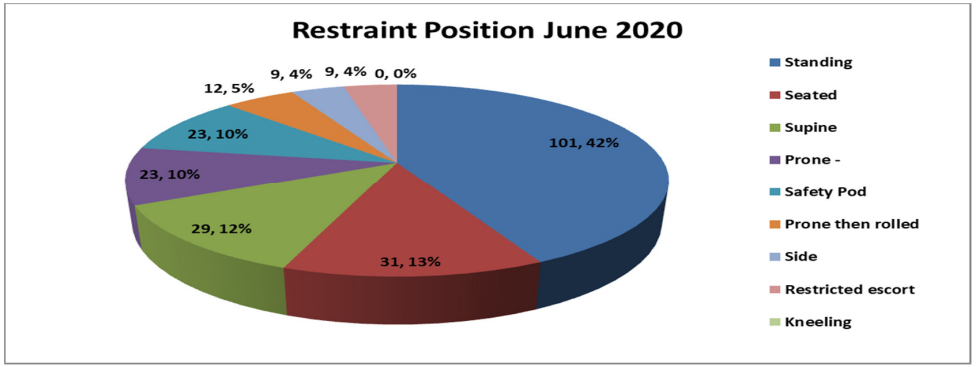
Infection Prevention Board Assurance Framework

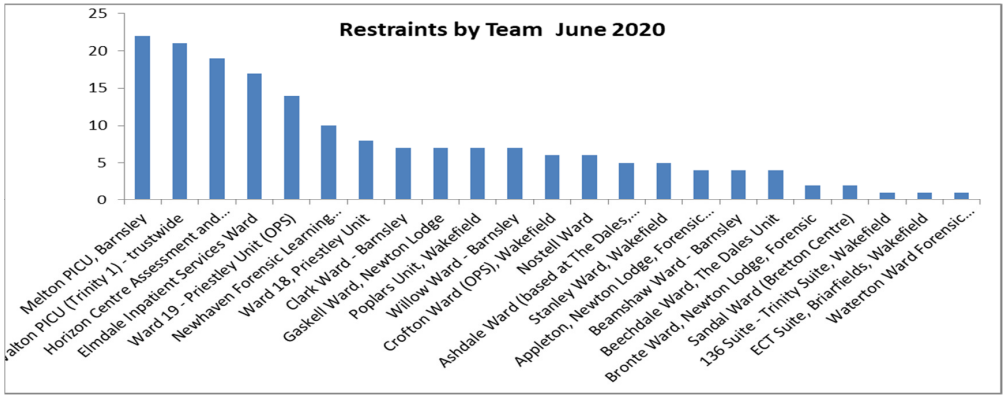
Maintaining Substantial amount of work being undertaken in response to COVID19 Pandemic.
Annual report 2020/21, due September 2020
Surveillance: there has been zero cases of C difficile, there has been zero cases of MRSA Bacteraemia, MSSA bacteraemia. and Ecoli bacteraemia.
Mandatory training figures are healthy: Hand Hygiene-Trust wide Total –94%, Infection Prevention and Control- Trust wide Total –88%
Policies and procedures are up to date.

Reducing Restrictive Physical Intervention (RRPI)

There were 177 reported incidents of Restrictive Physical Interventions used in June 2020 this being an increase in only 4 incidents since May2020. There were 237 different restraint positions used in the 177 incidents. The standing position was used most often 101 (42%) followed by seated restraints at 31(13%).
Prone restraint was reported 29 (14%) times in June 2020. Wakefield BDU had the highest number of Prone Restraints with 11. Barnsley BDU and Forensic BDU both had 7, Kirklees had 1 and Calderdale had 3 and Specialist services had no reports of Prone Restraint.
The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised. In June the percentage of prone restraints lasting under 3 minutes was 90% and the target was achieved
The RRPI team suspended training from 23rd March due the Covid 19 outbreak. Refresher periods have increased temporarily to prevent staff falling out of date. Work has been ongoing to provide information, support and advice to staff on the wards. From 21st July 2020 the RRPI team will restart the four day courses for ward based substantive and bank staff who have not previously received RRPI. These four day courses will continue each week until the backlog of untrained staff is cleared. This may take several months as the training venue can only accommodate eight participants and three instructors.

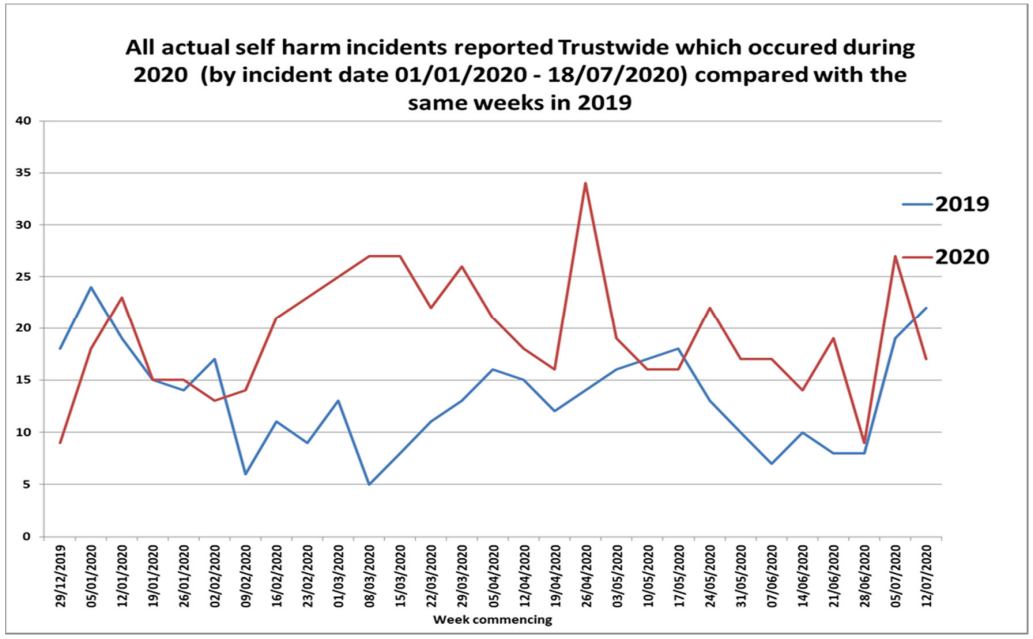






Self Harm

Actual self-harm incidents reported on Datix occurring between 01/01/2020 and 18/07/2020 at 20/07/20, compared with incidents occurring in the same period in 2019

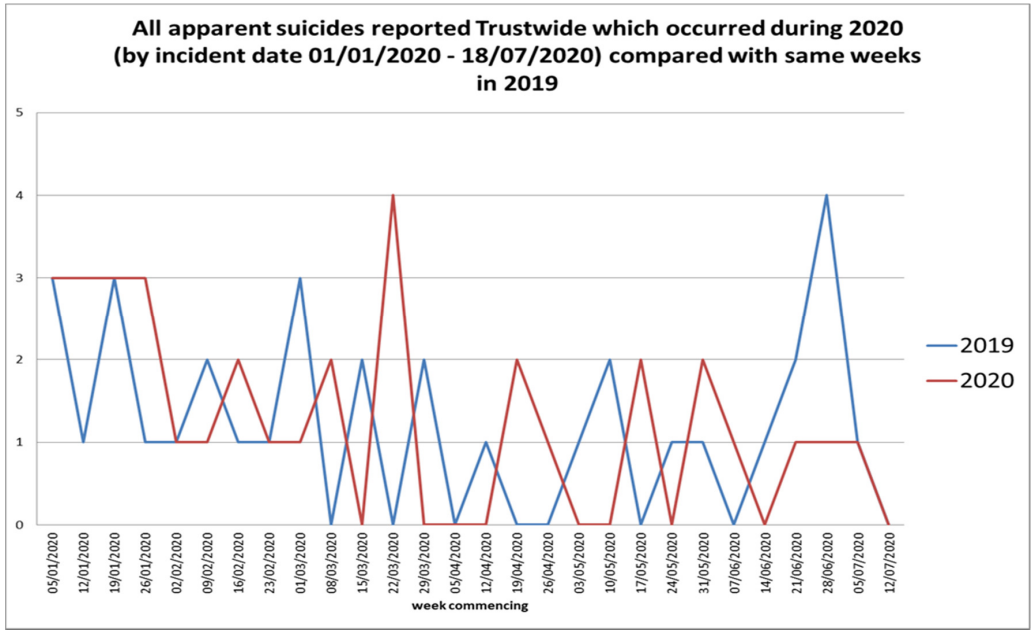


Actual Self Harm comparison

	2019	2020
29/12/2019	18	9
05/01/2020	24	18
12/01/2020	19	23
19/01/2020	15	15
26/01/2020	14	15
02/02/2020	17	13
09/02/2020	6	14
16/02/2020	11	21
23/02/2020	9	23
01/03/2020	13	25
08/03/2020	5	27
15/03/2020	8	27
22/03/2020	11	22
29/03/2020	13	26
05/04/2020	16	21
12/04/2020	15	18
19/04/2020	12	16
26/04/2020	14	34
03/05/2020	16	19
10/05/2020	17	16
17/05/2020	18	16
24/05/2020	13	22
31/05/2020	10	17
07/06/2020	7	17
14/06/2020	10	14
21/06/2020	8	19
28/06/2020	8	9
05/07/2020	19	27
12/07/2020	22	17
Total	388	560

Apparent Suicide

Apparent suicides reported on Datix occurring between 01/01/2020 and 18/07/2020 at 20/07/2020, compared with incidents occurring in the same period in 2019



Apparent suicide comparison

	2019	2020
05/01/2020	3	3
12/01/2020	1	3
19/01/2020	3	3
26/01/2020	1	3
02/02/2020	1	1
09/02/2020	2	1
16/02/2020	1	2
23/02/2020	1	1
01/03/2020	3	1
08/03/2020	0	2
15/03/2020	2	0
22/03/2020	0	4
29/03/2020	2	0
05/04/2020	0	0
12/04/2020	1	0
19/04/2020	0	2
26/04/2020	0	1
03/05/2020	1	0
10/05/2020	2	0
17/05/2020	0	2
24/05/2020	1	0
31/05/2020	1	2
07/06/2020	0	1
14/06/2020	1	0
21/06/2020	2	1
28/06/2020	4	1
05/07/2020	1	1
12/07/2020	0	0
Total	34*	35*

Please note:

*2020 figure includes 3 apparent suicides reported but which after initial review were not SWYPFT incidents.

**In comparison, the 2019 figure includes 6 apparent suicides of people who were not under SWYPFT care.

Covid-19 related incident reporting

There continues to be a decrease in the number of COVID-19 reported incidents with only six incidents reported so far in July, with the incidents being reported as COVID-19 impacting on a service users mental health and staff having contact with a service user who may be presenting with COVID-19 symptoms. In total there have been 150 COVID-19 related different themes identified from the beginning of March.

127 incidents	Mar	Apr	May	Jun	Total
Coronavirus or Covid 19 used in threat against patient	1	1	0	0	**2**
Coronavirus or Covid 19 used in threat against staff	3	2	1	0	**6**
Death of patient from suspected Covid 19 - no underlying health conditions	0	0	1	0	**1**
Death of patient from suspected Covid 19 - underlying health conditions	2	16	3	1	**22**
Death of patient from suspected Covid 19 related death - pending further info	0	7	4	3	**14**
Impact of coronavirus/Covid 19 on patient and staff safety	4	5	9	3	**21**
Impact of Covid 19 on community patient, changes to care delivery	2	2	2	1	**7**
Impact of Covid 19 on patients mental health	2	2	1	0	**5**
Issues relating to PPE equipment	1	1	1	0	**3**
Non compliance with social distancing - inpatient area	1	7	4	8	**20**
Patient being nursed in isolation	5	4	3	4	**16**
Patient in contact with symptomatic person	0	0	2	0	**2**
Staff in contact with other person displaying Covid-19 symptoms	1	0	2	0	**3**
Staff in contact with patient displaying Covid-19 symptoms	2	8	5	3	**18**
Staff member on swabbing team exposed to Covid 19	0	1	0	0	**1**
Staff presenting with Covid 19 symptoms	1	1	1	0	**3**
Total	**25**	**57**	**39**	**23**	**144**

Mental Health Act

This section provides some key metrics related to performance against the Mental Health Act (MHA) requirements. Development of these has been taking place over the last few months. Monthly reporting of performance against Section 17 leave is now available. 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 SystmOne and where to access The SystmOne 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. Further update regarding this can be seen below.

Section 17 leave

The Care Quality Commission have regularly raised an issue with the non completion of page 2 of the Section 17 leave from. The recording of who has been informed of the leave and the involvement of the service users is a requirement of the MHA code of practice. Previous initiatives have not proven successful, therefore 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 since September 2019 and has proven effective in most areas.
Guidance note for staff has been completed and circulated to all clinical services.
The numbers quoted 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 reviewing and returning where not completed. The 100% compliance target is what is expected by the MHA code of practice.

	Jan-20			Feb-20			Mar-20			Apr-20			May-20			Jun-20		
	Section 17 form			Section 17 form			Section 17 form			Section 17 form			Section 17 form			Section 17 form		
Service	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete
Older people services Trustwide	149	128	85.9%	72	55	76.4%	23	22	95.7%	43	34	79.1%	58	49	84.5%	77	58	75.3%
Working age adult - Trustwide	346	261	75.4%	245	160	65.3%	240	168	70.0%	234	186	79.5%	247	210	85.0%	292	192	65.8%
Specialist Forensic services	121	85	70.2%	193	161	83.4%	63	35	55.6%	0	n/a	n/a	6	5	n/a	18	16	88.9%
Rehabilitation services - trustwide	32	26	81.3%	18	18	100.0%	32	32	100.0%	17	16	94.1%	24	24	100.0%	15	15	100.0%

Patients rights

Work is progressing on reporting for the adherence to reading of patients' rights. This data is now being recorded on SystmOne. We are now in the process of writing a report to flow this data. We were anticipating this data to be available in last months integrated performance report but due to Covid-19 this has been delayed. A further update will be provided in next months report.
There is currently a manual process in place monitoring the reading of patients' rights which is being undertaken by the mental health act administrators in conjunction with the wards.

This section of the report outlines the Trust's performance against a number of national metrics. These have been categorised into metrics relating to:
• NHS Improvement Oversight Framework - NHS providers must strive to meet key national access standards, including those in the NHS Constitution. One element of the framework relates to operational performance and this is be measured using a range of existing nationally collected and evaluated datasets, where possible. The table below lists the metrics that are monitored and identifies baseline data where available and identifies performance against threshold.
• 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 - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Data quality rating [8]	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	98.8%	98.2%	97.8%	90.0%	98.3%	98.3%	97.8%	97.0%	95.6%	90.0%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100.0%	100.0%	100.0%	29.0%	100.0%	100.0%	100.0%	52.0%	32.1%	29.0%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	99.7%	99.7%	97.9%	100%	100%	96.0%	97.7%	99.0%	99.2%	100%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	344/354 97.18%	319/327 97.55%	269/279 =96.42%	297/299 = 99.33%	83/87 =95.4%	81/85 =95.29%	105/107 =98.13%	90/92 =97.8%	102/102 = 100%	105/105 = 100%		
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	97.1%	98.3%	98.5%	*98.5%*	98.5%	98.5%	98.6%	*98.5%*	*98.6%*	*98.5%*		
Out of area bed days [5]	Improving Care	Responsive	CH	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	318	108	440	103	133	170	137	23	8	72		
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	53.4%	53.6%	54.3%	*46.7%*	55.4%	52.4%	55.7%	*51.4%*	*49.2%*	*42.8%*		
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	77.5%	79.3%	85.3%	*88.1%*	85.8%	83.7%	86.5%	86.3%	*87.9%*	*89.4%*		
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	98.3%	97.6%	98.9%	*98.7%*	99.2%	98.5%	99.1%	99.3%	*98.3%*	*98.6%*		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	56%	84.0%	82.6%	85.6%	84.6%	86.7%	84.4%	85.7%	70.7%	95.8%	92.3%		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	89.4%	90.5%	91.3%	*91%*	91.0%	91.3%	91.3%	91.3%	91.2%	*91.2%*	⚠	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	11.6%	11.8%	12.1%	*12%*	11.8%	12.1%	12.3%	12.3%	12.3%	*12.7%*	⚠	
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 August 20											

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Data quality rating [8]	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	28	27	17	10	12	0	5	2	5	3		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	2	3	3	4	1	0	2	1	2	1		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	183	206	180	258	180			258				
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	13.1%	11.2%	10.0%	14.7%	10.0%			14.7%				

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q2 19/20	Q3 19/20	Q4 19/20	Q1 20/21	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Data quality rating [8]	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%	99.4%	98.8%	99.3%	*99.1%*	99.4%	99.0%	99.7%	99.5%	98.7%	*99.0%*		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.9%	99..9%	99.9%	*99.9%*	98.8%	99.9%	99.8%	99.9%	99.9%	*99.9%*		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	98.6%	98.7%	98.8%	*98.7%*	99.9%	98.8%	98.9%	98.8%	98.7%	*98.6%*		

** 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.

Headlines:

- The Trust continues to perform well against most NHS Improvement metrics
- The percentage of service users waiting less than 18 weeks from referral to treatment has dropped. This is due to the current situation surrounding Covid-19 meaning that only urgent diagnostic tests can take place at BHNFT.
- The percentage of service users seen for a diagnostic appointment within 6 weeks has dropped. This is due to the current situation surrounding Covid-19. The national reporting for this line has been suspended by NHS England for this interim period.
- Inappropriate out of area bed placements amounted to 72 days in June. This increase is accelerating further in July.
- During June 2020, 1 service user aged under 18 years was placed in an adult inpatient ward for a total of 3 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request. This issue does have an impact on total Trust bed availability and therefore the use of out of area bed placements. In addition, the Trust's operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
- % 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 scope of the data quality maturity index changed in July 2019 as part of a national CQUIN, though the target has remained the same. The Trust has been consistently achieving this target.
- IAPT treatment within 6 weeks of referral has achieved the 75% target although there are continuing challenges in meeting this particularly in regard to staffing numbers.

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 June the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for June shows 13.5% of records have an unknown or missing employment and/or accommodation status, this is a decrease from May which showed 15% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work takes place within business delivery units to review this data and improve completeness.

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

Barnsley general community services

Key Issues
• Covid-19 – in response to the national request we have continued to deliver a refined service offer across general community services in line with current emergency planning arrangements. Recovery plans are being developed.
• Therapy services - aiming towards recovery requires a several pronged approach due to the high clinical element of service provision and ensuring we maintain distancing requirements to protect both staff and patients.
• Speech and language therapy (SLT) currently operating with reduced staffing due to vacancies
• Podiatry - some staffing gaps due to retirement. Recruitment underway but note there is national shortage.

Strengths
• General community staff continue to provide asymptomatic and symptomatic swabbing service for community patients and care homes residents and staff.
• Care home asymptomatic swabbing was undertaken by the community swabbing team. In a 6 week period a total of 2118 swabs were taken by our staff in Barnsley
• There is an increasing demand for face to face visits for community nursing, neighbourhood rehab and crisis response.
• There has been an increased demand for more complex end of life (EOL) patients in community settings.
• Live well Wakefield (LWW) service continues to attract additional support work with funding from the local authority
• Services continue to utilise technology to undertake telephone/video call contacts to maintain service provision.
• Discharge to assess (D2A) – project continuing with partner organisations is benefiting from improving relationships, communication and working together. It is enabling a better understanding of the whole system in order to offer solutions to issues.
• Therapy services - telephone consultations and other media communication with patients and staff continues to allow some form of assessment to identify patients who definitely need to be offered face to face contact with an offer of advice to others.
• Creation of one therapy team across domiciliary physio, occupational therapy and neighbourhood rehabilitation service allowing improved working practices to be identified.
• Primary care network decision to agree to recruit first contact physiotherapist as part of SWYPFT musculoskeletal service.
• Stroke early supported discharge service is now operational and has patients on the caseload. Providing priority 1 face to face visits and in addition, using technology to undertake telephone/video call contacts.
• Psychology neuro outpatient service are also undertaking video/telephone calls to all new patient referrals.

Challenges
• Support to care homes, particularly those with Covid-19 symptomatic and positive residents due to increasing numbers and infection control challenges
• Increased patient flow into home visiting elements of services.
• Services not providing face to face appointments are providing telephone and video conferencing support. Some services are reporting that despite staff working smarter clients are requiring more support from services.
• Health integration team in Urban House – continue to work in a challenging environment. The service is working with the Director of Public Health/Commissioner/Home Office/Public Health England and other stakeholders to maintain a safe environment for staff and clients
• Live Well Wakefield Team - remain extremely busy and have a number of staff sicknesses, which is impacting on the service manager's resource. Additional support is being put in place.
• Children's services are moving into the recovery phase. Vaccinations and immunisations team are delivering catch up sessions in community settings due to school closures and requirement to ensure secure "bubbles".
• Long term working from home appears to be impacting on staff wellbeing and team cohesion and therefore recovery plans with agreed timescales are being developed as well as staff being supported by service managers, HR and occupational health
• BHNFT is utilising approx. 50% capacity of D2A over the course of a week for discharging patients. Encouraging BHNFT to support earlier in the day discharges as this is where capacity is not being maximised fully.
• Patients' expectations are that services should be returning to normal and are therefore making demands on services whilst we still go through the recovery planning stages.
• Significant increase in referrals to neuro rehab/stroke rehab as patients present with symptoms post Covid-19.

Areas of Focus
• Discharge to Assess (D2A) service continues
• Recovery group in place which will link to strategic partner plans.
• Antigen testing for partner organisations provided by SWYPFT staff – 47 samples taken in the first week-end and 71 slots booked for the following week-end.
• Recovery planning for children's service
• Support staff working from home and those who are absent from work (and their managers)
• Continue to support health integration team and lead nurse to deliver safe service
• Speech & language therapy – aiming to flex limited work force across entire system.
• First contact physiotherapist development within the MSK service alongside the primary care network and GP Federation.

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

Barnsley mental health services and child and adolescent mental health services:

Mental Health:
Strengths
• 24/7 crisis support arrangements simplified and strengthened. Adult intensive home based treatment service providing all-age single point of access function out of hours. This is designed to reduce 111 calls, attendances at A&E and is complementing implementation of a 24/7 helpline.
• Formal staff consultation to re-commence regarding establishment of an all-age liaison model.
• Community contacts and single point of access activity have increased. Community contacts significantly above target. Majority are currently provided by telephone/video-link but face to face contact offered where clinically required.
• Proactive support of in-patients in facilitating discharge planning through joint community allocation group
• Recovery College prospectus for September completed – to be published in August 2020.

Areas of focus
• IAPT performance reporting suspended and KPIs to be re-negotiated with the CCG. All activity is currently being undertaken on video or by telephone. Suspension of group-based activity has significantly reduced access and activity levels. Virtual options for group work to be trialled.
• Following robust environmental risk assessment memory service diagnostic clinics have been re-instated with increased capacity to address the backlog. Expected to address backlog by end of December 2020.
• Focus on inputting to ensure all non- face to face activity is reliably recorded/reported. As an example carer support contacts are currently significantly under reported in memory services.
• Management focus on recording to improve clustering data.

Child and adolescent mental health services:
Strengths
• Discussions held with Barnsley CCG following cancellation of the procurement. A joint governance approach has been agreed to achieve the service specification.
• Community services provided essentially through telephone/video (AirMid) contact with ability to support on a face-to-face basis where there is a clinical need. An evaluation report has been produced regarding the new ways of working and the learning is being used to inform next steps.
• Referral numbers across all services have reduced but are slowly increasing. Waiting numbers in Barnsley/Wakefield have continued to reduce.

Areas of focus
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees continue to increase. This is despite additional commissioned activity. The position is recognised by commissioners and business cases have been submitted to support further resource and improved service.

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

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Inpatient & Wakefield:

Key issues

• A significant rise in demand for inpatient beds, together with the ability to maintain patient flow and sufficient ward capacity, has been extremely challenging resulting in a notable increase in patients placed out of area in acute and PICU beds, although the majority of the latter placements were for safeguarding or gender-specific reasons. Concerted work is continuing on optimising patient flow including the appointment to seconded roles and the provision of services at week-ends. Intensive input is taking place in front line services 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. Work is underway in intensive home based treatment teams (IHBTs) to look at building up early discharge, alternatives to admission and to ensure robust gatekeeping, including progress on accompanying approved mental health professionals (AMHPs) on mental health act assessments. The care closer to home programme is focusing on patient flow, PICU usage, and IHBT and community team interfaces. A task and finish group has been established to review the patient flow protocol.
• Cohorting standard operating procedures for acute and older people's services are in place and an inpatient clinical pathway operationalised for Covid-19 positive patients. This has now been reviewed to take into account the latest guidance and testing on admission and post-admission interval requirements for patients. The position with regard to the number of patients requiring isolation is reviewed daily by the matrons in relation to the potential implementation of phased cohorting plans and to determine how services can best be managed in the event of an outbreak.
• Acute wards have been experiencing protracted periods of pressure with levels of acuity and service user distress (including serious incidents). There have also been challenges in meeting the range of needs of patients in the wards including cohorted patients and those requiring shielding. Staffing levels have generally been able to be maintained without significant growth in bank and agency usage. Weekly meetings with integrated care system (ICS) partners have enabled the strengthening of collaborative approaches, shared learning and innovative practice developments.
• Average length of stay (ALOS) remains in excess of target and has been identified as part of the trust wide programme of improvement in addressing demand and capacity in acute services, drawing on the work around criteria led discharge, which has been re-launched and re-focused for each area with early indications of success.
• The action plan and training around care programme approach (CPA) reviews, data quality and activity and improvement in how we use SystmOne is leading to some positive impact but requires more work, and is being closely monitored and supported at trio level.
• Community services continue to provide assessment, care management and interventions with service users utilising a range of innovative means of communication and ensuring face to face contacts are made wherever these are clinically indicated.
• Building risk assessments are in place for all community bases and are now being tested against phased recovery plans. Services are working collaboratively across BDUs to optimise safety and patient and staff access and usage.

Strengths

• Willow ward has been accredited under the Royal College of Psychiatrists QNOAMHS scheme -The Quality Network for Older Adults Mental Health Services accredits wards which are providing services to older people and engages staff and people who use services in a comprehensive process of self and peer review for the purposes of accreditation and quality improvement. Good practice and high quality care are recognised and services are supported to identify areas for improvement.
• Work continues to improve patient flow and work with partners in the wider system to improve patient experience and pathways.
• A workshop facilitated by association of directors of social services (ADASS) has taken place across SWYPFT and all our local authority partners to explore improved integration and to agree priorities and action planning for the next 6 months.
• Community teams have continued to optimise the use of technology, team functions and supervision being held via Microsoft Teams, and using AirMid & AccuRx for appointments with service users. Telephone appointments and WhatsApp have also been utilised. Work has now commenced in services around the implications of digital exclusion and a local evidence base is building around how we can best support all service users and carers in terms of future access and best use of our services.
• Performance remains good for 72 hour follow up CQUIN.
• Fire training stats have continued to demonstrate progress for inpatients with specific action plans in place for those wards still under achievement, supervised and tracked by the matrons. The use of e-learning at this time has supported this performance.
• Electroconvulsive therapy (ECT) is fully staffed and has remained operational. Improvements to the environment in the context of Covid-19 are now being scoped to increase capacity for treatment sessions.
• Work continues with advocacy services to look at providing advocacy services via digital platforms
• Use of virtual visitor for engaging patients with their families is proving popular with patients and carers.
• Production of a patient led Covid-19 questions and answer booklet produced in Barnsley and to be shared across our inpatient services.
• Purchasing of goods from charitable bids to enhance patient activities during Covid-19 has significantly improved the quality of patient experience and has been received really well by patients and carers.
• We have relaunched inpatient strategy meetings and linked to the acute care forums, utilising digital technology - taking into consideration additional actions from Covid-19.
• We have successfully appointed to two substantive general manager roles in the BDU, community and recovery and inpatient services.
• There has been a proactive approach to recruitment to successful outcome across the board throughout the last 3 months, including the appointment to posts in community teams, IHBTs and police liaison.
• Work continues to mobilise an all age liaison service between CAMHS and psychiatric liaison teams PLT with commencement of consultation imminent.

Challenges

• Adult acute occupancy remains at full capacity and acuity levels remain high, together with Covid-19 requirements, leading to sustained challenges on the wards.
• There has been an increased usage of acute and PICU out of area bed placements.
• Staffing difficulties remain in medical posts in older people's wards – this is being addressed through a task and finish group
• CPA reviews have been subject to action planning lead by the general manager and quality and governance lead - this has made significant progress but there are still areas for improvement.
• Maintaining service delivery in community settings in ways which keep pace with changes in how society is functioning and meeting service user needs.

Areas of Focus

• Patient flow and out of area bed placement usage.
• Support for staff on inpatient wards
• 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 in all services.
• Continuing and developing service delivery, innovation and recovery.
• Staffing challenges in older people's medical teams.
• Continue to improve performance in service area hotspots through focused action planning tracked team by team by general managers.
• Recruitment and retention and successful mobilisation of new investment.
• Continue our contribution to the primary care networks in local areas and the partnership working in the provider alliance.
• Develop and strengthen the creative community offer lead by recovery colleges and our wider partners.

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

Calderdale & Kirklees:

Key issues

• Demand for acute admissions in the system and levels of activity in IHBT and mental health liaison teams (MHLT) leading to pressures for inpatient beds.
• Community services including IHBTs are seeing high levels of acuity and distress and relapse rates in service users on their caseloads, leading to continued pressures.
• Acute medical and A&E systems remain under intense admission and delayed transfers of care (DTOC) pressures leading to associated pressures in our pathways and services.
• Community services continue to provide assessment, care management and interventions with service users utilising a range of innovative means of communication and ensure face to face contacts are made wherever these are clinically indicated.
• The project around 'how we can work effectively with service users at present and keep ourselves safe' which emanated from serious incidents in the community has commenced a focused piece of work around improving how we support patients in the community who are subject to Ministry of Justice restrictions.
• Older adult wards remain under pressure due to acuity associated with mental health, physical health and end of life.
• MHLT is making good progress towards the development towards provision of an all-age liaison service in conjunction with CAMHS.
• Since the onset of Covid-19 IAPT services in line with local and national IAPT service providers have shown a similar pattern of low referrals and access rates, increasing waiting times and lower recovery rates. The IAPT teams have been early implementers of digital usage and have robust plans in place to manage wait times and increase access and have been participating in workshops with NHSE around service provision during and post Covid-19.

Strengths

• Kirklees IAPT have developed a comprehensive action plan to address waiting times and recovery standards which incorporates the use of videoconference type-talk cognitive behavioural therapy (CBT); individual practitioner productivity; review of average treatment episode durations in line with national standards and sign up to PCMIS outcome monitoring service to measure projected recovery rates.
• Single point of access (SPA) has continued work on service improvement and is implementing the UK triage tool, working with local GPs to develop electronic paperwork and referral systems.
• Performance remains good for 72 hour follow up
• Action plans and data improvement plans are in place to address areas identified for performance improvement.
• Training and development has continued for the trauma informed personality disorder (TIPD) pathway which involves a number of staff across community and IHBT teams and linking with inpatient areas to build collaborative approaches and optimise care in community setting.
• Mandatory training concordance remains high. Good progress made with supervision. Action plans are in place closely tracked by each general manager.
• The 'Think Ahead' trainee social work programme under the leadership of the consultant social worker has successfully completed work with its second cohort of practitioners who have all passed and become qualified social workers, now moving on to their assessed and supported year in employemnt (ASYE) years in Kirklees teams. The new cohort of four trainees will commence in placement in August.
• Calderdale and Kirklees held a virtual workshop for team managers and trios 'we want to be outstanding' looking at safety, quality, improvement and learning from experience, inspection, and serious incidents. Over 40 people attended and evaluation was really positive with action plans developed at team and individual level.

Challenges

• Demand and patient flow issues and optimising community solutions.
• Maintaining service delivery in community settings in ways which keep pace with changes in how society functions and service user needs.
• In line with other national IAPT services referral rates fell to below 30% of expected between Feb and April but started to recover in May and June. Usual reporting will be required from Quarter 2. IAPT continue to offer bespoke wellbeing interventions for people who have been negatively impacted by lockdown using digital methods of delivery and are preparing a series of video stress control groups which can be booked through our new online self -referral portal.
• There has been a proactive approach to recruitment to successful outcome throughout the last 3 months, with interviews for key posts planned.
• CPA reviews have been subject to action planning lead by the general manager and quality and governance lead - this has made significant progress but there are still areas for improvement.

Areas of focus

• Contributing to patient flow and effective use of inpatient resources and alternatives to admission.
• Continuing and developing service delivery, innovation and recovery.
• Recruitment and mobilisation of new investment.
• Continue to improve performance and concordance in service area hotspots
• Support for staff wellbeing across the BDU.
• Develop and strengthen the creative community offer lead by recovery colleges and our wider partners.
• Continue with developments at ICS and CCG level around rehabilitation and recovery modelling.
• Continue focus on improvement in SPA and IHBT models.
• Continue our contribution to the primary care networks in local areas and the partnership working in developing the provider alliances.
• Develop and strengthen the creative community offer lead by recovery colleges and our wider partners.

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

Forensic business delivery unit and Learning Disability services:

Learning Disability

• Data Quality relating to initial screening and service provision within 18 weeks is currently being worked through to manually correct on the system.
• 'Did not attends' (DNAs) via telephone/video link have reduced.
• There was a reduction in referral rates at the start of the outbreak of Covid-19 but have now started to increase again.
• Varying changes in circumstances during lockdown for some of our clients with learning disabilities, such as no day care provision and families not working so able to provide full-time care to their family member, have meant temporarily lower requirement for a service during the pandemic. We have created some temporary waiting lists on SystmOne to support the management of this, which will feature in restoration and Reset plans.
• Kirklees CCG have approved the 4 month appointment of a strategic health facilitator to specifically focus on learning disability in care homes- this is to support GPs to complete annual health checks and ensure every service user has a health action plan in place. The post has been advertised already.

ASD/ADHD

• Positive survey results from remote appointment experience - these have been shared with relevant directors.
• Operational activity unfolding according to plan with limiting factors being availability of estates.
• Transformed diagnostic pathway for ADHD working so far.
• Business plan prepared for Barnsley CCG to increase capacity of the service and address the waiting list for autism.

