South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 27 April 2021 at 9.00
Virtual 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 March 2021**	Chair	**Paper**	2	To approve
4.	**9.05**	**Matters arising from previous Trust Board meeting held 30 March 2021 and board action log**	Chair	**Paper**	5	To approve
5.	**9.10**	**Service User / Staff Member / Carer Story**	Director of Operations	**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**				

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	9.30	8.1 Board Assurance Framework	Director of Finance & Resources	**Paper**	10	To receive
	9.40	8.2 Corporate / organisational risk register	Director of Finance & Resources	**Paper**	15	To receive
	9.55	8.3 Consultation on the System Oversight Framework and Trust response	Director of Finance & Resources	**Paper**	10	To approve
9.	**10.05**	**Business developments & collaborative partnership working**				
	10.05	9.1 Integrated Care System developments – white paper update	Director of Strategy	**Paper**	5	To receive
	10.10	9.2 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates and Director of Strategy	**Paper**	10	To receive
	10.20	9.3 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	Director of Strategy and Director of Provider Development	**Paper**	10	To receive
	10.30	9.4 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive
	10.35	*Break*			*10*	
10.	**10.45**	**Performance reports**				
	10.45	10.1 Integrated Performance Report (IPR) month 11 2020/21	Director of Nursing & Quality / Director of Finance & Resources	**Paper**	45	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.30	10.2 Safer Staffing report	Director of Nursing & Quality	**Paper**	10	To receive
	11.40	10.3 Guardian of safe working hours report	Medical Director	**Paper**	10	To receive
	11.50	10.4 Serious Incidents report Q3	Director of Nursing & Quality	**Paper**	5	To receive
11.	**11.55**	**Strategies and policies**				
	11.55	11.1 Workforce Strategy	Director of HR, OD & Estates	**Paper**	15	To approve
12.	**12.10**	**Governance matters**				
	12.10	12.1 Draft Annual Governance statement	Director of Finance & Resources	**Paper**	5	To receive
	12.15	12.2 Going concern report for annual accounts	Director of Finance & Resources	**Paper**	5	To receive
	12.20	12.3 Committee Membership Changes	Chair	**Paper**	5	To receive
	12.25	12.4 Audit Committee Annual Report 2020/21 including updated terms of reference for Trust Board Committees	Director of Finance & Resources	**Paper**	10	To receive
	12.35	12.5 Compliance with NHS provider licence conditions and code of governance self-certifications	Director of Finance & Resources	**Paper**	5	To receive
	12.40	12.6 Data Security and Protection Toolkit	Director of Finance & Resources	**Paper**	5	To receive
13.	**12.45**	**Assurance and receipt of minutes from Trust Board committees**	Chairs of committees	**Paper**	5	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
		- Audit Committee 13 April 2021 - Clinical Governance & Clinical Safety Committee 6 April 2021 - Finance, Investment & Performance Committee 23 April 2021 - West Yorkshire Mental Health Services Collaborative Committees in Common				
14.	**12.50**	**Trust Board work programme 2021/22**	Chair	**Paper**	3	To note
15.	**12.53**	**Date of next meeting** The next Trust Board meeting held in public will be held on 29 June 2021	Chair	**Verbal item**	2	To note
16.	**12.55**	**Questions from the public** *(received in advance in writing)*	Chair	**Verbal item**	10	To receive
	13.05	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Trust Board meeting held on 30 March 2021
Microsoft Teams Meeting

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Non-Executive Director
	Mike Ford (MF)	Non-Executive Director
	Chris Jones (CJ)	Deputy Chair / Senior Independent Director
	Erfana Mahmood (EM)	Non-Executive Director
	Kate Quail (KQ)	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 (ST)	Medical Director
Apologies:	Members	
	Sam Young (SYo)	Non-Executive Director
	Attendees	
	Carol Harris (CH)	Director of Operations
In attendance:	Charlotte Cummings	Perinatal Mental Health Team Peer Support Worker
	Claire Lowe	Perinatal Mental Health Team Leader
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
	Sean Rayner (SR)	Director of Provider Development
	Sue Threadgold (ST)	Deputy Director of Forensic Services (in attendance on behalf of Carol Harris)
	Salma Yasmeen (SY)	Director of Strategy
Observers:	Laura Colby	Member of the public
	John Laville	Public governor – Kirklees (Lead Governor)
	Tom Sheard	Public governor – Barnsley
	Tony Wilkinson	Public governor - Calderdale

TB/21/16 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. Apologies were noted as above and the meeting was deemed to be quorate and could proceed.

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

AM informed attendees the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would not be retained. Attendees of the meeting were advised they should not record the meeting unless they had 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/21/17 Declarations of interests (agenda item 2)

Name	Declaration
Chair	
MONAGHAN, Angela Chair	Chair of Corporate Trustee for EyUp! and linked charities Creative Minds, Spirit in Mind and Mental Health Museum. Spouse – Non-Executive Director, National Association for Neighbourhood Management.
Non-Executive Directors	
DYSON, Charlotte Non-Executive Director	Independent Marketing Consultant, Beyondmc (including consultancy for Royal College of Surgeons of Edinburgh). Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional). Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Bradford Teaching Hospitals NHS Trust Clinical Excellence Awards Committee (CEA). Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee. Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.
FORD, Mike Non-Executive Director	No interests declared.
JONES, Chris Deputy Chair / Senior Independent Director	Director, Chris Jones Consultancy Ltd. Consultancy work in the Education and Skills sector.
MAHMOOD, Erfana Non-Executive Director	Non-Executive Director for Riverside Group. Non-Executive Director for Omega / Plexus part of Mears Group. Sister – Employed by Mind in Bradford.
QUAIL, Kate Non-Executive Director	Director of The Lunniagh Partnership Ltd, Health and Care Consultancy.
Non-Executive Directors	
YOUNG, Sam Non-Executive Director	Owner / Director, ISAY Consulting Limited. Transformation Director, Irwell Valley Homes (none voting).

Chief Executive	
WEBSTER, Rob Chief Executive	Chair, Stakeholder Advisory Board for Rapid Service Evaluation Team, Nuffield Trust. Visiting Professor, Leeds Beckett University.

	Honorary Fellow, Queen's Nursing Institute. Honorary Fellow, Royal College of General Practitioners. Lead Chief Executive, West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System). Member of the NHS Assembly. Member of the National People Board. Member of the Equality and Diversity Council. Member of the Advisory Board for National Centre for Creative Health. Former CEO of NHS Confederation. Son – Mencap Ambassador. Son – Parkrun UK Ambassador.
Executive Directors	
BREEDON, Tim Director of Nursing and Quality / Deputy Chief Executive	Son – works in the Trust's Occupational Health Service as a Registered Nurse.
BROOKS, Mark Director of Finance and Resources	Trustee for Emmaus (Hull & East Riding) Homelessness Charity
DAVIS, Alan Director Human Resources, Organisational Development and Estates	No interests declared.
THIYAGESH, Dr Subha Medical Director	Spouse – Trustee, Hollybank Trust; Hospital Consultant & Clinical Director CHFT.
Other Directors (non-voting)	
HARRIS, Carol Director of Operations	Spouse – Engineering Consultancy company specialising in healthcare which has involved work with local NHS Trusts including Mid Yorkshire Hospitals NHS Trust. Son – Registered with the Trust Bank.
RAYNER, Sean Director of Provider Development	No interests declared.
YASMEEN, Salma Director of Strategy	No interests declared.

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

TB/21/18 Minutes from previous Trust Board meeting held 26 January 2021 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 26 January 2021 as a true and accurate record.

TB/21/19 Matters arising from previous Trust Board meeting held 26 January 2021 (agenda item 4)

The following items from the action log were reviewed:

TB/21/08b – Tim Breedon (TB) updated in relation to the Ockenden review that a process had been undertaken in South Yorkshire through the chief nurse's group and this was reported back into the South Yorkshire Integrated Care System (ICS). Agreed to close.

TB/21/10b – Mark Brooks (MB) reported that the Integrated Performance Report (IPR) working group looking at the re-structure of the IPR was time limited and the work is now complete. MB suggested the action is closed as the IPR will continue to evolve over time. Agreed to close.

TB/20/66a – Chris Jones (CJ) noted demand and capacity work for tenders is a continuing piece of work. Finance, Investment and Performance (FIP) Committee will keep the issues in view and keep the Board updated. Agreed to close.

It was RESOLVED to NOTE the changes to the action log.

TB/21/20 Service User/Staff Member/Carer Story (agenda item 5)

Sue Threadgold introduced the item, a story relating to perinatal services. Charlotte Cummings, a previous service user and now peer support worker, with baby Rupert, would provide today's story supported by Claire Lowe, the Perinatal Team Leader.

Charlotte introduced herself and reported she is currently on maternity leave. She initially came to the team after the birth of her second daughter Madeline. Charlotte was very poorly but frightened to ask for help for fear of her baby being taken away. Her husband reassured her to speak to someone.

Initially Charlotte saw her GP who sent her to A & E. Charlotte was referred to the crisis team who after some day to day support referred her to the perinatal team. Charlotte states the service saved her life, there was support for her and her husband, eldest daughter Milly and baby Maddie.

When Charlotte recovered, she reflected how amazing the team was and was asked to bring Maddie to help conduct interviews for nurses for the team. Charlotte asked her mental health nurse if there were any job vacancies to let her know. She was told about the peer support role and applied.

Rupert is Charlotte's third child and is 12 weeks old. Charlotte reported a totally different experience with Rupert to that of having Maddie.

Charlotte will always be grateful to the team and stated it is amazing to be able to help other mums.

AM thanked for Charlotte for her story and stated she is thrilled she has joined the team.

Claire Lowe (CL) reported the team started with a model with one peer support worker across the Trust. There are now six and it has transformed the service offer. The recovery model works very well. More peer support workers are needed if more funding becomes available.

AM noted the Equality and Inclusion Committee has recently received a report on peer support workers and how important they are.

TB asked how helpful Charlotte's personal experience had been in helping her in terms of her support worker role.

Charlotte stated others can see that she didn't have her children taken away and so an honest conversation can take place. Charlotte understands the service user fear and knows where it comes from. It can be overwhelming.
She is now able to signpost friends of friends to get help and tells them not to be afraid. There are instances where things have to happen to safeguard individuals, but these are rare.

Charlotte Dyson (CD) noted the importance of signposting. Has signposting improved with GPs so they know where to send people in need?

CL reported things have definitely improved. There is consistent periodic training with primary care and third sector services. Referrals are rare now from Mental Health Liaison at A & E. The service now has its own four-hour crisis response.

Dr Subha Thiyagesh (ST) asked what learning from working during the pandemic would she want to keep?

Charlotte reported being open and honest, and communication has been key, and it needs to remain that way. Her husband has been able to advise his colleagues from their experience.

Rob Webster (RW) stated it is a fantastic story to hear. RW has read the report about peer support workers and asked how we are making sure we can communicate with our diverse communities.

CL stated since the team started, it has been looking at this. It takes a lot of expertise and the team don't know the birth rate for the BAME population. Commissioners can't tell CL what it is and so she can't judge what the intake level should be. At ground level the team has a peer support worker who is part of a diverse community. They have been able to get an educational piece into a magazine and speak to different generations.

CL is involved in working across the ICS and looking at barriers to accessing specialist services for different populations. Speaking to women from deprived and BAME communities can be difficult, but this is work in progress and the team is looking at how to engage better with these communities.

AM thanked Charlotte and CL for their time and they left the meeting.

RW noted the birth rate data from diverse communities should be available from commissioners and CL needed support to obtain this. TB also believed the data does exist.

Action: Mark Brooks

It was RESOLVED to NOTE the Staff Member Story.

TB/21/21 Chair's remarks (agenda item 6)

AM highlighted the following:

- Voting is open for new governors and will close on 6th April 2021.
- New governors whose appointments are uncontested will start on 1st May 2021.
- Natalie MacMillan has been appointed as the new Non-Executive Director by the Members' Council starting 1st May 2021.
- AM congratulated RW for being voted number one Chief Executive in the NHS in the Health Service Journal awards.

- RW reported the award was a surprise and is pleased the judges noted the focus on staff wellbeing, underrepresented groups and collaboration, this reflects the focus of the Board.

It was RESOLVED to NOTE the Chair's remarks.

TB/21/22 Chief Executive's remarks (agenda item 7)

RW asked to take his report as read and presented the following additional updates:

- Some restrictions have been eased. The stay at home requirement has been lifted. People are expected to proceed with caution.
- Restoration of services and return to work is being reviewed with the executive directors, considering Trust buildings which have been altered to accommodate social distancing.
- Yorkshire and Humber still have the highest prevalence of Covid-19 in the country.
- Calderdale and Kirklees and other areas adjacent have had some level of restriction in place since March 2020.
- Vulnerable groups such as over 65s now have much lower prevalence.
- The second round of vaccinations for staff has started. There is a strong focus on changing appointments for Ramadan, Eid and to accommodate childcare arrangements where required.
- It is one year since the first lockdown and over 120,000 people have passed away. We reflected last week on the people we have lost and how the pandemic has touched everybody's lives.
- We have reflected on the magnificent effort from staff who have exceeded expectations for a substantial period of time.
- The resilience of staff, the command structure, the support, the communications and our systems in South and West Yorkshire has been strong.
- It is positive to see staffing and staff wellbeing being the first item of focus in the planning guidance.
- Pay can make people feel valued or devalued and there are current political debates about pay for NHS staff. The Trust is focusing on the things we can control, examples being the additional days leave and vouchers for staff.
- Improvements are still being made and today's Board story is a good example.
- We are at a pivot point, the weather is getting warmer and restrictions are easing. Planning guidance for the next phase is here. It is time to take stock and refocus our efforts and give our staff a break.

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

TB/21/23 Performance reports (agenda item 8)

TB/21/23a Integrated performance report month 10 2020/21 (agenda item 8.1)

MB highlighted the work that has taken place in relation to the IPR:

- Review of IPR structure by the time limited sub-group of the Board.
- The group met twice and looked at a number of options.
- The team responsible for the IPR have also been busy with the vaccination process. Further developments will likely be seen in May.
- The new dashboard shows each strategic objective with agreed metrics and also highlights key priority milestones.
- Areas for development include further streamlining of the quality section and more metrics to be completed for the workforce section.
- There may be additional metrics developed for sustainability and as a result of the planning guidance.
- MB recognised John Laville's (Lead Governor) input into the development of IPR.

AM asked for a briefing for governors on the IPR and to train them on the new format after May 2021. This should be added to the Members' Council work programme.

Action:Andy Lister

TB noted the following:

Covid-19

- The Infection Prevention and Control (IPC) team continue to work across the Trust, providing support and guidance.
- There are no current outbreaks within the organisation
- Personal Protective Equipment remains in good supply.
- Lateral flow tests are continuing well with the Trust benchmarking well against others.

Quality

- Complaints management continues to be monitored.
- There is pressure on some responses due to capacity for investigations. Timescales are being agreed with individuals dependent on the circumstances. The Clinical Governance Clinical Safety Committee (CGCS) is getting briefed on progress next week
- Under 18 admissions to adult wards continues to be a pressure. Numbers are low but they are still significant events.
- There is pressure on our 136 suite
- We have had three avoidable pressure ulcers which is unusual. This has been reviewed and investigated and there is a change in training for Waterlow assessments as a result.
- Incident reporting remains within normal levels but categorisation has changed dramatically. There is to be a team discussion on Thursday.
- Staffing is pressured. We are undergoing a trial of the "safe care system" in the Unity centre, which is going in the right direction. The safer staffing report will include this work which is going to CGCS, then to Board.
- Monitoring of self harm and suicide during Covid-19 continues. We will change the way we report this to a graph in future.
- Quality needs to be maintained; we need to increase the pace on the improvement agenda without losing the focus of the main piece of work around IPC in relation to Covid-19.

Erfana Mahmood (EM) noted restraints had increased and asked if we investigate each instance?

TB reported the IPR provides a slimmed back version of restraint information. A more detailed report is received in CGCS. The Reducing Restrictive Practice and Intervention (RRPI) team monitor all incidents, debrief teams and then share any learning.

CD noted the IPR summary. Under delivering improvements in CAMHS and forensic services CD asked if the information presented will really demonstrate improvements. CD did not feel forensic staff turnover was a key marker. The threshold for contacts is useful but there is no context as to whether the numbers are showing an improvement.

TB reported we look at Trust figures compared to benchmarking information in the IPR or elsewhere. For the CAMHS figures there is a decision to be made as to what is in the IPR and what goes to CGCS.

CJ asked when IPR targets are refreshed and agreed benchmarking is something we need to look at. CJ queried the incident report, noting a dip in February, as a possible concern and asked for progress on the community safer staffing work. FIP had looked at benchmarking data which suggested the Trust has less registered than unregistered staff and asked how we compare to other trusts.

TB confirmed there is a dip in incident reporting, but it is within normal range. Incidents are being reviewed due to gradings, but there is nothing specific to a ward or area to note.
The community staffing trial is ongoing in Barnsley and the feedback is coming to the safer staffing group with recommendations in May.
Registered nurse levels do not suggest we are an outlier. This will be one of the benefits of the safe care model and review of the establishment.

Kate Quail (KQ) reported she was on the IPR sub-group and questioned how more detailed service performance information and issues were identified and highlighted.

TB reported that performance data is coordinated and reported to the Operational Management Group (OMG). Incident levels, staffing and sickness data is triangulated at OMG. A decision would be made here as to whether things needed to be added to the risk register. TB reported he would speak to KQ separately about some other items to confirm where they are reviewed.

Action: Tim Breedon

Mike Ford (MF) stated the IPR is heading in the right direction and will continue to evolve but items showing as red must not be overlooked. He added that regarding safer staff reporting, there was a suggestion of grouping wards together to provide an overview and classifications of staffing? He asked if this would still be meaningful.

TB noted the six-monthly report to Board on safer staffing will include the points raised by MF.

MB explained the rationale for metrics for CAMHS and forensics which the sub-group agreed needed to focus on staffing metrics given some of the challenges previously highlighted at Trust Board. This could evolve and change in the future.

In response to KQ's question MB reported there is a performance management framework in place, which means at service level there is a performance dashboard which provides a range of metrics to individual services. There are monthly meetings within business delivery units (BDU) that monitor performance and discuss any issues. From there, items are escalated as required to the IPR and additional reporting is made to OMG and Executive Management Team (EMT) and ultimately Board.

MB noted the question of what level of depth Board members should know and understand compared to the role of operational teams and management. This could perhaps be discussed at the next time out strategy session.

AM noted to explore further in a strategic Board the point at which information comes to Board from the operational domain.

Action:Andy Lister

RW stated the approach should be based on risk. For example, a recent operational risk involving seclusion was escalated through the Organisational Risk Register (ORR) to the Board.
RW would expect that as the Finance, Investment & Performance (FIP) Committee matures such issues will get escalated through FIP.

MF queried if there could be an additional report in the IPR that cuts the data by service/ward.

AM queried if this report could be discussed at FIP and any issues be escalated to Board by FIP as required.

RW queried if the locality report in the IPR needs more structure. FIP could consider a locality report and threshold outliers go to FIP and then to Board. CJ and MB could consider this.

CJ noted the difficulty is determining which performance elements to focus on. One driver may be red items on the IPR, the other may be benchmarking. CJ is aware of pressure on the Performance and Information team.
The question of how the Trust Board sees emerging risks, before they are a problem, and an escalation process, is the next challenge.
CJ liked RW's idea of using what is going on in the Trust to highlight ideas for FIP to focus on and would take this to FIP for discussion.

Action: Chris Jones

AGD noted the Trust needs to focus on the good as well as the bad. Benchmarking is not always useful as a performance tool, but it is about providing insight to provoke questions and learning. If we understand how others are doing well, we can bring this into the organisation.

RW agreed and stated the Board should note the recent strong performance on people dying in a place of their choosing, particularly during the pandemic.

National Metrics

MB stated there is nothing further to add that hasn't already been discussed. The Trust continues to perform well against national metrics.

Locality

Sue Threadgold (ST) highlighted the following points:

Trust wide Inpatient Services

- Acute wards continue to see high levels of acuity and occupancy.
- Maintaining patient flow remains challenging.
- There has been increased use of the Psychiatric Intensive Care Unit (PICU) out of area bed placement in March.The reasons being gender specific beds and safeguarding rather than routine bed availability.

Trustwide Community Mental Health Services

- Demand to single point of access (SPA) is increasing.
- Staff continue to engage with service users via various means and ensuring face to face contacts are made where clinically indicated.
- Space is being optimised across the Trust so group work and face to face work can be delivered.

Barnsley general community services

- The team is working closely with Barnsley hospital to reduce the length of stay of patients by identifying early discharge with community support.
- Covid-19 related issues remain a key challenge within the service.
- Continued support to GP practices and vaccination hubs.

Forensics, Learning Disability (LD), Autistic Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD)

- Forensic staffing levels remain a challenge, registered nurse levels are a concern.
- Covid-19 and non Covid-19 sickness remain high.
- Staff wellbeing is a key focus.

- Supervision levels remain positive and have done so throughout the pandemic.
- Supervision levels have improved in LD.
- LD continues to work with Bradford and Leeds for the collaborative inpatient assessment and treatment offer (IATO). This is expected to go live in the summer.
- Calderdale have committed to some investment for a strategic health facilitator to help LD clients access primary care. This has already been rolled out in Kirklees and Wakefield with good results.

Child and adolescent mental health services (CAMHS)

- Access to Tier 4 beds remain problematic, in relation to both standard CAMHS and the forensic estate in Wetherby.

KQ noted the splitting of inpatient and community LD service reporting may be helpful. KQ asked about the structure of the new (ATU) reconfiguration, governance arrangements, key risks for the Trust, staff, and the impact on our staff and how are we engaging them?

ST stated the Assessment and Treatment Unit (ATU) work has been ongoing for a couple of years. ATU provision will move from three units to two. Sites will be in Bradford and Wakefield and share a common clinical and operational model. Both units will have eight beds. Bradford is the lead provider and the service will include Leeds patients.

There is outstanding work around governance and structure, and the collaborative could benefit from seeing the forensic collaborative work that has taken place.
Bed capacity is a risk and one option is to have a shared operational manager and clinical lead across the two units.

An operational risk is that SWYPFT's Horizon Centre is the only unit to have a seclusion room. In the short term this this will mean SWYPFT get people who may be more likely to reguire a higher level of support. Staffing is generous in the model, but recruitment is a challenge which may bring pressure in the future.

AM reported West Yorkshire Mental Health, Learning Disability and Autism Committees in Common cover the collaborative in terms of governance.

RW noted the locality report included good examples of the benefits of collaboration for people and demonstrated how organisations are working differently across the systems.

AM noted the communications and engagement report. The team continue to perform well in helping to support staff with information about the pandemic.

Finance and Contracts

MB highlighted the following points:

- There will be a substantial underspend in 2020/21 compared to the income received.
- The income received this year is very different to a normal year.
- We are delivering surpluses every month, this is a combination of the level of income received,the time it takes to fully recruit into services i.e. Mental Health Investment Standard, strong operational performance e.g. out of area bed placements and a number of non-recurrent savings/income
- Capital expenditure forecast is lower than the original budget
- Cash balance is extremely strong but will reduce by circa £25m in the last month of the year. This is due to receiving an advance payment, earlier in the year.
- The year-end process is going to be challenging due to current uncertainties with the treatment of some transactions which is being determined nationally.

- One example is the Trust has received some national funding to compensate for the loss of NHS income. Final accounting treatment will be confirmed. There is also updated guidance regarding the annual leave accrual and accounting for the Flowers adjudication.
- In summary we are more than achieving against our financial target. This is partly due to underspends that have arisen following the higher prevalence of Covid-19 over late autumn and the winter months.

CJ, as chair of FIP, reported the Trust is solvent and will deliver an outturn favourable to the plan. OOA beds has been positive but there is some disappointment with achievement against our capital programme.

AGD note this has been a very unusual year in relation to capital spend. The estates and facilities team have seen a significant impact of Covid-19. The Trusts has a good track record in previous years of spending money in the right way.

RW noted when financial planning took place with the integrated care system, we weren't in the second or third waves of Covid-19. Some of costs of service delivery we would have incurred haven't materialised. There has also been substantial change in the financial regime. We have typically reported our position in lieu of provider sustainability funding (PSF) in the past, for example, with the PSF leading to surpluses. MB and his team have done a good job in challenging circumstances.

Workforce

AGD highlighted the following points:

- Covid-19 and non Covid-19 absence are starting to merge, and the team are looking at how to manage this in the longer term.
- Outstanding trusts are great places to work which ties into quality, safety and compassionate care.
- AGD reported the issue with food safety training has been the training was historically face to face, which due to Covid-19 had created challenge which has now been resolved.

RW asked the Board to note most indicators are green including supervision.The reporting issue has been resolved and with the revised figures, we are now over target.

RW noted 14 RIDDOR (reporting of injuries, diseases and dangerous occurrences regulations) incidents, which is significantly higher than other quarters.

AGD reported there was a detailed process which went through the health and safety TAG with staff side. AGD did not believe there were any issues of concern but would check the context of the incidents to ensure there are no themes or trends.

Action:Alan Davis

AM thanked all staff on behalf of the Board for their continued performance over the last year,noting improvements have continued to be made despite the enormous challenges the year has presented.

It was RESOLVED to NOTE the Integrated Performance Report and COMMENTS made during its presentation.

TB/21/23b Staff survey results and Workforce Race Equality Standards (WRES) report (agenda item 8.2)

AGD asked the paper to be taken as read and highlighted the following:

- This is an important document and to note it relates to October/November.
- In 5 of the 10 key themes we have improved.
- Staff engagement has improved again.
- The results place us as “average” in most indicators, there is still work to do.
- 7.5 % more staff would recommend the Trust as a place to work than last year.
- There are lessons to learn from other trusts, both locally and further afield.
- We are comparing our Trust to outstanding Mental Health, Learning Disability and Community Trusts to see what the differences are.
- These trusts excelled in four areas; staff engagement, staff health and wellbeing, immediate managers and teamworking.
- These four areas are a future focus for us and will influence the workforce strategy.
- Forensic services have undertaken much work and received good support Theyhave improved in all ten key themes and although not yet where they aspire to be it is good sign that the support is working.

AM noted staff morale has held up well, and there have been improvements in the workforce disability standards which has previously been an area of concern.

EM noted the metrics for BAME colleagues and bullying and harassment. There are signs of improvement for service users, but we are still in the position where bullying and harassment exists for colleagues.

AGD agreed there was further work to do and “Race forward” should help to drive the initiative for bullying and harassment for service users and carers. The freedom to speak up guardian’s role in relation to bullying and harassment is being reviewed. A model around civility and respect is being considered and built upon.

The “great place to work” will look at what creates a healthy team. It is a team where people feel safe and bullying and harassment aren’t tolerated.
BAME colleagues are more likely to be subjected to bullying and harassment and if we can get it right for them, we will get it right for everyone.

AGD stated the bigger issue is whether behaviour is being tolerated within teams. The figures from the staff survey are much greater than the formal cases being processed. Creating team cultures is important. Formal processes involving bullying and harassment are dealt with seriously. AGD stated he was confident in the formal process.

The Trust is learning and has just created an independent review panel for any incident with a racial element is reviewed by the Workforce Race Equality Lead (WRES) OD lead, Freedom to speak up guardian and deputy director of HR.

CJ reported it is great to see areas of improvement, but five of the ten key themes are below average. Are the actions focussed enough and working quickly enough to address these issues in order to meet our objectives?

AGD reported we need to focus on local ownership with BDUs, action, support around the “immediate manager”, and learning from the best organisations.

RW stated we have a report that says we are getting better in tough times with more to do. Generally, we are average with a degree of variance. The Board hasn’t identified where it wants to be in relation to certain indicators. This is something we should consider in the workforce strategy and action plan. Focus needs to be on immediate line manager, WRES indicators and bullying and harassment. These indicators should be reported to the Board.

Action:Alan Davis

KQ stated in relation to bullying and harassment staff to staff, in addition to sanctions there is a need to roll out in-depth training for all staff including intersectionality and power dynamics. E-learning will not change hearts and minds behaviour and there is a need to celebrate positive examples and approaches.

CD agreed the focus on immediate managers was vital

It was RESOLVED to NOTE the report and high-level actions and next steps, and comments made.

TB/21/24 Business developments (agenda item 9)

TB/21/24a Integrated Care System developments white paper update (agenda item 9.1)

SY introduced the item and highlighted the following points:

- Both West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) and South Yorkshire Integrated Care System (SYBICS) continue to develop their operating models and are moving to supporting the changes required of Clinical Commissioning Groups (CCGs).
- There is a common change framework in use across the ICSs
- In WYHHCP there is a leader's design team which will be chaired by RW
- In SYBICS we are represented through place and through sector through the provider collaboratives.

AM updated that the chairs and leaders reference group has just been established in WYHHCP and has nominated sector representatives from each of the provider collaboratives. AM is not the nominated representative from the Mental Health Learning Disability and Autism (MHLDA) collaborative, however, all chairs and leaders are welcome to join the reference group at any time.

MF queried the new provider selection regime.

RW reported this is an important part of the Government's consultation on new arrangements. It replaces the arrangements around the requirement to tender and more on collaboration. From the WYHHCP board meeting public concerns were raised about how we would continue to drive improvement and what safeguards are in place to make sure the right providers are selected.

The WYHHCP response to the white paper will welcome the arrangements and set out a range of things we need to safeguard such as "value for money" and other public concerns. RW noted as a Trust there is a need to consider whether to submit a Trust response or rely on the WYHHCP response and the response of our representative bodies, particularly NHS Providers.

AM felt the Trust could get its views heard through the WYHHCP response and also has the opportunity to influence the response of NHS Providers. MF agreed.

RW noted the planning guidance requires ICSs to have a development plan. By April 2021 systems should have a broad view of what they want to do, by September/October should be operating in shadow form and staff from CCGs should be being told what their destination is going to be. By 1st April 2022 statutory legislation should be implemented.

Work across North East, Yorkshire and Humber is being coordinated collectively. The four ICSs are working with NHSE for the region and looking at what this means for the system, places, provider collaboratives, primary care networks and neighbourhoods. WYHHCP are leading on place developments, SYBICS have been leading on system developments. RW reported the Board should be assured that there is collaborative work taking place to make sure there is a common framework even if the ICSs all have subtle differences.

It was RESOLVED to NOTE the contents of the white paper and proposed changes to integrated care and update on progress through ICS.

TB/21/24b South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.2)

AGD highlighted the following in addition to the report:

- Priorities continue to be Covid-19 and response.
- New variants of Covid-19 are being monitored.
- RW welcomed the report stating it is good to the see the progress on the MHLDA collaborative. The Trust has been significantly involved in the development of the memorandum of understanding (MoU). RW fully supports the MoU
- AGD reported at an operational level there has been some great collaboration and engagement in the MoU

It was resolved to NOTE the update for South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS).

Barnsley integrated community and primary care agreement

- SY reported the agreement has been to private Board and discussed the draft MoU.
- It has the full support of Barnsley CCG, Barnsley Healthcare Federation and the Primary Care Network.
- Today we are looking to approve the agreement and work towards mobilising with the Primary Care Network and the Barnsley Healthcare Federation.
- The aim of this is to enable our staff to work in a structured way to deliver joined up care in neighbourhoods.

CJ and AM noted that the “Barnsley Pound” reference has been embedded in the work from the beginning.

RW feels it is a positive signal to partners in Barnsley. One aim is to ensure the monies allocated to community and primary care are spent in the best possible way to improve care.

SY reiterated this agreement is reflecting where we want to head in a point in time and is not the end product. We will continue to develop the partnership.

It was RESOLVED to formally SUPPORT the agreement and SUPPORT the approach to continue to work with partners in developing the integrated care model.

SYB Mental Health Learning Disability and Autism Alliance Memorandum of Understanding

Sy highlighted the following points:

- The document has previously been discussed at private board.
- It sets out the ambition but collectively we are looking to ensure we have a strong voice, as a sector in the ICS.
- Work is already underway and access to transformation funding to support joined up integrated community services is a good example of this.
- This has been supported through all partner private Boards and is for formal approval today.
- The lead Chair and lead Chief Executive is still to be agreed.

It was RESOLVED to APPROVE the establishment of a MHLDA Alliance of the five providers that will operate under the attached MoU. REVIEW and NOTE that the MoU is not legally binding and does not replace any of the statutory duties that Boards currently hold, SUPPORT the three phases of the development as set out in the MoU Annex 1, NOTING the phases need to align with the white paper timelines, SUPPORT the establishment of a Board, made up of the provider organisations, to in the first instance provide oversight of the three Provider Collaborative enterprises and AGREE to be a formal signatory to the MoU.

TB/21/24c West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.3)

SY highlighted the following points:

- Work in Wakefield is setting the benchmark in respect of ensuring that people with learning disabilities and enduring mental illness access physical health checks and are supported with a joined-up approach.
- Work on race equality has won an award and been recognised for the speed at which the work took place.
- An anti-racism campaign has started which is likely to have broader implications than just the public and health sectors.
- WYHHCP posted a three-day event on trauma informed care, as a joint piece of work with the violence reduction unit. The Trust is already doing substantial work in this area and a paper will be going to EMT.
- Through transformation funding we are continuing to work with our partners in place to co-design models of care and to stop people falling through the gaps between accessing primary care and not meeting the threshold for secondary care.

SR reported in Wakefield the Integrated Partnership board received a report on support for people with learning disabilities. Fiona Sharp and Catherine Horbury from our Trust gave a presentation which really raised the profile for people in Wakefield with learning disabilities.

SY reported Kirklees are working towards what their ICS arrangements will look like. The future of general community services in Kirklees was discussed on 24th March. The current care closer to home contract terminates in September 2022. Partners met to take stock of progression in Wakefield and how this is taken forward In Kirklees.

RW reported the two CCGs in Kirklees merge on 1st April 2021. This is a step into a place-based arrangement with the Council. The Integrated Care partnership will now be considered in Kirklees.

CJ welcomed the work on the anti-racism campaign. Co-production is important, and the focus has to be on changing behaviour and impact.

SY added the intention in West Yorkshire will be to try and shift culture. SY and ST have attended a national conference involving public sector organisations where the development of inclusive cultures uses the concept of “allyship” and leaders at every operational level being aware of how to be an ally and a leader are key. This is being discussed within the Trust.

RW reported the partnership board had a good discussion on this. The anti-racism campaign is one of a number of recommendations from the Dame Donna Kinnair report.

AGD reported this is about organisational culture. Cherill Watterston is the new WRES OD lead. It is more than individual behaviours, it’s about policies procedures and much broader organisational thinking.

Adult Secure Lead Provider
SR highlighted the following points:

- We are awaiting an updated budget offer from NHSE. At the partnership board last week it was reported that this will be received shortly.
- SR is trying to ensure a good position with NHSE with a budget to come through Board before the go live date in July.
- All other aspects of the collaborative are ongoing and we are now looking at the commissioning arrangements.
- We have flagged with NHSE that we need support for the adult secure collaborative on contracting capacity. Discussions are ongoing regarding support available from NHSE and a proposal is being developed by the North East Commissioning Support Unit as to what support they can offer.

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 developments in Calderdale, Wakefield and Kirklees and update on the Adult Secure Lead Provider Collaborative.

Refreshed Memorandum of Understanding for WYMHLDA Committees in Common
AM introduced the item and highlighted a detailed review of the terms of reference had taken place noting how much the committee had evolved and the Memorandum of Understanding has been updated as a result.

It was RESOLVED to approve the refreshed MoU at Appendix 1; NOTE the use of the 'Triple A' assurance report that will be used to summarise C in C meetings to Trust Boards; an NOTE that a more substantial review of the MoU will be commissioned by the CinC when appropriate.

TB/21/24d Receipt of Partnership Board Minutes (agenda item 9.4)
AM asked for the minutes to be taken as read.

It was RESOLVED to RECEIVE the minutes of the relevant partnership boards and the summaries as documented.

TB/21/25 Strategies and Policies (agenda item 10)

TB/21/25a Green plan and update on sustainability strategy (agenda item 10.1)
AGD highlighted the following points:

- The Green plan took the Trust forward. Separate work around sustainability was needed.
- The two documents may come together in time. The purpose of today is to sign off the Green plan and allow a more sustained engagement process around the sustainability strategy.

CJ reported the plan is much clearer and supports the intention. CJ queried the road to net zero and the move to green electricity tariffs.

AGD explained there are two ways to get a green tariff, to sign up to a "green tariff" or ensure we only want our electric through sustainable resources. The latter will be our approach. There will be an element of offset as well as reduction. We use carbon in travel and our buildings. We can reduce consumption through green energy and insulation methods.

CJ reported we need to understand how we will offset our residual carbon emissions.

Action:Alan Davis

AM reported we needed a Board that drives this agenda and have a governance group in place within the Trust. AM stated she does not feel a further Board committee was a requirement. There is a need to review governance arrangements.

Action:Alan Davis

AM noted there isn't a Equality Impact Assessment and asked for one to be completed

Action Alan:Davis

In response to AM's query about reusable PPE TB reported there had been talk in nursing forums, but this was in its infancy and no information had been received from the centre. TB will make an enquiry through the chief nursing officer.

Action:Tim Breedon

It was RESOLVED to APPROVE the five-year Green Plan and NOTE the update on the sustainability strategy.

TB/21/25b Estates Strategy Update (agenda item 10.2)

AGD asked to take the strategy as read.

EM noted from the discussion with the staff disability network there are some disability network basics that haven't been met and these need to be included. EM noted the overlap of the three strategies, digital, green and estates and asked if there is any duplication.

AGD stated there is a programme of work developed through the staff disability network that is built into minor capital programmes. This does need to be built into the estates strategy. Overlap is important. Estate and digital go hand in hand.

KQ queried the involvement of staff in developing the capital plan. How does NICE guidance and other national guidelines affect our capital plan?

AGD reported services are engaged, they are at the heart of the capital plan. Services have all had a chance to contribute and prioritise what is in the capital programme. Statutory and NICE guidance are built into the capital plan. The pandemic has highlighted the importance of environment for staff wellbeing.

It was RESOLVED to NOTE the update on the Estates Strategy and estate related safety arrangements in the Trust.

TB/21/25c Digital Strategy (agenda item 10.3)

MB highlighted the following points:

- The Board approved the previous digital strategy in January 2018.
- The Board has been kept updated with the considerable progress made against the strategy, which reaped dividends during the pandemic.
- We now have better infrastructure and business intelligence
- 170 staff were engaged in the strategy as well as service users and carers.
- The Equality Impact Assessment is included.
- As well as the technical facets of the strategy there is increased focus on culture and winning hearts and minds
- Further detailed plans are being developed
- There is more focus on partnership working and inclusion.
- We aim to improve our digital maturity.
- Better staff, service user engagement and training

- A focus on care records and being shared across systems, sharing information and intelligence.
- Delivery is dependent on resources as well as hearts and minds.
- The recent additions of devices, systems and licences during the pandemic has resulted in significant incremental recurrent cost.

AM noted there are health and wellbeing risks that need to be referenced such as eyecare, and musculoskeletal risks. The equality impact assessment reported no equality impacts. AM queried if older people or those with disabilities may be affected. MB agreed and stated the EIA will be updated and further thought will be given to health and wellbeing risks associated with the increasing use of digital ways of working.

RW noted we needed to reflect on digital inclusion. There is work ongoing in WYHHCP.

MF asked if a high-level summary of the strategy could be produced. MB commented that when he re-read the strategy he felt a summary of key points would help.MB added that some of the priorities in the updated strategy are determined internally by our own identified risks and objectives whilst others are part of national and regional programmes.

RW noted the strategy is coherent and comprehensive. RW proposed using the Communications team to design some infographics to go at the front of the strategy. It would also be good to make sure we note we have staff that work in Leeds, Sheffield, Rotherham and Doncaster.

Action: Mark Brooks and Salma Yasmeen.

AM reported a further action was to revisit the EIA and include some of the work going on in WYHHCP, and note comments about implementation, data and the health and wellbeing of staff in terms of digital technology use.

Action:Mark Brooks

It was RESOLVED to APPROVE the updated Digital Strategy spanning 2021-24.

TB/21/25d Trust Board declaration and register of fit and proper persons, interests and independence policy (agenda item 10.4)

MB asked to take the paper as read. All changes are highlighted in the document and we will be asking Board members to update their declarations if they haven't been already.

It was RESOLVED to APPROVE the Trust Board declaration and register of fit and proper persons, interests and independence policy.

TB/21/26 Governance Matters (agenda item 11)

TB/21/26a Interim Governance Arrangements update (agenda item 11.1)

MB asked to take the paper as read. This has been discussed at Audit Committee and the Board has received regular updates since the onset of the Covid-19 pandemic.

It was RESOLVED to NOTE the update to the interim governance arrangements as outlined in the paper.

TB/21/27 Assurance from Trust Board Committees and Members' Council (agenda item 12)

Audit Committee 26 February 2021 (minutes received from 5 January 2021)
MF highlighted the following:

- Year end audit timetable has been reviewed.
- External audit plan has been approved.

Clinical Governance and Clinical Safety Committee 9 February 2021 (minutes received from 10 November 2020)
CD highlighted the following:

- CQC improvement plan continues to progress despite Covid-19
- Waiting list improvement plan continues to progress
- There are commissioning issues with Calderdale Core Psychology
- Covid-19 risks
- Assurance reports were received on Serious Incidents and Nursing revalidation

RW noted the core psychology issue and suggested this was escalated through the partnership arrangements. This will be dealt with through the collaborative arrangements and may need to be picked up in the MHLDA Committee in Common at some point.

Action: Rob Webster

Equality and Inclusion Committee (minutes received from 8 December 2020)
AM highlighted the following:

- A shortened version of the Committee took place and some items were deferred due to Covid-19
- Feedback received from staff equality network, staff side and the BDU equality forums so we understand issues for our people across the organisation
- The equality, involvement, communication and membership action plans were agreed
- Some good progress on the performance dashboard
- We received a peer support workers report which was very positive.

Finance, Investment and Performance Committee 22 March 2021 (minutes received from 24 November 2020)
CJ highlighted the following:

- Received the finance report and noted the OOA beds performance and prompt payment of suppliers
- A discussion was held around the challenges to forecast outturn
- National benchmarking on mental health services and identified three areas for exploration around restraint, readmission rates and staff mix
- We approved the draft capital plan for 2021/22.
- Noted the (then) lack of progress on the financial challenges around the lead provider

Mental Health Act Committee 9 March 2021 (minutes received from 3 November 2020
KQ highlighted the following:

- White paper update, KQ has met twice with chairs from MHA Committee of partner trusts to conduct a joint response to consultation
- Advocacy, since the report we have had a CQC visit. We are well on with our side of things, there is an issue with providers which we are dealing with.

Workforce and Remuneration Committee 9 February 2021 and 16 March 2021 (minutes received from 19 January 2021 and 9 February 2021)
AGD asked to take the update as read.

Members' Council 29 January 2021 (minutes received from 30 October 2020)
AM highlighted the following:

- Approved the appointment of a new Non-Executive Director
- Receive the further updates and take as read.

It was RESOLVED to NOTE the assurance from Trust Board committees and Members' Council and RECEIVE the approved minutes as noted.

TB/21/28 Use of Trust Seal (agenda item 13)

AM asked to take the paper as read. The seal has been used to renew the lease of premises in Wakefield and to obtain a car parking licence for staff in Huddersfield.

It was RESOLVED to NOTE use of the Trust Seal since the last report in December 2020.

TB/21/29 Trust Board work programme (agenda item 14)

AM suggested the work plan would benefit from a small working group. The final version would then come back to Trust Board in due course.

Action:Angela Monaghan

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

TB/21/30 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on 27 April 2021, which will be a virtual meeting.

TB/20/31 Questions from the public (agenda item 14)

Nil

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 30 MARCH 2021 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 30 March 2021 (in draft)

Min reference	Action	Lead	Timescale	Progress
TB/21/20	During the service user story Claire Lowe, the perinatal service manager stated she had difficulty obtaining Birth rate data for the BAME population and as such found it hard to assess what their intake level should be. After the story RW reported the data did exist and asked if we could assist Claire to get access to this.	Mark Brooks	May 2021	
TB/21/23a	Once the renewed IPR has been to Board in May 2021 training should be arranged for governors on the new IPR and how to use it for their role as a governor. To be added to the Members Council work programme.	Andy Lister	April 2021	Noted to take to Members Council after May and included in governor training programme work with Deputy Lead governor.
TB/21/23a	TB reported that performance data is coordinated and reported to the Operational Management Group (OMG). Incident levels, staffing and sickness data is triangulated at OMG. A decision would be made here as to whether things needed to be added to the risk register. TB reported he would speak to KQ separately about some other items to confirm where they are reviewed.	Tim Breedon	April 2021	The IPR was discussed at recent CGCS meeting and included consideration of review and escalation arrangements.

TB/21/23a	MB noted the question of what level of depth Board members should know and understand compared to the role of operational teams and management. This could perhaps be discussed at the next time out strategy session. AM noted to explore further in a strategic Board the point at which information comes to Board from the operational domain.	Andy Lister	May 2021	
TB/21/23a	RW queried if the locality report needed more structure and to be monitored by FIP. CJ noted the difficulty is determining which performance elements to focus on. The question of how the Trust Board sees emerging risks, before they are a problem, and an escalation process, is the next challenge. CJ liked RW's idea of using what is going on in the Trust to highlight ideas for FIP to focus on and would take this to FIP for discussion.	FIP	May 2021	
TB/21/23a	RW queried the need to discuss the 14 riddor incidents in the IPR. AGD did not believe there were any areas of concern but would check and report back to Board.	Alan Davis	April 2021	Verbal update to given in Board meeting
TB/21/23b	RW reported the workforce strategy needed to focus on the importance on immediate line manager, WRES indicators and bullying and harassment. This should be part the workforce strategy action plan.	Alan Davis	April 2021	This is included in the Workforce Strategy on the Board agenda.

TB/21/25a	CJ reported that the Trust needs to understand how it will offset residual carbon emissions.	Alan Davis	June 2021	
TB/21/25a	AM reported we needed a Board that drives this agenda and have a governance group in place within the Trust. AM stated she does not feel a further Board committee was a requirement. There is a need to review governance arrangements.	Alan Davis	June 2021	
TB/21/25a	AM asked for an EIA to be completed for the Green Plan.	Alan Davis	April 2021	EIA is being finalised and will be completed for by end of May 2021
TB/21/25a	In response to AM's query about reusable PPE TB reported there had been talk in nursing forums, but this was in its infancy and no information had been received from the centre. TB will make an enquiry through the chief nursing officer.	Tim Breedon	April 2021	No information regarding reusable PPE has been received – to raise further query through regional MD/DON network
TB/21/25c	MB and SY to look at infographics to present simple headlines about the strategic objectives in relation to the digital strategy	Mark Brooks/Salma Yasmeen	May 2021	PC has met with PF to determine next steps. The strategy is now with the comms team to proof, design and finalise. An infographic based 'plan on a page' is in development. Once these are produced a dedicated intranet/website section will be developed in advance of a launch to staff through multiple communication channels.
TB/21/25c	Look at work from the Digital Strategy EIA, in relation to implementation and the health and wellbeing of staff in relation to Digital resources.	Mark Brooks	April 2021	This work is being conducted currently and expected to be completed by the end of May
TB/21/27	RW noted the core psychology commissioning issue and suggested this was escalated through the partnership arrangements. This will be dealt with through the collaborative arrangements and may need to be picked up in the MHLDA Committee in Common at some point.	Rob Webster	May 2021	
TB/21/29	Small working group to be established to review the Trust Board workplan.	Angela Monaghan	May 2021	

Actions from 26 January 2021

Min reference	Action	Lead	Timescale	Progress
TB/21/08b	RW noted as work through our systems changes, there should be more public health support and insight into the work the Trust does. Dr Andy Snell, consultant in public health in Barnsley, has demonstrated the benefits of having this expertise embedded in a trust, with access to data to effectively manage services. As we work through the changes in our systems, we need to know how we are going to access the public health intelligence and information needed to plan Trust services effectively.	Salma Yasmeen/ Mark Brooks	June 2021	

Actions from 29 September 2020

Min reference	Action	Lead	Timescale	Progress

TB/20/74	RW reported the West Yorkshire and Harrogate ICS recorded the public meeting and posted it on their website for a number of days. AL could speak to Karen about their experience of doing that. RW also queried how well we were promoting this meeting on social media before and during the meeting. If AL and AM were to review it would be useful to involve SYa and Dawn Pearson.	Andy Lister	June 2021	15.10.20 meeting held with Karen Coleman from the WY&H ICS. AL to discuss outcome with AM. 27.10.20 AL updated a production company are used by the ICS and there is an editing process that takes place before meetings are published online. 20.11.20 Further discussion has taken place with Julie Williams and due to concerns around governance further discussion needs to take place. 18.01.21. Further guidance has been developed for members of the public and how to join public meetings. This will be circulated with papers each month. Board meetings are now promoted on social media on a monthly basis. 19.03.21. The discussion relating to the recording and publishing of Board meetings will continue after the response to Covid-19.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
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:	We are heading towards the end of the financial year and into the Spring. We have successfully faced a challenging Winter through effective partnership working and strong leadership within the Trust. This is reflected in the latest monthly briefing for all staff attached at **[Annex 1]** as well as developments included within this report. Effective communication continues to be delivered via the publication of The Brief, The View, the weekly Coronavirus update and a weekly virtual Chief Executive Huddle open to all staff. Since publication of The Brief, we have seen: • **Progress on the Government roadmap for easing restrictions continues to be made.** This is due to a continuing reduction in the numbers of cases and deaths; the ongoing successful rollout of the vaccination programme; and hospitals being able to demonstrate capacity to deal with surge. We cannot be complacent. Firstly, we are seeing variants of concern globally causing substantial issues in other countries such as Brazil, South Africa and India. Secondly, there are predictions that there will be a third wave on infections following the full easing of lockdown restrictions – though the vaccine programme should have broken the link between infections, serious illness and death. • **We have submitted a first draft financial plan to the West Yorkshire & Harrogate Health and Care Partnership (WY&H HCP).** This is the first element of our plan for restoration and recovery which sits within system priorities and national planning guidance • **Planning guidance and financial envelopes for the next six months have been augmented by additional expectations and detail for mental health services**, this should allow for greater opportunity to recruit staff at risk and attempt to make progress on this part of our agenda. This is in the context of estimated significant increases in demand for mental health services and a backlog of treatments that needs to be cleared.

- **Research published in The Lancet suggested there has been no significant increase in suicides in the early part of the pandemic.** It also suggests that we need to be vigilant and manage risks especially for children and young people, and for adults as we witness the economic impact of the pandemic.

- **Inequalities continue to be exacerbated by Covid-19** which will, in turn, lead to health inequalities unless we take actions to prevent this from happening. Within the Trust we have taken stock of the eight actions required of us in addressing inequalities. In our systems we are working on a range of issues for specific populations e.g. people with a learning disability or of black and Asian minority, and for specific environmental factors. This has led to for example people with a learning disability being prioritised on waiting lists in acute hospitals, partnership working on Covid-19 vaccination in unserved areas and our work at anchor institutions that employ staff and buy goods**.**

- **The vaccination programme is well into the second dose rollout** with nationally more than ten million people having received their second dose, and the majority of our staff having received their second dose. During this period we continue to ensure that no one is left behind and our vaccination teams are available to those who lack confidence in the vaccine.

- **Government plans on integration and ICS' continues to progress.** We have been engaged in consultations for example on the Oversight Framework and local developments for new arrangements in both of our ICS'. This is substantial work which is reflected in provider collaborative Memorandums of Understanding (MoU), place-based developments and staff engagement. There is much on the Board agenda today to reflect this.

- **Children and young people remain a topic of concern nationally, regionally and locally.** We have made some substantial progress on community CAMHS with more to do. Specialist support and treatments are under significant pressure with a lack of beds and community alternatives also under pressure. We anticipate further action on this nationally.

- **Performance remains good in most places with the organisation continuing to manage substantial risks.** Whilst this is often a feature of organisations like ours, we should not become blind to the risks we carry or be complacent about our ability to manage them. The strong focus on risk at Board and Committee level provides some safeguards and the reinstatement of Quality Monitoring Visits (QMV) is very welcome.

- **Staff sickness from Covid-19 is now down to double figures, and less than 1% of staffing at the time of writing.** This sits alongside historically lower levels of sickness for other causes sitting at 4%. Our Workforce Plan informed by the Staff Survey will maintain a focus on staff wellbeing and it is good to see a focus on this issue at Board today.
- **We continue to see a focus on good practice and innovation,** for example we have been selected to be a site for testing mechanisms for digital inclusion in WY&H; and work with Incredible Edible Wakefield and Creative Minds has created mini allotments on the Fieldhead site for

	service users as part of their therapy and these are tailored to the needs of different people. • **Finally, it is worth noting that I signed the S106 agreement for the sale of Mount Vernon Hospital this month.** The agreement ensures that Barnsley Council receives a substantial sum to support affordable housing, woodland protection, education provision and other social issues. We have also agreed with the developer that there will be a recognition of Mount Vernon enshrined in the development through either street names or other appropriate means. Proceeds from the sale coming into the Trust will be spent on capital developments in Barnsley. • **As we cross over the year end there is a substantial amount of governance work being concluded within the organisation.** This work is often unseen by the majority of staff yet is an essential component of a high performing organisation like ours. I wanted to thank the staff for all they are doing at this point in time. As we leave the last financial year it's worth noting that this was a year like no other. People within the Trust deserve great credit for what they've achieved, and Board colleagues deserve credit for leading us through the pandemic.
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

1 April 2021

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

We are working with Wakefield Trinity Community Foundation to support young people's mental health and wellbeing through exercise, training and education. The new 'Homes Goals' initiative supports people aged 11 to 18 who use our Wakefield CAMHS.

With **all of us** in mind.

Coronavirus

Keeping informed, acting responsibly

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Stay focused and keep up to date by reading the guidance on the Trust intranet, the Public Health and NHS England websites.

Lockdown restrictions continue to be eased gradually. From 29 March two households of any size can meet up, or up to 6 from any households (the rule of 6); and the stay at home rules end. From today (1 April) those people who had to previously shield no longer need to. The next phase is the opening of non-essential shops, gyms, personal care businesses and outdoor hospitality on 12 April.

Our **Gold** and **Silver** command meet twice a week. This helps us to react quickly. **Bronze** meetings continue to take place in operational and corporate services, often daily.

We continue to work in each of our local areas as part of weekly Gold, Silver and Bronze meetings and are a part of local decision making.

It is important that we follow the rules and be cautious as the lockdown eases – including after you have had your vaccine.

With **all of us** in mind.

Coronavirus
Keeping up to date

NHS
South West Yorkshire Partnership
NHS Foundation Trust

It is important to keep informed of what is happening nationally and in our local areas.

Europe is facing a third wave of coronavirus infections because of the Kent variant. This is a lesson on the need to maintain all of our safety practises and increase vaccination.

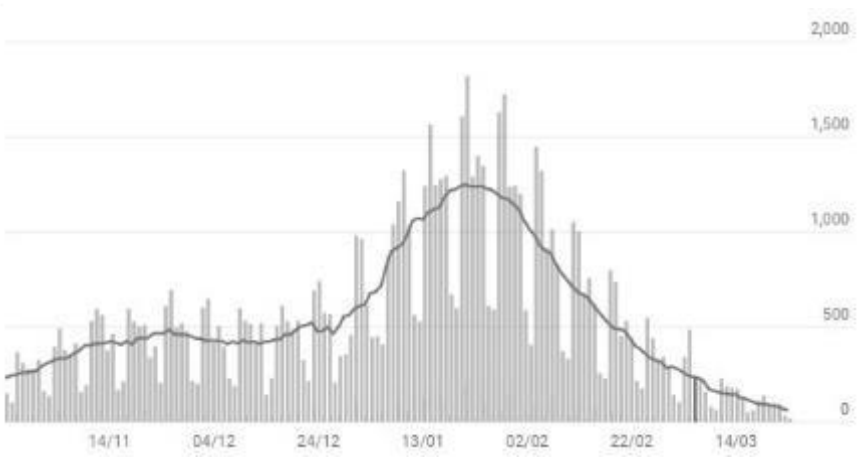
Hospital admissions are reducing across the country which is thought to be because of the reducing prevalence and vaccination rollout. Having the vaccine and following the rules helps us to reduce the impact on our hospitals.