Forensics

• Forensic development plan remains a priority.
• Review of the implementation of the cohort ward has been undertaken. This included the infection prevention & control (IPC) review supplemented by the operational view. Recommendation is that the cohort facility remains available but the service will regularly review. Silver command supported this.
• Recruitment to the SCFT (Specialist Community Forensic Team) is positive despite the Covid-19 crisis.
• Weekly calls with the specialist commissioner continue.
• Sickness absence from work remains a focus across the service.
• All risk assessments in place for 'shielded' staff to support return to work.

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Communications, Engagement and Involvement

Communications, Engagement and Involvement

- Bronze command meeting taking place internally for communication and engagement
- Coronavirus update sent out to all staff and governors.
- Coronavirus sections on the intranet and website maintained and updated.
- Face covering marketing materials distributed.
- Sharing of staff and service user good news stories, internally, externally and through social media channels.
- Wakefield Families Together and Wakefield 'early help' website supported.
- Wakefield CAMHS transformation programme – PR, media and internal comms.
- Awareness days and weeks supported including children's art week, NHS Birthday.
- Partner Bronze command meetings continue to taking place in all areas. Support provided re outbreak management.
- 'Top tips on looking after your mental wellbeing' campaign ran on social media.
- Support provided to EyUp Charity, Creative Minds and Spirit in Mind.
- Support provided to SystmOne information roll out project, including letters to stakeholders and service users
- Recovery college comms, including promotion of online courses and newsletters. New websites procured and designs in development.
- Media responses, including on restrictive practises, electronic prescribing and BAME risk assessments.
- Proactive media including on #stillhereto help campaign, Creative Minds and Barnsley library project, cardio/pulmonary rehab restarting, virtual visitor, Wakefield CAMHS, electronic prescribing.
- Promotion of West Yorkshire and Harrogate initiatives, including autism survey, mental health helpline and grief and loss helpline.

Engagement, Equality and volunteering update

- Trust wide Virtual Visitor scheme in place. Gathering feedback now to evaluate and develop a business proposal to mainstream the offer
- Covid-19 Trust wide equality impact assessment (EIA) and action plan now on version 2 and a supporting toolkit containing literature and research now in place – 2 task forces set up and being fully supported by the team. Process in place to deliver the EIA and a website page set up and now being used by people – lots of contact in the team to support this work
- EIA urgent decision making form and process now approved by Silver command and on the Covid-19 section of the website. To be taken to Operational Management Group (OMG) as part of an approach to enable the recovery and reset work.
- Plan to involve Wakefield in a conversation on mental health developed and will be shared with the Wakefield mental health alliance. The work will also pick up the ask for Wakefield Safespace
- Creation of a Trust wide patient engagement and experience toolkit – a number of conversations planned with intelligence gathered centrally to inform Trust wide next steps. Continue to encourage BDUs and staff to use the toolkit.
- Work to support the involvement of stakeholders in the ethics committee – looking at a clinical senate approach and a proposal will be drafted by August to be shared with the committee early Autumn.
- Equality delivery system 2 report of findings is now complete – the Trust assessed complaints and patient experience and achieved an overall 'Achieving' which is great news.
- Report of findings from the strategy engagement is now being circulated to stakeholders who participated in the engagement in draft for comment. The findings have already been used to support initial strategy development. The Trust in total received over 700 responses from all protected groups through postcards, focus groups, conversations and a survey.
- Carers matter online event complete and a report of findings developed with a number of actions included. Future meetings to be set up to progress the work Trust wide strategy in first draft and out for comment. The associated action plans for equality, engagement and carers will follow once the objectives are agreed
- Linking into wider volunteering approaches and supporting partners such as Barnsley council to mobilise volunteer opportunities
- Working in partnership with Barnsley community & voluntary services (CVS), council and SWYPFT colleagues to mobilise a preventative mental health support network along the lines of Virtual Visitor.
- Short term project officer post recruited to – post is for 3 months and will look at diversity in volunteering and carers
- Successful bid to charities commission – our involvement has secured 2 posts focussed on BAME staff and BAME communities
- Peer support worker report, action plan and draft job description have now been developed. The next steps will be to promote the opportunities for BDUs to host a peer worker post in any vacant posts going forward. A number of presentations will be planned.
- Developing a strategy for volunteering – framework to support volunteers is in place and has been shared for comment with Trust staff and recovery colleges.

This is the July 2020 priority programme progress update for the integrated performance report. It is a summary of the activity conducted in the period for June 2020. The priority programme areas of work providing an update in this report have been refocused in response to the covid19 pandemic. The following programmes of work reported in the IPR this month are:

1. CAMHS improvement
2. Forensic improvement
3. Advance our wellbeing and recovery approach
4. Work with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield, West Yorkshire
5. Accelerating use of digital technology
6. Providing care as close to home as possible

The framework for this update is based on the revised Trust priority programmes agreed in March 2020, and provides details of the scope, aims, delivery and governance arrangements, and progress to date including risk management. The proposed delivery is in line with the Trust's Integrated Change Framework.

Priority	Scope	SRO	Change Manager	Governance Route	Narrative Update	Progress RAG rating
IMPROVE HEALTH						
Advance our wellbeing and recovery approach	Focus on how we change the offer to support community wellbeing and recovery in light of Covid19, working with Creative Minds, recovery colleges, SIM, and volunteer services to develop and deliver innovative offers to help people in their own homes.	Salma Yasmeen	Sue Barton & Matt Ellis	EMT	Online courses are being delivered by the recovery colleges using Microsoft Teams and are being well received. Other methods continue to be used to engage with learners such as YouTube, texting and circulation of newsletters (both virtually and in paper form for those who require it). Work has commenced to understand the requirements for a safe return to some face to face courses. The recovery college websites are at the initial design stage. Creative Minds are supporting a range of partners to deliver digital offers to vulnerable groups. Interviews are scheduled for the new posts for Active Calderdale and Arts and Health	
Work with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield, West Yorkshire	Work with partners in Barnsley, Kirklees, Calderdale, Wakefield, South Yorkshire and West Yorkshire to develop a joint response to Covid-19 and placed based recovery plans.	Sean Rayner / Salma Yasmeen	Sharon Carter	EMT	Work continues with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield and West Yorkshire to develop a joint response to stabilisation and recovery. As part of this a number of helplines have been established to support staff, carers and services users. An example of this is the establishment of the West Yorkshire bereavement helpline in June. To support the joint response, a series of stress test exercises are being undertaken at place based level across the regions in early July, designed to stress test the stabilisation and reset of health and care services in a Covid-19 environment. We have contributed to the development of plans to respond to diffrent scenarios as part of the integrated care system (ICS) stress testing workshops. This will enable us to provide safe joined up care with partners in places. We have also fed our learning into the recent Rapid Insights report published by West Yorkshire and Harrogate Health and Care Partnership and the Yorkshire & Humber AHSN which provides insights from across the region on how we have responded to the Covid-19 challenge. In WY&H, the mental health, learning disabilities and autism programme (MHLDA) programme board met on 16 June 2020, and agreed that workstreams either continue as they have been doing during Covid-19 pandemic or continue in a re-purposed form. Wakefield – Close partnership working continues with sharing and involvement in Wakefield stabilisation and reset review. The Wakefield Mental Health Alliance programme of work for 2020/21 continues to progress to plan. Dialectic behavioural training was successfully delivered virtually in June, and the next round of alliance emotional and mental wellbeing small grants funding, managed by Nova, went live on 26th June. The Live Well small grants funding also went live on the same day. Calderdale work has focused on building on the improved integration during covid-19 and designing together a collaborative communities model to provide care closer to home for the people of Calderdale . In Kirklees SWYPFT continue to work with partners to establish Kirklees place stabilisation and reset priorities and programme. The SY&B wave 2 roll out of Individual Placement and Support (IPS) was progressing well with South Yorkshire Housing (SYHA) as the lead provider and coordinating the mobilisation process, prior to Covid-19. All the posts had been advertised across SY&B, and the two SWYPFT roles recruited to by SWYPFT to cover Barnsley. The partnership agreement, data sharing agreement and collaboration agreement between SYHA and the Trust have been agreed and signed. Throughout Covid-19 the two SWYPFT workers have maintained roles as IPS workers for the majority of time, and have successfully supported 5 service users to gain paid employment. The Quit programme is now being implemented in inpatient mental health services in Barnsley. A new band 8a role working 15 hours per week for two years on secondment has been recruited (fixed term for 2 years). A band 6 post working 15 hours per week is to be recruited along with 3 band 3 posts (2.5 wte) and a band 3 admin support role. Outstanding recruitment was put on hold due to Covid-19 as face to face contact can only be limited. The band 8a will focus on setting up internal QUIT systems, processes, IT, training, data collection etc. in readiness for team recruitment and the service becoming fully operational. An internal QUIT steering group is in place which is strongly linked into the wider local and ICS wide systems. Barnsley CCG has confirmed that at this stage they do not intend re-procuring the Barnsley CAMHS service and that the contract for the CAMHS service will be extended to 31 March 2021 with a view to working with SWYPFT during the next few months to develop the future service model from April 2021. Our community teams in Barnsley continue to support care homes in their coronavirus response, including outbreak testing.	

IMPROVE CARE							
Provide all care as close to home as possible	Focus on PICU, patient flow and criteria led discharge (CLD) All other workstreams to maintain a momentum but at an appropriate pace	Carol Harris	Ryan Hunter	OMG	Ongoing increase in occupied bed usage has resulted in some acute OOA placements in recent weeks and a spike in out of area (ooa) bed placements in late June and into early July. Feedback is that people are hitting the system with high acuity, often people that are new to service or have been previously settled for a considerable period of time. PICU - standard operating procedure (SOP) drafted - to be reviewed in July and then taken through governance process. CLD - handover to matrons to manage as business as usual. Development of option to implement directly into SystmOne Patient flow - review of patient flow protocol and aim to revise draft in next period to then take through Trust governance. Implementation of new patient flow service ongoing with recruitment into the team taking place. Intensive home based treatment (IHBT) - 72 hour assessment more embedded but impact is difficult to assess due to Covid-19 - review in approx 3 months. Joint approved mental health profesisonals (AMHP) and IHBT assessment work being taken forward - initial review in July TIPD - recruited advanced clinical practitioner (ACP) role into North Kirklees. Work continues to understand and capture learning from experiences with services users through Covid-19, including analysis of contacts and development of questions to be used in service user engagement. Community - Referral levels have reduced but so has throughput from the caseload. Concerns that due to Covid-19 pressures and breakdown of social networks that people are breaking down more quickly. Plan for stocktake and refresh of community activity in the next period. Single point of access (SPA) - triage scale go live in July, with forms and appointment systems being established through SystmOne. Testing of e-referral has taken place on a very small scale and refinements made to the referral form. Work continues on pathways from primary care.	Progress Against Plan	
					Failure to deliver timely improvement due to lack of resource, other work priorities and skills - the likelihood of this has decreased a little in recent weeks as work is progressing across the programme now following Covid-19 prioritisation. However, pressures are now increasing across the whole system as the numbers of highly acutely unwell people access the system increase.		
					Milestones include: Patient flow protocol finalisation before taking through governance - Jul 2020 PICU SOP Review - Jul 2020 SPA triage scale live - Jul 2020 IHBT joint AMHP assessment initial review - Jul 2020 CLD future system decision - Jul/Aug 2020 Performance management - inpatient report development - Summer 2020 Community - refresh of activity - Summer 2020		
CAMHS Improvement work	Re-scoping based on project capacity and required support to implement changes to operational delivery. Will maintain a momentum but at a slower pace. This also includes improvement work to consolidate changes made in response to the pandemic that have had positive outcomes.	Carol Harris	Supported by Michele Ezro (Wakefield) and Maeve Boyle (Barnsley) Sharon Carter	CAMHS Improvement Group with monthly report to OMG	Full implementation of all age liaison service is not yet fully operational in both Barnsley and Wakefield. Staff consultation re-commenced in Barnsley on 6th July and expected to run for 2 weeks. The staff consultaton is expected to commence by mid-July in Wakefield and will run for a period of 4 weeks. Work, being led by Julie Warren-Sykes is ongoing with finalisaton of the competency framework following receipt of further comments within the Trust. Revised action plan for Barnsley all age liaison service continues to be progressed . Waiting list numbers are still coming down both within Wakefield and Barnsley. Specialist therapies are now showing impact from Covid-19 however continues to remain close to trajectories that were set in Wakefield. Alternative approach has commenced within Barnsley to enable full completion of ADHD assessments in Barnsley irrespective of school closures.	Progress Against Plan	
					Barnsley CCG confirmed with SWYFT following its June 2020 CCG Governing Board meeting that it would be cancelling the procurement exercise and will be working with SWYFT to agree a new service model from April 2021 onwards.	Management of Risk	
					Implementation plan/Key milestones include: By 31/07/20 production of a summary report regarding the key changes, current learning and experiences across all CAMHS services By 31/08/20 completion of the staff consultations for both Barnsley and Wakefield relating to all age liaison services. By 30/09/20 implementation of all age liaision services in both Barnsley and Wakefield with appropriate support from CAMHS , delivery of competency framework and transition arrangements in place. By 31/08/20 commencement of the roll-out of the recovery pathway in Wakefield as part of response to children in crisis. By 14/09/20 evaluation of 3 virtual groups within Barnsley completed based on PDSA model approach to assist with wider learning within all CAMHS services. By 14/08/20 completion of further update reports (for months of June and July) to Barnsley CCG regarding progress made on WLI with potential exploration regarding extending the waiting list initiative (WLI) in light of Covid-19 situation.		
Forensics Improvement work	Improvement plan has been prioritised by steering group with clear focus on safety, learning lessons, staff engagement and staff wellbeing	Carol Harris	Sue Barton	Forensics Improvement Group with monthly report to OMG	Work continues to deliver the key actions in the forensic improvement plan. Organisational Development, including communication and engagement are areas of focus. Staff workshops are being planned, virtually, to commence this work. A communication approach has been developed for the directorate which includes regular, systematic communication mechanisms.		

IMPROVE RESOURCES					
Make better use of digital technology and introducing new ways of virtual working to help support staff and service users	Focus on testing, implementing and evaluating digital technology to help maintain services in light of Covid19 EPMA – electronic prescribing project AirMid & WhatsApp for E Consultations Virtual Visitors Continue to maintain I Hub to support staff wellbeing and facilitate conversations	Mark Brooks	Vicki Whyte	ISIG	Accelerating the use of digital technology Video conferencing: A number of solutions continue to be used; AirMid part of TPP's SystmOne offer continues to support practitioners to maintain contact with patients with 850 consultations in June. AccuRX utilised by non SystmOne users supported 900 consultations during June and over 1,000 clinical video consultations were supported by MS Teams during the same period. MS Teams has been rolled out to devices across the Trust to support video conferencing and instant messaging enabling teams and staff to maintain virtual contact whilst working offsite and to date 5,500 accounts are in place. During June 2020, there were 956 group calls, 9,233 one to one meetings, 15,450 meetings and 74,631 messages. Working from home – there is continued demand for working from home and to date: 300 additional laptops have been provided, 100 desktops enabled with wifi, 1,000 additional VPN tokens provided and circa 4,000 daily VPN connections are supported. SystmOne – the sharing of clinical information held within SystmOne has been switched on during an accelerated rollout. Under the Covid Act 2020 the need for consent to share was temporarily lifted until 30 September to support patient and public health. Work is now commencing to gain consent for sharing from service users before this deadline. EPMA (Electronic Prescribing and Medicines Administration) – The second project board has been held and computers on wheels to enable medication to be administered on wards have started to be rolled out across the Trust. Virtual Visitor - to ensure the people in our care do not become socially isolated, continue to have contact with their families, friends and volunteers a Virtual Visitor scheme using a dedicated android device on every ward continues to be used across inpatient areas. An evaluation looking at usage and feedback from users, family and friends and staff is currently underway. Recovery Colleges - online virtual Recovery College courses continue to be supported through MS Teams. Cards of Kindness - the digital way for friends and family of those in our care to send messages to their loved ones on wards continues to be supported with 26 cards sent to date to various wards across the Trust during the pandemic. The scheme has received positive feedback with comments such as 'thank you, what a lovely surprise.' The Digital Strategy Group discussed and considered the learning from working differently using digital solutions during covid-19 at the June Strategy Group which will now be fed into the revision of the Digital Strategy 2021/22.
MAKE THIS A GREAT PLACE TO WORK				EMT	Focus on this in relation to Covid 19: Support the wellbeing of #allofus to help people cope & connect Support people to embrace new ways of working that have been beneficial . These programmes of work report at key milestones directly to EMT and thus no update is required via the IPR

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

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

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

Glossary of terms:	
AMHP Approved Mental Health Professional	MH Mental Health
ATU Assessment and Treatment Unit	MOU Memorandum of Understanding
Bassetlaw	NHS National Health Service
BDCFT Bradford District Care Trust	NHSE/I National Health Service England/ NHS Improvement
C&YP Children and Young People	NMOC New model of care
CCG Clinical Commissioning Group	OMG Organisational Management Group
CSDG Clinical Safety Design Group	OPS Older Peoples Services
DBT Dialectic Behavioural Therapy	P&I Performance and Information
EMT Executive Management Team	PCH Primary Car Hub (also referred to as Primary Care Network)
ESD Early Supported Discharge	PCN Primary Care network (also referred to as Primary Care Hub)
FIRM Formulation Informed Risk Assessment	QI Quality Improvement
GP General Practitioner	QSIR Quality, Service Improvement and Re-design
HASU Hyper Acute Stroke Unit	RACI Roles and responsibilities indicator
HCP Healthcare Partnership	SBAR Situation - Background - Assessment - Recommendation quality improvement tool
IAPT Improving access to Psychological Therapies	SPA Single Point of Access
ICS Integrated Care System	SPC Statistical Process Control
ICT Integrated Change Team	SRU Stroke Rehabilitation Unit
IHBT Intensive Home Based Treatment	SSG an external consultant agency
IHI Institute for Health Improvement	SWYPFT South West Yorkshire Partnership Foundation Trust
IM&T Information management and technology	TIPD Trauma Informed Personality Disorder
IPS Individual Placement Support	UEC Urgent and Emergency Care
LD Learning Disabilities	VCS Voluntary and Community Sector
LTC Long Term Conditions	WY West Yorkshire
LTP Long term plan	WY&H West Yorkshire and Harrogate

Overall Financial Performance 2020/21

Executive Summary / Key Performance Indicators

Performance Indicator		Year to date	Forecast July 20	Narrative
1	Surplus / Deficit			In line with national guidance the Trust is reporting a breakeven position for April to July 2020. To achieve this additional national funding is required for both reimbursement of covid-19 costs incurred and additional top up. For June this equated to £478k and £393k respectively.
	Covid-19 reimbursement	£1.4m		
	Top Up	£0.9m		
	Reported position	£0m	£0m	
		Year to date	**Forecast 20/21**	**Narrative**
2	Agency Cap	£1.5m	£6.3m	Whilst there is currently no NHS Improvement agency cap set for 2020/21 the Trust continues to monitor agency spend and action plans remain to ensure agency staffing usage and costs is appropriate. Spend in June was £0.5m.
3	Cash	£54.1m	£39.5m	Cash in the bank continues to be above expected levels. The main reason is the timing of block income payments (which are a month in advance). This is reduced partially by the earlier timing of invoice payments as demonstrated by the better payment figures.
5	Capital	£0.1m	£6.6m	The Trust submitted a revised capital plan for 2020/21 of £6.6m. This continues to be reviewed in light of access, affordability and value for money driven by the implications of covid-19.
6	Better Payment			This performance is based upon a combined NHS / Non NHS value and demonstrates that 83% of invoices have been paid within 7 days.
	30 days	97%		
	7 days	83%		

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

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.7%	4.7%	4.9%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	4.9%	4.0%	3.9%	3.9%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.7%	4.7%	5.20%	5.30%	5.10%	5.10%	5.10%	5.0%	5.30%	5.0%	4.6%	4.2%	3.9%	3.9%	4.0%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	76.2%			75.1%			76.1%				73.3%		68.3%		
Bank Cost	Improving Resources	Well Led	AD	-	£625k	£844k	£695k	£708k	£889k	£770k	£700k	£887k	£705k	£769k	£685k	£1,241k	£727k.	£866k	£721k
Agency Cost	Improving Resources	Effective	AD	-	£613k	£641k	£619k	£722k	£629k	£628k	£674k	£572k	£559k	£537k	£581k	£613k	£469k	£507k	£518k
Health & Safety																			
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	7			4			15						Due August 20		

1 - this does not include data for medical staffing.

- Focus has shifted to metrics showing the impact of Covid-19 on the workforce. These are expanded on in the earlier Covid-19 section.
- As at July 22nd, 47 staff off work Covid-19 related, not working
- 2238 staff tested as at July 22nd
- 134 staff have tested positive for Covid-19 of which 92 have returned to work
- Staff turnover increased to 9.8%
- Non-Covid sickness absence was 3.9% in June 20.
- Preparations are being made to recommence mandatory training and appraisals from September onwards
- Whilst underlying sickness absence levels are lower than last year there has been a 22% increase in staff off work with stress and anxiety

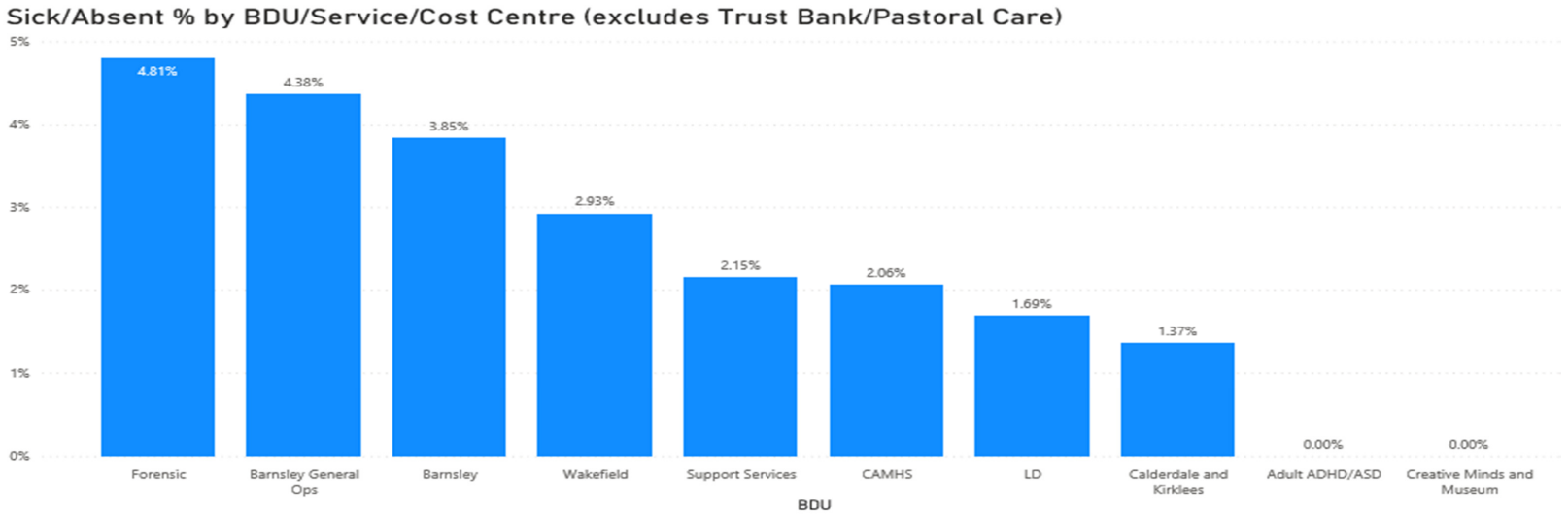
Sickness reporting

As at 2:30pm on Wednesday 22nd July, the Trust has 138 staff absent or working from home due to Covid-19. This makes up 2.7% of the workforce. Of those absent, 7.3% are symptomatic, 3.6% have household symptoms, 78.3% are shielding and 2.2% are occupational health advised isolation. The business delivery unit (BDU) with the biggest impact is Forensic with 4.8% of staff impacted (20/416), the BDU with the second biggest impact is Barnsley general ops with 4.4% of staff affected (33/753), the BDU with the third biggest impact is Barnsley with 3.9% of staff affected (20/520). This is obviously having a significant impact on operational services and resources are being deployed accordingly to ensure patient and staff safety during this challenging period.

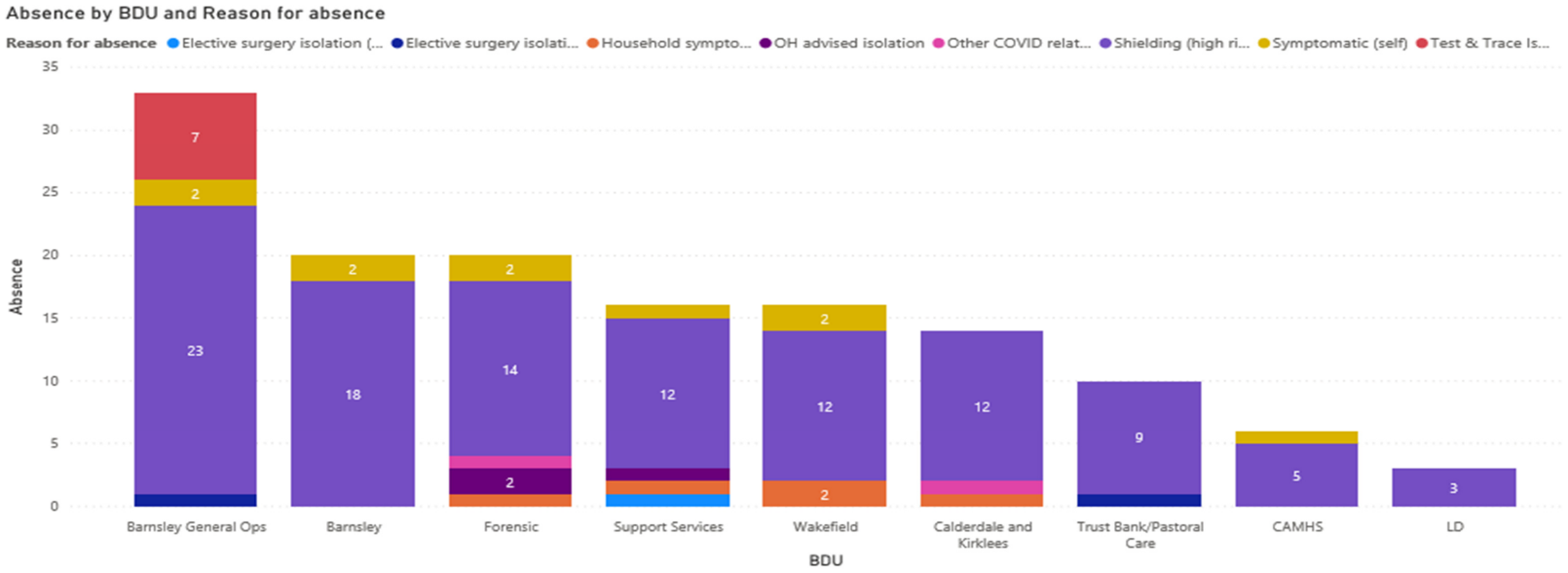
- The Trust continues to use a Gold, Silver and Bronze command structure.
- Business continuity plans have been updated across the Trust
- Bank and agency availability is being reviewed to assist with resource availability.
- Previous retired workers have been contacted and a number of those have agreed to come back to work to support.
- Critical functions for corporate support services are now generally working from home to adhere to the government's social distancing guidelines.
- Communications team are ensuring guidance is distributed and working hard to keep staff up to date.
- Average length of absence (days) for those not working due to covid symptoms (based on absence start date) (July is a to date figure)

Mar 10.3 days, Apr 10.7 days, May 9.4 days, Jun 6.7 days, Jul 4.4

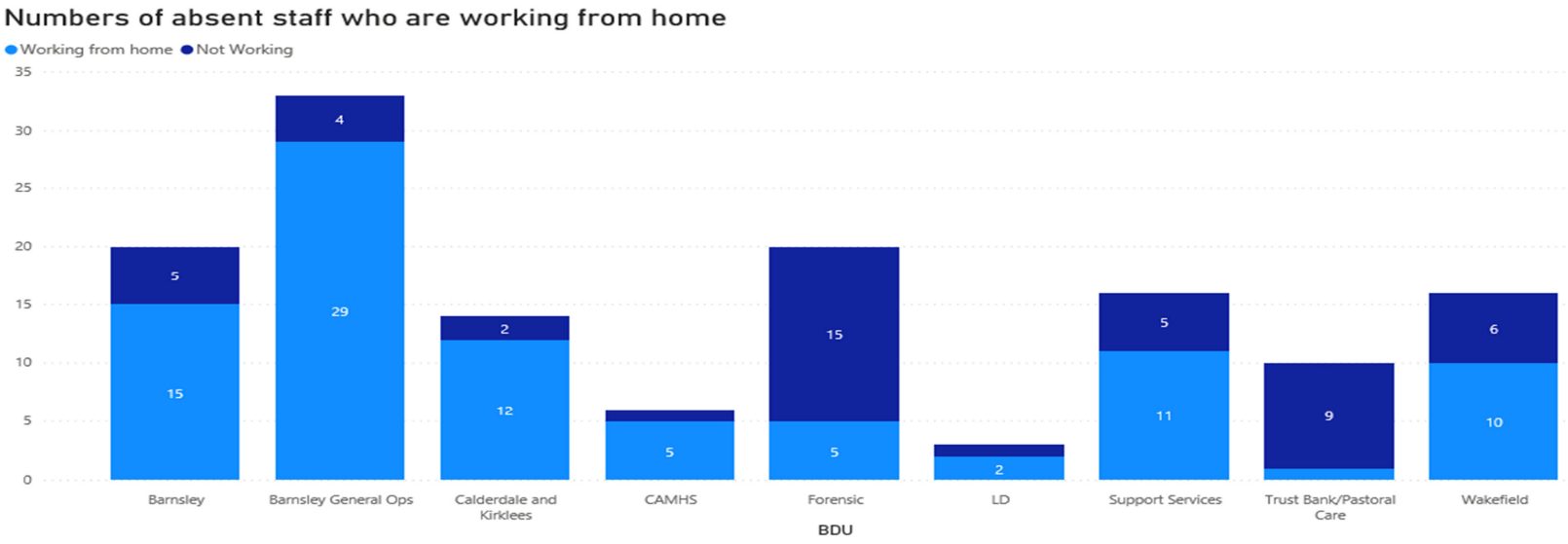
The following graph show the percentage of staff absences attributed to Covid-19 as a proportion of the BDU headcount. Wakefield, Barnsley ADHD/ASD services business delivery units are currently the greatest affected areas in the Trust.



The following graph shows the reasons for Covid-19 absence by BDU. The largest reason for absence relates to staff being advised to shield.



The following chart shows Covid-19 staff absences over the period 16th March - 22nd July:



Publication Summary

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

Seasonal flu vaccine uptake in healthcare workers: winter 2019 to 2020

Provisional monthly Hospital Episode Statistics for admitted patient care and outpatient data: April 2020

NHS sickness absence rates: February 2020, provisional statistics

NHS workforce statistics: March 2020

Psychological therapies: reports on the use of IAPT services, England, April 2020 final, including reports on the IAPT pilots

Out of area placements in mental health services: April 2020

Community services statistics for children, young people and adults: March 2020

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 3
(2020 / 21)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

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Performance Indicator		**Year to Date**	**Forecast July 20**	**Narrative**
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	Reported position	£0m	£0m	
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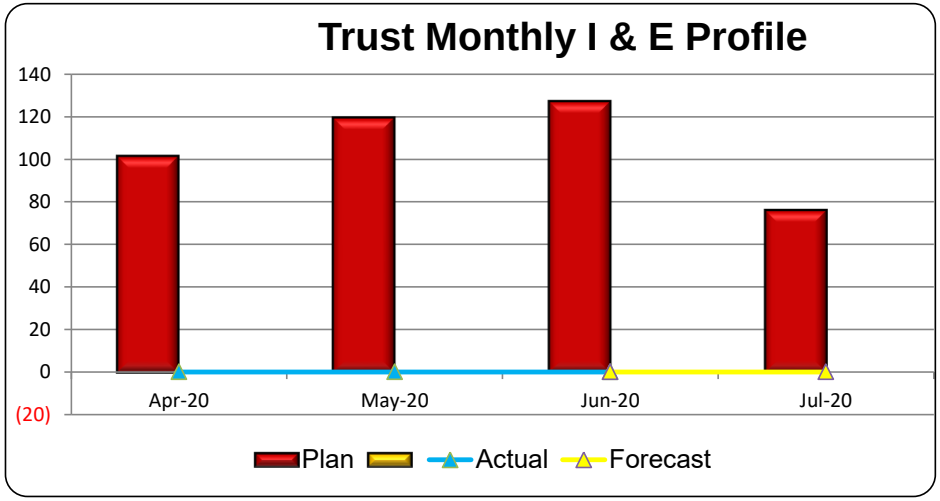
4	Capital	£0.1m	£6.6m	The Trust submitted a revised capital plan for 2020/21 of £6.6m. This continues to be reviewed in light of access, affordability and value for money driven by the implications of covid-19.
5	Better Payment			
	30 days	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 83% of invoices have been paid within 7 days.
	7 days	83%		

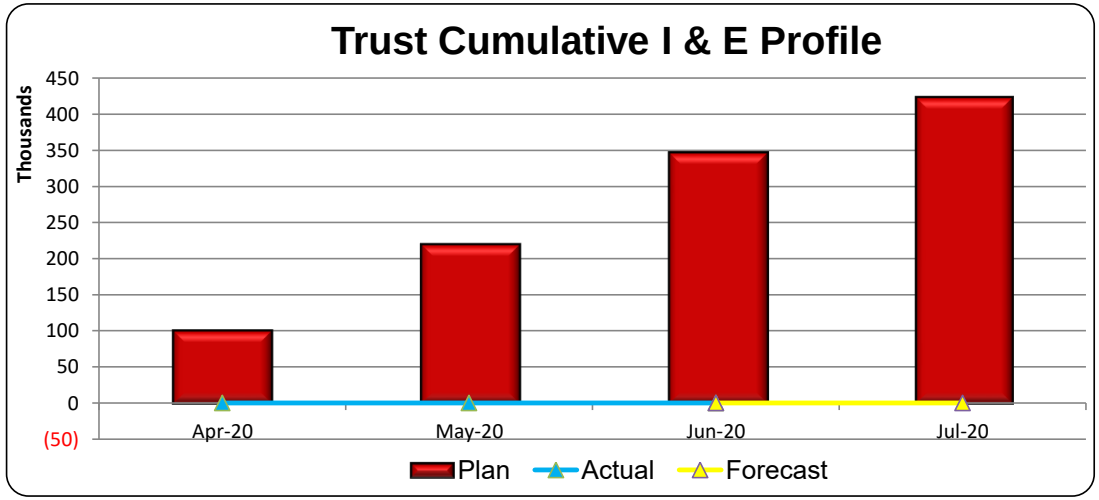
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

2.0 Income & Expenditure Position 2020 / 2021

Budget Staff	Actual worked	Variance		This Month	This Month	This Month	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Apr - Jul Budget	Apr - Jul Outturn	Apr - Jul Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				18,823	18,387	(436)	Clinical Revenue	56,469	54,718	(1,751)	75,289	73,297	(1,993)
				18,823	**18,387**	**(436)**	**Total Clinical Revenue**	**56,469**	**54,718**	**(1,751)**	**75,289**	**73,297**	**(1,993)**
				1,203	1,862	659	Other Operating Revenue	3,710	5,258	1,548	4,928	6,944	2,016
				20,026	**20,248**	**222**	**Total Revenue**	**60,179**	**59,975**	**(204)**	**80,217**	**80,240**	**23**
4,284	4,302	18	0.4%	(15,534)	(15,709)	(175)	Pay Costs	(46,952)	(46,870)	82	(62,664)	(62,737)	(73)
				(3,612)	(3,236)	376	Non Pay Costs	(10,618)	(9,947)	671	(14,139)	(13,550)	590
				7	(541)	(548)	Provisions	22	(871)	(893)	53	(907)	(961)
				0	0	0	Gain / (loss) on disposal	0	0	0	0	0	0
4,284	**4,302**	**18**	**-0.4%**	**(19,138)**	**(19,486)**	**(348)**	**Total Operating Expenses**	**(57,548)**	**(57,689)**	**(140)**	**(76,750)**	**(77,194)**	**(444)**
4,284	**4,302**	**18**	**-0.4%**	**888**	**762**	**(126)**	**EBITDA**	**2,630**	**2,286**	**(344)**	**3,467**	**3,047**	**(421)**
				(516)	(517)	(1)	Depreciation	(1,547)	(1,550)	(3)	(2,063)	(2,065)	(2)
				(253)	(245)	8	PDC Paid	(760)	(736)	24	(1,014)	(982)	32
				8	0	(8)	Interest Received	25	0	(25)	33	0	(33)
4,284	**4,302**	**18**	**-0.4%**	**127**	**(0)**	**(127)**	**Surplus / (Deficit)**	**348**	**0**	**(348)**	**424**	**0**	**(424)**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,284	**4,302**	**18**	**-0.4%**	**127**	**(0)**	**(127)**	**Surplus / (Deficit)**	**348**	**0**	**(348)**	**424**	**0**	**(424)**

The position above includes a budget value. This has been included for high level comparative purposes only and is based upon the Trust draft annual plan submission in March 2020. Due to timing this draft budget did not include any consideration of changes arising from covid-19.





Income & Expenditure Position 2019 / 20

A breakeven position has been reported for June. This assumes £393k of additional income via the 'top up' process.

The Trust financial position continues to be shaped by covid 19, through both additional costs incurred and changes to the financial architecture nationally. As part of this the Trust has identified £478k covid reimbursement income in June 2020 and a further top up of £393k in order to deliver an overall breakeven position. A separate breakdown of covid costs is provided on page 6.

Income

NHS England / Improvement (NHSE & I) instigated an interim approach to financial and commissioning arrangements for April to July 2020 (initially). The block arrangements were calculated nationally based on income received from key local commissioners during 2019/20 plus a tariff uplift. No further invoices or recharges are to be made and developments from new investment have been paused.

These nationally calculated values were internally assessed against 2020/21 draft contract positions. This highlighted a shortfall in income and this has been raised with NHS E & I to inform any future decision making. This shortfall is the reason we currently require additional top up income. Increases in this block value would reduce the need for additional top up funding.

The aim of this approach is to ensure consistency, certainty on cashflows and reduce administrative burdens.

This shortfall in current income is shown in the I & E position on page 4 which highlights £1.8m less income for the year to date when compared to draft plans. Other operating revenue includes the income due for covid cost imbursement.

Pay

Pay spend in June was £15.7m. This is £1.7 more than the average run rate from 2019/20. This is, in part, due to the impact of annual pay awards and increments but also due to additional staff working in the Trust. This is both additional substantive staff recruited as part of supporting the covid 19- response and planned service expansions relating to the mental health investment standard.

Non Pay

When compared to the draft plan non pay is £0.4m lower in month. This is shown on page 10. Savings in costs arising from the new ways of working adopted by the Trust, such as travel, stationery and other general office costs, are helping to reduce the amount of top up funding required. The sustainability of this continues to be assessed.

Covid-19 Financial Impact

Covid-19 is a key contributor to the financial position and the table below highlights the areas where the Trust has incurred costs as part of its response. These costs have been identified as additional and reasonable in line with national guidance.

Review and validation of these cost claims are undertaken within the Trust and the true costs of the response will be higher than those identified for recovery. This is both for the year to date and also into the future. For example existing Trust staff have been redeployed into roles to support the covid effort. As the Trust was already incurring the cost of these staff they have been excluded from this reclaim. It should be noted that there may be a future financial impact of this as those staff return to substantive roles as part of the recovery programme.

The table below includes the period of April to July as this is the current expected period of costs to be recovered in this way.

		Apr-20	May-20	Jun-20	Jul-20	Total
Heading	**Description**	**£k**	**£k**	**£k**	**£k**	**£k**
Staffing	Backfill of shifts due to covid (sickness, isolation, shielding)	110	150	133		**393**
Staffing – community	Community additional shifts	13	81	71		**165**
Staffing – cohort	Dedicated ward within Forensics required due to positive covid cases	0	26	51		**77**
Staffing - students	Costs of student nurses and medics over and above previous	0	2	132		**134**
Staffing – out of area	Costs of out of area placement providers to provide additional staff due to potential covid cases	16	0	0		**16**
Total – Pay		**139**	**259**	**387**		**785**
IM & T	Equipment to support new ways of working, from home, video conferencing, increased telecommunications	128	88	4		**220**
Laundry	In house laundry service including scrubs	96	8	13		**117**
Infection Control	Central store of additional infection control supplies (wipes,	27	49	18		**94**
Catering	Staff meals - those working on inpatient wards and in the community. Supply of refreshments	19	22	22		**63**
Discharge Equipment	Purchase of additional equipment to support hospital discharges	0	34	0		**34**
Communications	Consent to share letter			17		**17**
Misc / other	Other general non pay not captured in the headings above	8	16	17		**41**
Total – Non Pay		**278**	**217**	**91**		**586**
Total cost recovery		**417**	**476**	**478**		**1,371**

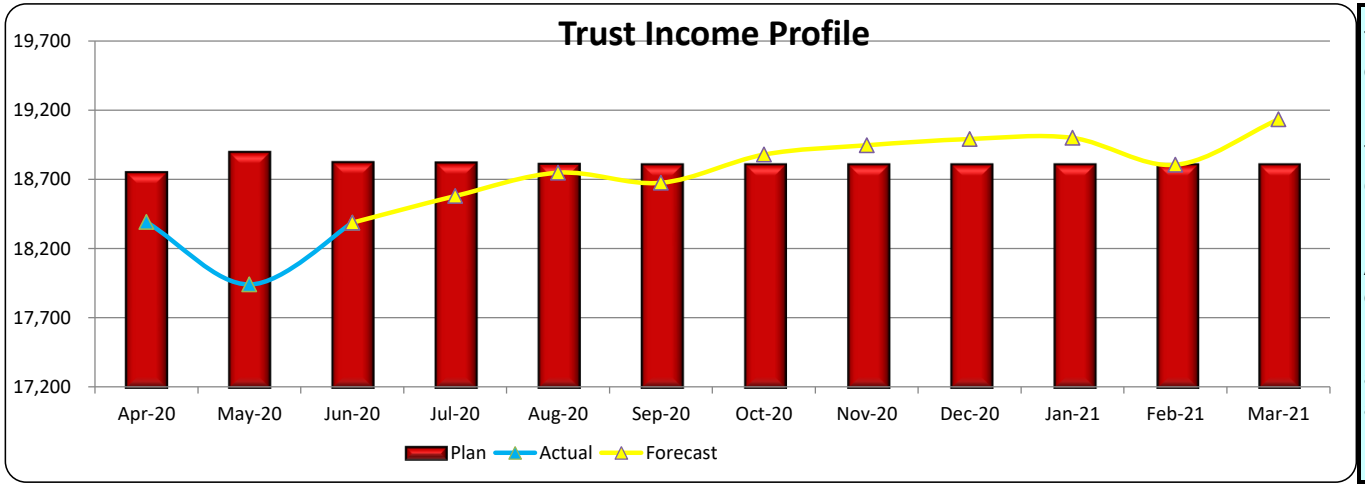
2.1 Income Information

As a national response to the covid-19 pandemic NHS England / Improvement announced that all income from NHS commissioners (Clinical Commissioning Groups and NHS England) would become a fixed block payment arrangement for April to July 2020. This would provide some cashflow certainty for a period of time and reduce administrative burdens.

The value of this was calculated centrally based upon information the Trust had provided within the 2019/20 Month 9 agreement of balances exercise plus a 2.8% uplift to cover tariff and mental health investment. There was no efficiency assumption applied. A further national top up value was also calculated to take account of income movements up to February 2020. There was no assessment in these calculations for items which were one off / non-recurrent or the full year effect of additional investment made in the latter part of the year.

The block payments covered all income from these commissioners. Therefore this included payment for services, staff recharges, recharge for projects etc. Income expected for these additional services has been allocated to BDUs but the overall value to the Trust remains unchanged.

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k	Total 19/20 £k
CCG	14,530	13,931	14,286	14,406	14,405	14,410	14,404	14,404	14,404	14,404	14,405	14,404	**172,393**	**171,720**
Specialist Commissioner	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,322	**27,869**	**27,895**
Local Authority	335	473	409	409	409	409	409	409	409	409	409	409	**4,896**	**7,755**
Partnerships	619	637	597	618	618	618	618	618	618	618	618	617	**7,410**	**7,673**
Top Up	550	550	702	785	954	876	1,085	1,153	1,198	1,206	1,011	1,339	**11,411**	**0**
Other	35	27	70	40	40	40	40	40	40	40	40	41	**490**	**418**
Total	**18,391**	**17,940**	**18,386**	**18,579**	**18,747**	**18,675**	**18,878**	**18,946**	**18,991**	**18,999**	**18,805**	**19,133**	**224,469**	**215,461**
19/20	17,509	17,502	17,373	17,646	17,765	17,628	17,906	17,572	18,061	19,031	18,334	19,134	**215,461**	



The Trust draft plan included contract values following initial discussions with commissioners and application of the national planning tariff uplift for 2020/21.

This represented significant increases across all main commissioners to take account of mental health investment in line with national guidance.

As a result the graph to the left shows income as less than draft plan.

It is currently unclear what the contract income arrangements will be post July 2020. The current forecast assumes that current arrangements will continue with a national top up.

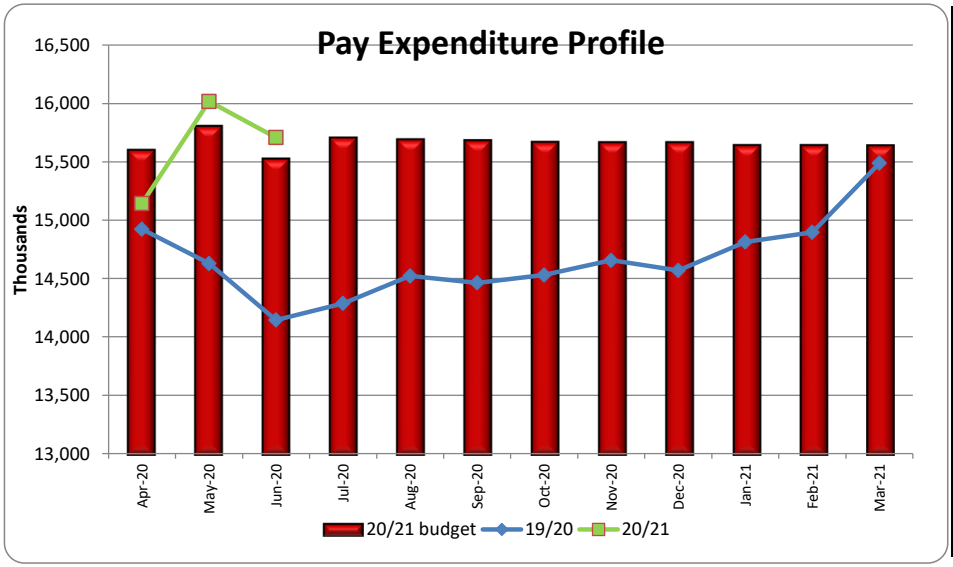
2.2 Pay Information

Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for 79% of our budgeted total expenditure.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
Substantive	13,947	14,646	14,470										**43,062**
Bank & Locum	727	866	721										**2,314**
Agency	469	507	518										**1,494**
Total	**15,142**	**16,019**	**15,709**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**46,870**
19/20	14,923	14,629	14,145	14,288	14,522	14,463	14,531	14,656	14,568	14,815	14,896	15,490	**168,476**
Bank as %	4.8%	5.4%	4.6%										4.9%
Agency as %	3.1%	3.2%	3.3%										3.2%

	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Current
Substantive	3,900	4,004	4,026										**4,026**
Bank & Locum	203	253	193										**193**
Agency	68	75	83										**83**
Total	**4,171**	**4,332**	**4,302**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**4,302**
19/20	3,989	4,013	4,002	4,002	4,057	4,069	4,119	4,191	4,138	4,152	4,160	4,285	**4,098**



As shown in the table and graph pay costs overall have increased from 2019/20 (average run rate £14.7m per month). Of this annual pay awards and increments are estimated at £450k per month.

Costs, and WTE, have reduced from the peak in May 2020 but remain higher than the 2019/20 run rate. Key themes are:

Substantive staffing increases due to continued recruitment for additional commissioner investment which was agreed in 2019/20.

Substantive WTE increases due to increased overtime payments; utilising Trust staff to ensure that shifts are covered. Overtime payments have increased significantly with £213k cost incurred in June. This compares to an average run rate of less than £7k in 2019/20.

The Trust employed student medic and nurse placements to support the covid 19 response.

Overall this has meant that bank and agency spend has been limited as described on page 9.

2.2 Agency Expenditure Focus

Agency spend continues to be a Trust focus area with increasing trends for the last 3 years

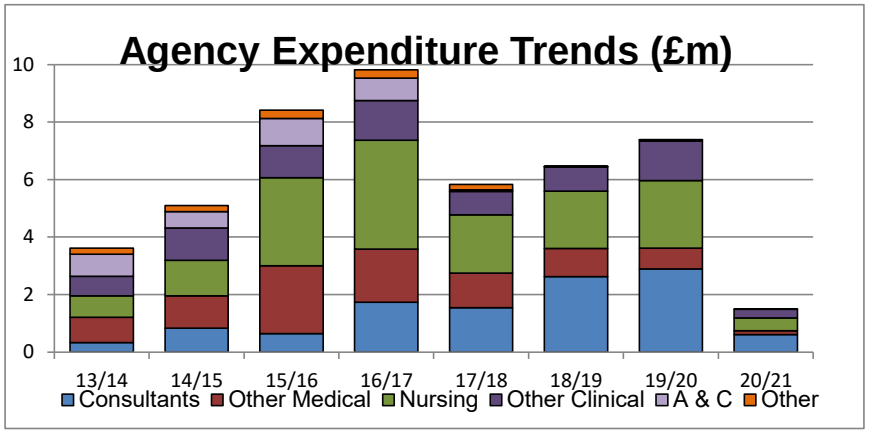
Agency costs continue to remain a focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below.

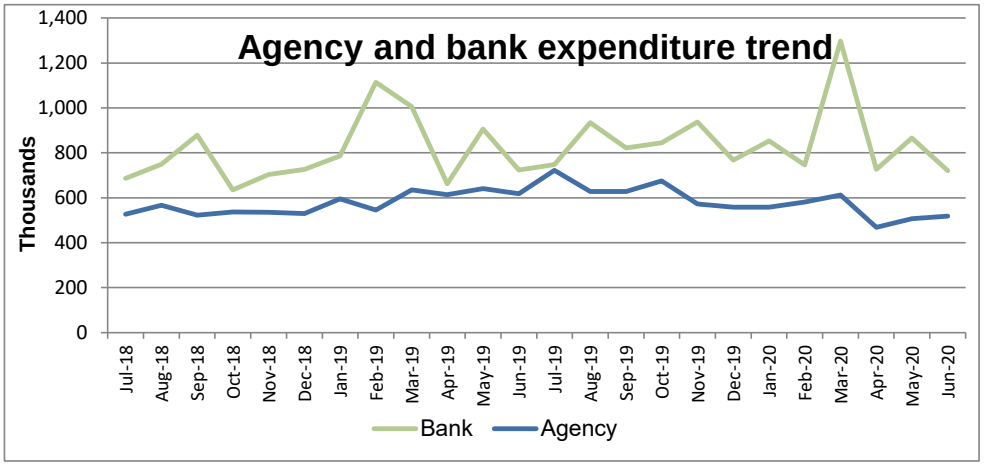
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

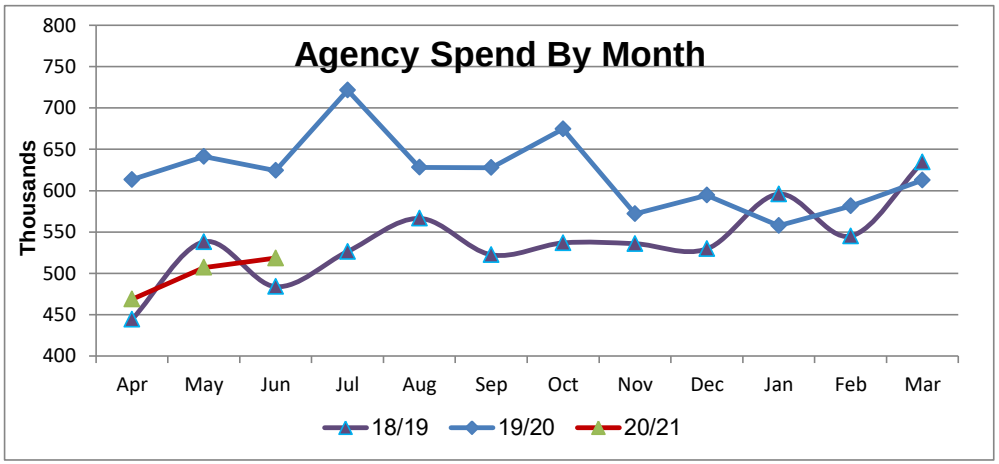
NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.

June 2020 spend is £518k and as shown by the 24 month rolling agency expenditure trend below this is lower than previously (2019/20 average was £617k per month).

Due to covid 19 there is currently no agency cap for 2020/21, however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised and performance against suggested maximum agency rates (caps). Shifts exceeding these caps continue to require appropriate prior approval including approval by the chief executive.







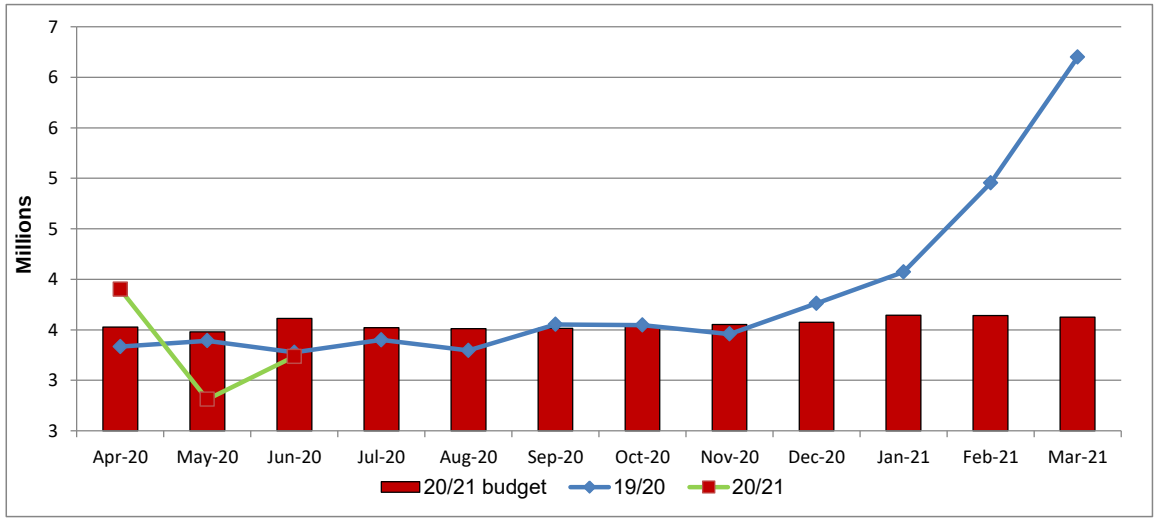
2.3 Non Pay Expenditure

Whilst pay expenditure represents over 80% of all Trust expenditure, non pay expenditure presents a number of key financial challenges. This analysis focuses on non pay expenditure within the BDUs and corporate services and therefore excludes provisions and capital charges (depreciation and PDC).

Please note the budget shown is per the draft operating plan and for indicative comparative purposes only.

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
2020/21	3,900	2,811	3,236										**9,947**
2019/20	3,333	3,391	3,276	3,400	3,295	3,554	3,547	3,458	3,762	4,073	4,954	6,200	**46,244**

	Indicative Budget Year to date	Actual Year to date	Variance
Non Pay Category	**£k**	**£k**	**£k**
Clinical Supplies	604	626	(22)
Drugs	883	830	53
Healthcare subcontracting	1,266	1,434	(168)
Hotel Services	428	467	(38)
Office Supplies	1,368	1,345	23
Other Costs	1,071	1,025	46
Property Costs	1,620	1,619	1
Service Level Agreements	1,630	1,486	144
Training & Education	247	93	154
Travel & Subsistence	895	478	417
Utilities	281	312	(31)
Vehicle Costs	325	232	93
Total	**10,618**	**9,947**	**671**
Total Excl OOA and Drugs	**8,469**	**7,683**	**786**



Key Messages

The national and Trust response to covid-19 is having a notable impact on non-pay costs. Additional PPE and cleaning material costs have been mitigated in part by national supply of key product lines. These have been at nil cost to the Trust. The non pay impact identified directly as a result of covid (in-house laundry, scrubs, provision of staff meals and refreshments) totals £0.6m for the year to date as highlighted earlier in this report. This is included within each of the non pay categories.

Although savings are in a number of categories the largest relates to travel and subsistence. The Trust response, through increased technology and agile ways of working, has enabled the reduction in travel for both clinical and non-clinical travel. Work is ongoing to see what efficiencies and best practice can be adopted sustainably going forwards. Travel spend in Q1 is £206k than the same period last year, down 30%. Some services are experiencing increased costs to meet the new ways of working.

Overall non pay costs are similar to June 2019. Healthcare subcontracts, as discussed on page 11, remain volatile.

2.3 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 reasons 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 geographical 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 or the purchase of other healthcare services.

Out of Area Expenditure Trend (£)

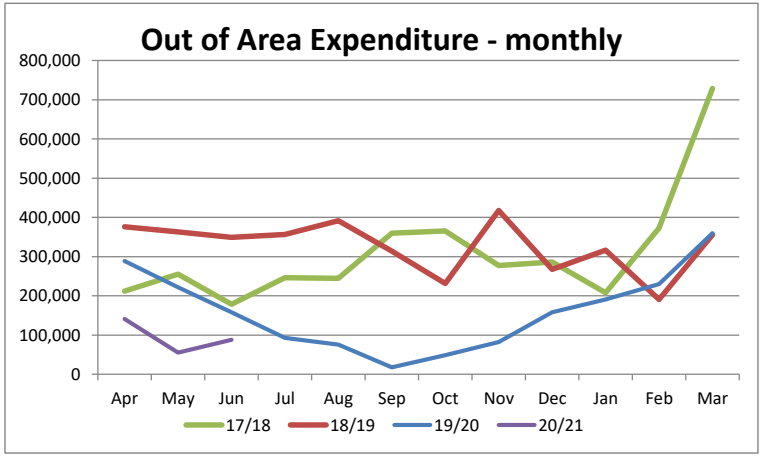
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	76	17	48	82	158	191	230	359	**1,924**
20/21	141	55	88										**283**

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	53	129	166	216	305	275	**2,408**
20/21	110	55	115										**280**

Bed Day Information 2020 / 2021 (by category)

PICU	92	45	34										**171**
Acute	18	10	81										**109**
Total	110	55	115	0	0	0	0	0	0	0	0	0	**280**



Delivery of service demands remains a challenge for the Trust, and whilst the focus remains on ensuring that costs are minimised and care is provided in the most appropriate environment and location, some out of area placements are being utilised.

Activity, and costs, have increased from May to June with increased acute activity. This remains lower than the same period in each of the three previous years. This is not directly covid-19 related although this continues to have an overall impact on Trust activity.

There are a further 37 bed days (reduction from 120 for April and May) which are paid for by commissioners i.e. for gender specific reasons.

Previous experience has demonstrated that out of area placement activity has fluctuated and usage and action plans continue to be developed to ensure that future usage is minimised.

3.0 Balance Sheet 2020 / 2021

	2019 / 2020 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	107,617	106,209	1
Current Assets			
Inventories & Work in Progress	238	238	
NHS Trade Receivables (Debtors)	6,576	4,494	2
Non NHS Trade Receivables (Debtors)	953	1,233	3
Prepayments, Bad Debt, VAT	2,219	3,060	
Accrued Income	1,904	2,874	4
Cash and Cash Equivalents	36,417	54,148	5
Total Current Assets	**48,307**	**66,046**	
Current Liabilities			
Trade Payables (Creditors)	(4,102)	(1,352)	6
Capital Payables (Creditors)	(272)	(321)	
Tax, NI, Pension Payables, PDC	(6,311)	(7,275)	
Accruals	(10,869)	(11,366)	7
Deferred Income	(1,462)	(19,104)	
Total Current Liabilities	**(23,016)**	**(39,418)**	
Net Current Assets/Liabilities	**25,291**	**26,628**	
Total Assets less Current Liabilities	**132,909**	**132,837**	
Provisions for Liabilities	(8,724)	(8,653)	
Total Net Assets/(Liabilities)	**124,185**	**124,185**	
Taxpayers' Equity			
Public Dividend Capital	44,971	44,971	
Revaluation Reserve	12,763	12,763	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	61,231	61,231	8
Total Taxpayers' Equity	**124,185**	**124,185**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2020.

1. Capital expenditure is detailed on page 13

2. NHS debtors continue to reduce. All outstanding invoices are being actively pursued prior to system changes in October 2020.

3. Non NHS debtors also continue to reduce and continue to be proactively managed.

4. Accrued income has increased with the largest values linked to settlement for covid-19 cost reimbursement and top up payments. For April - June these total £2.3m.

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 15.

6. Payments to creditors continue to be paid in line with the Better Payment Practice Code (page 17) and the revised 7 day payment target.

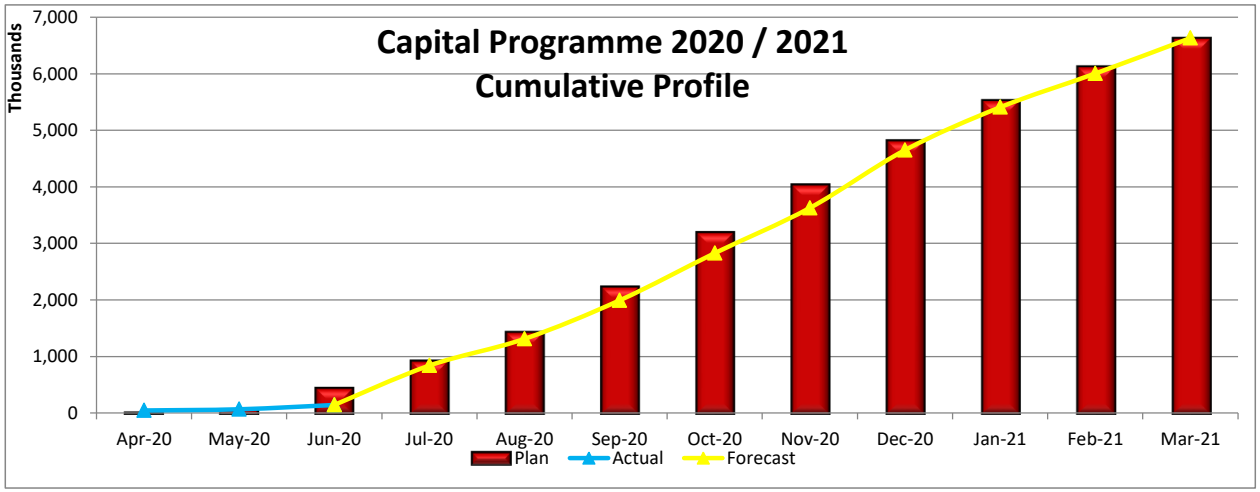
7. Accruals are higher than year end as the Trust awaits invoices for goods and services received.

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

3.1 Capital Programme 2020 / 2021

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	3,475	15	87	72	3,489	14	
Equipment Replacement	100	25	14	(11)	102	2	
IM&T	2,455	424	41	(383)	2,439	(16)	
Major Capital Schemes							
Hub Development	600	0	0	0	600	0	
						0	
						0	
VAT Refunds			0			0	
TOTALS	**6,630**	**464**	**142**	**(322)**	**6,630**	**0**	

The revised capital plan for 2020 / 21 is £6.6m



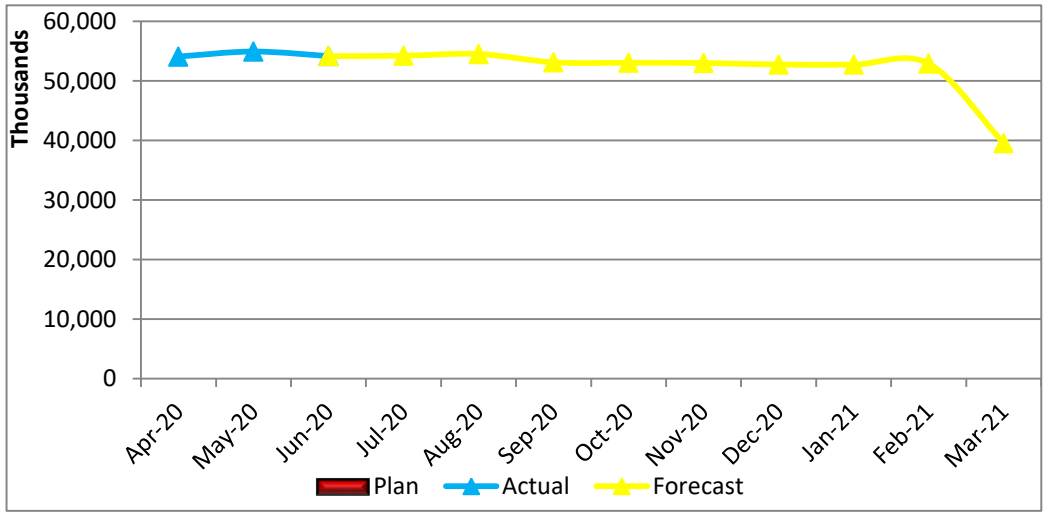
Capital Expenditure 2020 / 21

The Trust submitted a revised capital plan in May 2020 of £6.6m. This represents a 15% reduction from the original £7.8m

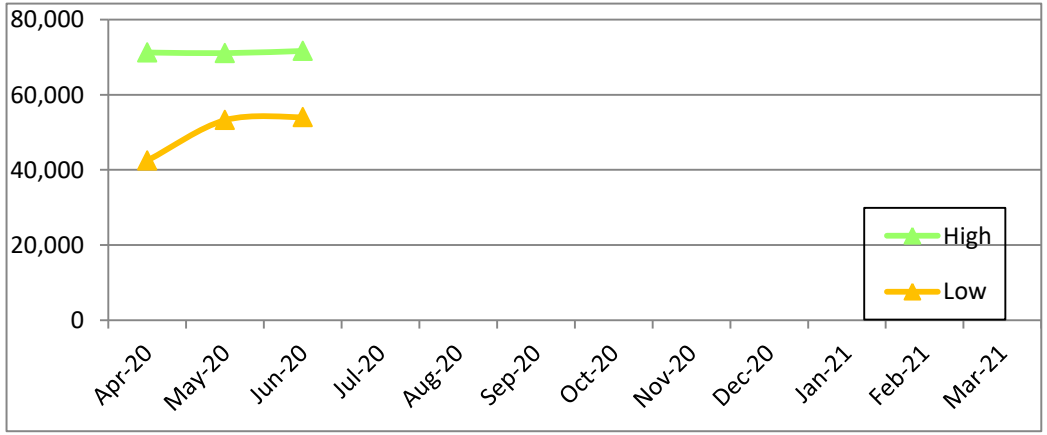
This reduction takes account of the fact that schemes have largely been on hold in Q1. This continues to be monitored taking account of current accessibility, supplier and contractor availability, extended timelines and different ways of working.

There are currently no covid specific schemes within this plan however the Trust has bid for some national capital monies to support the response to covid-19 as part of a process within the ICS.

3.2 Cash Flow & Cash Flow Forecast 2020 / 2021



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	36,417	
Closing Balance	0	54,148	54,148



Cash remains positive boosted by the timing of national block contract payments

Even though block contract payments are being received a month in advance, which has a positive impact on the cash position, the Trust continues to look to maximise cash.

A detailed reconciliation of working capital compared to plan is presented on page 15.