Local Authority figures per 100,000 population are still high (as of 22 March):

- Barnsley – 163
- Calderdale - 109
- Kirklees - 106
- Wakefield – 140

National infection rate

Daily reported deaths due to coronavirus



Our proposed priority areas 2021/2022

NHS
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NHS Foundation Trust

Understanding equality, and addressing inequality through inclusive involvement

Improve health	Play a full role in our Integrated Care Systems and associated places to contribute to outcomes in their 5 year plans	We deliver the targets agreed in our ICS strategies
	Improve outcomes through our wellbeing services, physical health and services for people with mental health and learning disabilities	
	Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges	
	Deliver improved integrated mental health community services with our partners in each of our places	
Improve care	Continually improve patient safety	We restore services, deliver our quality targets and improve our CQC ratings
	Safely deliver and restore inclusive services locking in innovation	
	Provide care as close to home as possible	
	Deliver improvements, particularly in CAMHS and forensic services	
Improve resources	Integrate digital approaches to the way we work	We deliver our financial duties and improve efficiency
	Spend money wisely and reduce waste	
Make this a great place to work	Support the provision of a healthy, resilient and safe workforce	We improve our staff survey results and deliver our WRES/WDES indicators
	Refresh and deliver our sustainability strategy and action plan	

#allofusimprove and be outstanding

Underpinned by #allofusimprove, using quality improvement to ensure we learn from organisational change.

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.

- Increased critical care
- Vaccination
- 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

West Yorkshire and Harrogate ICS' **suicide prevention** campaign has been adopted by the Trust and continues to promote support and services available. More information is available on the intranet. A new anti-racism campaign, which are are a part of, is due to start soon.

The **NHS Operational Planning Guidance** has been published, and places an increased focus on staff wellbeing, mental health and learning disability services, tackling health inequalities, and on the ICS' role in supporting hospital capacity. The guidance sets out the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands, and reduce the care back logs that are a direct consequence of the pandemic.

South Yorkshire and Bassetlaw ICS has launched a new website 'Healthier Together' which provides health and wellbeing advice for parents, young people and pregnant women, as well as clinical resources to support healthcare professionals. It enables patients and professionals to work together to improve local healthcare with the aim of reducing the need for A&E and GP appointments.

Improving Health:
Joining up the response in every place

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Working with each of our places to evolve partnerships and continuing to work in all of our areas on a joined up response to the coronavirus pandemic.

Barnsley
With support from Barnsley Hospital NHS Foundation Trust and Barnsley Healthcare Federation, we'll be delivering the **B**arnsley **RE**spiratory **A**ssessment and **THE**rapy **(BREATHE)** service. The service will improve the patient journey and help people to receive more treatment in their own home and GP surgery, avoiding hospital visits where possible.

Kirklees
North Kirklees and Greater Huddersfield CCGs have now joined together to form on organisation – Kirklees CCG. We continue to work together in Kirklees on further developing integrated care and on the pandemic response.

Calderdale
We've been part of a successful bid for Thriving Communities funding in Calderdale, which will be used to plan and deliver community activities; including those involving the arts, creativity and culture, sport and activity and those focused on wellbeing.

Wakefield
The Wakefield recovery and wellbeing college has held their first meeting of a new 'family and carers alliance and support group' and will now meet every 4 weeks. If you are interested in attending call 01924 316946 or email the college direct.

With **all of us** in mind.

Improving Care:
Safety and quality

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In February we had:

- 947 incidents – 643 rated green (no/low harm)
- 292 rated yellow or amber. It was 178 in January
- 12 rated as red, up from 10 in January
- 32.1% of incidents are recorded as either red, amber or yellow. Up from 19.1% in January.
- There were 2 reported serious incidents this month
  1 cause of death unknown and 1 apparent suicide.

The increase in the percentage of incidents rated as red, amber or yellow is as a result of changes made to our Datix system, following an internal audit recommendation. Further information will be forwarded to all teams.

There were **13 confidentiality breaches** in February. 12 of which involved incidents of information disclosed in error. This included the wrong information included in emails and letters, overtyping letters and not removing the original information, and letters sent to the wrong address. Make sure you are up to date with advice on the intranet.

Kirklees memory service has received a Sustainable Mental Health Service Commendation from the Royal College of Psychiatrists. The team have been recognised for their commitment to enabling patients to prevent mental illness, help service users to manage their own conditions and reducing waste.

With **all of us** in mind.

Improving care:
Our performance in February

South West Yorkshire Partnership NHS Foundation Trust

- **50** inappropriate out of area bed days
- **95%** of people recommend our community services
- **80%** of people recommend our mental health services
- **1.6%** delayed transfers of care
- **64.1%** referral to treatment in CAMHS timescales
- **1** person under 18 admitted onto adult inpatient wards
- **90%** of prone restraint lasted less than 3 minutes
- **185** restraint incidents
- **96%** of people dying in a place of their choosing
- **51.6%** of people completing IAPT treatment and moving into recovery

We had **44** falls in February, the same as in January. All falls are reviewed to identify measures required to prevent reoccurrence and more serious falls are subject to investigation.

We had **3** avoidable pressure ulcers in February. The teams have investigated each one and put in place improvement plans to ensure learning is acted upon and shared.

Electronic prescribing is now live at Poplars, Lyndhurst, Enfield Down and Ward 19.

Feedback from the pilot wards has been positive and the project is moving on to the next in Kirklees.

Please see the **EPMA** intranet page for more information.

With **all of us** in mind.

Improving care:
Our coronavirus related performance

NHS
South West Yorkshire Partnership
NHS Foundation Trust

As of 29 March:

- **There are currently 164 members of staff absent or working from home due to coronavirus.** We reported 178 in the February Brief. **This is 3.2% of our total workforce.**

- **81 members of staff are absent and 83 are working from home.** Of those absent, **76%** are shielding (which ends today), **11%** are symptomatic, **5%** have household symptoms, and **2%** have been advised to isolate by occupational health.

- **We've processed 3,498 swab test results for staff and household members so far**, with **641** of these testing positive and **2,857** testing negative.

As of 23 March:

- **297 service users have been tested** on the wards. This is **19** more than reported in January. **134** tested positive 119 of which have since recovered.

Discover 2020: Pandemic Stories is a series of audio stories collected by volunteers from Calderdale and Kirklees. Working with the Mental Health Museum volunteers from the Kirklees recovery college recorded people's experiences of the lockdown and its effect on their mental health. Learning from these personal stories will help us to shape and improve mental health services in the future.

With **all of us** in mind.

Coronavirus
Vaccinations at the Trust

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We've so far provided the first dose of the COVID-19 vaccine to over **4,900** staff – which is **86.8%** of substantive staff at the Trust. Thank you to everyone who's supported the vaccination programme so far**.**

If you haven't had your first vaccine yet you can still book an appointment through:

- The Trust's vaccination programme team on Covid19.VaccinationProgramme@swyt.nhs.uk (monitored Mon - Fri, 9am to 5pm) or by calling 01226 644292 (Mon - Fri, 9am to 4pm).
- The national booking system: Book a coronavirus vaccination - NHS (www.nhs.uk)
- Calling 119 to arrange a vaccination near to where you are

On 29 March we began providing second doses of the vaccine at the Trust. Staff who had their first dose at a **Trust vaccination site** will be contacted and given a pre-booked appointment slot for the second dose. **Please don't turn up outside of your allotted time.** If you had your vaccine outside of the Trust they will contact you directly to book your second dose. **It's important that everyone has two doses to ensure maximum protection.**

For clinical or health and wellbeing vaccine queries contact the occupational health coronavirus support helpline on 01924 316036 (Mon - Fri, 8am - 4pm).

We continue to keep our COVID-19 vaccine page on the intranet updated with all the latest news, research and information. You can also read our FAQs: www.southwestyorkshire.nhs.uk/covid19-vaccine-faq

With **all of us** in mind.

Coronavirus
Vaccinations at the Trust

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We've so far vaccinated over **200** service users in our inpatient units. This includes all of the service users in forensics; which is an amazing achievement.

COVID vaccine stories: Read about our staff experiences of having the coronavirus vaccine, describing what it was like for them, why they did it, and how it has made them feel. If you want to share your story let our comms team know.

Having the vaccine prevents you from becoming seriously ill from COVID-19. Even after having the vaccine, we must continue to follow guidance on hand hygiene, use of personal protective equipment (PPE) and social distancing.

Remember if you've had the vaccine outside of the Trust let us know by emailing BusinessIntelligence@swyt.nhs.uk

Our **Calderdale and Kirklees Community learning disability (LD) teams** worked with colleagues in Calderdale Royal Hospital to support a one-off session for people with LD who were not able to attend mainstream vaccine clinics. Their support helped 30 people with LD to be vaccinated on the day.

Improving resources
Our finances in 2020/21

NHS South West Yorkshire Partnership NHS Foundation Trust

	Performance Indicator	Year to date	Forecast 2020/21
1	Surplus / Deficit	£3.7m	£2.2m
2	Agency Cap	£5.7m	£7m
3	Cash	£75.5m	£52.8m
5	Capital	£2.4m	£4.9m
6	Better Payment Practice Code	95%	

In February we had a surplus of £0.5m. This is due to good operational performance, recruitment into new investments and the impact of the pandemic on our cost profile.

The Trust continues to monitor agency spend and action plans remain to ensure agency staffing usage and costs are appropriate.

Cash in the bank continues to be above planned levels. The main reason is the timing of block income payments which ended in March.

The capital forecast continues to be reviewed to take account of current capital priorities and the impact of covid-19. There is increased spend forecast in March.

The Trust aims to pay all valid invoices as quickly as possible.. On average invoices were paid within 13 days in February.

A great place to work
Priority updates

South West Yorkshire Partnership NHS Foundation Trust

This month general staff sickness is **4%**.Turnover is **10%**. Remember there's support for **#allofus**

We have deferred our 2021-22 WORKPAL appraisal window to May 2021 - October 2021. In line with our usual process band six and above staff should now complete their appraisals between May and July 2021. Guidance for conducting e-appraisals is available on the intranet.

The Government is reviewing the way the Mental Health Act works. We would like everyone to have the chance to feed into the proposed reforms. They have implications for all of us. Take a look on the intranet to find out more.

The Trust is continuing to make improvements on green technology and sustainability. This includes use of solar panels, electric vehicle charge points, energy efficient boiler replacements and heating control upgrades. See the intranet for more details.

Kirklees outreach team community mental health practitioner Dan Hughes has created a new board game with his daughter Cora. The game, called 'CoraQuest', was created during lockdown to break up home schooling.

New guidance for CEV people who were shielding is available on the intranet. Talk about it with your manager and update your individual risk assessment.

A great place to work
NHS staff survey 2020

The survey is carried out every year and was sent out between Oct-Dec 2020

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Provides important feedback on your experience of working for the Trust

1,864 responses

43% response rate (down from 45% in 2019)

Theme results	Trust score 0-10	Average
Equality, diversity and inclusion	9.2	9.1
Health and Well-being	6.4	6.4
Immediate managers	7.2	7.3
Morale	6.5	6.4
Quality of Care	7.4	7.5
Safe environment-Bullying	8.3	8.3
Safe environment-Violence	9.4	9.5
Safety Culture	6.9	6.9
Staff Engagement	7.1	7.2
Team Working	6.9	7.0

69% of staff would recommend the Trust as a place to work. An increase from 61.5% last year and higher than the national average of 67.7%.

71.8% Of Staff would recommend the Trust to family and friends as a place to receive care and treatment. This is up from 65.6% last year and above the national average of 70.4%.

Results below are summarised using the ***key themes*** which have been identified by staff as being important in making the Trust a great place to work.

Feeling safe

16.2% of staff said they have personally experienced violence from patients, service users or relatives. *This is slightly above the national average.*

27.0% of staff said they had experienced bullying or harassment by service users or relatives. *This is in line with the national average.*

9.4% of staff said they had been bullied or harassed by their line manager. *This is below the national average.*

13.4% of staff said they had been bullied or harassed by their colleagues. *This is below the national average.*

Quality of care

82.1% of staff say that care of patients and service users is the Trust's top priority. *This is above the national average.*

81.9% of staff say they are satisfied with the quality of care they give. *This is slightly below the national average.*

88.5% of staff say their role makes a difference to patients and service users. *This is slightly below the national average.*

68.7% of staff say they feel able to deliver the care they aspire to. *This is in line with the national average.*

Developing my potential

71.9% of staff feel happy with the opportunities they have to use their skills. *This is down fractionally from last year and slightly below the national average.*

A great place to work
NHS staff survey 2020

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Positive support to keep me fit and well

39.6% of staff think the Trust definitely takes positive action on **health and wellbeing.** *This is above the national average.*

66% of staff feel there are opportunities for **flexible working.** *This is in line with the national average and a 2% increase on last year.*

42.2% of staff say they have had time off work due to **work related stress.** *This is the same as last year and slightly below the national average.*

Working in a supportive team

75.4% of staff say they receive the **respect** they deserve **from colleagues.**

This is fractionally below the national average

74.9% of staff feel **supported by their manager.**

This is just below the national average.

65.7% of staff feel they have a choice in **deciding how to do their work.** *This is above the national average.*

My Voice Counts

77.3% of staff feel able to **make suggestions to improve the work of my team or department.**

This is an improvement on 2019 and just below the national average.

60.2% of staff feel able to **make improvements at work.**

Up from 57.1% last year.

75.1% of staff feel there are **frequent opportunities to show initiative.**

This is broadly in line with the national average.

With **all of us** in mind.

A great place to work
NHS Workforce Race Equality Standard (WRES)

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Implementing the WRES is a requirement for NHS providers. We are expected, and want to show progress against a number of indicators of workforce equality.

40% of BAME colleagues had experienced bullying, harassment and abuse from service users/members of the public in the last 12 months. This is down from 42% in 2019 and is 8% above the average.

26% of BAME colleagues had experienced bullying, harassment and abuse from colleagues in the last 12 months. This is up from 24% in 2019 and is 1% above the national average.

11% of BAME colleagues had experienced discrimination at work. This is very similar to the 2019 rate and compares to a national average of 15%.

76% of BAME colleagues feel the Trust provides equal opportunities for promotion and career progression. This is very similar to 2019 & above the 73% national average

Our WRES organisational development lead Cherill Watterston, and our health and wellbeing practitioner for our BAME workforce Charlene Sibanda will be working on what we need to do as a Trust to ensure we act on these results and that experiences for our staff are improved.

With **all of us** in mind.

A great place to work
Next steps

South West Yorkshire Partnership NHS Foundation Trust

The staff survey and WRES results give us an opportunity to learn about staff experiences and make improvements. Below are some of the actions planned or already taking place:

We will be working with our BDU and corporate teams to develop action plans which address the local findings of the NHS staff survey, linked to our workforce plan and the feedback from our staff insight sessions.

We are refreshing our bullying and harassment adviser scheme, and strengthening how they can work alongside our freedom to speak up guardians so that staff find it easier to raise issues and have their concerns addressed.

Our ‘Race Forward’ campaign aims to improve experiences for staff by reducing incidents of bullying and harassment and making our workplaces safer places to be. Keep an eye out on the intranet and Headlines for more info.

Reviewing our policies to ensure they support all staff; and further building on our work to ensure diverse and transparent recruitment, including diverse representation on recruitment panels.

Support to our staff networks – BAME, LGBT+, disability and carers

Working with our partners across the ICS’ on equality and diversity issues and development opportunities.

Support to BAME colleagues around coronavirus, including bespoke resources and films, wellbeing support, vaccine advice and ongoing risk assessments

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 phone line for general advice around coronavirus - **01924 316036** (Mon-Fri, 8am - 4pm) and a **coronavirus psychological support line**. You can all it on **07774 335800** (Mon to Fri 8am - 4pm)

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

West Yorkshire and Harrogate ICS' will be launching their staff health and wellbeing hub on 6 April. The new hub microsite contains a range of resources for individuals, leaders and teams to browse, as well as information about the new helpline (0808 1963833) and their counselling service.

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

You can also contact the national **#OurNHSPeople** phone line on 0300 131 7000 (7am – 11pm). There are online resources available https://people.nhs.uk/

With **all of us** in mind.

Coronavirus
What you can do to help

#allofusimprove and be outstanding

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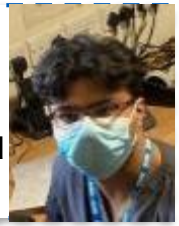
Please ensure you wear a mask when you need to, and follow the PPE rules for wherever you are. These may be different depending where you are so please check.



Continue to **wash your hands** and use hand sanitizer whenever you need to.

Make sure you follow **social distancing** rules at work and in your day to day life; and don't exceed the occupancy numbers shown on the doors in Trust buildings.

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

If you, or someone you are close to develops **symptoms** book a test. You can find details of how to get a test on the intranet.

Support your own health and wellbeing by taking **annual leave** and **socially distanced breaks** whenever you can.

And remember that the coronavirus vaccine will help to keep us all safe. If you haven't had one yet there is still time, and make sure you attend your second dose appointment.

With **all of us** in mind.

Take home messages

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Covid-19 pressures are real and still with us. We cannot be complacent.

Safety comes first, always. We are now at OPEL 2.

Always follow the rules for wherever you are, including wearing appropriate PPE.

Look out for second dose appointments, there is still time for a first jab, talk to others if you need to about how you feel about it.

Discuss the staff survey and WRES results in your teams and develop a plan on how to make things better.

Appraisals and supervision remain essential. Make sure you have yours.

Have your say and get involved in the Mental Health Act review.

Your health and wellbeing is our priority – use the support when you need it.

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 27 April 2021
Agenda item 8.1

Title:	**Board Assurance Framework (BAF) Quarter 4 – 2020/21**
Paper prepared by:	Director of Finance & Resources
Purpose:	For Trust Board to be assured that a system of control is in place with appropriate mechanisms to identify potential risks to the delivery of its strategic objectives.
Mission / values:	The BAF 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, strategic objectives and adhering to its values.
Any background papers / previously considered by:	Previous quarterly reports to Trust Board. Presentation and discussion at September Board strategy meeting Separate meeting in October to discuss and amend the draft strategic risks.
Executive summary:	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. The BAF is used by the Trust Board in the generation of the Trust Board agenda in the management of risk, and by the Chief Executive to support his mid and full 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** Following discussion at the Trust Board meeting in January 2021, it was agreed next steps include a review controls and assurances and target dates for actions.

	All comments raised have been recorded and considered. Where agreed, the BAF has been amended for these comments. In other instances, reference is made to the organisational risk register. Much thought and discussion has gone into the scoring of each risk by the Executive Management Team. At this point in time there are no recommended changes to assurance levels. Key areas of focus included: • Risk 1.1 – recognition that the intent of the White Paper is to make commissioning more consistent in each system. Currently this is in the early stages of planning for any transition, so there is some level of uncertainty. As such it is recommended the rating of amber remains • Risk 1.4 – recognition that uptake of digital solutions across our places has been lower than national averages. It is also recognised the use of digital technology could exacerbate exclusion and access to services if appropriate mitigations are not put in place • Risk 3.1 – whilst currently in a strong financial position the funding for H2 has not yet been confirmed for the NHS and it is considered likely that funding will reduce in H2 with a return to efficiency requirements • Risk 3.3 – constant focus on available resources and capacity, particularly in light of changes anticipated through the White Paper. A detailed consideration of resources required to meet current priority programme demand is being assessed by EMT in May • Risk 4.1 – the amber rating is driven by the availability of clinical workforce • Risk 4.3 – it is recognised we provide a strong health & wellbeing offer for staff. We also recognise our ambition is higher and that Covid-19 is having an impact on many members of staff There is an action to consider the results of the 2020 staff survey to inform any further assurances or gaps that are not currently highlighted in the BAF. Of the 14 strategic risks, four are attributed to the objective of 'improving health', four to the objective of 'improving care', three to the objective of 'improving resources' and three to the objective of 'make this a great place to work'. The BAF will continue to be reviewed and developed during 2021/22.
Recommendation:	**Trust Board is asked to APPROVE the updates to the Board Assurance Framework**
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

Strategic 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

Organisational level risk register, where the risk is outside the Trusts risk appetite, mitigated in accordance with Trust risk appetite statement. Summary reports into relevant Committees of the Board.

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 – 2021/22

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					
			2020/21		2021/22			
			Q3	Q4	Q1	Q2	Q3	Q4
Improve health	1.1 Changes to commissioning arrangements, an increasing role for each place and variations in local priorities could lead to service inequalities across the footprint.	8	A	A				
	1.2 Differences in how services are provided internally between different BDUs may result in unwarranted variation and therefore inequitable service offers across the Trust.	12	Y	Y				
	1.3 Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.	15	Y	Y				
	1.4 Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.	18	A	A				
Improve care	2.1 Lack of suitable and robust information systems backed by strong analysis leading to lack of high-quality management and clinical information.	21	Y	Y				
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.	23	G	G				
	2.3 Increased demand for services and acuity of service users exceeds supply and resources available leafing to a negative impact on quality of care.	25	A	A				
	2.4 Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.	27	Y	Y				
Improve resources	3.1 Changes to funding arrangements, increases in costs and failure to deliver efficiency and productivity improvements result in an unsustainable organisation and inability to provide services effectively.	30	Y	Y				
	3.2 Failure to develop relationships with commissioners and other key partners to improve services and respond to local needs.	32	G	G				
	3.3 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.	35	Y	Y				
Make this 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.	38	Y	A				
	4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively.	40	Y	Y				
	4.3 Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.	41	Y	Y				

Key:
Lead Directors: CEO = Chief Executive Officer, DFR = Director of Finance & Resources, DHR = Director of HR, OD & Estates, DNQ = Director of Nursing & 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

Strategic objective 1: Improve health	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 275, 773, 812, 1077, 1212, 1511, 1531	As noted below.	EMT, CGCS, MHA, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
			Y A	Y A				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
1.1	**Changes to commissioning arrangements, an increasing role for each place and variations in local priorities could lead to service inequalities across the footprint.**	A
1.2	**Differences in how services are provided internally between different BDUs may result in unwarranted variation and therefore inequitable service offers across the Trust.**	Y
1.3	**Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.**	Y
1.4	**Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.**	A

Rationale for current assurance level (strategic objective 1: improve health)
• 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. • Strong and robust partnership working with local partners, through integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield. • Partnering provider collaborative development in West Yorkshire and lead provider for forensic provider collaborative.

Rationale for current assurance level (strategic objective 1: improve health)
• Covid-19 pandemic has highlighted the disproportionate impact upon protected characteristics and specifically people with a learning disability and from the black, Asian, minority ethnic (BAME) community. Eight priority actions have been implemented through the Equality and Inclusion Committee. • A range of executive and board arrangements with trusts, commissioners 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. A similar approach is being developed in Kirklees. • Stakeholder engagement plans in place. • Integrated Performance Report (IPR) summary metrics regarding improving people's health and reducing inequalities – IPR Month 11: out of area beds – red, children and young people accommodated on an adult inpatient ward – one service user for a total of 6 days, seven 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, Policy Management Framework, Patient Safety significant assurance, Data Security & Protection Toolkit (DSPT) substantial 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. • Comprehensive creative and cultural offer through Creative Minds and recovery colleges in each of our places to diverse communities. • Compliance with the public sector equality duty. • Standard approach in place to develop an involvement plan which includes a requirement to review previous insight gathered. • Process and approach in place to support formal consultation which is used when required • Patient experience and engagement toolkit in place. • Trust website rated good on Accessible Information Standard. • Mandatory training in place for all staff on equality and diversity. • All services have a baseline Equality Impact Assessment (EIA) in place. • Deliver and report on compliance with Equality Delivery System (EDS2) annually.

Strategic objective 2: Improve care	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 852, 1078, 1080, 1132, 1159, 1319, 1424, 1523, 1527, 1530, 1567	As noted below.	EMT, CGCS, WRC, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
			Y	Y				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	Description	RAG rating
2.1	**Lack of suitable and robust information systems backed by strong analysis leading to lack of high-quality management and clinical information.**	Y
2.2	**Failure to create a learning environment leading to lack of innovation and to repeat incidents.**	G

2.3	**Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.**	**A**
2.4	**Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.**	**Y**

Rationale for current assurance level (strategic objective 2: improve care)
• 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. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • Care Quality Commission (CQC) assessment overall rating of good. • CQC conducted a well-led review in 2019 which contributed to the overall rating provided. • Internal audit reports – Governance & Risk, Policy Management Framework, Patient Safety Incidents – significant assurance, DSPT substantial assurance. • 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 and infection prevention and control response to Covid-19. • Data warehouse implementation original plan completed. Additional development in train. • 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 118 shows: Friends & Family (F&F) Test MH – green, F&F Test Community – green, safer staff fill rates – green, IG confidentiality breaches – red. • Programme of optimisation for SystmOne for mental health complete. • Testing and support for service users and staff in response to Covid-19. • Investment in IT and facility infrastructure. • Bed occupancy has been consistently high, particularly in adult acute, psychiatric intensive care units (PICU) and medium secure forensic services. • Development and implementation of Trust wide OPEL tool to ensure services remain responsive to levels of acuity.

Strategic objective 3: Improve resources	**Lead Director(s)**	**Monitoring and assurance**	**Overall assurance level**					
			2020/21		**2021/22**			
Links to ORR (risk ID numbers): 275, 522, 695, 1076, 1077, 1114, 1156, 1212, 1214, 1217, 1319, 1335, 1511, 1567	As noted below.	EMT, AC, WRC, Trust Board	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
			Y	**Y**				

Strategic risks – to be controlled, consequence of non-controlling and current assessment

Ref	**Description**	**RAG rating**
3.1	**Changes to funding arrangements, increases in costs and failure to deliver efficiency and productivity improvements result in an unsustainable organisation and inability to provide services effectively.**	**Y**
3.2	**Failure to develop relationships with commissioners and other key partners to improve services and respond to local needs.**	**G**
3.3	**Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.**	**Y**

Rationale for current assurance level (strategic objective 3: improve resources)
• 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 in 2019/20 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. • Mental health investment standard and other recent income growth. • Small surplus in 2019/20. Surplus in H2 2020/21. Break-even plan for H1 2021/22 • Current cash balance and cash management processes. • Positive well-led results following Care Quality Commission (CQC) review. • Capital investment prioritisation process. • Updated priority programmes for 2020-22 are aligned to strategic objectives. • Interim financial arrangements in place for H1 2021/22. • Current uncertainty with regard to the financial and contracting arrangements for 2021/22. • Partnership arrangements in each place. • Lead provider collaboratives for forensics, CAMHS and eating disorders in West Yorkshire. • Partnership arrangements at different stages of development in each of the places in which we provide services. • Development and implementation of Trust wide OPEL tool to ensure services remain responsive to levels of acuity.

Strategic objective 4: Make this a great place to work	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 905, 1151, 1153, 1154, 1157, 1158, 1432, 1522, 1524, 1525, 1526, 1533, 1536	As noted below.	EMT, WRC, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
			Y	Y				

Strategic risks – to be controlled, 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
4.2	**Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively.**	Y
4.3	**Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.**	Y

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Excellent uptake of staff flu and Covid-19 vaccinations • Vacancies in key areas – forensics and LD, including use of medical locums. • Staff turnover rates have reduced and comparable with other trusts in Yorkshire. • Staff sickness absence slightly lower than target on sickness and Covid-19 absence, but lower than majority of other trusts in Yorkshire. • Staff survey feedback average across the Trust, with some good areas and some hot spots.

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Robertson Cooper survey provides more granular information to inform local plans. • In the main, positive Friends and Family Test feedback from service users and staff. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • Care Quality Commission (CQC) visit overall rating of good. • 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, vaccinations, health and wellbeing offer and BAME taskforce and WRES OD lead. • A range of staff networks in place including BAME and LGBT+. • Appointment of full-time lead Freedom to Speak up Guardian

Strategic risk 1.1

Changes to commissioning arrangements, an increasing role for each place and variations in local priorities could lead to service inequalities across the footprint.

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	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)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire mental health, learning disability and autism collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	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)	DS	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C08	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	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. Targets paused during 2020/21, to return for 2021/22. *Temporarily on hold until financial and contracting arrangements are clear for 2021/22 onwards.* (I, E)	DO	1.1, 1.4, 3.3

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DS	1.1, 1.3, 2.3
C11	Governors' engagement and involvement on Members' Council and working groups, holding Non-Executive Directors (NEDs) to account. (I)	DFR	1.1
C12	Partnership Fora established with staff side organisations to facilitate necessary change. (I)	DHR	1.1
C13	Priority programmes supported through robust programme management approach. (I)	DS	1.1
C14	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)	DS	1.1, 1.2
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C16	Operational leadership structure in place to reflect the ICS boundaries (West and South) and focus on reducing unwarranted variation service wide. (E)	DO	1.1
C17	Member of South Yorkshire & Bassetlaw mental health, learning disability and autism programme board. Partner in emerging SYB provide alliance. (I, E)	DS	1.1, 1.4
C18	Meetings with Healthwatch organisations in each place. (E)	DS	1.1
C19	Process and approach in place to support formal consultation. (I, E)	DS	1.1
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality & Inclusion Committee. (E, I)	DS / DNQ / MD	1.1, 1.2, 1.3, 1.4
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	1.1, 1.2
C124	Enhanced internal monitoring arrangements put in each PLACE. Estates TAG receive quarterly updates. (P) (I)	DHR	1.1, 1,2, 1.3
C125	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established. (P, N) (I, E)	DHR, DS	1.1, 1.3, 1.4, 2.3
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, DO	1.1, 1.2, 1.4, 3.2

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). Increase in delayed transfers of care apparent during 2020/21.	To be reviewed by 30 June 2021	DO / DS
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)	To be reviewed by 30 June 2021	DS / DPD
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.*	April 2021	DO
Provider alliance / collaborative in South Yorkshire in development for mental health, learning disability and autism	March 2021	DS / DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Roles and views of primary care networks could differ by place and lead to inconsistent commissioning of services	To be reviewed by 30 June 2021	DS/DPD

Assurance (strategic risk 1.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A03	Care Quality Commission (CQC) registration in place and assurance provided that Trust complies with its registration.	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC. (P) (I)	DNQ	1.1
A06	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 scheduled for CG&CS Committee February 2021. (P) (I)	DNQ	1.1, 1.2, 1.3
A07	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)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	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)	DS	1.1, 1.2, 1.3, 2.3, 3.3
A10	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. (ORR 1212) 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)	DO	1.1, 1.2, 3.1, 3.2

Assurance (strategic risk 1.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A12	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. Quality monitoring visits are now being planned for 2021/22 with a report going to CG&CS Committee in February 2022. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	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) annual and 5-year plans (P, N) (I). Financial plan for second half of 20/21 approved by Trust Board in September (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Investment for 2020/21 agreed and provided by each commissioner. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A16	Update reports on WY and SY ICS progress.	Routine report into EMT and Board. (P) (I)	DS	1.1
A17	Reports from Barnsley, Calderdale, Kirklees and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	DS / DPD	1.1, 1.2
A19	Proactively involved as a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated (P) (I, E)	DPD / DS	1.1
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion dashboard. (P) (I)	DNQ	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**
Development of place-based arrangements have some differences by place and are operating at different timescales	April 2021	DS / DPD
Active member of place based / ICS integrated care governance arrangements in all areas. Potential legislative and structural changes in ICS April 2021.	To be reviewed by 30 June 2021	DS
The expectation is that when Covid-19 pandemic is over we will review previous plans and arrangements as part of recovery planning. It is unclear at this stage if this will be the case or if different approaches and requirements will emerge.	To be reviewed by 30 June 2021	DS
Current lack of clarity of commissioning arrangements from April 2022 onwards.	To be reviewed by 30 June 2021	DFR

Strategic risk 1.2 Differences in how services are provided internally between different BDUs may result in unwarranted variation and therefore inequitable service offers across the Trust.

Controls (strategic risk 1.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	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)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C14	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)	DS	1.1, 1.2
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality & Inclusion Committee. (E & I)	DS / DNQ / MD	1.1, 1.2, 1.3, 1.4
C21	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)	DNQ	1.2, 1.4, 2.3
C22	Operations management structure reflects an approach to ensuring consistent delivery of services. (I)	DO	1.2
C123	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives. (P, I)	CEO	1.1, 1.2
C124	Enhanced internal monitoring arrangements put in each PLACE. Estates TAG receive quarterly updates. (P) (I)	DHR	1.1, 1,2, 1.3
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, DO	1.1, 1.2, 1.4, 3.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A06	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 scheduled for CG&CS Committee February 2021. (P) (I)	DNQ	1.1, 1.2, 1.3
A07	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)	DS	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	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)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A10	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. (ORR 1212) 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)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, CG&CS and MC.	Annual unannounced and planned visits programme in place and annual report is now received directly by the CG&CS Committee. Quality monitoring visits are now being planned for 2021/22 with a report going to CG&CS Committee in February 2022. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	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)	DFR	1.1, 1.2, 3.1, 3.2, 3.3

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
		annual and 5-year plans (P, N) (I). Financial plan for second half of 2020/21 approved by Trust Board in September (E)		
A17	Reports from Barnsley, Calderdale, Kirklees and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	DFR	1.1, 1.2
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard.	DNQ	1.1, 1.2, 1.3, 1.4
A21	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. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	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)	DNQ	1.2, 2.2
A23	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)	DFR	1.2, 3.1, 3.2, 3.3
A24	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)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG) deviations identified, and remedial plans requested.	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I) CQUIN did not operate in 20/21 due to Covid-19.	DO	1.2, 3.1, 3.3
A26	New workforce and OD strategy in development in line with national people plan.	Update reports into EMT and Workforce & Remuneration Committee. (P) (I)	DHR	1.2

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**
Assessment of place-based plans in light of the impact of the NHS long term plan. Potential legislative and structural changes in ICS April 2021 to be in force by April 2022.	April 2021	DS
Board to board or exec to exec meeting in place with all partners as required. Potential legislative and structural changes in ICS April 2021.	To be reviewed by 30 June 2021	DS
The expectation is that when Covid-19 pandemic is over we will review previous plans and arrangements as part of recovery planning. It is unclear at this stage if this will be the case or if different approaches and requirements will emerge.	To be reviewed by 30 June 2021	DS

Strategic risk 1.3 **Lack of or ineffective communication and engagement with our communities, service users and carers could result in poor service delivery that does not meet the needs of the populations we serve.**

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DS	1.1, 1.3, 2.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C23	Strategic priorities and underpinning programmes supported through robust programme and change management approaches and in line with the Integrated Change Framework. (I)	DS	1.3
C24	All senior medical staff participate in a job planning process which reviews and restates priority areas of work for these senior clinical leaders. (I)	MD	1.3
C25	Participate in national benchmarking activity for mental and community health services and act on areas of significant variance. (I)	DFR	1.3
C26	Community reporting used as a tool to enable people to talk to members of their own community about their experience. (E)	DS	1.3, 1.4
C27	Governors supported to involve people at a locality level, Toolkit in place. (I, E)	DS	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DS	1.3, 1.4
C29	Process in place to demonstrate compliance with the public sector equality duty. (I)	DS	1.3
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality & Inclusion Committee. (I)	DS	1.3, 1.4
C31	JNA data reflected in all service EIAs. (I)	DS	1.3, 1.4
C32	JNA data used to identify involvement approaches. (I)	DS	1.3
C33	Service line equality data used to identify the existing target audience to ensure methods and approaches meet the needs of those audiences. (I)	DS	1.3
C34	Provision of information, leaflets, and posters which meet the Accessible Information Standard. (I)	DS	1.3
C35	Translation and interpretation service in place. (I)	DS	1.3
C124	Enhanced internal monitoring arrangements put in each PLACE. Estates TAG receive quarterly updates. (P) (I)	DHR	1.1, 1,2, 1.3
C125	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established. (P, N) (I, E)	DHR, DS	1.1, 1.3, 1.4, 2.3
C127	Place based / ICS communications lead networks in place. (P, I, E)	DS	1.3
C128	Senior level representation at Health & Wellbeing Boards in each place. (P, E)	DS	1.3
C129	Ongoing meetings with Healthwatch organisations in each place. (P, I, E)	DS	1.3

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C130	Working with partners such as Healthwatch, public sector colleagues and ICSs to collectively capture and share insight and intelligence and avoid duplication. (P, I, E,)	DS	1.3
C131	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes. (P, I)	DS	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 direct control and ensure engagement takes place in each area impacted, as well as using the Long-Term Plan, proposed changes to ICSs and relationships with groups of commissioners to ensure consistency. (Linked to ORR Risk ID 812).	To be reviewed by 30 June 2021	DS/DPD
Trust wide Equality Impact Assessment – develop a Trust wide Equality Impact Assessment and intelligence data base to support planning. The Trust wide EIA is progressing well with a completion date for the end of April and upload to the internet in May 2021. The database will include research and literature for each protected group, a prepopulated template of all common impacts that the Trust should routinely address for each group and additional links to further reading and insight. There will also be links to the newly developed business intelligence tool and local area JNA data to support completion.	May 2021	DS

Assurance (strategic risk 1.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A06	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 scheduled for CG&CS Committee February 2021. (P) (I)	DNQ	1.1, 1.2, 1.3
A07	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)	DS	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	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)	EMT	1.1, 1.2, 1.3, 2.3, 3.3

Assurance (strategic risk 1.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A20	Reports to Equality & Inclusion and Mental Health Act Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard.	DNQ	1.1, 1.2, 1.3, 1.4
A21	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. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A32	Trust website rated as good on Accessible Information Standard.	? P, I, E	DS	1.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
It is unclear at this stage of the full extent of the l impact of Covid-19 on different populations. 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.	To be reviewed by 30 June 2021	DO
Use of data and informatics could be more comprehensive to support engagement and service delivery. Health Intelligence and Insight Group established to consider the data and insight. The current gap is the full and comprehensive use of data to inform service change.	To be reviewed by 30 June 2021	DPD

Strategic risk 1.4

Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	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)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire mental health collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	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)	DS	1.1, 1.4, 2.3

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C08	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	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. Targets paused during 2020/21, to return for 2021/22. *Temporarily on hold until financial and contracting arrangements are clear for 2021/22 onwards.* (I, E)	DO	1.1, 1.4, 3.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C17	Member of South Yorkshire & Bassetlaw mental health, learning disability and autism programme board. Partner in emerging SYB provide alliance. (I, E)	/DS	1.1, 1.4
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality & Inclusion Committee. (E & I)	DS / DNQ / MD	1.1, 1.2, 1.3, 1.4
C21	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)	DNQ	1.2, 1.4, 2.3
C26	Community reporting used as a tool to enable people to talk to members of their own community about their experience. (E)	DS	1.3, 1.4
C27	Governors supported to involve people at a locality level, toolkit in place. (I, E)	DS	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DS	1.3, 1.4
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality & Inclusion Committee. (I)	DS	1.3, 1.4
C31	JNA data reflected in all service EIAs. (I)	DS	1.3, 1.4
C36	Recovery group and Health Intelligence and Insight Group – to ensure we restore services inclusively locking in innovation. (I)	DS / DPD / DO	1.4
C37	Equality & Inclusion Committee and task force in place. (I)	DS	1.4
C38	Trust website rated good on Accessible Information Standard. (I)	DS	1.4
C39	Translation and interpretation service in place. (I)	DS	1.4
C40	Photo symbol package available to staff. (I)	DS	1.4
C41	Patient experience and engagement toolkit in place. (I)	DS	1.4
C125	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established. (P, N) (I, E)	DHR, DS	1.1, 1.3, 1.4, 2.3
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, DO	1.1, 1.2, 1.4, 3.2

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Some services experience inequality of access and this is being addressed through actions identified in the Equality, Involvement, Communication and Membership strategy action plan.	To be reviewed by 30 June 2021	DS / DNQ

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Equality data collection requires improvement. Campaign and behaviour change programme to be undertaken. The behaviour campaign will be shared with EMT for sign up in April and a soft launch will take place in May with further work to develop resources for specific groups will take place with target audiences of staff which will include staff networks and staff side.	To be reviewed by 30 June 2021	DS

Assurance (strategic risk 1.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A07	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)	DS	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meeting between Chief Executive and Directors. (P) (I)	CEO	All
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard. (P, N), (I)	DNQ	1.1, 1.2, 1.3, 1.4
A24	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)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A33	Customer service reports to Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P, N) (I)	DNQ	1.4, 2.3
A34	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)	DNQ	1.4, 2.3
A35	Equality dashboard presented to Equality & Inclusion Committee.	Regular reports and papers provided. (P) (I)	DS	1.4
A36	All services have a baseline Equality Impact Assessment (EIA) in place.	Monitoring processes (P), (, I),	DS	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
Collate learning and insight from engagement surveys with feedback to identify themes. Continue capturing learning from engagement service and ensure that insight is used within internal processes.	To be reviewed by 30 June 2021	DS
More granular level of reporting required of access to our services by protected characteristic compared to the demographics of the communities.	April 2021	DFR

Strategic risk 2.1
Lack of suitable and robust information systems backed by strong analysis leading to lack of high-quality management and clinical information.

Controls (strategic risk 2.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C42	Access to the model hospital to enable effective national benchmarking and support decision making. (I)	DFR	2.1
C43	Development of data warehouse and business intelligence tool supporting improved decision making. (I)	DFR	2.1
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report to Trust Board. (I)	DFR	2.1
C45	Risk assessment and action plan for data quality assurance in place. (I)	DFR	2.1
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	DNQ / MD	2.1, 2.3, 4.1
C48	Improving Clinical Information & Information Governance Group (ICIG) reviews clinical information systems and data quality. (I)	DNQ / DFR	2.1
C49	Internal process to impact assess / review potential new systems from a technical and information governance (IG) standpoint. (I)	DFR	2.1
C50	Change control process in place for operational / service level requests / changes, for system-wide changes and developments. (I)	DFR	2.1
C51	National benchmarking data is reviewed and analysed and taken to OMG, EMT and Finance, Investment & Performance Committee. (I)	DFR	2.1
C132	Trust health intelligence and insight group. Meets monthly – feeds into recovery planning group. (I)	DPD	2.1

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Inconsistent use of reports generated using the data warehouse tool. *Comprehensive data sets and dashboard in place. Awareness and training in use under development*	30 June 2021	DFR
Limited data on caseload, real time waiting list issues, face to face time. *Business Intelligence Group established as part of reset and restoration of services.*	30 June 2021	DPD
Use of benchmarking information not fully embedded in the Trust.	30 June 2021	DFR / DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Impact of Covid-19 has been to re-focus information requirement priorities and will potentially result in less directly comparable information year on year.	30 June 2021	DFR

Assurance (strategic risk 2.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A37	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)	DNQ	2.1
A38	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)	DS	2.1
A39	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)	DFR	2.1
A40	Data quality focus at OMG and ICIG.	Regular agenda items and reporting of at ICIG and OMG. (P, N) (I)	DNQ	2.1
A41	Benchmarking reviews and deep dives conducted at Board Committees.	Reports provided regularly. (P) (I)	DNQ / DFR	2.1
A42	BDU and OMG performance management processes.	OMG notes taken into EMT, summary of finance and performance reviews into EMT monthly. (I)	DO	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
Completeness and accuracy of data is highlighted as an issue with some metrics.	30 June 2021	DFR
Level of granularity to enable effective reporting on inequalities needs to increase. *Focus being applied to what changes to reporting need to take place to report on progress against the eight urgent actions to address inequalities.*	30 June 2021	DFR
Process for reviewing internal benchmarking data is not applied consistently or fully embedded across the Trust.	30 June 2021	DNQ / DFR
Visibility of information to a wider audience to improve understanding is required.	30 June 2021	DNQ / DFR

Strategic risk 2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.

Controls (strategic risk 2.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	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)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C52	Customer services reporting includes learning from complaints and concerns. (I)	DNQ	2.2, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1
C55	Quality Strategy achieving balance between assurance and improvement. (I)	DNQ	2.2
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C57	Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services. (I)	DO	2.2, 4.1
C58	Learning lessons reports, BDUs, post incident reviews. (I)	DNQ	2.2
C59	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training. (I)	DFR	2.2
C60	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)	DNQ	2.2
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate and improve. (I)	DS	2.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DS	2.2

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Monitoring of closure and evidence challenge of action plans linked to serious incident (SI) reports.	30 June 2021	DNQ
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.	April 2021	DNQ
Develop use of improvement case studies. Process established. Further developments to embed and effectively share	To be reviewed by 30 June 2021	DS
Covid-19 has introduced a range of new ways of working including further use of digital technology. There is an ongoing process to identify and evaluate the learning.	To be reviewed by 30 June 2021	DS
In the last 12 months there has been pausing, suspending, and converting face-to-face staff training to digital. The step down and emergent step up process was managed via Silver Command and EMT. A training room risk assessment process and training risk assessment process have been developed to aid staff safety. A risk managed approach has been taken from mandatory training. In March 2020, with the support of NHS Employers, The Trust extended renewal dates for staff by 12 months for all mandatory training subjects, and 6 months for fire and food safety, which provided space for services where capacity was impacted by Covid-19. A review is taking place of emerging	To be reviewed by 30 June 2021	DHR

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
developments that we need to consider as part of our roadmap to recovery delivering a blend of face-to-face training and digital delivery which requires changes in our estate and IM&T support.		

Assurance (strategic risk 2.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A21	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. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	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)	DNQ	1.2, 2.2
A44	Weekly risk scan update into EMT.	Weekly risk scan update into EMT. (P, N) (I)	DNQ	2.2
A45	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)	DNQ	2.2
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P) (I)	DS	2.2, 4.1
A47	Examples of co-production in recovery colleges and Creative Minds	(P, I) Reports to CFC and to CTCF. Creative Minds produce reports that go to CFC and recovery colleges report into OMG.	DS	2.2
A48	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. (P) (I)	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) Increase in IG breaches since the onset of Covid-19 and associated ways of working. Updated communication & awareness plan is in progress.	June 2021	DFR
Although opportunistic work has taken place on the inpatient strategy improvement plan, this is on hold given the work required to manage the Covid-19 response. To agree new date by April 2021.	Review by April 2021	DO

Strategic risk 2.3

Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	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)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C04	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)	DS	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DS	1.1, 1.3, 2.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C21	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)	DNQ	1.2, 1.4, 2.3
C47	Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	DNQ / MD	2.1, 2.3, 4.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C63	Care Closer to Home Partnership Meeting and governance process. (I)	DO	2.3
C64	Care closer to home priority programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	DO	2.3
C65	Safer staffing policies and procedures in place to respond to changes in need. (I)	DNQ	2.3
C66	TRIO management system monitoring quality, performance and activity on a routine basis. (I)	DO	2.3
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	DO	2.3
C68	Targeted improvement support in place to deliver waiting list management improvement plans to support people awaiting a service / treatment. (I) (ORR 1078, 1132)	DO	2.3

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C69	Process to manage the CQC action plan. (I)	DNQ	2.3
C125	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established. (P, N) (I, E)	DHR, DS	1.1, 1.3, 1.4, 2.3
C134	Workforce bronze group established. This is to be reviewed in line with changes to the command structure, but the workforce group will be retained and linked into operational management arrangements. (P, I)	DHR	2.3, 3.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

Assurance (strategic risk 2.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A07	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)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	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)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, CG&CS and MC.	Annual unannounced and planned visits programme in place and annual report is now received directly by the CG&CS Committee. Quality monitoring visits are now being planned for 2021/22 with a report going to CG&CS Committee in February 2022. (P, N) (E	DNQ	1.1, 1.2, 2.3

Assurance (strategic risk 2.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A33	Customer service reports to Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P, N) (I)	DNQ	1.4, 2.3
A34	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)	DNQ	1.4, 2.3
A49	CQC self-assessment process.	Reviewed by EMT as part of preparation for CQC inspection process. (I)	DNQ	2.3
A50	Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care.	Unannounced visits as scheduled by Health Watch. (E)	DNQ	2.3
A51	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)	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**
The Care Closer to Home work continues, with progress noted 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 Trust wide. Thus, acuity and turnover has increased, adding significant pressure to the delivery system on inpatient wards. 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. (ORR 1319) date to be agreed by April 2021.	April 2021	DO
Impact of waiting list in CAMHS services. Improvements have been sustained throughout Covid-19 phase. Specific demand for ADHD.ASD in Calderdale and Kirklees exceeds capacity. Resources have recently been agreed with commissioners to improve the position. Until the impact of additional resources is seen, the gap in assurance remains. This is monitored through the CAMHS improvement group.	To be reviewed by 30 June 2021	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 June 2021.	To be reviewed by 30 June 2021	DS

Strategic risk 2.4

Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.

Controls (strategic risk 2.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C70	Anti-virus, encryption and security systems in place for IT devices, servers and networks. (Links to ORR 1080) (I)	DFR	2.4

Controls (strategic risk 2.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C71	Annual infrastructure, server and client penetration test (E)	DFR	2.4
C72	Data protection policies and business continuity plans in place. (I)	DFR	2.4
C73	Data Security and Protection Toolkit compliance process (I, E)	DFR	2.4
C74	Weekly fire risk scans and any issues escalated in line with the policies in place. (Linked to ORR 1159) (I)	DHR	2.4
C75	Trust smoking policies. (I)	DO	2.4
C76	Use of sprinklers and other fire suppressant systems within our estate. (I)	DHR	2.4
C77	Staff training. (I)	DHR	2.4
C78	Capital prioritisation process to ensure funds are allocated to support IT security and safety of estate. (I)	DFR	2.4

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Not all the estate we use have sprinklers in place. Roll out system based on risk assessment for existing estate. All new buildings have sprinkler systems	To be reviewed by 30 June 2021	DHR

Assurance (strategic risk 2.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A52	Annual report on compliance with Data Security and Protection Toolkit	Report to Improving Clinical Information & Information Governance Group, Audit Committee and Trust Board	DFR	2.4
A53	Monthly / quarterly reports on fire / operational fire / unwanted fire activation.	Fire Safety Advisor produces reports with review by EFM senior managers and Estates TAG.	DHR	2.4
A54	Twice yearly reports on actions to maintain and promote cyber security to the Audit Committee.	Latest report to the January 2021 Audit Committee.	DFR	2.4
A55	Regular reports on health & safety to Clinical Governance & Clinical Safety Committee and annual report to Trust Board.	Reported periodically to CGCS and annually to Trust Board (P) (I)	DFR	2.4
A56	Cyber awareness tested with staff by means of a survey and phishing exercise.	Internal audit report provided in 2019. (P, N) (I)	DFR	2.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Phishing exercise demonstrated incomplete awareness and some gaps in understanding. Regular communications and awareness raising taking place.	30 June 2021	DFR
Cyber audits and penetration testing have highlighted some areas for improvements. Formal action plan in place to address.	July 2021	DFR
Actions identified from internal and independent inspections & audits have resulted in formal action plans to address identified gaps.	July 2021	DFR / DHR

Strategic risk 3.1

Changes to funding arrangements, increases in costs and failure to deliver efficiency and productivity improvements result in an unsustainable organisation and inability to provide services effectively.

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C79	Finance managers aligned to Business Delivery Units (BDUs) acting as integral part of local management teams. (I)	DFR	3.1
C80	Standardised process in place for producing business cases supporting full benefits realisation. (I)	DFR	3.1
C81	Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	DFR	3.1
C82	Annual financial planning process, cost improvement programmes (CIP) and Quality Impact Assessment (QIA) process. (I)	DFR, DNQ	3.1
C83	Financial control and financial reporting processes. (I)	DFR	3.1
C84	Regular financial reviews at Executive Management Team (EMT). (I)	DFR	3.1
C85	Service line reporting / service line management approach. (I)	DFR	3.1
C86	Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	DO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DS	3.1, 3.2

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).	30 June 2021	DFR

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Risk of inability to achieve priorities identified in our plan (Linked to ORR Risk ID 695, 1114).	To be reviewed by 30 June 2021	DS/DHR
Trust has a history of not fully achieving its recurrent CIP targets (Linked to ORR Risk ID 1076). *CIP delivery not required in 20/21 given the Covid-19 pandemic*	Annual target to be reviewed by 30 September 2021	DFR / DO
Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource (Linked to ORR Risk ID 275).	To be reviewed by 30 June 2021	DO
Recurrent impact of Covid-19 on underlying cost structure and financial sustainability plan not fully clear.	September 2021	DFR

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	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)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A10	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. (ORR 1212) 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)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	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) annual and 5-year plans (P, N) (I). Financial plan for first half of 21/22 to be approved by Trust Board in May (I)	DFR	1.1, 1.2, 3.1, 3.2, 3.3

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A14	Mental Health Investment Standard income and reporting of performance.	Investment for 2020/21 agreed and provided by each commissioner. (P) (I) (E). Investments for 21/22 agreed in principle	DFR	1.1, 3.1, 3.2
A21	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. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	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)	DFR	1.2, 3.1, 3.2, 3.3
A24	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)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG) deviations identified, and remedial plans requested.	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I)	DO	1.2, 3.1, 3.3
A58	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 and Finance, Investment & Performance Committee. (P, N) (I)	DO	3.1, 3.3
A59	Temporary financial arrangements in place for 2021/22.	Financial plan for first half of 21/22 to be approved by Trust Board in May (P) (I)	DFR	3.1

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Variable spend on out of area bed placements and an overspend against income received. *Ongoing – Programme board in place implementing improved bed management processes.* (ORR 1319)	30 June 2021	DO
Increasing expenditure on staffing in inpatient wards with spend higher than income. Ongoing raising of this issue during contract negotiations.	30 August 2021	DFR
Cash position is largely dependent on us delivering a surplus. Cash balance of circa £56m at the 2020/21 year-end.	30 June 2021	DFR
Financial plan for H2 2021/22 not yet developed. Timescale dependent on planning guidance availability	September 2021	DFR
Recurrent position is a deficit in excess of circa £4m *Ongoing - Financial sustainability work is focusing on recurrent improvement opportunities.* *Focus on the financial sustainability plan has been temporarily reduced to ensure there is clear focus on the Trust response to Covid-19.*	30 June 2021	DFR
Financial arrangements for 2021/22 and recurrent cost base given the impact of Covid-19 are not yet fully known.	September 2021	DFR

Strategic risk 3.2 Failure to develop relationships with commissioners and other key partners to improve services and respond to local needs.

Controls (strategic risk 3.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C08	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C88	Clear strategy in place for each service and place to provide direction for service development. (I)	DS	3.2
C89	Forums in place with commissioners to monitor performance and identify service development. (I, E)	DO	3.2
C90	Independent survey of stakeholders' perceptions of the organisation and resulting action plans. (I, E)	DS	3.2
C91	Strategic Business and Risk Report including PESTEL / SWOT and threat of new entrants / substitution, partner / buyer power. (I)	DS	3.2
C92	Quality Impact Assessment (QIA) process in place. (I)	DNQ	3.2
C93	Partnership agreements in place or being developed in the systems in which we provide services. (I, E)	DS / DPD	3.2
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, DO	1.1, 1.2, 1.4, 3.2
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DS	3.1, 3.2

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.	30 December 2021	DFR/DS
Tendering activity taking place. (Linked to ORR Risk ID 1214). Partnership and collaborative arrangements in each place being used to minimise this wherever possible.	30 June 2021	DFR

Assurance (strategic risk 3.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All

Assurance (strategic risk 3.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A07	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)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A10	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. (ORR 1212) 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)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	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) annual and 5-year plans (P, N) (I). Financial plan for first half of 21/22 to be approved by Trust Board in May (P)(I)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Investment for 2020/21 agreed and provided by each commissioner. (P) (I) (E). Investment for 21/22 agreed in principle	DFR	1.1, 3.1, 3.2
A23	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)	DFR	1.2, 3.1, 3.2, 3.3
A24	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)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A60	Current contracts reflect growth in line with mental health investment standard as well as some specific service pressures.	Funding for 2020/21 includes investment in line with the mental health investment standard. Investment for 21/22 agreed in principle (P) (I, E)	DFR	3.2
A61	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)	DO	3.2
A62	Documented update of progress made against Equality, Involvement, Communication and Membership Strategy.	Monthly IPR to Executive Management Team (EMT) and Trust Board. Quarterly report to EIC. (P, N) (I)	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
Assessment of place-based plans within the Integrated Care Systems. Potential legislative and structural changes in ICS April 2021.	To be reviewed by 30 June 2021	DS / DPD

Strategic risk 3.3
Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C09	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. Targets paused during 2020/21, to return for 2021/22. *Temporarily on hold until financial and contracting arrangements are clear for 2021/22 onwards.* (I, E)	DO	1.1, 1.4, 3.3
C86	Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	DO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C94	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)	DHR	3.3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DS	3.3
C97	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)	DS	3.3
C98	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)	DFR	3.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2020-22 priorities. (P), (I)	DS	3.3
C100	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)	DS	3.3
C134	Workforce bronze group established. This is to be reviewed in line with changes to the command structure, but the workforce group will be retained and linked into operational management arrangements. (P, I)	DHR	2.3, 3.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

Assurance (strategic risk 3.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A09	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)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	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) annual and 5-year plans (P, N) (I). Financial plan for first half of 21/22 to be approved by Trust Board in May (P)(I)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A21	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. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	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)	DFR	1.2, 3.1, 3.2, 3.3
A24	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)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG) deviations identified, and remedial plans requested.	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I)	DO	1.2, 3.1, 3.3
A58	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 and Finance, Investment & Performance Committee. (P, N) (I)	DO	3.1, 3.3

Assurance (strategic risk 3.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A63	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)	DS	3.3
A64	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)	DS	3.3
A65	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)	DS	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**
Assessment of place-based plans within the Integrated Care Systems and potential legislative and structural changes in ICS April 2021 to include understanding of capacity required for implementation and any implications this has on capacity overall.	To be reviewed by 30 June 2021	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.*	To be reviewed by 30 June 2021	DS

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)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	DNQ / MD	2.1, 2.3, 4.1
C52	Customer services reporting includes learning from complaints and concerns. (I)	DNQ	2.2, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1

Controls (strategic risk 4.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C57	Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services. (I)	DO	2.2, 4.1
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	DHR	4.1, 4.2
C102	Annual learning needs analysis undertaken linked to service and financial meeting. (I)	DHR	4.1
C103	Education and training governance group established to agree and monitor annual training plans. (I)	DHR	4.1, 4.2
C104	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)	DHR	4.1
C105	Mandatory clinical supervision and training standards set and monitored for service lines. (I)	DHR	4.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	MD	4.1
C107	Revising Organisational Development plan to support objectives “the how” in place with underpinning delivery plan, strategic priorities and underpinning programmes supported through robust programme management approach. (I)	DHR	4.1
C108	Recruitment and Retention action plan agreed by EMT. (I)	DHR	4.1
C109	Recruitment and Retention Task Group established. (I)	DHR	4.1
C110	Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs). (I)	DHR	4.1, 4.3
C111	Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures. (I)	DHR	4.1
C112	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements regarding training, equality and diversity. (I)	DHR	4.1
C113	Regular meetings established with Sheffield and Huddersfield University to discuss undergraduate and post graduate programmes. (E)	DHR / DNQ	4.1
C114	New appraisal process to discuss individuals’ intentions regarding future career development with a view to maximise opportunities within the Trust and promote staff retention. (I)	DHR	4.1
C135	Work ongoing around international recruitment and the development of new roles as part of increasing workforce supply	DHR	4.1

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Supply of labour for new roles and services not yet fully clear	To be reviewed by 30 June 2021	DHR

Assurance (strategic risk 4.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P) (I)	DS	2.2, 4.1
A66	Annual Mandatory Training report goes to CG&CS Committee.	CG&CS Committee receive annual report (P) (I)	DHR	4.1
A67	Appraisal uptake included in IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	DHR	4.1
A68	ESR competency framework for all clinical posts.	Monitored through mandatory training report. (P) (I)	DHR	4.1
A69	Mandatory training compliance is part of the IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	DHR	4.1
A70	Recruitment and Retention performance dashboard.	Quarterly report to the Workforce and Remuneration Committee. (P, N) (I)	DHR	4.1
A71	Safer staffing reports included in IPR and reported to CG&CS Committee. (ORR 905, 1158)	Monthly IPR goes to the Trust Board and EMT six monthly report to Trust Board. (P)	DNQ	4.1
A72	Workforce Strategy performance dashboard.	Quarterly report to the WRC Committee. (P) (I)	DHR	4.1
A73	Annual appraisal, objective setting and PDP timelines now set for 2021/22.	Included as part of the IPR to EMT and Trust Board. (P) (I)	DHR	4.1, 4.3
A74	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)	DHR	4.1, 4.3

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**
Report to Workforce and Remuneration Committee on reasons for leaving extracted from exit interviews. *WRC now receives a regular report on recruitment & retention including exit interviews*	June 2021	DHR
Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR ID 1151). Work ongoing around international recruitment and the development of new roles as part of increasing workforce supply	To be reviewed by 30 June 2021	DHR

Strategic risk 4.2	

Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively.	