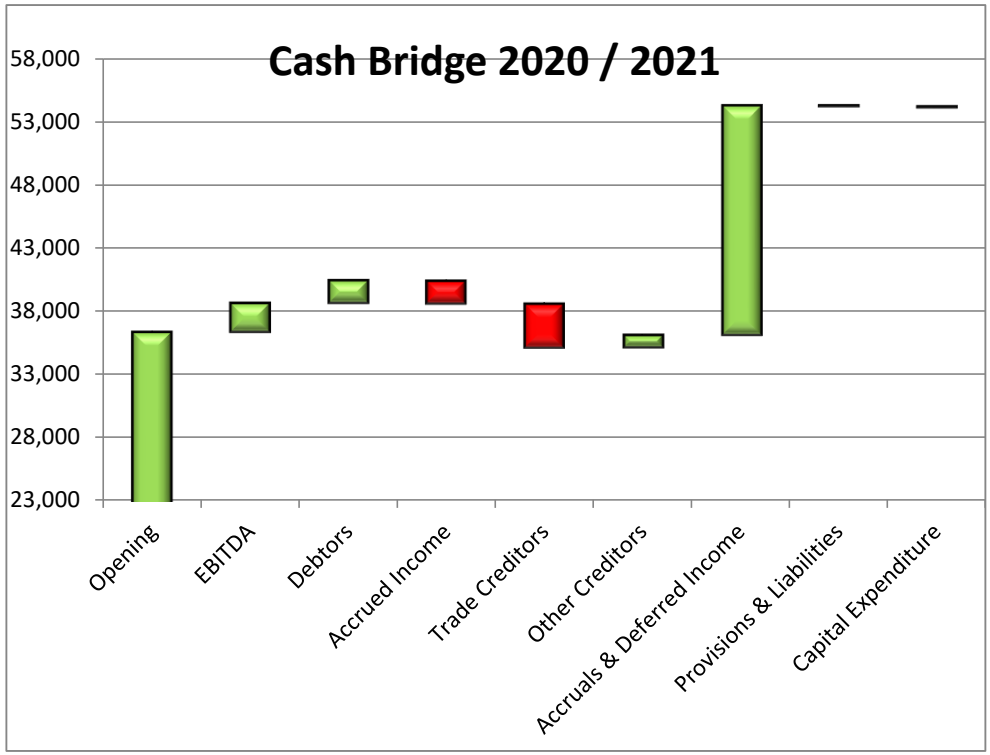
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £71.7m
The lowest balance is: £54m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Actual £k	Note
Opening Balances	**36,417**	
Surplus / Deficit (Exc. non-cash items & revaluation)	2,286	
Movement in working capital:		
Inventories & Work in Progress	0	
Receivables (Debtors)	1,802	
Accrued Income / Prepayments	(1,811)	
Trade Payables (Creditors)	(3,486)	
Other Payables (Creditors)	963	
Accruals & Deferred income	18,140	
Provisions & Liabilities	(71)	
Movement in LT Receivables:		
Capital expenditure & capital creditors	(93)	
Cash receipts from asset sales		
PDC Dividends paid		
PDC Dividends received		
Interest (paid)/ received		
Closing Balances	**54,147**	



The table above summarises the reasons for the movement in the Trust cash position during 2020 / 2021. This is presented graphically as well within the cash bridge.

The surplus / deficit movement is the Trust I & E position adjusted for depreciation which is non cash and adding back in PDC as this only generates a cash impact on a 6 monthly basis and is shown separately.

This highlights the largest positive cash impact is within accruals and deferred income. Of this £17.1m relates to the payment of July 2020 block invoices during June in line with national guidance. This is a timing benefit and will move back in line at some point during the financial year.

The largest cash reduction is within creditors and is a direct consequence of the national request to pay invoices within 7 days. In June a number of large annual invoices (insurances etc) have been paid which have impacted on the cash position.

4.0 Better Payment Practice Code

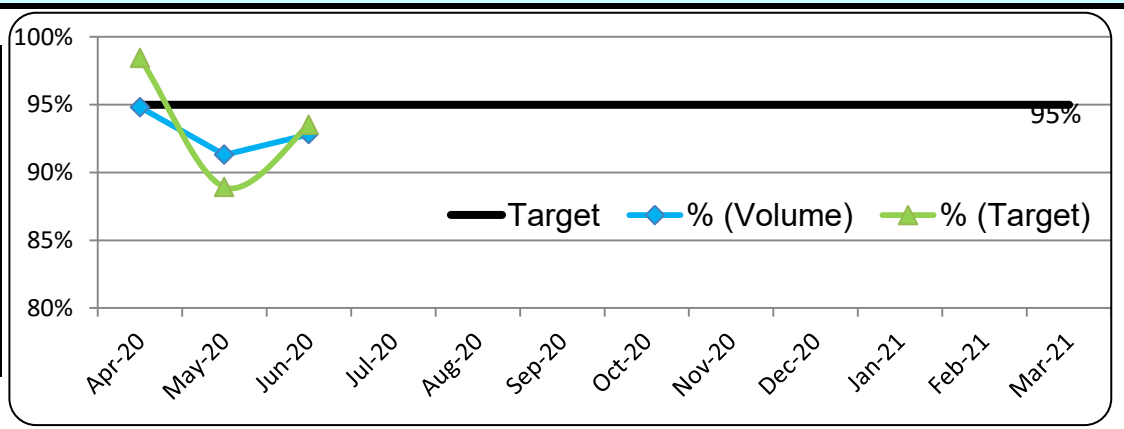
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process. Performance continues to be positive.

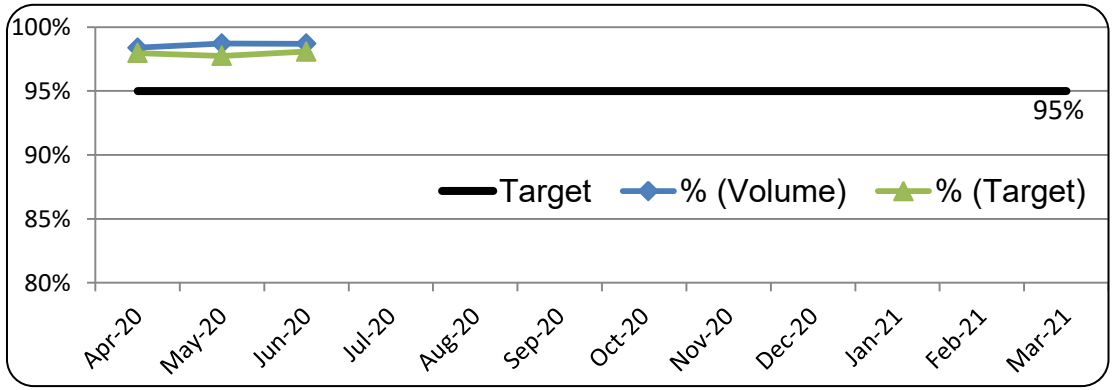
As part of the national response to the impact of COVID-19 all NHS Trusts were asked to pay suppliers within 7 days. Processes were reviewed to ensure that this could be supported and monitoring commenced immediately (20th April 2020).

To date, by value, we have paid 78% of NHS invoices and 84% of NHS invoices within this 7 day target. We continue to review processes to improve this performance further.

NHS	Number	Value
30 days	**%**	**%**
Year to May 2020	91%	89%
Year to June 2020	93%	94%
7 days		
Year to May 2020	68%	78%
Year to June 2020	73%	72%



Non NHS	Number	Value
30 days	**%**	**%**
Year to May 2020	99%	98%
Year to June 2020	99%	98%
7 days		
Year to May 2020	87%	84%
Year to June 2020	84%	84%



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 (£)
10-Jun-20	Vehicle Insurance	Trustwide	Zurich Insurance Company	3142036	584,817
29-May-20	Provider Block payment	Wakefield	Mid Yorkshire Hospitals NHS Trust	3140931	182,622
29-May-20	Provider Block payment	Wakefield	Mid Yorkshire Hospitals NHS Trust	3140932	182,622
01-Jun-20	Drugs	Trustwide	Bradford Teaching Hospitals NHS FT	3140977	143,124
02-Jun-20	Property Rental	Kirklees	Bradbury Investments Ltd	3141177	118,518
04-Jun-20	IT services	Trustwide	Daisy Corporate Services Trading Ltd	3141570	90,250
15-Jun-20	Computer Software / License Fees	Trustwide	Datix Ltd	3142433	67,052
08-Jun-20	Audit / Professional Fees	Trustwide	Deloitte LLP	3141923	59,006
01-Apr-20	Photocopying	Trustwide	Xerox (UK) Ltd	3136242	51,054
02-Jun-20	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3141113	44,989
05-Jun-20	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3141721	44,593
12-Jun-20	Computer Software / License Fees	Trustwide	Quadient UK Ltd	3142210	40,000
24-Jun-20	Drugs	Trustwide	NHSBSA Prescription Pricing Division	3143104	39,321
08-Jun-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	3141810	34,451
18-Jun-20	Telecoms	Trustwide	Vodafone Corporate Ltd	3142664	34,063
26-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3143295	33,936
02-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3141220	33,936
02-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3141221	33,936
02-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3141219	33,936
01-Jun-20	Purchase of Healthcare	Forensics	Cloverleaf Advocacy 2000 Ltd	3141049	32,358
02-Jun-20	Property Rental	Kirklees	Bradbury Investments Ltd	3141179	27,758
16-Jun-20	Property Rental	Wakefield	SJM Developments Limited	3142517	27,000
02-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3141219	26,295
02-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3141220	26,295
26-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3143295	26,295
02-Jun-20	Property Rental	Barnsley	Community Health Partnerships	3141221	26,295
25-Jun-20	Telecoms	Trustwide	Virgin Media Payments Ltd	3143196	25,918
08-Jun-20	Electricity	Trustwide	EDF Energy	3141885	25,760
12-Jun-20	Training Expenses	Kirklees	British Isles DBT Training	3142252	25,440

4.2 Glossary

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

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

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

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

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

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

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

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

* 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.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View

HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement

NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 11.1

Title:	**Digital Strategy update**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide the Trust Board with a review of the progress made on the 2019/20 digital strategy milestones and also how the digital agenda has supported the Trust's response to the Coronavirus pandemic.
Mission/values:	"Digital by Default" is one of the 6 priorities supporting delivery of our strategic objectives in pursuit of our mission. The Digital Strategy supports our values of being open, honest & transparent; and to be always improving.
Any background papers/ previously considered by:	Digital Strategy 2018 – 2021 presented to and approved by Board January 2018. Digital strategy update presented to Trust Board in October 2019.
Executive summary:	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 2019/20 Digital Strategy milestones as at 31 March 2020, which follows on from the update paper provided in October 2019. This report also demonstrates how the digital agenda has supported the Trust's response to the Coronavirus pandemic. The aims of the strategy are aligned with our strategic objectives and aim to deliver the following: • Digital technology is to be a key enabler to foster a culture in which safe, high-quality care is tailored to each person's needs and which guarantees their dignity and respect; • Digital technology is used to evidence the achievement of excellent outcomes for patients, carers and our community; • We improve digital capability while stimulating digital innovation, raising morale and supporting good decision-making; • We deliver a single electronic care record to support and enable the delivery of first-class care; • Usage of digital technologies assists the engagement with and listening to our patients, carers, families and partners so they can help shape the development and delivery of our services; • Digital technology is used to improve accountability and close and productive working relationships with other providers and our partners. 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: -

- Fit for Purpose IM&T Infrastructure.
- Integrated Electronic Care Record System.
- Digitisation & Information Sharing with our Partners.
- Business Intelligence Systems.
- A Skilled & Digitally Enabled Workforce.
- Engaging and Learning from Digital Best Practice.
- Championing Digital Inclusion for People Accessing our Services.
- Embedding Digital in our Culture.

Detailed within Appendix A of this report are the activities that have been and are currently being implemented and progressed in support of the agreed 2019/20 Digital Strategy key domain milestones. These include:

- Refreshed Digital Strategy approved by the Trust Board.
- Completion of the infrastructure modernisation programme (year 3 of 3 - 2019/20).
- Email platform review and approval of the business case for future strategic email platform, enabling migration.
- Whilst cyber security & threat monitoring is a constantly developing space, a number of remedial activities have been completed which support the Trust's drive towards cyber maturity.
- Development of the Trust's clinical record system (SystmOne) through a persistent development programme, with a number of service re-design activities have been completed.
- Significant business intelligence work performing deep dive comparative analysis into Model Hospital to consider how SWYPFT compares to other similar organisation's and internal benchmarking dashboards launched to support understanding of productivity and variation.
- Continued compliance against the 2019/20 Data Security & Protection toolkit by March 2020.
- Digital has played a pivotal role in enabling and supporting the Trust's response to the Corona Virus pandemic.

Capital investment of £2.725m was made during 2019/20 and £2.445m has been allocated in 2020/21.

Risk appetite

The provision of digitally enabled services is vital in enabling Trust staff to deliver safe care. As such risk appetite is considered low with a target score of 1-3. The work concluded in 2019/20 and priorities planned in 2020/21 will continue to reduce the likelihood of risk of system failure.

Risks that need to be highlighted include recognition that infrastructure modernisation and cyber security enhancements are ongoing areas of focus spanning disaster recovery, network resilience and application/systems availability improvements, as well as necessary

	controls and measures to reduce the risk and likelihood associated with the threat of cyber-attacks. Digital maturity is also fundamental to COVID-19 restoration and recovery planning accounting for sustained home working across the Trust which will require significant input, collaboration and participation from both clinical services and corporate support service. This requires careful consideration in balancing other organisational priorities and ensuring sufficient skilled and experienced staff are in place to deliver. There also is a risk that the Trust's dependency on the existing Microsoft SharePoint environments may severely impact Trust business due to the current platform going out of support on 13 October 2020 and it is possible that comprehensive migration will not be completed ahead of this timeline by the respective corporate services. Finally, the growing demands on digital technologies, solutions and available resources during the challenging times we are experiencing will lead to heightened demands and these expectations need to be carefully managed.
Recommendation:	**Trust Board is asked to NOTE the achievements made in respect of the 2019/20 milestones and the digital enabled reaction as part of the Trust's response to the pandemic.** The Board and other stakeholders will be kept informed of all current and future Digital Strategy developments on a regular basis.
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Digital Strategy

Progress Report

Assistant Director of IT Services & Systems Development

June 2020

www.southwestyorkshire.nhs.uk

With all of us in mind.

Purpose of Report
The purpose of this report is to inform the Board of the progress and developments made during the last 8 months in respect of the Trust's digital strategy and also how the digital agenda has supported the Trust's response to the coronavirus pandemic.

Executive Summary
This report focuses on the progress made during the second 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 2020/21 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 was completion of the three year infrastructure modernisation programme, which built on the progress made during the previous two financial years. All planned technical activities were delivered and the final elements of the work are now being completed and documented, which supports the Trust's business continuity and disaster recovery position.

It is worth emphasising that had the Trust not made the enhancements to its IT infrastructure during the last 3 years, the technical ability to support over 3,000 VPN users to work from home in response to the pandemic would not have been possible. Neither would the adoption of video conferencing solutions rapidly deployed.

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.

Focus remains on developing the Trust's electronic care record systems and the drive towards seamless integration and enhanced interoperability that in turn supports the electronic exchange of information and messaging capabilities. Optimisation work continues to develop system utilisation to support the provision of frontline clinical care, whilst also enhancing delivery of business intelligence data to aid performance management and service improvement.

3. Digitisation & Information Sharing with our Partners
The focal point for this domain is to make inroads into the reduction of paper and to increase the Trust's digital footprint as a result, thus enabling improved information sharing opportunities with our partners and stakeholders.

This domain supports the Trust in moving towards becoming paper free. 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, with good overall progress being made.

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. SystmOne optimisation referred above has a significant reporting dimension, helping to develop effective reporting, consistency of data recording and quality, whilst enhancing the ability to report on what is considered important.

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 is shifting towards alternative intuitive e-learning materials and remote training utilising solutions such as Microsoft Teams for delivering clinical systems and mandatory training, especially in light of the pandemic and safe working arrangements.

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 is 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 constantly developing domain exploring opportunities determined internally, in collaboration with our partners at both place and Integrated Care System (ICS) levels and nationally.

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.

To date focus has been on patient reminder systems but during 2020/21 we will look to consider wider accessibility to our services and information by service users and carers in the digital space, which will require significant upfront engagement and communications.

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 continue to be supported through hosting digital events, launching digital challenges on iHub to gather ideas, adopting a digital-by-default approach to service re-design and tenders, and piloting the use of new and emerging digital innovations.

Digital Strategy Progress
Detailed within this report is a summary of the activities and progress to date, particularly over the last eight months, in particular in respect of the agreed 2019/20 milestones as well as activities and implications that the pandemic has brought about. Below is a summary of the main achievements and items to note in this reporting period. It is also worth noting that a significant number of initiatives are making substantial progress which have not reached natural conclusion at the time of the report and will therefore carry on as planned into 2020/21.

- **Infrastructure modernisation - year 3 (2019/20):** Key IT infrastructure improvements and enhancements made to the Trust data centres, disaster recovery capabilities, cyber security, core network infrastructure and Wide Area Network (WAN) together with the rolling programme of IT network hardware and server hardware upgrading, replacement and refresh.

- **Email platform review:** An options appraisal was conducted that informed the business case recommending the move to Microsoft Office365 for the Trust's corporate email platform replacing the legacy Microsoft Exchange platform. This was approved, enabling email platform migration activities to progress.

- **Cyber security & threat monitoring:** Whilst this is a constantly developing space, a number of remedial activities have been completed which support the Trust's drive towards cyber maturity.

- **Clinical record system (SystmOne):** SystmOne, the Trust's main clinical record system that is used by both mental health and physical health services continues to be enhanced as part of a persistent development programme, a number of service re-design activities have been completed.

- **Data Protection & Security Toolkit (IG Toolkit):** The requisite evidence to ensure continued compliance against the 2019/20 toolkit was submitted by the end of March 2020.

- **Business Intelligence/Data Warehouse (information hub & dashboards):** Deep dive comparative analysis undertaken into Model Hospital to consider how SWYPFT compares to other similar organisation's and internal benchmarking dashboards launched to support understanding of productivity and variation.

- **COVID-19:** Digital has played a pivotal role in enabling and supporting the Trust's response to the pandemic. Whilst the rapid deployment and availability of digital solutions and technologies has required a more relaxed short-term approach to engagement and testing prior to launch, a number of digital initiatives have been introduced in less than two weeks with much reduced testing. This has been carefully balanced as far as practically possible to ensure that security considerations remain at the forefront, keeping services and information safe. Below is a summary of the Trust's digital response in mobilising resources and effectively maintaining services throughout:

COVID-19 Organisational Need	**Digital Response**
Significant increase in demand for Trust staff to work from home.	**Over 300** additional laptops issued. **100** desktops Wi-Fi enabled for staff to work from home. **1,000** additional VPN tokens to enable remote network connectivity (33% increase in Trust estate). **4,000** daily VPN connections (10 fold increase based on pre-COVID-19

	levels). **222** additional mobile phones issued.
Rapid deployment of video conferencing/consulting solutions.	**1,000** additional Skype for Business licences and additional call channels to facilitate increased telephone dial in capacity/demand. **Microsoft Teams:** Deployed across the Trust to support enhanced collaboration providing video conferencing and messaging capabilities only at the time of writing this report. **5,500** client accounts created and what is considered to be a highly successful adoption across the Trust. **Airmid:** Developed by TPP to enable video consultations linked to SystmOne record has been deployed and averaging circa **850** consultations a week during June. **AccuRX:** Has also been deployed as an alternative video consultation solution to Airmid and averaging circa over **700** video consultations a week during June.
To ensure the people in our care do not become socially isolated and continue to have contact with their families/friends.	A 'virtual visitor' initiative has been devised that uses dedicated Trust issued android devices based on inpatient wards in a controlled environment so as to allow service users to stay connected with families, friends and carers. Feedback has been positive to date and the approach is actively being deployed in all ward areas.
Enhanced reporting	Support for swab test reporting and recording processes Covid-19 absence reporting and dashboards used for daily sitrep reporting internally and externally as well as supporting BDU operational activity and development of an interim report for commissioners to identify activity pre and during the pandemic
Sharing of clinical information held within the SystmOne electronic care record system	The temporary covid-19 'consent dispensation' given by the Government has allowed the Trust to accelerate its switch on of SystmOne record sharing. This was initially planned for September 2020 but temporary legislation has enabled the accelerated rollout. Processes are in place to gain individual approval prior to the cessation of the Covid Act.
Network infrastructure enhancements	In support of the accelerated deployment of digital solutions referenced above, the Trust has put in place additional urgent infrastructure changes to accommodate increased network traffic, balancing capacity between Fieldhead and Kendray to facilitate the increase in staff working from home.

The Improving Clinical Information Group (ICIG) has overseen the collating and approval mechanisms in respect of rapid digital improvements and key decisions made to ensure appropriate robust governance is maintained during the Trust's response to Covid-19.

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:

- **Infrastructure Modernisation:** Continuation of persistent infrastructure modernisation spanning disaster recovery, network resilience and application / systems availability improvements. This 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. This is necessary for digital maturity and is fundamental to covid-19 restoration and recovery planning accounting for sustained home working across the Trust.

- **Microsoft SharePoint:** There remains a risk that the Trust's dependency on the existing Microsoft SharePoint environments may severely impact Trust business due to the current platform going out of support in October 2020. However, as of 19 June 2020 it has been confirmed that the end of support date for SharePoint has been delayed 6 months by Microsoft to 13 April 2021. Whilst this change reduces the risk to the organisation somewhat, it is planned that comprehensive migration activities continue to progress at pace to ensure the necessary work is completed ahead of this revised timeline by the respective corporate services.

- **Coronavirus Pandemic (COVID-19):** The highly challenging circumstances that the Trust, the wider NHS and the United Kingdom collectively are facing with regard to covid-19 have meant that there is a need to ensure rapid access to digital solutions and technologies which requires a more-relaxed approach in the short-term. Cyber and security considerations must remain at the forefront so as to ensure services continue to be safe and effective.

The ability to deliver on all of the 2020/21 priorities in line with the timescales identified later in this report remain very much dependent on availability of suitable resources and continuous balancing of competing priorities, together with the lifting of restrictions, maintaining social distancing and developing restoration & recovery plans to return services to 'new' business as usual operations.

A particular point to note is the ever-increasing growing demand on digital technologies and solutions within available resources, significantly heightened in light of the pandemic, which will require careful management of expectations. 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 has been completed and that which continues during 2020/21, notwithstanding the more recent covid-19 driven interventions.

A considerable amount of time has been afforded in the planning of activities to support progress being made, which has also taken account of the annual planning processes. This means timescales for delivery of the initiatives in this document remain realistic and achievable, subject to allocated / available resources and required Covid-19 focus. Any associated risks are managed with mitigating actions put in place where 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 completed in line with our plan. The reported position has been rated as **GREEN** overall.

It is important that the digital strategy continues to align with the Trust's strategic objectives and plans, and also with the wider NHS long term plan. It is also important that in developing the future roadmap that the Trust reflects on what has been achieved and any lessons learned from the delivery of the current digital strategy. To this end the Trust has initiated an internal audit of the digital strategy which will provide valuable insight and support the Trust in preparing the next iteration of its digital strategy. This audit work focused on:

The Board is asked to note the progress in respect of the delivery against the 2019/20 milestones noting where applicable any implications that the covid-19 pandemic has brought about as stated throughout the report. 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 at a date to be agreed.

Dashboard Key

C	Completed	G	On track	G/A	On track but management of risk needed
A	Off track but in control	A/R	Off track with urgent action being taken to address risk/issue	R	Off track major issues impacting overall viability
P	Planned for the future	↗	Improving position	→	No progress
↘	Deteriorating position	✓	Completed activities	➢	Ongoing activities

Digital Strategy Summary Dashboard (deferred position June 2020)

	October 2019 Position			June 2020 Position		
Domain 1: Fit for purpose IM&T infrastructure	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
Infrastructure Modernisation	N/A	G	↗	COVID-19	G	↗
Health & Social Care Network Implementation	N/A	G	↗		G	↗
Migration to Microsoft Windows 10	N/A	G	↗	COVID-19	A	↗
Email Platform Migration	N/A	G	↗	COVID-19	A	↗
Microsoft Licences Trust Wide Agreement	N/A	G	↗	COVID-19	G	↗
Cyber Security & Threat Monitoring	N/A	G	↗	COVID-19	G	↗
Telephony Services Review	N/A	P	→		P	→
Domain 2: Integrated Electronic Care Record System	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
Physical Health Services Clinical Record Systems	N/A	G	↗	COVID-19	A	↗
Mental Health Services Clinical Record System	N/A	A	↗	COVID-19	G/A	↗
eCorrespondence	N/A	G	↗	COVID-19	A	→
Clinical Portal Development	N/A	G	↗	COVID-19	A	→
Electronic Prescribing & Medicines Administration (EPMA)	N/A	P	→	COVID-19	G	↗
Domain 3: Digitisation & Information Sharing with Partners	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
ICS Digital Work Streams	N/A	G	↗	COVID-19	G	↗
Records Management	N/A	G	↗	COVID-19	G	↗
Paper Digitisation	N/A	G	↗	COVID-19	A	↗
Multi-Function Device (MFD)	N/A	A	↗	COVID-19	A	↗
Video Consultation/Conferencing	N/A	P	→	COVID-19	G	↗
Domain 4: Business Intelligence Systems	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
Business Intelligence / Data Warehouse	N/A	G	↗	COVID-19	G	↗
Performance Management & Reporting	N/A	G	↗	COVID-19	G	↗
Information Governance	N/A	G	↗	COVID-19	G	↗
National Data Opt-Out Programme	N/A	G	↗	COVID-19	G	↗
Domain 5: A Skilled & Digitally Enabled Workforce	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
Microsoft SharePoint Developments (formerly Intranet)	N/A	P	→		A	↗
Social Media Access for Staff	N/A	G	↗	COVID-19	G	↗
Succession & Workforce Planning (IM&T Staff)	N/A	G	↗	COVID-19	G	↗
Development of Staff Training (IT/Digital Skills)	N/A	G	→	COVID-19	G	↗
Domain 6: Engaging and Learning from Digital Best Practice	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
NEW Digital Dictation					P	→
Domain 7: Championing Digital Inclusion for People Accessing our Services	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
Patient Reminder System	N/A	G	↗	COVID-19	A	→
Collecting and Reporting Health Outcomes	N/A	P	↗	COVID-19	P	→
Service User (Patient) Portal Development	N/A	P	→	COVID-19	P	→
Domain 8: Embedding Digital in our Culture	Covid-19 Impacted	RAG Status	Progress Indicator	Covid-19 Impacted	RAG Status	Progress Indicator
Apps for Service Users and Carers	N/A	G	↗	COVID-19	G	↗
i-Hub Digital Challenge	N/A	G	↗	COVID-19	G	↗
NEW Virtual Visitor				COVID-20	G	↗

Financial Investment

In order to meet the priorities outlined in this report an initial capital allocation of £2.725m was made available during 2019/20 and subsequently revised in year following national requests to reduce compared to the base plan. The table below provides a summary of the associated expenditure for 2019/20.

Scheme		19/20 (£k)			20/21 (£k)
		Allocation	Expenditure	Variance	Allocation
IT Infrastructure	Data Centre/Disaster Recovery	400	400	0	150
	Infrastructure/WAN	250	250	0	100
	Server Hardware Refresh	150	150	0	100
	Network Switch Upgrades	300	300	0	100
	HSCN				50
	Cyber Security	200	200	0	200
	Email Enhancements	25	18	7	50
	Microsoft Office365 Implementation				175
	Mobile Device Management				100
	WiFi (Corporate) Refresh	100	100	0	100
	Cyber Security - Secure Boundary*	240	240	0	0
Clinical Systems Development	Mental Health Clinical Records System				50
	Integration & Portals (Inc Interoperability)	100	100	0	150
Business Intelligence	Business Intelligence, Data Warehousing and Reporting				50
Corporate Development	Finance Ledger System	300	0	300	350
Digital Innovation	Paper Digitisation (Paperlight/Paperless NHS)**	260	260	0	80
	Electronic Prescribing & Medicines Administration	250	250	0	100
	SharePoint Migration				250
	eConsultation				100
	Digital Innovation Opportunities (Digital Strategy Group)	100	60	40	100
Contingency	IM&T Contingency	10	10	0	100
Overall Capital Total		**2,685**	**2,338**	347	**2,455**

*£240k external funding secured

**£260k external funding secured

COMPLETED MILESTONES FOR 2019/20 SCHEMES (April 2020 position):

Status C	**Infrastructure Modernisation Programme Phase 3: Data Centre Improvements (Year 3 of 3)**		
Summary update		***Milestone***	***Achieved***
Purpose: A 3-year programme of work that focuses on the review and modernisation of the Trust's core IT infrastructure and the two existing data centres located at Fieldhead and Kendray. The purpose is to provide a strategic, robust and secure IT environment which provides the Trust with the necessary assurances of business resilience and disaster recovery capabilities to support the digital future. **Key Activities:** ✓ ***Year 3 (2019/20) Plan:*** Completion of the year 3 capital programme with all planned works and activities achieved by 31 March 2020 and within the agreed capital budget allocations. This focused on: ▪ Further enhancements to the Trust data centres & disaster recovery capabilities. ▪ Core network infrastructure and Wide Area Network (WAN) enhancements. ▪ Rolling programme of IT network hardware and server hardware upgrading, replacement and refresh. ▪ Enhancements to cyber security solutions and capabilities ▪ Improved application availability		**Mar 2020**	**Mar 2020**
✓ **COVID-19:** The planned works in March 2020 had to be adjusted to accommodate some technical reconfiguration of the Trust's VPN solution to support the covid-19 response. This was to allow staff to remotely connect to the Trust network via both Fieldhead and Kendray, rather than running solely through Fieldhead. Without the enhancements to the IT infrastructure over the last 3 years, it would not have been possible to scale up remote home working to the levels required and adopt the video conferencing solutions rapidly deployed. **Achieved Outcomes:** • Improved resilience providing the Trust with the ability to maintain services more easily in the event of a disaster (e.g. from Fieldhead to Kendray) • Reduced requirement for short term investment in event of a disaster. • Introduction of enhanced software monitoring that enables better management of Microsoft licensing. • Proven disaster recovery position with confirmed recovery points and associated timelines. • Enhanced cyber security position reducing the risk or exposure from cyber-attack, malicious or otherwise.		**Mar 2020**	**Mar 2020**

Status	Email Platform Review		
C			
Summary update		***Milestone***	***Achieved***
Purpose: To undertake an evaluation of email platform options for the future provisioning of the Trust's strategic corporate email environment to enable migration and replacement during 2019/20. **Key Activities:** ✓ A business case recommending the move to Microsoft Office365 for the Trust's corporate email platform replacing the legacy Microsoft Exchange platform was approved by the Trust. **Achieved Outcomes:** • Ensuring the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources.		**Oct 2019**	**Oct 2019**

Status	Cyber Security & Threat Monitoring		
C			
Summary update		***Milestone***	***Achieved***
Purpose: The threat of cyber-attack remains constant. The Trust continues to take such threats extremely seriously and has established a number of steps to safeguard against their likelihood and considers cyber security in all aspects of the digital agenda. **Key activities:** ✓ ***Simulated phishing exercise:*** In December 2019, the Trust undertook a phishing email campaign by issued two separate phishing emails to a number of staff (750 in each case) and monitored staff responses (clicking on links and who provided personal credentials). The response rate indicated there remains a level of susceptibility among staff, which could potentially be exploited by cyber-criminals. This feedback is being incorporated into the constant review of training, communications and guidance to staff. ✓ ***Cyber campaign for staff awareness:*** The cyber campaign which aims at improving staff cyber awareness across the Trust has been re-vamped. This was released following the phishing exercises and was aimed at establishing how aware end users are, again informing further communication and training. Staff vigilance remains an integral defence and staff are constantly reminded to raise any questions or concerns with the IT service desk in the first instance at the earliest opportunity. ✓ ***Cyber table top exercise:*** An annual cyber security table top exercise was conducted in January 2020 to ensure that processes, roles and responsibilities are clear in support of mobilising against a cyber-attack. **Achieved Outcomes:** • Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats • Adoption of industry standard best practices, as appropriate. • Improved the defences against a cyber attack		**Dec 2019** **Jan 2020** **Jan 2020**	**Dec 2019** **Jan 2020** **Jan 2020**

Status	Telephony Services Review		
C			
Summary update		***Milestone***	***Achieved***
Purpose: Conduct a review of the telephony services and to explore opportunities to further improve the service offer which being cost-effective. **Key activities:** ✓ ***Mobile Telephony Services:*** The Trust's existing contract with Vodafone for mobile telephony services reached its two year anniversary in December 2019 with services continuing on a rolling monthly basis in lieu of conclusion of options appraisal. The evaluation was concluded and recommendations approved in March 2020 to remain with Vodafone on revised terms which based on current usage, will potentially save around £56k over the two year term. **Achieved Outcomes:** • Ensures the Trust has a stable and resilient corporate telephony platform which is cost effective and makes best use of available resources.		**Oct 2019**	**Mar 2020**

Status	Community Services Clinical Records System (SystmOne)		
C			
Summary update		***Milestone***	***Achieved***
Purpose: Development of SystmOne to support physical health community services development priorities, service re-design and new models of care agendas. **Key Activities:** ✓ ***Neuro-physiotherapy (Barnsley):*** Work commenced at the start of July 2019 and following a standard deployment timeline, this service went live in October 2019. **Achieved Outcomes:** • Ensuring continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information.		**Oct 2019**	**Oct 2019**

Status	Mental Health Services Clinical Records System (SystmOne)		
C			
Summary update		***Milestone***	***Achieved***
Purpose: SystmOne optimisation ensures that SystmOne enables the Trust with the opportunity to improve how we work now and in the future. **Key activities:** ✓ ***Care plans:*** The Trust has been actively working with TPP (SystmOne supplier) to make some changes to mental health act functionality and medics care plan. The medics care plan has been deployed into the live system following successful testing. **Achieved Outcomes:** • SystmOne is used more consistently and effectively.		**Oct 2019**	**Nov 2019**

• Processes and workflows are developed that help staff and improve outcomes for our service users. • 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 ICSs and commissioning intentions.		