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	DHR	4.1, 4.2
C103	Education and training governance group established to agree and monitor annual training plans. (I)	DHR	4.1, 4.2
C115	Appointment of WRES OD lead and BAME talent pool established as part of the Trust's overall leadership and management development arrangements. (I)	DHR	4.2
C136	ILDBO Trust Board development programme on inequalities	DHR	4.2

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Great place to work programme on hold due to Covid-19 pandemic.	To be reviewed by 30 June 2021	DHR

Assurance (strategic risk 4.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A75	HR exception report.	Report received by WRC bi-monthly. (P) (I)	DHR	4.2

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

Strategic risk 4.3 Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.

Controls (strategic risk 4.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed, and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C110	Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs). (I)	DHR	4.1, 4.3
C116	Provision of appropriate personal protective equipment (PPE) in line with national guidance. (I)	DNQ	4.3
C117	Access to wellbeing apps. (I)	DHR	4.3
C118	Occupational Health Service operating extended hours, coronavirus psychological support line for staff operative seven days a week. (I)	DHR	4.3
C119	Workforce Support Hub established. (I)	DHR	4.3
C120	Established Covid-19 vaccination bronze command meeting to focus on staff vaccination. (I)	DHR	4.3
C121	Flu vaccination programme for all staff within the Trust with clear targets. (I)	DHR	4.3
C122	Lateral flow Covid-19 testing for staff to protect staff and service users. (I)	DNQ	4.3
C137	Covid-19 vaccination programme for all staff within the Trust	DHR	4.3

Gaps in control – what do we need to do to address these and by when?	Date	Director lead

Assurance (strategic risk 4.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	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)	DFR	All
A02	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)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All

Assurance (strategic risk 4.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A73	Annual appraisal, objective setting and PDPs extended to May, June, July 2021 due to the Covid-19 pandemic.	Included as part of the IPR to EMT and Trust Board. (P) (I)	DHR	4.1, 4.3
A74	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)	DHR	4.1, 4.3
A76	Routine scan of national guidance as part of horizon scanning in command structure.	Discussed weekly as part of command structure. (E)	DNQ / DHR	4.3
A77	Review of support to staff / staffing levels through command structure.	Discussed weekly as part of command structure. (I)	DHR	4.3
A78	Review of workforce information by the Workforce & Remuneration Committee and Trust Board.	Reported to Trust Board through IPR. (I)	DHR	4.3

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**
Development around the impact of long Covid-19.	To be reviewed by 30 June 2021	DHR

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 8.2

Title:	**Corporate / Organisational Risk Register Quarter 4 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 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** **Improve health** | **Improve care** **Improve resources** | **Making SWYPFT a great place to work** The risks 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 Board is asked to note that the Trust's Risk Appetite Statement will be reviewed in September 2021. The Covid-19 pandemic has resulted in a change in emphasis in some risks and the addition of 13 Covid-19 related risks (one of which is within risk appetite). The full organisational risk register, including the Covid-19 related risks, are reviewed on a regular basis by EMT.

This report provides a full update on the organisational risk register since the previous quarterly report in January 2021.

The following **new risks** have been added in the last quarter:

	Risk ID	Description
	1611	Organisational and local policies and procedures do not keep pace with Covid-19 vaccination requirements, which could lead to gaps in practice that result in an adverse impact on staff and patient safety.
	1585	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.
	1612	Lower uptake of the Covid-19 vaccination by those staff identified as more at risk could lead to a disproportionate risk of infection across the Trust workforce, service users, patients and carers.
	1613	Insufficient numbers of staff receive the Covid-19 vaccination leading to an increased risk of infection across the Trust workforce, service users, patients and carers.
	1614	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.
	1615	Non-delivery of the actions identified to make SWYPFT a Great Place to Work leading to higher turnover of staff, increased absence, lower quality of care and resistance to change and innovation.

The Workforce and Remuneration Committee will consider the new and existing workforce risks to determine if the existing risks should remain on the register or are superseded by the new risks.

The following risks have been **merged**:

	Risk ID	Description	Rationale
	1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	The risks have been merged under risk ID 1154 under the following description: Risk of the loss of staff due to their health and wellbeing being adversely effected by the impact of increased service pressures and the longer term effects of the coronavirus on them and their families and therefore reducing the ability to provide safe and effective services. Risk ID 1526 has been removed from the risk register.
	1526	Risk that staff health and wellbeing is adversely affected by the impact of coronavirus on service users, their families and themselves.	

The following risks have been **recommended for closure**:

	Risk ID	Description	Rationale
	1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases the risk of redundancy	Risk discussed and recommended for closure by WRC with the following comments – the development of stronger place based working and the ICS has meant the likelihood of

			decommissioning at short notice has significantly reduced and is considered rate. This would give a risk level of 2.
	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.	Risk discussed and recommended for closure by WRC with the following comments – the arrangements at place and in the ICS together with the likely changes with the establishment of the ICS as a statutory body, the abolition of CCGs and duty of collaboration means tendering activity and likelihood have reduced to 2 and 1 respectively, giving a risk level of 2.
	1521	Risk that staff do not have appropriate IT equipment and access to facilitate home working during the Covid-19 pandemic meaning staff are unable to work effectively or provide appropriate clinical contact and key activities not delivered.	Risk discussed and recommended for closure by AC with the following comments – staff have appropriate equipment and access. The issue in future could be one in terms of managing expectations given the recurrent costs associated with the additional equipment and systems we have provided over the past year.

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) that cannot be met.

The following changes have been made to the ORR since the last Board report in January 2021:

Risks 15+

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Controls and actions updated	Controls updated to include introduction of Microsoft AppLocker. Actions updated to include amendment of Lightweight Directory Access Protocol, remediation plans from testing, MS Teams controls review and backup solution being enhanced.
	1530	Risk that Covid-19 leads to a significant increase in demand for our services (as anxiety	Controls and actions updated	Controls updated to include contribution to stress testing through the ICS and place based planning.

		and mental health issues increases in our populations) that cannot be met.		Actions updated to include review of increased demand through restoration and recovery priority programme.

Risks below 15 (outside risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	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.	Controls and actions updated	Controls updated to include financial due diligence, internal audit report, shadowing of NHSE systems and learning from other provider collaboratives. Actions updated to reflect further due diligence required, clinical oversight of plans, requests to NHSE/I for baseline income and delayed 'go live'.
	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	Controls updated to include monitoring of staffing levels and risk panel monitoring newly qualified nurses undergoing preceptorship asked to take charge of a shift and BDU meetings review of safer staffing. Actions updated to include established vaccination programme, safecare tool rollout and use of overtime.
	1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	Actions updated	Actions updated to include resources agreed in Kirklees to address ADHD / ASD waits.
	1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	Controls and actions updated	Controls updated to include monitoring of waiting lists and associated actions through CG&CS. Action timescales updated.
	1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	Actions updated	Actions updated to include rollout of sprinkler system and completion of fire risk assessments. Lead director changed to Director of HR, OD and Estates.
	1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention	Controls and actions updated	Minor amendments to wording of controls. Action timescales updated.

		• Restraint reduction • Covid-19		
	1568	Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.	Controls and actions updated	Controls updated to include review of seclusion facilities and a set of standards in place for seclusion. Actions updated to include the next phase of the seclusion review.
	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	Actions updated	Actions updated to include assessment of Q1 funding and financial arrangements and plans for 2021/22.
	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.	Controls and actions updated	Controls updated to include controls agreed to safeguard personal data used in the vaccination and lateral flow testing programmes. Action timescales updated.
	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.	Controls updated	Controls updated to include use of national / internal benchmarking.
	1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	Controls updated	Controls updated to include use of national / internal benchmarking, actions updated to include assessment of 2021/22 financial arrangements.
	1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to the impact of the pandemic on staff wellbeing, an ageing workforce and competition from other NHS and private sector employees.	Risk descripti-on updated	
	1158	Risk of not having a flexible workforce leading to an over reliance on bank and agency staff which	Risk descripti-on updated	

		could impact on quality and / or finances.		
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	Controls updated	Controls updated to include temporary contracting arrangements for first half of 2021/22.
	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.	Actions updated	Minor amendments to wording of actions.
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	Controls and actions updated	Controls updated to include Actions updated to include temporary contracting arrangements for first half of 2021/22, actions updated to include contract negotiation process.
	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 quality of care being compromised.	Risk description, score, controls and actions updated	Risk description updated to include potential compromise to quality of care. Risk likelihood increase from '2 unlikely' to '3 possible' increasing the risk score from 8 to 12 due to increased demand. Controls updated to include system-wide meetings to review demand and take action to address. Actions updated to include recent increase in demand escalated to commissioners and establishment of care collaborative board with LYPFT to monitor the new inpatient facility.
	1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	Actions updated	Actions updated to include establishment of work group to look at development of new clinical roles.
	1154	Risk of the loss of staff due to their health and wellbeing being adversely effected by the impact of increased service pressures and the longer term effects of the coronavirus on	Risk merged. Risk description, score and actions updated	Risk merged with risk ID 1526. Risk likelihood increased from '3 possible' to '4 likely' increasing the risk score from 9 to 12. Actions updated to include roll out of staff vaccination programme.

		them and their families and therefore reducing the ability to provide safe and effective services.		
	1157	Risk that the Trust does not have a diverse and representative workforce which reflects all protected characteristics to enable it to deliver services which the meet the needs of the population served and fails to achieve national requirements linked to EDS2, WRES and WDES.	Risk description, controls and actions updated	Controls updated to include delivery of WRES and EDS2 action plans and establishment of BAME talent pool. Actions updated to include review of representation in decision making groups and introduction of internal review panel.

<u>Covid-19 related risks below 15 (outside risk appetite):</u>

	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	Controls updated to include CBAR templates and timely delivery of flu vaccination. Actions updated to include inpatient vaccination programme.
	1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.	Risk score and actions update	Risk likelihood decreased from '3 possible' to '2 unlikely' decreasing the risk score from 12 to 8 – current pressures are not as a result of focus of Covid-19. Actions updated to remove completed action.
	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.	Actions updated	Actions updated to remove completed actions.
	1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	Controls and actions updated	Controls updated to include approved strategy action plans. Action timescales updated.
	1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be	Controls and actions updated	Controls updated to include approved strategy action plans. Action timescales updated.

		disproportionately affected by Covid-19.		
	1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	Controls and actions updated	Controls updated to include approved strategy. Action timescales updated.
	1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**	Actions updated	Actions updated to include response to consent letter. Action timescales updated.
	1567	Inability to meet the competing demand of responding to current waves of the pandemic, the regulatory reporting and restoration drives.	Risk descripti -on updated	
	1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	Risk score, controls and actions updated	Risk consequence decreased from '4 major' to '3 moderate; decreasing the risk score from 12 to 9. Controls updated to include BAME staff risk assessment. Actions updated to include staff vaccination programme.

The Director of HR, OD and Estates has considered any potential risks in relation to the EU exit and suggests that at the current time there are no risks in relation to this for inclusion in the ORR. Should any risks emerge in the future, they will be discussed and reported via EMT.

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.

As part of the discussions relating to review of the Board Assurance Framework (BAF), a number of potential additional and expanded risks have been identified. These are being reviewed in further detail by identified lead directors and the appropriate Board Committee as follows:

<u>Finance, Investment and Performance Committee</u>

- How Trust estate is used given the impact of social distancing and Covid-19 secure premises.
- Lack of a clear and consistent strategy for community health services.

<u>Clinical Governance and Clinical Safety Committee</u>

- New or extended services requirements such as Covid-19 aftercare and long Covid-19.
- Risk of a major incident.

	In terms of risk profile, the consolidated risk scores has increased from 385 to 422 since the previous quarter, reflecting the ongoing challenges to the Trust in the current operating environment. **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.**
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	
Improve health	Improve care
Improve 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
FIP = Finance, Investment & Performance 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 & risk) 27 April 2021

NEW RISKS

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
1611	Organisational and local policies and procedures do not keep pace with Covid-19 vaccination requirements, which could lead to gaps in practice that result in an adverse impact on staff and patient safety.	• Governance and clinical safety Trust action group (TAG) established. • Bronze and Silver command structure. • Process for receipt, review and adoption of national guidance. • Use of qualified and experienced staff. • Training for staff involved in the vaccination programme. • Organisational representation on each place-based vaccination co-ordination group, receiving real time vaccination updates, guidance and clinical advice from place-based experts.	3 Moderate	3 possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Engage with Trust-wide clinical safety and governance groups to identify any changes required in local processes. (DNQ) • Communicate any changes in procedures and processes via the command structure. (DNQ) Support the release of staff involved in the programme for training. (DO)	DHR		EMT (monthly)	4 Yellow / moderate (1 – 6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review
1585	The current NHS capital regime could result in the Trust not having sufficient	• Detailed internal capital planning and prioritisation process. • ICS capital allocation process. • Internal cash availability.	3 Moderate	4 Likely	12 Amber / high	Minimal / low – Cauti-ous /	• Updated estates strategy. (DHR) • Updated digital strategy. (DFR) (March 2021) • Effective communication of Trust capital priorities to West and South Yorkshire ICS partners.	DFR		EMT (monthly)	4 Yellow /	FIP	2021/22 capital allocation to be confirmed	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
	allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.				(8 – 12)	moder-ate (1 – 6)					moder ate (1 – 6)		by the ICS early April 2021.	busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review
1612	Lower uptake of the Covid-19 vaccination by those staff identified as more at risk could lead to a disproportionate risk of infection across the Trust workforce, service users, patients and carers.	• Trust command structure. • Real time reporting and monitoring of uptake by different staff groups. • Communications programme. • Support and information availability for all staff networks. • BAME health & wellbeing taskforce. • Formal arrangements internally and with partner organisations to ensure staff receive and invitation for the second dose of the vaccine.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Daily analysis of vaccination update. (DHR) • Targeted communication and engagement with staff network groups. (DNQ) • Ensure focus on ongoing robust use of IPC guidance including PPE and social distancing. (DNQ / DHR) • Explore the potential use of risk assessments. (DHR) • Updating risk assessment including the impact of the vaccine. (DHR) (June 2021)	DHR		EMT (monthly)	2 Green / low (1 – 6)	CG&C S OR EIC		Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review
1613	Insufficient numbers of staff receive the Covid-19 vaccination leading to an increased risk of infection across the Trust workforce, service users, patients and carers	• Trust Command structure • Real time reporting and monitoring of uptake • Communications programme • Support and information available for all staff networks • BAME health & wellbeing taskforce •	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Daily analysis of vaccination uptake (DHR) • Targeted communication and engagement with staff network groups (DNQ) • Engage with staff through individualised approaches to support informed decision making. (DHR) •	DHR		EMT (monthly)	2 Green / low (1 – 6)	CG&C S OR WRC	This risk has been expanded to include the risk of lower staff numbers coming forward for the vaccination including the second dose given media reports regarding the rare occurrence of blood clots following receipt of the AstraZeneca vaccine.	Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
1614	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.	Safety • Safer staffing levels for inpatient services agreed and monitored. • E.Rostering system in place to support safe rostering. • 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. • Business Continuity Plans. • Increased staff bank arrangement. • Business Continuity Plans. • Silver Command Review. • Potential for additional incentives in key holiday periods. • Reallocation of support / corporate staff. • Establishment of talent pool. Recruitment • Agreed turnover and stability rates part of IPR. • Strong links with universities to increase placements. • New students supported whilst on placement. • Regular advertising of clinical roles. • Workforce plans incorporated into new business cases. • Workforce strategy implementation of action plan. • Retention plan developed. • Workforce plans linked to annual business plans. • Working in partnership across West Yorkshire on international recruitment. • On-line job fairs programme. New workforce supply • 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. • Development of new roles including advance nurse practitioners, physician associates, nursing associates. • Fast track mental health social workers training. • Ethical international recruitment for nursing and doctors.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	Safety • Implementation of SafeCare linked to e.rostering system. (DHR) (June 2021) • Development of collaborative bank across West Yorkshire MH/LD Trusts. (DHR) (September 2021) Recruitment • Developing a more diverse and representative workforce where SWYPFT is seen as the employer of choice. (DHR) (December 2021) • Link into and support place-based recruitment. (DHR) • On Boarding project relaunched. (DHR) (June 2021) • Health Care support worker targeted recruitment. (DHR) (April 2021) New workforce supply • New internal group established to look further development of new roles. (DHR) (April 2021)	DHR		EMT (monthly)	6 Yellow / moder ate (1 – 6)	WRC		Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
		• Mutual aid arrangements with partners.												
1615	Non-delivery of the actions identified to make SWYPFT a Great Place to Work leading to higher turnover of staff, increased absence, lower quality of care and resistance to change and innovation.	<u>Feeling safe</u> • Safe staffing levels review. • Management of violence and aggression training. • Race Forward programme. • Bullying & Harassment Policy. • Appointment of Harassment Advisers. • Staff equality networks. • Individual risk assessments. • Appointment of equity guardians. <u>Supportive teams</u> • Great Place to Work programme. • Leadership and management development pathway. • Engaged leaders programme. • Implementation of the e-appraisal. <u>Positive wellbeing</u> • Enhanced Occupational Health Service. • Health and Well Being Practitioners. • Individual wellbeing reviews. • Psychological support helpline. • BDU wellbeing groups and champions. • Annual staff wellbeing survey and action plan. • Staff vaccination programmes. <u>Personal & professional development</u> • Systematic learning needs analysis linked to workforce plans. • Continuous professional development fund. • Study leave policy. • Establishment of BAME talent pool. • WRES and WDES action plan and KPIs. • Appointment of WRES OD Lead. • Talent and succession plans. <u>Everyone's voice counts</u> • Staff engagement and insight events. • Communications and engagement strategy. • Full-Time Freedom to Speak Up Guardian. • FTSUG network. • Board engagement programme.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	<u>Feeling safe</u> • Roll out of equity guardians across the Trust. (DHR) (September 2021) • Revisit bullying and harassment plan linked to civility model and approach. (DHR) (June 2021) • Revised workforce strategy for 2021-24. (DHR) (April 2021) • Workforce strategy action plan 2021-22. (DHR) (May 2021) • Tackling hate crime against staff. (DHR) (June 2021) <u>Supportive teams</u> • Renew Great Place to Work Programme. (DHR) (June 2021) • Adapt the E-appraisal following feedback. (DHR) (June 2021) • Review of leadership and management pathway. (DHR) (June 2021) <u>Positive wellbeing</u> • Enhance Occupational Health Service linked to Long COVID. (DHR) (June 2021) • Support Mental Health first aider or similar approach. (DHR) (June 2021) • Physical health plans. (DHR) (June 2021) • Appointment of staff dietician. (DHR) (May 2021) • Strengthen link to regional staff suicide prevention plan. (DHR) (review before July 2021) <u>Personal & professional development</u> • Review of training provision. (DHR) (June 2021) • Development of succession plan for second level post based on review directors. (DHR) (April 2021) • Support the BAME Fellowship Programme. (DHR) (April 2021) <u>Everyone's voice counts</u> • New Freedom to Speak Up Strategy and Action Plan. (DHR) (April 2021) • Programme of Insight events for 2021/22. (DHR) (April 2021) • Sustainability Strategy. (DHR) (April 2021) • Review social partnership model to include staff side involvement in decision making groups. (DHR) (June 2021)	DHR		EMT (monthly)	6 Yellow / moder ate (1 – 6)	WRC		Every three months prior to busi-ness and risk Trust Board – April 2021 & 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.	• Microsoft Windows Defender in place including additional email security and data loss prevention. • The Trust's end user computer estate is all Windows 10 which relies on Microsoft technologies, including Microsoft BitLocker for encryption. • Security patching regime covering all servers, client machines and network devices. • Annual infrastructure, server and client penetration testing and regular cyber health checks. • 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 in line with best practice guidance. • NHS Digital Care Cert advisories reviewed on a regular basis & where applicable applied to Trust infrastructure. Any critical alerts are actioned in line with NHS Digital guidance. • Key messages and communications issued to staff regarding potential cyber security risks. • Microsoft software licensing strategic roadmap in place to ensure all software is supported. • Cyber security has been incorporated into mandatory Information Governance training. The Trust achieved the compliance requirement. • Annual table-top cyber exercise scheduled with last exercise completed in January 2021. Next one scheduled for January 2022. • Windows defender advanced threat protection in place. • Strengthened password requirements in place. • IT infrastructure modernisation programme. • Data Security & Protection Toolkit compliance maintained. • Successful adoption of NHS Digital secure boundary service.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	• Ongoing capital programme to upgrade IT infrastructure – with some of the Cisco network equipment replaced during 2020/21. • Training needs, communications and guidance to staff. Remains under constant review. • 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. • Annual cyber survey conducted annually. (DFR) (January 2022) • Improving Clinical Information & Information Governance Group (ICIG) partly re-purposed to review additional risks and identify practical mitigations to decisions taken during the pandemic. • Lightweight Directory Access Protocol (LDAP) has been amended to force any connection via LDAP to be authorised before allowing a connection to proceed. • Responsibility for patching of SQL and non-security-based Microsoft Office updates transferring to IT. (DFR) (April 2021). • Remediation plans from the Penetration test conducted in January 2021. (DFR) (June 2021) • Microsoft Teams controls review. (DFR) (June 2021) • Backup solution being further enhanced to include additional physical air-gap backups at both primary and secondary data centre locations, for additional controls in relation to Ransomware. (DFR) (July 2021)	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 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. Overall, from the January 2021 penetration test, when compared to the 2019 and 2020 tests	Every three months prior to business and risk Trust Board – January 2021 & weekly Covid-19 review

		• Routine replacement of legacy / end of life equipment. • Regular reviews and health checks of all firewall rulesets. • Adoption of Microsoft Advanced Threat Protection (ATP) platform. • Cyber Essentials Plus accreditation programme. • Microsoft AppLocker has been introduced to prevent users from installing unauthorised software applications.											conducted, this demonstrates significant progress and robust security controls are in place across the Trust's IT infrastructure.	

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 Partnership and Delivery Group. (DS / CEO) • 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. We have internal groups established to co-ordinate contribution and involvement in each place and in both West and South Yorkshire integrated care systems. (DO / 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 – April 2021 & weekly Covid-19 review
1511	Risk that carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical	• Collaborative Partnership Board. • Individual work streams developing clinical pathway models, accounting to the Partnership Board. • Trust Board review and approval prior to 'go live'. • NHS England assessment process.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Share learning from other lead providers and early implementers across the country. (DPD) • Engagement with other lead provider collaboratives across Yorkshire & Humber. (DPD) • Financial due diligence carried out (DFR) in January 2021 and shared with NHSE/I, and further due	DPD	30 June 2021	EMT (monthly)	4 Yellow / moder ate (4-6)	FIP	Timescales for 'go live' of the collaborative is now July 2021.	Every three months prior to busi-ness and

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
	and other risk to the Trust.	• Financial due diligence of NHSE financial offer and current spend prior to 'go live'. • Internal audit report on collaborative governance and associated action plan. • Shadowing of NHSE systems and processes prior to 'go live'. • Learning from other Provider Collaboratives that have already gone live.					diligence to be undertaken upon receipt of revised NHSE financial offer. (DFR) • Clinical oversight of repatriation plans for the collaborative of patients currently placed out of West Yorkshire. (DPD) • Request made to NHSE/I for revised baseline income to recognise increase in activity, and additional supporting measures e.g. safeguard against exceptional packages of care costs in first year. (DFR) • Request made to NHSE/I and agreed to delay 'go live' of finance and contracting elements of the collaborative until 1 July 2021 while financial discussions are concluded. (DFR) (July 2021) • Development of appropriate financial risk and gain share with other providers in the collaborative. (DPD) Option agreed with partners, subject to agreement of financial offer from NHSE. • Development of quality assurance processes and monitoring across the Collaborative. (DPD) (March 2021) • Development of opportunities for financial efficiencies. (DPD) (March 2021)						risk Trust Board – April 2021 & 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 via IPR with appropriate escalation arrangements in place. • Biannual safer staffing report to Board and Commissioners. • Review of establishment for adult inpatient areas completed and implementation plan developed. 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. Safer staffing reported on inpatient wards to OMG via IPR. • Medical staff bank established.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Additional funding requests with commissioners will be maintained throughout contract negotiations for 2021/22. (DO / DFR) • Staff redeployment plan (DHR) • Regular review of staff testing capacity through silver command to minimise staff absence with Covid-19 symptoms. (DNQ) • Pandemic flu plan response including BCP stress testing. (DHR) • Further review of forensics and older peoples' services establishment to take place. (DNQ / DO) (review delayed and revised date now Q2 2021/22) • Relaunch pilot of safer staffing judgement tool within community teams. (relaunch delayed and revised implementation plan under review in line with Covid-19 response). (DNQ) (Q1 2021/22) • International nurse recruitment funding approved with recruitment activity taking place throughout 2021/22. (DHR) • Covid-19 vaccination programme established with second dose appointments now being booked (led through bronze command group). (DHR) (regular review throughout programme). • Safecare tool has commenced roll out with a review to be reported to OMG October 2021. (DNQ) (October 2021) • Overtime is currently used as a temporary staffing option to increase capacity and strengthen skills and	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 Board – April 2021 & 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
		• Allied Health Professionals master agency contract in place. • Staffing levels monitored locally by matrons and / or general managers with actions taken to increase staffing levels above establishment in accordance with presenting need. • Risk panel monitors the occasions where newly qualified nurses undergoing preceptorship are asked to take charge of a shift. • BDU meetings review safer staffing and take action to prioritise redeployment of staff to maintain safe staffing levels.					knowledge. The impact of this is under review with a report to OMG in May 2021. (DO) (May 2021)							
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. • First point of contact is in place in all areas. • Waiting list initiatives have been agreed in all areas.	4 Major	2 Unlikely	8 Amber / High risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Recruitment to vacant positions takes place in a timely way and showing successes in maintaining 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) (Details to be confirmed by CCG). • Improvement noted from waiting list initiatives in Wakefield and Barnsley. Work remains in place and is reported to CG&CS. (DO) • Calderdale and Kirklees neurodevelopmental pathways still have excessive waits and are now included in the CAMHS improvement work and will report through priority programmes. (DO) • Resources have been agreed in Kirklees to address waits in ADHD / ASD. Work to commence and be reviewed in June 2021. (DO) (June 2021)	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 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 outstrips the additional capacity. Position understood by CCG but potentially increases again the broader reputational	Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
		• Waiting list initiatives details and outputs reported to Clinical Governance & Clinical Safety Committee routinely. • Young people are contacted on the waiting list every three months. • Ethnicity monitoring is now in place for those waiting. • Learning from the business continuity plans is captured and shared across CAMHS to support working differently in the future. This includes using technology to provide contacts. • CAMHS Improvement Group established with identified change leadership across each of the pathways for improvement. This reports to EMT monthly as part of the priority programmes.											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. • Ethnicity monitoring is now in place to monitor whether there is a disproportionate impact for specific communities or groups. • Waiting lists and associated actions are monitored through the Clinical Governance and Clinical Safety Committee.	4 Major	3 Possible	12 Amber / high risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Waiting list initiatives agreed with Barnsley and Calderdale CCGs. Demand will be reported via contract meetings during 2021/22. (DFR) • Waiting list reports developed, further work required to ensure they are comprehensive. Additional reporting will be developed as part of SystmOne optimisation. This has been delayed due to Covid-19. (DPD / DO / DFR) (to be reviewed May 2021) • The reporting of 'hidden waits' where the wait is secondary to the formally reported waiting information has started within the operational performance report but embedding this into routine monitoring has been delayed due to Covid-19. This will be further reviewed in May 2021. (DO) (to be reviewed May 2021)	DO	Ongoing (review in May 2021)	Performanc e reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performanc e reports reviewed by BDU.	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2	Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review

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1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	• 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: ○ The allocation and definition of responsibilities and standards for the provision, installation, testing and planned maintenance of fire safety equipment, devices, alarm and extinguishing systems; ○ The identification of standards for the control of combustible, flammable or explosive materials; ○ The allocation of responsibilities for the implementation of fire emergency plans including evacuation procedures, first-aid firefighting, contacting the emergency services, emergency co-ordination and staff training; ○ The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures; ○ The development and delivery of suitable staff training in fire safety awareness; ○ Fire safety training compliance measured monthly at OMG with time constrained action plans required for non-compliant areas. ○ The development and implementation of emergency procedures to ensure early recovery from unforeseen incident involving fire in order to maximise safety, minimise problems and enable the core business structure to continue. • Use of sprinklers across all Trust buildings reviewed as part of the capital programme.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – 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) • Rollout programme of sprinkler system. Fire risk assessments completed. (DHR) (June 2021)	DHR	Ongoing	EFM (weekly and monthly) Estates TAG (quarterly) OMG (monthly)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 Note - A failure to effectively manage compliance with the Trust Fire/Smoking policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings.	Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review

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		• 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 quarterly report. • 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 risk of suicide. • Monthly complaints review meeting with CEO / DNQ / MD / DO to scan and act on themes. • Introduction of revised arrangements to improve reliability & validity of ligature assessment process and to prioritise remedial action. • New AMD for patient safety appointed to revised job description. • Updated clinical risk report that captures a wider range of risk information for OMG. • Mental health safety improvement partnership in place with NHS I / CQC. • Clinical risk assessment training programme.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Formulation of informed risk assessment training has commenced, plan to risk assess process and outcome included in patient safety strategy. (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) • Recent CQC communication around ligature risks reviewed by environmental safety group and recommendations being implemented. (DNQ) • Quality improvement network focus on patient safety improvement. (DNQ) – to commence in Q1 2021/22 (Implementation plan to be reviewed in line with Covid-19 restoration and reset) (June 2021) • Recent Learning Disability Mortality Review (LeDeR) reports identifying Covid-19 impact on learning disability community are being reviewed for organisational learning opportunities and reported into EMT. (DNQ) (October 2021) • Complaints policy and metrics reviewed. Revised proposal agreed and under implementation. (DNQ) (review July 2021) • Inpatient Covid-19 vaccination programme established and delivering to plan. (MD) (review June 2021)	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 – April 2021 & weekly Covid-19 review

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		• Our Learning Journey report disseminated across all teams and discussed at team level annually. • 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 cohorting 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 including step-up and step-down guidance in partnership with acute trust colleagues and additional training and support plan for staff to respond to needs of suspected and positive Covid-19 patients.												
1568	Risk that a seclusion room will not be available due to damage that occurred placing staff and service users at an increased risk of harm.	• The leadership team monitor the use of seclusion across all areas and can provide immediate advice on the availability of seclusion in each area. • Seclusion rooms on different wards within acute / medium and low secure can be accessed if available and provide the appropriate level of security (particularly for medium secure restrictions). • The seclusion policy supports the use of bedrooms / other rooms if safe and appropriate for seclusion.	4 Major	3 Possible	12 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• The next phase of the seclusion review work will include a review of all suites against the standards with an estate plan to address any gaps by October 2021. OMG will receive a progress update in June 2021. (DO / DHR) (October 2021)	DO	Ongoing	EMT monthly	4 Yellow / moder ate (1 – 6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-

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		• Incidents are monitored through risk panel with actions escalated as appropriate. • Completion of risk assessments for each individual case to determine whether seclusion can be implemented safely and appropriately in other available spaces. • Issues regarding access to seclusion are reported via Datix and reviewed by the risk panel and escalated to the executive trio if required • Estates team response to repair requests. • The review of seclusion facilities was undertaken and OMG agreed a set of standards for seclusion based on available guidance, learning from incidents and knowledge of the current position.												19 review
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. • 5 year funding arrangements increases income allocated to mental health services. • Mental health investment standard. • Confirmed block income for remainder of 2020/21. • System wide funding provided on a fair shares basis for 2020/21.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• The Trust is approach to change and transformation includes a communication and engagement plan to co-produce and explain the benefits of 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) • Full engagement with ICSs in relation to system financial position and funding. (DFR) • 2021/22 contract negotiation process. (DFR) (May 2021) • Assess 2021/22 planning guidance when received. (DFR) (April 2021) • Assess Q1 funding and financial arrangements when available. (DFR) (April 2021) • Develop plans for 2021/22 mental health investment standard and demand surge income. (DFR) (April 2021)	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 Funding arrangements for the remainder of 2020/21 have been provided and there is an increase in proportion of monies being channelled via the ICS. 2021/22 financial arrangements are not known at this stage.	Every three months prior to busi- ness and risk Trust Board – April 2021 & weekly Covid-19 review
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate	• 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.	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. (DFR) • Individual letters asking for action plans from services where there has been a recurrence of incidents. (DFR) • Corporate and Clinical Governance leads working together to deliver focussed improvement work. (DFR / DNQ)	DFR	ICO external monitori ng of progres s by external evidenc e / desk	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

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	circulation and / or use of personal data leading to reputational and public confidence risk.	• 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 DSPT Toolkit. • Internal Audit programme of work. • Use of blue light system to highlight specific breaches. • Agreed controls to safeguard personal data used in the vaccination and lateral flow testing programmes.					• 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 self-assessment using workbooks. Face-to-face training is currently on hold due to restrictions imposed by the Covid-19 outbreak. (DFR) • Commitment to support comprehensive attendance at the ICIG meeting. (DO) • Formal decision logs to be maintained 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 is ongoing. (DFR) (June 2021) • Quality improvement project initiated. (DFR) (June 2021)		based reviews					Board – April 2021 & weekly Covid-19 review
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.	• Financial planning process includes detailed two year projection of cash flows. • Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately. • Capital prioritisation process to ensure capital is funded where the organisation most needs it. • Stated aim of development of financial plans that achieve at least a small surplus position. • CIP identification and review process. • Treasury Management policy. • Non-Executive Director led Finance, Investment & Performance Committee. • Cash management procedures. • Financial sustainability plan. • Confirmed financial arrangements for the remainder of 2020/21. • Use of national and internal benchmarking to support productivity improvements.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Increased robustness of CIP and expenditure management. (DFR) • Increased focus on raising of invoices to ensure timely payment. (DFR) • Increased focus on robust financial management via training. (DFR) • Collaborative working within West Yorkshire and South Yorkshire ICSs. (DFR / CEO / DPD) • Investigate additional sources of capital funding should they be required. (DFR) • Assess 2021/22 financial arrangements and planning guidance when received. (DFR) (April 2021) • Re-assess the financial sustainability plan in light of the impact of Covid-19. (DFR) (June 2021) • Estates strategy being updated. (DHR) (April 2021)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO3	Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review

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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. • Equality, Involvement, Communication and Membership strategy. • Updated Trust strategy in place. • Approved commercial strategy. • Non-Executive Director led Finance, Investment & Performance Committee. • Prospectus and Board stakeholder engagement plan. • Annual contracting process. • Significant change programmes identified as priorities for the Trust that have high cost, high risks and / or high complexity. • Updates to Trust Board through business tendering opportunities.	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Implementation of longer term financial sustainability plan. (DFR) (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 and regular discussions at strategic Trust Board meetings.) • *In light of Covid-19 outbreak there is currently only limited tendering of services.* • Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. (DPD / DO) • External stakeholder engagement plans will be refreshed as part of the Equality, Involvement, Communication and Membership strategy development and supporting action plans. (DS) (March 2021) • 2021/22 contract negotiation process. (DFR) (May 2021)	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 – April 2021 & weekly Covid-19 review
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	• Board and EMT oversight of progress made against transformation schemes. • Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP. • Active engagement on place based plans. • Enhanced management of CIP programme. • Updated integrated change management processes. • 2019/20 contracts agreed and in place. • Non-Executive Director led Finance, Investment & Performance Committee. • Confirmed block income in place for 2020/21. • Mental health investment standard. • System-wide funding provided on a fair shares basis. • Use of national and internal benchmarking information to support productivity improvements.	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Implementation of longer term financial sustainability plan. (DFR) • Increased use of service line management information by directorates. (DFR) • Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS) • Assess 2021/22 financial arrangements and planning guidance when received. (DFR) (April 2021)	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	4 Yellow /Moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Every three months prior to busi- ness and risk Trust Board – April 2021 & 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
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to the impact of the pandemic on staff wellbeing, an ageing workforce and competition from other NHS and private sector employees.	• 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. • Board succession planning in paper discussed at Trust Board. • Second level reports succession plans discussed at Workforce and Remuneration Committee.	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) (March 2021)	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 – April 2021 & weekly Covid-19 review
1158	Risk of not having a flexible workforce leading to an over reliance on bank and agency staff which could impact on quality and / or 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 Programme. • A dedicated recruitment resource was sourced to target areas with the greatest recruitment issues / highest agency use.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Business case for potential use of NHS Professionals underway. (DHR) (awaiting NHSP proposal) (delayed due to Covid-19) • Exit strategy for all agency locums has been requested from all clinical leads who refresh this on an ongoing basis. (MD)	DHR	Ongoing through agency project group and workforc e 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 – April 2021 & 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
		• Implementation of new roles across 2020 including Nursing Associates and Advanced Clinical Practitioners.												
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. • Partnership agreement with Barnsley Healthcare Federation. • Temporary contracting arrangements in place for the first half of 2021/22.	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• The Trust leadership is developing productive partnerships with other organisations to develop joint bids and shared services in preparation for integration of services. (DFR / DS / DPD / DO) • The Trust as part of its change approach develops communications and engagement plans that drive external engagement and communications to explain the benefits of 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 / DPD / DO) • *Currently only limited tendering of services in light of Covid-19 outbreak. (DFR)* • 2021/22 contract negotiation process. (DFR) (May 2021)	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 – April 2021 & 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. • Additional PICU capacity has been purchased to assist with managing the current Covid-19 phase as part of the mental health collaborative.	3 Moder ate	3 Possib le	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) • Ongoing work as part of West Yorkshire and Harrogate ICS to develop a system wide approach to management of out of area beds to manage peaks in demand. (DO) • Participation in the Getting It Right First Time (GIRFT) is in the early stages. The outputs will be shared across the ICS. (DO) • Additional funding to support discharge packages during the current Covid-19 phase has been made available. Teams will work with partners across the ICS to make best use of the available resources. (DO) (July 2021)	DO	Ongoing / monthly review	OMG	4 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Reviewed in light of the current pandemic. The patient flow processes remain in place. If people need to be placed out of area to manage pressures related to Covid-19, the current control regarding routing contact with them will remain in place.	Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
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. • Temporary contract arrangements in place for the first half of 2021/22.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Ongoing review with commissioners to prioritise areas of expenditure. (DFR) • Implementation of actions identified through independent review of our bed management processes. Remains a priority throughout the Covid-19 outbreak. (DO) • Review recommendations made by Niche regarding PICU bed management across West Yorkshire. (DO) • 2021/22 contract negotiation process. (DFR) (May 2021)	DO / DFR	Ongoing	OMG monthly EMT monthly Trust Board monthly	4 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk 1 – 6 The Trust has remained involved with ICS proposals to purchase additional beds and contributed to the final recommendati on.	Every three months prior to busi-ness and risk Trust Board – April 2021 & 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 quality of care being compromised.	• 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. • All age liaison teams are now embedded in each place. • System-wide meetings take place to review the demand and take action to	4 Major	3 Possib le	12 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Leeds and York Partnership FT have established the care collaborative board to verse the development of the new inpatient facility and to lead work across the system to reduce demand on inpatient care. (DO) • Development of new CAMHS inpatient facility in Leeds for West Yorkshire. (DO) (2022) • Recent increase in demand / pressure noted – potentially linked to closed T4 beds due to Covid-19 and this has been escalated to commissioners and to LYPFT for consideration through the collaboration work. (DO) (May 2021) • There is now a regional focus on the increased demand and reduced T4 inpatient capacity with data on capacity being shared by NHSEI regularly. (MD / DO) (July 2021)	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. April 2021 – the likelihood has been increased as demand for out of area beds appears to have increased potentially as a result of closed beds due to Covid-19.	Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
		address delays in discharges of young people to release inpatient capacity.												
1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	• Safer staffing levels for inpatient services agreed and monitored. • Agreed turnover and stability rates part of IPR. • Weekly risk scan by DNQ and MD to identify any emerging issues, reported weekly to EMT. • Reporting to the Board through IPR. • Datix reporting on staffing levels. • Strong links with universities. • New students supported whilst on placement. • Regular advertising. • Development of Associate Practitioner. • Workforce plans incorporated into new business cases. • Workforce strategy implementation of action plan. • Retention plan developed. • Workforce plans linked to annual business plans. • Working in partnership across 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. • Marketing of the Trust as an employer of choice. • New roles developed e.g. Advanced Nurse Practitioner.	3 Moderate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Proposal for On Boarding System to include recruitment Microsite. (DHR) (delayed due to Covid-19) • International nurse recruitment funding bid awarded. (DHR) • Establishment of work group to look at development of new clinical roles. (DNQ) (June 2021)	DHR	Ongoing given external influence outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performance report)	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3 34 TNA posts recruited to (October – November 2019) both internal and external to a total establishment of 52 WTE.	Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review
1154	Risk of the loss of staff due to their health and wellbeing being adversely effected by the impact of increased service pressures and the longer term effects of the coronavirus on them and their families and therefore reducing the ability to provide	• 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.	3 Moderate	4 Likely	12 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Bronze operational workforce group to be established with links into silver command. (DHR) • Roll out of vaccination programme to all staff by end of January 2021. (DHR) • Review of physical health and wellbeing support being undertaken in light of Robertson Cooper survey result. (DHR) • Roll out of staff vaccination programme in line with national guidance (DHR)	DHR	Ongoing	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly

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	safe and effective services.	• Extend use of e-rostering. • Retention plan developed. • HR and service managers ensuring consistent application of sickness policy. • BAME health and wellbeing task force established. • Risk assessment process for all staff linked to Covid-19 complete. • Health and wellbeing reviews included in staff appraisals. • 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. • Financial support guidance. • Strengthened bereavement support.											Covid-19 review
1157	Risk that the Trust does not have a diverse and representative workforce which reflects all protected characteristics to enable it to deliver services which the meet the needs of the population served and fails to achieve national	• 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.	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Review of how representative our decision making groups are. (DHR) (June 2021) • Introduction of internal review panel on disciplinary and grievance cases related to discrimination on the grounds of race. (DHR) (June 2021)	DHR	Ongoing	EMT (quarterly) EIC Committee (quarterly)	6 Yellow / moderate (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 – April 2021 & weekly

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 linked to EDS2, WRES and WDES.	• 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. • Appointment of WRES OD lead. • Full time freedom to speak up guardian appointed. • Delivery of WRES and EDS2 action plans. • Established BAME talent pool.												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)
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	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
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) that cannot be met.	• 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	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Learning from Covid-19 is being captured as it becomes available. This continues to support working in a different way in the future. (DO) • Work with partners in each place to understand emerging impact of Covid-19, need and demand. (DS / DPD) • Prioritisation of service planning based on what is known of impact. (DO)	DO	Ongoing during the Covid-19 pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS	Risk score reviewed and remains the same. The risk is being reviewed on an ongoing basis to ensure that	Every three months prior to busi-ness and risk Trust

		in Wakefield, IPCG in Barnsley and ICHLB in Kirklees. • Health and wellbeing boards. • Local stress testing exercise demonstrated strengths in business continuity systems. • Command structure supports the immediate management of peaks in demand. • Digital and telephone solutions are part of the standard offer for service users. • Contribute to stress testing exercises through the ICS and use learning internally. • Contribute to place based planning including recovery and reset.					• Service delivery is prioritised to meet need, manage risk and promote safety with cross service and BDU support utilised. (DO) • Business continuity plans to remain responsive to difference phases and impact of the pandemic. (DO) • Where demand exceeds capacity this will be escalated through the command structure with bespoke arrangements put in place. (DO) • Detailed activity, workforce and finance planning for 2021/22 in light of increasing referral activity. (DPD) • Emerging information on increased demand under review through restoration and recovery priority programme, this includes the impact of and response to the emerging demand from long Covid. (DS) (review June 2021)						actions remain appropriate subject to monthly review.	Board – April 2021 & 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)	• Timely action and intervention on outbreak management. (DNQ) • Timely response to change in restrictions or social distancing guidance. (DNQ) • Review of IPC precautions in light of new variant underway and national guidance awaiting – current position no change. (DNQ) • Introduction of lateral flow testing for all frontline staff commenced 7 December 2020. 100% of tests distributed, additional tests requested to expand scope, early data suggests positive position in terms of uptake and compliance and benchmarking well against comparator trusts. Routine review via silver command. (DNQ) (review June 2021) • Covid-19 vaccination programme established with over 87% of staff receiving initial doses and 50% of second doses to date. (preparations led through new bronze command group). (DHR) (regular review throughout programme) • IPC BAF routine review and update into CG&CS Committee. (DNQ) (July 2021) • Inpatient vaccination programme is nearing completion. Ongoing second vaccination programme. (MD) (July 2021)	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 – April 2021 & 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
		• Risk assessments complete to determine if areas are Covid-19 secure. • Daily follow up of actions identified through command structure. • Routine scan of national guidance as part of horizon scanning in command structure. • Membership of clinical and professional regional and national networks. • SBAR templates are produced to share learning from recent outbreak management investigations. • Timely delivery of flu vaccination programme with learning taken into Covid-19 vaccine preparations.												
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. • Supporting infrastructure now available to the operational teams over seven days as / when required. • A 24/7 helpline is available to service users and members of the public who can raise concern and ask for help. • The Datix reporting system has been simplified to support staff to report incidents which are then reviewed at the risk panel. • All services remain open to referrals.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Bronze command / operational 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 management, stabilisation and recovery of services in line with Covid-19 restrictions. (DO) • OMG continues to monitor performance and take appropriate actions to address areas of concern, with appropriate escalation to EMT. (DO) • Enhanced clinical risk report considered by OMG and action taken to address areas of concern. (DO) • Cross BDU / team working is in place to manage areas of high demand. (DO)	DO	Ongoing through Covid-19 phase	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS	Risk score reviewed. Likelihood reduced, current pressures exist but not as a result of focus on Covid-19.	Every three months prior to business and risk Trust Board – April 2021 & weekly Covid-19 review
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.	• Bronze PPE group. • Trust guidance on application and use of PPE in line with national guidance. • Part of national delivery process for PPE. • Process in place for delivering to Trust services. • Confirmed delivery process with the supplier. • Mutual aid scheme across ICSs. • Development of basic forecasting and stock usage information. • Routine scan of national guidance as part of horizon scanning in command structure. • PPE supply and demand monitored through IPR.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Routine review of IPC guidance and horizon scanning. (DNQ)	DNQ	Ongoing	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to business and risk Trust Board – April 2021 & 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
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. • Safer staffing reported on inpatient wards to OMG monthly via IPR. • 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. • Staff testing arrangement available to all staff including bank and student workforce. • During Covid-19 pandemic, Bronze command meetings review safer staffing and take action to prioritise redeployment of staff to maintain safe staffing levels. • Regular review of staff testing capacity through Silver command to minimise staff absence with Covid-19 symptoms. • Testing for staff remains available throughout the pandemic.	4 Major	3 Possible	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. (DHR) • Staff portability arrangements within each place. (DHR) • Link to national wellbeing offer to keep staff resilient. (DHR) • Procedures are reviewed as the national and regional situations change through the command structures to ensure that they reflect the current position and the impact is understood. (DHR / DNQ / DO) • Timely implementation of Covid-19 vaccination programme. (DHR)	DHR / DO	Ongoing	Command structure	8 Amber / high (8-12)	CG&CS		Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	• Business continuity plans. • Performance management processes including monthly reporting on quality metrics to the Trust Board via IPR • Risk panel review process. • There is clear escalation structure through bronze / silver / gold meetings in place. Silver reviews all changes in care models. • Use of local clinical expertise in development of models. • Log of all changes made during the outbreak. • QIA process for clinical pathway changes. • EIA rapid decision making framework • Summary log of legal risks reviewed by MHAC. • An interim CEAG has been established to provide urgent ethical advice to clinical teams and provides a governance framework reporting into CG&CS Committee. • New guidance for staff on decision making regarding face to face or virtual visits has been issued. • The Equality, Involvement, Communication and Membership strategy is now approved and embeds the people plan and phase 3 requirements. Supporting action plans from the strategy have been approved by E&I Committee.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• An enhanced patient safety risk stratification tool is being developed. (DNQ) (July 2021) • Survey of patient experience who have had involvement with MHA. (MD) (review before July 2021) • Roll out and implementation of Covid-19 patient experience and engagement toolkit for changes and reset and recovery toolkit developed to support services returning to a new normal. (DS) (review before July 2021) • National guidance on integrating learning from Covid-19 pandemic to be reviewed on receipt. (DS) (June 2021) • Restoration and recovery programme – need for enhanced clinical leadership under review. (DNQ / DO / MD) (June 2021)	MD / DNQ	Ongoing	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – April 2021 & weekly Covid-19 review
1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.	• Enhanced clinical risk scanning. • Engagement with staff equality networks to advise on specific issues. • Charitable funds donated to support Kirklees BAME communities and bereavement work. • Equality Impact Assessment process. • Vitamin D supplements position statement in place for all inpatient service users. • Covid-19 clinical pathways for inpatients in place. • Place based partnership working to support population health mapping and initiatives in each of our places. • Equality, Involvement, Communication and Membership Strategy approved by Trust Board 1 December 2020.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Timely implementation of the Covid-19 vaccination programme once national guidance is issues. (MD / DNQ) • 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. (DNQ / MD / DO) • Task group reviewed risk description and amended to incorporate protected characteristics and BAME individuals. (DNQ) • Quality improvement initiatives to continually improve recording and insight. (DNQ) (ongoing review through OMG / ICIG)	DNQ	Ongoing during Covid-19 pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	EIC		Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
		• Covid-19 information leaflets provided to patients and carers. • High risk groups identified by clinical teams and treatment plans reviewed. • Support / advice provided on shielding to LD patients and their families. • Equality, Involvement, Communication and Membership strategy - supporting delivery action plans approved by E&I committee - plans include the equality action plan including annual review of EIA, improved data capture and evidence of equality considerations. Tools developed to capture include: ○ Checklist approach for equality, engagement and communication. ○ Equality Impact Assessment (EIA) quick decision tool and action log. ○ Trust wide Covid-19 EIA and process to embed at service level in place. ○ Improvements being made in data quality and data collection in line with national guidance.					• Roll out and implementation of the action plan related to the Physical Health Optimisation Strategy. (MD) (review July 2021) • Easy read versions of new information being developed. • Staff training plan to be initiated on use of translation and interpretation services. • PPE guidance managing communication with those who use non-verbal communication. carers assessments reviewed in context of Covid-19 support. • Additional guidance from community based learning disability teams to families and carers. • Learning disability VIP cards reviewed.							
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. • Revised guidance issued to clinicians to support appropriate clinical review. • CAMHS “we are still here” campaign. • Enhanced activity data reporting into IPR highlighting themes and trends. • ICS system wide working to improve awareness of secondary services being open for routine referral. • Equality, Involvement, Communication and Membership Strategy approved by Trust Board.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Risk to be considered as part of recovery and restoration programme. (DO) • Review of new benchmarking data. (DO) • Review impact of vaccination programme upon demand through data group as part of restoration and recovery programme. (DS) • Review recent increase of referral data to understand to what extent this risk has been mitigated. (Risk score to be reviewed once the data is received.) (DO) (June 2021)	DNQ / MD	Ongoing	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to business and risk Trust Board – April 2021 & weekly Covid-19 review
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. • Committee structure. • Trust understanding of Equality law – training / EIA process and governance.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• 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. • Checklist approach for Equality, Engagement and Communication. • Equality Impact Assessment (EIA) quick decision tool and action log.	DFR		EMT (monthly)	6 Yellow / moderate (4-6)	AC	Covid-19 Act has been extended to 30 September 2021	Every three months prior to business and risk Trust Board – April

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
		• Adoption of accessible information standard to support information and communication. • NHS Constitution embedded in Trust strategies, policies and procedures. • Information and communication in accessible formats including easy read, a range of translated materials available to services on the intranet, use of translation in leaflets and letters. • Equality, Involvement, Communication and Membership Strategy. • Systematic review of national guidance.					• 8,284 patients responded positively to the consent request sent March 2021. Communications plan being developed for the patients and staff for further roll-out. (DFR) (June 2021) • Reset and recovery of services. • Review of estates requirements. (DHR) (to be reviewed by June 2021) • Regular consideration of staff wellbeing offers. (DHR) (to be reviewed by June 2021)						2021 & weekly Covid-19 review
1567	Inability to meet the competing demand of responding to current waves of the pandemic, the regulatory reporting and restoration drives.	• Mature command structure established and functioning well. • Clear protocol established for review of OPEL levels. • Restoration and recovery programme established within priority programmes. • Strong links to national and regional networks allowing for early alert to emerging risks / competing pressures. • History of strong partnership working arrangements with regulators. • Established arrangements for mutual aid during first wave. • Regular review of priorities at EMT. • Business continuity plans.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Escalation arrangements established. • Routine contact with key regulators to brief on current status and impact. • Recovery and restoration work subject to routine review through performance EMT. (monthly review) • IPR review and triangulation providing early warning of emergent pressures and risks to delivery. (monthly review)	EMT	Ongoing through out the pandemic	EMT Trust Board	4 Yellow / moderate (1 – 6	FIP		Every three months prior to busi-ness and risk Trust Board – April 2021 & 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 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Review of essential training provision being undertaken. (DHR) • Wellbeing plans developed for each BDU. (DHR)	DHR		EMT (monthly)	4 Yellow / moderate (4-6)	WRC		Every three months prior to busi-ness and risk Trust Board – April 2021 & 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
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 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. • Equality Impact Assessment of staff health and wellbeing offer and occupational health. • Review of BAME staff risk assessment to be undertaken.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Staff vaccination programme. (DHR) (June 2021)	DHR	Ongoing	Command structure of Gold, Silver, Bronze (daily) Trust Board through IPR (monthly) Safer staffing reports (monthly) WRC (as appropriate)	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 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.	Every three months prior to busi-ness and risk Trust Board – April 2021 & 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)