Status C	**Business Intelligence/Data Warehouse (information hub & dashboards)**	
Summary update	***Milestone***	***Achieved***
Purpose: The development of a business intelligence / data warehouse that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service improvements and delivery. **Key activities:** ✓ Deep dive analysis undertaken into Model Hospital to consider how SWYPFT compares to other similar organisation's and establishing potential opportunities in relation to productivity and variation. ✓ Internal benchmarking dashboards launched to support understanding of productivity and variation within the organisation, available at cost centre, team, and HCP level. Dashboards available via the SWIFT site and workshops rolled out across all areas. **Achieved Outcomes:** • Continue to improve and make available the use of real time information to support operational services and transformation agendas.	**Sept 2019** **Oct 2019**	**Sep 2019** **Oct 2019**

Status C	**Information Governance**	
Summary update	***Milestone***	***Achieved***
Purpose: To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations. **Key Activities:** ✓ **Data Protection & Security Toolkit (IG Toolkit):** The requisite evidence to ensure continued compliance against the 2019/20 toolkit was collated and submitted by the end of the original March 2020 deadline and ahead of the revised September 2020 deadline. ✓ **General Data Protection Regulations (GDPR):** Monitoring audits were conducted during 2019/20 and appropriate actions taken. The internal audit opinion was 'significant assurance'. **Achieved Outcomes:** • DSP toolkit target of meeting the standards is maintained and mandatory IG training target attained • GDPR processes are established to ensure ongoing compliance.	**Mar 2020** **Mar 2020**	**Mar 2020** **Mar 2020**

ONGOING MILESTONES FOR 2020/21 & BEYOND (June 2020 position):

Domain 1: Fit for Purpose IM&T Infrastructure	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability***

G	↗	**Infrastructure Modernisation**

Summary update	***Milestone***	***Achieved***
Purpose: Please see previous section. **Key Activities:** ➢ **COVID-19:** ***IT Services contract extension:*** A proposal was approved in April 2020 for the Trust to engage Daisy in establishing a 12-month contract extension for the continued provision of IT Services. Once in place, this would delay the commencement of a re-procurement exercise to the start of 2021/22. The proposal is a direct result of the COVID-19 pandemic and the need to maintain IT infrastructure stability at a time demand has never been so high. Negotiations are expected to be completed during July.	**Apr 2020**	**Apr 2020**
➢ ***Year 3 (2019/20) Review:*** An end of period review report covering 1 April 2019 to 31 March 2020 is being prepared that will provide a summary position of progress made concluding this programme and what this work has achieved / delivered in line with the business case previously approved.	**Jul 2020** **Mar 2021**	
➢ ***2020/21 Infrastructure Programme:*** This ongoing programme of work will focus on: ▪ Further enhancements to the Trust data centres & disaster recovery capabilities. ▪ Core network infrastructure and Wide Area Network (WAN) enhancements. ▪ Network resilience enhancements on reflection of the outcome of the COVID-19 pandemic, transitioning in return to business as usual incorporating new ways of working . ▪ Rolling programme of IT network hardware and server hardware upgrading, replacement and refresh. ▪ Enhancements to cyber security solutions and capabilities. ▪ Improved application availability.		
Expected Outcomes: • Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g. from Fieldhead to Kendray). • A more readily scalable infrastructure that can flex to meet changing demands		

• 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.		

Status	*Direction*	**Health & Social Care Network (HSCN) Implementation (N3 Replacement)**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Migrating NHS premises to the Health & Social Care Network (HSCN) is hugely important to provide a resilient data network to meet both the immediate need whilst also providing underpinning fabric for digital transformation of health and care services. Following approval in July 2019, the Trust is only replacing N3 with dedicated HSCN circuits at the six larger hub sites (Fieldhead, Kendray, Folly Hall, Laura Mitchell, Drury Lane, Baghill House). **Key activities:** ➢ All N3 circuits at the six larger hub sites are no longer in use. New circuits being installed from Q2 2020/21, milestone March 2021. A small number of network devices are currently being replaced by Virgin Media as part of ensuring all equipment is up to date, support and able to run the latest software versions. **Expected outcomes:** • Continuity of wide area network (WAN) connections that essentially provide inter-connectivity between Trust & external partner's infrastructure. • Improved bandwidth and resilience of WAN IT infrastructure. • Nationally 80% of all NHS premises have now moved to HSCN, benefiting from increased bandwidth, highly performant and reliable connectivity.			**Mar 2021**	

Status	*Direction*	**Migration to Microsoft Windows 10**		
A	↗			
Summary update			***Milestone***	***Achieved***
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. This deadline was extended to 31 March 2020 and then subsequently extended further to 30 June 2020 in response to the pandemic. **Key activities:** ➢ ***Windows 10 Migration:*** From October 2019, the Trust initiated a project to complete the migration to Windows 10 before the 31 March 2020. The intention was to complete this work by 13 March 2020, with the remaining two weeks to focus on a mop-up exercise for all remaining devices, for which the Trust was on track to complete this work by. ➢ **COVID-19:** However, the outbreak switched IT services priorities to issuing			**Was Mar 2020 now Jun 2020**	

IT equipment and mobilising remote home working across the Trust. As at the end of March 2020 95% of all Trust computers had been migrated to Windows 10. In light of this, NHS Digital were engaged regarding the potential for granting an extension to our licensing position beyond 31 March 2020 if there is a delay in mop-up activities on the Windows 10 upgrade project as a result of the pandemic. Although no formal statement was issued, NHS Digital confirmed that as SWYPFT are in the top quartile of Trust's involved in Windows 10 migrations and as such the Trust should not have any concerns with this state. ➢ **COVID-19:** Activities have reconvened to replace / upgrade the reducing 200 remaining Windows 7 devices ahead of the 30 June 2020 deadline. The remaining Windows 7 machines are still under extended support and continue to be proactively patched. ***Please note: During 2019/20 the Trust provided significant investment (£1.2m) to support the replacement of all remaining desktops / laptops in use which are Windows 10 incompatible. Without this investment the rapid deployment of kit to staff to work from home at the outset of the pandemic would not have been possible*** **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 and centralising control of assets. • 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 Migration**		
A	↗			
Summary update			***Milestone***	***Achieved***
Purpose: To oversee the migration of the Trust's legacy Microsoft Exchange platform to Microsoft Office 365 email environment hosted by Microsoft in the cloud. **Key activities:** ➢ A project was initiated to complete the necessary implementation and email account migration activities. As at 31 March 2020, over 5,300 SWYPFT email accounts had been migrated to the Microsoft Office365 platform and the project was on track to complete the email account migrations by the end of March 2020. ➢ **COVID-19:** However, the outbreak meant that this work was paused as focus was prioritised on supporting the Trust's digital response to the pandemic. As at mid-May 2020, all remaining email accounts have been migrated to the new email platform, 5,800 accounts in total. ➢ Some technical activities remain to be completed. The new email platform has been built to comply with the NHS Digital standards, therefore once the outstanding technical activities have been fully completed and NHS Digital accreditation achieved, the need for operating a mixed economy of email accounts (@swyt.nhs.uk for corporate business and NHS mail @nhs.net for personally identifiable information transmission) will no longer be required.			**Mar 2020 now Sep 2020**	

Please note: Once all these technical activities have been completed, this may mean that the Trust's existing NHS mail accounts may be decommissioned. Whilst a national position remains to be determined by NHS Digital, indications are that the Trust will need to decommission NHS mail accounts belonging to all SWYPFT staff within 12 months. The existing Microsoft Outlook 2010 client will continue to be used by staff until we look to upgrade from the Microsoft Office 2010 suite to Microsoft Office365 before October 2020. **Expected outcomes:** • Ensures the Trust has a stable and resilient corporate email platform which is cost effective and makes best use of available resources. • Compliance with NHS Digital's advanced security protocols meaning that emails can then be sent and received containing sensitive/confidential information using this new email platform.		

Status	***Direction***	**Microsoft Licences Trust Wide Agreement (2020-2023)**		
G	↗	***Summary update***	***Milestone***	***Achieved***
		Purpose: To review and re-provision the Trust's requirements for Microsoft products based on usage. This will explore the most appropriate and cost effective strategic way forward for continued access to Microsoft products as used by the Trust. The focus during 2020/21 being to replace the Trust's existing 3-year enterprise wide agreement (EWA) with Microsoft which expires on 30 June 2020. In addition to this, the Trust also utilises the Microsoft Office 2010 suite (Word, Excel, Outlook, PowerPoint, OneNote and Publisher) via an NHS Digital centrally funded legacy EWA which is formally ending in October 2020. From this point forward, the Trust will be directly responsible for provisioning its own Microsoft Office licencing arrangements. **Key activities:**		
		✓ **COVID-19:** The Trust's own existing Microsoft licencing entitlement has leveraged the ability to rapidly deploy Microsoft Teams across the entire Trust (circa 5,800 accounts created and installed on 4,800 devices) as part of the digital response to the outbreak.	**Apr 2020**	**Apr 2020**
		✓ ***Microsoft licencing business case:*** A business case for Microsoft Office365 (N365 option) was approved by the Executive Management Team on 4 June 2020 and is subject to Trust Board approval at the June meeting. This paper has evaluated all the options available and made a recommendation on the best approach for the Trust. Costs will increases significantly (by over £0.6m per annum) which is a predicament that all NHS Trusts are facing.	**Dec 2019**	**Jun 2020**
		✓ ***NHS X/NHS Digital negotiations with Microsoft:*** These concluded in June 2020. In order to support these negotiations, NHSX/NHS Digital required 75% of NHS organisations to sign up in principle to this N365 agreement and by the 15 May 2020 deadline, this threshold had been achieved nearing 100%.	**Jun 2020**	**Jun 2020**

Expected outcomes: • Microsoft Office365 provides a newer, supported and resilient platform which enables the Trust to further exploit software collaboration opportunities afforded by Microsoft Teams and SharePoint which are cloud hosted and therefore eligible for ongoing upgrades moving forward. • The proposed new NHS-wide agreement for Microsoft Office365 (N365) once established will reduce the Trust direct annual costs associated with Microsoft licence arrangements.		

Status	*Direction*	**Cyber Security & Threat Monitoring**	
G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: Please see previous section. **Key activities:** ➢ **COVID-19:** ***Cyber monitoring:*** Present circumstances that the NHS is facing in mobilising resources and in responding to managing the Coronavirus outbreak, means the potential threat of cyber-attack remains potent and heightened. The measures the Trust has established remain in place and all associated activities are continuing as business as usual. Whilst rapid access to digital solutions and technologies requires a more-relaxed approach in the short-term, security considerations remain at the forefront so as to ensure services remain safe. Reinforcement and additional key messages relating to cyber security are being issued to staff as part of the Trust's covid-19 communications during these unprecedented times.		**Ongoing**	
➢ ***NHS Digital secure boundary service:*** The Trust is actively engaged in a pilot with NHS Digital for a new security service offer (secure boundary service which is a suite of enhanced security products) that could potentially be available to all trusts at no additional cost. This service offers the potential to further enhance or even replace the existing Trust security services provided through the current web gateways network solutions. In support of this, the Trust was successful in securing £240k NHS England cyber security funding via West Yorkshire & Harrogate Integrated Care System (WY&H ICS) in February 2020. This first phase of this work is due to go live in June 2020.		**Jun 2020**	
➢ ***Penetration testing:*** The Trust undertakes an independent annual infrastructure, server and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed. In January 2020 the Trust engaged with Sec-1 Ltd who are an NCSC (National Cyber Security Centre) approved company offering penetration testing of IT systems to identify potential vulnerabilities and recommend effective security countermeasures. **COVID-19:** Sec-1 and SWYPFT agreed the scope of works and the internal element of the pen test has been completed but the external aspects have had to be rescheduled part way through the work due to covid-19 outbreak. Therefore the penetration test report and findings will be provided on completion of these remaining activities.		**Was Feb 2020 now Jun 2020** **Sep 2020**	
➢ **COVID-19:** ***Cyber security survey:*** An annual cyber security survey to further gauge staff awareness, understanding and determine if vigilance is			

improving. This was due to be published in June 2020 but was delayed due to the volume of communications relating to the pandemic. This is currently being re-planned and will likely be published in September 2020. ➢ ***Cyber table top exercise:*** Annual cyber security table top exercise to be scheduled early 2021 in line with the cyber progamme. ➢ ***Cyber essentials:*** A schedule of strategic IT roadmap workshops that support this work are established between Trust IT services and Daisy. This remains a constantly evolving environment and a challenge to support and enable cyber essentials certification. **Expected outcomes:** • Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats • Adoption of industry standard best practices, as appropriate. • Improve the defences against a cyber attack	**Feb 2021** **Jul 2021**	

Status	***Direction***	**Telephony Services Review**		
P	→			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key activities:** ➢ ***Desk Telephony Services:*** To conduct a review of the Trust's desk telephony service requirements and undertake an evaluation of the options. **Expected outcomes:** • Ensures the Trust has a stable and resilient corporate telephony platform which is cost effective and makes best use of available resources.			**Sep 2020**	

Domain 2: Integrated Electronic Care Record System	***Supports Digital Strategy Aims*** ***1. To enhance quality of care and patient safety*** ***3. To foster integration, partnership and working together*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status	***Direction***	**Physical Health Services Clinical Records System (SystmOne)**		
A	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key activities:** ➢ ***Neighbourhood teams (Barnsley) service re-design:*** A major programme of work in support of service re-design and enhancements for new models of care for integrated neighbourhood teams in collaboration with partners.			**May 2020** **Now TBC**	

COVID-19: Activities had been suspended in light of the pandemic but plans to recommence activities are now underway: ▪ *Integrated Single Point of Access (SPA)*: To create an integrated SPA incorporating community nursing referral service and Barnsley Rightcare located in the Lodge at Kendray Hospital. Activities were on track for an April 2020 commencement. The pandemic initially paused this work stream but Barnsley Rightcare have now fully relocated to Kendray Hospital. ▪ *Integrated SystmOne unit for NTS*: Palliative care services were migrated into the integrated SystmOne unit. The impact of the pandemic was to pause this work. Planned activities have recommenced from mid-June 2020 with a revised implementation plan being determined. **Expected outcomes:** • To ensure continuity of care with key clinical documentation re-designed to meet service needs and provide easier access to clinical information. • To support the development of new integrated models of care. • To ensure that all community services are fully optimised in their usage of SystmOne.	**Apr 2020 now Jun 2020** **TBC**	

Status	***Direction***	**Mental Health Services Clinical Record System (CRS) (SystmOne)**		
G/A	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key activities:** ➢ ***SystmOne Record Sharing-Out:*** A high level action plan for turning on record sharing (sharing out of the SWYPFT SystmOne mental health care records) has been developed giving consideration to standard operating procedures, patient consent and management of risks. The programme team have undertaken an initial scoping exercise / document for consultation with service improvement groups and it was planned for this to be enabled from September 2020, following a programme of engagement and communications with stakeholders, partners and service users. **COVID-19:** Under regulations within the Covid Act the Trust is required to temporarily share out service user's records to other health organisations via SystmOne (refer to the Information Governance update on page 46). The purpose of the notice is to: ▪ Protect and support service users who may be receiving coronavirus-related care from other health providers ▪ Provide GPs and other healthcare providers with a view of a service user's healthcare records (including medications and mental health history) to support them when receiving coronavirus-related healthcare. ▪ To alleviate the current situation, where larger numbers of people are being treated by clinicians who may have no prior knowledge of their medical history. ➢ These changes will impact services accessing SystmOne mental health as Barnsley community services were already sharing the patient record. As the Trust was preparing to implement sharing out of care records from		**Apr 2020 brought forward from Sept 2020**	

September 2020, these new regulations, in response to the coronavirus pandemic have resulted in bringing this date forward. Actions taken to date in respect of this are summarised below: ▪ Considerable work has taken place at short notice to engage with CCGs to facilitate sharing. ▪ Email communications to all clinicians and admin / clerical staff who use SystmOne mental health have been issued for awareness of these changes. ▪ Any practice on EMIS can access in a read-only manner our summarised care record information from within their system. This follows separate record sharing arrangements established between TPP and EMIS to facilitate this. ▪ Plans to gain service user consent ahead of 30 September (the date the Covid Act is currently scheduled to end) are in place.	**Sep 2020**	
➢ ***Task Management:*** SystmOne tasks are closely aligned with record sharing, therefore the Trust has developed a high level action plan giving consideration to standard operating procedures, patient consent and management of risks. Both sharing out and task management are system-wide settings within SystmOne so cannot be enabled for a particular GP practice or area. The programme team have undertaken an initial scoping exercise for consultation with service improvement groups.	**TBD**	
➢ **COVID-19:** The introduction of task management is being accelerated as part of the Trust digital response to the pandemic. Calderdale and Kirklees single point of access taking first steps at the start of June 2020 and likely that ADHD / Autism service will follow. These early adopters will help expand and re-inforce our documentation and training materials.		
➢ ***FIRM Risk Assessment:*** The FIRM assessment is designed to enhance current clinical practice and will provide a more robust, evidence-based and up to date framework for staff to use to record clinical judgements about risk and to inform management and care plans. This has been undertaken via close liaison with quality improvement. The pandemic has paused this work.	**Jun 2020 brought forward from Sept 2020**	
➢ ***eReferrals:*** Whilst part of the SystmOne optimisation programme, please refer to the eCorrespondence section below.	**Revised to Sep TBC**	
Expected outcomes: • SystmOne will be used more consistently and effectively. • 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 ICSs, further demonstrating our commitment in meeting commissioner intentions.		

Status	Direction	eCorrespondence		
A	→			
Summary update			***Milestone***	***Achieved***
Purpose: Enables the Trust to reduce the reliance and flow of paper both internally and with our partners in respect of delivering patient care. **Key activities:** ➢ ***eReferral Services in Mental Health:*** The adoption of eReferral service has been included in the national contract guidance for mental health services and is something that has been written into local commissioning contracts. This national target had been revised for mental health services to March 2021 from March 2020. The work conducted by Wakefield SPA to date had highlighted some significant changes to working practices, overheads and could potentially introduce clinical risk. This therefore requires further investigation in addition to gaining insights into the experiences of other NHS organisations that have adopted the eReferral service in SystmOne. A planned outcome of this work is to improve referral processes and bring about data quality improvements through the development of a standardised referral template / letter. Calderdale and Kirklees SPA are testing the paper form initially before rendering within SystmOne for further testing. **COVID-19:** This work has been paused in lieu of the pandemic. **Expected outcomes:** • Supports the drive towards digitisation of the NHS and the paperless NHS by 2020, further supporting the Local Digital Roadmap (LDR) plans and aspirations of ICSs. • 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.			**Ongoing revised National deadline Mar 2021**	

Status	Direction	Clinical Portal Development (PORTIA)		
A	→			
Summary update			***Milestone***	***Achieved***
Purpose: Enables the Trust to bring together information from different clinical information systems into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need. **Key activities:** ➢ ***PORTIA development:*** The end user interface has been re-designed to improve the presentation of the information displayed within the Trust's clinical portal solution. The upgrade to this new release (Viper v3) had commenced and was due to be completed by 31 March 2020. **COVID-19:** However, the COVID-19 outbreak has meant that a number of activities remain to conclude this work. A revised plan has been developed to			**Mar 2020 Now Jul 2020**	

reflecting the changed timeline. **Expected outcomes:** • Provision of a single integrated holistic patient record view. • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner.		

Status	*Direction*	**Electronic Prescribing & Medicines Administration (EPMA)**	
G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: Electronic Prescribing and Administration of Medications (EPMA) is a key development which is designed to improve patient safety, efficiency in service delivery, quality of data and deliver financial benefits for the organisation. Essentially, it converts the traditional paper prescription and administration card into an electronic record accessible by an authorised user from any device with the requisite software. This approach is being taken by many trusts. **Key activities:**			
✓ ***ePrescribing / EPMA:*** The Trust successfully submitted a bid for external funding to support the implementation of ePrescribing and electronic prescription management administration (EPMA). £250k was awarded to the Trust in 2019/20.		**Oct 2019**	**Oct 2019**
➢ A project has been initiated to oversee the implementation of EPMA for inpatient services with good progress made since the programme manager commenced employment with the Trust during April.		**Ongoing**	
COVID-19: EPMA has a strong part to play in delivering flexibility and the ability to work safely remotely. **Expected outcomes:** • This approach 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. • Reduce risks associated with medicines administration • This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution • Improves the Trust's overall digital maturity			

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		
G	↗			
Summary update			**Milestone**	**Achieved**
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. **Key activities:** ➢ ***WY&H and SY&B ICSs:*** Trust continues to participate in a number of external groups/forums in support of the ICS digital work stream initiatives in collaboration with health and social care partners. ➢ **COVID-19:** Recent focus has been on organisational responses to the pandemic and learning from the experiences collectively. ➢ **Digital maturity:** The digital strategy for the West Yorkshire and Harrogate Health and Care Partnership (WYHP) was developed last year and the strategy recognised the ability to enable transformation is not only dependent on the maturity of our constituent organisations but also of our places. Therefore a digital maturity assessment for each of our places is underway with the aims being to identify potential synergies and to prioritise opportunities for our local systems. The findings will be brought together across the ICS and inform the next steps for the digital strategy. ➢ ***Yorkshire & Humber Care Record:*** 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 in production that aims to deliver a shared care record solution across the Barnsley place. COVID-19: Various options for a shared care record solution are being considered. They each require careful deliberation upfront in respect of potential future costs, governance, potential commercial challenges/risks etc. downstream as this is a strategic decision. **Expected outcomes:** • The vision will lead to an integrated digital infrastructure across ICS regions, making more effective use of the technical expertise available and allowing		**Ongoing**	

our collective digital capabilities to develop in parallel with technological advancement. • Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Local systems will support digital pilots and wider delivery and the scaling up of successful interventions will be coordinated by digital work streams and the supporting key interventions.		

Status	Direction	Records Management (Scanning – Archive/Paper Records)		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Continue to develop the onsite scanning bureau and work towards meeting the 2020 paper free target. **Key activities:** ➢ Subject access requests (SARs): From October 2019 to February 2020 100% of SARs were compliant with required timescales. This dropped to 96% in March 2020 due to delays because of additional pressures caused by **COVID-19:**. In April 2020, information governance sign-off was implemented as a temporary measure to prevent delays and SARs are 100% compliant within timescales.			**Mar 2020**	**Mar 2020**
➢ **COVID-19:** The clinical coding is currently just below the 100% target for finished consultant episodes within 6 weeks of discharge or transfer due to the pandemic.			**Ongoing**	
➢ 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 31 May 2020, over 47,500 records (7.7m pages) have been scanned since the programme of work commenced in April 2017. This is an increase of 15,500 records (2m pages) since the position reported in October 2019.			**Ongoing**	
➢ The scanning bureau has also taken on the scanning of records retrieved from offsite storage, with all boxes retrieved being scanned in full. Almost 33% of boxes held by Iron Mountain have been identified for destruction and the remainder will be retrieved for scanning to further reduce off-site storage costs			**Ongoing**	
Expected outcomes: • Reduced reliance on off-site storage (avoidance of increased costs). • Improved governance through having easy, electronic access to all records related to a Trust client, supporting the digitisation and paperless NHS agendas.				

Status	Direction	Paper Digitisation (Paperlight/Paperless NHS)		
A	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Paperlight forms part of the wider care record digitisation agenda and aims for all clinical services (predominantly those services that currently use				

SystmOne as their main clinical information system) to work towards achieving paperlight accreditation.

Key activities:

- ***BDU Paper digitisation areas for prioritisation:*** The project team are working with BDUs on this programme of work. Different services are at different stage of the paperlight accreditation process

Mar 2021

- **COVID-19:** The project team have been proactively contacting the services that they have been working with to help with any queries they may have to provide/offer support. The team are also engaged in exploring new ways of working to provide the services and support virtually given prior working arrangements have had to be adapted since the outbreak.

- ***Facsimile machines:*** This project has also focused on the decommissioning of facsimile 'fax' machines in line with the national requirement. The team were working with services to consider alternative means of communication as appropriate. Currently, there are 7 remaining fax machines that will shortly be removed.

Was Mar 2020 Now Jul 2020

	Total	**Removed**	**Pharmacy** (remaining)
Barnsley	28	26	2
Wakefield	34	32	2
Kirklees	11	10	1
Calderdale	15	13	2
	88	**81**	**7**

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 as part of the wider national agenda.
- Improved contemporaneous record keeping.
- Reduce time on inputting referrals.
- Reduction in costs associated with 'green paper files'.

Status	*Direction*	**Multi-Function Device (MFD) Re-procurement**
A	↗	

Summary update	*Milestone*	*Achieved*
Purpose: To re-procure the Trust's multi-function device fully managed service. This provides an opportunity to review the Trust's current and future requirements and to explore the prospects of securing service efficiencies, cost savings and improving the existing quality of service. **Key activities:** ✓ The Trust recently conducted a mini-tender exercise via the Crown Commercial Services Framework for the provision of a managed print	**Dec 2019 now**	**Mar 2020**

solution to replace our existing contract with Xerox (UK) Limited which was due to expire. An extensive evaluation process concluded with contract award to Kyocera Document Solutions (UK) Limited. The award of contract was signed on 1 March 2020 with a planned 1 April 2020 start date, allowing for a three month implementation programme and removal of the legacy Xerox equipment.	**Mar 2020**	
➢ **COVID-19:** The impact of the pandemic has resulted in a delay with commencing the contract with Kyocera to 1 July 2020 and a decision to extend the current contract with Xerox (UK) Limited until 30 September 2020.	**Jun 2020 now Sep 2020**	
➢ The procurement team have engaged a project manager who will work with a recently appointed procurement senior contracts manager that has experience in MFD contracts		
Expected outcomes: • Ensures the Trust has a stable and resilient corporate MFD platform which is cost effective and makes best use of available resources.		

Status	***Direction***	**Video Consultation/Conferencing**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Video consultations are electronic means of establishing consultative communications between clinician-to-clinician either at a provider-to-provider level or in collaboration with patients/service users / carers via video conferencing appropriate solutions. **Key activities:** ➢ The digital strategy group had been exploring opportunities with video consultation solution providers, the outcome of which was hoped would enable the Trust to conduct a pilot project to test out the feasibility, inform suitability, assess overall clinical fitness for purpose, scalability and wider rollout opportunities for such technologies. Recent events have changed the dynamic of this opportunity. ➢ **COVID-19:** The Trust rapidly implemented and made available a number of video conferencing solutions to enable the Trust to conduct its business functions effectively, albeit remotely in these extremely challenging times. The response to the outbreak meant some of these video conferencing solutions were introduced in an accelerated manner across the Trust in less than 2 weeks with much reduced testing. The summary provided below provides an outline of the Trust's uptake over recent weeks which is witnessing an increase in the use of these solutions, with feedback generally positive. ▪ ***AirMid:*** This solution allows consultation details to be recorded within SystmOne as it offers inherent video capabilities but limited to 1-2-1 consultations between the healthcare professional and the service user. During June there was an average of 850 Airmid consultations undertaken weekly. ▪ ***AccuRX:*** Whilst AccuRX does not link to the SystmOne record it does provide the added capability of allowing upto 4 people to attend the consultation. During June 2020 there was an average of 700 AccuRX		**Apr 2020**	**Apr 2020**

consultations undertaken weekly. ▪ ***Microsoft Teams:*** This technology is being actively used for group sessions. The Microsoft Teams platform was rapidly deployed successfully as part of the Trust's response to the pandemic and corporate uptake / usage across the Trust has been truly staggering. ▪ **WhatsApp:** WhatsApp was enabled during the early stages of the outbreak as a means for staff to maintain contact and video call service users, so contact is not lost. Please note that in line with the Trust's position statement on video conferencing/consultation solutions, it is advised that WhatsApp only be used as a last resort and where the other Trust supported solutions are considered not suitable and have been explored appropriately. ➢ The IM&T team are continuing to work collaboratively with services to obtain feedback from the use of these solutions both from a clinician and service user experience perspective and also offering advice / support on an ongoing basis. ➢ Following any return to 'normal' business operations and as part of the restoration & recovery planning incorporating opportunities for continued new ways of working, this will require a review and evaluation of the Trust supported products that have been made available in response to covid-19. Some solutions have been made available by the vendors 'free of charge' for a limited period, however, continued usage will incur costs which need to be fully understood. Any decisions will be subject to Trust governance and approval processes. **Expected outcomes:** • Improve the patient experience. • Improve access to services, engaging information users and further supporting the digitisation agendas in line with wider ICS digital aspirations.	**Sep 2020**	

Domain 4: Business Intelligence Systems	***Supports Digital Strategy Aims*** ***3. To foster integration, partnership and working together*** ***5. To maximise efficiency and sustainability***

Status	***Direction***	**Business Intelligence/Data Warehouse (information hub & dashboards)**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key activities:** ✓ **COVID-19:** Work undertaken to establish systems and reporting for Covid-19 absences and testing. New reporting deployed via SWIFT site and used to inform Silver and Gold command. ➢ Development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available.			**Apr 2020** **Ongoing**	**Apr 2020**

➢ **COVID-19:** Initial workshop with service leads to review team dashboards and consider variation internally and potential opportunities for improvement. Work undertaken with change team to establish a wider plan for reviewing and analysing Model Hospital & internal team benchmarking moving forward. Further work on this put on hold due to Covid-19. **Expected outcomes:** • Continue to improve and make available the use of real time information to support operational services and transformation agendas.	**TBD**	

Status	*Direction*	**Performance Management & Reporting**	
G	↗		
Summary update		***Milestone***	***Achieved***
Purpose: The development of the Trust's performance management and reporting capabilities to improve service line reports, key performance indicators and business performance information provisioning. **Key activities:**			
✓ Q3 and Q4 reporting for CQUINS undertaken.		**Apr 2020**	**Apr 2020**
✓ Development of MHSDS to ensure meet requirements for V4.1		**Apr 2020**	**Apr 2020**
✓ Development of CSDS V1.5 to meet new requirements		**Apr 2020**	**May 2020**
✓ **COVID-19:** Development of an interim report for commissioners to identify activity pre and during the pandemic (this is now circulated monthly to CCGs).		**May 2020**	**May 2020**
✓ Development of activity report to show daily bed occupancy, weekly referrals and weekly contacts for commissioner pre and present.		**Jun 2020**	**Jun 2020**
➢ Development of timeline in conjunction with operational services to identify when Trust can return to BAU commissioner reporting.		**July 2020**	
➢ **COVID-19:** Work related to the support for operational services and reporting for CQUINS to be determined and presently on hold due to the pandemic.		**TBD**	
➢ Preparation and planning for 2020/21 – awaiting further national guidance regarding implementation.		**TBD**	
➢ Review of activity in preparation for operational planning requirements.		**TBD**	
Expected outcomes: • Continue to improve performance information to support operational services and transformation agendas.			

Status	Direction	Information Governance		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: Please see previous section. **Key activities:** ➢ **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. Classroom training sessions are now managed by L&D and places can be booked via e-Learning. ➢ **Data Protection & Security Toolkit (IG Toolkit):** The new Data Protection & Security toolkit will not be available until September 2020. **COVID-19:** <u>New/amended legislation & guidance in response to the COVID-19 pandemic</u> ➢ **Information Commissioner's Office (ICO):** The ICO released guidance during March 2020 to confirm it cannot extend statutory timescales but acknowledges that organisations have to prioritise other areas and adapt their usual approach to compliance and IG work at this time. Therefore, organisations will not be penalised if it takes longer to respond to subject access and freedom of information requests or whose data protection practices might not be up to the usual standard during the pandemic. ➢ **The Health Service (Control of Patient Information) Regulations 2002:** On 23 March 2020 the Secretary of State for Health & Social Care served a statutory requirement notice on health care providers, GPs, local authorities and arm's length bodies of the Department of Health & Social Care to disseminate confidential, patient information to organisations permitted to process such information where it is to be processed solely to manage and mitigate the spread and impact of the current COVID-19 outbreak. Necessary processing for the specified purpose shall be taken to be lawfully done despite any duty of confidence owed in respect of the information. The notice will expire on 30 September 2020 unless an extension is notified on or before that date. ➢ The Trust is continuing to deliver an Information Governance service during the COVID-19 outbreak, applying appropriate governance and assurance mechanisms in order to fast-track decision-making to allow processes to be adapted and adhering to new and amended guidance, via the Improving Clinical Information Group (ICIG). **Expected outcomes:** • Mandatory IG training target is achieved. • The Data Protection & Security toolkit target of meeting all mandatory standards is maintained. • Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.			**Ongoing** **Sep 2020**	

Status	Direction	National Data Opt-Out		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: The national data opt-out is a new service which allows individuals to choose if they do not want their confidential patient information to be used for purposes beyond their individual care and treatment, for research and planning. Service users or people acting for them by proxy have control over setting or changing their own opt-out choices, which they can change at any time. **Key activities:** ➢ We have implemented the process whereby we can send a list of NHS numbers to NHS Digital and receive the ones back that have opted-out, so if the Trust needs to conduct any work that falls into the research category we have a mechanism in place. Publication materials are ready but have not been displayed as of yet due to the pandemic and the reduction in patients attending Trust premises. This requirement will be completed once a return to normal service operations resume. ➢ **COVID-19:** In recognition that the health and social care system is going to face significant pressures in the coming months due to the covid-19 outbreak, and that staff will need to work in different ways, NHS Digital has made the decision to extend the compliance deadline for the national data opt-out for six months up to 30 September 2020, at which point the position will be reviewed. **Expected outcomes:** • Preparedness for the national data opt-out is assured and processes established to ensure compliance within prescribed timescales.			**Ongoing** **Sep 2020**	

Domain 5: A Skilled & Digitally Enabled Workforce	***Supports Digital Strategy Aims*** ***4. To develop an effective and digitally empowered workforce***

Status	Direction	Microsoft SharePoint Developments		
A	↗			
Summary update			***Milestone***	***Achieved***
Purpose: The Trust has a major dependency on Microsoft SharePoint and the current version (Microsoft SharePoint 2010) that is in use across the organisation goes out of extended support (end of life) in April 2021 (extended 6 months by NHS Digital from October 2020) as identified earlier in this report. Therefore, appropriate plans and activities need to be established to support the proposed migration to a Microsoft SharePoint365 cloud hosted environment to ensure continuity. The Trust is reliant upon SharePoint for the following service areas: • Intranet (Communications, Marketing & Engagement) • Payroll forms and processes (HR) • Business Intelligence dashboards and performance reporting (P&I) • Criteria led discharge dashboard and processes (Integrated Change Team) • Membership database (Corporate Governance)				

Key activities: ✓ To facilitate this, a SharePoint working group has been established whose primary purpose is to oversee and co-ordinate the programmes of work in respect to the planning, preparation and upgrade activities to support the Trust's continued utilisation of SharePoint capabilities.	**Mar 2020**	**Mar 2020**
➢ A scope of works to commission a third party SharePoint specialist to conduct a readiness check on the current SharePoint environments ahead of the potential move to SharePoint365 is being prepared.	**Jun 2020**	
➢ Outline implementation plans are being developed by the respective corporate services asset owners to determine the migration plans via the SharePoint working group. ***Once the implementation plans are agreed, the necessary activities will be supported through the planned 20/21 digital capital programme which incorporates a scheme for SharePoint migration (£250k).***	**Jul 2020**	
➢ Develop a business case that proposes the establishment of a robust and adequate resource structure for ongoing maintenance & support and continuous development of the SharePoint environment, subject to Trust governance and approvals.	**Dec 2020**	
➢ Creation and maintenance of a SharePoint development register to support future bids for funding streams and also internal annual planning cycles.	**Dec 2020**	
There remains a risk that the Trust's dependency on the existing Microsoft SharePoint environments may severely impact Trust business due to the current platform going out of support in April 2021. Whilst this change reduces the risk to the organisation somewhat, it is planned that comprehensive migration activities continue to progress at pace to ensure the necessary work is completed ahead of this revised timeline by the respective corporate services. An organisational risk has been created.		
Expected outcomes: • To improve access to corporate systems and information in a timely and responsive manner. • To ensure that the Trust corporate intranet is developed, maintained and services/information is accessible across the workforce. • Supports information asset management, integrity and confidentiality to comply with GPDR requirements. • Establish a robust and strategic approach for ongoing maintenance & support and continuous development of the SharePoint environment, subject to Trust governance and approvals.		

Status	*Direction*	**Social Media Access for Staff**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: To enable more staff to access information online and join online networks / discussions forums.				

Key activities: ➢ **Social media guidance updates:** Collaborate with staff side, IT HR and IG for comments.	**Ongoing**	
➢ **Social media savvy guides:** Bitesized do's and don'ts guides for staff, working with staff side to review content. Produced a Facebook & Twitter guide which was issued direct to services as part of the response to the pandemic, so requires further review and amending prior to officially launching	**Ongoing**	
➢ **Social media drop-ins:** Open workshops for troubleshooting, suggestions, hints and tips. A Twitter guide has been developed and is to be reviewed with staff side ahead of workshops/drop-ins, however, worked directly with services throughout pandemic rather than drop-ins, using Microsoft Teams	**Ongoing**	
➢ **COVID-19:** Specific actions taken as a result of responses to the pandemic are summarised below: ▪ Updated staff app everyday throughout the pandemic including push notifications directing staff to important information. ▪ Responsive dedicated Intranet section with centralised information for Coronavirus. ▪ Real-time website updates for service users, colleagues and visitors to all our Trust sites. ▪ New FAQ staff section for Trust website for coronavirus pages. ▪ Cards of kindness web form update. ▪ Barnsley immunisation website pages to allow collection of child data in order to prepare for jabs – post lockdown. ▪ IAPT social media advertising campaigns "we're still here to help". ▪ Support with recovery college standalone websites bid and brief. ▪ Kirklees IAPT website migration to a new hosting platform ▪ Work to improve Barnsley IAPT website, new workshop booking section. ▪ Support for services launching social media platforms during pandemic, these include Kirklees IAPT Facebook Page, Wakefield learning disability Facebook page, Barnsley speech and language therapy YouTube page and perinatal YouTube channel. ▪ Launch of new Vimeo video hosting platform allowing us to host videos privately – for use internally. ▪ Increase in video editing jobs during the pandemic. ▪ Support with IT in order to move Extended EMT meetings to Microsoft Teams. ▪ Audit of the entire Trust website service directory.	**Ongoing**	
➢ **COVID-19: WhatsApp:** As part of the Trust's response to the COVID-19 pandemic, WhatsApp was enabled during the early stages of the outbreak as a means for staff to maintain contact with service users, so contact is not lost. To be reviewed as part of video conferencing solution evaluation.	**Sep 2020**	
Expected outcomes: • Improve staff access to social media to enhance digital capabilities.		

Status	Direction	Succession & Workforce Planning (IM&T Staff)		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: 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. **Key activities:** ➢ A programme of work to aid continuous development and service improvements is being initiated from the timeout workshop outcomes and key themes identified. This is supported by Learning & Development. ➢ A workforce plan has been drafted in support of annual planning activities and this also incorporates the develop succession plans. ➢ Working with Learning & Development to consider opportunities for wider eLearning training provision in line with staff appraisal development needs. ➢ **COVID-19:** From the outset of the covid-19 outbreak and during the lock down restrictions, the IM&T functions have adapted their ways of working so as to continue to operate in a safe and effective manner, whilst adhering to Trust and national guidance. Staff across all IM&T functions are setup with the ability to work from home and are predominantly continuing to work remotely, attending Trust premises only when necessary and with skeleton staff working from Trust sites. Throughout this time, the majority if not all IM&T services have continued to operate to expected levels of performance. An outline recovery plan has been produced which will be implemented in due course in line with national and Trust guidelines. However, during this time a balance between service delivery and the health & wellbeing of staff is maintained and individual staff members are supported, through joint agreement of expectations. **Expected outcomes:** • Improve staff retention. • Improve access and availability of training and development opportunities in support of identified needs. • Improves service resilience and delivery. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience and capabilities. • An effective work/life balance with individual health & wellbeing at the centre.		**Ongoing**	

Status	Direction	Development of Staff Training (IT & Digital Skills)		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: To explore opportunities from which to support staff development (capacity / capability) in the use of IT/digital technologies and solutions in the workplace. Individual need will be based on employee capability on using new systems as well as general IT/digital skills in using applications such as				

Microsoft Office etc. **Key activities:** ➢ IT skills development requests are continuing to be actively managed via the Trust study leave procedure and accessing alternative training routes available via learning & development. ➢ The digital strategy group will help support the development of a wider digital culture and digital champions within the workforce. ➢ **COVID-19:** The advent of accelerated video conferencing capabilities available across the Trust in response to the covid-19 pandemic is witnessing an increasing utilisation of solutions such as Microsoft Teams, which are being explored for the delivery of remote elearning training. Such technologies are being used to deliver effective training both internally and externally as an alternative means to traditional classroom based face-to-face training. ▪ Delivery of SystmOne training to Trust clinical services e.g. neighbourhood teams integration in Barnsley. ▪ All non-essential non-mandatory training paused with any essential and mandatory training converted to elearning and digital where possible. ▪ Induction processes delivered through videos and information access via the Trust's intranet and workforce support hub. ▪ Leadership and management development support provided as part of the workforce wellbeing offer such as coaching provided using Microsoft Teams. ▪ Plans being developed to develop training and mitigate face-to-face training and support social distancing arrangements for the longer-term as part of the restoration and recovery phased process. ➢ The Trust's e-appraisal WorkPAL system to be implemented in line with the Trust's revised September to December appraisal window. **Expected outcomes:** • Improve staff retention. • Improve access, timeliness 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. • Better use of Trust resources	**Ongoing** **Jun 2020** **Sep 2020**	

Domain 6: Engaging and Learning from Digital Best Practice	Supports Digital Strategy Aims: 1. To enhance quality of care and patient safety 2. To enable prevention, wellbeing and recovery 3. To foster integration, partnership and working together 4. To develop an effective and digitally empowered workforce 5. To maximise efficiency and sustainability 6. To support people and communities

Status	Direction	Digital Dictation		
P	→			
Summary update			**Milestone**	**Achieved**
Purpose: Exploration of digital dictation solutions to inform a strategic Trust-wide approach. **Key activities:** ➢ It was planned to progress a pilot within Wakefield BDU medical secretarial team using Lexicom's digital dictation solution following a positively received demonstration at the January 2020 digital strategy group meeting. This pilot was being developed in partnership with internal and external stakeholders and planned to run for an 8 week period with a full evaluation that will be submitted back to the digital strategy group for consideration of next steps and development of a business case. ➢ **COVID-19:** The proposed pilot was curtailed by the Covid-19 pandemic and commencing this work remains subject to the recovery planning and ongoing social distancing requirements. **Expected outcomes:** • To develop a Trust wide solution for digital dictation that offers standardisation • Supports the paperless agenda • Improves service effectiveness and efficiencies			**TBC**	

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		
A	→			
Summary update			**Milestone**	**Achieved**
Purpose: We have a patient appointment reminder system in operation which aims to reduce "did not attend" (DNA) levels across Trust services. **Key activities:** ✓ **COVID-19:** In response to the pandemic the patient reminder system has been adapted, changing the wording of the SMS message to reflect the changing situation. An SMS is now being sent for both telephone			**Apr 2020**	**Apr 2020**

appointments and face-to-face appointments, distinguishing for the service user the type of appointment and any practical considerations (e.g. locating appropriate work space when answering). ➢ Initial scoping has confirmed clinicians are not using rotas consistently, so roll-out of the reminder service to include these appointments requires further work. There is also work underway to determine numbers of health care professional appointments that have been added retrospectively as this may impact DNA rate reporting. ➢ **COVID-19:** Barnsley MSK, podiatry and dietetic community service are still planning to use the patient appointment reminder service to collect friends & family feedback. This work has been curtailed due to the pandemic. ➢ A review and evaluation of the Trust's patient reminder solutions is being co-ordinated via the non-pay delivery group. At present the Trust has two such systems for historic reasons. This evaluation will consider the merits of both solutions in terms of usage, capability, future opportunities and associated costs with a view to standardising on one solution at an appropriate time. **Expected outcomes:** • Reduce DNAs, increase re-use of appointment slots ('fast-track' patients in need of urgent appointment) and in turn reduce costs and waiting times. The pilot teams have been able to demonstrate a 30% reduction in DNA rates. • Improve efficiency of services. • Improve quality of services. • Improve patient experience. • Make best use of Trust resources	**Ongoing** **TBD** **TBD**	

Status	*Direction*	**Collecting and Reporting Health Outcomes**	
P	→		
Summary update		***Milestone***	***Achieved***
Purpose: The Trust is exploring digital solutions to collection and reporting of outcomes. Some services such as IAPT, CAMHS and early intervention are required to routinely collect outcome measures. There is no consistent approach to outcome measure collection presently within the Trust. Clinical outcomes can be measured by data such as hospital re-admission rates, or by the 5 domains set out in The NHS outcomes framework indicators: • Preventing people from dying prematurely • Enhancing quality of life for people with long-term conditions • Helping people to recover from episodes of ill health or following injury • Ensuring that people have a positive experience of care • Treating and caring for people in a safe environment and protecting them from avoidable harm **Key activities:** ➢ The Trust is exploring digital solutions to collection and reporting of outcomes as there is no consistent approach to outcome measure collection presently within the Trust. 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:		**TBD**	

▪ 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. ➢ Three potential solutions are being considered. These will be revisited later in the year with a view to presenting an updated proposal to digital strategy group. ➢ **COVID-19:** The proposed pilot was curtailed by the Covid-19 pandemic and commencing this work remains subject to the recovery planning and ongoing social distancing requirements. **Expected outcomes:** • Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient. • Improved timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment. • Automatic analysis, scoring and reporting in real time at clinical, service and organisational level. • Better understanding of clinical need and effectiveness of services.		

Status	*Direction*	**Service User (Patient) Portal Development**	
P	→		
Summary update		***Milestone***	***Achieved***
Purpose: Development of a SWYPFT capability that provides service users and 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. **Key activities:** ➢ ***Service user access to electronic care records:*** SWYPFT has registered interest with TPP in becoming a pilot organisation for the impending SystmOne App, which is being developed and planned to make available by the end of December 2019 in line with the national requirement to provide access to records electronically. ➢ ***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. ➢ **COVID-19:** The impact of the pandemic has halted any opportunity to progress this.		**TBC**	

Expected outcomes: • Provision of a single integrated holistic patient record view that facilitates a patient's access to their own electronic care record. • Sourcing data from Trust internal systems, reducing the need to access multiple systems and moving forward from partner systems. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner.		

Domain 8: Embedding Digital in our Culture	***Supports Digital Strategy Aims:*** ***1. To enhance quality of care and patient safety*** ***2. To enable prevention, wellbeing and recovery*** ***3. To foster integration, partnership and working together*** ***4. To develop an effective and digitally empowered workforce*** ***5. To maximise efficiency and sustainability*** ***6. To support people and communities***

Status	***Direction***	**Apps for Service Users and Carers**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: As part of the wider digitisation agenda, the Trust is exploring opportunities from which to make information and services more accessible to our patients, service users and carers. **Key activities:** ➢ Marketing, communications and engagement continue to help promote Orcha within our services and have included specific information on Orcha and downloading of apps in relation to covid-19 on the intranet site. Promotional material has been developed and circulated to services. ➢ Services signed up to rolling out Orcha are: stop smoking services, CAMHS and IAPT. **COVID-19:** Orcha have given all professionals access to accounts until July 2020 so they can search for and recommend apps to the people in their care during the pandemic. ➢ **COVID-19:** Data from Orcha will continue to be evaluated including any increased usage during the pandemic. ➢ As part of the digital innovation we will continue to work with services with a view to roll out to more services across the Trust. **Expected outcomes:** • Improves the overall patient experience. • Improves access to services, supportive information users and is part of the wider digitisation of the NHS, further supporting the LDR plans and aspirations of ICSs.			**Ongoing** **Ongoing** **Ongoing** **Ongoing**	

Status	***Direction***	**i-Hub Digital Challenge**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: i-Hub is a social innovation platform where the aim is to crowdsource ideas and experiences, to help develop and realise identified organisation				

priorities. i-Hub is centred around a number of 'conversations' that pose a key question, opportunity or area of development to engage our workforce about (including volunteers). **Key activities:** ➢ Promote and increase awareness of i hub as a place to put ideas, share learning and ask others for help with now over 2,300 users. Examples of conversations in the last year include: ▪ Going green - environmental conversation receiving over 50 ideas with successes being the development of sustainability group and reduced plastic across the Trust. ▪ Spending money wisely with 25 submitted ideas. ▪ Move more SWYPFTly – increasing physical activity for the people we care for and our staff with 32 submitted ideas. ▪ **COVID-19:** The latest conversation supports the changes made as a result of the pandemic and learning from our different ways of working. ➢ We continue to crowdsource My Ideas and Fab Stuff **Expected outcomes:** • This online tool helps the Trust connect, share, discuss, develop and spread ideas. • Support staff to continuously innovate, improve and transform. • Improve efficiency of services. • Improve quality of services. • Improve patient experience.	**Ongoing** **Ongoing**	

Status	***Direction***	**Virtual Visitor**		
G	↗			
Summary update			***Milestone***	***Achieved***
Purpose: **COVID-19:** To help prevent the spread of covid-19, visiting across SWYPFT inpatient areas has been restricted. To ensure the people in our care do not become socially isolated, continue to have contact with their families, have up to date information and are still able to stay in contact with services, a virtual visitor project has been launched to support well-being with a solution being implemented across the Trust. **Key activities:** ✓ The 'engagement and equality' team have completed some research with service users, carers, families and third sector partners to test the concept of the virtual visitor scheme ✓ A pilot utilising dedicated android tablet devices based on inpatient wards in a controlled environment to connect with families, friends and volunteers. ✓ The pilot took place on 2 May 2020 in forensic BDU Newhaven ward with positive feedback received from staff, service users and family members. ➢ Following the pilot and positive feedback, the virtual visitor scheme is being rolled out to all inpatient wards across the Trust and a dedicated android device purchased for each ward to ensure that all people in our care have the opportunity to connect with their friends, family and Trust volunteers			**Apr 2020** **Apr 2020** **May 2020**	**Apr 2020** **Apr 2020** **May 2020**

during this time. ➢ Evaluation forms have been issued to all wards to capture feedback from staff and experiences of service users and their family and friends. Continuation of the virtual visitor scheme is to be reviewed as part of restoration and recovery planning. **Expected outcomes:** • To combat service user isolation and enhance contact with family; and • To combat service user isolation and enable contact with services and initiatives to support wellbeing This online tool helps the Trust connect, share, discuss, develop and spread ideas. • Support staff to continuously innovate, improve and transform. • Improve quality of services. • Improve patient experience.	**Jun 2020**	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020
Agenda item 12

Title:	**Interim governance arrangements**
Paper prepared by:	Director of Finance and Resources
Purpose:	The purpose of this paper is to provide Trust Board members with updates to the interim governance arrangements during the Covid-19 pandemic.
Mission / values:	To ensure that the Trust meets its governance requirements, and to allow the Trust to fulfil with mission and values during the pandemic.
Any background papers / previously considered by:	Trust Board papers – March and April 2020 Interim Governance arrangements paper circulated separately to executive and non-executive directors Audit Committee paper – April 2020 and July 2020 Trust Board papers – June 2020 Amanda Pritchard Letter to all NHS Chief Executives 06 July 2020
Executive summary:	• Recommended changes to the running of Trust Board meetings for 3 – 6 months were agreed at the March Board meeting. • Temporary changes have also been in operation for each Board Committee since March. • There has been a return to full agendas at June Trust Board and the forthcoming Members' Council in July. Agendas still incorporate Covid-19 related updates and items. • There has been no use to date of the emergency powers and urgent decisions process has not been used at the time of writing this report. • Delegated authority was agreed at May board to allow the Chief Executive and Chair to approve the final annual report and accounts in order to allow submission to parliament in a timely manner. • As agreed at Trust Board on 30 June 2020, Committee chairs will be reviewing the temporary arrangements and identifying what regular elements from the annual work plan can be incorporated into agendas from July onwards. • Identified Covid-19 risks on the operational risk register have been allocated to committees in addition to the overview being taken at Trust Board. • Meetings continue to be held virtually using either Microsoft Teams or Skype. • Command structure meetings have been reduced in frequency given the current status of the pandemic. • The Corporate Governance team have created (and will maintain) a consolidated log of decisions made at Gold, Silver and key Bronze meetings (e.g. PPE) to ensure that escalation and decision requests have correctly flowed through the command structure. • A weekly meeting review for non-executive directors is now taking

	place fortnightly. • The Internal Meeting Governance Framework received at June Trust Board. • A letter received from Amanda Pritchard, the chief operating officer for NHS England & Improvement, on 6 July 2020, highlighted the stepping back up of some key reporting and management functions. • A review of the key elements of this letter show that the Trust is operating in line with recommendations identified and plans are ongoing in relation to the Annual Members' Meeting which will be held virtually in September this year. **Risk appetite** The Trust has a declared risk appetite for compliance risks to score 1-6. It is considered the processes in place mean the Trust is operating within its risk appetite for this issue.
Recommendation:	**Trust Board is asked to REVIEW and COMMENT on the update to the interim governance arrangements as outlined in the paper**
Private session:	Not applicable.

NHS
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NHS Foundation Trust

Interim Governance Arrangements

Introduction

The purpose of this paper is to update Trust Board on the interim governance arrangements including command structures during the Covid-19 pandemic. Initially it was assumed these temporary arrangements would be required for the three to six months from March onwards. Other papers previously provided on this subject for reference are:

- Trust Board – 31 March 2020
- Non-Executive Meeting – 3 April 2020
- Audit Committee – 14 April 2020
- Trust Board – 28 April 2020
- Trust Board – 30 June 2020
- Audit Committee – 14 July 2020

Following the paper presented to Trust Board on 31 March 2020 it was agreed Board and Committee business from April would be confined to:

- Delivery of the national Covid-19 response plan, as outlined by NHS England and NHS Improvement in their joint letter of 17 March 2020 and any subsequent guidance.
- Business continuity.
- Any other business the Trust believes to be essential.

It was also confirmed that Board meetings would be held virtually whilst social distancing guidance remains in force.

It was also agreed that Committee activity would focus on:

- Staff wellbeing and staffing changes.
- Delivery of clinical services.
- Reporting and management.

This report provides an update on the progress being made with each.

Trust Board

Trust Board agendas continue to be agreed by the Chair and Chief Executive taking the points above into consideration. Meetings are taking place virtually with plans in place to enable members of staff and the public to listen to the meetings and submit questions at the end of the meeting.

Minutes and papers have been provided on the Trust's website. The referenced 'emergency powers and urgent decisions' process referred to in the March board paper, has not been used.

Delegated authority was agreed at the May private board meeting to allow the Chief Executive and Chair to approve the final annual report and accounts in order to allow submission to parliament in a timely manner.

The internal meetings governance framework was received at June Board.

The company secretary is to meet with Committee chairs and lead executives to review agendas and work-plans.

Technology
The Microsoft Teams solution has been used to facilitate Board and Committee meetings. The new Microsoft licencing arrangements were approved at the June Board which included the ability to enable a dial in function.

Clinical Governance & Clinical Safety Committee
The national guidance is that there is an expectation that quality committees continue to meet. The Chair and lead director of the Committee discussed how this Committee would operate during the pandemic. The frequency remains as originally planned and meetings have been scheduled to last a maximum of two hours. The agenda sections remained the same as previous, with the clinical risk section focusing on Covid-19.

The Committee has continued to receive assurance during the pandemic. A number of reports have continued to be received and as of September there should be a return to normal Committee function. The quality account, having been postponed as a result of Covid-19, will be presented in the September meeting.

Audit Committee
The April Audit Committee operated with largely the same agenda as the work plan. The timing of the meeting was such that the majority of papers had already been prepared or were required in order to meet year-end reporting and governance requirements.

The work plan was assessed to identify what remains necessary, what could be reported by exception and what could be deferred.

The Audit Committee scheduled specifically to review the year-end reporting and submission requirements went ahead on 2 June 2020.

The July meeting similarly had largely the same agenda as outlined in the work plan with the exception of triangulation of risk. The next scheduled meeting is October.

At June Board it was reported that Audit committee had continued to function without too much impact but the triangulation of risk had been more difficult given availability of some information and reports.

Finance, Investment & Performance Committee
There continues to be a range of financial governance and reporting requirements during the Covid-19 pandemic as well as notable changes in terms of the financial and contracting arrangements for April to July 2020. There is also an amended integrated performance report produced and reviewed on a monthly basis. Other than these a number of the agenda items outlined in the work plan such as financial sustainability and focus on productivity were deferred.

Frequency of meetings has remained as planned with meetings lasting approximately one hour.

At June Board it was reported that financial stability, benchmarking and productivity would be need to be re-introduced into the agenda at some stage, and this would largely be dependent on what the financial arrangements are for the remainder of the year.

Workforce & Remuneration Committee
The Chair and lead director of the Committee had discussed and recommended that operation of this committee would be suspended during the initial part of the Covid-19 outbreak.

Given the more regular frequency of Trust Board meetings, coupled with the fact all Board members are very interested in the impact of the pandemic on the workforce it was agreed the Board would be the most appropriate forum to review workforce issues during this period of time. This approach ensures any duplication is reduced as far as possible. Clear focus is applied to staff wellbeing, attendance and Covid-19 testing.

An update was received at June Board that the committee would re-convene in July with a reduced Covid-19 based focus, after which meetings would return to normal agenda and frequency. All items that would have gone to Committee had been discussed through Trust Board as per the agreed process above.

Mental Health Act Committee
The Chair and lead director of the Committee discussed and agreed the following approach:

- The meeting and agenda were to be significantly shorter than usual with a maximum of 1 hour anticipated, with many items deferred or cancelled.
- The only agenda items to be taken were specific to Covid-19.
- There are currently no external attendees e.g. local authority, acute trust colleagues, hospital managers) although they are able to submit questions in advance (related to Covid-19).
- Associate hospital managers are asked for feedback on problems / challenges in advance and this is an agenda item.
- Only 2 executive directors need to attend (for quoracy).

An update at June Board reported that the committee would return to having a fuller agenda. Valuable input had continued to be received from the acute trusts and partners and feedback continued to be received on agenda items.

The next meeting is to be held in August with a focus on delayed and deferred items that had not been core work during recent months.

Equality & Inclusion Committee
The Chair and lead director of the Committee discussed and agreed that the Committee would continue to meet with the meeting time reduced to an hour, a shorter agenda and verbal updates for most agenda items.

The staff network / BDU forum feedback section would specifically focus on the impact of Covid-19 given the possible issues for the BAME community.

It was reported at June Board that the focus of the committee had been Trust staff, items had been suspended as agreed and there would be a number of items to consider through the dashboard when the next meeting took place in September.

Charitable Funds Committee
Similarly to other Committees the Chair and lead director reviewed frequency and agendas for these meetings. It was agreed to keep the existing planned meetings in place, but to operate with a shortened agenda, with several items deferred until later in the year.

An update at June Board reported that work had continued and although there had been a focus towards Covid-19 no standard agenda items had been missed.

West Yorkshire Mental Health Collaborative Committees in Common
This committee is continuing to meet with a reduced agenda and attendance. It will focus on workstream status, the provider collaboratives, wider work being undertaken across the collaborative during the Covid-19 period, and business continuity.

Members' Council
The Chair and Corporate Governance Team keep in regular contact with all governors and provide them with updates as required.

A virtual Members' Council meeting took place on 1 May 2020, with a shorter timescale and the agenda was limited to items specific to Covid-19, Members' Council business items, Trust Board appointments, and any other items considered to be essential.

The Members' Council on 31 July 2020 will be a virtual meeting and sees a return to a full agenda.

The Annual Members Meeting will be held virtually and planning is taking place in relation to the format of the meeting and content.

Command Structure
As a result of the Covid-19 global pandemic both national and local command structures were put in place. These ranged from Cobra meetings held at Government level to the Gold, Silver and Bronze command structure meetings taking place within the Trust.

The Trust emergency preparedness, resilience and response (EPRR) policy 2019 describes a major incident as:
"*Any occurrence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hospitals, ambulance trusts or primary care organisations".*

It goes on to state that there are four levels of incident that may affect the Trust, level four being described as:
"An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level."

The Covid-19 pandemic required a level four incident response and in line with the EPRR policy the communications and coordination network was set up within the Trust to ensure information flowed through from bronze (operational) to silver (tactical) to gold (strategic) command and back down again. Actions and decisions made as part of the command structure are formally recorded and logged to maintain an audit trail.

The EPRR policy states the Trust Board will ensure, so far as is reasonably practicable, that appropriate command structures are in place to implement effective business continuity arrangements.

As recorded in the Trust's scheme of delegation, Non-Executive Directors should, as part of their role as members of a unitary board, constructively challenge and help develop proposals on strategy in line with the "Foundation Trusts Code of Governance".

Internally the command structure was put in place in the latter half of March 2020.

Bronze command structures were implemented throughout operational services to manage day to day decisions, escalating to silver command as required. Other trust-wide bronze command structures were implemented for Covid-19 specific items such as PPE and Covid-19 testing, so as to ensure a coordinated response across the Trust.

Silver command has senior manager representation across the Trust and during the peak of the pandemic met daily during week-days at 16.00. During the week-end an update call by exception also took place each day at the same time. Currently there are two meetings taking place each week.

Gold command largely consists of EMT members plus the Deputy Director of Nursing and Head of Estates & Facilities. It initially met on a Monday, Wednesday and Friday at 8.30 in the morning. This has now reduced to one meeting each week on a Friday.

This command structure received instruction and / or guidance from regional and national bodies to determine what action needed to be taken. Actions were escalated where required and are logged for information, ratification or approval on a weekly basis.

<u>Governance of Decisions Made</u>

As referred to in the introduction, a paper was shared with Executive Directors, Non-Executive Directors and the Audit Committee which outlined a process to enable decisions to support the response to Covid-19 to be made rapidly.

The Director of Finance and Resources has held weekly meetings with Trust governance leads and Executive Directors to review decisions made and to identify and mitigate risks associated with the pandemic. The process involves the use of a senior internal group reviewing required decisions on a weekly basis and either agreeing or making a recommendation. All such decisions are logged and forwarded on to the Chief Executive and Non-Executive Directors within 24-hours.

The Chief Executive and Director of Finance and Resources have therefore held weekly meetings with the Non-Executive Directors to keep them informed of strategic decisions made each week during Covid-19.

The Corporate Governance Team have created (and will maintain) a consolidated log of decisions made at Gold, Silver and key Bronze meetings (e.g. PPE) to ensure that escalation and decision requests have correctly flowed through the command structure.

NHS trusts will need to demonstrate appropriate governance and transparency of actions and decisions taken during this time and the Corporate Governance Team is working with legal services, human resources, and nursing and quality teams to ensure documentation is comprehensive and clear with records stored safely and securely for future use.

The Corporate Governance Team above will also undertake Trust based audits on key decisions over the next three months.

External Guidance
Approaches being taken by other trusts have been shared and considered with guidance from a number of sources being taken e.g. NHS Providers.

Summary and Recommendation
Interim governance arrangements have been in operation since the onset of the pandemic, which have been summarised in this paper.

As the Trust moves into the phase three of the pandemic these interim arrangements are being reviewed with an expectation that there will be a move towards covering an increasing number of items on the annual work plan. This review is being co-ordinated by the company secretary. Further to this committees have also been allocated Covid-19 related risks for future monitoring.

Trust Board is asked to REVIEW and COMMENT on the update to the interim governance arrangements and decision-making processes as outlined in the paper.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 July 2020

Agenda item 13 – Assurance from Trust Board committees

Audit Committee

Date	14 July 2020
Presented by	Laurence Campbell, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Impact of change during the pandemic on Information Governance. • Risk around need to prioritise activity. • Support for approval of the Charitable Funds annual report and accounts. • New process re approval of General Ledger entries as raised in ISA 260. • New Finance and procurement system - need for broad engagement. • Consideration of impact of Covid-19 on Internal Audit workplan.
Approved Minutes of previous meeting/s for receiving	• Minutes of the Committee meeting held on 14 April 2020 and 2 June 2020 attached.

Finance, Investment & Performance Committee

Date	27 July 2020
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	Key items from 23 June 2020: • Reporting break even position. • Significant achievement of 7 day payment of suppliers, thanks to the finance team. • Evolving financial planning arrangements. • Capital papers sent to ICS, put together at some pace. Key items from 27 July 2020: • Verbal update at Board.
Approved Minutes of previous meeting/s for receiving	• Minutes of the Committee meeting held on 26 May 2020 attached.

West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees in Common

Date	23 July 2020
Presented by	Angela Monaghan, Chair
Key items to raise at Trust Board	The committee: • Received a status update on each of the collaborative's programmes, showing which work had been paused, resumed, repurposed, continued and initiated due to Covid-19. • Received an update on the transformation of assessment and treatment units (ATUs) and complex rehabilitation services across West Yorkshire. • Agreed a revised version of the terms of reference following a review of the committee's operations and effectiveness. These will come to the Board for approval in September. • Discussed early learning from Covid-19. • Agreed to support a new piece of work aligning our approach to the prevention of management of violence and aggression (PMVA). • Received an update on the progress of the new tier-4 CAMHS unit in Leeds.
Approved Minutes of previous meeting/s for receiving	N/A (no public minutes from 23 April 2020)

Workforce & Remuneration Committee

Date	21 July 2020
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Integrated Workforce Performance Report – noted that whilst non Coronavirus sickness has reduced overall there has been an increase around stress and anxiety – committee for a breakdown by service area and protected characteristics in a future IPR. • Staff Risk Assessments – positive work – recognised the importance of ensuring actions are followed through. • Workforce Strategy and Organisational Development Strategy – Scheduled to come back to the November Trust Board with discussion at September's Strategic Board Session. • Ratified approval for Clinical Excellence Awards – agreed to review the eligibility criteria with the BMA. • Workforce Risk Register – reviewed. • Discussed joint items that might want to share with the Equality and Inclusion Committee – agreed to have a Workforce and Remuneration Committee and Equality and Inclusion Committee in October.
Approved Minutes of previous meeting/s for receiving	• Minutes of the Committee meeting held on 11 February 2020 attached.

Note, assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Audit Committee held on 14 April 2020 (Virtual meeting, via Skype for Business)

Present:	Laurence Campbell	Non-Executive Director (Chair of the Committee)
	Chris Jones	Non-Executive Director
	Sam Young	Non-Executive Director
Apologies:	Members	
	Nil	
	Other	
	Alan Davis	Director of HR, OD & Estates
	Charlotte Dyson	Non-Executive Director
	Angela Monaghan	Chair
	Subha Thiyagesh	Medical Director
In attendance:	Rob Adamson	Deputy Director of Finance
	Tim Breedon	Director of Nursing and Quality [item 16]
	Mark Brooks	Director of Finance (lead Director)
	Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
	Leanne Hawkes	Deputy Director, 360 Assurance
	Paul Hewitson	Director, Deloitte
	Kate Quail	Non-Executive Director [item 8]
	Julie Williams	Assistant Director, Corporate Governance [item 17 & 19]
	Jane Wilson	PA to the Director of Finance (author)

AC/20/21 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. Apologies were received from Alan Davis (AD), Charlotte Dyson (CD), Angela Monaghan (AM) and Subha Thiyagesh (ST).

It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

AC/20/22 Declaration of interests (agenda item 2)

MB informed the committee that there had been a new declaration of interest for him since the previous meeting and that this had been reported at Trust Board on 31 March 2020.

AC/20/23 Minutes from the meeting held on 7 January 2020 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the meetings held on 7 January 2020 as a true and accurate record.

AC/20/24 Matters arising from the meeting held on 7 January 2020 (agenda item 4)

Action log

Progress against actions in the action log was noted.

AC/20/25 Consideration of items from the organisational risk register relevant to the remit of the Audit Committee (agenda item 5)

MB stated that when preparing the risk register this was at the same time the Trust was

assessing the impact of the major changes brought about by the Covid-19 pandemic. He reported the 2 key risks allocated to the Audit Committee for its oversight remained the same. He noted that following review it was considered there is currently further risk of both cyber threats and information governance breaches. The controls and actions being taken have been updated to reflect this. One new risk, emerging from the need for social distancing and encouraging staff to work from home where possible, was the Trust not having enough appropriate IT equipment and access to enable staff to work from home. He also noted that many actions have already taken place to enable a significant number of staff to work effectively from home. MB stated that the risk register would be updated within the next week to fully reflect these updates. He informed the committee that as a result of Covid-19 11 new risks in total would need to be added to the register, and that some risks score might be higher than normal due to the outbreak. In relation to the risk around IT access MB confirmed:-

- A further 250 laptops have already been deployed
- 780 VPN licenses have been allotted and added
- An increase in Skype licenses of 840
- An extra 120 mobile telephones deployed out into the workforce
- Microsoft Teams enabled to over 3,500 staff
- An increase in bandwidth of approximately 50-60% split between Kendray and Fieldhead.
- Airmid video conferencing facility rolled out

MB explained the Trust Board will receive a fully updated risk register at its meeting on 28 April 2020.

It was RESOLVED to NOTE the current Trust-wide Corporate/Organisational level risks relevant to this Committee and be ASSURED that the current risk level, although above the Trust risk appetite, given the current environment is appropriate.

ACTION: Mark Brooks

AC/20/26 Triangulation of risk performance and governance report (agenda item 6)

MB informed the committee that work on this report had been put on hold due to the need to focus on the response to the Covid-19 pandemic. There was some discussion of any new items in the IPR or on the BAF which may impact other existing risks, or add new risks, and none were noted.