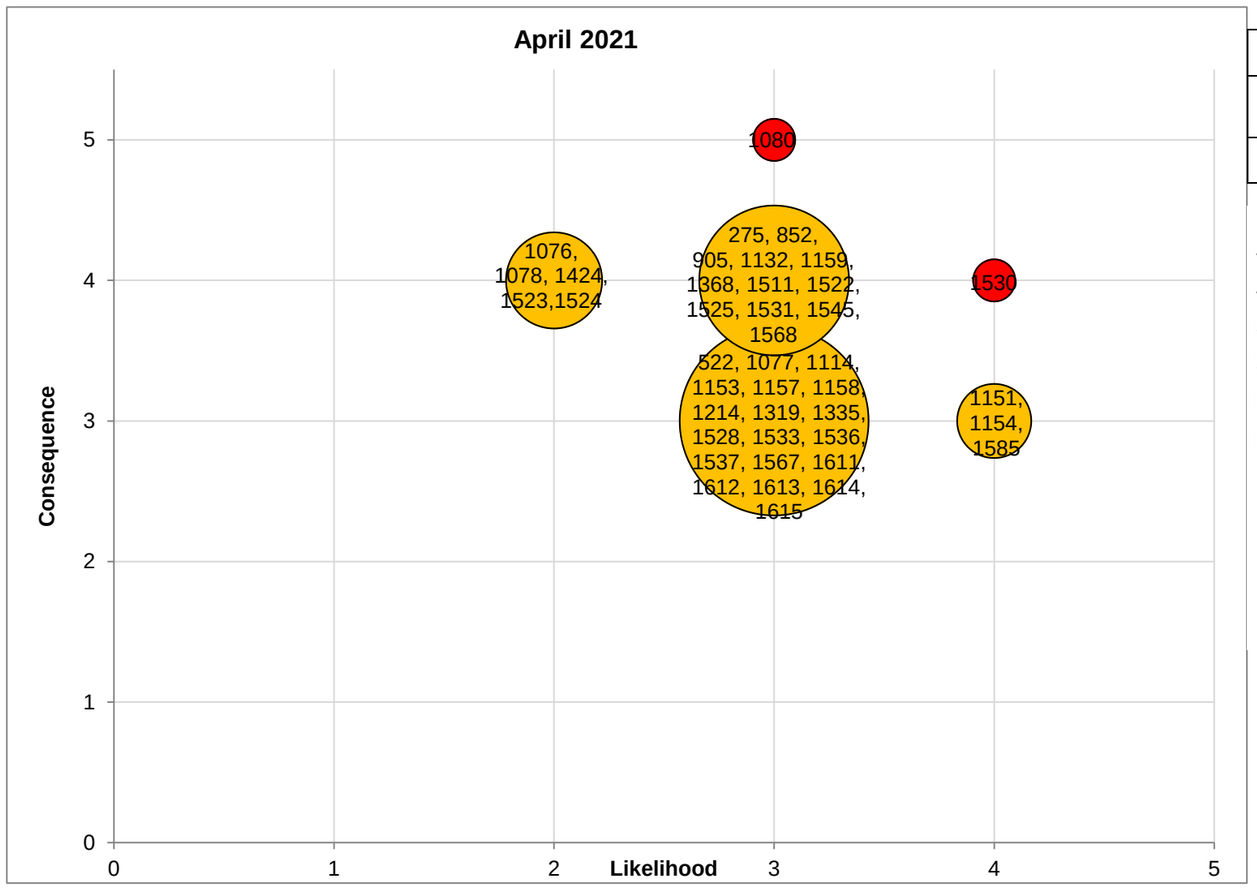
South West Yorkshire Partnership NHS Foundation Trust

Risk profile (risks outside the risk appetite) **– Trust Board 27 April 2021**

Risk ID	Risk description	Apr-20	Jul-20	Oct-20	Jan-21	Apr-21	Notes
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	12	12	12	12	12	
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	6	9	9	9	9	Risk level reduced Jan 20, within risk appetite Apr 20, increased Jul 20.
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	12	12	12	12	
905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	12	12	12	12	12	
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.	8	8	8	8	8	
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.	9	9	9	9	9	
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	8	8	8	8	8	
1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	15	15	15	15	15	
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.	9	9	9	9	9	
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	12	12	12	12	12	
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.	12	12	12	12	12	
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	9	9	9	9	
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	9	9	9	9	12	Risk merged with risk ID 1526. Risk level increased April 21.
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	9	9	9	9	9	
1158	Risk of over reliance on agency staff which could impact on quality and finances.	9	9	9	9	9	
1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	12	12	12	12	12	
1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	9	9	9	9	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	9	9	9	9	
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	9	9	9	9	9	
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	8	8	8	12	Risk level increased April 21.
1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.				8		Risk closed Jan 20.
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.	8	8	8	8	8	
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	12	12	12	12	
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.	8	4				Risk level within risk appetite Jul 20. Risk closed April 21.
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	12	12	12	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	12	12	12	8	Risk level decreased April 21.
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.	12	12	8	8	8	
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	12	12	12	12	
1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves.	12	12	12	12		Risk merged with risk ID 1154 April 21.
1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	9	9	9	9	9	
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) that cannot be met.	16	16	16	16	16	

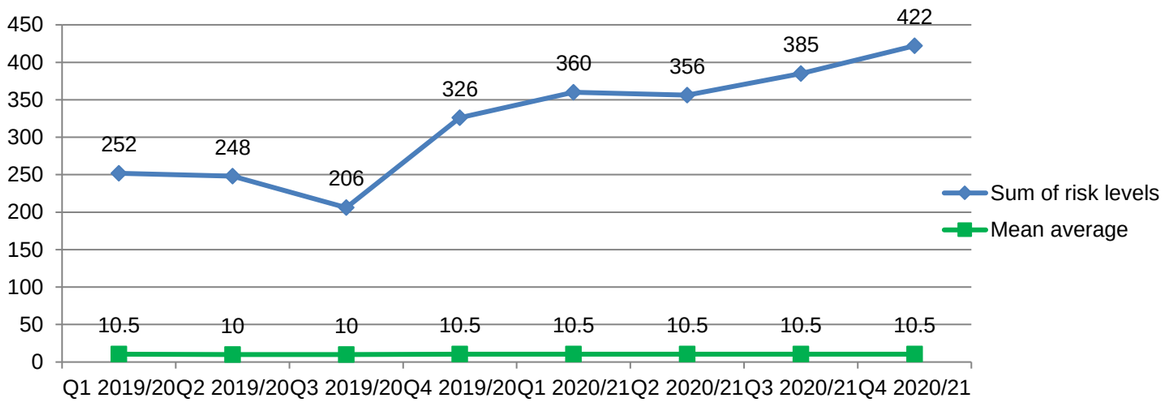
Risk profile (risks outside risk appetite) **– Trust Board 27 April 2021**

1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.	12	12	12	12	12	
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.	9	9	9	9	9	
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.		12	12	12	9	Risk level decreased April 21.
1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.		9	9	9	9	
1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic.		12	12	12	12	
1567	Inability to meet the competing demand of responding to the second wave of the pandemic, the regulatory reporting and restoration drives.				9	9	
1568	There is a risk that a seclusion room will not be available when required which will place staff and service users at an increased risk of harm due to damage that has occurred to a number of seclusion rooms. This risk is present due to the current increased acuity.				12	12	
1585	The current NHS capital regime could result in the Trust not having sufficient allocation to complete all its capital plans in any one year adversely impacting on ability to meet its strategic objectives and priorities.					12	
1611	Organisational and local policies and procedures do not keep pace with Covid-19 vaccination requirements, which could lead to gaps in practice that result in an adverse impact on staff and patient safety.					9	
1612	Lower uptake of the Covid-19 vaccination by those staff identified as more at risk could lead to a disproportionate risk of infection across the Trust workforce, service users, patients and carers.					9	
1613	Insufficient numbers of staff receive the Covid-19 vaccination leading to an increased risk of infection across the Trust workforce, service users, patients and carers.					9	
1614	National clinical staff shortages resulting in vacancies which could lead to the delivery of potentially unsafe and / or reduced services, increased out of area placements and / or breaches in regulations.					9	
1615	Non-delivery of the actions identified to make SWYPFT a Great Place to Work leading to higher turnover of staff, increased absence, lower quality of care and resistance to change and innovation.					9	



2019/20				2020/21			
Q1 (24 risks)	**Q2** (24 risks)	**Q3** (21 risks)	**Q4** (31 risks)*	**Q1** (34 risks)*	**Q2** (34 risks)*	**Q3** (37 risks)*	**Q4** (41 risks)*
10.5	**10**	**10**	**10.5**	**10.5**	**10.5**	**10.5**	**10.5**

*includes Covid-19 related risks



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item

Title:	**System Oversight Framework - Consultation**
Paper prepared by:	Director of Finance and Resources Director of Strategy
Purpose:	To provide the Board with the summary points in the proposed system oversight framework for 2021/22 and engage with Trust Board members to enable an agreed response to be submitted
Mission / values:	All Trust values
Any background papers / previously considered by:	The proposal is being reviewed by the Executive Management Team (EMT) on April 22nd
Executive summary:	• The current single oversight framework has been in place for several years • Nationally there is recognition of the Long Term Plan, the increasing role of integrated care system (ICSs) and the changing operating environment • A new system oversight framework is being proposed and the Trust has an opportunity to provide feedback via the consultation process • The proposal is summarised in the attached paper and the detail proposal is being made available to all Trust Board members • Systems and organisations will be placed in one of four segments (default position is segment 2 based on performance against six key themes identified • A monitoring and review process is highlighted • A new Recovery Support Programme is being proposed to replace the current special measures process • Nine questions are asked in the consultation document, which are again highlighted in the main paper
Recommendation:	**It is recommended Trust Board consider the proposed system oversight framework and agree any comments and feedback it wishes to make on the proposal.**
Private session:	Not applicable

NHS System Oversight Framework 2021/22

Introduction

The current single oversight framework operated by NHS Improvement has been in place for several years. Given the emergence and increased role of ICSs, and the changing landscape in which the NHS operates, NHS England & improvement (NHSE&I) are consulting on a new system oversight framework (SOF) for 2021/22.

The SOF aims to provide clarity to ICSs, providers and commissioners on how NHSE&I will monitor performance, set expectations on working together to maintain and improve the quality of care, and describe how identified support needs will be co-ordinated and delivered. It will also be used by NHSE&I's regional teams to guide oversight of ICSs and describe how NHSE&I will work with the Care Quality Commission (CQC)

The purpose of this paper is to explain the summary points in the proposal and engage with the full Trust Board to enable an agreed response to be submitted.

The detailed consultation document is also provided separately to all Trust Board members.

Current Framework

The current framework considers five themes which cover:

- Quality of care
- Finance and use of resources
- Strategic change
- Leadership and improvement capability
- Effective board and governance

Several sources of information and metrics are used to assess each trust's position, and this will result in an oversight rating of 1 to 4. Essentially the various ratings are classified as follows:

1 – maximum autonomy – no potential support identified

2 – target support – some support for one of more concerns

3 – mandated support – significant concerns

4 – special measures

The Trust has typically been classified in segment 2 (targeted support).

Purpose and Principles

The purpose and key principles associated with the new SOF are listed in the document and can be summarised as:

- To align the priorities of the ICSs and NHS organisations within them
- To identify where ICSs and organisations may benefit from or require support
- To provide an objective basis for decisions about when and how NHSE&I will intervene where there are serious problems or risks to the quality of care

The approach aims to be characterised by:

- Working with ICSs to tackle problems
- Greater emphasis on system performance and quality of care outcomes
- Matching accountability for results with improvement support
- Greater autonomy for ICSs with evidence of collective working and a track record of successful delivery of NHS priorities
- Compassionate leadership behaviours

Role of Integrated Care Systems

The importance of the role of the ICS is recognised in the documentation and it is highlighted they will become increasingly involved in the oversight process and support of organisations in partnership with NHSE&I. The proposed oversight arrangements also reflect an expectation for evidence of effective provider collaboration. It is proposed that NHSE&I plays a lead role in the oversight of the ICS and individual organisations up to the point the ICS is well developed and takes the lead role itself

Proposed Approach to Oversight

It is proposed the new SOF will be built around the five national themes that reflect the ambitions of the NHS Long Term Plan with a single set of metrics aligned to these five national themes. The five national themes are:

- Quality of care, access and outcomes
- Preventing ill health and reducing inequalities
- People
- Finance and use of resources
- Leadership and capability

In addition to these five themes a sixth has been identified regarding local strategic priorities. This recognises unique challenges in each ICS, renewed ambition to support greater collaboration, a description of how ICSs will work alongside NHSE&I and a three step cycle that frames how support will be identified and deployed to address the most complex and challenging problems.

It is noted the existing statutory roles and responsibilities of NHSE&I remain unchanged for 2021/22 and that there will be a need for flexibility in the approach, particularly in light of the ongoing need to manage the impact of Covid-19 and recovery and restoration of services.

Monitoring

NHSE&I will conduct monitoring by gathering insights and information regarding performance across each of the key themes. Examples include annual plans, reports, regular financial and operational returns, quality insight, risks and issues. Other sources of information will also be used. It will include in-year, annual and exceptional reporting where required. Ongoing oversight will include review meetings with ICSs and potentially smaller groups of providers and commissioners and in exceptional cases with individual organisations. NHSE&I will work with ICSs to ensure there are appropriate oversight arrangements at system, place, and organisation level. It is also acknowledged that some

oversight arrangements may need to span more than once ICS e.g. some specialised services

A table highlighting the proposed monitoring process by ICS, place and individual organisations and collaboratives is provided in the detailed consultation document. Operating as an individual organisation and within a collaborative it is likely review meetings will be held at place and typically led by the ICS unless by exception

Support Segments

It is proposed there will still be four segments that can be applied to ICSs, CCGs, and trusts.

1 – No specific support needs identified

2- Flexible support delivered through peer support, clinical networks, NHSE&I universal support offer e.g. GIRFT, Right Care, or a bespoke package. This will be the default segment unless the criteria for moving into another segment is triggered.

3 – Bespoke mandated support need

4 – Mandated intensive support delivered through Recovery Support Programme

There are various criteria attached to each segment, which are again identified in the detailed consultation document. There will clearly need to be alignment and close working between the ICS and NHSE&I when support needs are identified, agreed, and deployed, whether this be at a system, place, or organisation level.

For systems or organisations classified as segment 4, a new nation Recovery Support Programme (RSP) is being proposed. This in effect replaces the current special measures categorisation. This is proposed to be a system-oriented process, whilst still providing focused and intensive support to individual organisations. It will be led by a credible and experienced system improvement director and focus on underlying problems that need to be addressed. Exit from segment 4 will be decided by NHSE&I

CCG Assessment

Proposals are also made regarding CCG assessment which NHS England has a legal duty to complete annually. This will be based on the existing process, albeit adapted. It will be based on:

- Performance against the oversight metrics
- Key lines of enquiry
- Assessment of how CCGs work with others

Consultation Questions

Should the Trust wish to respond to the consultation there are nine questions that have been asked. Initial thoughts by individual EMT members are shown in italics

1. Do you agree that the proposed approach to oversight set out in this document meets the purpose and principles set out? If not, how could the proposed approach be improved?

2. Do you agree that oversight arrangements for place-based systems and individual organisations within the ICS should reflect both the performance and relative development of the ICS? If not please give your reasons

   Greater emphasis upon mutual governance and outcome focussed commissioning

3. Do you agree that the framework's six themes support a balanced approach to oversight, including recognition of the importance of working with partners to deliver priorities for local populations? If not how could the proposed approach be improved?
4. Do you agree that the proposed approach will support NHS England & Improvement regional teams to work together to develop locally appropriate approaches to oversight? If not, how could the proposed approach be improved?

   The intention is correct but ultimately reliant upon the development of learning and "no blame culture" – the OD approach required should be described.
   There should be a clear focus on outcomes and balanced measures and the use of QI approaches at system level to improve performance and outcomes.
   Consideration to providers working as part of more than one ICS should also clearly be set out to reduce any additional burden.

5. Do you support the proposed approach to segmentation across ICSs, trusts and CCGs? How could the proposed approach be improved to better inform oversight arrangements and effectively target support capacity?

   This section introduces the concept of earned autonomy which is not signalled in the overarching principles – there is a risk that the system tries to align the segments with CQC ratings

6. Do you have any additional suggestions that could improve the proposed approach to oversight, support and intervention?

   A stronger emphasis on providing interventions that enhance a culture of improvement and safety while building local capacity and capability to maintain and sustain improvement approaches

7. Do you agree that the current model of special measures for individual organisations should be replaced by a more system-focused support programme? If not, please give your reasons?
8. Do you support the proposed approach to the Recovery Support Programme? How could the proposed approach be improved to better support systems, trusts and/or CCGs to address complex and/or longstanding challenges?

   The focus should be on local system partnership to address quality concerns

9. Do you support the proposed approach to CCG assessment? If not, how could the proposed approach be improved?

Summary and Recommendation

In summary the Trust has an opportunity to participate in the consultation regarding the proposed system oversight framework and a response is required by May 14th. The proposal is being discussed at the Trust's Executive Management Team (EMT) meeting on April 22nd, so any comments made at that meeting can be provided verbally at the Trust Board meeting.

It is recommended Trust Board consider the proposed system oversight framework and agree any comments and feedback it wishes to make on the proposal.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 9.1

Title:	Integrated Care System response to White Paper - Integration and Innovation: working together to improve health and social care for all
Paper prepared by:	Director of Strategy
Purpose:	To provide an update to Trust Board on how the two Integrated Care Systems that the Trust is part of are responding to the White Paper and the NHSE/I proposals on integrated care and next steps.
Mission/values:	The Trust is a committed partner in two established Integrated Care Systems and in four place-based Integrated Care Partnerships that are at differing levels of maturity. Delivering joined up care, improving health and outcomes for people in each of our places continue to be key priorities for the Trust in delivering its **vision and mission.** The development of integrated care and system working is in line with our **value to be relevant today and ready for tomorrow and has been an integral part of the Trust's strategic and operational approach over the last few years.**
Any background papers previously considered by:	Updates on integrated care developments and the national policy context are discussed regularly at Strategic Board and Trust Board meetings. The NHSE/I Consultation document on the next steps for integrated care was discussed in depth at the December Strategy Board, including key considerations and implications for the Trust. The Government's response in the form of the White Paper was further discussed in detail at the February Strategy Board and March Trust Board.
Executive summary:	**Background/Context** The national policy context recognises the role of Integrated Care Systems as a key driver in improving health outcomes, reducing health inequalities and supporting sustainability through collaboration rather than competition. In November 2020, NHSE/I set out proposals to develop Integrated Care Systems. This was followed by the White Paper Integration and Innovation: working together to improve health and social care for all being published in February 2021. This was discussed in March at Trust Board. Over the coming months, it is anticipated that as the proposals to legislate for ICSs start to work their way through the parliamentary process, key guidance and process to support implementation and establish ICSs will be issued to systems to further inform the approach and work. During 21/22, it is anticipated that there will be further guidance on provider governance (to support providers to work collaboratively).

	The Trust is part of two advanced ICSs and is also part of place-based partnerships and provider collaboratives. **WYH ICS** have established a Future Design and Transition Group to oversee the transition and help make the right connections between 7 workstreams and a Chairs and Leaders Reference Group, which will act as a sounding board, has been established. *Paper attached that summarises the 7 workstreams.* **SYB ICS** has also established an overarching Steering Group that draws on members from the 4 workstreams including: • Place-based partnerships • Provider collaboratives • Commissioning changes • ICS operating model In addition, there are two enabling work streams: • HR and people transition • ICS Financial framework To support the changes to commissioning, all four ICSs in the north are taking a consistent approach with agreed HR principles that build on the FAQs that came out with the White Paper. These are minimum disruption, smooth transition, reducing anxiety, employment commitment and "one workforce", whilst recognising the importance of place and place teams. Hill Dickinson have been commissioned to provide facilitation to the Steering Group and Design Groups and expert legal support in production of key documents and products. A Design Sub-Group was established from the broad membership to co-design a number of key products and these include: • A Health and Care Compact and Health and Care Partnership Terms of Reference • A Development Matrix • A Route Map for 2021/22 **Place-based Developments** We continue to work with partners in each of the places that we provide services - Calderdale, Kirklees, Wakefield and Barnsley - to review and develop Integrated Care Partnerships and arrangements to ensure that each place has a clear development plan in place to develop mature place-based partnership arrangements that can respond to the changes set out in the White Paper and ICS developments.
Recommendation:	**Trust Board is asked to: Note the update on the local ICS approaches to respond to the White Paper.**
Private session:	Not applicable.

WY&H Future Design and Transition

Paper E

We have proposed seven workstreams to support the change to these new arrangements:

- **Reviewing the ICS operating model** – how the ICS is structured, how it functions and the relationship between WY&H and place
- **Producing an ICP (Place) development framework,** which will describe the components of an effective place arrangement, and the delegation and accountability arrangement with the ICS.
- Developing **new financial arrangements,** including how money flows through the system, and contracting and planning approaches
- Developing an approach for **system clinical leadership** at WY&H and place level – building on the arrangements we have got
- Designing future **workforce strategy and leadership** arrangements, in partnership with HEE and NHSE/I
- Progressing our **strategic commissioning work** which will define how population health planning is carried out in line with our subsidiarity principle.
- Supporting the **transition for staff affected by change** in a way that is fair and transparent.

Falling out of the white paper there will be a range of specific governance questions that will need to be addressed, as well as a range of practical actions to manage the transition.

We have established a future design and transition group to oversee the transition and help make the right connections between these workstreams; and a chairs and leaders reference group which will act as a sounding board.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 9.2

Title:	**South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) Update including Mental Health, Learning Disability and Autism Provider Alliance (MHLDA)**
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 key developments in SYB ICS and the SYB ICS MHLDA Alliance and linked programmes. • To update on partnership developments in Barnsley.
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 the development of the Alliance and the MoU was formally approved and supported by Trust Board in March 2021.
Executive summary:	**<u>SYB ICS Update</u>** **COVID -19 Response:** The SYB vaccination programme continues to make good progress with efforts recently focused on encouraging people to take up the offer in cohorts 1-9 who have not yet been vaccinated. Cases continue to fall across SYB. Three months ago, the regional seven-day rolling average was between 2000-2200 cases a day and it is now between 850-650. In SYB, the latest data (April 6th) shows a 90 per cent reduction in COVID-19 cases in over-70s age groups. The over-50s and 60s age-ranges, school and working age groups are also showing a similar steady decline in new cases. In summary overall trends continue to be positive with vaccination levels in at risks progressing well. **Planning 21/22:**

	In SYB ICS, partners are now coming together to develop a plan for SYB which puts the national priorities into action, with final plans expected to be completed by early June. **Finance update** The SYB system is still on track to achieve operating within the system revenue and capital envelopes. The latest forecast is to achieve an adjusted revenue surplus of £32.4m and an underspend against the capital envelope of £13.7m. The system has been notified of its funding envelope for the first half of the year which is £1.45b and represents a 1.9% increase over the system funding for the second half of 20/21. Work is ongoing to develop draft system plans for submission to NHS England and Improvement by 6 May. **MHLDA** The MoU which is the culmination of work undertaken by the five providers of MH services across SYB that supports the development of a MHLDA Alliance is currently still being approved through partner Boards. The Alliance are supporting the development of three specialist provider collaboratives, Forensics new model of care, Eating disorders and CAMHS tier 4. The Trust are a partner in the SYB ICS eating disorder collaborative as well as the WYH ICS in terms of enabling the overarching vision to support people as close to home as possible. For the other provider collaboratives, the Trust is leading the Forensic provider collaborative as part of the West Yorkshire and Harrogate ICS and partners in CAMHS tier 4. **MHLDA programmes** **Suicide Prevention project**– funded until end of June 21, project is well established and discussions around sustainability are **IPS** – Building on the success of this programme in Barnsley, an additional two IPS workers have been employed by SYH and are placed within the Recovery college. **Quit** – The contract between QUIT programme and Yorkshire Cancer research has been signed, tabaco advisors anticipated to be in place by July 2021. **Community mental health transformation** The Trust has secured funding as part of the SYB ICS Community transformation funding. Partnership discussions with Primary Care Network in Barnsley are underway to discuss the

	new roles and the VCS to develop joined up pathways for support and early help. Recovery Colleges are developing proposals for peer support workers and a forum for people with lived experience established with inaugural meeting taking place in May 2021. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register and will need to be kept in view as the SYB ICS and MHLDA Alliance develops, new risks may emerge.
Recommendation:	**Trust Board is asked to:** • **NOTE the SYB ICS update.** • **NOTE the MHLDA Alliance and programme update.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 9.3

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 with: 1. An update on key developments within West Yorkshire and Harrogate Health and Care Partnership (WYH HCP), including response to Covid-19 and key priorities. 2. Local Integrated Care Partnership developments in Calderdale, Wakefield and Kirklees.
Mission/values:	The development of **joined-up care and response to Covid-19** through **place-based arrangements** is central to the Trust's 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 March 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 Covid-19 response and Vaccination programme** The partnership has continued to deliver a joined-up response to Covid-19 and the delivery of the vaccination programme across the region and in each of the places that make up the partnership. **Operational Planning and financial framework 21/22** On 25 March 2021, NHS England and NHS Improvement issued priorities and operational planning guidance for the NHS, covering the first half of 2021/22. This sets out a range of specific requirements that will be addressed through the partnership planning process. **System Clinical Leadership**

	The partnership has approved a set of principles to strengthen clinical leadership as part of its response to the white paper. **WY&H Partnership response: Learning disability deaths and COVID-19** The partnership has supported proposals to develop and deliver a whole system approach to addressing health inequalities experienced by people with a Learning Disability. **Mental Health, Learning Disabilities and Autism Collaborative** An overview of key work streams and developments being progressed collaboratively are included in the paper, including transformation funding to support the development of community and crisis services. **Place-based developments** We continue to work with partners to develop and deliver joined-up Covid-19 response and the vaccination programme in each of the places that we provide services. We also continue to contribute to place-based recovery and reset planning. **Risk Appetite** The development of the partnership's 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 developments in Calderdale, Wakefield and Kirklees.**
Private session:	Not applicable.

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - Update
Trust Board 27 April 2021

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 Covid-19 response and Operational Priorities

We have seen the national Covid-19 infection rates continue to reduce and the case rates remain higher in Yorkshire and the Humber than other regions, but the situation continues to be an improving one. The weekly system briefing meetings have continued and provide up to date information on partnership priorities and Covid-19 response plans. WYH has continued to deliver a co-ordinated Vaccination programme across the region and the focus on recovery and planning has commenced.

4. Operational Planning and financial framework 21/22

On 25 March 2021, NHS England and NHS Improvement issued priorities and operational planning guidance for the NHS, covering the first half of 2021/22. This sets out a range of specific requirements that will be addressed through the partnership planning process. **The Trust is a key partner in the ICS planning process and has been fully engaged through place-based planning discussions. There is a separate paper covering the Trust's financial plans for Trust Board to review.**

5. System Clinical Leadership

Clinical engagement throughout the West Yorkshire and Harrogate Partnership is strong; there are many good examples of how clinicians have helped shape and deliver priorities and improvements - for example, through the clinical leadership forum, we have seen the roll out of the healthy hearts and Atrial fibrillation programmes and the ethical decision making framework in response to Covid-19. **There is also strong clinical leadership through the numerous mental health, learning disability and autism programmes that the Trust is either leading or a partner in.** Principles to strengthening clinical leadership in the ICS going forward were presented at the System Leadership Executive and supported. The principles include clinical

leadership in strategy formulation, including setting strategic priorities and resource allocation. Clinical leaders to play a key role in ensuring service user, carer and community involvement in service and system redesign and improvement**. This approach is embedded in the Trust's approach to innovation, quality improvement and change and the proposals will help strengthen this approach through our place-based work and partnerships.**

6. WY&H Partnership response: Learning disability deaths and COVID-19

One of the ten ambitions that the partnership is committed to achieve is a 10% reduction in the gap in life expectancy between people with mental health conditions, learning disabilities and/or autism and the rest of the population, however, the recent Public Health England (PHE) report into learning disability deaths during the Covid-19 pandemic laid bare the inequality in mortality rates at a national level. A proposal that was supported by the System Leadership Executive set out a whole system approach to be developed through each place-based partnership to address the needs of people with learning disabilities. This includes the following recommendations:

a) Setting the expectation that people with a learning disability will be prioritised for vaccine distribution
b) Asking all providers of care to immediately consider:
    - Current application of the mental capacity act for people with a learning disability in their organisation
    - How they know who, within their current care, has a learning disability and whether they are making appropriate adjustments to support referral, diagnosis, treatment and wider support
    - Their plans to ensure that reasonable adjustments are made proactively to ensure services meet the needs of people with a learning disability, without them needing to be identified or be provided with reactive support
c) Asking all Primary Care Networks to consider where people with a learning disability sit within their identified population priorities and to ensure they are prioritised appropriately
d) Asking the Mental Health, Learning Disability & Autism programme to propose the infrastructure needed to run with a learning disability health inequalities challenge campaign
e) Asking SOAG to consider how issues of learning disability inequality are regularly monitored and assured that we are presenting our approach to respond to this challenge

Additional resources have been secured to enable a WYH level of support to address health inequalities for people with a Learning Disability over the next three years. Expectations of NHS Trusts will include:

- To access system-wide training, once procured, to help staff, carers and family members identify as early as possible signs of deteriorating health with people with LD and how to respond
- To support data robustness and data sharing that allows improved understanding of people with LD on waiting lists, number of patients with LD treated for different conditions and differing causes of death, the number of people with LD who are classed as 'did not attend' for appointments and the number of people with LD attending screening invitations
- To share self-assessments against the Learning Disability Improvement Standards with the Learning Disability steering group to support wider learning programme of work to support places and partners to deliver on the recommendations.

The Trust has been working with partners in each of its places to support the development of action plans and approaches to address the inequalities experienced by people with learning disabilities - this includes increasing annual health checks, improving access to universal services and engagement in physical, creative and cultural, employment opportunities.

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

The Trust Board was appraised at the March meeting on the work that the Mental Health, Learning Disabilities and Autism (MHLDA) programme board and the Specialised MHLDA programme board are progressing. The programme boards meet monthly. Issues to highlight to the Trust Board from the April MHLDA programme board meeting include:

Transformation Funding - Community Mental Health:
The Board has been previously appraised of the background and process undertaken that led to approval from NHSE to support implementation in each district of:

- A new, inclusive, generic, community-based offer based on redesigning community mental health services in and around Primary Care Networks**.**
- New models will also improve access and treatment for adults & older adults with a diagnosis of 'personality disorder', eating disorders and people with mental health community-based rehabilitation needs.

The Trust is supporting each district's implementation model for the community mental health service offer, including the primary mental health practitioners to be employed by the Trust working into the Primary Care Networks (PCNs) as part of the Additional Roles Reimbursement Scheme (ARRS) for PCNs.

West Yorkshire Adult Secure Lead Provider Collaborative:
The Board received an update report at its January meeting, which summarised further steps to be completed working with NHSE, particularly in respect of a number of actions to be completed by 31 January on the financial plan and associated assumptions in the plan. This was done and further discussions have taken place with NHSE to clarify a number of points. At the time of writing this report, the NHSE regional team does not have final budgets for 2021/22 and has been unable to confirm the income into the Collaborative and therefore what the response to our 'asks' will be.

In this context, the National Provider Collaboratives Oversight Group has agreed to extend the deadline for implementation to **1 July 2021** for those Collaboratives not able to go live by 1 April, therefore, subject to completion of financial due diligence and Board approval - this is now the revised target 'go live' date. The Finance, Investment and Performance Committee will be receiving an update report at its meeting on 23 April 2021. The Provider Collaborative Partnership Board received an update report at its meeting on 20 April and all partners are aware of the current projected governance timetable.

WY Mental Health, Learning Disabilities and Autism (MHLDA) Programme:
The April meeting of the WY MHLDA programme board covered a wide-ranging agenda. This included:

- Following the feedback received on the draft 'MHLDA Future Mechanics' work, for which the Trust provided a detailed response, a smaller workshop is being arranged to 'stress test' the proposals.
- There were presentations on the progress of the work on: Professions workforce strategy; Suicide reduction; Learning Disabilities Assessment and Treatment Unit (ATU); Autism Allies event and next steps; Development of a children and young people App (MHabitat); Perinatal mental health.

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.

Calderdale

SWYPFT is a strong partner in delivering the Calderdale Vision 2024 and Calderdale Cares. We have continued to work with partners to develop a place-based approach and response to the national white paper - this builds on the work that we have been doing with partners over the last few years.

The Trust is also a key partner in the Calderdale System Creativity and Health programme - to ensure that arts, creativity and culture is used across Calderdale to support people's health and wellbeing. The first suite of projects/interventions to support people within Calderdale have commenced including a Couch to Creativity app, The Lullaby Project in partnership with Carnegie Hall, our perinatal mental health services, music making in Children's Centres in partnership with Youth Music Now and Art Boxes for families. A big conversation bringing together the world of Arts and Health organisations is being co-produced on several agreed themes with an initial series of podcasts scheduled to start during April 2021. A Thriving Communities bid was successful and will support the ambitions of creative approaches in Calderdale. Work is underway with the National Centre for Creative Health to capture stories and learning from the Creativity & Health programme and identify how this can be scaled up and replicated across the WY&H ICS footprint. Discussions are underway with Arts Council England regarding future funding opportunities and sustainability of the programme.

We continue to be a partner in the Active Calderdale programme and have secured two years funding. Three services have been selected to pilot integrating physical activity into their systems and processes including Learning Disability, EIP and Perinatal Services. Design thinking improvement workshops commenced in February 2021 with these services in partnership with Active Calderdale and a number of QI projects are in progress and being tested. In addition, work to implement changes to assessment forms and care plans within these services which capture physical activity metrics and outcomes is in progress. 1:1 peer support sessions continue to be provided through the Recovery College's Active Surgery and a Let's Get Physical publication is circulated to learners and services. A 'Moving More SWYFTly' Trust wide campaign has been launched to encourage staff to be more physically active and support their health and wellbeing alongside a survey to capture baseline data. A Bollywood and Latin dance class has been held and attended by both staff and partner organisations and was well received. 30 members of staff have undertaken the Moving Medicine online training package which supports increasing staff confidence in undertaking conversations about physical activity and work is progressing with L&D services about future sustainability of motivational interviewing with a focus on physical activity.

Wakefield

The Trust continues to be a partner in the Wakefield Integrated Care Partnership (ICP) and associated work, leading in specific areas, for example, the Wakefield Mental Health Alliance, the emotional health and mental wellbeing strand in the Children and Young People's Partnership Board.

An update was provided at the March Trust Board meeting on the work of the ICP. The next meeting of the ICP is scheduled to take place on 27 April 2021. The ICP organisational development sessions continue to be scheduled over the next few months and will be important in the context of the design of the ICP from 1 April 2022 onwards.

Kirklees

The Kirklees Integrated Health and Care Leadership Board continues to meet monthly. The most recent meeting took place on 1 April 2021. A main agenda item was a presentation on the

Kirklees ICP development plan. There are now weekly meetings of an ICP Design Team and the Trust is represented on this.

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 - https://www.wyhpartnership.co.uk/meetings/partnershipboard
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 27 April 2021

Agenda item 9.4 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	4 February 2021 Next meeting scheduled for 10 June 2021
Member	Chief Executive / Director of Strategy
Items discussed	• Covid-19 intelligence update. • Report from Health and Wellbeing Board development session. • Tackling excess winter deaths and cold related illnesses. • Better Care Fund. • Mental health partnership.
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Calderdale Health and Wellbeing Board

Date	28 January 2021 and 4 March 2021 Next meeting scheduled for TBC
Non-Voting Member	Medical Director / Director of Nursing & Quality

Items discussed	28 January 2021
	• Covid-19 updates:
	  ○ Covid-19 vaccination update.
	  ○ Covid-19 impact update.
	  ○ Healthwatch report on Covid-19.
	  ○ Scrutiny rapid review – Covid-19.
	  ○ Wider impacts of Covid-19.
	• HWB staying well report.
	• Forward plan.
	
	4 March 2021
	• Covid-19 impact update.
	• Health and Wellbeing Strategy – dental decay age 5.
	• Addressing the climate emergency action plan.
	• Tackling health inequalities for black, Asian and minority ethnic communities and colleagues review.
	• Forward plan.

Minutes	Papers and draft minutes are available at: https://www.calderdale.gov.uk/council/councillors/councilmeetings/results.jsp?committee=190&start=15%2F10%2F2020&p_SQ_ID=5102139&phrase=N&type=agenda&offset=0&id=211221434

Kirklees Health and Wellbeing Board

Date	25 March 2021 Next meeting schedule for TBC
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Covid-19 update. • Kirklees Joint Strategic Assessment Overview 2020/21 and Director of Public Health Annual Report 2021. • Update on Kirklees Inclusion Commission and development of the Kirklees joint health and wellbeing strategy. • Proposed revisions to the terms of reference for the Health and Wellbeing Board. • Kirklees Safeguarding Adults Board Annual Report 2019/20. • The Kirklees Safeguarding Children Partnership Assurance Report.
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	25 March 2021 Next meeting provisionally scheduled for 15 July 2021
Member	Chief Executive / Director of Provider Development
Items discussed	• Focussed Discussion – Reducing Health Inequalities in the Wakefield Health and Care System under the Health and Wellbeing Plan Priorities.
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	12 March 2021 Next meeting scheduled for 14 May 2021
Member	Director of Human Resources, Organisational Development and Estates / Director of Strategy
Items discussed	• ICS System Leader update. • Future ICS – Health and Care Partnership Development. • Developing a population health led ICS and addressing health inequalities 2021/22.
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 March 2021 Next meeting scheduled for 1 June 2021
Member	Chief Executive
Items discussed	• Update from the West Yorkshire & Harrogate Partnership CEO Lead. • Accessing health and care services curing Covid-19. • Tacking health inequalities for black, Asian and minority ethnic communities and colleagues. • Government White Paper: "Integration and Innovation: working together to improve integration and innovation for all" – implications for our partnership. • West Yorkshire devolution • Planning priorities for 2021/22.
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 10.1

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Finance, Investment & Performance Committee with the Integrated Performance Report (IPR) for March 2021.
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 March is in line with developments agreed by Trust Board, including a new section on monitoring progress against our strategic objectives. **Quality** • The majority of quality reporting metrics continue to be maintained during the pandemic • Certification has been achieved from bild in meeting the restraint reduction training standards • Accreditation has been achieved for our serious incident processes by the Royal College of Psychiatrists. • High acuity on inpatient areas continues, placing additional pressure on staffing • Clinical supervision target has been achieved **NHSI Indicators** • Three young people under the age of eighteen was admitted to an adult ward in February for a total of six days • Inappropriate out of area bed usage increased to 82 days in March, largely driven by psychiatric intensive care unit (PICU) beds • Performance against nationally reported targets remains largely positive • Strong progress has been made in paediatric audiology with regard to the maximum six week wait. It is now marginally below target and represents good recovery given the impact of the pandemic **Locality** • Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased with escalating demand outstripping commissioned capacity. Business case under consideration by CCG in Calderdale and Kirklees

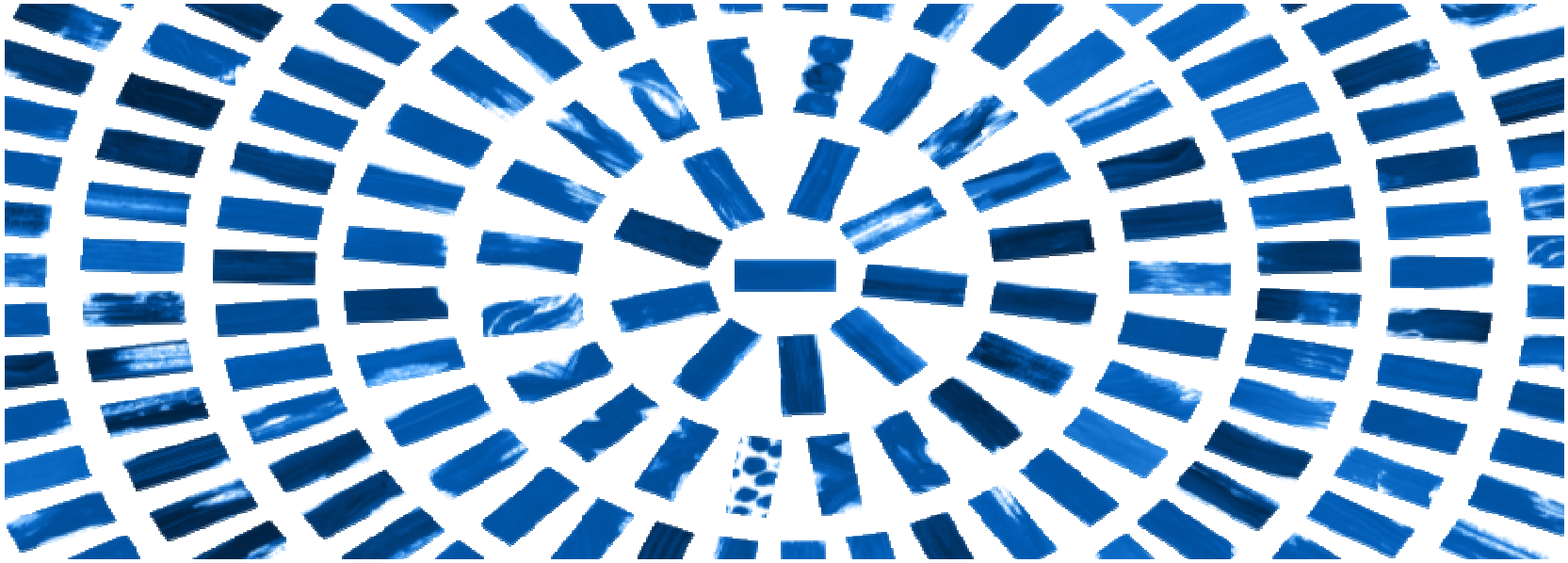
	• Proactive engagement with urgent care board in Barnsley and positive acknowledgment of liaison and intensive home-based treatment team performance • Referral numbers in CAMHS placing pressure on waiting times. Exceptionally high rate in March following school return. • Challenges in recruiting to nurse prescriber role at Urban House • Mobilisation has commenced for the Barnsley Breathe service • Staffing levels remain under constant review in forensics and are being managed through robust arrangements including the service business continuity plans • The availability of consultant psychiatry cover in learning disabilities has been challenging, with gaps in consistent responsible clinician (RC) provision. Temporary measures provide cross cover and safer care, but they are not sustainable in the longer term • Maintaining patient flow and facilitating sufficient ward capacity has been challenging in adult acute and PICU inpatient settings. High levels of acuity and service user distress are being witnessed • The action plan and training around care programme approach (CPA) reviews is ongoing, closely monitored and supported at trio level and performance in each area of the BDU has exceeded target for Quarter 4. **Priority Programmes** • An internal project group has been established to support the community mental health transformation programme. • We await a revised baseline income offer for the forensics lead provider collaborative • Discussions taking place with commissioners in Calderdale and Kirklees to address CAMHS neuro waiting lists • The Trust is working with partners in each place to further develop integrated care partnership arrangements in line with the potential implications arising from the recent NHS white paper • Financial planning underway for the first half on 2021/22 **Finance** • The full year surplus (pre audit) is £4.6m. This is £6.7m favourable to the original plan. • A number of nationally agreed transactions at the end of the year have contributed to this position. These include compensatory income for the loss of non-NHS income during the Covid-19 pandemic, funding for additional annual leave being carried over as a result of the pandemic and some contribution towards the estimated costs associated with the Flowers adjudication. • Further additional income arose via commissioners and other sources towards the end of the year. • A summary of the key variances to plan is shown in the main finance report. • It is estimated that on a comparable basis to the original plan (i.e. excluding additional national funding streams) the surplus would have been £2.7m.

	• Agency staffing costs increased slightly to £0.8m in the month and finished at £7.0m for the full year, slightly below last year. • Excluding the impact of a nationally agreed transaction for PPE £0.4m of costs were identified as being reasonably incurred as part of the Covid-19 response. These include costs relating to the vaccination programme. • Out of area bed costs were £218k, which is an increase compared to previous months given higher demand, particularly for PICU beds. There also continues to be high spend on locked rehab placements in Barnsley. • Underlying pay costs were similar to previous months although the reported position was higher due to holiday pay and bank and enhancement accruals. • Capital expenditure closed the year at £4.9m following a detailed review of work completed to date on the estates programme and conclusion of a number of IT related schemes. • The cash balance reduced to £56.6m given the unwinding of advance income payments in March. • Cumulatively 95% of all third-party invoices have been paid within 30 days. The average number of days to pay suppliers in March was 14. **Workforce** • As at April 20th there were 33 staff off work and not working Covid-19 related. This is much reduced compared to February • Non Covid-19 sickness reduced to 3.9% in March • 610 staff have tested positive for Covid-19. There were no positive test results in March • Staff turnover increased slightly to 10.3% in March, which remains lower than last year • 4,482 staff members (including bank staff) have received their first Covid-19 vaccination as at April 20th (87%) with 3,254 receiving their second vaccination by the same date **Covid-19 response** In addition to the points identified in the sections above: • Sufficient PPE remains in place • The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in • Lateral flow testing for staff continues to be used • Significant support to care homes is provided by our community teams in Barnsley • The Trust Opel level remains at 2 • Silver and Gold Command meetings have reduced to once a week

	• National guidance continues to be monitored, reviewed, and adopted • A range of staff and wellbeing support offers continue to be available and used
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Integrated Performance Report
Strategic Overview



March 2021

With **all of us** in mind.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for March 2021. Following recent discussions at Trust Board and work conducted by a sub-group this IPR represents the recommended updates to the structure and contents of the report. This development of the IPR will continue to evolve in the coming months.

It continues to be the case that given the focus of all staff on responding to Covid-19 and the vaccination programme, coupled with the level of staff absence, not all the normal information is necessarily 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 sometimes with reduced content. It should be emphasised that the majority of services have continued to be provided during the pandemic, although in some cases in a different manner such as less face to face contact and in some services referrals have been lower than historical averages.

A number of metrics identified to monitor performance against our strategic objectives have been populated, whilst others are in development with indicative timescales provided. Reporting against some metrics may take a little longer to develop and where appropriate, alternatives may be considered in the short term

With reference to key information relating to Covid-19, where possible the most up-to-date information is provided as opposed to the March 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
- Emergency Preparedness, Resilience and Response (EPRR)
- Quality
- National metrics
- Priority programmes
- Finance & contracting
- Workforce

Further consideration will be given to performance targets during the first quarter of 21/22 and it is likely additional metrics will be included as a result of the introduction of the new system oversight framework. we will also need to consider how Trust Board monitors performance against the reset and recovery programme. Our integrated performance strategic overview report is publicly available on the internet.

The following four pages highlight the performance against the Trust's strategic objectives.
EMT has now agreed to include community mental health transformation as an additional priority. An initial programme group meeting has been held and milestones will be agreed in the March meeting and updated in future reports on a monthly basis.

Improving health

Priority programme	Metrics	Threshold	Jan-21	Feb-21	Mar-21	Trend	Year end forecast	Notes
Play a full role in our integrated care systems and associated places to contribute to outcomes in their 5 year plans	1.Number of suicides for patients with an open referral to SWYPFT services		1	3	3			
	2.Smoking Quit rates for patients seen by SWYFT Stop Smoking services (4 weeks) *		*67.4%**					Quarter 4 figures are provisional and will be refreshed in May 2021.
	3.Proportion of people from BAME communities accessing IAPT		Reporting Commenced Feb 21	14.5%	14.4%			BAME population 13.0%
Improve outcomes through our wellbeing services, physical health and services for people with mental health illnesses and learning disabilities	1. Cardio metabolic assessment & treatment		Data currently unavailable					Work has been taking place in relation to reviewing the reporting for cardio metabolic assessments. A small task and finish group has been established to review. The detail behind the indicator is being worked up and there are some issues identified that may impact on the reporting outcome. A numerator and denominator have been identified to ensure that reporting against this metric relates to service users on CPA who have a diagnosis of psychosis. It is anticipated that the initial focus for reporting will be on inpatients and early intervention services. Initial data has been pulled and is being analysed.
	2. IAPT - proportion of people completing treatment who move to recovery	50%	53.1%	53.4%	*53.6%*			March data is provisional and will be refreshed in May 2021
	3. % service users on CPA followed up within 7 days of discharge	95%	89/90 =98.9%	90/90 =100%	98/101 =97.0%			
	4. % of service users on CPA with a 12 month follow up recorded	95%	94.5%	94.8%	96.8%			Upward trend overall since April 20, targeted work continues to be undertaken with learning shared across teams
	5. % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 week	90%	*86.2%*	*88.1%*	*73.8%*			January, February and March data is provisional and will be refreshed in May 2021
Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges	Full understanding of baseline of performance against the Creative Minds performance framework by March 2021 to enable targets to be set for 21/22 * 1. Number of people accessing creative cultural learning activities	TBC	Due April 2021					Direct contact = with the Covid response projects only. Indirect contact = takes into consideration online 'traffic' and postage of packs

Notes:
* - quarterly data.

Below we have set out key milestones for priority areas of focus in the current and next quarter. This only covers those priority areas that are being supported and managed as a programme of work. It does not reflect the breadth of improvement/change work happening on all priority areas or those that are being supported at a more local level in line with our integrated change framework

Improve health (Salma Yasmeen and Sean Rayner)

Key Milestones		Comments:
1. Creativity & Health: Commence an initial series of big conversation initiatives including podcasts to bring together the Arts and Health organisations in February and on track for first round of conversation to be held by April 2021.	On track	• Working with each place to review and further develop integrated care partnership arrangements in line with the potential implications of NHS E/I proposals • Focus of work in integrated care systems is on providing ongoing Covid support and a joined up Covid response. • Working with each place to establish local recovery plans. • Established a SWYPFT programme group to support the community transformation.
2. Active Calderdale: integrating physical activity into systems and processes: Conduct design thinking improvement workshops with three services in Calderdale commencing February 2021 and on track for completion in April 2021.	Complete	
3. Forensic Lead provider collaborative: Given the current lack of clarity on income available for next year and following discussions within WY Collaborative Partnership Board/NHSE, a revised 'go live' date is now 1 July 2021. This is subject to reaching agreement with NHSE on income and financial safeguards, and agreement from governing bodies in the lead provider collaborative.	Amber	
4. Community Mental Health Transformation: Agreed hosting of programme manager positions (Calderdale and Kirklees), recruitment into the posts, April – May 2021.	On track	

Improve Care

Priority programme	Metrics	Threshold	Jan-21	Feb-21	Mar-21	Trend	Year end forecast	Notes
Continually improve patient safety	1. Incidents involving moderate or severe harm or death	Trend monitor	29	25	28			
	2. Number of c-diff avoidable cases	0	0	0	0			
	3. Number of pressure ulcers	Trend monitor	33	29	34			
	4. Safer staffing fill rates (%)	90%	114.3%	116.2%	116.2%			
	5. Number of children & young people in adult wards	0	2	1	3			Total of 6 days in March
	6. Staff absence due to Covid-19		22	13	13			No of staff still absent from work - Covid-19 positive
	7. Number of nosocomial incidences of Covid-19 in our inpatient units		115	134	137			Cumulative
Provide care as close to home as possible	1.Out of area bed placements (days)	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	91	78	82			Continued pressure and demand with the number of placements minimised
Deliver improvements particularly in CAMHS and forensic services	1.Numbers waiting over 4 weeks for assessment (CAMHS)		192	173	156			
	2.Numbers waiting over 18 weeks for treatment (CAMHS)		122	132	136			
	3. Friends & Family test - CAMHS	80%	75.9%	74.6%	77.6%			79 responses in March
	4. Forensics staff sickness	<=5.4%	6.1%	5.4%	4.1%			
	5. Forensics staff turnover		Currently unavailable due to covid-19 response					
	6. Race related incidents in forensics		9	4	4			
Safely deliver and restore inclusive services locking in innovation	1a. Waiting lists - Referral to assessment within 2 weeks (external referrals)	75%	90.5%	92.2%	95.7%			
	1b. Waiting lists - Assessment to treatment within 6 weeks (external referrals)	70%	95.5%	95.3%	96.1%			
	1c. Waiting lists - Referral to assessment within 4 hours (external referrals)	90%	95.0%	91.5%	91.0%			
	2a. Average contacts per day - Core MH		259	266	279			Pre Covid-19 - 240 (October 2019 which is representative of the following 6 months)
	2b. Average contacts per day - IHBTT		116	109	112			Pre Covid-19 - 154 (October 2019 which is representative of the following 6 months)
	2c. Average contacts per day - Learning disability community		144	146	157			Pre Covid-19 - 89 (October 2019 which is representative of the following 6 months)
	2d. Average contacts per day - District nursing, end of life and community matrons		551	603	616			Pre Covid-19 - 710 (Average from September 2019 to January 2020)
	3. Access representative of community population		Data currently unavailable					New referrals compared to population health data to be reported in May 21.

Improve care (Carol Harris)

Key Milestones	
1. Recovery plan development and restoration of services: stabilisation phase March - June 2021	Recommencing
2. Care as close to home: Formal patient flow 7-day service, new target to in place by 31.04.21	On track
3. Care as close to home: Gatekeeping analysis commence by end Apr and be taken forward through May and complete in June.	On track
4.CAMHS improvement **Neuro waiting lists (Calderdale and Kirklees:)** Agreement with Calderdale & Kirklees commissioners for trajectory for CAMHS waiting list reduction by now forecast for end May 2021 (previously end March). Conversations are still ongoing with both Calderdale and Kirklees commissioners with verbal confirmation of	Amber
5. CAMHS Barnsley: Plan to reach agreement with commissioners regarding Access KPIs depending on additional funding for 2021/22 by end of June 2021	On track

Comments:

- Operational services are stabilising and moving into recovery phase. Focus on maintaining core critical services and prioritise/address emerging and immediate impact (service and workforce) and commence/refresh insight and learning to inform recovery planning.
- Reprioritisation of resources agreed to focus on the high priority areas of pandemic management and response including vaccination programme
- Recovery of services continues in line with service level business continuity plans
- Verbal confirmation received from Calderdale and awaiting feedback from Kirklees commissioners on CAMHS proposals.
- Barnsley and Wakefield - Some early indication that both services are receiving higher number of referrals and accepting as requiring CAMHS input. Unclear whether this is a spike in demand as a result of COVID-19.

Improve resources

Priority programme	Metrics	Threshold	Jan-21	Feb-21	Mar-21	Trend	Year end	Notes
Spend money wisely and reduce waste	1. Surplus/(deficit) vs target	In line with Plan	£824k	£533k	£963k		£4.6m	Over-achieved compared to plan
	2. Underlying surplus/(deficit)							Not currently calculated due to interim financial arrangements
	3. Cash		£70.1m	£75.5m	£56.6m		£56.6m	
	4. Performance against efficiency targets							Not currently calculated due to interim financial arrangements
Integrate digital approaches to the way we work	1. Number of 'did not attends'		4.2%	3.9%	3.8%			
	2a. Percentage of video consultations		4.2%	3.8%	3.8%			Slightly lower than national averages
	2b. Percentage of telephone consultations		47.9%	41.1%	38.0%			
	2c. Percentage of face to face consultations		47.9%	55.1%	58.3%			
	3. Prescribing errors (EPMA) (development required)		Currently unavailable due to covid-19 response					6 wards are now fully live using EPMA, over the next month an evaluation of these wards will take place alongside a continuation of training. Further work to be undertaken to scope out implementation across other wards.