It was RESOLVED to NOTE the update

AC/20/27 Review of accounts progress verbal (agenda item 7)

Rob Adamson (RA) reported that the timetable brought to the audit committee in January had now changed to take account of the required response to Covid-19. He confirmed the national submission date for the annual accounts of 27th April. This can be extended to May 11th if required, but providing key Trust staff remain well, then we continue to target the earlier date.
MB to forward a set of draft accounts early next week to LC & CJ for review. SYo to be also provided with a copy if desired. Audit committee meeting to recommend the annual accounts and annual report for approval is scheduled to take place on 21 May 2020. MB informed the committee that should there be any delays, a reserve date in early June was being held in people's diaries. He added the aim was to complete the year-end process at the earliest opportunity whilst staff remain well, providing this does not have an impact on the response to Covid-19.

It was RESOLVED to NOTE the update

ACTION: Mark Brooks

AC/20/28 Review other 'risk' committees' effectiveness and integration for annual report to Trust Board. Annual reports from:- (agenda item 8)

Audit Committee
Chair – Laurence Campbell; Lead Director – Mark Brooks

Key areas highlighted for 2019/20 are:

- Review of all year-end reporting documents enabling approval to be recommended to the Board and within required timescales
- Review and comment on the Annual Governance Statement
- In-depth review of issues where it has been felt there are specific areas of risk or concern
- Regular update and review of internal audit and counter fraud programmes of work
- Engagement with external audit to agree audit plan, review areas of risk and receive external audit reports

LC asked if it was correct only one member of the Audit Committee had completed the self-assessment. MB confirmed this was the case. LC asked why there wasn't an annual report from the Mental Health, LD and Autism Committees in Common. MB explained that due to the timing of that meeting it had not been possible to provide before this meeting took place. Angela Monaghan, Trust Chair, will provide an update when it has been possible to complete the annual review for this committee. LC noted the point on page 24 regarding the freedom to speak up guardians. MB commented that we may need clarification of what oversight takes place in the Clinical Governance & Clinical Safety Committee and what takes place in the Audit Committee. LC agreed and will discuss with Charlotte Dyson.

ACTION: Laurence Campbell

Clinical Governance and Clinical Safety Committee
Chair – Charlotte Dyson; Lead Director – Tim Breedon

Key areas highlighted for 2019/20 are:

- Oversight of the Care Quality Commission (CQC) action plan and the work undertaken resulting in an improved rating to 'good' for the Trust
- Review and comment on the Quality Account
- Quarterly review of the serious incidents report
- Review of key issues arising from the formal sub-groups of the Committee (Drugs and Therapeutics, Safety and Resilience, Physical Health, Infection Prevention and Control, Safeguarding Children and Vulnerable Adults, Reducing Restrictive Physical Intervention, Improving Clinical Governance Group)
- Monitor and review of the plans for the Trust's child and adolescent mental health services including Adel Beck and Wetherby
- Review of quality impact assessments for cost improvements on Trust services.
- Review of feedback and action plans in relation to Care Quality Commission visits
- Review and scrutiny of Internal audit reports
- Review of annual reports from key clinical areas
- Receive updates on the progress being made in relation to the optimisation of SystmOne
- Receipt and review of safer staffing report
- Monitor and review of waiting lists

TB commented that this is an established committee reporting to the Board regularly. From the survey it was noted that in relation to induction of committee members, it would be helpful for new members to get more detailed induction before commencing.

TB added that there is continued interface with Finance, Investment & Performance (FIP) to ensure there is no duplication, this is an ongoing piece of work. With regard to its terms of reference the Committee has met all its requirements.

Equality and Inclusion Committee
Chair – Angela Monaghan; Lead Director – Tim Breedon

Key areas highlighted for 2019/20 are:

- Review of progress made against the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and Equality Delivery System
- Receive updates from equality impact assessments
- Receive feedback from staff equality networks and business delivery unit (BDU) equality forums
- Receive updates from the Inclusive leadership and development programme
- Received reports on the equality and diversity annual report prior to Trust Board, the Trust's Commitment to Carers, learning from NHS staff survey and well-being at work survey and the equality, inclusion and engagement review
- Consideration of items from the corporate/organisational risk register aligned to the Committee
- Development of an equality and inclusion performance dashboard to support improvement
- Receipt of updates on the Equality Strategy action plan
- Review of the revised Involving People Strategy prior to Trust board

TB added that this is newly established committee following a period of time as a forum. It has provided expanded opportunities for network reports from BDUs and networks. He added that operating as a Committee it has enabled a broader understanding of quality and diversity issues across the organisation.

TB summarised by adding that the Committee has met all the requirements under its term of reference this year.

LC further commented that he had attended a committee meeting and felt that good progress had been made in the year.

Finance, Investment & Performance
Chair – Chris Jones; Lead Director – Mark Brooks

Key highlights for 2019/20 are:

- Review of financial performance for the year-to-date and the full year forecast
- Review of the financial sustainability plan including deep dives on some areas of focus including income growth, out of area bed placements, estates & facilities management and non-pay
- Received a presentation detailing the progress being made on the development of the data warehouse and how it will support a deeper understanding of internal productivity
- Received an initial presentation on the initial areas for further review after considering the information held in the model hospital
- Conducted a detailed review of performance against one of our learning disability metrics

CJ noted that this is still a relatively new committee and is maturing along the lines of the other more established board committees. He noted the Trust has had a good year in terms of financial performance and the committee has sought to develop more detailed insight into the financial sustainability plan. There was a good response to the annual survey and points raised related to the availability of training for non-finance members of the committee and frequency of meetings. CJ felt that one area still for development is the oversight of performance, ensuring there is no duplication with other committees. To date the investment focus has been on the use of the decision tree and Trust response to tender opportunities. Given the relative newness of the Committee it is not felt as necessary to make any changes to the terms of reference at this point in time.

Mental Health Act Committee
Chair – Kate Quail*;* Lead Director – Dr Subha Thiyagesh

Key areas highlighted for 2019/20 are:

- Focus on a quality improvement (QI) approach. Improvement includes ethnicity recording, section 17 leave documentation and fewer CQC Mental Health Act actions required
- Receipt and scrutiny of quarterly monitoring information and exception reports
- Benchmarked and improved the quarterly Performance report: data analysis, content and format
- Inclusion of new metrics relating to performance against the Mental Health Act (MHA) requirements in the Trust's Integrated Performance Report (IPR)
- Establishment of a new clinically led Mental Health Act Code of Practice Oversight Group reporting to MHA Committee. This allows clinicians to undertake detailed analysis of risks and issues and further improve operational grip and service delivery
- Consideration of changes in case law, legislation and key legal developments
- Receipt of update reports from the work of the independent associate hospital managers and scrutiny of the processes and outcome of appeals and tribunals
- Oversight of a programme of audit
- Receipt of reports following Care Quality Commission MHA monitoring visits, to ensure actions are implemented
- Review of complaints and compliments received in respect of the use of the Mental Health Act
- Receive a quarterly presentation from Trust professionals and partner agencies on the practical application of the Mental Health Act, the 'Act in Practice', highlighting pressure points, challenges and good practice

KQ reported that the Committee has met all the requirements under its terms of reference. KT also updated on membership of the committee. It has been recommended that Carol Harris (CH) becomes a member and Salma Yasmeen (SY) becomes an attendee. In addition there is senior operational representation, with Deputy Director of Operations Chris Lennox now attending meetings. KQ also added that In 2019/20, a new process was developed to ensure every local authority provides information to each meeting, to highlight good practice and provide challenge and scrutiny.

MB confirmed that EMT has agreed this. No issues were identified through the annual survey.
KQ noted that the annual work programme is aligned to the risks and objectives of the organisation. The work programme for the first half of 2020/21 has been amended to reflect the Trust response to Covid-19.

Workforce and Remuneration Committee (previously the Remuneration and Terms of Service Committee)
Chair – Sam Young (from1 April 2019); Lead Director – Alan Davis.

Key areas highlighted for 2019/20 are:

- The Committee agreed in line with national guidance a scheme to support services through arrangements for payments to active clinical staff, where the impact of the annual tax allowance could adversely affect the delivery of safe and effective services
- The Committee received reports on the workforce strategy implementation plan, action plan and dashboard, organisational development strategy action plan.
- The Committee received reports on sickness absence, recruitment and retention, agency expenditure, interim pay audits plans on gender, ethnicity and disability and directors' appraisals
- Agreed 1 senior redundancy payment
- Reviewed the pay arrangements for directors
- SY reported that the Committee has met all the requirements under its term of reference She added that the self-assessment was very consistent with no issues were raised

LC summarised by saying that he was keen not to have committees with overlapping agendas and he was confident this was operating well. He also felt that based on the annual reports each committee and the committee structures seem to be working well. LC added that he had attended a number of committee meetings throughout the year with the aim of helping him provide an overarching view of whether the audit committee and overall committee structure was working effectively. He also stated that he felt the audit committee was meeting the terms of reference.

MB commented that 20/21 work plans would normally be agreed at Trust Board. All committee chairs and directors are currently reviewing work plans over the next three to six months and determining what interim changes may need to take place as a result of the focus on the response to Covid-19.

It was RESOLVED to:

- **RECEIVE the annual reports from the committees for 2019/20 to provide assurance to the Trust Board in terms of the effectiveness and integration of risk committees and that risk is effectively managed and mitigated through:**
  - **committees meeting the requirements of their Terms of Reference;**
  - **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**
  - **Committees can demonstrate added value to the organisation.**
  - **APPROVE the Audit Committee annual report for 2019/20, and updated terms of reference.**

AC/20/29 Approval of internal audit plan (agenda item 9)

Leanne Hawkes (LH) 360 Assurance reported that she had progressed development of the annual internal audit plan following discussion with LC and MB. Given the outbreak of Covid-19 they were continually assessing how this would impact on the delivery of the 2020/21 plan. LH stated they would continue to monitor events as they unfold and assess the adjustments being made by clients, considering changes that may need to be reflected in audit work.

LC asked if anything needed to change now. MB replied that his personal preference would be to review things over the course of the coming weeks as the impact of Covid-19 on the Trust and for what length of time becomes more apparent. He noted for example that the planned audit of the governance and process relating to the forensics lead provider programme was very

worthwhile, but much of the work is currently paused. This would therefore at least impact on the timing of the audit. He emphasised that over the next 6/8 weeks the focus needed to remain very on year end accounting and reporting processes. Following this he suggested we could assess and review the position and look at realigning our internal audit priorities for the year if required. LC asked where the focus on strategic objectives was covered in the annual internal audit plan. LH explained that it was included in the governance and risk management audit.

CJ raised the question of whether the Mental Health, LD and Autism Committees-in-common was making a real difference for the trust and service users. He felt this would be a useful focus for the planned audit.

It was RESOLVED to APPROVE the internal audit plan 2020/21 as it is currently and to bring back to the meeting in May for further discussion.

ACTION: Mark Brooks/Leanne Hawkes

AC/20/30 Counter fraud draft annual plan (agenda item 10)

Shaun Fleming (SF), Audit Yorkshire reported the plan was largely unchanged from 2019/20 with only minor changes to reflect the current situation around Covid.

LC stated that he felt the plan was much stronger than previously seen and looked forward to reviewing progress made against it. He also commented that he supported the plan to increase the use of staff surveys in terms of fraud awareness.

SF confirmed that Andy Lister (AL) had been nominated as Counter Fraud Champion. He stated there was no guidance out as yet as to how this will work practically.

Julie Williams (JW) commented that regular communications were being circulated to staff along with regular updates being included in the chief executive's briefing.

It was RESOLVED to APPROVE the Counter Fraud Annual Plan 2020/21.

AC/20/31 Reference Costs - approval of methodology and submission (agenda item 11)

Rob Adamson (RA) explained there was a significant change to the process for mental health providers in that the national cost collection would be provided at a patient level cost (PLC) for the majority of mental health services and an average unit cost for providing other non-mental health services. Initial deadlines have already been deferred nationally due to COVID-19, with as yet no confirmed timetable for completion. Work has been taking place in the background to co-ordinate and test data. RA confirmed that the paper outlined the stages of the process and the paper includes an explanation of the process being followed for the Audit Committee to approve.

It was resolved to APPROVE the process and methodology being followed in relation to the 2019/20 national cost collection exercise

AC/20/32 Counter fraud policy update (agenda item 12)

MB stated the policy has been reviewed both internally and by Audit Yorkshire. SF reported that only minor amendments had been required so as to ensure that the policy remains current and reflects best practice. A summary of the changes were:

- Changes to Local Counter Fraud Specialist (LCFS) name and contact details throughout
- Changes to LCFS and Counter Fraud Authority details in Appendix Form 1

LC raised the question of whether Covid 19 would have any effect on this. SF replied that there was no indication of any changes.

It was RESOLVED to SUPPORT the approval of the updated Counter Fraud (anti-fraud, bribery and corruption) policy by the Executive Management Team.

AC/20/33 Draft annual governance statement (agenda item 13)

MB reported that as part of the annual accounting and reporting requirements the accounting officer (Chief Executive) is required to provide an annual governance statement (AGS), which needs to be approved in line with other annual reporting requirements. He stated this report enables Audit Committee members to have an early oversight of the AGS and provide any feedback. He stated some additions to the standard wording have been included to reflect the impact of the Covid-19 pandemic on governance in 2019/20.

He reported that the draft document would also go to the Board meeting on 28 April 2020, and be audited by Deloitte. The final document will be approved at the May Trust Board meeting.

LC commented that this was a substantial document and read very well.
MB stated that this was still a working document and that certain information could not be provided yet, and that he was waiting to see if there were any further national updates.
It was agreed that any comments should be fed through to Julie Williams (JW) and MB.

It was RESOLVED to NOTE the draft annual governance statement.

ACTION: ALL

AC/20/34 Update on internal audit on complaints (agenda item 14)

Tim Breedon provided the update, and reported there had been some sensible and helpful system enhancements that have been advised. He stated there was an issue around systems lead and getting timeframes right around formal concerns. He confirmed that actions had been completed as a result of the original audit.

LC asked if remaining enhancements were causing concerns**.** TB replied no but that it would be helpful if these were done as it would make it even easier for people. He commented that manual calculations could be built in and made simpler for people.

It was RESOLVED to NOTE the improvements made to provide assurance on the customer services process.

AC/20/35 Internal audit action timescales (agenda item 15)

MB reported there would be a number of audit recommendations coming up for completion in the next few weeks. He stated that with the outbreak of the Covid-19 pandemic it was unrealistic to expect the majority of outstanding internal audit actions to be completed within the next three months.
He stated there may well be some actions that can be completed relatively easily and also some that would remain a priority in the shorter term.

It is proposed that the Director of Finance, Deputy Director of Finance and Assistant Director of Corporate Governance, Performance & Information review all current outstanding actions and determine priorities for completion. A revised timescale can then be agreed with action owners and a proposal made for changing target completion dates.

It is expected that for most actions (low risk and potentially some medium) timescales for completion will be extended by at least three months or until life returns back to some normality.

JW confirmed she was working with individuals who were leads for audit actions to see what could be updated.

It was RESOLVED to NOTE the update

ACTION: Mark Brooks/Julie Williams

AC/20/36 Interim governance arrangements (agenda item 16)

LC reported that non executives have been briefed in new weekly meetings so had already picked up this issue but that it was right that the audit committee formally reviewed the interim governance arrangements. MB added that an update paper will also be provided to Trust Board on 28 April 2020.

It was RESOLVED to NOTE the update

ACTION: Mark Brooks/Julie Williams

AC/20/37 Cyber Security (agenda item 17)

MB stated that he wanted to provide the committee with an update on what has happened in last 6 months in relation to cyber security.
Key deliverables in this time period have been:-

- Windows 10. The move to Windows 10 had largely been completed at the time of the Covid-19 restrictions coming into place. He noted that approximately 250 devices are operating on Windows 7 still as the process to update had had to be postponed
- Communications have supported an awareness campaign on the intranet, via the brief, and the headlines
- Moved our email provision to Microsoft 365
- Annual penetrative test. This was largely complete, but again due to the impact of Covid-19 was not 100% complete at the year-end. There were no significant issues identified from the work completed
- The phishing work carried out by 360, previously reported to Audit Committee, was completed

CJ stated this was an excellent report and very comprehensive. He emphasised the need to log all changes, so they could be referred back to. He also commented briefly on the backup regime and asked if restore testing was being done. MB confirmed that it was.

In relation to the rapid installation of software during the pandemic, LC asked if it had increased risk. JW stated that during the pandemic individual risk assessments had been carried out on every proposed product and that none had been rolled out where NHS Digital/other bodies had raised concerns e.g. Zoom. MB added that clearly implementations were being completed in much quicker time than would normally take place. This does carry some risk, but the process JW outlined supports what we have done. All such decisions with rationale have been logged. He also added that the Improving Clinical Information Group (ICIG) is playing a key role in terms of being consulted with both before and after these implementations.

He stated the IT helpdesk was experiencing a significant increase in calls and that he saw this as positive in that staff were asking questions if they had issues.

JW informed the committee that elements of the penetrative testing needed to be face to face and therefore could not be carried out due to the current social distancing restrictions in place. She confirmed that it was currently in date up to the end of March 2020.
LC asked if it was possible for the Committee to see the outcome of this before the July meeting.
JW confirmed she would ask Paul Foster (PF) to circulate this if it is available before the meeting in July.

ACTION: Julie Williams

AC/20/38 Procurement report (agenda item 18)

MB presented the procurement update. Seventeen major contracts were let with a value of £2.5m including a contract for a managed print solution, supply and installation of anti-ligature bedroom doors, an eAppraisal system and a candidate Onboarding software system. Seven contracts are currently in progress including master vendor contracts for temporary nursing staff and AHPs, and provision of taxi services. A total of £15k CIP (Cost Improvement Plan) savings with a further £66k cost avoidance savings have been recorded and achieved within the final quarter of 2019-20. Total cost savings are £115k CIP (£178k full year effect) and £120k cost avoidance.

The impact of Covid-19 on procurement activity continues to be assessed on a regular basis. The key current priority is to ensure delivery of appropriate goods and services to support our Covid-19 response, particularly personal protective equipment.

CJ commented that as this was a hot topic locally and nationally it is appropriate to probe as a committee due to current sensitivity.

MB stated that much work has taken place into understanding what our daily requirements are and ensuring we understand what stock we have in place. Currently we have sufficient stock for our needs. He added the Trust is also working collaboratively with partners across both West and South Yorkshire. CJ emphasised importance of consistency when messages are being reported.

MB confirmed that there have been a number of developments since this report had been written, including further deliveries of PPE. He informed the committee that there is a bronze command PPE group in place which meets regularly to focus on ensuring we use PPE correctly and have sufficient product for our staff to use.

LC raised the question of whether agresso was stable. MB replied that he remained nervous regarding the version the Trust currently uses. A business case and proposal is required for a new system and a decision will be taken in the coming months. RA confirmed that work has been progressing in the background to support the development of a proposal.

It was RESOLVED to NOTE the Procurement Report

ACTION: Mark Brooks/Tony Cooper

AC/20/39 SystmOne optimisation update (agenda item 19)

Julie Williams (JWi) presented a progress update to the Committee. At the previous meeting CJ requested further information on data quality issues.

Key highlights:-

- Overall, recording of contacts has significantly improved
- P&I team has focused some time on going out to services to show them how to record contacts accurately; this has lead to an improvement. The P&I and training teams are working together to look at new ways to ensure SystmOne is being used with data inputted in a standard way
- It has been encouraging to see more staff use new live Team Benchmarking Dashboards
- JW confirmed that regular reports went to the Operational Management Group meeting (OMG)

- JW stated that there were still a number of issues with regards to the levels of data entry for some measures stating the majority of these issues were also present in RiO. As part of the reducing variation and improving data quality work-stream (optimisation) work is being undertaken with key managers and staff to ensure complete, contemporaneous and accurate record keeping as priority
- LC asked about the use of video contact and if these are being recoded. JW confirmed it had and that this was now being used as opposed to face to face contact in a number of situations during pandemic along with telephone contacts. Updated data quality report to be provided ahead of July meeting if possible
- LC asked are there any checks and balances that offset these and is it indicating someone who has not been contacted who should have been. TB replied the issue with open allocation tends to be about diligent housekeeping. There is a need to ensure staff keep case lists up to date from both a clinical perspective and admin perspective. There is a significant push on this via OMG and with Dr Subha Thiyagesh (STh) in her role as Medical Director
- CJ stated the information on contacts made him slightly nervous as did the information related to DNAs. He reiterated that from his perspective changes in numbers recorded represented a data quality issue somewhere and at some time irrespective of where in the system it has arisen. JW explained that the number of planned appointments has increased. The difference in data is because we didn't go live with that part of the system initially. There is a need to ensure clinicians are using system in robust way
- JW added that a key piece of work is trying to alleviate work arounds
- SYo asked what the impact was of staff working in a more stressed environment. JW responded by stating a close eye was being kept on this at silver command meetings
- LC asked if we have a list of priorities in terms of data quality and what needs to be fixed first. Perhaps this could feed into the decision matrix that MB does weekly for non-executive directors and at EMT
- TB added that business continuity plans outline the need for key issues to be reported
- JW concluded by commenting that during this period we still continue to report data quality.

It was RESOLVED to COMMENT and RECEIVE the report and NOTE the actions taken to ensure on-going compliance.

AC/20/40 Treasury management (agenda item 20)

RA confirmed that all funds remain within the Government Banking Service (GBS) unless invested with the National Loan Fund. Unless external investment rates exceed 3.5% plus GBS rate this will continue to be the case. We currently have no funds invested.

Interest receivable for 2018/19 was £161k (£65k 17/18). This increased to £238k in 2020/21. Given the reduction in the GBS interest rate to 0% no interest income is expected in 2020/21.

It was RESOLVED to RECEIVE the update.

AC/20/41 Internal audit progress report (agenda item 21)

Leanne Hawkes (LH) 360 Assurance presented the key headlines. There have been six reports issued since the last Audit Committee meeting:

Recruitment - Client Wide Project – which was an advisory review
Payroll Analytics – which was an advisory review
Capital Prioritisation - which provided significant assurance
Governance and Risk Management - which provided significant assurance
Data Security and Protection Toolkit - which provided significant assurance. JW stated that the submission date had been extended to September, but that they were able to submit on 1st April, she thanked LH & 360 Assurance for their response.

LH confirmed the draft Head of Internal Audit Opinion (HOIA) report had been included in the progress report and that it could be revised up to time of issue and brought back to the meeting on 21 May 2020.

LH confirmed that the Data Quality - Phase 2 draft report is currently being prepared and expected to be available shortly.

Action Tracking
LH advised that as at 31 March 2020 there were two actions outstanding, one of which cannot be implemented until a system upgrade is completed later in the year. She stated that due to the current pressures the Trust is facing regarding Covid-19, 360 Assurance will work with the Trust to review the position of the remaining actions and those due over the next few months.

For 2019/20 to date:-
74% (34/46) of recommendations have been implemented by the first agreed follow up date. The complaints audit actions account for 15% of those not completed in line with the first agreed follow up date.
96% (44/46) have been implemented as at 31 March 2020.

Complaints - Follow Up
LH stated that as requested by the Audit Committee, for the actions agreed as part of the complaints review, of the eight medium risk actions and three low risk actions agreed at the time of the review, 360 Assurance were happy to provide independent assurance that ten of these were complete and only one low risk was outstanding. Of the ten that are complete LH stated she believed that three would benefit from further work to optimise the process.

LC thanked LH for the update and stated this had been a good comprehensive summary.

It was RESOLVED to RECEIVE and NOTE the update provided.

AC/20/42 Counter fraud progress report (agenda item 22)

Shaun Fleming (SF) presented the progress report which included the following key highlights:

- Constantly looking at ways of getting fraud awareness message out to all our staff
- The impact of Covid-19 is being considered which will no doubt lead to changes in ways of working for the next few months
- A number of fraud alerts have been shared with the Trust and these have been included in Trust comms messages
- National fraud initiative is close to completion. No issues have been identified to date
- Andy Lister, Company Secretary designate, has been nominated as fraud champion

Passport Investigation
- The case has been referred to Leeds Crown Court and after initial hearings a trial date has now been set for March 2021.
- The investigations into agency fraud and working whilst off sick have progressed to the stage of obtaining witness statements and arranging interviews under caution. Under the current lockdown conditions progress will inevitably be delayed to an extent. The Counter Fraud Authority will be kept informed of progress.

SF confirmed the counter fraud benchmarking report referred back to 2018/19 activity when the numbers reported were low. He stated that in 19/20 there had been an increase in the number of referrals and that this was now moving in the right direction. SF/MB meet regularly to discuss ways of raising awareness in the Trust. SF stated the main focus in terms of the fraud plan going

forward was to continue to ensure there is not stigma attached to whistleblowing. MB commented that it was very important that staff feel confident they can safely report concerns.

ACTION: Shaun Fleming/Laurence Campbell/Mark Brooks

It was RESOLVED to RECEIVE the update.

AC/20/43 External audit update (agenda item 23)

Paul Hewitson (PH) provided the external audit update. He confirmed discussions had taken place with the finance team around timetabling and also in relation to potentially using SharePoint to share documents required for audit. He stated that communication between the Trust and Deloitte would need to be far more structured given the circumstances and the plan is to stick to the original timetable, as long as this proves feasible.
PH raised the point that there are national discussions taking place with regard to asset valuations for year end, in light of Covid and he expected further guidance to be provided.
PH advised the committee that he felt very assured that the SWYPFT finance team was well drilled and therefore able to support a remote audit and that sickness aside he felt confident that the audit would go smoothly. He stated that he would keep the committee appraised.

It was RESOLVED to RECEIVE the update.

AC/20/44 Losses and special payments (agenda item 24)

RA confirmed the report provided details of the payments made since the last report to the Committee on 7 January 2020 and covers payments made to 5 March 2020.

In total the Trust has made payments of £10,470 since the last report to the Audit Committee.

LC noted the figure included a large salary write off. MB noted that this was an overpayment when a member of staff left and the individual has not been traceable despite us being successful with a county court judgement. He has raised the question of whether the individual concerned should be reported to their professional body and TB confirmed that on balance he didn't think it was worth it. LC remarked can we be assured this will not happen again. MB replied that he didn't think we could guarantee this and noted that the number of irrecoverable overpayments each year is typically low. RA confirmed he would be taking a paper through OMG on lessons learnt.

ACTION: Rob Adamson

It was RESOLVED to NOTE the contents of the report.

AC/20/45 Any other business (agenda item 25)

No other business was raised.

AC/20/46 Items to report to Trust Board (agenda item 26)

The following items were agreed as being reportable to the Trust Board:

- Impact of Covid19 on risk register and triangulation of risk, including expansion of IT equipment and home working. EMT has developed initial Covid-19 risks and reviewing controls & actions;
- Board Committee effectiveness review largely pre-Covid19 in 19/20 and showing enhancement in a number of areas and satisfactory coverage of TORs;
- Board Committee work programmes being updated to take into account the impact of Covid-19;

- High quality review of Cyber security with identification of Covid19 risks including accelerated rollout of hardware and software and impact on ongoing infrastructure development;
- SystmOne optimisation highlights data quality improvement journey for further discussion at Trust Board;
- Draft Head of Internal Audit opinion of Significant Assurance at date of Audit Committee;
- Internal Audit plan for 20/21 approved but subject to further review in light of Covid19, with post review of how our Emergency Planning and Business Continuity process have operated one of the possible additions/substitutions;
- External Audit of Foundation Trusts by remote access is new territory for both the Trust and Deloitte, but we are well placed to achieve this, subject to staff availability.

AC/20/47 Date of next meeting (agenda item 27)

The next meeting of the Committee (review of Annual Report and Accounts) will be held on Tuesday 21 May 2020 at 14:00.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Audit Committee held on 2 June 2020 (Virtual meeting)

Present:	Laurence Campbell (LC)	Non-Executive Director (Chair of the Committee)
	Chris Jones (CJ)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
Apologies:	Members	
	Other	
	Tim Breedon	Director of Nursing & Quality
In attendance:	Rob Adamson (RA)	Deputy Director of Finance
	Mark Brooks (MB)	Director of Finance (lead Director)
	Shaun Fleming (SF)	Local Counter Fraud Specialist, Audit Yorkshire
	Leanne Hawkes (LH)	Deputy Director, 360 Assurance
	Paul Hewitson (PH)	Director, Deloitte
	Caroline Jamieson (CJa)	Assistant Director, Deloitte
	Jane Wilson (JW)	PA to the Director of Finance (author)

AC/20/48 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Laurence Campbell (LC) welcomed everyone to the meeting. The apologies, as above, were noted.

It was noted that the meeting was quorate as per the terms of reference.

AC/20/49 Consideration of the Annual Accounts for the period 1 April 2019 to 31 March 2020 (agenda item 2)

Report to the Audit Committee on the audit for the year ended 31 March 2020 - ISA 260 Audit of Accounts 2019/20 report to those charged with governance (agenda item 2.1)

Paul Hewitson (PH) reported that the ISA260 set out the conclusion of the audit and any unadjusted errors. He confirmed that this year's audit process had seen nothing markedly different to other years, and stated under the current circumstances this was very impressive. The audit is substantially complete subject to finalising a small number of principal matters as highlighted in the ISA 260 report included in the papers, completion of 1 key audit matter to draw the committee's attention to, plus 2 minor errors.

Key highlights:-

- PH reminded the Audit Committee that the two key risks tested as part of the audit related to fixed assets (modern equivalent asset valuation) and management override of controls. PH explained that the findings from the management override of controls testing identified one weakness previously highlighted by the internal auditor during the year. This is due to not having a review mechanism of journals in place. He noted that management have some retrospective controls, but these are not sufficiently strong to reduce the risk sufficiently. He confirmed there were no other issues within this domain and there would be no change to the audit opinion, but the Trust should look to improve its control in this area. MB accepted the finding and agreed that an update on action taken would be provided to July 2020 Audit Committee. He added that his understanding was the implementation of the new

SBS system during the year will address this risk at source.

- PH stated the audit finding relating to modern equivalent asset valuations were in line with the previous year and not considered to be a significant risk for the Trust.
- PH noted that there was an impact of Covid-19 in respect to the wording that needs to be included in the annual accounts in relation to asset valuations. The Registered Institute of Chartered Surveyors (RICS) changed its guidance in respect of material uncertainty identified by your property valuers due to Covid-19. This is common across the NHS as the impact of Covid-19 on property valuations is that there is less certainty over them.
- PH added that there was 1 mis-statement reported which occurs due to the timing difference in asset valuation between the Trust receiving its valuation and calculating the impact as at the end of December and the end of the financial year.
- The timetable for completing the audit of the charity will be met in time for the Charitable Funds Committee meeting.
- PH was pleased to report no issues in respect of operating as a going concern for the next twelve months and added that the audit work showed the accounts to be as clean as ever.
- PH referred to page 10 of the ISA 260 in terms of the Trust making proper arrangements for securing economy, efficiency and effectiveness in its use of resources (value for money). He was satisfied there are no concerns around this.
- PH stated that as a footnote, any issues arising from the review of the Agreement of Balances exercise, all adjustments were below the materiality threshold.
- There were no disclosure statements to draw to the Committee's attention.
- PH concluded by noting that whilst the Quality Account no longer needs an audit, a sizeable proportion of the work had been carried out. He has therefore agreed with MB that 50% of the annual fee would be included in the fees charges. He added that there were no notable issues identified in the work that had been completed. There were two minor errors in the EIP indicators relating to a stop clock issue.

PH asked if the committee had any questions following his update:-

LC thanked PH for taking the committee through the report and asked MB for his comments.

MB stated the report was pleasing in the circumstances and that conducting an audit report in a timely and comprehensive manner remotely was a credit to the staff in both organisations. He added that from an earlier conversation with PH that the Trust was one of the first Deloitte clients to complete the year-end audit work.

MB stated that as a Trust we like to set the bar very high, and whilst it is again a good clean audit it is slightly disappointing that a weakness in control has been identified. This will be addressed and a report provided back to the Audit Committee meeting in July.

LC congratulated MB and RA for an excellent performance under difficult circumstances, and also thanked Deloitte for meeting the challenge.

ACTION Mark Brooks

It was RESOLVED to NOTE the ISA 260 audit of the accounts for 2019/20.

Report from the Director of Finance on the Accounts (Agenda item 2.2)

MB provided some key highlights in respect to the annual accounts for 2019/20:-

MB felt the report was self-explanatory and members of the Committee have already received updates on 2019/20 financial performance at Trust Board. He noted that when

reviewing the annual accounts and comparing to the management accounts it was always very evident a significant impact was the value of asset impairments, driven by the annual valuation exercise.

- He added there has been a good increase in income year on year although it was worth noting that £7m related to funding of pension contributions which was directly offset by the same amount of cost.
- He was pleased to report a strengthening balance sheet, visibly captured by an improvement in the cash position.
- LC commented that looking back cash management was always going to be critical. The Trust has developed good infrastructure throughout this period, managing its debtors and still paying suppliers on time which is a really good result. This is the first year there has been some income growth for some time which is good news after a long lean period, as a result of tendering and national tariff policy.

It was RESOLVED to NOTE the report from the Director of Finance on the accounts.

Internal Audit Annual Report 2019/20 including Head of Internal Audit Opinion (agenda item 2.3)

Leanne Hawkes (LH) presented the key highlights:-

- The interim report was presented at the April meeting, this final report provides significant assurance within the Head of Internal Audit Opinion.
- The Trust did not quite meet the 75% target of completing audit recommendations within the original dates stated, but did achieve completion of 96% of all actions associated with recommendations.
- In relation to client satisfaction questionnaires, no responses were received from the Trust during 2019/20 and LH asked if the Audit Committee could provide some focus to this in 2020/21 as it does help with improving internal audit performance.
- LH added that the last 2 audit reports prior to Covid period have been completed and circulated. There is currently 1 audit assignment at draft report stage. 360 Assurance are working closely with the Trust to conclude the audit plan for 2020/21 while recognising the current pressures and the fact some audits may need to change given the impact of Covid-19.
- The full key performance indicators for the year were highlighted in Appendix C for information.

LC thanked LH for the update, stating the biggest challenge during the year was related to the complaints system audit and noted that recommendations have now been implemented. LH confirmed that she will provide suggestions for further improvement.

On the subject of the 20/21 plan LC asked for consideration of what was the most appropriate work to carry out and if anything needed to change from the original approved plan. LH explained that a number of other areas can be considered given the impact of Covid-19 and she would discuss with MB prior to the July Audit Committee meeting.

It was RESOLVED to NOTE the Internal Audit Annual Report 2019/20 including the Head of Internal Audit Opinion which provided significant assurance.

Letter of Representation (agenda item 2.4)

PH confirmed that this was the standard letter of representation, he asked the Committee to note that all quality indicator representations had been removed as they were not part of the process this year.