Improve resources (Mark Brooks)

Key Milestones	
1. Digital: Agreement of new Digital Strategy by 31.03.21	**Complete**
2. Digital: EPMA live in 2 clinical areas by 31.01.21	**Complete**
3. Financial Plan: development of financial plan for 21/22 by 30.04.21	On track

Comments:

- Spend money wisely and reduce waste: Current focus is on the development of a financial plan for the first half of 2021/22
- The Trust needs to prepare to re-focus on waste reduction and improving productivity in anticipation for the need for efficiency savings in H2 21/22 and beyond

Make SWYPFT a great place to work

Priority programme	Metrics	Threshold	Jan-21	Feb-21	Mar-21	Trend	Year end forecast	Notes
Support the provision of a healthy, resilient & safe workforce	1. Sickness absence	4.5%	4.0%	4.0%	3.9%			Non Covid-19 sickness lower than previous years
	2. Staff turnover	10%	10.0%	10.0%	10.3%			Staff turnover has reduced in 2020/21
	3a. Clinical supervision	>=80%	81.3%					Improved performance reported locally this quarter
	3b. Appraisal	>=95%	Data currently unavailable					Suspended due to Covid-19
	4. Incidents of violence and aggression against staff	Trend monitor	75	69	82			
	5a. Staff survey - % staff recommending the Trust as a place to receive care and treatment	80%	71.8%					Increased from 65.6% in 2019
	5b. Staff survey - % staff recommending the Trust as a place to work	65%	69.0%					Increased from 61.5% in 2019
	6. Cases of bullying & harassment		1	1	0			
	7. Absence due to stress & anxiety and MSK		2.4%	2.5%	2.3%			
	8. Relative likelihood of appointment to roles band 5 and above for people from BAME backgrounds	>1	1.14	0.73	1.06			Above 1 indicates that white applicants are more likely to be appointed
	9. Access to training for staff members from BAME backgrounds		Currently unavailable due to covid-19 response					
Refresh and deliver our sustainability strategy and action plan	Dependent on what is identified in the updated sustainability plan							Requires further development

Make this a great place to work (Alan Davis)

Key Milestones	
1. Healthy, resilient and safe workforce: Establish and operationalise Covid vaccine hubs	**Complete**
2. Healthy, resilient and safe workforce: Develop stratification model for delivering Covid vaccine	**Complete**
3. Healthy, resilient and safe workforce: Deliver vaccine to workforce in line with stratification and supply	Ongoing
4. Healthy, resilient and safe workforce: source staff to work on the vaccination programme including the staffing of covid-19 vaccination clinics	Ongoing

Comments:
• Current key focus has been supporting the delivery of the vaccine programme across the Trust with this now starting to be decommissioned over the next few weeks.
• There are a series of Great Place to Work measures being developed linked to the Workforce Strategy which will inform future IPR metrics.

Lead Director:
• This section has been developed to demonstrate progress being made against Trust objectives using a range of key metrics.
• Headlines from recent benchmarking reporsts are provided this month.
• More detail is included in the relevant section of the Integrated Performance Report.

Quality
• The majority of quality reporting metrics continue to be maintained during the pandemic
• Certification has been achieved from BILD in meeting the Restraint Reduction Training Standards
• Accreditation has been achieved for our Serious incident processes by the Royal College of Psychiatrists.
• The number of admissions under 18's to adult wards has increased
• High acuity on inpatient areas continues, placing additional pressure on staffing
• Clinical supervision target has been achieved

NHSI Indicators
• Three young people under the age of eighteen was admitted to an adult ward in February for a total of six days. It should be noted that one of these your people was aged 14 and was admitted to and adult ward for one night.
• Inappropriate out of area bed usage increased to 82 days in March, largely driven by psychiatric intensive care unit (PICU) beds
• Performance against nationally reported targets remains largely positive
• Strong progress has been made in paediatric audiology with regard to the maximum six week wait. It is now marginally below target and represents good recovery given the impact of the pandemic

Locality
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased with escalating demand outstripping commissioned capacity. Business case under consideration by CCG in Calderdale and Kirklees
• Proactive engagement with urgent care board in Barnsley and positive acknowledgment of liaison and intensive home-based treatment team performance
• Referral numbers in CAMHS placing pressure on waiting times. Exceptionally high rate in March following school return.
• Challenges in recruiting to nurse prescriber role at Urban House
• Mobilisation has commenced for the Barnsley Breathe service
• Staffing levels remain under constant review in forensics and are being managed through robust arrangements including the service business continuity plans
• The availability of consultant psychiatry cover in learning disabilities has been challenging, with gaps in consistent responsible clinician (RC) provision. Temporary measures provide cross cover and safer care, but they are not sustainable in the longer term
• Maintaining patient flow and facilitating sufficient ward capacity has been challenging in adult acute and PICU inpatient settings. High levels of acuity and service user distress are being witnessed
• The action plan and training around care programme approach (CPA) reviews is ongoing, closely monitored and supported at trio level and performance in each area of the BDU has exceeded target for Quarter 4.

Priority Programmes
• An internal project group has been established to support the community mental health transformation programme.
• We await a revised baseline income offer for the forensics lead provider collaborative
• Discussions taking place with commissioners in Calderdale and Kirklees to address CAMHS neuro waiting lists
• The Trust is working with partners in each place to further develop integrated care partnership arrangements in line with the potential implications arising from the recent NHS white paper
• Financial planning underway for the first half on 2021/22

Finance
• The full year surplus (pre audit) is £4.6m. This is £6.7m favourable to the original plan.
• A number of nationally agreed transactions at the end of the year have contributed to this position. These include compensatory income for the loss of non-NHS income during the Covid-19 pandemic, funding for additional annual leave being carried over as a result of the pandemic and some contribution towards the estimated costs associated with the Flowers adjudication.
• Further additional income arose via commissioners and other sources towards the end of the year.
• A summary of the key variances to plan is shown in the main finance report.
• It is estimated that on a comparable basis to the original plan (i.e. excluding additional national funding streams) the surplus would have been £2.7m.
• Agency staffing costs increased slightly to £0.8m in the month and finished at £7.0m for the full year, slightly below last year.
• Excluding the impact of a nationally agreed transaction for PPE £0.4m of costs were identified as being reasonably incurred as part of the Covid-19 response. These include costs relating to the vaccination programme.
• Out of area bed costs were £218k, which is an increase compared to previous months given higher demand, particularly for PICU beds. There also continues to be high spend on locked rehab placements in Barnsley.
• Underlying pay costs were similar to previous months although the reported position was higher due to holiday pay and bank and enhancement accruals.
• Capital expenditure closed the year at £4.9m following a detailed review of work completed to date on the estates programme and conclusion of a number of IT related schemes.
• The cash balance reduced to £56.6m given the unwinding of advance income payments in March.
• Cumulatively 95% of all third-party invoices have been paid within 30 days. The average number of days to pay suppliers in March was 14.

Workforce

- As at April 20th there were 33 staff off work and not working Covid-19 related. This is much reduced compared to February
- Non Covid-19 sickness reduced to 3.9% in March
- 610 staff have tested positive for Covid-19. There were no positive test results in March
- Staff turnover increased slightly to 10.3% in March, which remains lower than last year
- 4,482 staff members (including bank staff) have received their first Covid-19 vaccination as at April 20th (87%) with 3,254 receiving their second vaccination by the same date

Covid-19

- Sufficient PPE remains in place
- The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in
- Lateral flow testing for staff continues to be used
- Significant support to care homes is provided by our community teams in Barnsley
- The Trust Opel level remains at 2
- Silver and Gold Command meetings have reduced to once a week
- National guidance continues to be monitored, reviewed, and adopted
- A range of staff and wellbeing support offers continue to be available and used

Covid-19 response

This section of the report focuses on a number of components of the Trust's response to Covid-19 including testing, support to the system and PPE.

Managing the clinical response

PPE position

• Stock levels remain good, ensuring sufficient supply to meet staff needs
• Additional demand anticipated late March and into April to meet the requirements of the vaccination programme

PPE Levels	Approx days stock as at 12-Jan	Approx days stock as at 09-Feb	Approx days stock as at 16-Mar	Approx days stock as at 13-Apr
Surgical masks	43	26	31	31
Respirator masks	142	102	93	109
Aprons	30	24	25	23
Gowns	66	63	59	62
Gloves	35	24	21	22
Visors	132	32	26	46

Testing

KPI	As at 24th November 2020	As at 22nd December 2020	As at 19th January 2021	As at 17th February 2021	As at 23rd March 2021	As at 20th April 2021	Notes
No of service users tested (ward)	174	225	257	278	297	300	Symptomatic
No of service users tested positive (ward)	60	83	94	115	134	137	Cumulative
No of service users recovered	60	83	94	115	119	121	2 patients deceased

Patient testing & pathway/Outbreak response & management

Symptomatic patient testing is being undertaken and revised regime under review.
Outbreaks continue to be managed by the infection prevetion and control team.

Testing approach

Current position
Patients:

• Swabbing for symptomatic testing through Pillar 1 inpatient and through Pillar 2 if required for community setting.
• Inpatient asymptomatic COVID19 testing is undertaken through Pillar 1, taking place on admission, day 3 and day 5 and testing prior to discharge to adult care facility. Patient are also re-tested on their return if they leave the ward or unit over a 24 hour period. Also testing takes place for some patient on treatment pathways e.g.- planned operation/ treatment/ procedures.
• Outbreak and hotspot testing is provided through an internal testing route, with adequate capacity from local labs as required.

Staff

• Symptomatic testing - access via pillar 2 or through internal testing route. Testing staff per and post-operative and procedures as required
• Outbreak and hotspot testing is managed and provided through internal testing route, with adequate capacity from local labs as required
• Identified SWYFT staff are undertaking Lateral flow testing.

Lateral flow testing has been implemented, 100% test kits have been distributed and a system established to confirm usage. Current information suggests that low levels (below 1%) are showing as positive, this is being monitored. In addition all generally community staff who have previously not taken part in the Trust testing system are now undertaking a lateral flow test 3 x a week to be able to evidence a negative result when going into care homes.

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

Emergency Preparedness

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.

Supporting the system

ICS stress test and outbreak support

- 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.

Covid-19 Vaccinations

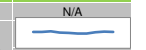
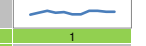
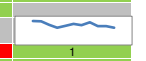
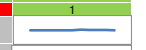
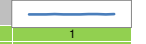
- The Covid-19 Vaccination programme phase 2 is active with many staff members noted as now having their second vaccination;
- The patient vaccination programme continues to be delivered within the wards;
- Mapping of governance structures and ways of working as Business as Usual becomes the norm being discussed.
- A total of 4,483 staff have received their first vaccination (87.2%) and 3,254 staff have received their second vaccination (63.3%)
- In addition to providing vaccinations for our staff we have provided 968 first vaccinations and 864 second vaccinations for partner organisations.

Standing up services

Emergency prepardness, resilience and response (EPRR) update inc OPEL levels

- The Trust OPEL Level remains at 2. This is being managed by way of business continuity plans and also partnership working.
- Silver and Gold command meetings have reduced to 1 per week in light of reduced workings required, however if the need arises to stand up an urgent meeting this can be immediately achieved.
- Consideration is being given to how Covid-19 response is managed in future and whether the commant structure needs to remain in place as it currently stands.

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	42.3%	46.5%	48.8%	47.9%	47.4%	55.7%	65.4%	70.6%	66.7%	63.7%	64.1%	64.2%	N/A
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	10.0%	0% 0/14	17% 5/29	12% 3/25	30% 8/27	19% 6/32	4% 1/24	22% 4/18	8% 2/25	15% 4/27	7% 2/30	16% 7/43	1
	Number of compliments received	Improving Health	Caring	TB	N/A	13	13	41	34	18	19	21	28	45	24	8	31	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	trend monitor	34	35	41	28	25	18	17	32	39	36	24	Due May 2021	
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	trend monitor	7	2	10	11	5	2	4	1	3	4	4		N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	0	0	0	0	0	0	0	1	0	0	0		1
	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	40.3%	40.2%	40.4%	39.6%	39.3%	39.5%	39.2%	38.6%	39.0%	41.3%	41.1%	40.4%	2
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=9	15	20	14	25	17	19	12	17	12	12	13	13	2
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	2.0%	1.7%	1.4%	1.3%	1.1%	1.5%	1.6%	2.9%	2.2%	1.8%	1.6%	1.8%	1
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	90.4%	91.5%	89.4%	84.3%	93.4%	81.0%	20.9%	46.6%	54.0%	55.5%	53.0%	53.2%	N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%	71.2%	83.3%	79.1%	70.0%	74.6%	77.4%	37.3%	47.4%	51.9%	56.0%	63.2%	56.8%	N/A
Quality	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	969	945	1047	1253	1114	981	1169	1149	1041	944	947	1152	
	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	32	27	30	20	19	17	11	21	29	20	17	20	
	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	3	3	4	2	1	2	2	7	2	1	5	
	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	1	5	8	5	6	2	2	8	8	7	7	3	
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	115.1%	119.4%	123.3%	120.5%	118.0%	114.4%	114.0%	114.0%	115.6%	114.3%	116.2%	116.2%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	95.7%	94.3%	93.9%	90.9%	88.6%	85.6%	90.1%	92.2%	90.9%	88.9%	92.7%	92.9%	
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	trend monitor	45	44	36	29	34	38	35	42	33	33	29	34	
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0		3		0	0	0	0	1	0	0	3	2	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	90%	93.0%	91.5%	90.0%	80.0%	94.5%	94.0%	87.5%	100%	90.2%	100%	90.0%	79.0%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	38	44	46	34	46	44	57	47	49	47	44	40	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	121	111	137	188	138	125	165	202	189	166	185	179	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	95.3%	91.5%	90.2%	87.8%	84.4%	94.1%	92.7%	86.8%	85.7%	82.8%	96.0%	100%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	0	0	0	0	0	0	1
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Improving Resource	Single Oversight Framework metric	Improving Resource			2	2	2	2	2	2	2	2	2	2	2	2	2	2
	CQC Quality Regulations (compliance breach)	Improving Resource			Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

** 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 recent months 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. Up to and including September 2020 the 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. Given the recent implementation of the FIRM risk assessment tool, from October 2020 onwards - Older people and working age adult Inpatients, we are counting how many staying safe care plans were completed within 24 hours and for community services for service users on care programme approach we are counting from first contact then 7 working days from this point.
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.

Quality Headlines

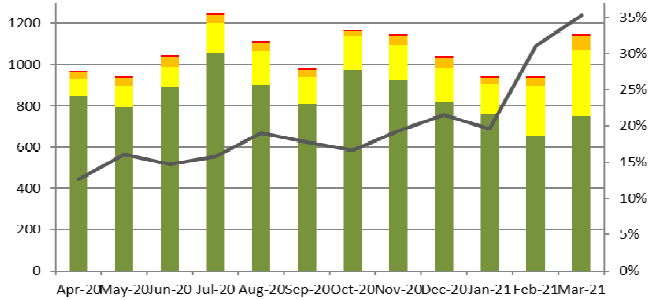
Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.
• Number of restraint incidents - the number of restraint incidents during March decreased from 185 to 179. Further detail can be seen in the managing violence 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) – Total number of falls was 40 in March which is in line with the previous month . 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.
• Duty of candour - no breaches in February
• % Service users on CPA offered a copy of their care plan - Reporting has now been developed to enable us to monitor performance against this metric. To meet the standard all care plans for an individual have to have been identified as offered to the service user. For example, if an individual has 5 care plans, all of these must be marked as offered to the service user for this to achieve the standard. Work is ongoing to improve data quality.
• Number of pressure ulcers (avoidable) - there were 2 incidences of avoidable pressure ulcers to report during March.

NHS Improvement - the development of new programmes introduced in the NHS patient safety strategy are either continuing with amended timescales to be confirmed, or paused. Our Patient safety specialists (Dr Kiran Rele, Associate Medical Director and Helen Roberts, Patient Safety Manager) join national and regional patient safety discussions/information sessions and sharing information into the Trust. NHS England have issued a document with priorities for patient safety specialists which is being aligned with our patient safety strategy and identifying organisational leads.
Serious Incident Review Accreditation Network (SIRAN) - the Patient safety support team has achieved accreditation of our serious incident investigation process by the Royal College of Psychiatrists.
360 Assurance audit of Patient safety - focus on incidents - The Trust received Significant Assurance. Evidence of completion of actions has been provided. All evidence was submitted to 360 Assurance before the 31 March 2021 timescale. We are awaiting feedback.
Policy review - The Incident Reporting and Management policy and Investigating and analysing incidents policy have both been approved by EMT on 25 March 2021.

Safety First

Summary of Incidents April 2020 - March 2021

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



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Red (should not be compared with SIs)	5	10	11	11	10	7	8	13	9	9	11	12
Amber	35	41	48	41	37	32	25	42	51	28	42	69
Yellow	82	101	95	146	165	135	161	167	164	148	241	325
Green	847	793	893	1055	902	807	975	927	817	759	653	746
Total	969	945	1047	1253	1114	981	1169	1149	1041	944	947	1152
Percentage of total that are Red/Amber/Yellow *	12.6%	16.1%	14.7%	15.8%	19.0%	17.7%	16.6%	19.3%	21.5%	19.6%	31.0%	35.2%

Degree of harm analysis:

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 (06th April 2021).

Deaths: of the 3 deaths that were recorded for March 2021, there are 2 Suicide (incl apparent) - community team care - current episode incidents. These are recorded 1 each at Core Team – Calderdale and Enhanced Team North 2 – Kirklees. There is also 1 death caused by homicide by patient recorded at Enhanced Team North 2 – Kirklees.

Severe: of the 5 severe harm incidents recorded for the month of March 2021, these were 2 Pressure Ulcer - Category 4, incidents recorded for the Neighbourhood team in Barnsley, 1 Physical violence (contact made) against patient by patient incident (at Stanley Ward), and 2 self-harm incidents. These were recorded 1 each at Ashdale Ward (based at The Dales, Kirklees BDU), and Enhanced Lower Valley Team – Calderdale.

Moderate: of the 20 moderate harm incidents reported in March 2021, 11 were pressure ulcer category 3 incidents recorded across the neighbourhood team in Barnsley. There were also 1 Pressure Ulcer - Category 3 (medical device related) incident and 1 Tissue viability incident recorded for the Barnsley Neighbourhood Team.
There were also 4 self-harm incidents reported in March 2021. These were recorded 1 each at Core Team – Barnsley, Intensive Home-Based Treatment Team (IHBTT) – Barnsley , and 2 at Ward 18 Priestley.
There was 1 Safeguarding Adults - Neglect concerns incident recorded at Intensive Support Team - Calderdale (PLD), 1 Slip, trip or fall – patient incident recorded at ward 19 (OPS) and 1 Emotional abuse of child incident recorded at Children's Speech and Language Therapy – Barnsley.

** 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…

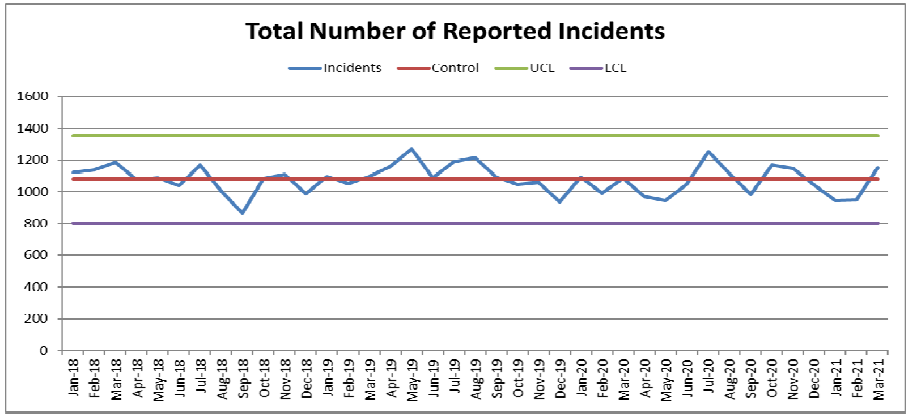
Summary of Serious Incidents (SI) by category

Please Note: initial reporting is upwardly biased, and staff are encouraged to report. Once reviewed and information gathered, this can change, hence the figures may differ in each report

• 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.
95% of incidents reported in March 2021 resulted in no harm or low harm or were not under the care of SWYT. For 2020/21 this figure was 92% overall. This percentage cannot be compared to previous reports as from March 2021, we have amended the way this is extracted from Datix. Previously this was based on severity and now uses degree of actual harm, which should be more accurate.
• 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.

Following a decrease in incidents being reported in February 2021, the number of incidents reported in March 2021 is back at the expected level of average reporting. In February 2021 there were 953 incidents reported compared with March 2021 which was 1152 incidents were reported. This is near the average level of incidents being reported each month, before levels had dropped in January and February 2021.

Mortality
Learning: Clinical mortality review group has been postponed during to Covid 19 pressures on services, although learning continues to be shared through the production of SBAR's which are shared via the learning library.
Regional work: No further regional meetings taken place.
Structured judgement reviews: allocations are on track.
Reporting: Annual data is being prepared and information will be included in the annual incident management report 2020/21.



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.

Safer Staffing Inpatients

High levels of acuity continue to be reported by the inpatient areas across the BDUs. There is a higher requirement for increased observation levels which in turn increases the demands on the regular workforce as well as the need for additional flexible staff. Staff absences caused by COVID related issues has decreased in this time however, we are still faced with challenging staffing issues. The number of vacancies within the RN group remains consistent and we are still showing a near negative balance in the HCA workforce vacancies, albeit that there is an under establishment within band 2s which is balanced by an over established band 3 workforce.
SafeCare has been rolled out within the Unity Centre and we are experiencing some sustainability issues which are being addressed with the wards in the next few days. This will allow a better understanding of the lessons learned and when we can start the process within the next planned area in May which is forensics.
Any incidents where the registered nurse cover has fallen below the expected establishment are supported by local escalation plans which remain robust in the face of the staffing pressures. Each incident where a Preceptee is left alone as a result of an emergency, i.e. sickness or clinical incidents, are looked at and assurances have been given around what support was in place for that incident.
The current band 5 recruitment has allowed us to ensure that the vacancy situation has not worsened, which has allowed us to outperform our neighbouring trusts in the main, however we are looking at different ways to improve this. Included is the international recruitment processes where we are currently completing the tender process to appoint a partner agency. SWYT continues to take the lead in this collaboration with 5 other MH trusts.
Recruitment of band 2s has proven to be effective with residual appointable candidates being taken onto the bank. Bank recruitment also continues at a pace with around 70 HCAs with experience being interviewed in April.
No ward has fallen below the 90% overall fill rate threshold in March, which is a decrease of one ward. Of the 31 inpatient areas, 18 (57.6%), consistent with the previous month, achieved 100% or more. Indeed, of those 18 wards, 11 (a decrease of three wards) achieved greater than 120% fill rate. The main reason for this being cited as acuity, observation and external escorts.

Registered on Days -Trust Total 87.3% (a decrease of 0.9%).
The number of wards that have failed to achieve 80% registered nurses decreased again by one to nine (28.8%). Four wards were within the Forensic BDU, two in Barnsley and three in Calderdale and Kirklees. Although our overall fill rates remain high, all inpatient areas remain under pressure from a registered staffing perspective. This continues to be compensated by increasing the number of HCAs per shift. Contributory factors included high levels of acuity, high sickness/absence and existing vacancies. We are running bespoke adverts for several areas as well as attending virtual University Career fairs. We continue sourcing block bookings for the areas from both bank and agency.

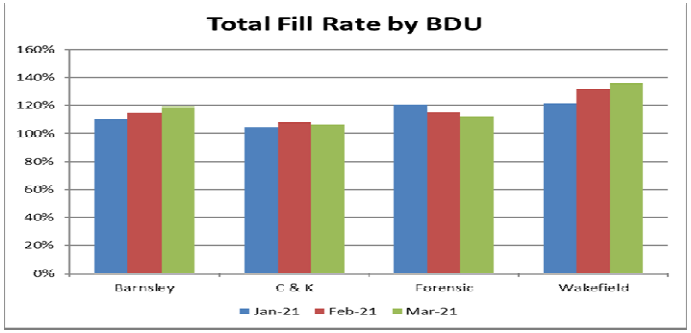
Registered on Nights- Trust Total 98.6% (an increase of 4.1%).
Three wards (9.6%), consistent with the previous month, fell below the 80% fill rate in the month of December. Two were within Barnsley BDU and one within Forensics. This was due to several reasons reflective as above. The number of wards who are achieving 100% and above fill rate on nights decreased by one to 16 (51.2%). Two wards within the Forensic and one within Wakefield BDUs utilised more than 120%.
Overall fill rate for registered staff increased by 0.25% to 92.9%.
Overall fill rate for all staff within inpatient areas remained at 116.2%.

Forensic and LD BDU decreased by 3.0% to 112% , Barnsley increased by 4.0% to 119%, Calderdale and Kirklees BDU decreased by 2.0% to 106%. Wakefield BDU increased by 4.0% to 136%.

Throughout March the main wards where staffing was a raised concern were Ward 18, Barnsley, and Newton Lodge. Shifts were picked up quickly and the fill rate of requested flexible staffing shifts remained high as can be seen in the figures below. These figures do not include OT shifts.
Without the overtime fill rate the requested sum of additional shifts, indictive or acuity including sickness absence, increased to 4,658 (1,067 RN and 3,591 HCA) shifts.

Unfilled Shifts				Filled Shifts
Categories	No. Of Shifts	Total Hours	Unfill Percentage	
Registered	293 (+29)	3,179.50	27.34% (-1.65%)	774 (+114)
Unregistered	375 (+26)	4,211.27	10.24% (- 0.13%)	3216 (+300)
Grand Total	668 (+55)	7,390.77	14.01% (-0.29%)	

We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.



Covid-19 response
The response to the Covid-19 pandemic continues to be led by operations assisted by the support services. Safer staffing has supported the staff bank with focusing temporary staffing resources to the areas of need, offering block bookings, and engaging with other external stakeholders to increase the staffing resource available.
The uptake in bank staff of a vaccine has continued to improve following an extensive and personal comms campaign including personally contacting all bank staff who had yet to receive their vaccine in April.

Information Governance

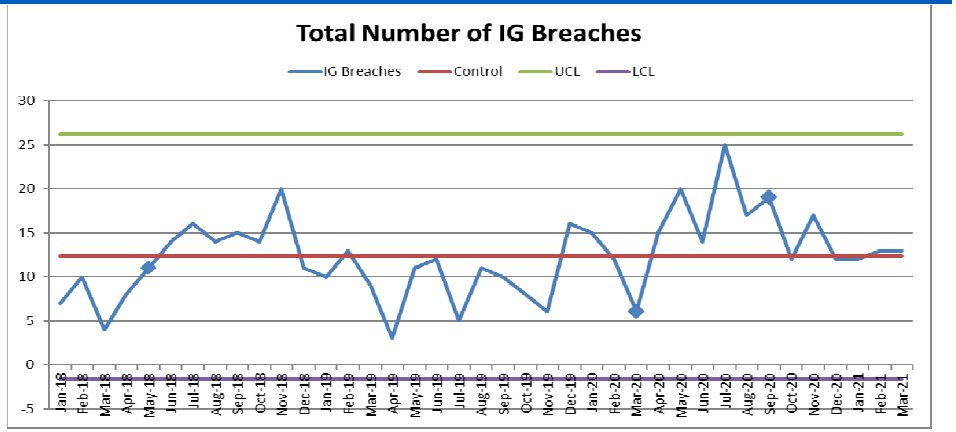
13 data breaches were reported during March and this continues the trend of lower numbers of incidents being reported since December 2020.
All incidents reported involved information being disclosed in error which was the most reported category throughout 2020/21.

It should be noted that all teams engaged with the Information Governance Manager and completed the additional information requested in Datix in a timely manner.

The communications plan is being assessed to ensure it remains meaningful and has an impact.

The Trust did not report any incidents to the Information Commissioner's Office (ICO) during March and no complaints were made about the Trust by members of the public.

SPC Chart
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 of GDPR.
The data point in March 2020 highlights the start of the Covid-19 pandemic, which resulted in changes to some working practices.
The data point in September 2020 has been highlighted given the start of the refreshed awareness and communication plan.



Commissioning for Quality and Innovation (CQUIN)

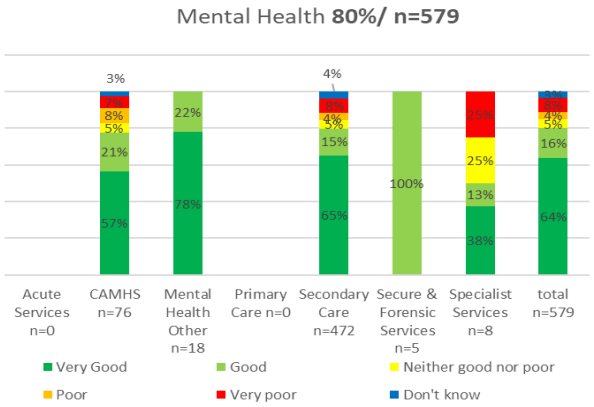
Schemes for 20/21 were suspended during the Covid-19 pandemic period. Similarly there are no CQUIN schemes for H1 2021/22.

Patient Experience

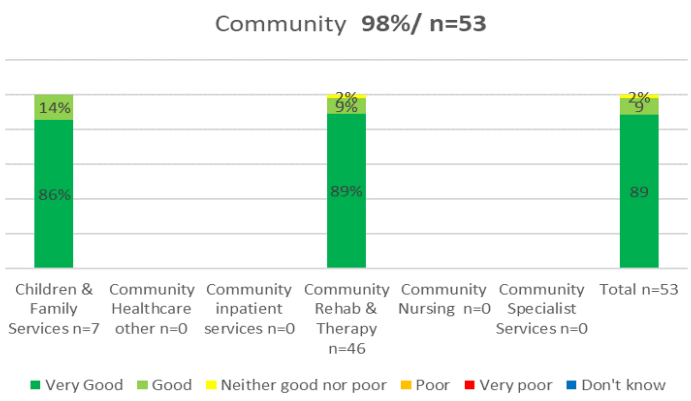
Friends and family test shows

- 98% would recommend community services.
- 81% would recommend mental health services

Mental Health Services



Community Services



- 82% (658) of respondents felt that their experience of services had been very good or good across Trust services.
- 98% (n=53) of respondents felt that their experience had been very good or good across community services.
- 81% (n=605) of respondents felt that their experience had been very good or good across mental health services.
  - After reviewing the comments received (3/160 were negative comments), I was unable to identify any trends or themes for those that stated that the service was poor.
- The text messaging service provided 84% of responses for March.

Safeguarding

Safeguarding remains a critical service, all statutory duties have been maintained, data flow (internally and externally) has continued in a timely manner and the team have continued to provide supervision. Level 3 Safeguarding adults and children training continues to be delivered virtually via MS Teams. This has been positively received although further work to support interaction is being undertaken. Levels 1 and 2 have been accessed via e-learning with all mandatory courses (including PREVENT) reported above the 80% mandatory training target. The team are delivering the parental mental health and the impact on children package and this has been well received.
The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections.
External information gathering requests have been responded to and the team have continued to attend Child Safeguarding Practice Review panels, Safeguarding Adult Review panels and a Domestic Abuse panel.
The safeguarding team provided a bespoke training session for the Forensic Community team on the Learning from Mental Health Homicide.
The Specialist Advisor for Safeguarding Adults has been joint working with the Safeguarding Adult Board manager in Barnsley to review partner agency chronologies and develop questions for partner agencies to support the development of a report for a learning lessons review.
The Safeguarding Adult Advisor has supported practitioners through the attendance at a learning lessons event following a Safeguarding Adult Review and Kirklees Network event.
The Safeguarding Team have co-produced the values based work / boundaries leaflet, this has been finalised and is to be sent out with pay slips for April.
Safeguarding Children Nurse Advisor attended the County lines, proactive safeguarding conference, and the Public Health Approach to modern day slavery conference.

Infection Prevention Control (IPC)

Ongoing work for COVD19 pandemic

Surveillance: There has been zero cases of ecoli bacteraemia, C difficile, MRSA Bacteraemia and MSSA bacteraemia.

Mandatory training figures are healthy:

Hand Hygiene-Trust wide Total –97%
Infection Prevention and Control- Trust wide Total –94%

Policies and procedures are up to date.

Complaints

There were 43 new formal complaints in March 2021. Of these 7 has a timescales start date, 9 have been closed as no consent/contact and 27 are awaiting consent/questions
16% of new formal complaints (n=7) had staff attitude as a primary subject
31 compliments were received

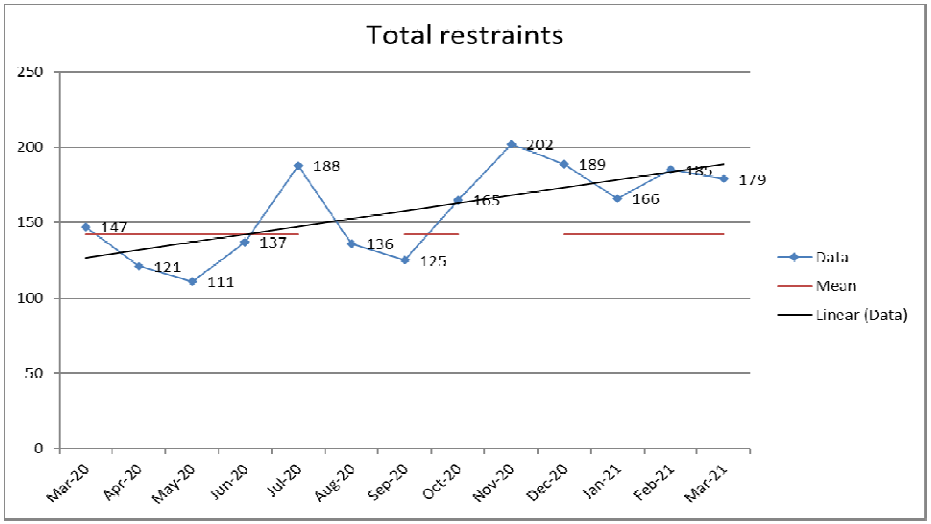
12 formal complaints were closed in March 2021. Of these, 58% of complaints (n=7) were closed within 40 working days. Of the 5 complaints that exceeded 40 working days, the average working days to close was 73 days. The reasons why complaints exceeded the 40 day target included delays obtaining the required approval during sign off and the complexity of the complaint and the lack of quality information provided in the toolkit which required further clarification from clinical services.

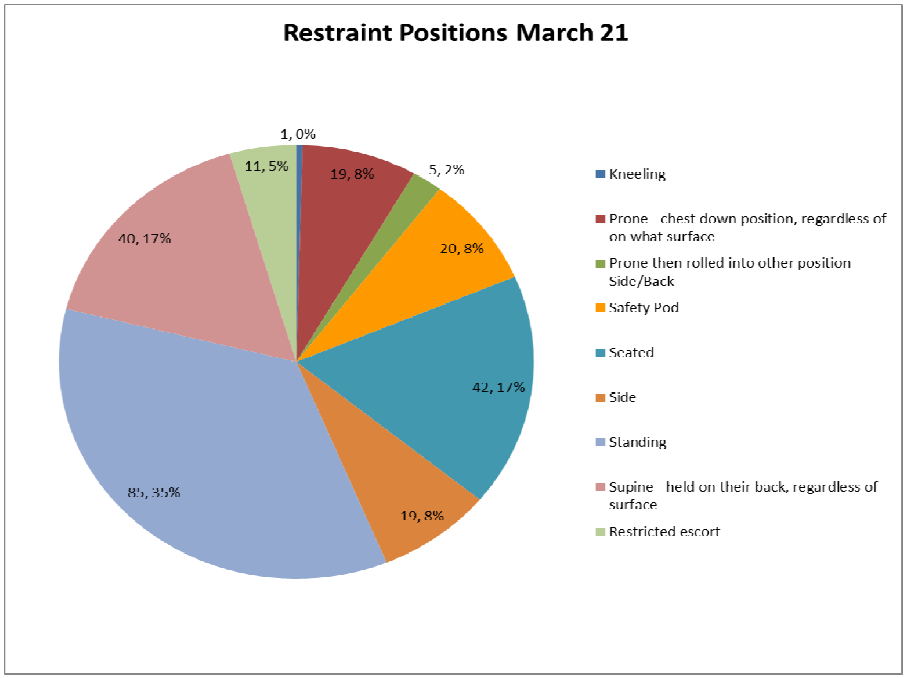
Count of written complaints/count of whole time equivalent - 4.73WTE (including a band 6 and 7)

Reducing Restrictive Physical Intervention (RRPI)

179 Physical Interventions used in March 2021 this is a decrease of 6 (3.2%) incidents since February 2021 which stood at 185 incidents. Of the different restraint positions used in the 179 incidents, standing position was used most often 85 (35%) followed by seated at 42 (17%). Prone restraint was reported 19 (8% of total restraints) times in March 2021, this is an increase of 10 (111%) from last month. 16 prone restraints were directly linked to seclusion events. Incidents where prone descent immediately turned into a supine position were recorded at 5 (2%) this is a separate entity to prone restraint. Forensic services recorded six prone Restraints, Wakefield five, Calderdale had five. Barnsley, Kirklees and Learning disabilities all reported one. We continue to explore how we benchmark with comparable providers, both in our practice and in our recording 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 March the percentage of prone restraints lasting under 3 minutes was 79% which is a decrease of 11% from the previous month. Each incident of prone restraint has been reviewed by a member of the RRPI team for assurance as to the practice in that clinical situation.

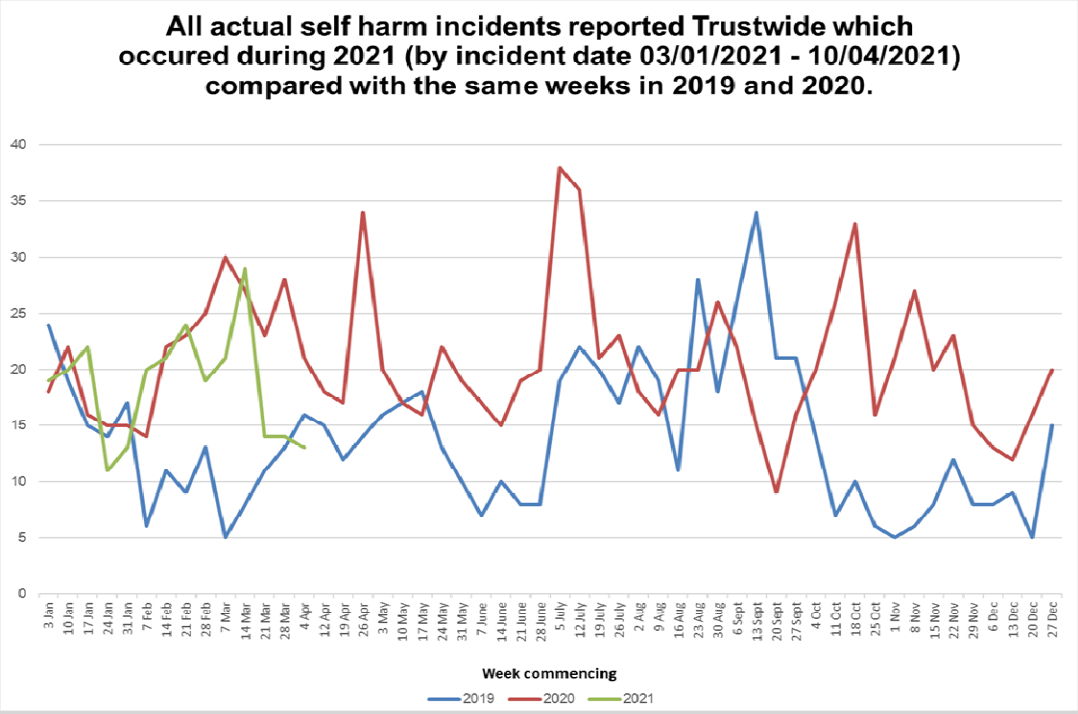
The use of seclusion continues to show an increase of 16 from 39 to 55 (41%) from the previous month. One incident of seclusion has been attributed to Covid themes in March
The RRPI team continue to provide face to face training in line with current IPC guidance. Although COVID restrictions have impacted on our delivery we have maintained a compliance of over 80% in all courses. (figures sourced from the Mandatory training report). The refresher courses will be re-introduced in May this year with update periods extended by 12 months from March 2020. Supplementary to this we will provide a trial of workplace competency assessments from April 2021, to ensure skills are maintained at the frontline. Discussions regarding the planning for the reintroduction of training has occurred within the Mandatory and Essential to Job Role Training Group, and proposed dates have been distributed to the Learning and Development team for circulation. Other courses such as personal safety and de-escalation and breakaway courses have been adapted to workbooks and e-learning packages. The practical face to face elements will be delivered as one hour sessions over a day in each location from April 2021.





Self Harm

Actual self-harm incidents reported on Datix occurring between 03/01/2021 and 10/04/2021 at 12/04/2021, compared with incidents occurring in the same period in 2019 and 2020



Please note:

To ensure this data is accurate as possible, it includes all actual self harm incidents even where the incident has not yet been approved by managers (5 in total pending review). Figures may change as incidents are reviewed and approved.

Analysis of trends

The peak in July 2020 was explored further and analysis showed that between 1/7/2020 - 1/8/2020 there was a total of 135 incidents of actual self-harm.

This involved 34 patients. 27 patients had 3 or less self harm incidents in the period. There were 6 patients who had more than 3 incidents. Of these, one patient had 30 incidents (28 on Clark, 2 on Beamshaw), Another patient had 30 incidents (Elmdale). The next highest total of self harm in the period was for a patient with 12 incidents (10 on Clark and 2 on Ward 18).

Of the 135 incidents between 1/7/2020-1/8/2020, it involved 20 different teams. 12 were assigned to inpatient wards, and 8 were incidents occurring in the community. Of the inpatient wards, Clark had the highest number (52), followed by Elmdale (47). The third highest wards were jointly Stanley ward and Horizon Centre both with 5 incidents.

The peak in incidents in October 2020 was explored further. Analysis showed that this was primarily due to an increase in incidents on Clark Ward, for one individual patient using self strangulation methods. Within the data overall, there were 3 incidents reported as moderate or severe harm in this reporting period (October 2020), which occurred in 3 different teams - CAMHS ReACH Team (Crisis Team) Wakefield, Single Point of Access (Wakefield) and Wakefield CAMHS West Team involving prescription medication - self poisoning, jumping from height and headbanging. Self-strangulation, cutting, hanging and scratching/biting are the highest reported self harm incidents in October 2020.

Analysis of the data from 2021 shows that two subcategories of self harm remain higher than other methods. These are self strangulation(61) and by cutting (59), tincidents each reported.

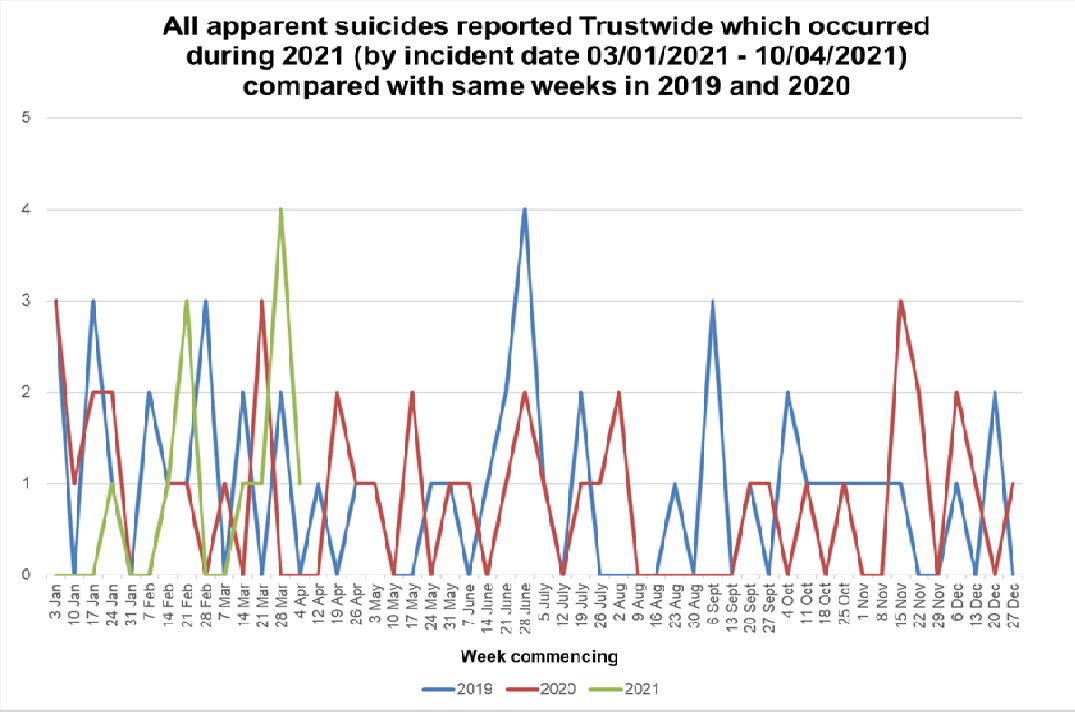
Analysis of the cutting incidents showed that the incidents took place over 14 wards/teams with the majority of incidents occuring on Elmdale ward.

Analysis of the self strangulation incidents showed that the incidents took place over 6 wards with the majority of incidents occuring on Clark ward. Analysis of incidents shows that a small number of individual service users account for this higher number of incidents.

The next highest subcategory is headbanging (41 incidents). Again analysis of incidents shows that a small number of individual service users.

Apparent Suicide

Apparent suicides reported on Datix occurring between 03/01/2021 and 10/03/2021 at 12/04/2021, compared with incidents occurring in the same periods in 2019 and 2020



Please note:

Data refreshed and verified on 12th April 2021 from Datix for 2019, 2020 and 2021 data.

When this report was originally requested, data included any apparent suicide that was reported within the Trust. This included apparent suicides that were not within the Trust's mortality scope, such as deaths of patients discharged more than 6 months prior to death, death of someone who had touched the police liaison practitioner but had no mental health concerns, etc. (A list can be provided if required).

The report content has been revised to ensure it mirrors the same data as other apparent suicide reports in circulation in the Trust to avoid differences in data because of different criteria being used.

This report is now based on apparent suicides that are in the Trust's scope for mortality review. All data has been refreshed for past years.

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	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Data quality rating [8]	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	90.0%	98.7%	99.2%	99.9%	97.0%	95.6%	90.0%	94.9%	96.8%	98.7%	98.5%	98.9%	99.2%	98.2%	99.6%	99.9%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	28.5%	43.8%	56.8%	97.8%	55.2%	31.4%	28.5%	26.2%	33.9%	43.8%	42.9%	49.5%	56.8%	43.7%	74.3%	97.8%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	100%	96.1%	98.7%	99.4%	99.0%	99.2%	100%	96.8%	96.4%	95.2%	100%	100%	98.0%	100%	99.1%	99.1%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	297/299 = 99.3%	300/302 =99.3%	301/302 =99.7%	277/281 =98.6%	90/92 =97.8%	102/102 = 100%	105/105 = 100%	110/110 = 100%	84/85 =98.8%	106/107 =99.1%	97/98 =98.9%	103/103 =100%	101/101 =100%	89/90 =98.9%	90/90 =100%	98/101 =97.0%		
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	98.5%	98.7%	*98.8%*	*98.7%*	98.5%	98.5%	98.6%	98.7%	98.7%	98.8%	98.8%	98.8%	*98.9%*	*99.0%*	*99.0%*	*98.3%*		
Out of area bed days [5]	Improving Care	Responsive	CH	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	415	737	316	251	167	108	140	336	224	177	106	88	122	91	78	82		
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	46.6%	52.7%	56.3%	*53.4%*	51.4%	49.1%	42.8%	50.1%	54.3%	54.1%	55.6%	57.3%	56.7%	53.1%	53.4%	*53.6%*		
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	88.3%	92.8%	96.5%	*98.8%*	86.3%	88.1%	89.7%	91.1%	92.8%	94.5%	95.2%	96.9%	97.6%	98.4%	99.0%	*98.7%*		
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	98.9%	99.1%	99.9%	*99.9%*	99.3%	98.5%	98.9%	98.5%	99.2%	99.6%	99.8%	100%	100%	100%	100%	*100%*		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	84.6%	87.0%	94.4%	91.5%	70.7%	95.8%	92.3%	87.8%	79.5%	94.3%	97.0%	91.3%	95.6%	92.0%	90.6%	91.9%		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	91.3%	91.1%	91.7%	*92.1%*	91.3%	91.2%	91.2%	91.1%	91.1%	91.1%	91.3%	91.9%	91.9%	92.0%	92.2%	*92.2%*	⚠	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	12.5%	12.6%	12.5%	*12.5%*	12.3%	12.3%	12.7%	12.6%	12.6%	12.6%	12.6%	12.5%	12.4%	12.4%	12.4%	*12.6%*	⚠	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Data quality rating [8]	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	10	34	48	23	2	5	3	0	8	26	10	34	4	11	6	6		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	4	6	8	6	1	2	1	0	3	3	2	4	2	2	1	3		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	258	205	210	189		258			205			210			189			
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	14.7%	13.7%	18.1%	19.0%		14.7%			13.7%			18.1%			19.0%			

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	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%	99.1%	99.8%	99.5%	*99.6%*	99.5%	98.7%	99.0%	99.3%	100%	100%	100%	99.3%	99.8%	99.8%	99.4%	*98.5%*		
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%*	99.9%	99.9%	99.9%	99.9%	100%	99.9%	99.9%	99.9%	99.9%	100.0%	100.0%	*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%	98.7%	98.4%	98.0%	*98.1%*	98.8%	98.7%	98.6%	97.8%	97.9%	98.2%	98.3%	98.0%	98.0%	98.0%	98.2%	*98.1%*		

** See key included in glossary.*
Figures in italics are provisional and may be subject to change.
1 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data.
2 - Black, Asian & Minority Ethnic (BAME) includes mixed, Asian/Asian British, black, black British, other
4 - This indicator was originally introduced from November 2017 as part of the revised NHSI Oversight Framework operational metrics and changed from April 19 to extend the number of valid and complete data items from the MHSDS (now includes 36 data items).
5 - Out of area bed days - The reported figures are in line with the national indicator and therefore only shows the number of bed days for those clients whose out of area placement was inappropriate and they are from one of our commissioning CCGs. Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021. Sustainability and transformation partnership (STP) mental health leads, supported by regional teams, are working with their clinical commissioning groups and mental health providers during this period to develop both STP and provider level baselines and trajectories.
6. Clients in Employment - this shows of the clients aged 18-69 at the reporting period end who are on CPA how many have had an Employment and Accommodation form completed where the selected option for employment is '01 - Employed'
8 - Data quality rating - added for reporting from August 19. This indicates where data quality issues may be affecting the reporting indicators. A warning triangle identifies any issues and detailed response provided below in the data quality rating section.

Headlines:

- The Trust continues to perform well against most NHS Improvement metrics
- The percentage of service users waiting less than 18 weeks remains above the target threshold at 99.9%
- The percentage of service users seen for a diagnostic appointment within 6 weeks improved but remains below target at 97.8% . This is a direct consequence of the impact of Covid-19.
- Inappropriate out of area bed placements amounted to 82 days in March. This is an increase from 78 in February, and is reflective of the intense effort within our operations teams.
- During March 2021, there were 3 service user aged under 18 years placed in an adult inpatient ward for a total of 6 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.
- The proportion of people detained under the Mental Health Act who are from a BAME background increased from 18.1% to 19.0% quarter on quarter. This compares to a BAME population of 11.3% across the places the Trust operates.

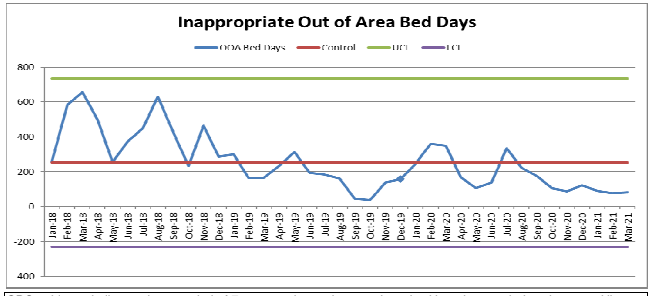
Data quality:

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.

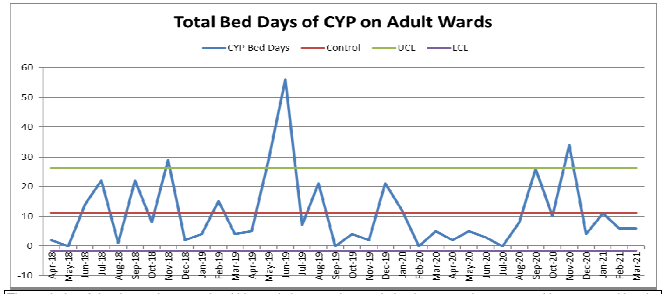
For the month of February the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for February shows 13.2% of records have an unknown or missing employment and/or accommodation status, this is an increase compared to February which showed 13.1% 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.

SPC Charts



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 2019 has been highlighted for this reason.



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.

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

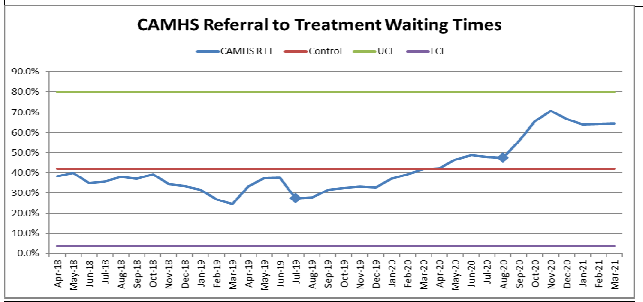
Barnsley mental health services and child and adolescent mental health services:

Mental Health:
Strengths
• In discussion with primary care network (PCN) / GP Federation to develop detail of local transformation development plan.
• Service resilience maintained. Contacts continue to be delivered by telephone/video link where practical, with face to face support offered as necessary.
• Proactive engagement with urgent care board and positive acknowledgment of liaison and intensive home based treatment team performance

Areas of focus
• Improving urgent access (assessment within 4 hours) performance. Working to improve the accuracy and reliability of inputting.
• Improving % service users on care programme approach (CPA) with a formal review within the previous 12 months and ongoing attention in supervision to recording
• Non-recurrent recovery investment made available by CCG. Plans being developed to manage referral and caseload pressure on SPA and core teams

CAMHS
Strengths
• Business continuity plans have to date been effective.
• Trend in waiting numbers from referral to treatment in Barnsley being maintained
• SWYPFT has recently agreed to take on lead provider responsibility for the Kirklees mental health support team trailblazer initiative.

Areas of focus
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased – with escalating demand outstripping commissioned capacity. Business case under consideration by CCG in Calderdale and Kirklees. Need to agree risk sharing in relation to existing waiting lists.
• Referral numbers placing pressure on waiting times. Exceptionally high rate in March following school return. Medium term trajectory unclear.
• Crisis referrals – particularly in relation to eating disorders – increasing. Bed access remains problematic and also some staffing pressures across the eating disorder pathway. Options being explored to increase capacity
• Small number of high risk cases in Wetherby young offenders institute (YOI). Unable to source appropriate specialist beds and placing pressure on CAMHS staffing resource.
• Wetherby YOI staff recruitment and retention remains a key focus – specifically in relation to band 6 practitioner roles.
• Embedding outcome measures within service interventions will be prioritised in 2021. Also reviewing approach to collection of friends and family test data within a broader engagement strategy.



The data point in July 2019 has been highlighted as the neurodevelopmental teams have been excluded from this point onwards.
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 August 2020 has been highlighted for this reason.

Barnsley general community services

Key Issues
• Yorkshire smoke free Calderdale (YSFC) contract – potential contract extension under discussion
• Yorkshire Smoke Free Wakefield (YSFW) – TUPE information sent to Commissioner, tender process likely to commence in the first quarter
• Urban House health integration team (HIT) nurse prescriber role – unable to recruit to band 6 role, so looking to develop a band 7 role to incorporate additional commissioned work through Wakefield CCG. This creates operational risks as this is a nurse led service and additional pressure for Lead Nurse who is now the sole nurse prescriber within the service. No suitable temporary solution has been found and the issue is on the local risk register.

Strengths
• All children's and health and wellbeing services performing well
• Successful tender bid for the Breathe service. Mobilisation has commenced.
• Annual report for stroke early supported discharge (ESD) has been completed with focus on the first 12 month's achievements.
• The first quarterly integrated stroke team newsletter has been produced and will be circulated shortly

Challenges
• Urban House HIT nurse prescriber role
• Ongoing response to Covid-19 and supporting staff and patient vaccination hubs

Areas of Focus
• Commencing organisational change process across the integrated neighbourhood team
• Tissue viability – ONPOS roll out, development of a joint lymphoedema pathway with the hospice and the pilot of the Healthy.io wound care app
• Neuro rehabilitation service review continues

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:

Forensics
• Staffing levels remain under constant review and are being managed through robust arrangements including the service business continuity plans
• Occupancy levels in Newhaven and Newton Lodge are below target, however there are 8 admissions planned to Newton Lodge.
• Supervision levels are 88.3% in medium secure, 92.3% in low secure and 87.3% in Newhaven
• Staff well-being remains a focus, the service is utilising the recent NHS survey results to modify the plan.
• Focus on recruitment and retention continues.

Learning Disability services
• Supervision has improved and is now 86.8%.
Community:
• Activity continues to rise, including an increase in demand for face to face treatment
• Waiting lists continue to be well managed with minimal breaches over 18 weeks
• Locality Covid-19 vaccination programs for continue to be supported by our community teams
• We have had an increase of Ministry of Justice cases moving into localities from out of area requiring support
• Mayman Lane in Batley which is a local authority new development of beds to meet complex care needs has recently opened with service users moving in from out of area.
Inpatients:
• Recent increase in admissions has meant we are again relying on high usage of bank/agency cover
• A new OT/AHP lead is now in post who has a focussed plan in place to improve environment, activities etc. for our service users on the ward
• The ward has recently had a quality monitoring visit and an action plan is currently being developed to incorporate learning from this review
• The availability of consultant psychiatry cover has been challenging, with gaps in consistent responsible clinician (RC) provision. Temporary measures provide cross cover and safer care, but they are not sustainable longer term and do not provide consistency within the team.
• Work on the assessment & treatment unit reconfiguration across West Yorkshire continues.