CJ asked for clarification of the wording in paragraph 6. PH agreed to find a different form of words.

It was RESOLVED subject to minor amendments being made to SUPPORT the signing of the letter of representation by the Chief Executive

Annual accounts and Trust Accounts Consolidation (TAC) schedules including draft audit opinion (attached) and Director of Finance & Chief Executive certificates on TACs (Agenda item 2.5)

RA advised he had nothing further to update given the final accounts show very little change from the draft version of annual accounts that were shared with Audit Committee members back in April. He confirmed there had only been small presentational changes since then.

LC commented that with only minimal changes required it showed what a good early draft set of accounts they were.

Unfortunately the draft audit opinion had not been available in advance of the meeting and Paul Hewitson (PH) Deloittes, was able to share this document with the Committee during the meeting via Microsoft teams. He reported it had been prepared in accordance with the requirements and asked the committee for comments.

MB commented that there was a slight change of wording required on the report. PH thanked MB for highlighting this and updated the report accordingly.

LC asked PH if he thought the report was the final version. PH stated it was following agreement with the independent reviewer of the accounts and report within Deloittes.

Caroline Jamieson (CF) confirmed that during the meeting confirmation of only minor wording change had been received.

MB confirmed that following review of the minor changes the Trust would add the updated audit opinion into the annual accounts.

It was RESOLVED subject to minor amendments to RECOMMEND the APPROVAL to the Trust Board of the final audited accounts and draft audit opinion for 2019/20.

AC/20/50 Consideration of the draft Annual Report 2019/20, including the Statement of Accounting Officer's Responsibilities and Annual Governance Statement (agenda item 3)

MB confirmed this was the final version of the annual report that he would be asking the Chair and Chief Executive to sign off tomorrow.

PH and CJ confirmed that they had reviewed and fed back on the report, and were satisfied that the items raised had been responded to satisfactorily.

MB added that more information was included in the report than was actually required. Both he and Tim Breedon had reviewed what information was available for the performance analysis and quality report and included that so as to provide more comprehensive information in the annual report.

LC commented that the report looked very good and thanked everyone who had helped pull this together.

It was RESOLVED to RECOMMEND the APPROVAL of the Annual Report 2019/20 including the Annual Governance Statement by the Trust Board subject to any final minor amendments.

AC/20/51 Timescales for approval of Quality Account 2019/20 (agenda item 4)

MB confirmed this paper was almost a replica of the paper that went to Board last month. He noted that submission of the Quality Account has been deferred national until December and there is no longer a requirement to audit for this year.

He said the aim is to complete the Quality Account by the end of September with a view for submission to the October Board, this is subject to review in light of changing circumstances.

It was RESOLVED to NOTE the update

AC/20/52 Counter Fraud Annual Report and Self Review Tool 2019/20 (agenda item 5)

Shaun Fleming (SF) reported that the annual counter fraud plan takes into account the key criteria that NHS Counter Fraud Authority (CFA) stipulates must be carried out annually and is in a standard CFA format.

He confirmed that following review the Self Review Tool submission had taken place at the end of April before the mandatory deadline. The submission identified that the Trust has assessed it has fully met 19 of the 23 standards, partially met 3 standards (Inform and Involve) and recorded a neutral/not applicable response against 1 standard (Hold to Account) resulting in an overall assessment level of green. The 2020/21 Fraud Plan includes work and measures designed to move amber ratings towards fully compliant – this will primarily include work to assess the effectiveness and staff awareness of key documentation and counter fraud actions e.g. Fraud Policy, Code of Conduct and Inform and Involve programmes.

SF explained that referrals are an indicator of the effectiveness of counter fraud work but were only part of the story. He added that an improvement could be the level of awareness across the Trust, which can be assessed through various proactive measures such as feedback analysis, targeted staff surveys etc.

LC thanked SF for the update.

It was RESOLVED to APPROVE the Counter Fraud Annual Report and Self Review Tool 2019/20.

AC/20/53 Any other business (agenda item 6)

No other business was raised.

AC/20/54 Date of next meeting (agenda item 7)

The next meeting of the Committee will be held on Tuesday 14 July 2020 via Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Finance, Investment & Performance Committee (FIPC) – Tuesday 26 May 2020
Virtual meeting, via Microsoft Teams

Present **Members** Mark Brooks (MB) Chris Jones (CJ) (Chair) Kate Quail (KQ) Rob Webster (RW) *Attendees* *Carol Harris (CH)*	Jane Wilson (JW) (Note taker)	**Apologies** Sam Young (SYo) Tim Breedon (TB)

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting. Apologies were received from Tim Breedon (TB) and Sam Young (SYo). It was noted that the meeting was quorate as per the terms of reference	CJ	
2.	Declarations of interest	There were no new declarations of interest	CJ	
3.	Minutes from previous meeting	The minutes from the FIP meeting held on 23rd April were approved.	CJ	
4.	Review of progress against agreed actions	MB confirmed that most actions were understandably deferred given the impact of the response to the Covid-19 pandemic; stating from a financial perspective the Trust will operate with temporary financial arrangements until at least July.	MB	
5.	Review of committee related risks and any exception reports as required	MB explained that some of the risks on the report were actually allocated to the Audit Committee and this would be addressed for the next report. Key highlights:- • Risk 511 - the work relating to the lead provider collaborative for forensic services remains largely paused. • Risk 522 - there is uncertainty around national funding beyond July, MB stated he could not foresee any notable risk for these first four months of the year with the system designed to allow trusts to achieve a break even position. RW	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		confirmed that on recent a Claire Murdoch call the focus of conversation was on the mental health investment standard, with a strong line that trusts should continue to expect to see an increase in finances and that these should mirror those previously announced. RW advised that it was right to remain prudent for this year. • RW commented that the cash balance position was significantly better. MB advised this was as a result of receiving both the April & May block payments in April, which resulted in an increase in cash balance of £54m.		
6.	Current year financial performance	<u>Month 1 key highlights</u> • MB confirmed that interim financial arrangements would remain in place until at least July. • MB stated a break-even position has been reported for April. This assumes £241k of additional income via the 'true-up' process • MB advised that all trusts in West Yorkshire reported a break-even position in the first month of the year. • MB confirmed that income for CAMHS provision in Barnsley was excluded from the calculation of block income for April to July. He stated that following discussion with NHSE&I the Trust is assuming this income will be provided via the monthly 'true-up' process. • MB reported that £417k of costs were identified as being reasonably incurred as part of the Covid-19 response, with costs relating to:- - Staffing - additional backfill of shifts to due COVID-19 absence and additional temporary and other staffing requirements - IM& T - equipment and resources to enhance agile working and digital solutions - Laundry - Set up costs for building, equipment, scrubs, uniforms - Catering - provision of staff meals and sandwich boxes whilst working long shifts - Other - including central purchase of additional infection control supplies • MB stated that new national guidance had been received and that he would discuss this further in the horizon scanning update. • MB advised the committee that there will be some form of independent audit of the Covid-19 costs claimed for at some stage, he did not know any further details at this time. • MB advised that the EMT view is that agency/bank staffing will increase when staff start to take annual leave and core services increase in activity. • KQ asked how the new process of paying suppliers within 7 days was working and how staff were coping. MB confirmed that in the first two weeks they achieved over 70% which was positive. He stated the last couple of weeks have not been as good as there are a number of procurement staff currently off with Covid-19. He confirmed that daily payment runs are continuing with a member of staff going in to the office daily to carry out this task. • CJ asked how the Trust would go about identifying our underlying financial position when the temporary arrangements come to an end. MB replied that it was likely that the Trust would be required to complete some form of operating plan for the remainder of the year. • MB explained it is currently difficult to forecast the remainder of the year and any assumptions used will need to be made	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		very clear, with recognition they could change as the year progresses. He noted that not all services are currently operating as they were pre Covid-19 and there are also additional services being provided. Ways of working have changed quite considerably for many staff. He explained there is a need to understand how much of the cost added in the past couple of months would be recurrent in nature and what impact this would have on the underlying position. As an example he also added there is a need to understand what the IT requirements are for each role, now that more staff are working remotely and using digital technology. It could also be that service pathways and estate configuration will need to change as a result of Covid-19. • CJ raised the question of whether the financial consequences were part of lessons learnt work that Salma Yasmeen (SYa) referred to in the Trust Board meeting on 21st May. MB responded that this needs to be considered and also noted that a few weeks of operation might not be enough to understand the ongoing effect. As an example travel costs were very low in April given the reduction in face to face consultations. We need to understand what a realistic assumption is for the future. • RW emphasised the priority to continue with the benchmarking and internal productivity work once there is headroom to allow this. • RW highlighted the need to recognise people who have worked very hard for a sustained period of time and who will need a break. • CJ stated it is important that reporting break-even prior to top-up income needs to remain in the report. MB added this would be the case and it was important to remind members of the committee that the financial arrangements for the first four months are very different to what we are used to seeing. <u>Financial principles for months 1-4</u> • MB advised the aim is for all trusts to break-even each month to July, stating there are no formal local contracts agreed for 20/21. Instead income is based on a calculated block amount supplemented by covid-19 cost reimbursement and a top-up process. • The Trust needs to agree appropriate operating principles so that it can fairly and appropriately record what level of true-up income is required in order to break-even. • MB reported the Trust has financial principles that they are currently operating to. These are identified in the detailed paper. • RW asked if we are in line with other trusts locally. MB responded that he was unaware, but he felt it was important to have transparency and be clear on what we need each month to break-even. • RW also asked in relation to capital if there is need to have any principles around this. MB replied that anything for Covid-19 will now require pre approval by NHSE&I. • MB stated that the funding should not be used to top up charitable funds and there is need to have a separate look at our charity for these four months. He advised that we do receive a level of fixed income from the staff lottery, other than that fund-raising activities are likely to be adversely impacted.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• RW stated there was a substantial income available for NHS charities of which we have been notified that £60k will be provided to EyUp! • The committee agreed to operate with the financial principles outlined in the paper. <u>Horizon Scanning</u> • MB advised that a central call for NHS finance directors has been taking place regularly, and the committee has been appraised of guidance provided from these calls. • MB explained that any Covid-19 capital requests now need pre approval by NHSE&I. He confirmed £65k had currently been identified for IT requirements. This can be supported via our own capital programme, so additional funding will not be sought for it. • MB highlighted from the latest call it was highlighted it was likely there would be some form of block contracting arrangement from August to October and details will be provided in the coming weeks. • MB highlighted that if the opportunity arises it would be helpful to have the Barnsley CAMHS funding provided as part of the block. As previously identified it is not yet clear what arrangements will be put in place for the mental health investment standard. • MB advised that there could be increased focus on financial governance and control beyond the end of July. • MB confirmed he had written to, NHSE&I outlining his views on what is required to be taken into account for funding arrangements post July. • CJ asked about progress with the financial audit for 2019/20. MB advised that based on a recent discussion with Deloitte the Trust is well progressed compared to many others. • RW advised that on the Claire Murdoch call different policy makers were giving updates providing the latest draft of what planning guidance says and we need to review the guidance once it is published. • KQ commented that the meeting papers were good.		
7.	Review of April IPR	• MB stated the IPR report is a complicated report to pull together under normal circumstances, but doing it remotely and in the middle of an unprecedented crisis has made it even harder. • MB advised the report was not collecting all data at the moment but that he was fairly confident in the level of data completed, and felt the Trust is performing well against most metrics. • Out of area bed performance has improved and there has been a reduction in the number of young people needing to use an adult bed. • Non Covid sickness is down to 4%. MB stated this normally hovers around 5%. • Staff turnover is also showing a reduced percentage. CH provided key highlights • Barnsley community health - focus is currently on nursing homes, early discharge and enabling people to stay out of		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		hospital. Contacts have increased to crisis support. Teams are currently managing to see everyone they need to. • Mental health community services - there has been a reduction in referrals through the single point of access. CH noted there have been two serious incidents in Kirklees. • CAMHS - performance has improved for Wakefield and Barnsley. Referrals have dropped so far during the pandemic. It is anticipated there will be an increase in demand as children return to school. • Inpatient wards – there have typically been a number of vacant beds during the pandemic to date. Recently there has been an increase in demand for intensive home based treatment (IHBT) services and an, increase in referrals for inpatient males. There are currently 3 out of area PICU beds being used. • Learning Disability - visits to service users have continued where needed. The Trust has continued to work across the West Yorkshire ICS in relation to the future configuration of assessment and treatment units. • KQ asked what assurance do we want from FIP around CAMHS, is it a balance between CG&CSC and FIP, do we want details on how we are managing waiting lists. CH replied that Wakefield is the legacy of people waiting a long time. CH stated she is happy to provide more details if needed for the next meeting. • RW stated that maybe we do need to share these as the improvements in Wakefield and Barnsley are substantial. • CJ commented that he found the slide on quality data really helpful, as this detail could not be found in the IPR report. He stated it was very useful to see and provides assurance that we are on track. • KQ highlighted that staff were currently working under huge pressure and wanted to thank everyone who had helped prepare this report. • KQ queried the number of children admitted to adult beds in Q4, and asked if 3 was correct. Yvonne French, legal services had stated it was 4. CH confirmed she would check this figure for accuracy. • CJ advised that he also agreed that a more detailed update from CH would be helpful and that it would also be useful to see if there was any data on waiting analysis by ethnicity. With regards to the Covid-19 data on the summary page CJ advised he was struggling to get the true impact of what was happening in the Trust as a result of the pandemic. He felt more assurance was required and asked if the report could be evolved further in the future. • MB advised that the committee will still receive this update as a minimum and that he would take this back to the team to see how this can be evolved into the future. • CJ asked if the paper could be linked to Covid-19 risks. • RW explained that due to current staff availability, much of what is being done is driven by 2 factors, social distancing and level of staff sickness. He stated that there was really good data available in the workforce section around how many people are absent re Covid-19 related issues and that live data shows the current number of people absent is increasing which is cause for concern. He explained that in terms of testing work there is a testing dashboard which provides information around this which might give us a bit more intelligence. He stated that the team have done a fantastic job pulling all this information together in such circumstances. • CJ stated he was not questioning all the hard work that had gone in to producing the report but merely making a comment with a view to tweaking the report in future. RW suggested CJ & MB have a discussion outside of this meeting.		Action CH Action - MB

Item no.	Item/area	Progress and actions/decisions	Lead	Action
8.	Investment business case (Finance Ledger System)	Key highlights:- • MB reported he was concerned with the level of risk we are operating with, stating the Agresso system was upgraded when he first joined the Trust, but that it is an old version on extended support, which will expire next year. He stated that an unsuccessful tender process had taken place last year and the Trust is allowed to direct award from a framework. • MB stated that organisations using SBS have given positive feedback. He advised that he did have experience of using SBS in a previous trust and felt it would make sense for the Trust to use this system. • MB explained there were possible ramifications of balancing the risk of remaining on Agresso with implementing a new ledger system during a pandemic. He advised that staff side and staff were engaged with this during the procurement process and further engagement will take place upon approval. • MB stated he would also forward this business case to Laurence Campbell (LC), Chair of Audit Committee for his views. • MB stated this approach has been agreed by EMT members, and that he was looking for agreement from the Committee to procure this system and he would then seek final approval from the weekly meeting of non-executive directors. • CJ thanked MB for providing a good summary of a difficult and sensitive situation. • CJ asked if there are any particular risks transitioning part way through the financial year. MB responded that this approach is preferred by the finance team, and a detailed implementation plan and risk register will need to be developed to manage the risk effectively. He re-iterated his view that staying with existing Agresso system is the greatest risk. • MB advised that the SBS system is more expensive than current but he expected efficiency savings in time. • RW confirmed that EMT supported this approach. • MB commented that there is a financial benefit if the Trust signs the contract off before end of May as a cost increase comes into effect from June 1st. • The Committee agreed to the recommendation to approve the business case and that MB would take to Board for final sign off of the contract.		Action - MB
9.	Revised Capital Plan 20/21	Key highlights:- • There is more capital available to the NHS this year. £2.1bn is allocated to nationally approved schemes. • Across the West Yorkshire ICS providers have a capital envelope of 85% of what was included in the draft operating plans. • Applying the 85% target the Trust has a target of £6.6m for 2020/21. Given the impact of Covid-19 on accessibility to sites and uncertainty over some programmes this is felt to be achievable, although there is an expectation some costs will increase due to the need for social distancing. • MB advised this approach has been discussed and agreed at EMT and the revised plan for 20/21 of £6.6m will be submitted. • MB confirmed he will be submitting the capital plan at the end May and was happy to receive committee agreement		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		today. • RW emphasised need to confirm that any safety critical schemes are included in plan and are covered. • MB advised that the normal process of quality impact assessments for any programme of work deferred will be carried out. • MB explained there is clearly an increased role for the ICS with regard to managing and prioritising capital budgets. This needs to be borne in mind with our inpatient strategy including the potential consolidation of The Dales and Priestley wards. • KQ felt this was a very helpful update on The Dales and Priestley and noted they are not in the 2020/21 plan. MB stated this would be a future year scheme if it is deemed appropriate. • CJ asked in relation to North Kirklees hub and taking it as it is presented what would we be spending £600k on. MB replied that this is one reason the Trust can be confident it will meet the revised capital spend target. Any monies expended in this financial year would likely be on feasibility works. • RW commented with the commissioning ructions currently going on between NK CCG & Greater Huddersfield CCG the likelihood of getting integrated support was unlikely and so the likelihood of spending this year was low. • The Committee agreed with the recommendation to approve this revised version of the capital plan.		
10.	New risks identified	• No new risks were identified		
11.	Items to be brought to the attention of Trust Board/Committees	• Reporting break even position, this assumes £241k of additional income via the 'true-up' process • Strong cash position • Finance working hard on 7 day payment of suppliers and challenges that come with that • Return of financial planning framework in future • Agreed to get more detail on CAMHS performance, building on existing data • Approval of business case for new finance ledger system		
12.	Any other business	<u>Financial governance</u> • The papers received today provide assurance that the Trust has appropriate financial governance procedures in place.		
13.	Date and time of next meeting	The next meeting of the Committee will be held on Tuesday 23 June 2020, 9:30-11:30. This will be a virtual meeting, via Microsoft Teams.		

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Workforce and Remuneration Committee held on 11 February 2020

Present:	Sam Young	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Charlotte Dyson	Non-Executive Director (Vice-Chair)
In attendance:	Alan Davis	Director of HR, OD and Estates
	Janice White	PA to Director of HR, OD and Estates (author)
Apologies:	Rob Webster	Chief Executive

WRC/20/1 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Sam Young (SY) welcomed everyone to the meeting. An apology was received from Rob Webster.

It was noted that the meeting was quorate and could proceed.

WRC/20/2 Declaration of Interests (verbal item)
There were no further declarations over and above those made in the annual return to the Trust Board in March 2019 or subsequently.

WRC/20/3 Minutes of the meeting held on 7 November 2019 (agenda item 3)
The Committee confirmed that these are an accurate reflection.

The Committee RESOLVED to APPROVE the minutes of the meeting held on 7 November 2019

WRC/20/4 Matters arising (agenda item 4)

The Committee discussed the schedule of actions from the previous meeting and no further comments were made.

WRC/20/5 Making SWYPFT A Great Place to Work (agenda item 5)

The Committee following its meeting on the 7th November 2019 agreed to explore how the agenda and workforce reports could be better integrated and include more engagement with senior managers. The Great Place to Work report presented to the committee was designed to be a prototype which would continue to be developed and be supported with presentations from relevant senior managers. This report will include presentations from Andrew Cribbis and Sue Threadgold.

(a) **Prototype Integrated Performance Report**

Alan Davis (AGD) introduced the prototype report and said that this is a learning exercise and it would be helpful to have feedback from the Committee on the format. He said that Richard Butterfield (RB) had pulled together the report with a focus around recruitment and retention. The Committee felt that the report was a positive move forward and it was helpful to see a much more integrated set of workforce performance indicators. The Committee recognised that there was further development required and some of the graphs and trajectories needed to be clearer.

The Committee discussed the bank and agency usage and noted this continues to be above plan and felt that a more detailed review would be helpful at the next meeting.

It was noted that there continues to be an increase in staff in post although this remains below planned levels mainly due to the phased recruitment plan for Trainee Nurse Associates.

Sickness is higher than target at the end of December with Forensics still the highest. However, it was noted that the projection is that sickness rates will fall in the last quarter based on previous trends. The Committee said that it would like to explore with Sue Threadgold the sickness absence in Forensics when she attends the meeting later.

The Committee discussed the report in detail and noted:

- There has been significant progress in reducing agency doctors and a new model of direct engagement appears to be working.
- The Trust has procured an On-Boarding system which has been used by the Leeds Trusts and this is due to go live in April 2020.
- As part of the recruitment and retention project the Trust has developed new promotional material and will be attending a number of nursing recruitment events across the UK.
- Sickness continues to be higher than target levels with Forensics still above other BDUs.
- Agency and bank spend is above planned levels but is not above staffing budgets.

It was agreed that AGD and SY would have a debrief to discuss the work on the Prototype Integrated Performance Report.

Action: Alan Davis/Sam Young

(b) Leadership and Management Development Update

Due to time constraints, it was agreed to defer this item to the next meeting and invite Andrew Cribbis to attend that meeting.

(c) Forensic Focus
[Sue Threadgold]

SY welcomed Sue Threadgold (ST) to the meeting and said the Committee wanted to understand better the challenges in the Forensic BDU and to explore how we can best support the managers and staff within the service.

ST outlined some of the service challenges including a number of serious incidences over the last 18 months which had clearly impacted on staff. There are concerns about the retention of qualified nursing staff and ST said that there has been a focused piece of work to improve the situation. The service continues to introduce the Trainee Nursing Associate role and recruitment in band 2 Health Care Support Worker posts appears to be positive.

ST said there is a Forensic improvement plan which includes actions built around the Making SWYPFT a Great Place to Work. There has already been engagement with

the Forensic Trio and Band 7s on improving staff engagement and leadership development.

ST sickness levels are an area of concern and she has been working closely with Human Resources to ensure that managers are following the agreed policy. Forensics have established a wellbeing group and there is good partnership working with staff side.

ST was asked what impacted on staff morale of the serious incidents. She replied that whilst the response of the staff has been very positive there had clearly been an impact on staff morale. There were a range of feelings from could we have done anything different, to concerns about service and staffing pressure as well as worries about what other services think of the staff in Forensics. The management team have been keen to ensure that staff are well supported, increased their visibility and improve communications. ST mentioned that Andrew Cribbis and Ashley Hambling have been very supportive and have been developing a programme for the service.

ST said that the focus was on cultural change and not just completing a set of action and that work has started but it would take time.

The Committee noted the good work already taking place but asked ST what more could the Board do to support her and the team. ST replied that it was really important that staff knew the Board appreciated the pressures staff were facing and that managers felt supported by the directors. She also believed it was important that the Board recognised that there is a real commitment to improve staff experience as part of ensuring we deliver safe and caring services.

The Committee NOTED and COMMENTED on the Prototype Integrated Performance Report and AGREED that Alan Davis and Sam Young would have a de-brief to discuss the work on the report.

WRC/20/6: Staff Survey 2019 (agenda item 6)

AGD informed the Committee that the NHS Staff Survey results have only just been sent and the attached presentation shows the high level results broken down by Business Delivery Unit (BDU). The headlines were that in three of the key indicators: Quality of Care, Staff Engagement and Quality of Appraisals there had been a statistical improvement from 2018 with the other eight indicators statistically remaining the same.

The results of the survey are being used in the Great Place To Work programme, which is the replacement to Middleground, and BDUs and teams will be developing locally based action plans as part of this.

The Committee noted a further update will be provided at the next meeting.

Action: Alan Davis

The Committee NOTED a detailed presentation will come back to the next meeting.

WRC/20/7 Equality Pay Audits (agenda item 7)

AGD informed the Committee that the Trust is required to publish a Gender Pay Gap report by the 31st March 2020 for the financial year 2018/2019. The Trust has decided to expand the pay audits to cover gender, ethnicity and disability. This paper provides an update on the previous action plan and details the results of the three pay audits for 2018/2019. The headlines are that:

- The average hourly rate for Male staff is £4.01 higher than it is for Female staff which appears to be due to 3 factors:

- In the lower bands male staff are undertaking more shift work which attracts additional payment.
- Male staff have longer average length of service which on an incremental scale means they are on a point within the salary band.
- The percentage of male staff in the overall workforce is 22.4% whilst in the higher bands (8a and above) the percentage of men is about 30%.

- BAME staff have a higher hourly rate than white staff which is due to higher percentage of BAME doctors.
- Disabled staff have a slightly higher hourly rate than non-disabled staff.

The Committee felt that it was important to better understand the issues around shift working and suggested we might need to look at an Equality Impact Assessment on the shift patterns.

The incremental progression was noted as a difficult issue as they are part of the national terms and conditions.

It was noted that position of BAME staff having a higher average hourly rate than white colleagues reverses if doctors are exclude to a negative position.

It was agreed that there should be further work undertaken to identify best practice in reducing the gender pay gap in both the private and public sector to help inform the action plan.

It was agreed that this needs to be a key area of focus for the Committee and for the next meeting it would be helpful to have an early look at 2019/2020 pay audits.

Action: Alan Davis

The Committee NOTED the report and proposed actions.

WRC/20/8 Clinical Excellence Award Update (agenda item 8)

AGD informed the Committee that the next round of the Clinical Excellence Award scheme has gone out and there will be a meeting held on the 12th February 2020 for a decision to be made on the awards. He said that this year they are not recurring amounts of money and it is a one off payment. AGD said that the pension tax worry has put some people off applying even though it is not pensionable as it would take them over the threshold. There are seven applications. A report will come back into the Committee in April.

Action: Alan Davis

The Committee RESOLVED to NOTE the update.

WRC/20/9 Pension Tax Guidance for Employers: Local Measures to Support Senior Clinical Staff and Service Delivery During 2019/2020 Financial Years (agenda item 9)

AGD updated the Committee on the implementation of the agreement to support senior clinical staff, in line with national guidance, with the impact of annual tax allowance on NHS Pensions. At its last meeting the Committee asked for an agreed procedure and equality impact assessment (EIA). AGD informed the Committee that this procedure and EIA has been agreed with the British Medical Association (BMA) as part of the national arrangements and a common framework is being used across the north. He said there has been a lot of issues raised nationally around pension tax and how we can protect services through supporting senior clinical staff. It is communicated nationally that it is only for active clinical staff and therefore Executive Directors are not included. In this Trust Consultants are the only active clinical staff whose earnings are sufficient to be eligible but technically it would be available to any active clinical staff.

It was agreed that AGD will take another look in terms of EIA and update to say active clinical guidance is just for consultants.

The Committee NOTED the agreed procedure and equality impact assessment for the 2019/2020 financial year to pay senior clinicians an additional salary equivalent to the employer's pension contribution where they have withdrawn from the NHS Pension Scheme due to the tax implications to protect service delivery.

WRC/20/11 Employment Law Update (agenda item 11)
AGD confirmed there was no update to report to the Committee.

The Committee RESOLVED to NOTE that there was no update to report to the Committee.

WRC/20/12 Workforce Risk Register (agenda item 12)

The Committee discussed the Risk Register in detail and believed the consolidated workforce reflected the overall risk and noted the Executive Management Team would be developing it further.

It was noted that 1157 on a diverse workforce had now moved to the Equality and Inclusion Forum.

The Committee felt that it would be helpful to focus on the following risks at the next meeting:

- Succession Planning and Talent Management.
- Use of agency staff and the impact on quality and finance

Action: Alan Davis

The Committee RESOLVED to AGREE the Workforce Risk Register, subject to the changes made above.

WRC/20/13 Committee Annual Report 2019/2020 (agenda item 13)

(a) Annual Report 2019/20

The Committee had no comments on the Annual Report for 2019/20.

(b) Terms of Reference

The Committee had no comments on the draft Terms of Reference.

(c) Annual Work Programme 2019/2020

The Committee had no comments on the draft Annual Work Programme.

(d) <u>Self Assessment</u>

The Committee discussed the self-assessment and made the following comments:

Question 11: Does at least one Committee member have a financial background?

Some members of the Committee have got financial experience and the Committee has got the ability to call upon a qualified accountant from the Non-Executive Director pool if required.

Question 15: Has the Committee formally considered how it integrates with other committees, particularly the Audit Committee that are reviewing risk?

The Committee agreed that it integrates with all the Committees.

Question 20: Does the Committee receive internal and external audit reports appropriate to its terms of reference?

The Committee discussed this and agreed that it does receive internal and external audit reports appropriate to its terms of reference i.e. Workforce Planning, internal audit report on recruitment, looked at good practice.

Question 23: Are papers circulated in good time and are minutes received as soon as possible after the meeting

The Committee agreed that the draft minutes of the meeting once they have been approved by the Chair and lead director will be sent out to members of the Committee as soon after the meeting as possible.

It was RESOLVED to APPROVE the Committees Annual Report 2019/20 subject to actions identified on the self-assessment report above.

WRC/20/14 Matters to report to the Trust Board and other Committees (agenda item 14)

These were agreed as:

- **Focus on Forensics** – The Committee welcomed Sue Threadgold to the meeting and heard the actions that had been taken to make the Forensic Service a great place to work.

- **Equality Pay Audits** – The Committee received Equality Pay Audits covering gender, ethnicity and disability and will be reviewing the action plan at the next meeting.

- **Prototype Integrated Performance Report** – The Committee received a prototype Workforce Performance Report to consider how we report into future Committee meetings.

- **Risk Register** – The Committee agreed a collective workforce risk which the Executive Management Team will include on the next update of the Risk Register.

WRC/19/69 Any other Business (agenda item 18)
The Committee NOTED there were no further items.

WRC/19/70 Date and Time of next meeting
The next meeting will be held on the 21st April 2020 at 12.30pm in the Chair's office, Block 7, Fieldhead Hospital.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board annual work programme 2020-21

! – item amended to focus on Covid-19 and business continuity
 # - item deferred
Note that some items may be verbal

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Standing items													
	Declarations of interest	✘	✘	✘	✘		✘	✘	✘		✘		✘	
	Minutes of previous meeting	✘		✘	✘		✘	✘	✘		✘		✘	
	Chair and Chief Executive's report	!		!	✘		✘	✘	✘		✘		✘	
	Business developments	!		!	✘		✘	✘	✘		✘		✘	
	STP / ICS developments	!		!	✘		✘	✘	✘		✘		✘	
	Integrated performance report (IPR)	!		!	✘		✘	✘	✘		✘		✘	
	Serious Incidents (private session) - verbal	✘		✘	✘		✘	✘	✘		✘		✘	
	Assurance from Trust Board committees	✘		✘	✘		✘	✘	✘		✘		✘	
	Receipt of minutes of partnership boards	✘		✘	✘		✘	✘	✘		✘		✘	
	Questions from the public (to receive in writing during Covid-19 pandemic)	✘		✘	✘		✘	✘	✘		✘		✘	

With **all of us** in mind.

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Quarterly items													
	Corporate / organisational risk register	!	!		✘			✘			✘			
	Board assurance framework	!	✘		✘			✘			✘	✘		
	Serious incidents quarterly report			#			✘		✘				✘	
	Emergency Preparedness, Resilience & Response (EPRR) Compliance – Covid-19 response update?			!			✘		✘				✘	
	Use of Trust Seal			✘			✘		✘				✘	
	Corporate Trustees for Charitable Funds# (annual accounts presented in July)			!			✘		✘				✘	
	Half yearly items													
	Strategic overview of business and associated risks	#						✘						
	Investment appraisal framework (private session)	#						✘						
	Safer staffing report	✘!						✘						
	Digital strategy (including IMT) update	#			✘									
	Estates strategy update				#				✘					
	Annual items													
	Draft Annual Governance Statement	✘												
	Audit Committee annual report including committee annual reports	✘												
	Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘												
	Guardian of safe work hours	✘												
	Risk assessment of performance targets, CQUINs and Single	#												

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Oversight Framework and agreement of KPIs													
	Review of Risk Appetite Statement	#												
	Annual report, accounts and quality accounts - update on submission		✘	✘?										
	Health and safety annual report			#										
	Customer Service annual report			#										
	Serious incidents annual report			#										
	Equality and diversity annual report				✘									
	Medical appraisal / revalidation annual report				✘									
	Sustainability annual report						✘							
	Workforce Equality Standards						✘							
	Assessment against NHS Constitution								✘					
	Eliminating mixed sex accommodation (EMSA) declaration												✘	
	Data Security and Protection toolkit												✘	
	Strategic objectives												✘	
	Trust Board annual work programme	✘!	✘!									✘ (draft)	✘	
	Operational plan										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)	
	Five year plan						✘							
	Board development													
	TBC		✘			✘				✘		✘		
	Policies and strategies													

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Constitution (including Standing Orders) and Scheme of Delegation *(January 2020)*	# (if req'd)			✘									
	Digital Strategy *(January 2021)*										✘			
	Customer Services policy *(June 2020)*			#				✘						
	Estates strategy *(July 2022)*			#					✘					
	Involving people strategy *(NEW – will replace Communication, Engagement and Involvement, Equality and Membership strategies)*	# (if req'd)					✘							
	Sustainability strategy *(June 2020)*			#					✘					
	Organisational Development Strategy*(June 2020)*			#					✘					
	Equality strategy				#		✘							
	Workforce strategy								✘					
	Quality strategy *(March 2021)*												✘	
	Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2021)*												✘	

Policy / strategy review dates:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(delegated approval authority to Audit Committee, reviewed as required)*
- Treasury management strategy and policy *(delegated approval authority to Audit Committee, reviewed as required)*

- Constitution *(January 2020) – under review*
- Communication, Engagement and Involvement strategy *(to be merged with the Involving People Strategy)*
- Customer Services Policy *(next due for review in June 2020, extended to October 2020)*
- Digital Strategy *(next due for review in January 2021)*
- Equality Strategy *(next due for review in July 2020, to be merged with Involving People Strategy)*
- Estates Strategy *(next due for review in July 2022)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2022)*
- Membership Strategy *(next due for review in April 2020, to be merged with Involving People Strategy)*
- Organisational Development Strategy *(next due for review in June 2020)*
- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(next due for review in February2023)*

- Procurement Strategy *(next due for review in June 2021)*
- Quality Strategy *(next due for review in March 2021)*
- Risk management strategy *(next due for review in April 2022)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in March 2022)*
- Sustainability Strategy *(to be reviewed with the Estates Strategy, by July 2022)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2021)*
- Workforce Strategy *(next due for review in March 2023 (if approved at Board March 2020))*