ASD/ADHD
• The service is operating fully without any operational challenges due to Covid-19.
• The service has secured new business from Barnsley CCG for ASD.
• The service has a list of new business opportunities/ developments to explore further including ADHD, dyslexia and tourette's

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Inpatient:
• Maintaining patient flow and facilitating sufficient ward capacity has been challenging, although the use of acute beds out of area has still been kept to a minimum. The use of PICU (psychiatric intensive care unit) out of area beds increased towards the end of March and is mainly attributable to gender specific and safeguarding clinical reasons rather than shortage of beds. High demand for inpatient beds continues. Concerted work on optimising patient flow is continuing and the service is now fully recruited and providing weekend cover, with a 6 day service in place, to move to a full 7 day a week service in May.
• The wards continue to deal with Covid-19 requirements for admission and episodic testing, and routine or infection related isolation and quarantining arrangements. Cohorting standard operating procedures to support the separation of people with symptoms or a positive Covid-19 diagnosis are in place for acute and older people's services together with an inpatient clinical pathway for Covid-19 positive patients. This is proving a robust framework within the parameters of demand and limitations of estate.
• Acute wards continue to see high levels of acuity and service user distress, with further challenges as above in managing isolated and cohorted patients. The difficulties have been compounded by staff absences and difficulties sourcing bank and agency staff leading to some staffing shortages across the wards. Senior leadership is available to the wards 7 days a week from matrons on site. Staffing levels have been maintained at safe levels with bank and agency usage and by utilising a trust-wide approach to staffing where possible. Continued weekly meetings taking place with mental health partners across the integrated care system have enabled the strengthening of collaborative approaches, shared learning and innovative practice developments.
• Whilst acute out of area placements have been low, bed occupancy levels have remained consistently high, even when moderated by the need for isolation areas, extra care zones and cohorting.

Community:
• Work continues in front line services to adopt collaborative approaches to care planning, to build community resilience; and to explore all possible alternatives to hospital admission for people who need acute care. This has included continued developments in the trauma informed personality disorder pathway. Work continues in the intensive home based treatment teams (IHBT) to look at building up early discharge, alternatives to admission and to ensure robust gatekeeping.
• Community services are providing 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. We are optimising our use of space across trust sites so that group work and more face to face therapies can be delivered, and currently reviewing space utilisation in each building to optimise clinical capacity.
• The action plan and training around care programme approach (CPA) reviews is ongoing, closely monitored and supported at trio level and performance in each area of the BDU has exceeded target for Quarter 4. Action and improvement plans continue at specific team and at practitioner level where needed.
• Demand into single point of access (SPA) continues to increase leading to some pressure in the service and necessitating the use of additional staff and sessions for assessment slots.

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

Communications, Engagement and Involvement

Communications, Engagement and Involvement

- Bronze command meeting taking place internally for communication and engagement. Participation in Trustwide Silver and other Bronze meetings.
- Coronavirus update sent out to all staff and governors
- Coronavirus sections on the intranet and website maintained and updated.
- Existing communication channels maintained.
- Sharing of staff and service user good news stories, internally, externally and through social media channels
- Coronavirus vaccination comms, general, focused and targeted.
- Continued promotion of 'Choose Well for Mental Health' guide.
- Staff wellbeing initiatives promoted, including the suicide prevention campaign and WY&H wellbeing hub.
- Design and print of materials continuing for services and corporate functions
- Awareness days and weeks supported on social media and in internal communication channels.
- Media enquiries managed.
- Support provided to EyUp Charity, Creative Minds and Spirit in Mind.
- New intranet development project in progress – migration of information ready for launch in April.
- IAPT and Recovery College services promoted in Kirklees and Barnsley.
- Promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS' initiatives and campaigns.

Engagement, Equality and volunteering update

- Equality, Engagement, Communication and Membership (EECM) Trust wide strategy signed off at Trust Board and published on the intranet
- Action plans for equality and engagement (including carers and peer support) have been signed off by March Equality & Inclusion Committee
- Work is now progressing to launch the equality data improvement campaign
- Trust wide EECM strategy short film and image, easy read and summary all being progressed as part of a full website content refresh
- Work continues to support recovery planning continues using insight and intelligence to inform decision making
- Support for process to capture feedback on the Mental Health Act reform consultation – including insight report
- Equality Impact Assessment for the roll out of the Covid-19 vaccination programme developed and revisions made periodically
- Process to support SEQUIN submission for secure services continues with monthly updates forming part of core work
- Recruitment of a carers' lead will take place this month following a successful charitable funds application
- Payment for involvement policy now being looked at and a draft will be circulated for comment by the Executive Management Team in the next month
- Community reported post which were part of a successful bid to charities commission focussed on BAME staff and BAME communities is being rolled out further in Calderdale, Kirklees and Wakefield
- Senior peer support worker post appointed and an event to launch the work and approach for peer support workers will take place. Training package and resources for peer workers has been co-designed
- Opportunities for BDUs to host a peer worker post in any vacant posts going forward are progressing. A number of presentations are planned for an event on Monday 17th May 11:30-1:30 to promote this way of working and to co-create an action plan for the forth coming year
- Draft strategy for volunteering developed and a framework to support volunteers is in place, further work to engage on the strategy is now being progressed
- Volunteers are starting to return with support and guidance. The return of volunteers will be supported by ESR training and DBS refresh

Overall Financial Performance 2020/21

Executive Summary / Key Performance Indicators

Performance Indicator		Year End Position	Narrative
1	Surplus / Deficit	£4.6m	A final position of £4.6m surplus has been achieved. This takes account of the different financial arrangements for H1 and H2 and includes additional income agreed in Q4 in line with national guidance.
2	Agency Cap	£7m	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 are appropriate. Spend in March was £0.8m.
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6	Better Payment Practice Code	95%	The Trust endeavours to pay all valid invoices as quickly as possible. The Better Payment Practice Code target is 30 days and for the year to date we have paid 95% within this target. On average invoices were paid within 14 days in March.

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Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	4.0%	3.9%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	3.9%	3.9%	4.0%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.0%	4.0%	3.9%
Staff Turnover	Improving Resources	Well Led	AD	10%	8.5%	7.9%	9.8%	8.4%	9.1%	8.9%	9.3%	9.3%	9.9%	10.0%	10.0%	10.3%
Actual level of vacancies	Improving Resources	Well Led	AD	-	8.7%	6.9%	6.0%	6.8%	7.4%	8.4%	8.0%	7.3%	6.9%	Due April 2021		
Aggression Management	Improving Care	Well Led	AD	>=80%	85.5%	85.5%	85.5%	85.5%	86.5%	86.0%	86.3%	85.4%	85.1%	84.1%	84.1%	82.3%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80%	89.4%	89.4%	89.4%	89.4%	90.3%	89.4%	88.7%	88.2%	86.2%	85.2%	84.5%	81.7%
Clinical Risk	Improving Care	Well Led	AD	>=80%	93.7%	93.7%	93.7%	93.7%	93.8%	93.6%	93.3%	93.2%	94.1%	93.3%	93.1%	93.5%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	95.2%	95.2%	95.2%	95.2%	95.7%	95.7%	96.0%	95.7%	95.7%	95.5%	95.6%	95.5%
Fire Safety	Improving Care	Well Led	AD	>=80%	93.7%	93.7%	93.7%	93.7%	93.9%	93.4%	92.8%	91.8%	87.9%	86.9%	87.6%	86.2%
Food Safety	Improving Care	Well Led	AD	>=80%	76.9%	76.9%	76.9%	76.9%	78.3%	76.7%	76.8%	76.5%	75.8%	74.8%	75.9%	75.3%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	95.8%	95.8%	95.8%	95.8%	96.2%	96.0%	96.1%	96.0%	95.6%	95.0%	94.7%	94.3%
Information Governance	Improving Care	Well Led	AD	>=95%	98.2%	98.2%	98.2%	98.2%	98.8%	98.8%	98.9%	98.8%	98.5%	97.5%	97.8%	97.9%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	95.0%	95.0%	95.0%	95.0%	95.5%	95.6%	95.5%	95.1%	95.0%	95.0%	95.1%	94.9%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80%	93.3%	93.3%	93.3%	93.3%	94.6%	94.3%	94.8%	94.9%	95.0%	94.6%	93.9%	91.0%
Mental Health Act	Improving Care	Well Led	AD	>=80%	89.5%	89.5%	89.5%	89.5%	91.2%	90.8%	91.4%	91.9%	92.1%	91.3%	90.5%	85.0%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	74.9%			79.3%			80.6%			81.3%		
Prevent	Improving Care	Well Led	AD	>=80%	93.2%	93.2%	93.2%	93.2%	94.6%	94.6%	94.4%	95.3%	95.7%	95.6%	95.6%	95.6%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	96.2%	96.2%	96.2%	96.2%	92.8%	92.8%	93.0%	92.8%	93.9%	94.0%	94.2%	94.0%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	92.4%	92.4%	92.4%	92.4%	93.6%	93.6%	93.3%	92.8%	93.2%	93.1%	93.6%	93.5%
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	96.9%	96.9%	96.9%	96.9%	96.8%	96.8%	No longer used					
Bank Cost	Improving Resources	Well Led	AD	-	£727k	£866k	£721k	£687k	£778k	£907k	£915k	£889k	£944k	£946k	£682k	£1,120k
Agency Cost	Improving Resources	Effective	AD	-	£469k	£507k	£518k	£558k	£606k	£588k	£604k	£573k	£686k	£587k	£562k	£760k
Overtime Costs	Improving Resources	Effective	AD	-	£196k	£382k	£342k	£257k	£276k	£213k	Data unavailable at the time of producing this report					
Additional Hours Costs	Improving Resources	Effective	AD	-	£58k	£61k	£66k	£71k	£59k	£53k						
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£374k	£388k	£399k	£408k	£411k	£387k						
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-	222.1	222.1	192.3	208.9	205.9	234.0						
Business Miles	Improving Resources	Effective	AD	-	193k	149k	138k	164k	166k	147k						
Health & Safety																
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	7			3			14			7		

Covid-19

KPI Additional Metrics to Highlight Response to and Impact of Covid-19	Target	As at 23rd April 2020	As at 19th May 2020	As at 17th June 2020	As at 22nd July 2020	As at 24th August 2020	As at 22nd September 2020	As at 20th October 2020	As at 24th November 2020	As at 22nd December 2020	As at 19th January 2021	As at 18th February 2021	As at 24th March 2021	As at 20th April 2021	Notes
No of staff off sick - Covid-19 not working [7]	N/A	**154**	**204**	**112**	**48**	**26**	**82**	**108**	**161**	**81**	**159**	**91**	**89**	**33**	
Shielding		54	59	52	37	0	0	0	29	0	48	42	50	1	
Symptomatic		69	118	46	5	14	31	57	51	45	64	29	19	16	
House hold symptoms		26	24	13	4	7	29	31	25	10	19	4	10	5	
OH Advised Isolation		5	1	0	0	1	1	2	2	0	0	1	1	1	
Test & Trace Isolation		0	0	0	0	0	0	0	0	0	0	0	0	0	
Other Covid-19 related		0	2	1	2	4	21	18	54	25	28	15	9	10	
No of staff working from home - Covid-19 related [8]		**125**	**136**	**107**	**90**	**7**	**53**	**79**	**147**	**35**	**84**	**78**	**88**	**16**	
Shielding		76	78	72	71	0	0	0	77	0	49	54	74	8	
Symptomatic		13	28	13	5	1	14	29	16	8	9	4	3	2	
House hold symptoms		29	23	13	1	0	26	21	33	14	6	10	4	1	
OH Advised Isolation		7	6	7	3	0	1	5	1	1	4	2	2	1	
Test & Trace Isolation		0	0	0	7	0	0	0	0	0	0	0	0	0	
Other Covid-19 related		0	1	1	3	6	12	24	20	12	16	8	5	4	
Number of staff tested [9]		89	783	1798	2038	2162	2294	2498	2917	3098	3241	3353	3386	3386	Cumulative
No of staff tested positive for Covid-19 [10]		23	103	128	130	133	149	217	398	462	545	598	610	610	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%	1498/1531 =97.8%	1547/1681 =92.0%	1771/1954 =90.6%	2027/2321 =87.3%	2339/2455 =95.3%	2381/2608 =91.3%	2588/2758 =93.8%	2605/2780 =93.7%	2775/2823 =98.3%	
No of staff returned to work (not working only) [13]		445/599 = 74%	609/807 =75%	800/908 =88.1%	872/928 =94.0%	952/979 =97.2%	992/1079 =91.9%	1122/1239 =90.6%	1295/1480 =87.5%	1492/1580 =94.4%	1533/1695 =90.4%	1723/1834 =93.9%	1726/1846 =93.5%	1858/1895 =98.0%	
No of staff still absent from work who were Covid-19 positive [12]		Data Unavailable	27	11	2	1	5	29	32	28	43	22	13	13	
Additional number of staff enabled to work from home		900	900	937	1003	1024	1043	1069	1095	1168	1175	1306	1369	1281	Cumulative
Calls to occupational health healthline		178	576	921	1230	1450	1536	1780	1967	2109	2274	2451	2565	2655	Cumulative

Staffing Issues

Our current response to Covid-19 infections, local restrictive measures and increased pressures on service areas

- Review message and guidance about protecting the most vulnerable staff
- Updating vulnerable and BAME staff risk assessments
- Review business continuity plans (BCPs) including staff escalation plans
- Review staff bank capacity in light of recent increase in recruitment
- The increase in prevalence of Covid-19 over winter and resource requirements for the vaccination programme have resulted in a reassessment of current priorities with work on some other priorities currently paused or slowed

Review the most recent shielding guidance

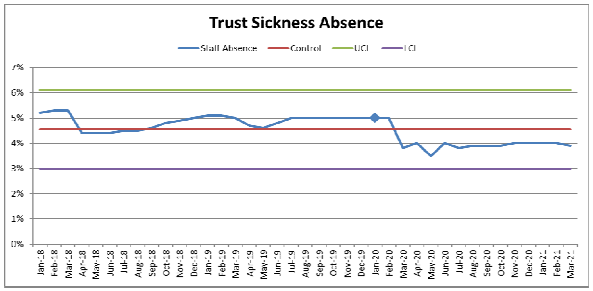
Staff Health & Well Being

- To ensure the health, safety and wellbeing of our workforce a comprehensive risk assessment has been completed for all BAME colleagues, pregnant staff, staff who have been shielding and over 70s. Managers have been asked to keep these under constant review. All Trust employees and bank only colleagues have been offered a risk assessment. A self-assessment questionnaire has been circulated to all staff which indicates their personal risk level, those in medium/high risk levels are offered a full risk assessment . Over 4000 colleagues have completed either a full risk assessment or a self assessment. In addition, we have maintained contact with all shielded staff via Trust managers and an Occupational Health well-being check. We also have a working from home/MSK risk assessment process.
- To accelerate preventative programmes for our workforce who are at greatest risk of poor health outcomes we have established a BAME health and wellbeing taskforce and have invested in our Occupational Health service by appointing a Health and Wellbeing practitioner for the BAME workforce. We also offer our colleagues support to maintain a healthy weight and offer smoking cessation support. We have a number of staff networks which support the Trust to address health inequalities and improve staff experience.
- To support our colleagues who experience mental ill health we have an in house occupational team including advisors, mental health nurse and an occupational therapist. We also provide an in house staff counselling service providing a range of therapies.

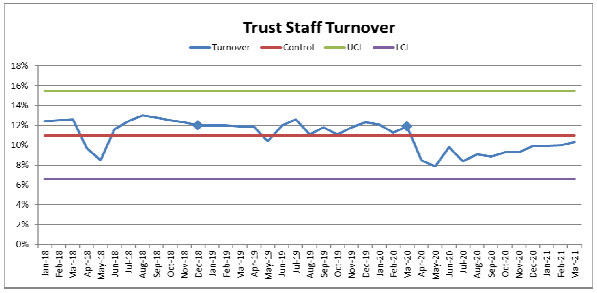
Workforce Issues

- As at 20th April, 33 staff off work Covid-19 related, not working which compares to 89 one month earlier. A further 16 were working from home.
- 3386 staff tested for Covid-19 as at 24th March.
- 610 staff have tested positive for Covid-19, none of which tested positive within the last month.
- Staff turnover increased to 10.3% in February.
- Non-Covid sickness absence was 3.9% in March and stands at the same percentage cumulatively. This compares favourably to previous years.
- Higher staff turnover in inpatient wards hass been noted.

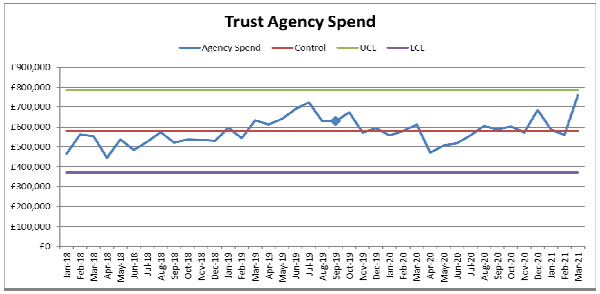
SPC Charts



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 January 2020 has been highlighted for this reason.



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. Turnover has been lower since the onset of the Covid-19 pandemic.



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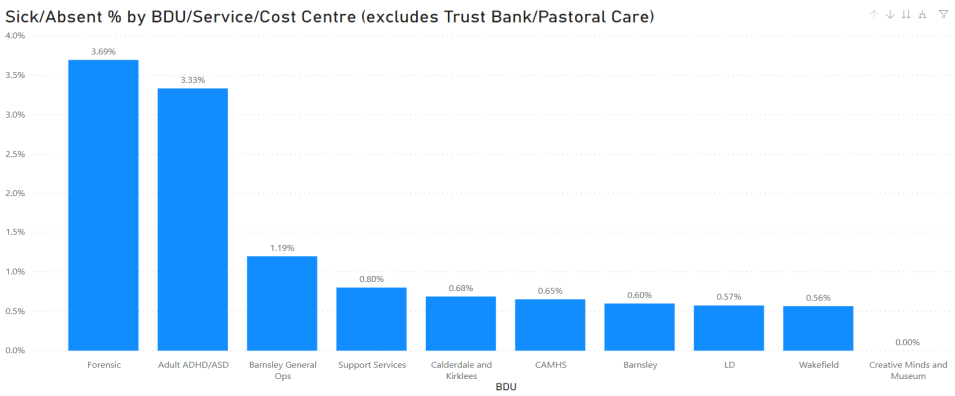
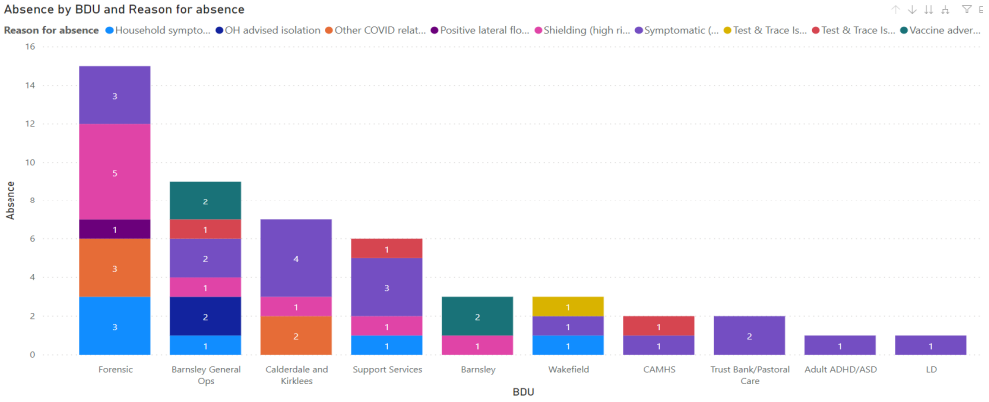
Sickness reporting

As at 20th April, the Trust has 49 staff absent or working from home due to Covid-19. This makes up 0.9% of the workforce. Of those absent, 12.2% are symptomatic and 18.4% have household symptoms. The business delivery unit (BDU) with the biggest impact is Forensic with 3.7% of staff impacted (15/406). 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.

- Bank and agency availability is continually reviewed to assist with resource availability.
- Critical functions for corporate support services are typically working from home to adhere to the government's social distancing guidelines.
- Communications team is ensuring guidance is distributed and keeping staff up to date.
- Average length of absence (days) for those not working due to Covid-19 symptoms (based on absence start date) was 9.3 days in March.





Publication Summary

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

NHS workforce statistics: December 2020 (including selected provisional statistics for January 2021)

Mental health services monthly statistics: performance January, provisional February 2021

Out of area placements in mental health services: January 2021

Psychological therapies: reports on the use of IAPT services, England - January 2021: final including a report on the IAPT employment advisors pilot

Learning disability services monthly statistics, Assuring Transformation: March 2021, Mental Health Services Data Set: January 2021 final

Provisional monthly Hospital Episode Statistics for admitted patient care, outpatient and accident and emergency data: April 2020 to February 2021

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Finance Report

Month 12
(2020 / 21)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

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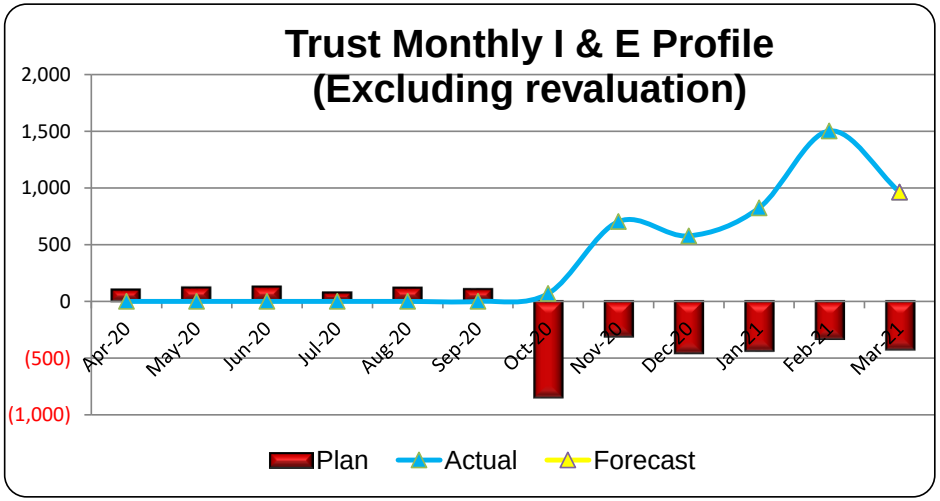
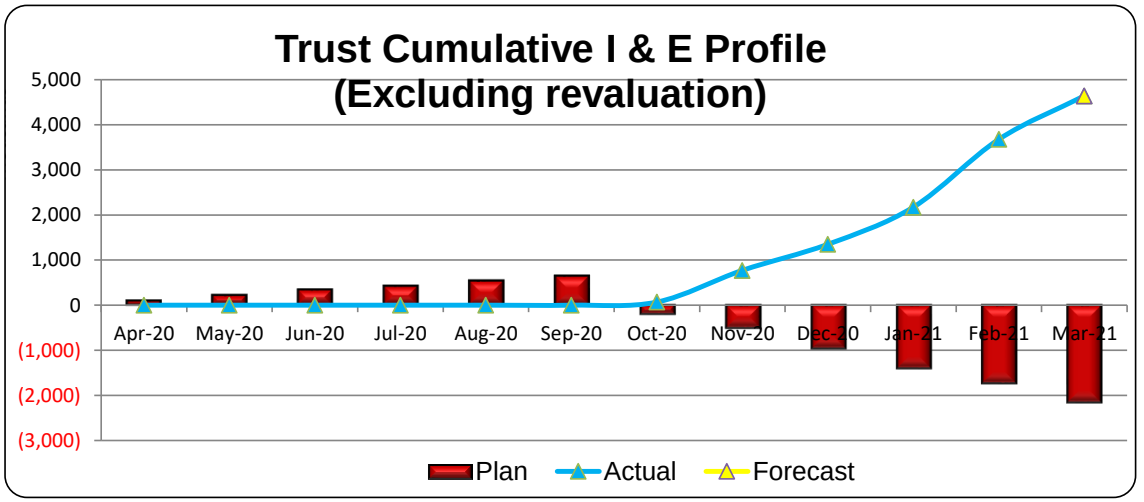
2.0 Income & Expenditure Position 2020 / 2021

Budget Staff	Actual worked	Variance		Month Budget	Month Actual	Month Variance	Description	Year to Date Draft Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				20,540	24,945	4,404	Clinical Revenue	233,416	238,457	5,041	233,416	238,457	5,041
				20,540	**24,945**	**4,404**	**Total Clinical Revenue**	**233,416**	**238,457**	**5,041**	**233,416**	**238,457**	**5,041**
				1,557	3,910	2,353	Other Operating Revenue	17,194	20,380	3,186	17,194	20,380	3,186
				22,097	**28,855**	**6,758**	**Total Revenue**	**250,610**	**258,837**	**8,227**	**250,610**	**258,837**	**8,227**
4,346	4,472	126	2.9%	(16,892)	(18,087)	(1,195)	Pay Costs	(193,532)	(193,574)	(42)	(193,532)	(193,574)	(42)
				(4,038)	(8,557)	(4,518)	Non Pay Costs	(45,351)	(49,210)	(3,859)	(45,351)	(49,210)	(3,859)
				(839)	(417)	422	Provisions	(4,762)	(2,912)	1,850	(4,762)	(2,912)	1,850
				0	(229)	(229)	Gain / (loss) on disposal	0	(157)	(157)	0	(157)	(157)
4,346	**4,472**	**126**	**-2.9%**	**(21,769)**	**(27,290)**	**(5,521)**	**Total Operating Expenses**	**(243,645)**	**(245,853)**	**(2,208)**	**(243,645)**	**(245,853)**	**(2,208)**
4,346	**4,472**	**126**	**-2.9%**	**328**	**1,565**	**1,237**	**EBITDA**	**6,964**	**12,983**	**6,019**	**6,964**	**12,983**	**6,019**
				(507)	(522)	(15)	Depreciation	(6,168)	(6,234)	(66)	(6,168)	(6,234)	(66)
				(245)	(80)	165	PDC Paid	(2,945)	(2,109)	836	(2,945)	(2,109)	836
				0	0	0	Interest Received	0	0	0	0	0	0
4,346	**4,472**	**126**	**-2.9%**	**(424)**	**963**	**1,387**	**Surplus / (Deficit)**	**(2,148)**	**4,641**	**6,789**	**(2,148)**	**4,641**	**6,789**
				0	0	0	Revaluation of Assets	0	(1,389)	(1,389)	0	(1,389)	(1,389)
4,346	**4,472**	**126**	**-2.9%**	**(424)**	**963**	**1,387**	**Surplus / (Deficit)**	**(2,148)**	**3,252**	**5,400**	**(2,148)**	**3,252**	**5,400**

The Trust budgets have been updated in October 2020 to reflect the new operational plan. This updated budget reflects a breakeven position for months 1 - 6 and a monthly deficit for months 7 - 12.





Income & Expenditure Position 2020 / 21

National guidance has continued to be updated including the treatment of specific accruals (Flowers legal case), additional national funding and treatment of national PPE.

The financial arrangements for 2020 / 21 differed between half one and two. For April to September national temporary arrangements enabled organisations to breakeven. From October to March a temporary arrangement remained although control totals were agreed for each organisation. This value was based on expenditure run rates in the first half of the year and resulted in a deficit plan of £2.1m. This took account of changes in accounting approach known at that period of time such as an estimated increase in untaken annual leave.

Additional guidance and funding has been provided late in the year which has resulted in an increased surplus / underspend position. Many elements of these were finalised and agreed in March 2021, hence the significant movement in the final position compared to forecast.

Income

The main block contracts with commissioners are based on national calculated blocks plus additional agreed Mental Health Investment Standard (MHIS) monies. This element of our income is largely as forecast. The favourable variance to plan includes additional national funding for untaken annual leave, the impact of the Flowers legal case (relating to overtime) and funding to cover a reduction in non-NHS income such as catering income.

There is also a further increase in other operating revenue for income received to offset additional costs. This includes income to offset the value of PPE provided, where the Trust has recognised costs for in year usage.

Pay

Pay spend in March was £18.1m which is higher than recent months. This includes year end assumptions for shifts worked in March and an estimate relating to the Flowers legal case. This estimate has been provided in conjunction with our payroll experts.

Overall the Trust has spent £25.1m more on pay than last year. An estimated £6m is due to incremental payments, pay awards and clinical excellence awards but the majority is due to an increase in workforce numbers, including new service investments.

Recruitment continues for substantive posts and new investment areas with a sustainable workforce model being factored into the 2021 / 22 planning process. This includes exploring new areas such as international recruitment for which SWYPFT is leading on behalf of the Yorkshire and Humber region.

Non Pay

Non Pay spend continues to experience both cost pressures and savings within the overall position. Healthcare subcontracts (out of area placements and the purchase of locked rehab beds) continue to be volatile and out of area placements are considered in more detail at page 11.

Income & Expenditure Position 2020 / 21

The Trust expenditure position is made up of numerous variances to plan; both favourable and negative, which are described throughout this report. As a summary of the position the main headlines are outlined below. This compares the movement from the £2.1m planned deficit to the £4.6m surplus position.

Description	Surplus / (Deficit) £m	Notes
Original deficit Plan	(2.1)	Half 2 2020 / 21 control total
Staffing / recruitment	2.1	Pace of recruitment into new investments
Public dividend capital (PDC)	0.8	Higher cash balances and lower capital expenditure
Operational performance	0.4	Out of area beds
Locked rehab beds (Barnsley)	(0.3)	Higher usage than forecast
Non-pay spend	(0.1)	
Income	1.9	Additional MHIS, national funding such as suicide prevention
Normalised surplus	**2.7**	
Holiday Pay	0.7	Funding provided for incremental costs
Flowers	(0.1)	Net movement in Flowers accrual including additional income
Non-NHS income support	0.7	National funding
Other additional income	0.6	Various national and regional sources
Draft H2 20 / 21 surplus	**4.6**	

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 incremental costs as part of its response. These costs have been identified as additional and reasonable in line with national guidance and there are further costs which have been absorbed within the standard expenditure profiles.

Costs identified for April to September 2020 (H1) have been directly reimbursed via national funding. Costs incurred in the second half of the year were met by a prospective system funding allocation for Covid-19 response costs. No additional top-ups will be made.

Costs from January 2021 include additional costs incurred in relation to the various vaccination programmes. This includes staff, inpatient service users, and our mutual aid support with partner organisations.

The nationally agreed transaction to cover PPE costs has been recorded as a Covid-19 cost in March 2021. This is shown separately in the table below.

		H1	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
Heading	**Description**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Staffing	Backfill of shifts due to covid (sickness, isolation, shielding). This includes premium payments to support safer staffing levels.	780	211	292	252	179	61	31	**1,806**
Staffing Vaccination	Additional shifts to support vaccination - clinical and non clinical staff	0	0	0	0	47	32	159	**238**
Staffing – community	Community additional shifts	249	0	0	0	0	0	0	**249**
Staffing – cohort	Dedicated ward within Forensics required due to positive covid cases	77	0	0	0	0	0	0	**77**
Staffing - students	Costs of student nurses and medics over and above previous	480	0	0	0	0	0	0	**480**
Staffing – out of area	Costs of out of area placement providers to provide additional staff due to potential covid cases	53	0	37	0	0	26	152	**268**
Total – Pay		**1,639**	**211**	**329**	**252**	**226**	**119**	**342**	**3,118**
IM & T	Equipment to support new ways of working, from home, video conferencing, increased telecommunications	441	161	0	4	167	53	19	**845**
Laundry	In house laundry service including scrubs	331	4	74	14	12	1	33	**469**
Infection Control	Central store of additional infection control supplies (wipes, cleaning products)	249	1	6	3	0	0	0	**259**
Catering	Staff meals - those working on inpatient wards and in the community. Supply of refreshments	69	0	0	0	0	0	0	**69**
Discharge Equipment	Purchase of additional equipment to support hospital discharges	71	0	0	0	0	0	0	**71**
Communications	Consent to share letter	40	0	0	0	0	0	0	**40**
Lateral Flow Testing	Distribution of kits to staff	0	0	0	50	(15)	0	20	**55**
PPE / national	Cost estimate for national PPE stock (offset by income)							2,244	**2,244**
Misc / other	Other general non pay not captured in the headings above	158	5	0	250	8	70	312	**803**
Total – Non Pay		**1,359**	**171**	**80**	**321**	**172**	**124**	**2,628**	**4,855**
Total cost recovery		**2,998**	**382**	**409**	**573**	**398**	**243**	**2,970**	**7,973**

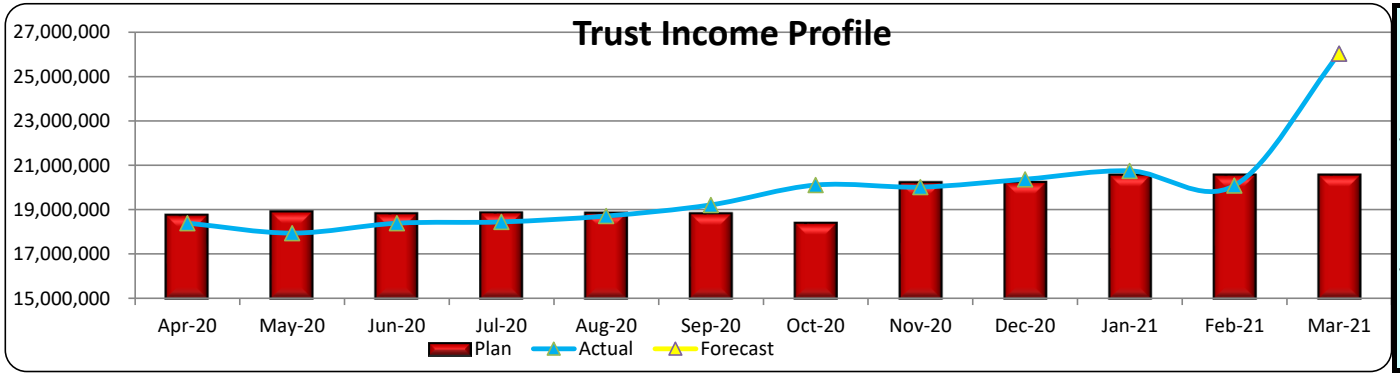
2.1 Income Information

As part of the operating plan for the second half of the year, contracting arrangements were also updated. The nationally calculated block income (based on 2019/20 plus 2.8% uplift) remains and supplemented by additional funding for the Mental Health Investment Standard (MHIS) agreed with commissioners.

In addition to main commissioner income, further funding has flowed through the Integrated Care System (ICS) on an allocations basis. This included funding to cover all covid related additional expenditure and this now shows as CCG income (as it flows through a lead local CCG). Additional national funding received in March 2021 is shown on the other line.

These block payments cover all income from NHS commissioners. This includes payment for services, staff recharges, recharge for projects etc.

	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	13,924	14,321	14,361	14,000	14,278	16,696	16,410	16,512	17,512	17,181	17,639	**187,364**	**171,720**
Specialist Commissioner	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,518	2,440	2,280	2,225	2,561	**28,281**	**27,895**
Local Authority	335	473	409	439	419	417	430	408	437	385	446	429	**5,025**	**7,755**
Partnerships	619	637	597	628	639	625	625	625	625	631	203	1,060	**7,514**	**7,673**
Top Up	550	550	702	658	1,254	1,537	0	0	309	(102)	0	0	**5,458**	**0**
Other	35	35	35	35	76	35	35	55	48	41	35	4,351	**4,815**	**418**
Total	**18,391**	**17,940**	**18,386**	**18,443**	**18,711**	**19,214**	**20,108**	**20,016**	**20,370**	**20,748**	**20,089**	**26,040**	**238,457**	**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**	



Further guidance has been received in February and March 2021 and as a result additional income has been recognised in the other category.

This funding includes :

Flowers legal case
Untaken annual leave
Top up Non NHS income

2.2 Pay Information

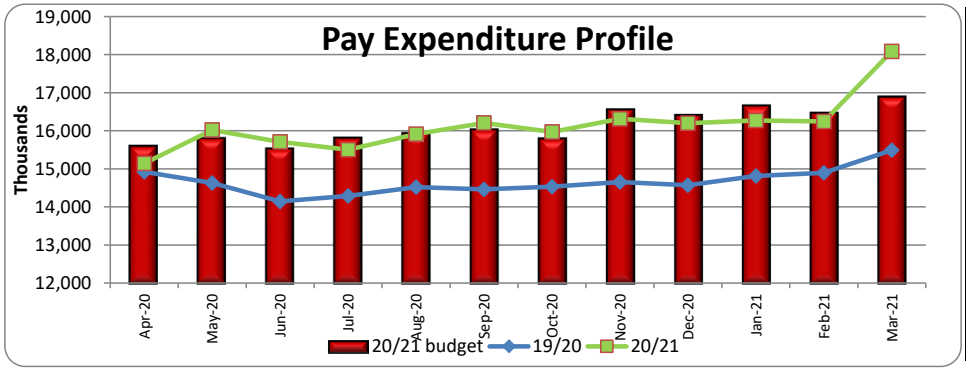
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for 79% of our budgeted total expenditure.

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	14,256	14,462	14,647	14,450	14,851	14,569	14,740	15,001	16,208	**176,244**
Bank & Locum	727	866	721	687	844	971	915	889	944	946	682	1,120	**10,312**
Agency	469	507	518	558	606	588	604	573	686	587	562	760	**7,018**
Total	**15,142**	**16,019**	**15,709**	**15,501**	**15,912**	**16,205**	**15,969**	**16,313**	**16,199**	**16,273**	**16,245**	**18,087**	**193,574**
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%	4.4%	5.3%	6.0%	5.7%	5.5%	5.8%	5.8%	4.2%	6.2%	5.3%
Agency as %	3.1%	3.2%	3.3%	3.6%	3.8%	3.6%	3.8%	3.5%	4.2%	3.6%	3.5%	4.2%	3.6%

	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Current
Substantive	3,900	4,004	4,026	4,026	4,006	3,965	4,263	4,293	4,255	4,048	4,085	4,118	**4,026**
Bank & Locum	203	253	193	197	244	225	277	240	303	257	240	244	**193**
Agency	68	75	83	90	108	93	121	100	120	119	82	110	**83**
Total	**4,171**	**4,332**	**4,302**	**4,312**	**4,357**	**4,283**	**4,661**	**4,634**	**4,678**	**4,424**	**4,407**	**4,472**	**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 have increased from 2019/20 (average run rate £14.7m per month). Of this annual pay awards and increments are estimated at £500k per month.

March pay expenditure is the highest in year, but the underlying performance is in line with previous months. The increase in March relates to additional costs recognised in line with national guidance such as holiday pay accruals, accruals for Flowers legal costs (relating to holiday and overtime payments), bank and enhancement accruals.

In line with the above bank, locum and agency costs have also increased in month and will continue to be reviewed in the future.

2.2 Agency Expenditure Focus

Agency spend is £760k in March.

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.

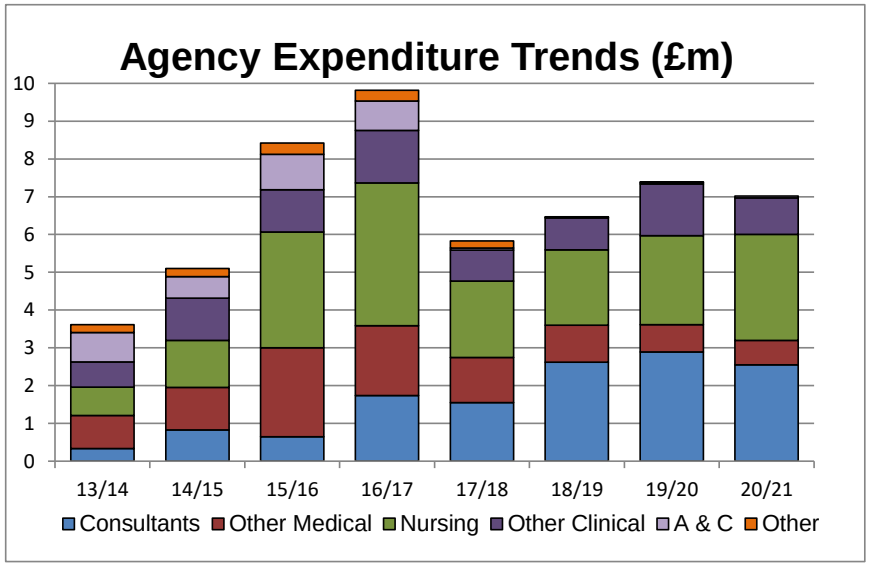
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

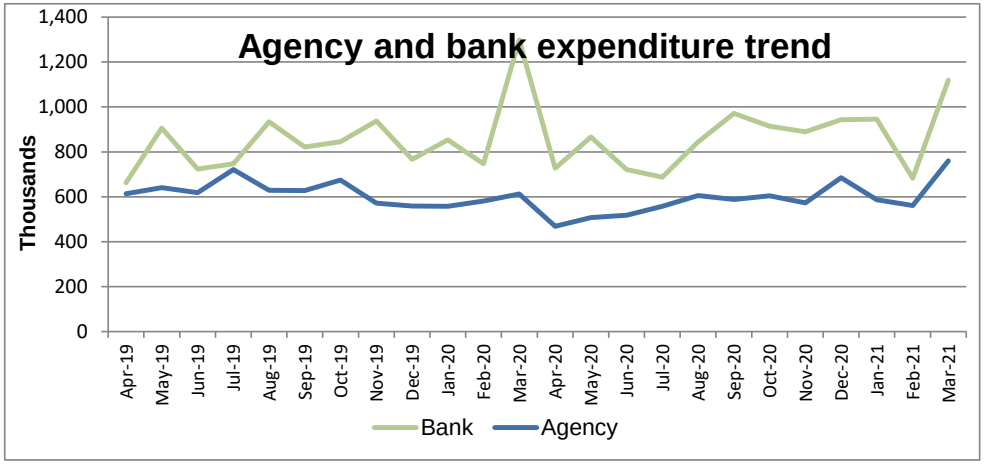
Due to covid 19 there is currently no nationally set agency cap for 2020/21, however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised and performance against suggested maximum agency rates (caps). Shifts exceeding these caps continue to require appropriate prior approval including by the chief executive as previous.

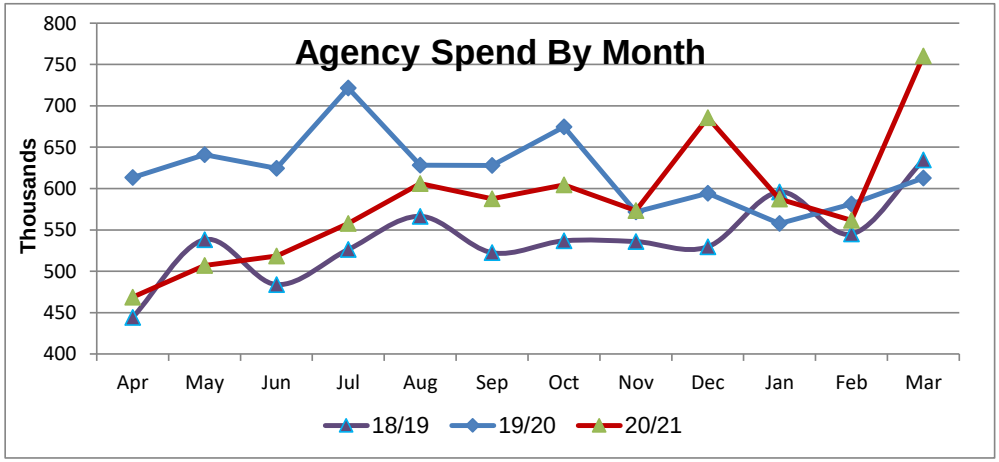
March 2021 spend is £760k which is higher than previous months but this is a normal trend each financial year as all invoices are chased. Total spend for the year is £7.0m, of which £3.2m relates to medical staffing (primarily covering vacancies / gaps) and £2.1m for unregistered nursing to support safer staffing.

There has been continued staffing pressures throughout the year but overall agency spend is £0.4m less than last year. This has been possible by increased substantive staff, additional bank and the payment of overtime to existing staff members.

The triangulation continues to compare agency spend with substantive staff and bank staff payments as part of the overall workforce strategy.





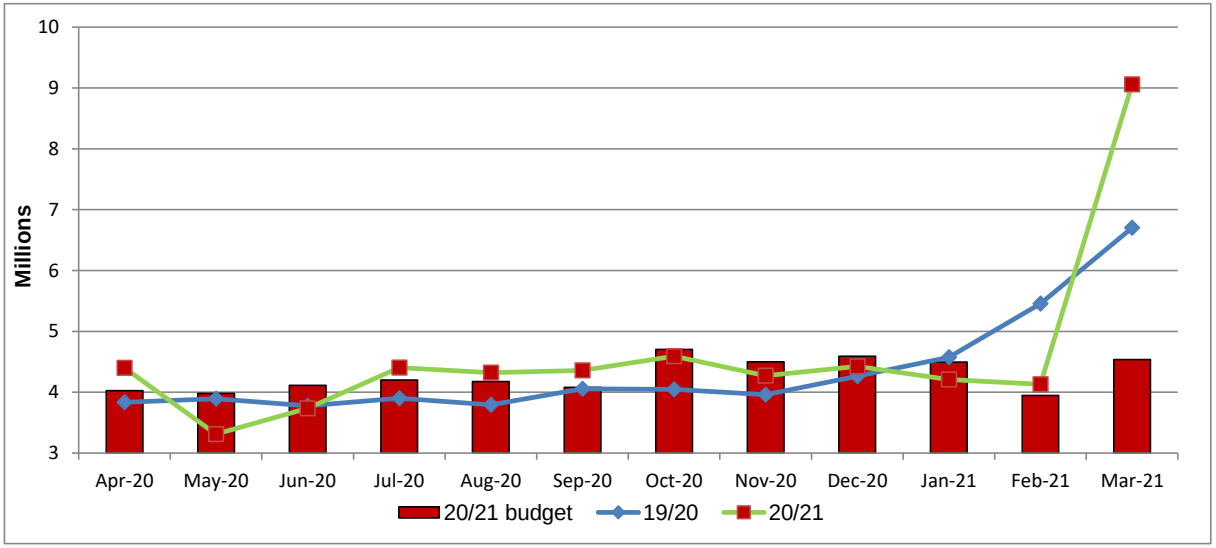


2.3 Non Pay Expenditure

Whilst pay expenditure represents approximately 80% of all Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the BDUs and corporate services and therefore excludes provisions and capital charges (depreciation and PDC).

	Apr-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	3,906	3,821	3,857	4,090	3,772	3,925	3,707	3,628	8,557	**49,210**
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**

	Budget	Actual	Variance
	Year to date	Year to date	
Non Pay Category	**£k**	**£k**	**£k**
Clinical Supplies	2,941	3,757	(816)
Drugs	3,487	3,824	(337)
Healthcare subcontracting	7,058	6,802	256
Hotel Services	2,188	2,764	(576)
Office Supplies	5,976	7,360	(1,384)
Other Costs	4,707	7,342	(2,635)
Property Costs	6,616	11,376	(4,759)
Service Level Agreements	6,321	0	6,321
Training & Education	1,143	646	497
Travel & Subsistence	2,453	2,851	(398)
Utilities	1,362	1,404	(42)
Vehicle Costs	1,098	1,084	13
Total	**45,351**	**49,210**	**(3,859)**
Total Excl OOA and Drugs	**34,806**	**38,584**	**(3,778)**



Key Messages

The graph above shows the significant increase in non pay expenditure in March 2021. Key elements of this include the value of PPE provided nationally (£2.2m) which has been recognised in our financial position with corresponding income to offset.

Excluding March 2021 non Pay spend over the last 8 months has remained relatively steady including Trust spend on covid-19.

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 adult acute and PICU 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 (£)

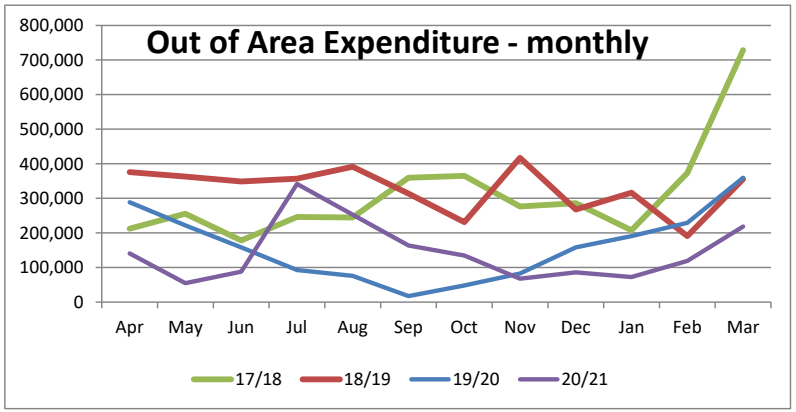
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	76	17	48	82	158	191	230	359	**1,924**
20/21	141	55	88	342	253	164	135	68	86	73	119	218	**1,741**

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	54	120	305	147	76	111	105	148	124	100	126	**1,526**

Bed Day Information 2020 / 2021 (by category)

PICU	92	45	34	113	102	53	109	105	148	116	100	93	**1,110**
Acute	18	9	86	192	45	23	2	0	0	8	0	33	**416**
Total	110	54	120	305	147	76	111	105	148	124	100	126	**1,526**



Costs and activity have increased in March 2021 as the Trust continues to experience high demand and acuity and covid-19 pressures. Costs relating to covid-19 continue to be charged to that cost centre. At the end of March 2021 there was 1 acute placement and 5 PICU. These were all male and are placed for gender specific reasons; this is a service line not provided by the Trust.

The overall delivery of activity remains a challenge for the Trust and, to date performance has been exceptional in ensuring that as many people as possible are supported within the Trust bed base especially considering the impact that covid has had. This includes reduced internal bed capacity for cohorting purposes, pressures on staff numbers and the changes in acuity experienced over the past 12 months.

3.0 Balance Sheet 2020 / 2021

	2019 / 2020 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	108,146	104,978	1
Current Assets			
Inventories & Work in Progress	238	173	
NHS Trade Receivables (Debtors)	6,048	1,143	2
Non NHS Trade Receivables (Debtors)	953	2,429	3
Prepayments, Bad Debt, VAT	2,219	3,184	
Accrued Income	1,904	3,090	4
Cash and Cash Equivalents	36,417	56,648	5
Total Current Assets	**47,778**	**66,668**	
Current Liabilities			
Trade Payables (Creditors)	(4,102)	(8,443)	6
Capital Payables (Creditors)	(272)	(585)	
Tax, NI, Pension Payables, PDC	(6,311)	(3,557)	
Accruals	(10,869)	(20,101)	7
Deferred Income	(1,462)	(3,981)	
Total Current Liabilities	**(23,016)**	**(36,667)**	
Net Current Assets/Liabilities	**24,763**	**30,001**	
Total Assets less Current Liabilities	**132,909**	**134,980**	
Provisions for Liabilities	(8,724)	(7,348)	
Total Net Assets/(Liabilities)	**124,185**	**127,632**	
Taxpayers' Equity			
Public Dividend Capital	44,971	45,384	
Revaluation Reserve	12,763	11,721	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	61,231	65,307	8
Total Taxpayers' Equity	**124,185**	**127,632**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2020.

1. Capital expenditure is detailed on page 14. The asset value is reducing due to depreciation charges and limited capital spend year-to-date. The annual revaluation exercise was completed in January which reduced the value by a further £2.6m

2. NHS debtors remain low with the majority due to NHS England funding as discussed earlier in the paper.

3. Non NHS debtors have increased in month due to a number of recharges agreed with a local authority covering the whole of 2020 / 21.

4. As many invoices as possible have been raised ahead of year end, hence the increase non-NHS debtors above.

5. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 16.

6. Outstanding invoices have increased at year end. This is system driven and includes purchase orders booked in but not yet invoiced.

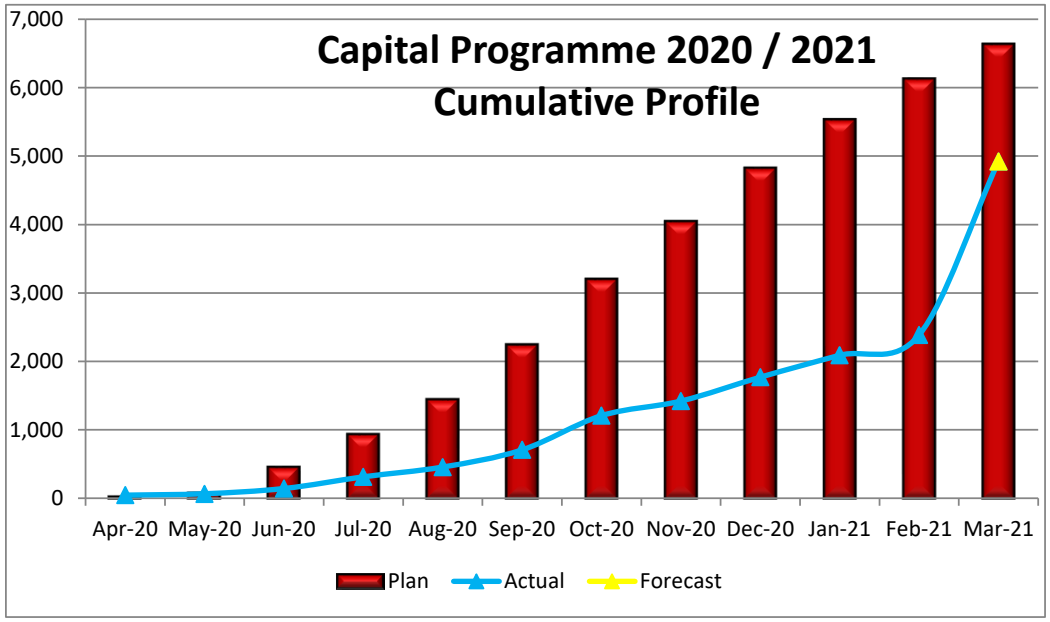
7. Accruals have remained high over the course of the year with a number of invoices outstanding. This value also includes additional year end accruals for Flowers, annual leave etc.

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

3.1 Capital Programme 2020 / 2021

	Annual Budget £k	Actual 20 / 21 £k	Variance 20 / 21 £k	Note
Maintenance (Minor) Capital				
Facilities & Small Schemes	3,479	2,765	(714)	
Equipment Replacement	100	340	240	
IM&T	2,455	1,819	(636)	
Major Capital Schemes				
Hub Development	600	0	(600)	
VAT Refunds		0		
TOTALS	**6,634**	**4,924**	**(1,710)**	

There is a significant increase in spend in March - £2.5m.



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.

2020/21 has proved to be a very challenging year for delivery of the capital programme. Covid-19 caused industries to close down and when reopened there were material and staffing shortages.

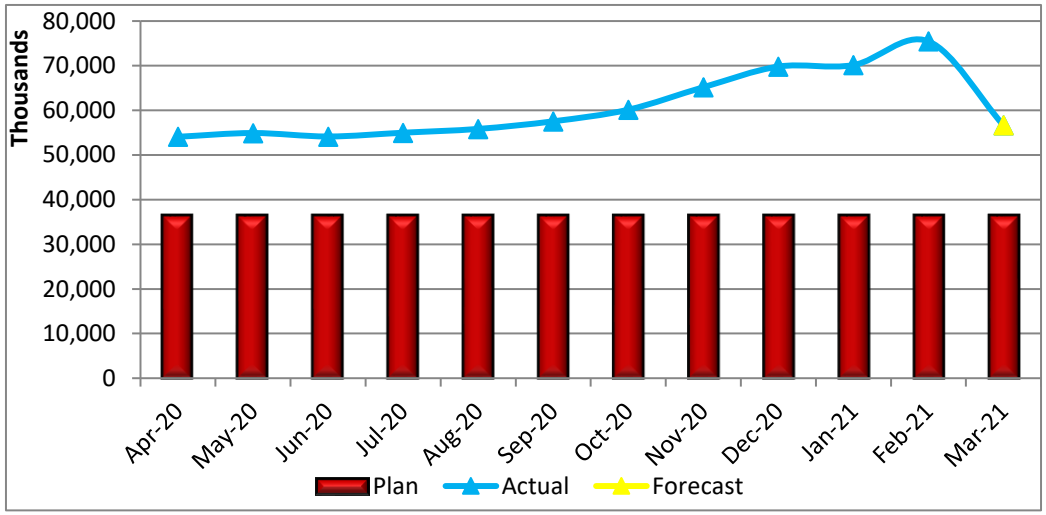
Staff were also redeployed internally to assist operational services.

This has meant that the majority of the scheme has been delivered late in the year with the team rising to the challenge to ensure that funds were appropriately utilised.

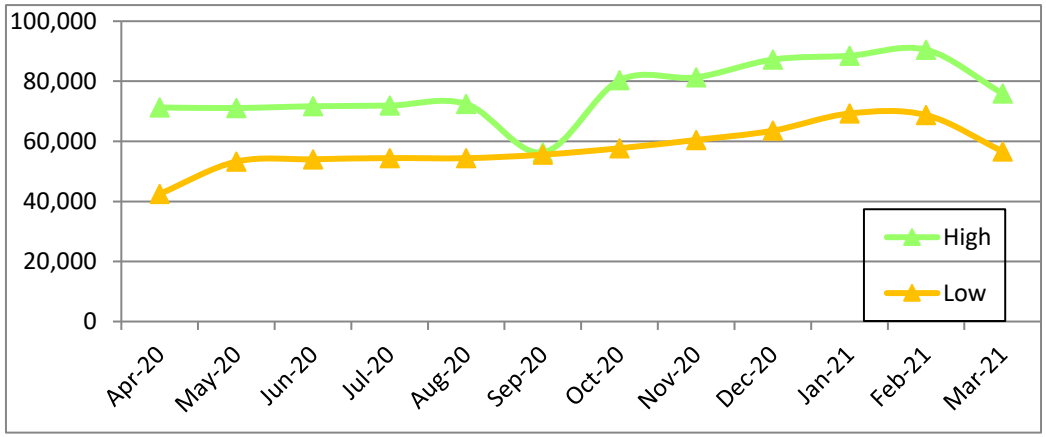
Notable schemes include improvements in response to covid-19 such as changes to reception areas and development of ventilation systems. The safety agenda has also continued with installation of new standard anti ligature doors and windows

Investment has also continued in our IT infrastructure and digital solutions.

3.2 Cash Flow & Cash Flow Forecast 2020 / 2021



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	36,417	
Closing Balance	36,417	56,648	20,231



Cash has reduced in March 2021 in line with expectations given income being in advance

As forecast the cash position reduced in March due to the unwinding of the block contract income payments. March also includes payment of 6 months of PDC.

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

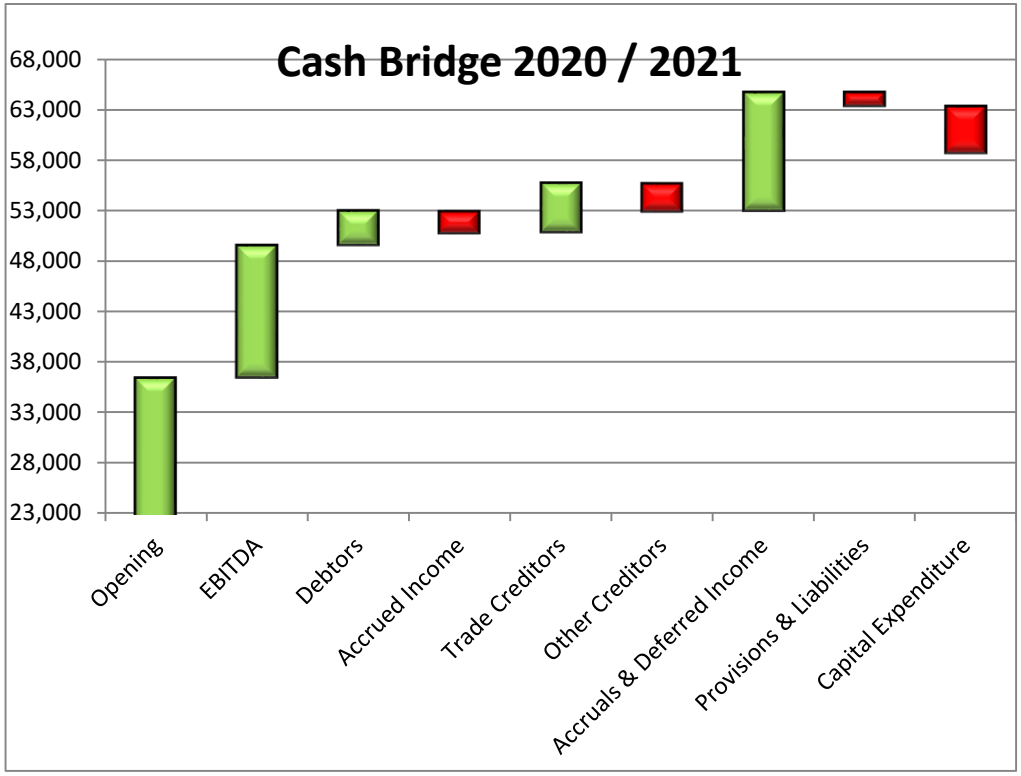
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£75.9m
The lowest balance is:	£56.6m

This reflects cash balances built up from historical surpluses. The dip in September was linked to the timing change of the finance system.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Actual £k	Note
Opening Balances	**36,417**	
Surplus / Deficit (Exc. non-cash items & revaluation)	13,140	
Movement in working capital:		
Inventories & Work in Progress	65	
Receivables (Debtors)	3,429	
Accrued Income / Prepayments	(2,152)	
Trade Payables (Creditors)	4,879	
Other Payables (Creditors)	(2,754)	
Accruals & Deferred income	11,751	
Provisions & Liabilities	(1,376)	
Movement in LT Receivables:		
Capital expenditure	(4,611)	
Cash receipts from asset sales	187	
PDC Dividends paid	(2,740)	
PDC Dividends received	413	
Interest (paid)/ received		
Closing Balances	**56,648**	



The table above summarises the reasons for the movement in the Trust cash position during 2020 / 2021. This is also presented graphically within the cash bridge. Overall there has been a £20.2m increase in the Trust cash position in year.

The main drivers of this improvement are the surplus position achieved in year, depreciation (which is a non-cash adjustment) being greater than the value of capital investment, reduction in debtors with the most notable being the £1.6m agreed debtor with CHFT, and an increase in the level of creditors.

20,231

4.0 Better Payment Practice Code

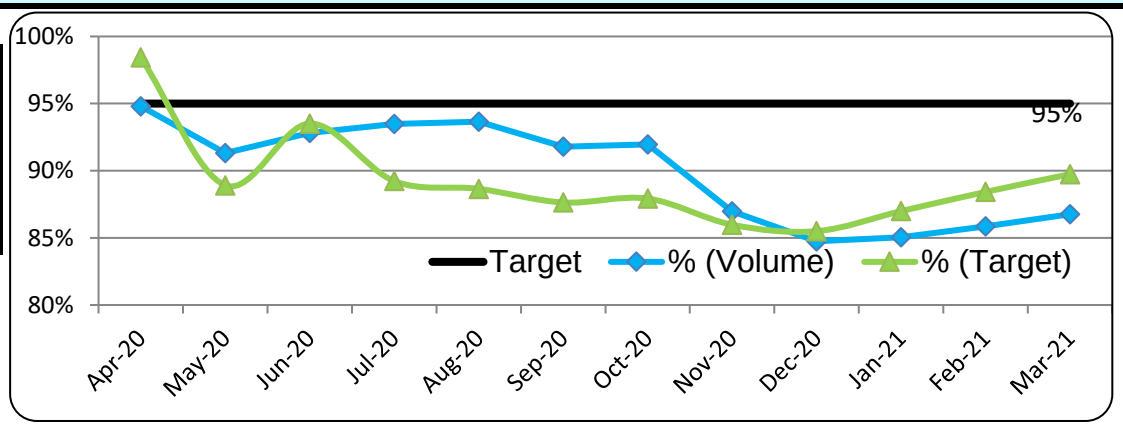
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process. A further focus has been provided following the implementation of the new finance and procurement ledger system.

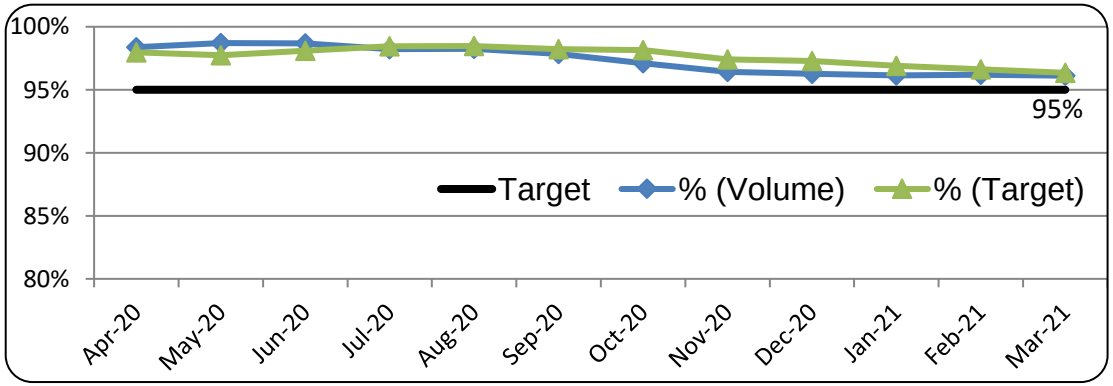
As part of the national response to the impact of COVID-19 all NHS Trusts were asked to pay suppliers within 7 days. Processes were reviewed to ensure that this could be supported and monitoring commenced immediately (20th April 2020).

This request was not extended past January 2020 and, whilst the Trust continue to endeavour to pay all suppliers as fast as possible, this has been removed as a key performance indicator. As a metric the team continues to monitor the average time taken to pay a non NHS invoice. This was 14 days in March 2021.

NHS		
	Number	Value
30 days	**%**	**%**
Year to February 2021	86%	88%
Year to March 2021	87%	90%



Non NHS		
	Number	Value
30 days	**%**	**%**
Year to February 2021	96%	97%
Year to March 2021	96%	96%



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-payroll 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 (£)
15-Mar-21	Property Rental	Calderdale	Calderdale & Huddersfield NHS Foundation Trust	4710172158	364,058
16-Mar-21	Property Rental	Wakefield	Mid Yorkshire Hospitals NHS Trust	1600016435	182,622
01-Mar-21	Property Rental	Kirklees	Bradbury Investments Ltd	1551	118,518
23-Feb-21	Drugs	Trustwide	Bradford Hospitals NHS Trust	318404	92,119
04-Mar-21	IT Services	Trustwide	Daisy Corporate Services	3I467761	90,250
18-Mar-21	Drugs	Trustwide	Bradford Hospitals NHS Trust	318641	86,528
19-Jan-21	Staff Recharge	Trustwide	Sheffield Childrens NHS Foundation Trust	2100213620	76,084
31-Dec-20	Drugs	Trustwide	Lloyds Pharmacy Ltd	96417	75,115
31-Jan-21	Drugs	Trustwide	Lloyds Pharmacy Ltd	97441	65,852
28-Feb-21	Drugs	Trustwide	Lloyds Pharmacy Ltd	98068	61,298
02-Mar-21	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	995020	55,602
14-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402687377	50,820
14-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402687378	50,820
14-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402687408	50,820
14-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402687409	50,820
14-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402687410	50,820
16-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402688174	50,820
16-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402688175	50,820
16-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402688178	50,820
16-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402688176	50,820
16-Feb-21	Computer Hardware	Trustwide	Dell Corporation Ltd	7402688177	50,820
23-Mar-21	Donations	Trustwide	EyUp!	CF0072	50,000
12-Mar-21	Bedding & Linen	Trustwide	James Walker Textiles Ltd	27611	48,467
03-Feb-21	Purchase of Healthcare	Trustwide	Wakefield Metropolitan District Council	91313220476	44,231
15-Feb-21	Drugs	Trustwide	NHS Business Services Authority	1000068266	41,564
05-Mar-21	Computer Software	Kirklees	Silvercloud Health Ltd	1066	37,500
11-Mar-21	Property Rental	Barnsley	Community Health Partnerships Ltd	0060190869	33,936
25-Jan-21	Purchase of Healthcare	Trustwide	North Yorkshire County Council	600009147	33,309
10-Mar-21	Catering Equipment	Wakefield	Nisbets Plc	22421410	33,221
17-Feb-21	Property Rental	Barnsley	Dr M Guntamukkala	PG10089	33,132
28-Feb-21	Purchase of Healthcare	Forensics	Cloverleaf Advocacy Ltd	9903	32,358
13-Mar-21	Telecoms	Trustwide	Vodafone Ltd	97472646	30,460
01-Mar-21	Property Rental	Kirklees	Bradbury Investments Ltd	1552	27,758
02-Mar-21	Utilities	Trustwide	EDF Energy	000009339808	27,091
17-Mar-21	Purchase of Healthcare	Forensics	Humber NHS Foundation Trust	59889676	27,015
01-Apr-21	Property Rental	Barnsley	SJM Developments Ltd	LINV38114	27,000

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.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.1%	4.7%	4.4%	4.3%	4.2%	4.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.8%	4.9%	4.8%	4.0%	3.8%	3.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.2%	86.7%	85.5%	83.7%	84.5%	82.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	91.0%	91.2%	89.4%	89.2%	86.8%	84.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	92.9%	93.3%	94.4%	94.8%	96.1%	96.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	98.2%	97.7%	98.0%	97.9%	97.7%	97.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	93.3%	91.6%	89.8%	88.4%	89.2%	87.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.0%	78.2%	78.0%	76.1%	77.3%	75.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	98.4%	98.0%	97.4%	96.4%	95.9%	95.7%
Information Governance	Resources	Well Led	AD	>=95%	99.1%	99.0%	98.8%	97.2%	97.3%	97.7%
Moving and Handling	Resources	Well Led	AD	>=80%	91.3%	90.4%	89.4%	89.8%	90.1%	89.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.6%	94.7%	94.6%	94.6%	94.0%	93.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	93.0%	94.0%	95.2%	95.5%	95.6%	93.4%
Prevent	Improving Care	Well Led	AD	>=80%	95.7%	96.2%	96.1%	96.1%	96.2%	95.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.2%	93.4%	94.5%	94.6%	94.8%	94.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.1%	94.8%	95.2%	95.3%	95.2%	94.8%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.1%	3.1%	3.2%	3.1%	3.2%	3.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.6%	3.1%	3.1%	2.8%	3.3%	3.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.6%	83.1%	83.0%	82.6%	83.2%	82.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	87.9%	86.3%	83.6%	83.6%	83.5%	82.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.6%	93.3%	93.9%	93.4%	94.0%	94.9%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.2%	96.6%	96.8%	96.6%	97.3%	97.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	95.2%	93.0%	88.3%	87.6%	89.2%	87.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.9%	76.2%	77.9%	77.2%	78.3%	76.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	96.5%	96.5%	95.9%	95.6%	95.6%	95.3%
Information Governance	Resources	Well Led	AD	>=95%	99.4%	99.1%	99.0%	98.6%	99.0%	99.3%
Moving and Handling	Resources	Well Led	AD	>=80%	95.3%	94.7%	94.4%	94.1%	94.5%	94.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	95.8%	95.6%	96.0%	95.7%	94.9%	91.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	94.4%	93.9%	94.0%	93.3%	92.7%	87.9%
Prevent	Improving Care	Well Led	AD	>=80%	95.5%	95.3%	96.1%	96.0%	96.1%	95.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.0%	90.9%	93.2%	93.5%	93.8%	94.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.1%	93.1%	94.2%	94.0%	94.4%	94.5%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.3%	5.6%	5.6%	5.6%	5.6%	5.5%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	5.2%	5.9%	6.1%	6.0%	4.5%	4.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	87.4%	86.8%	84.2%	83.8%	83.7%	80.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	91.6%	90.5%	88.6%	86.3%	87.4%	81.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.1%	94.8%	95.2%	93.7%	93.0%	91.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	95.0%	94.9%	94.6%	94.6%	94.6%	94.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	93.7%	93.1%	89.8%	88.2%	88.3%	86.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	69.7%	68.4%	66.7%	65.9%	65.3%	64.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.8%	95.5%	95.2%	94.6%	93.9%	92.7%
Information Governance	Resources	Well Led	AD	>=95%	98.4%	98.3%	97.5%	97.2%	97.2%	96.9%
Moving and Handling	Resources	Well Led	AD	>=80%	96.9%	96.8%	97.0%	97.3%	97.3%	96.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.6%	93.1%	93.5%	91.4%	90.1%	85.7%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.5%	89.0%	89.2%	87.1%	86.1%	78.3%
Prevent	Improving Care	Well Led	AD	>=80%	92.5%	92.6%	93.0%	93.1%	92.9%	93.3%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.6%	91.2%	92.0%	92.2%	92.4%	92.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.2%	87.9%	89.2%	89.2%	89.6%	90.4%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

CAMHS

Month	Objective	CQC Domain	Owner	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.8%	3.2%	2.8%	2.7%	2.6%	2.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.9%	3.0%	2.3%	1.9%	2.2%	2.3%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	75.5%	76.6%	76.6%	75.4%	77.0%	76.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	79.9%	80.6%	76.9%	75.2%	74.9%	72.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.3%	95.9%	96.5%	95.5%	94.0%	93.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.2%	93.9%	93.1%	92.5%	93.8%	95.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	91.1%	91.1%	87.8%	86.6%	88.2%	89.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	0.0%	0.0%	28.6%	33.3%	28.6%	28.6%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	93.5%	92.8%	92.7%	92.5%	92.5%	93.9%
Information Governance	Resources	Well Led	AD	>=95%	96.9%	97.6%	96.7%	95.7%	96.7%	97.7%
Moving and Handling	Resources	Well Led	AD	>=80%	97.3%	97.3%	97.4%	97.1%	97.7%	98.1%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.4%	93.5%	92.7%	92.8%	92.1%	83.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	89.0%	90.2%	89.4%	88.3%	88.7%	79.8%
Prevent	Improving Care	Well Led	AD	>=80%	92.4%	93.1%	93.6%	92.0%	92.3%	92.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	90.1%	90.1%	90.1%	90.5%	90.2%	91.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.1%	90.1%	90.4%	90.5%	90.9%	92.2%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.3%	3.5%	3.3%	3.3%	3.3%	3.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.5%	3.5%	3.3%	3.5%	3.5%	3.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	93.9%	92.7%	95.0%	92.5%	90.5%	89.3%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	87.5%	87.1%	87.1%	90.0%	90.0%	89.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	66.7%	80.0%	80.0%	80.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.8%	91.4%	91.8%	91.1%	90.5%	78017.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.8%	90.3%	81.2%	81.1%	80.9%	80.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.1%	97.8%	97.8%	97.8%	97.8%	97.8%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	94.2%	93.8%	93.6%	92.3%	92.3%	91.5%
Information Governance	Resources	Well Led	AD	>=95%	99.3%	99.5%	99.4%	97.6%	97.6%	97.6%
Moving and Handling	Resources	Well Led	AD	>=80%	98.6%	98.6%	99.0%	98.9%	99.0%	99.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.8%	98.9%	98.7%	98.7%	98.6%	98.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.4%	90.5%	90.9%	90.5%	86.4%	77.3%
Prevent	Improving Care	Well Led	AD	>=80%	98.2%	98.2%	98.5%	98.3%	98.2%	98.7%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	98.4%	97.7%	97.8%	97.6%	97.5%	97.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	98.1%	97.7%	97.6%	97.4%	97.5%	97.6%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	2.9%	4.1%	3.1%	3.3%	3.4%	3.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	3.4%	4.1%	3.6%	4.4%	4.2%	3.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	87.9%	87.2%	87.2%	87.6%	85.5%	82.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	88.1%	87.9%	85.2%	84.3%	83.1%	79.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.5%	90.7%	91.5%	91.1%	90.4%	92.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	96.1%	96.6%	95.9%	96.1%	96.9%	97.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.0%	90.4%	88.9%	87.6%	88.2%	87.9%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.5%	78.1%	73.8%	71.3%	76.3%	82.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.3%	95.6%	95.1%	95.1%	94.3%	94.1%
Information Governance	Resources	Well Led	AD	>=95%	99.0%	98.4%	98.5%	98.2%	98.7%	98.4%
Moving and Handling	Resources	Well Led	AD	>=80%	96.9%	96.9%	96.9%	96.4%	95.9%	93.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.8%	94.0%	93.3%	92.8%	92.5%	88.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	94.1%	93.0%	92.1%	92.4%	91.2%	85.4%
Prevent	Improving Care	Well Led	AD	>=80%	93.2%	94.0%	95.3%	95.6%	95.8%	96.1%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.1%	92.7%	93.8%	94.3%	94.3%	93.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.7%	92.5%	91.5%	91.2%	93.1%	91.8%
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

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

Inpatient Service										
Month	**Objective**	**CQC Domain**	**Owner**	**Threshold**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.4%	4.6%	5.1%	5.0%	5.0%	5.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.1%	4.7%	4.2%	4.4%	5.9%	6.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.4%	86.3%	87.7%	85.7%	85.8%	84.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	87.1%	86.7%	86.9%	84.2%	84.0%	81.1%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	88.0%	91.1%	94.2%	90.3%	87.7%	88.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.7%	97.8%	97.8%	97.3%	96.9%	96.7%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	91.7%	92.6%	89.8%	89.4%	89.4%	86.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.9%	75.0%	74.5%	73.5%	77.3%	76.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.7%	96.7%	97.0%	97.3%	97.2%	95.8%
Information Governance	Resources	Well Led	AD	>=95%	98.6%	98.6%	98.1%	97.3%	97.5%	97.2%
Moving and Handling	Resources	Well Led	AD	>=80%	97.2%	97.6%	98.1%	98.1%	98.1%	98.1%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.0%	91.0%	92.3%	92.6%	90.8%	88.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	88.1%	90.1%	91.5%	90.6%	88.7%	85.2%
Prevent				>=80%	92.6%	94.3%	95.3%	94.8%	94.2%	94.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.2%	90.7%	92.9%	92.0%	92.5%	92.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	86.6%	86.9%	86.9%	86.8%	88.6%	87.5%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	No longer used					
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 10.2

Title:	**Safer Staffing and Workforce Report**
Paper prepared by:	Director of Nursing & Quality
Purpose:	This is the prescribed six-monthly report that provides an update and overview of work in response to safer staffing challenges.
Mission / values:	Honest, open and transparent, person first and in the centre and improve and be outstanding.
Any background papers / previously considered by:	This report builds on the safer staffing paper presented at Trust Board in November 2020, which now includes updates on Workforce Planning, the Nursing Strategy, and financial plans within the Trust. This report has been scrutinised by the Clinical Governance and Clinical Safety committee (CGCS.) As a result of the discussions within CGCS, a further review of information contained within the report will take place prior to the next CGCS. This will ensure the visibility of key messages and will begin to reflect the lived experience of front-line staff.
Executive summary:	**The report shows** • Overall fill rates have remained at similar levels to previous report • Skill mix has been diluted to maintain staff to patient ratios • Covid-19 presented some challenges, such challenges included individual ward outbreaks which resulted in significantly reduced staffing • Although the challenge of the COVID-19 pandemic has eased we are none the less facing significant staffing challenges caused by a variety of issues including existing vacancies, an increase in workload and acuity of Service Users, sickness and retention challenges. From May 2020, our fill rates for acute mental health wards are reported against the new establishment staff numbers. The initial review reveals that overall capacity of actual versus planned staffing is at 115% when new establishment staff numbers are used. The roll out of SafeCare has commenced within the Unity Centre and is a priority to enabling staff to measure the nature of acuity on their wards and to make staffing-based decisions to meet patient needs safely and effectively. This will also ensure that the health roster and staffing resource is always accurate. The initial roll out was delayed due to a number of issues, most significantly due to the pandemic. The next roll out will be within forensics and will commence in May 2021. A detailed project plan with timeframes will be presented at the next safer staffing group for sign off in May 2021. Continuing to utilise Care Hours Per Patient Day (CHPPD) has allowed us to analyse and understand the skill mix needs as well as giving a further evidence-based indicator of whether we have the correct establishment

	figures. It should be noted that the national CHPPD data collection was halted in February 2020, thus the benefit of comparison is compromised We continue to assess when it would be practicable to deploy the staffing measurement tool within our community teams. The project was postponed due to the COVID-19 outbreak, a detailed project plan with timeframes for this work will be presented to the safer staffing group in July 2021 with a start date of August 2021 This report has been scrutinised by the Clinical Governance and Clinical Safety committee (CGCS.) on 6 April 2021 who commented as follows; • Assurance received on meeting the national safer staffing reporting requirements. • Recognition of significant work around staffing and recruitment to maintain pressured position • Recorded thanks to all staff for their outstanding efforts during the pandemic. • Committee wanted a greater understanding of the impact of staffing and mix on individual wards, particularly on the impact on staff. • Our understanding of impact upon staff should be considered as a topic for discussion at a future strategy board.
	Risk Appetite Failing to maintain safe staffing within the clinical, operational and support services within the Trust is likely to result in risks to service users, staff and other stakeholders. There are also significant reputational risks, 1-6. The Trust has invested in a safer staffing project to mitigate the risk to supplement existing environmental, procedural and relational solutions and policies and procedures. Capacity and demand are monitored closely and escalation processes in place to maintain safe staffing levels, 1-6.
Recommendation:	**The Trust Board is asked to note the report and the assurance taken by the Clinical Governance & Clinical Safety Committee**
Private session:	N/A

South West Yorkshire Partnership NHS Foundation Trust

Safer Staffing & Workforce Report

Trust Board Report
April 2021

Authorship

Specialist Advisor for Safer Staffing

Supported by
Deputy Director of Nursing and Quality
Associate Director of Nursing and Quality
Workforce Planning Manager
HR Business Manager
Senior Finance Manager

BACKGROUND OF THE REPORT

Safer Staffing within health care has been an ongoing issue since the formation of the National Health Service in one form or another. There have been various attempts at staffing models over the years from professional judgement to financially driven. It came sharply back into focus following publication of the Francis report on Mid Staffordshire (Francis 2013), the Keogh review into the quality of care and treatment provided in 14 hospital Trusts in England (Keogh 2013) and the Berwick report on improving the safety of patients in England (Berwick 2013). As a result, the Department of Health and NHS England requested that NICE developed evidence-based guidelines on safe and effective staffing.

The need for guidelines on safe and effective staffing has been highlighted in subsequent policy documents and responses: How to ensure the right people, with the right skills, are in the right place at the right time. A guide to nursing midwifery and care staffing capacity and capability (National Quality Board, 2013), and Hard Truths, the journey to putting patients first (Department of Health, 2014).

From a professional nursing perspective, the responsibilities in terms of safer staffing are clear.
"It is the responsibility of every registered nurse in the UK to ensure they are working in environments that have safe staffing and to report to senior management when safe staffing levels are not achieved" (Nursing and Midwifery Council, 2014). Since this statement was released, the safer staffing agenda has rightly remained a focal point in care settings and has been influenced by policy and, it must be said, public opinion.

Lord Carter wrote "One obstacle to eliminating unwarranted variation in the distribution of nursing and non-registered staff across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment".

Lord Carter highlighted this issue in his February 2016 report, Operational productivity and performance in English NHS acute hospitals: unwarranted variations. This led to the development of benchmarks and indicators to enable comparison across peer Trusts as well as wards and to the development of the care hours per patient day (CHPPD) measure in line with the second of Lord Carter's recommendations.

Since 2019 CHPPD has become the principal measure of nursing, midwifery, and healthcare support staff deployment on inpatient wards. It has now expanded to include all ward-based clinical professionals who are budgeted to the ward establishment and rostered into the 24/7 roster. This is important for considering how best to use staff to meet patient need, and it will be crucial for getting an integrated view of the staffing required to deliver patient care

Over the last 3 years the Shelford Group, in collaboration with Imperial College London and National Health Service Improvement (NHSI), have developed the most evidence-based staffing judgement tool to be utilised within mental health, learning disability and forensic services. Our Trust was involved in the development and testing of the tool and in 2019 were licensed to utilise the Mental Health Optimal Staffing Tool (MHOST).

This has subsequently formed the bedrock of staffing profiling within our transformation work, establishment reviews and will be utilised in the Trust wide establishment reviews going forward.

PURPOSE OF REPORT

This is the six-monthly TB report that provides an update and overview of work undertaken by SWYPFT in response to the safer staffing challenge. Following presentation, discussion and amendments from the CGCS Committee it is being presented to the April 2021 Trust Board.

The paper outlines the work we have undertaken and what our future plans are to ensure that our clinical areas remain appropriately staffed so that we continue to run safely and effectively.

This report builds on the safer staffing paper presented at Trust Board in November 2020, which now includes updates on Workforce Planning, the Nursing Strategy, and financial plans within the Trust.

A Trust Board Safer Staffing Checklist is also provided in Appendix 3 to provide additional assurance. The CGCS committee is asked to discuss and amend the report.

1. INTRODUCTION

Safer staffing continues to be at the forefront of any discussion to do with health and providing services to our communities. Ensuring that we have the right staff, with the right skills, in the right place at the right time as per the National Qualities Board guidance.

Covid-19 presented some challenges, such challenges included individual ward outbreaks which resulted in significantly reduced staffing within adult age acute inpatients, the Forensic BDU and Barnsley Community Services. This pressure aligned to the pressures in supporting the healthcare system were significant in our moving to operate at Opel 3 (currently we are operating at Opel 2). Although the challenge of the COVID-19 pandemic has eased we are none the less facing significant staffing challenges caused by a variety of issues including existing vacancies, an increase in workload and acuity of Service Users, sickness and retention challenges.

With that in mind we will be looking at our continued response to the Covid-19 pandemic. The steps we have taken so far are summarised in Section 3.

As a trust we have been involved in the development of the Mental Health Optimal Staffing Tool (MHOST), which has now been published and we have been licenced to utilise. This will be considered within the report.

The Trust is required through National Health Service Improvement (NHSI) to publicly declare staffing fill rates for inpatient settings as well as the Care Hours Per Patient Day (CHPPD) for each inpatient area. The CHPPD is categorised according to ward type. As a Trust, we are proactively comparing ourselves to our peers regionally by utilising the regional data, which is more diversified than the national figures. It includes, for example, a clear difference between Psychiatric Intensive Care Units (PICU) and acute mental health admission wards.

The focus of much of the work to date has been on ensuring safer staffing levels on inpatient wards. However, we continue to engage with our community teams providing mental health, learning disability and physical health care to scope what safer staffing means to them and what support can be provided following transformation processes.

SafeCare, which is a staffing resource and acuity tool, has been rolled out into the Unity Centre at Fieldhead as the early implementers. We will review this in the report.

The implementation of SafeCare allows us to move away from the traditional view of having a set “number” of staff on inpatient areas and utilise the acuity and demand to flex the staffing resources appropriately. This would allow us to ensure our skill mix within the teams is optimised and should lead to a reduction of the dependency on our flexible staffing resource.

2. COMPOSITE INDICATORS TAKEN FROM ELECTRONIC STAFF RECORD SYSTEM (ESR)

The Trust continues to maintain accurate and up-to-date information of “composite indicators” on the Electronic Staff Record System (ESR) in relation to the proposed Safer Staffing Indicators as follows:

	In-patient areas	**Trust average**
Staff sickness rate (taken from the ESR at the end of February 2021)	5.8%	4.0%
The proportion of mandatory training completed at the end of February 2021	89.1%	92.3%

Mandatory training has also remained consistent with the previous report and exceeds targets.

Based on the 2020 Wellbeing at Work survey, a focus was placed on Physical Health
And Psychological health. Staff wellbeing events are being embedded within the Trust through various working groups and a suite of wellbeing advice and measures has also been produced.

Within SWYPFT, there has been a focus on ensuring that the staffing levels on inpatient areas are correct to deliver the high standard of care that our Service Users are entitled to. This included the initial staffing review for working aged adults as well as the ongoing reviews within forensic, older peoples and rehabilitation areas.

3. SUMMARY OF PREVIOUS REPORT AND ACTIONS

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

Continue to build upon and improve data in exception reports

Action: Monthly exception reports continue to highlight areas where staffing levels fall below 90% overall and below 80% for Registered-qualified staff. Ward Managers in areas that do not achieve these thresholds are asked to provide updates to help improve our understanding of why we have shortfalls (Appendix 1 for fill rates). We are constantly reviewing this report to ensure it provides an accurate picture of the acuity on our inpatient areas matched against the available resources. This in turn has allowed the continued refinement of local escalation plans to support inpatient areas, an example of which is contained within Appendix 2, who are experiencing staffing challenges.

We are equally looking at the figures and speaking with managers to understand the acuity on the wards as shown by fill rates more than 120%.

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

Action: A report will continue to be sent weekly to the inpatient ward Managers and General
Managers providing an analysis of each ward's staffing and use of the e-roster system. This allows for anticipating pressures but also ensures that we extend out challenging processes in line with Lord Carter's report. We will be looking to ensure consistency with this requirement across our services.

The process of bringing all Health Care professionals, as recommended in Lord Carter's report, onto health roster continues.

Continue to provide effective and efficient support to meet establishment templates

Action: We will continue to utilise the robust process in place to ensure any changes to the establishment templates are to support the effective and safe management of resources. This has been particularly helpful in the current transformation work which is ongoing in several areas. These include Enfield Down, Lyndhurst and Older People's services which have recommenced following delays due to COVID issues.

SafeCare

Action: SafeCare will continue to be rolled out across all inpatient areas. A Standard Operating Procedure as well as a guidance paper have been produced and approved by EMT. This has begun with the early implementors of four wards within the Unity Centre with the next area to be Forensic BDU. Each area will take around 8 weeks for roll out to sustainable implementation. A detailed project plan, with timescales, learning from the early implementors, will be developed and presented to the next Safer Staffing group for sign off in May 2021.

Involvement in the National Performance Advisory Group

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

Continue to develop, manage and deploy the peripatetic workforce

Action: We have continued to utilise a small (up to seven staff) centrally managed peripatetic resource, which has helped in providing support across the inpatient areas. Given the number of bank HCAs we continue to utilise we are reviewing the size and effectiveness of this resource. All peripatetic staff, apart from one, have been deployed into substantive posts as a result of the COVID-19 response and supporting the inpatient areas.

Enhance the availability of resources within the Trust Staff Bank

Action: Recruitment has continued at a pace within the temporary staffing resource. Recently a cleanse has allowed us to reduce workers who had not engaged with the Trust for a significant period, allowing of course for any anxieties around the COVID-19 situation. This allowed us to focus our support on the staff who were shielding or continuing to work. It has also allowed us to go out currently for experienced HCAs to join the bank.

The Trust Bank has also been involved in collating staff who could support Trust interventions regarding COVID-19 response including drive through stations, test and trace and anti-body testing. We have also enlisted vaccinators and nurse prescribers onto bank as a result of our programme and continue to do so.

Finalise Staffing Models within Older People's Transformation Project

Action: Although initial modelling and data collection was done this has been paused primarily as other priorities, including our COVID-19 response, have taken precedence. Given the pressures on the ward the second data collection has been delayed; however, we are producing a report for the staffing of specialist wards within older people's services utilising the data already collected. A meeting to finalise these numbers will take place in the last two weeks of March.

Support the Forensic BDU's establishment and skill mix review

Action: The second set of comparative data was collected by the end of February from all wards within the BDU and the report is in its final stages. There will then follow further discussions around skill mix within the BDU and taking this forward. The headlines will be that a recommendation to increase the HCA establishment on most wards will be made as well as a continued review of the skill mix.

Participate and Support to the collaborative bank project as well as Service Line Agreements (SLAs) with neighbouring Trusts.

Action: We remain involved in discussions across the West Yorkshire Mental Health Trusts to explore the development of a collaborative bank which includes understanding the parameters of this. The latest meeting, led by Lindsay Jensen Deputy Director of HR & OD, was held in March with regular meetings in place. We continue to work with the local acute Trusts to develop Service Line Agreements for reciprocal specialist support through the bank services.

Develop a paper for proposing a Preceptorship Academy.

Action: The structure of a proposal has been explored in collaboration with the Non-medical Educational Lead and Learning and Leadership Development Manager. This will be presented to the Safer Staffing group for discussion and then further dissemination when completed. In the meantime, we are supporting the continuation of the Preceptorship Plus package.

Utilise the Mental Health Optimal Staffing Tool (MHOST) within a wider establishment review.

Action: Has been utilised within areas of the Trust to assess and review establishment templates and transformation work. To be discussed in the next Safer Staffing group about how and when we will launch the wider use of the tool as well as the parameters for its use. Develop an understanding of the outcomes as well as other composite figures to be factored in.

Continue to develop Staff Bank forums to support bank only staff

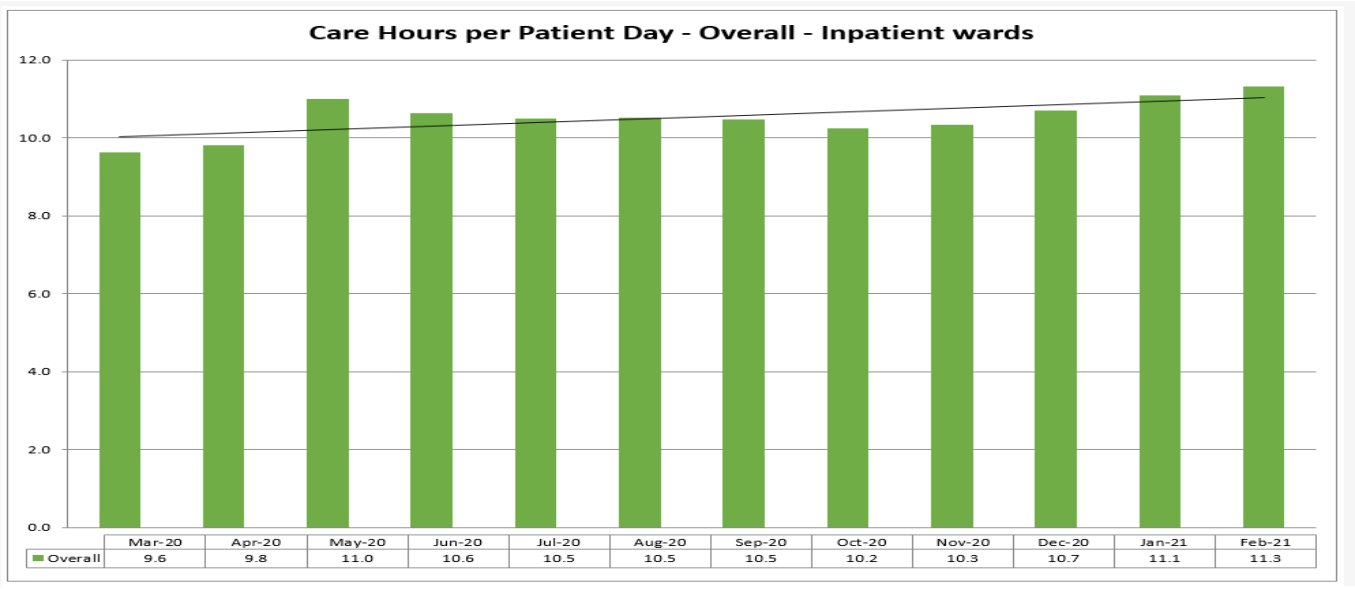
Action: in the last six months we have had three successful staff bank forums where attendance has increased each time. These have been supported throughout from various services and senior Trust staff which has been well received from bank staff. This integral part of our workforce must be valued in the same way as every other aspect and this has been a successful avenue in which to demonstrate this.

4. INTERPRETATION OF NHSI CARE HOURS PER PATIENT DAY (CHPPD)

We continue to review CHPPD data monthly within the safer staffing group and this will be viewed by OMG. There has been no collation of the national data regarding the CHPPD stats since the model was released and the collation of regional wide data for CHPPD purposes has been suspended since February due to the COVID-19 outbreak. This does lead to a devaluation of the comparison to both the national and regional figures. At present the best indicator is our own month on month comparison.

Figure 1.

Figure 1 shows that from September there has been a steady improvement in the average CHPPD delivered overall to the Service Users within inpatient areas. This coincides with sickness reducing, vacancies being filled and follows an initial drop off as students were withdrawn from ward areas upon completion of their paid placements where they were counted in the HCA numbers. The figures are improving due to some RN vacancies being filled post September but also due to HCA's backfilling RN shifts.



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Overall	9.6	9.8	11.0	10.6	10.5	10.5	10.5	10.2	10.3	10.7	11.1	11.3

Figure 2.

In figure 2 we see the split in RN and HCA CHPPD which reinforces what we stated above. There was a constant number of HCA hours until the engagement of student nurse paid placements, counted within the HCA numbers, which resulted in a marked decrease in these hours of engagement until November whilst the RN figures has slightly increased. This is also influenced by numbers of admitted Service Users and staff fill rates caused by vacancies, sickness and self-isolating.

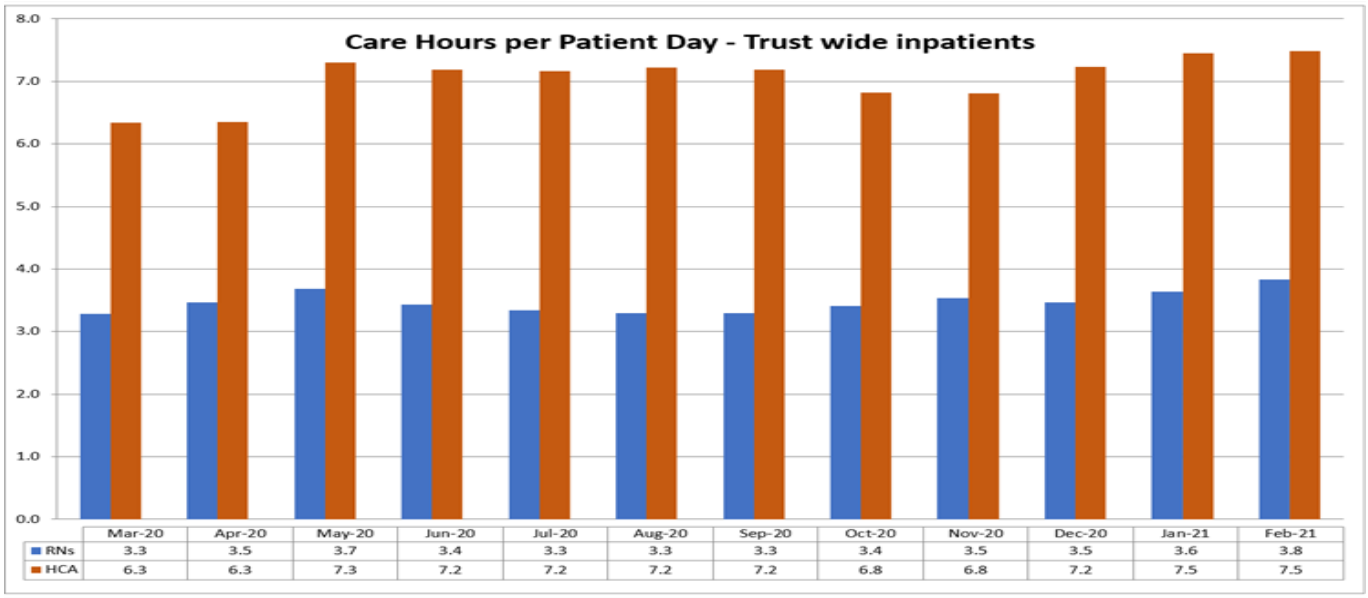


Figure 3.

The most recent review of our data compared to our regional partners within Y&H is summarised in figure 3 below. We will also utilise this in the current transformation work and any future establishment reviews. There continues to be a slight improvement in comparison to other Trusts across our regions, but we are all faced with similar challenges, not enough registered staff and higher acuity and demand.

Caution is advised when interpreting some of the data as comparison is made against figures for one month only and the rate can fluctuate from month to month and the figures also rely upon accurate and reliable reporting by respective Trusts. The regional average has not been updated in over 12 months so there will be a variance when this is done.

The main exceptions in this month are within the HCA numbers with wards having different functions and therefore we will be looking at their categorisation should this continue. The higher outliers can be traced back to smaller bed numbers and bespoke care packages thus increasing staff numbers as well as acuity driving the need for more staff. This is particularly evident in Barnsley and Horizon centre.

Ward Name	Area	Average Fill Rate - All Staff (%)	Care Hours Per Patient Day (CHPPD)			
			Trust		Regional Average	
			Registered Nurses	HCA	Registered Nurses	HCA
Beamshaw	Barnsley	131.2%	3.1	8.8	3.6	5.8
Clark	Barnsley	93.2%	4.5	5.8	3.6	5.8
Melton Suite PICU	Barnsley	134.7%	6.6	20.4	5.7	16.8
Neuro Rehab Unit	Barnsley	135.7%	7.2	10.8	3.4	5.3
Stroke Rehab Unit	Barnsley	93.5%	6.5	7.4	3.4	5.3
Willow Ward	Barnsley	102.7%	3.5	7.8	3.6	5.8
Ashdale	C & K	99.4%	2.6	4.1	3.6	5.8
Beechdale	C & K	164.1%	3.0	6.4	2.9	7.9
Elmdale	C & K	97.5%	2.7	4.5	3.6	5.8
Enfield Down	C & K	85.2%	3.4	6.1	3.6	5.8
Lyndhurst	C & K	96.3%	4.1	5.7	3.6	5.8
Ward 18	C & K	136.7%	2.6	8.7	3.6	5.8
Ward 19 - Female	C & K	94.9%	2.9	3.4	2.9	7.9
Ward 19 - Male	C & K	94.6%	3.4	4.3	2.9	7.9
Appleton	Forensic	92.3%	5.5	6.6	3.5	7.5
Bronte	Forensic	113.9%	9.3	14.0	3.5	7.5
Chippendale	Forensic	97.0%	3.3	4.7	3.5	7.5
Hepworth	Forensic	102.5%	3.2	4.9	3.5	7.5
Gaskell	Forensic	164.7%	4.0	10.9	3.5	7.5
Newhaven	Forensic	98.7%	4.0	7.1	3.5	7.5
Priestley	Forensic	93.1%	2.7	3.7	3.5	7.5
Ryburn	Forensic	101.1%	3.6	3.9	3.5	7.5
Sandal	Forensic	145.3%	2.9	11.7	3.5	7.5
Thornhill	Forensic	92.7%	3.3	4.4	3.5	7.5
Waterton	Forensic	126.7%	3.8	5.4	3.5	7.5
Crofton	Wakefield	159.0%	4.0	8.5	2.9	7.9
Horizon	Wakefield	121.2%	11.0	36.3	6.5	20.3
Nostell	Wakefield	137.3%	3.1	7.9	3.6	5.8
Poplars	Wakefield	123.0%	6.1	15.3	2.9	7.9
Stanley	Wakefield	121.2%	3.4	5.4	3.6	5.8
Walton PICU	Wakefield	126.0%	10.2	22.4	5.7	16.8
All Wards		116.2%				

CHPPD Key:	Within 10% of regional average
	More than 10% above regional average
	More than 10% below regional average

5. ANALYSIS OF FILL RATES SEPTEMBER 2020 – FEBRUARY 2021

Following an establishment and skill mix review within Working Aged Adults the establishment templates have been changed since May 2020. Further reviews in Forensics and other individual wards are ongoing.

Overall Fill Rates

Figure 4.

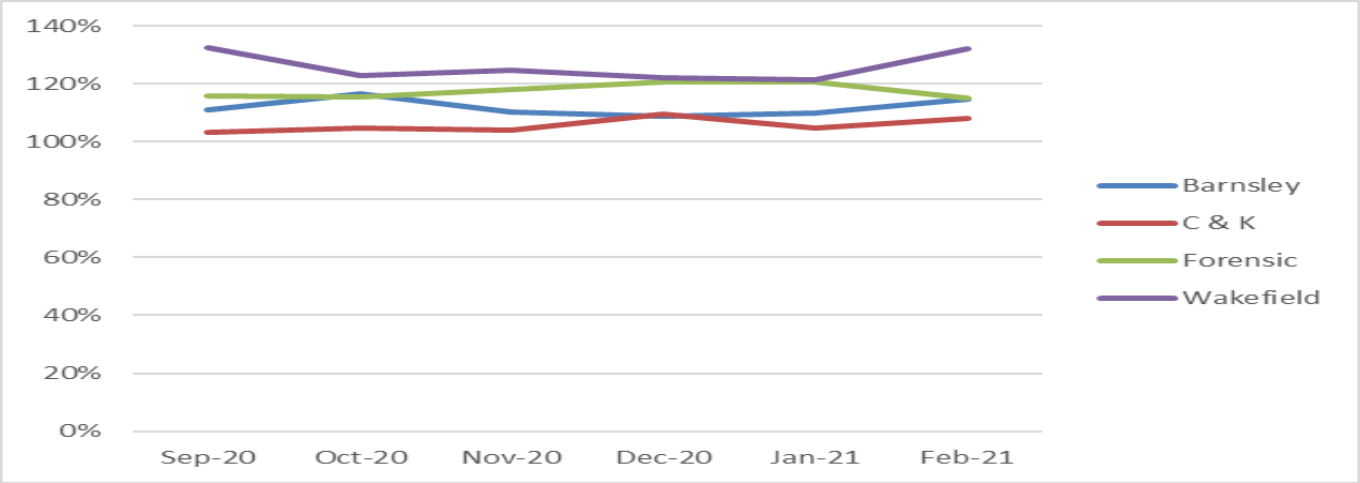


Figure 5.

Fill Rate BDU	Month Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Barnsley	111%	117%	110%	109%	110%	115%
C & K	103%	105%	104%	110%	105%	108%
Forensic	116%	115%	118%	120%	120%	115%
Wakefield	132%	123%	125%	122%	121%	132%
Grand Total	**114%**	**114%**	**114%**	**116%**	**114%**	**116%**

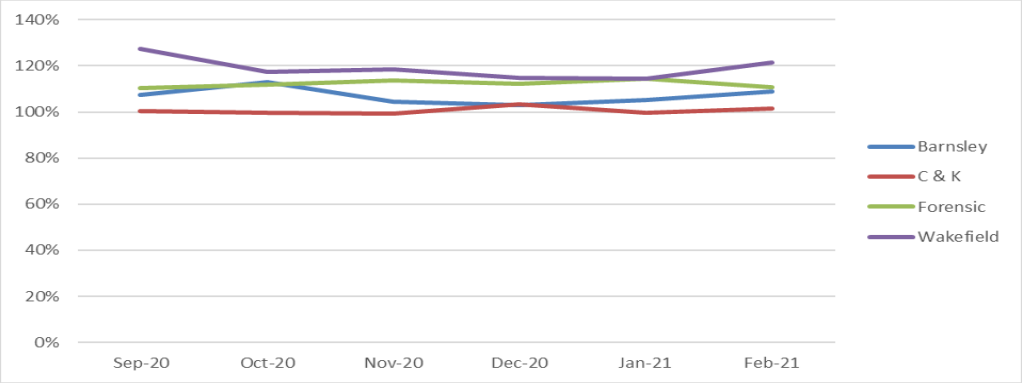
Fill Rate Key:	Within 20% of fill rate
	More than 20% abovefill rate
	More than 20% below fill rate

The Trust continues to reach its overall fill rate. This has been done with a high proportion of shifts (on average 3,500 per month) being covered by bank and agency as well as some registered shifts being taken by HCAs. We continue to produce these figures monthly (see Appendix 1) and ask ward managers for an explanation of why the ward hadn't reached a particular threshold and what impact this had. This allows us a broader understanding of the acuity on the wards. We will also be asking why the ward averages are 120% and above as several questions must be asked including is the template correct? Can we safely reduce staffing numbers? What is the acuity like to warrant this uplift?

The skill mix and shortages of registered nurses is being addressed within inpatients by establishing the various roles including that of the Nursing Associate, whilst in training will be within the HCA numbers/Advanced Nurse Practitioners and increasing the number of band 6 Team Leaders. We are also looking at international recruitment, see Section 7, as well as supporting the collaborative bank initiative.

Overall days

Figure 6.

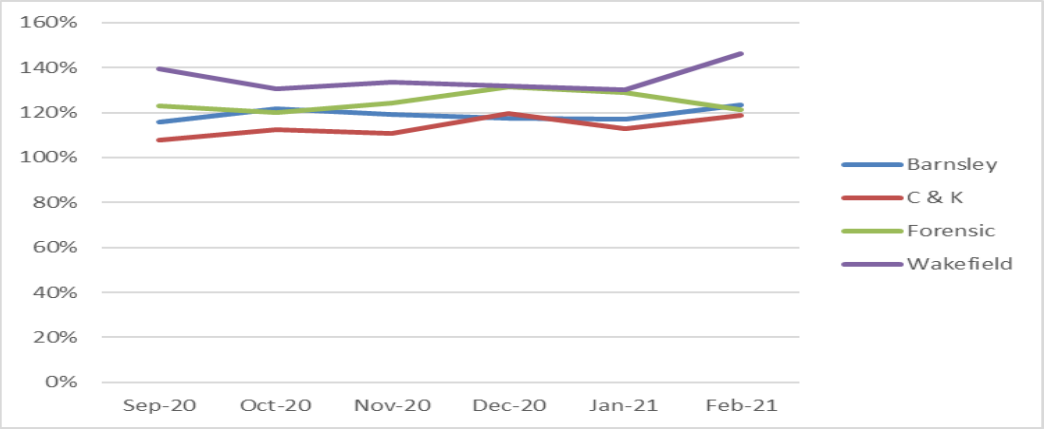


There have been 23 occasions, an increase of 15, where wards have fallen below this threshold of 80% with staff having to self-isolate due to Covid-19 accounting for a large proportion of these during outbreaks and subsequent breaches of protocols. All areas have improved on reducing breaches and staff's understanding of them. Vacancies and sickness accounted for others as well as reallocations to support clinical need. This was mitigated through local escalation plans to identify staff to cover.

There were also 48 instances where wards were filled to 120% and beyond which is indicative of acuity as well as the other reasons cited above.

Overall nights

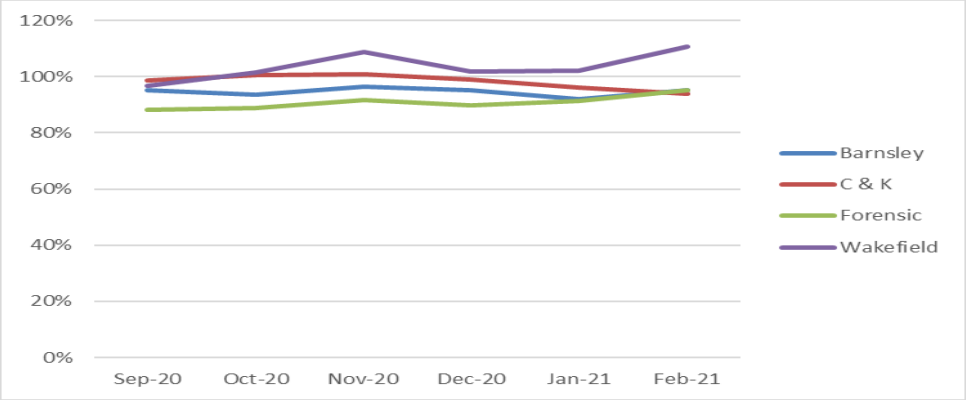
Figure 7.



Only on one occasion did a ward has fall below this threshold on nights. This was due to an outbreak of Covid-19 on the ward within the Service User and staff group. Indeed, due to clinical need/acuity and less senior clinical staff and activity, there tends to be a marked uplift in staffing. Teams concentrate their efforts on covering nights and weekends leaving them short at times. There are also more staff within the flexible workforce willing to work nights.

Registered staff nights

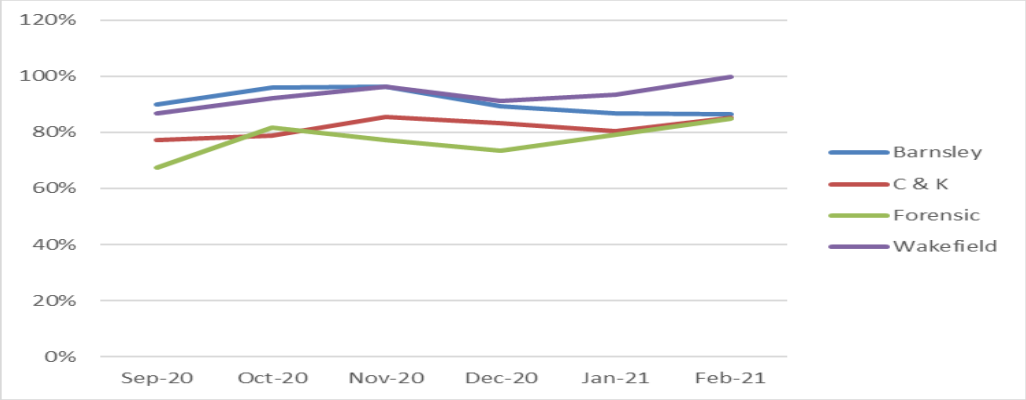
Figure 8.



We have had 44 incidents, an increase of 28, where wards have fallen below the required 80% fill rate for registered staff on nights. This was primarily from vacancies or sickness and the reasons cited in the section above around Covid-19. Local continuity and escalation plans supported those areas with clinically based reallocations accounting for some of these. The picture in the main, has improved within the last 2 months due to ongoing recruitment; however, there is a long way to go.

Registered staff days

Figure 9.



Registered staffing remains a significant pressure on the inpatient areas. We have introduced and embraced the Trainee Nurse Associate programme, which will increase our registered staffing resource as the cohorts complete their training programme. The Trust has also supported a clinical career pathway for nurses that include nurse practitioners, non-medical prescribers and advanced clinical practitioners in practice.

We continue to recruit band 5 nurses (40 have been recruited since September to date) and attend virtual university recruitment fairs nationally, (see recruitment and retention section) and continue to provide ongoing central recruitment centres. Again, this shows, in the main, an improving picture. We have bespoke adverts running for band 5s in Barnsley as well as the general adverts.

RN fill rate on days/nights
Figure 10.
Days
Nights

Appleton	71%	71%	80%	Appleton	116%	126%	111%
Ashdale	105%	94%	98%	Ashdale	100%	98%	94%
Beamshaw	94%	86%	72%	Beamshaw	95%	97%	94%
Beechdale	88%	98%	96%	Beechdale	100%	100%	122%
Bronte	75%	72%	82%	Bronte	76%	63%	89%
Chippendale	49%	64%	77%	Chippendale	97%	103%	103%
Clark	88%	92%	93%	Clark	99%	88%	102%
Elmdale	89%	80%	96%	Elmdale	97%	82%	85%
Enfield Down	84%	80%	64%	Enfield Down	101%	87%	79%
Hepworth	79%	84%	80%	Hepworth	73%	82%	75%
Lyndhurst	101%	98%	96%	Lyndhurst	104%	105%	101%
Melton Suite PICU	87%	87%	80%	Melton Suite PICU	85%	77%	84%
Neuro Rehab Unit	97%	95%	103%	Neuro Rehab Unit	100%	100%	100%
Newhaven	76%	85%	75%	Newhaven	86%	85%	93%
Poplars	86%	85%	75%	Poplars	103%	113%	111%
Priestley	73%	76%	72%	Priestley	139%	126%	111%
Ryburn	101%	100%	103%	Ryburn	97%	94%	90%
Sandal	93%	85%	98%	Sandal	84%	76%	70%
Stanley	95%	99%	105%	Stanley	99%	95%	105%
Stroke Rehab Unit	105%	100%	97%	Stroke Rehab Unit	100%	100%	100%
Thornhill	66%	79%	86%	Thornhill	70%	82%	84%
Ward 18	68%	71%	81%	Ward 18	89%	96%	91%
Waterton	64%	83%	90%	Waterton	103%	126%	158%
Willow Ward	58%	54%	62%	Willow Ward	94%	100%	93%
Ward 19 - Female	67%	62%	80%	Ward 19 - Female	110%	103%	104%
Ward 19 - Male	67%	63%	75%	Ward 19 - Male	100%	120%	105%
Nostell	100%	99%	93%	Nostell	104%	103%	98%
Crofton	85%	91%	121%	Crofton	110%	102%	136%
Walton PICU	87%	91%	103%	Walton PICU	97%	103%	116%
Horizon	119%	109%	126%	Horizon	105%	110%	111%
Gaskell	58%	67%	74%	Gaskell	90%	90%	102%
Overall Shift Fill Rate	**82%**	**83%**	**88%**	**Overall Shift Fill Rate**	**95%**	**95%**	**97%**

Although an improving picture, several wards have consistently fallen below the 80% threshold as above. They are in the main within Forensics who have developed a local support process, as have the other BDUs, to ensure the safety of both service users and staff.

Due to recruitment and retention measures this is an improving picture on days and is relatively stable on nights, however on days this tends to fluctuate and mirror starting dates for newly qualified RNs. We have seen an improvement this year with some universities now doing two cohorts a year as well as the Master's intake.

Within Barnsley there has been a substantial migration of RNs from inpatients into community teams and the pressures of this are being felt at the moment.

Steps have been taken to ensure an RN presence on all wards always. This could be in the form of reallocations, ward manger cover or basing supernumerary team leaders on the wards. Reasons for the shortfall are looked at and support offered. There are issues with correct recording within the health roster, which will account for some of this as ward managers are not always counted even though they are registered staff. This is being addressed.

All areas have business continuity plans in place as well as staffing escalation plans that have been, or will be in the next 2 weeks, reviewed with the safer staffing lead. This sets out what steps to take and in what order together with who's responsibility and accountability.

As we can see in Figure 11 the reduced fill rate for registered nurses is off set in the overall fill rate with the use of HCAs. Although this ensures safe number of staff on the wards it does lead to a dilution of the skill mix RN: HCA.

Among initiatives being considered, is the introduction of ward based AHP's and RGN's as the second registered professional, as well as ensuring that our Nursing Associates have access to book second RN

shifts as bank. SafeCare will also allow for a more accurate picture of acuity and the available staff resources which will aid in the clinical decision-making process of staff deployment.

Figure 11.

Overall fill rates per ward

Although, as mentioned above, the Registered Nurse fill rate, particularly on days, remains challenging our overall fill rates have in the main been sustained (see data on next page).

Ward Name	Sep-20 Average Fill Rate - All Staff (%)	Oct-20 Average Fill Rate - All Staff (%)	Nov-20 Average Fill Rate - All Staff (%)	Dec-20 Average Fill Rate - All Staff (%)	Jan-21 Average Fill Rate - All Staff (%)
Beamshaw	100.6%	106.0%	111.6%	109.1%	96.9%
Clark	113.1%	111.1%	96.8%	96.1%	98.7%
Melton Suite PICU	122.5%	122.1%	123.2%	136.6%	147.6%
Neuro Rehab Unit	124.4%	136.4%	139.0%	135.2%	139.5%
Stroke Rehab Unit	103.9%	111.8%	93.7%	93.0%	91.8%
Willow Ward	101.8%	118.5%	104.2%	84.0%	87.8%
Ashdale	99.0%	94.9%	97.9%	103.1%	96.9%
Beechdale	131.7%	150.2%	143.4%	156.5%	160.5%
Elmdale	97.7%	93.8%	98.6%	114.4%	110.7%
Enfield Down	98.2%	94.6%	93.6%	95.2%	89.3%
Lyndhurst	98.8%	100.9%	101.8%	99.6%	100.2%
Ward 18	105.8%	106.4%	107.4%	120.9%	104.2%
Ward 19 - Female	101.1%	105.3%	92.0%	90.1%	86.8%
Ward 19 - Male	101.3%	105.5%	105.1%	96.8%	98.0%
Appleton	87.3%	92.2%	95.8%	97.9%	97.0%
Bronte	122.4%	126.6%	112.2%	117.1%	122.5%
Chippendale	93.2%	94.8%	100.6%	80.6%	90.4%
Hepworth	103.4%	103.2%	125.5%	117.3%	114.8%
Gaskell	156.7%	168.7%	152.7%	158.9%	185.7%
Newhaven	90.2%	97.0%	103.8%	96.9%	99.0%
Priestley	89.0%	94.3%	92.4%	142.8%	91.0%
Ryburn	100.8%	99.1%	97.7%	100.3%	97.1%
Sandal	128.4%	119.6%	128.3%	141.8%	149.4%
Thornhill	107.9%	98.0%	100.0%	95.4%	95.6%
Waterton	112.8%	114.5%	118.0%	117.6%	123.9%
Crofton	116.9%	107.4%	115.2%	111.8%	110.6%
Horizon	152.2%	140.0%	148.3%	142.6%	133.0%
Nostell	122.3%	111.0%	121.5%	125.8%	115.6%
Poplars	153.7%	143.3%	127.0%	147.1%	134.8%
Stanley	135.7%	136.5%	123.5%	113.2%	123.6%
Walton PICU	134.8%	120.0%	132.2%	117.1%	122.3%
All Wards	114.4%	114.0%	114.0%	115.6%	114.3%

Fill Rate Key for All Staff:	Less than 90% fill rate
	Greater than or equal to 120% fill rate

6. ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING

Figure 12. **Datix Incidents recorded for staffing issue**

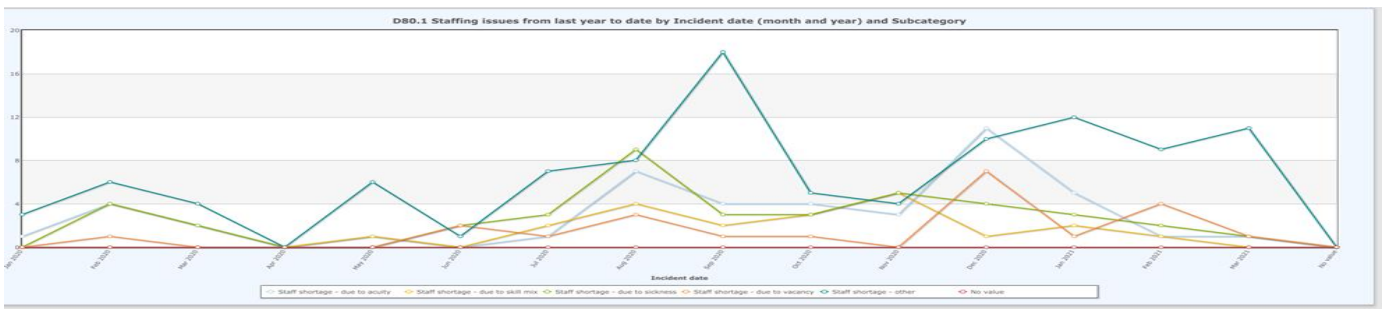
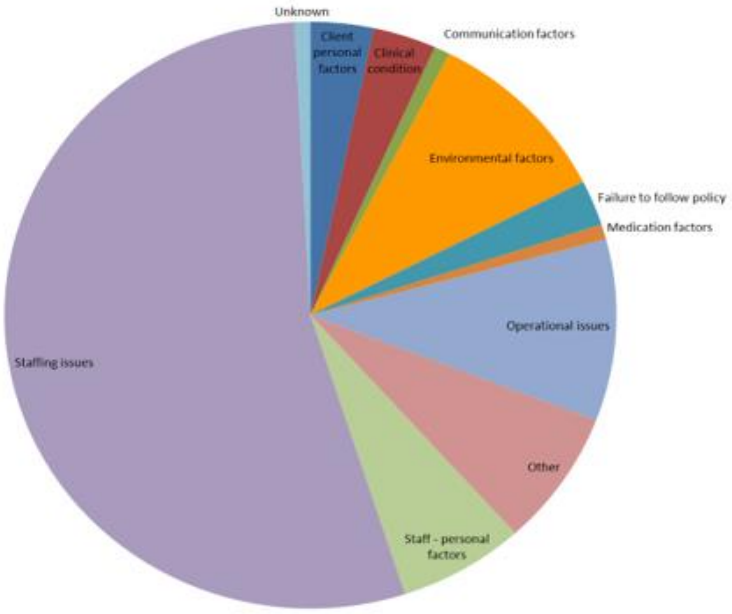


Figure 13. Datix incidents where staffing listed as a contributory factor



In the six months leading up to the 28th February 2021, there were 134 Datix incident reports highlighting staffing issues. This was an increase of 49 reports from the previous report and a further reminder that SafeCare should prompt a more realistic reporting of staffing incidents.

As we can see from Figure 12, there was a spike of reports around staffing in December which has since levelled off. This was due to an overall subjective increase in acuity as well as sickness and vacancies. Of the 134 incidents that were reported 69 were listed as staff shortages and 29 because of acuity. As SafeCare is rolled out across the Trust, there should be an improving picture.

Datix information is utilised to identify “hotspots” and work closely with the ward teams and managers to resolve any issues and ensure safety is maintained.

7. RECRUITMENT AND RETENTION

Work ongoing and current status includes:

Increased internal and external marketing of available roles across SWYPFT.

The Trust has now been fully utilising NHS Yorkshire Jobs Facebook feed for over 18 months. All new posts entered on NHS Jobs are now uploaded to Trust NHS Yorkshire Jobs Facebook and Twitter feeds. All posts are boosted by the Recruitment and Marketing Advisor on a daily basis to appropriate FB groups and LinkedIn networks, and also retweeted. Our LinkedIn networking has increased by over 5000% in the last six months and the Trust now has a dedicated LinkedIn recruitment account able to use wider engagement techniques and focus on our harder to recruit higher professional posts. Increases in applications to senior clinical posts have been seen since this has grown; in particular clinical psychology and secure CAMHS roles. Where appropriate posts are also uploaded onto local and national University and FE colleges websites to encourage applications and interactions, especially to increase Trust awareness in the sector.

International Nurse Recruitment.

The Trust is lead for a widescale 12-month recruitment programme across the WY&H ICS of mental health nurses. As a collaborative the Trust is partnering with 5 Trusts (TEWV, LYFT, BDCT, HTH and RDASH)

to recruit nurses from India, Philippines and other potential internationally allowed countries for recruitment. Support from NHSE for £216k has been achieved to support the implementation. The collaborative Trusts are all MH providers and the intention is to recruit MH nurses with transferable skills through official EILTS & OSCE regulations and requirements. If mental health nurses are not available a programme of recruiting RGN nurses will be made and MH conversion will be undertaken. The preferred recruitment agencies are currently being determined through the NoECPC procurement framework with award being made in April 2021. Once this is in place localised recruitment plans will begin on a quarterly cohort basis. A total of 110 nurses across the five Trusts are being recruited, with SWYPFT committing to recruiting 40. All five Trusts are undertaking international nurse recruitment for the first time and the aim is to work together closely, ensuring parity across Trusts for onboarding, employment, pastoral care, and retention.

Localised recruitment and retention task groups.
In place with action plans ongoing for delivery in Forensics and Secure CAMHS to meet staffing issues, particularly within Adel Beck, Wetherby YOI and the wider workforce shortages in medium and low secure; this work is ongoing. The ward areas within Forensics currently see a large number of nurse vacancies (32 WTE). Targeted recruitment fairs have been signed up to and earmarked to drive candidates to roles within forensics such as the British Forces Resettlement Services which occurred in November 2020 and further fairs will be earmarked post-COVID. This is in direct response to widening reach to promote male nurse uptake in forensics.

Professions led recruitment action plans.
Similar recruitment plans and action plans currently being undertaken with specific professions across the Trust, notably psychology, medical and allied health professions.

Implementation of a Trust onboarding & management portal system
Was agreed in September 2019. Procurement and tender exercises were completed, and implementation plans are still underway to deliver onboarding system into Trust by later in 2021. This has been delayed due to the COVID pandemic this year, but design and implementation has now re-started.

Development of career pathways in professions.
Nursing, AHP and Psychology leads developing career structure pathways. Plan to develop more visble progress opportunity for staff both within intranet and at job application, job advert / NHS Jobs e.g. ACP developments.

Trust recruitment fair attendance.
The Trust committed to an extensive programme of events to market its job opportunities and vacancies which began in February last year following extensive set-up to ensure we were business ready (marketing, stand equipment, volunteer availability, transport and planning etc.). The programme of attendance has been severely hit by COVID-19 however with all physical events being cancelled or moved to a virtual platform. This included five of the seven Royal College of Nursing events across the UK and Ireland, two Health Sector Talent events in London and Dublin, dozens of Jobs Fair UK events across the UK and various localised events at all the neighbouring Universities and colleges. In total approximately 45 events were directly affected in this time that SWYPFT were targeting. The Trust had physically attended two RCN events (Manchester and Birmingham), one Health Sector Talent event (London) and one Wakefield College collaborative event prior to the pandemic with good success from them on the whole. The Trust has since virtually attended a number of localised University fair events, British Armed Forces Veterans Association, and two RCN Virtual fair events (marketed as London and Glasgow Areas respectively) and these are ongoing. The virtual delivery is an emerging and developing platform and much more work is being done to increase our approach and involvement. This will also include our ability to target localised community recruitment with BAME networks and LBGTQ+ networks. Liaison is ongoing with BAME and LBGTQ+ Trust leads to fully engage in these areas for targeted recruitment.

Collaborative Virtual Recruitment.
The Trust is lead for a collaborative approach to hosting our own virtual recruitment events. External funding has been secured (£40k) to purchase our own virtual recruitment platform provider as a joint venture with Leeds & York Foundations Trust and Bradford District Care Trust and support from the WY&H ICS lead. The tender for the preferred platform is currently out to tender with award being made early April

2021. Once in place SWYPFT and our partners will identify a suite of virtual recruitment days themed across our recruitment needs and will be inviting a wider participation from other providers, universities, further education providers, health & social care providers and others. This will give SWYPFT an important and influential position around localised recruitment drives.

Staff ending employment procedure
To be re-designed via SurveyMonkey platform to allow for greater response rates and ease of use for staff. Shorter and more targeted simplified process. Current process antiquated and heavily narrative driven. Work ongoing.

A Trust-wide 'internal' transfer window
Has been in place since January 2020 following initial marketing campaign with communications on the intranet and headlines to pique interest. This continues to increase in success. Approximately 26 internal moves have been completed since from a total of 38 requests to the scheme implementation which have all been staff who were considering or actively looking for work outside the Trust due to work-life balance issues. Approximately half of these have been nurses (12 staff members are awaiting a suitable vacancy match according to their preferences).

HCSW zero vacancy target.
The Government have set out its aim to achieve zero vacancies by April 2021 and have provided all Trusts with funding support to fill identified vacancies as at October 2020 from the PWR workforce submissions (SWYPFT had four WTE at that time). The Trust has fluctuating vacancies from month to month and current weekly monitoring is in place to meet the zero-vacancy position. The Trust are currently shortlisting from the latest advert which identified 52 candidates and will be re-advertising again in May to meet the vacancy position.

Establishment of a Peripatetic Workforce.
The Trust's initial peripatetic workforce was severely reduced due to lack of centralised funding, but the emergence of the zero-vacancy drive is leading to the need for an agreed centralised peripatetic workforce, specifically within clinical support roles in the first instance. Both workforce and nurse professions leads are currently working with operational budget holders to set up an agreed peripatetic workforce alliance. This will reduce our need for agency and overtime spend. Work is ongoing and proposal being drawn up for consideration and agreement at EMT/OMG (April/May 2021)

Recruitment of TNA
TNA and nursing apprenticeships is a constant process across the Trust. TNA recruitment is continuing with the second wave of recruiting being undertaken shortly.

Peer Support Workforce Development.
External funding is being made available to further embed this role into wider mental health services. The Trust currently employs around 18 PSWs but is looking to increase this number. The recently appointed Lead Peer Support Development Coordinator is working closely with the lead for workforce planning to further develop (April 2021).

Annual workforce planning workshops
Were suspended due to COVID pressures this year, however a light touch approach to workforce planning and learning needs analysis has been made and the submission for these plans was given a deadline of the 13th March. Subsequent consolidation and understanding of these plans. This will focus on identification of numbers for development roles in teams for wider workforce TNA's, nurse associates, ACP roles, physician associates, pharmacy support development and other potential expansion roles. Several new role opportunities are currently being assessed and scoped within the Trust following external funding support from HEE, NHE and NHSI to deliver on the NHS Long Term Plan and the Mental Health Investment Standard.

New Roles Governance Group.

A new group looking at the implementation of new roles across the Trust from emerging national incentives has been set up with representation from Deputy Director of Nursing & Quality, Lead for Workforce Planning, Lead for Learning & Development, representatives from operational services and other professional leads. The initial focus will be on Advanced Clinical Practitioners and Nursing Associates, with a suggested focus of:

- How we identify these roles within our workforce planning
- How we then recruit to trainee positions, with clarity around contracts, expectations, and any contingency planning if the trainee does not complete the training
- How we support and oversee trainees to ensure they are able to access all that is required for successful completion, and continue to be on track to pass the course
- How we understand the potential benefits or risks of new roles
- How we inform clinical areas of any emerging new roles
- How we prepare current teams for the integration of any new roles

Establishment of Workforce Strategy Group (April 2021).

This will replace the Agency Project Group and the current COVID Bronze Workforce Group. It will report to the Workforce & Remuneration Group (W&RG). Chaired by Deputy Director of HR, there will be 4 key strategy groups (to be decided).

Flexible Workforce Model

- Develop the flexibility of the core substantive workforce
- Reduce agency spend including a focus on unregistered roles
- Ensure an engaged Staff Bank of an optimal size
- Promote the development of new roles and skill mix
- Ensure that there is effective rostering

Health and Wellbeing

- To ensure that the Trust effectively supports and promotes positive staff health and wellbeing
- To develop an annual health and wellbeing plan linked to NHS Staff Survey and the Trust's health and wellbeing survey
- To reduce sickness absence
- Increase staff engagement

Workforce Planning and Development

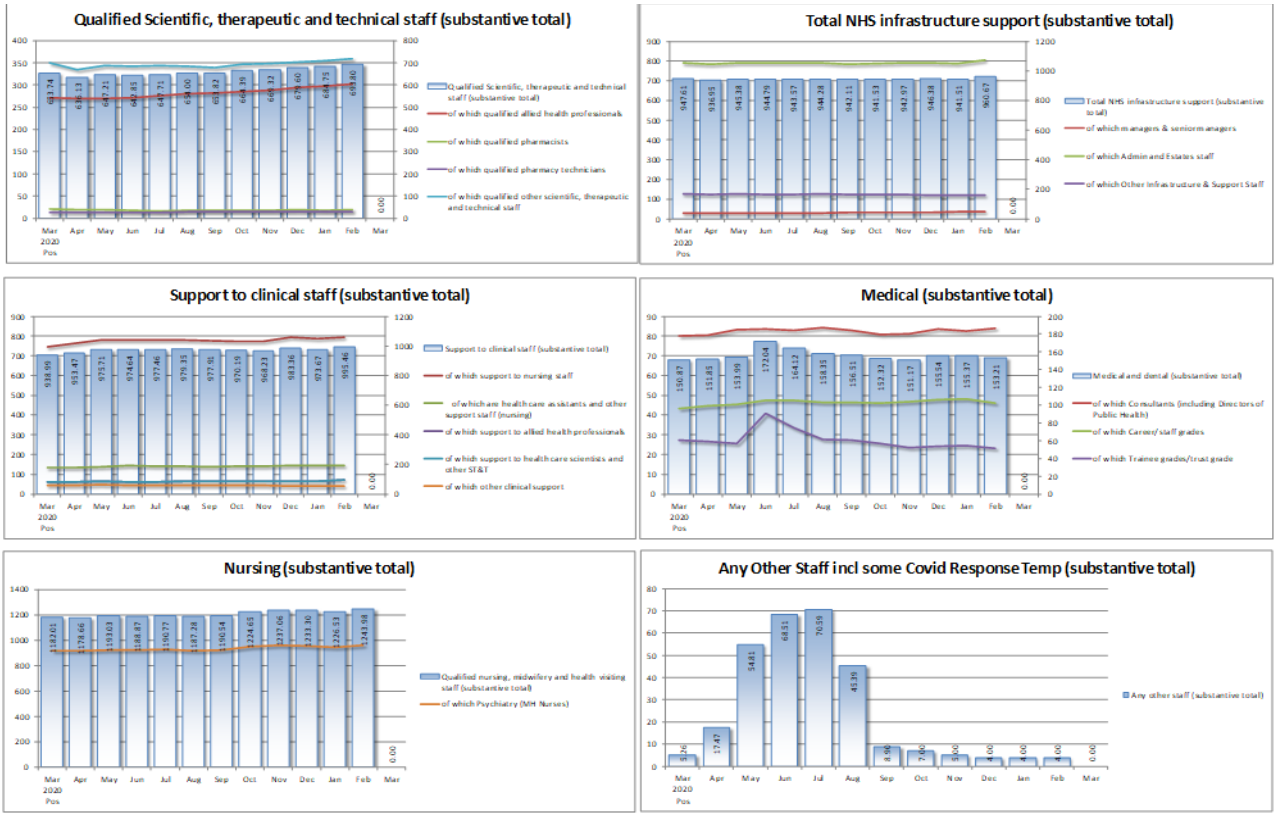
- To develop a strategic workforce plan which is aligned to the Trust's service and financial plans
- To develop robust recruitment and retention plan
- To reduce turnover

Leadership and Management Development

- To ensure that the Trust has a clear leadership and management development pathway
- To positively promote and support diverse and representative leadership and management development
- To enable staff to reach their potential through a talent management strategy and plan
- Overall Trust-wide turnover continues to reduce. This has been affected due to COVID-19 since March 2020 where overall recruitment movement has reduced across the health sector as a whole. Projected nurse turnover for 2020-21 is expected to be reduced to 10.2% by April 2021. Historically the Trust has seen turnover rates around 12-13% annually.

Figure 14 on the next page shows workforce staff in post numbers for the past 12 months. We see that the trend has been steadily rising since a Trust-wide low in August 2019. In the last 18 months the Trust has seen a 6.21% increase in nursing staff in post (FTE).

Figure 14.



8. INPATIENT REGISTERED AND NON-REGISTERED BANK AND AGENCY

The Trust continues to engage with the National Performance Advisory Group for Safer Staffing. As discussed earlier within the report, we are also engaging in work on collaborative banks. This is in line with our regional partners.

As well as continuing with our ongoing recruitment programme, we have also embarked on a cleanse of our staff bank to ensure that we have an engaged, active cohort of flexible staff. We have also embarked on a programme of transition from bank to substantive posts or temporary contracts. This shows a slightly distorted picture as staff on temporary contracts are not counted in the staff only numbers.

We continue also to recruit all care professional students onto the bank following a shortened interview process as well as transitioning, after engaging them, more agency staff onto bank than previously. This has resulted in a marked increase in active registrants and HCAs on the bank thus increasing our ability to react to staffing requirements.

During February 2021 bank and agency staff worked 660 RN shifts and 2916 HCA shifts on inpatient wards. This has a financial impact on the Trust's direction of travel regarding recruitment and budgetary planning.

Financial challenges remain in respect of both bank and agency spending. There is an understanding nationally that the flexible staffing workforce is an integral part of the modern workforce. However, the drive should remain to reduce the spending on these groups, agency colleagues in particular.

Figure 15

Staffing on the bank September 2019, March 2020, Sept 2020 and Feb 2021

Staff Group (Bank Only)	Sep 2019	Mar 2020	Sep 2020	Feb 2021
Additional Clinical Services	284	289	365	308
Administrative and Clerical	99	93	86	62
Allied Health Professionals	43	33	23	52
Estates and Ancillary	10	10	5	5
Medical and Dental	66	47	69	44
Nursing and Midwifery Registered	151	172	135	119
Grand Total	**653**	**644**	**683**	**590**

Figure 16.

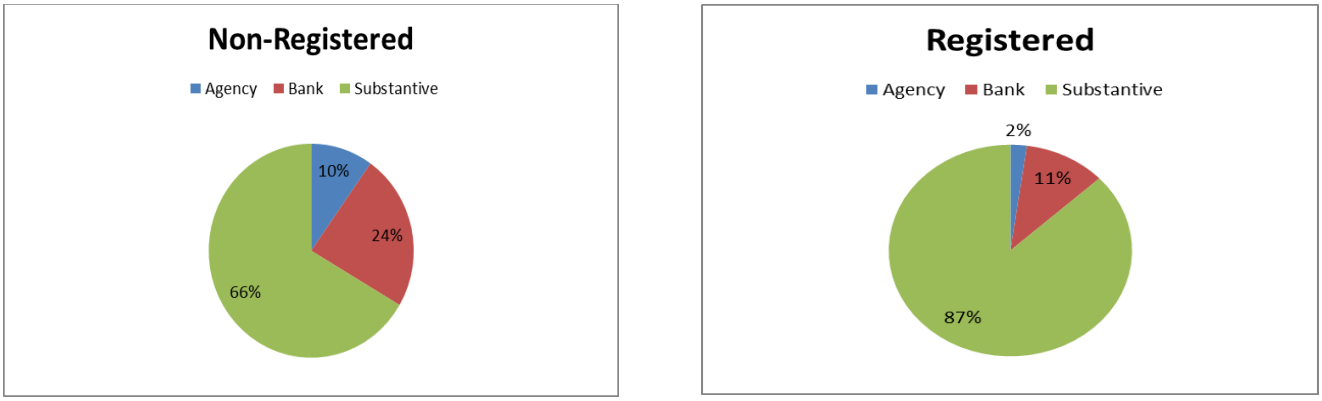


Figure 17.

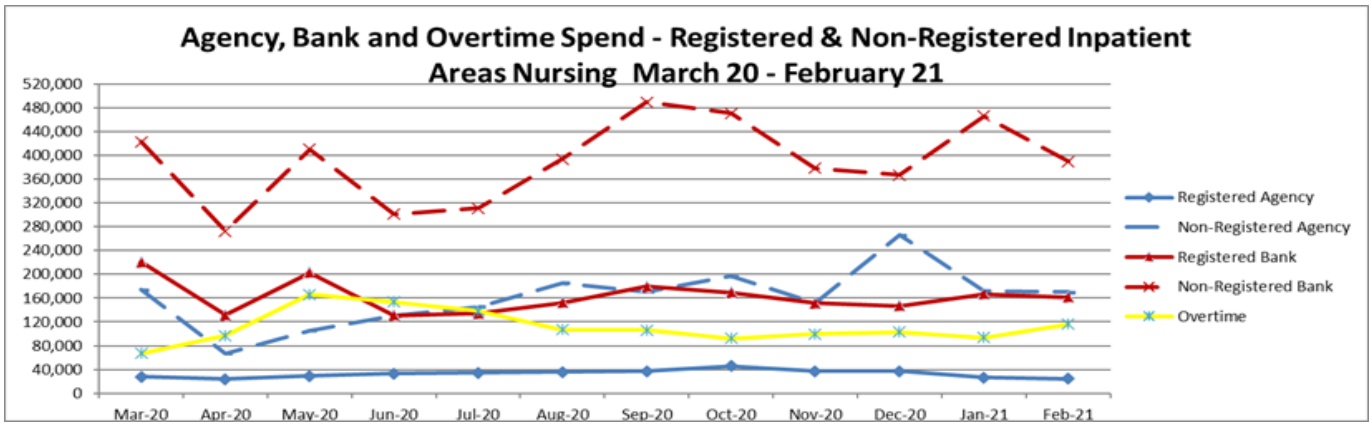


Figure 17 shows that agency spend for both registered nurses and non-registered staff has remained reasonably consistent over time although there have been some fluctuations between months. Although bank has shown similar fluctuations within the HCA workforce which mirror those of agency. The registered costs have been maintained whilst overtime shows little change. In March we expect a peak of bank and agency usage due to year end annual leave as in previous years.

Figure 18.

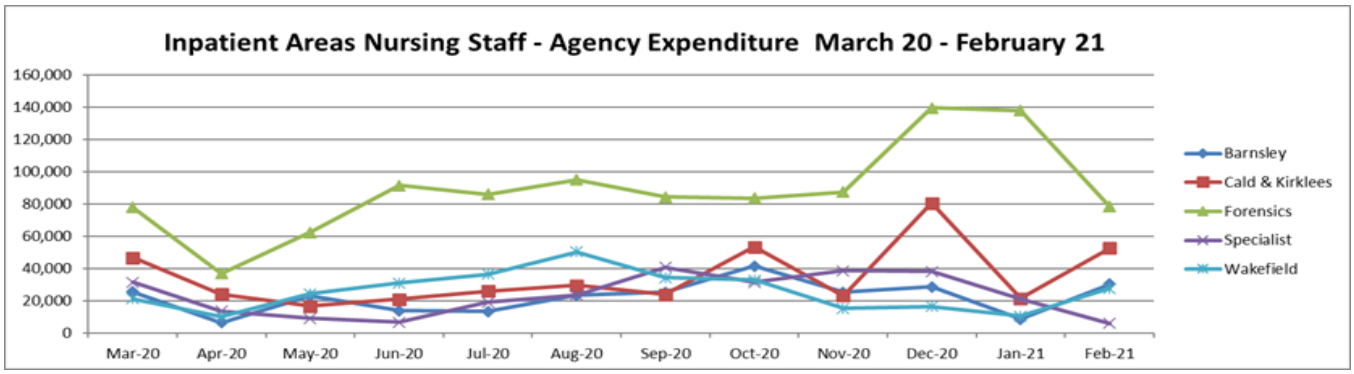


Figure 18 shows that agency spend on inpatient wards continues to be highest in forensic services. There are marked fluctuations around usage over high annual leave times and staff having to self-isolate or breaches on the wards

Figure 19.

Bank, Overtime and Agency use is no longer reported from Sept 2020 so this Figure will not be referred to in future versions of this report.

Figure 20.

Bank/ Agency/ Overtime hours on inpatient wards by year is no longer reported on from Sept 2020 so this Figure will not be referred to in future versions of this report.

Figure 21.

Agency and bank/ OT/ Excess hours on inpatient wards no longer reported on from Sept 2020 so this Figure will not be referred to in future versions of this report.

Figure 22.

Inpatient Ward - Vacancies - 31 March 2021

BDU	Ward	HCA/TNA/NA	RN	Grand Total
Barnsley		5.9	15.0	21.0
C & K		8.3	22.4	30.7
Forensic		-14.1	32.4	18.3
Specialist		1.7	0.1	1.8
Wakefield		1.5	13.7	15.2
Grand Total		3.3	83.6	86.9

N.B. Vacancies are calculated as the difference between demand (from the roster template) and staff in post. However, Horizon's vacancies are the difference between the budget establishment and staff in post. Shortfalls due to vacancies are mitigated by measures to increase additional hours including, bank and over-time, agency staff and new initiatives introduced as part of response to COVID-19 including return to practice, retire and return and voluntary postponement of annual leave.

9. SAFER STAFFING IN THE COMMUNITY

We continue to assess when it would be practicable to deploy the staffing measurement tool within our community teams. The project was postponed due to the COVID-19 outbreak, a detailed project plan with

timeframes for this work will be presented to the safer staffing group in July 2012 with a start date of August 2021. The majority of teams will also be on health roster by the end of October which is integral to the sustainability of Safer Staffing within community. We will be utilising the recent caseload benchmarking.

We will, in the meantime, continue to:

- Offer support where staffing shortages have been identified.
- Recruit bank specialists to support the services
- Support the AHP tender process to help secure a broader resource for the community teams

10. **SAFECARE**

We have adopted SafeCare within the early implementer's areas. This is the Unity Centre. This is a staffing resource management and acuity tool that is linked into the health roster system. This allows the creation of a "one stop" information resource where up to the minute staffing requirements can be established utilising the most evidence-based staffing tool available to date.

It has allowed staff to understand the nature of acuity on their wards and be able to verbalise what this means and what impact it actually has on them. It also allows for managers and senior staff to create an instant picture of the level of acuity over a bigger area, where staffing resources are and where alternative deployment can occur. It also ensures that health roster is up to date thus ensuring staffing records are accurate at all times. The next area to be implemented following our learning phase from the Unity Centre will be within the Forensic BDU.

11. COVID-19 RESPONSE

As we are all aware the health system is being severely challenged with the outbreak of the COVID-19 pandemic. This has impacted greatly on several of the interventions that Safer Staffing have had planned for this year. Figure 22 below shows the extent of absenteeism due to staff isolation arising from symptoms (7 days), household symptoms (14 days) and shielding (12 weeks).

At present 148 staff are either absent or working from home due to COVID-19. This is a 62.6% increase from last week (91), 80 of these are absent and 68 working from home. The 2278 absences recorded since 16th March is made up of 1772 individuals, with 368 people having 2 or more periods of absence.

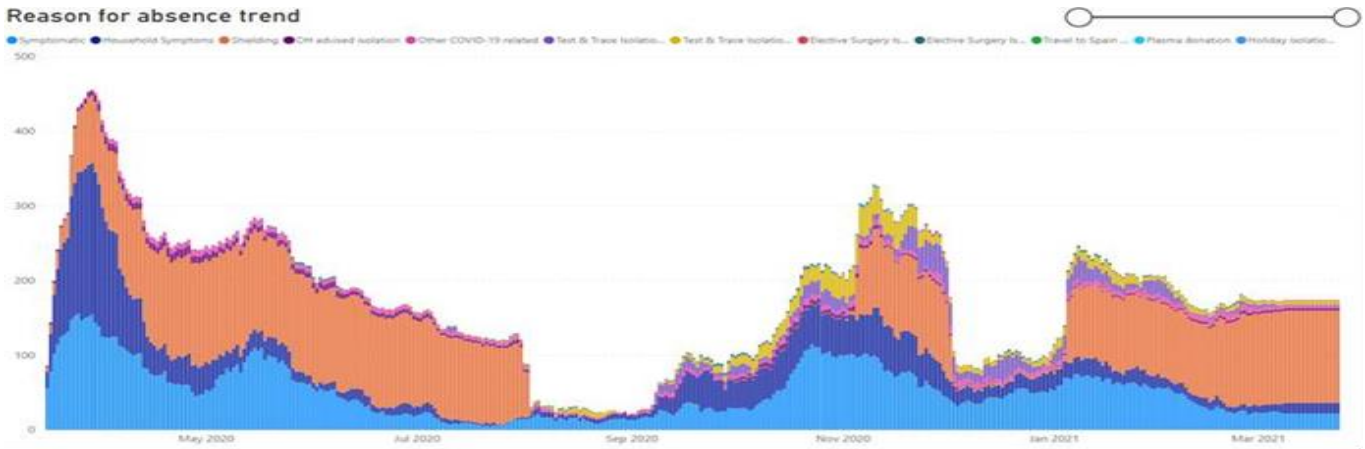
There are many different examples of multiple periods of absence e.g. where someone was off because of household symptoms, then became symptomatic themselves. Since 07th September 2020, the number of people absent due to COVID-19 has been increasing by an average of 27 per week.

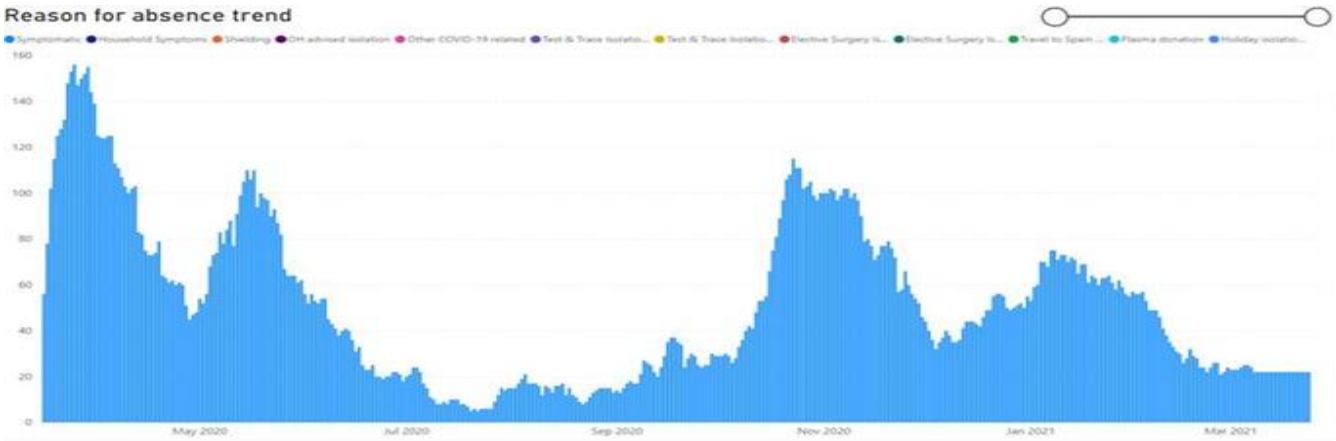
We continue to work with both inpatient and community teams to identify hotspots that require priority support as well as informing the flexible staffing resources of all relevant information. We are also engaging with further agencies as the increase in demand is rising. We are encouraging bank staff to work in one area rather than multiple to reduce the risk of cross infection. This is proving challenging as staff have always moved around the Trust and perhaps a uniformed approach has to be considered.

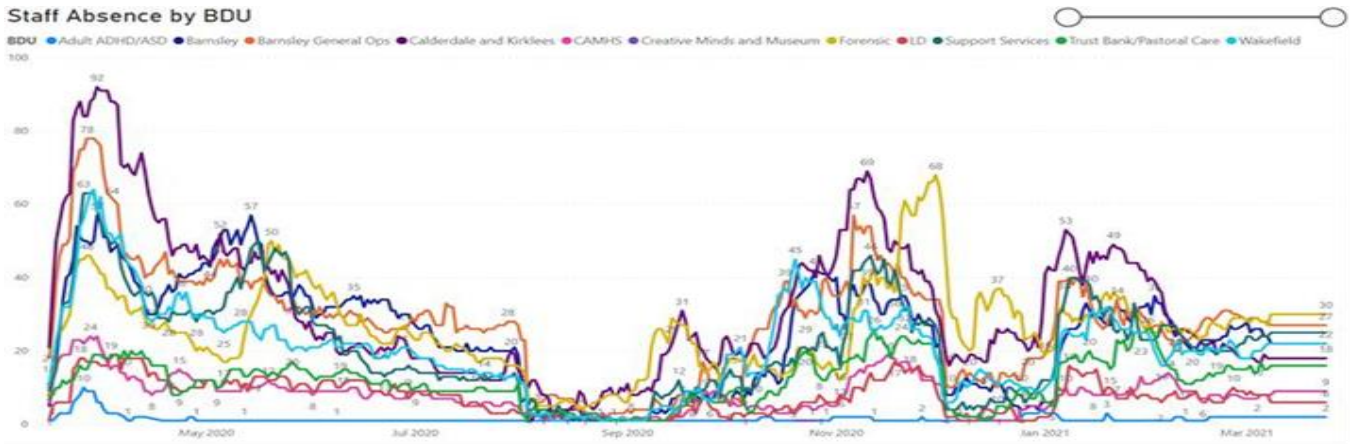
Figure 23 **Absenteeism due to staff isolating or shielding**

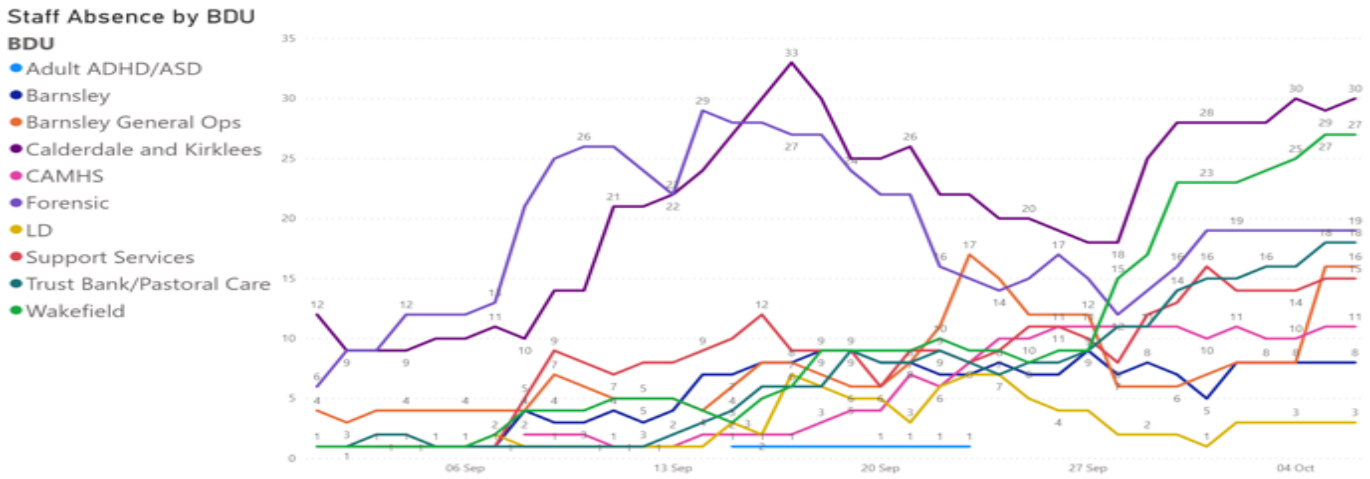
- As at 24th March, 89 staff off work Covid-19 related, not working which compares to 91 one month earlier. A further 88 were working from home.
- 3386 staff tested for Covid-19 as at 24th March.
- 610 staff have tested positive for Covid-19, 12 of which tested positive within the last months.
- As at 24th March, the Trust has 177 staff absent or working from home due to Covid-19. This makes up 3.4% of the workforce. Of those absent, 12.4% are symptomatic and 7.9% have household symptoms. The business delivery unit (BDU) with the biggest impact is Forensic with 7.4% of staff impacted (30/406). 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.

- Average length of absence (days) for those not working due to Covid-19 symptoms (based on absence start date) is currently 6.5 days.









12. SUMMARY

The continued focus on Safer Staffing remains in place locally, regionally, and nationally. It has been magnified during the COVID-19 pandemic. Particularly challenging was the "second wave" when services were asked to continue with their business whilst supporting the vaccination clinics, outbreaks, normal winter pressures and deal with the issues created.

Our ongoing recruitment campaigns, as well as the public's increased awareness of careers within the NHS, has allowed the Trust to avoid some of the staffing crises that other Trusts have had to manage. This is not to downplay the pressures that our teams within the community and inpatient areas felt. However, local escalation and safer staffing plans, staff willingness to support the teams and service users and utilising our staffing resource effectively has allowed us to manage the main spike.

Despite all the above, we continue to experience challenges in staffing in-patient registered posts, therefore we must ensure that we retain a flexible and adaptable approach. One initiative is the introduction of SafeCare which will hopefully replace sit reps with instant data. Workforce planning remains vital when looking at the challenges of the Registered workforce and the deployment of international recruits and their integration will be pivotal moving forward. Including the flexible workforce within the workforce planning will ensure that we continue to offer a modern, adaptable suite of options to staff to ensure that they continue to work and engage with our Trust.

The numbers of active registered nurses and HCA's on the staff bank continue to increase and we are looking at targeted recruitment to increase the active resources within other disciplines. The support offered to the Trust bank forums has allowed us to better understand the drivers behind the migration of substantive staff to the bank and we have managed to reverse this trend at times by offering a more adaptive, flexible approach avoiding a detrimental impact on the teams. The flexibility that bank offers can be reflected in annualised hours or peripatetic working and will be explored following the results of the survey. We are receiving more enquiries about the availability of the peripatetic workforce for registered staff and are exploring this avenue.

We are looking at the next stage in ensuring regular establishment reviews for all inpatient areas, as recommended nationally, are carried out in a safe and productive manner utilising the MHOST. Recruitment and retention plans remain in progress with more initiatives planned for 2021. As a recruiter, the Trust must continue to show flexibility, innovation and adaptability in today's recruitment market.

13. NEXT STEPS

We will continue to:

Build upon and improve data in exception reports including:

- Triangulation of DATIX, exception reporting and HR information
- Extend the narrative and analysis of the information
- Weekly roster analysis including unfilled shifts, acuity and bed occupancy
- Understanding any significant increase in staffing fill rates
- Provide effective and efficient support to meet establishment templates
- Work within areas of high acuity where there is pressure on meeting staffing numbers
- Support the development of the NHSI led acuity tool within community teams
- Develop, manage and deploy the peripatetic workforce
- Utilise the Safer Staffing Group, and monitor the action plan and new initiatives
- Build on work with Quality Leads to review Safer Staffing in the community and improve understanding and monitoring of direct care contact time
- Recruit onto staff bank
- Align Safer Staffing initiatives with Workforce Strategy
- Make effective use of the awarded agency master vendor contract for both Nursing and AHPs

New plans for Quarters 1 and 2 2021/22 include:

- Prioritise staffing in response to ongoing COVID-19 challenges
- Ensure that community staff teams are brought onto health roster in line with the rest of the Trust, utilising the awarded funding for this project. (End of July 2021)
- Develop the proposal for a Preceptorship Academy to support the retention of newly qualified staff. (April 2021)
- Relaunch the pilot implementation of staffing judgement tool within community teams
- Finalise the Forensic BDUs establishment and skill mix review (End of March 2021)
- Embed the MHOST within our inpatient wide establishment review (July 2021)
- Participate and support the collaborative bank project
- Continue with the Staff Bank forums to better understand why staff remain on the bank and offer alternatives to leaving the Trust altogether.
- Continue expanding the bank to support other areas including AHPs and community teams
- Continue with the roll out of the acuity staffing management tool, *SafeCare,* across the Trust moving into the Forensic BDU next.
- Develop reports that can be used by operations to reach resource management decisions and acuity levels instantaneously. (April 2021)
- Work with OMG to review how we capitalise on opportunities arising from new national workforce initiatives (e.g. nursing associates, advanced clinical practitioners)
- Contribute to implementation of SWYPFT Recruitment & Retention Strategy
- Maintain link with NHSE&I on Return to Practice programme for nurses, financial support for the introduction of Nurse Associates and encouraging collaborative banking and agency intelligence particularly across ICSs

13 APPENDICES

Appendix 1 FILL RATES: Actual and Planned Staffing Hours, February 2021

Ward Name	Area	Day		Night		Average Fill Rate - All Staff (%)	Care Hours Per Patient Day (CHPPD)			
		Average fill rate - Registered Nurses (%)	Average fill rate - Health Care Assistants (%)	Average fill rate - Registered Nurses (%)	Average fill rate - Health Care Assistants (%)		Trust		Regional Average	
							Registered Nurses	HCA	Registered Nurses	HCA
Beamshaw	Barnsley	72.3%	172.7%	93.8%	156.4%	131.2%	3.1	8.8	3.6	5.8
Clark	Barnsley	93.3%	92.6%	101.8%	88.1%	93.2%	4.5	5.8	3.6	5.8
Melton Suite PICU	Barnsley	80.5%	163.6%	84.3%	176.2%	134.7%	6.6	20.4	5.7	16.8
Neuro Rehab Unit	Barnsley	103.4%	137.9%	100.0%	400.0%	135.7%	7.2	10.8	3.4	5.3
Stroke Rehab Unit	Barnsley	97.1%	86.5%	100.0%	100.0%	93.5%	6.5	7.4	3.4	5.3
Willow Ward	Barnsley	62.4%	117.6%	92.9%	135.7%	102.7%	3.5	7.8	3.6	5.8
Ashdale	C & K	98.2%	94.1%	93.6%	112.9%	99.4%	2.6	4.1	3.6	5.8
Beechdale	C & K	95.8%	222.9%	122.0%	236.1%	164.1%	3.0	6.4	2.9	7.9
Elmdale	C & K	96.2%	92.3%	84.6%	115.8%	97.5%	2.7	4.5	3.6	5.8
Enfield Down	C & K	64.4%	95.7%	78.7%	100.0%	85.2%	3.4	6.1	3.6	5.8
Lyndhurst	C & K	95.7%	92.0%	101.3%	101.0%	96.3%	4.1	5.7	3.6	5.8
Ward 18	C & K	80.6%	161.4%	90.6%	176.2%	136.7%	2.6	8.7	3.6	5.8
Ward 19 - Female	C & K	80.0%	97.2%	104.5%	110.7%	94.9%	2.9	3.4	2.9	7.9
Ward 19 - Male	C & K	75.3%	112.9%	105.0%	100.7%	94.6%	3.4	4.3	2.9	7.9
Appleton	Forensic	80.3%	96.7%	110.7%	94.6%	92.3%	5.5	6.6	3.5	7.5
Bronte	Forensic	82.3%	150.3%	89.3%	142.9%	113.9%	9.3	14.0	3.5	7.5
Chippendale	Forensic	77.2%	124.1%	102.8%	92.9%	97.0%	3.3	4.7	3.5	7.5
Hepworth	Forensic	80.2%	127.3%	75.0%	130.4%	102.5%	3.2	4.9	3.5	7.5
Gaskell	Forensic	74.4%	230.9%	102.0%	291.1%	164.7%	4.0	10.9	3.5	7.5
Newhaven	Forensic	75.3%	96.4%	93.3%	137.5%	98.7%	4.0	7.1	3.5	7.5
Priestley	Forensic	71.8%	113.9%	111.2%	91.1%	93.1%	2.7	3.7	3.5	7.5
Ryburn	Forensic	103.5%	97.0%	89.6%	114.3%	101.1%	3.6	3.9	3.5	7.5
Sandal	Forensic	98.1%	152.6%	69.9%	215.8%	145.3%	2.9	11.7	3.5	7.5
Thornhill	Forensic	86.2%	93.7%	84.4%	107.5%	92.7%	3.3	4.4	3.5	7.5
Waterton	Forensic	89.9%	153.1%	158.1%	136.1%	126.7%	3.8	5.4	3.5	7.5
Crofton	Wakefield	120.8%	212.1%	135.7%	162.2%	159.0%	4.0	8.5	2.9	7.9
Horizon	Wakefield	125.9%	135.2%	111.0%	109.3%	121.2%	11.0	36.3	6.5	20.3
Nostell	Wakefield	92.8%	146.6%	98.3%	196.2%	137.3%	3.1	7.9	3.6	5.8
Poplars	Wakefield	74.8%	129.9%	110.8%	178.6%	123.0%	6.1	15.3	2.9	7.9
Stanley	Wakefield	105.4%	116.1%	105.1%	154.8%	121.2%	3.4	5.4	3.6	5.8
Walton PICU	Wakefield	103.2%	127.3%	116.1%	145.7%	126.0%	10.2	22.4	5.7	16.8
All Wards		87.9%	128.5%	97.4%	143.4%	116.2%				

Fill Rate Key for RNs and All Staff:	
	RNs - Less than 80% fill rate; All staff - Less than 90% fill rate
	Greater than or equal to 120% fill rate

CHPPD Key:	
	Within 10% of regional average
	More than 10% above regional average
	More than 10% below regional average

Appendix 2
Example of a Localised Escalation Plan

Stages	Who does this involve	Detail of step	Names	Responsibility
Across the wards	Stanley, Nostell, Poplars, Crofton, Walton	Check excess staff including office days.	Ward staff	Ward Manager/Matrons/On call manager/ Senior Nurse
Additional hours to existing staff	Ward and Unit staff	Offer alternative days off etc. to staff.	Ward staff	Ward Manager/ On call Manager/Matrons
Bank Staff	SWYT bank office	Send through health roster.	Bank staff	Ward Manager/Nurse in Charge/On call manager/ Matrons
Overtime offered	Trust Staff	Overtime is available to cover vacant shifts.	Substantive staff	Matrons/ General Manager
Agency Staff	SWYT bank office/ out of hours direct to agency	Send through health roster/ call direct.	Agency Staff	Ward Manager/ on call manager/ Matrons
Review seconded staff	Ward Staff	Review all staff secondments.	Ward Staff	Matrons/ General Manager
Review staff on sick (incl. long term) regarding temporary alternative duties to support services and return to work.	Staff on Sick	Review alternative duties for appropriate staff currently off sick.	Substantive staff	Ward Managers & Matrons/ General Manager

Review alternative roles for staff who are working from home due to being classed as extremely clinically vulnerable due to COVID-19 or other pandemics	**Staff judged to be clinically extremely vulnerable**	**Review of staff in this group to redeploy into appropriate alternative roles.**	**Substantive staff Bank Staff**	**Ward Managers & Matrons/ General Manager/ Safer Staffing lead**
Review staff leave and offer carry forward to next year if necessary	**Ward Staff**	**Look at flexibility within planned annual leave.**	**Substantive staff**	**General Manager**
Check registered nursing staff availability from other services	**Psychiatric liaison team, CMHT, IHBT, EIS. On Wakefield site: Forensic services via Newton Lodge and Horizon Centre. Across the Trust: Barnsley then C&K.**	**Assess whether other areas can support the inpatients safely. Ensure that staff have the correct skill set and adjust interventions accordingly.**	**Staff who have the appropriate training and knowledge. All registrants.**	**General Manager for AWA General Manager for Community teams. Deputy Director**
Identify non-clinical registered nursing staff (e.g. managers, PGC, nurse consultants) who can cover shifts or parts of shifts or carry out tasks within their capabilities i.e. audits, supervision	**Within BDU. Across the Trust: Nursing and Professions Directorate, L&D, EMT.**	**Access support from non-clinically based registrants**	**Can be provided by Safer Staffing Office or Workforce Information**	**General Manager**
Temporarily Redeploy community/non-ward clinical staff from within BDU on secondment	**Any Professional registrant who is on an external secondment**	**Review all secondments external to the BDU and evaluate whether they can be temporarily stopped.**	**General Managers Workforce Information**	**General Manager Deputy Director**
Temporarily Redeploy registered nursing staff from other areas on secondment	**Any Professional registrant who is on an external secondment**	**Review all secondments external to the BDU and evaluate whether they can be temporarily stopped.**	**General Managers Workforce Information**	**General Manager Deputy Director**

Appendix 3
Trust Board Safer Staffing Checklist

1. Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?

   Board receives regular presentations on staffing (e.g. IPR reports, regular assurance visits from Board members to the wards/departments in order to learn about and understand the services better (e.g. Quality and Exec Trio visits).

2. Are there processes for escalating issues identified by staff, patients or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services? Acuity is regularly and routinely monitored on wards including need for 1:1 observations. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system and regular reporting to safer staffing group.

3. Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence-based approach? How can the calculator tools be best deployed in delivering this?
   Originally the Trust has developed a bespoke decision support tool which was utilised to decide on the original staffing templates. We have moved to utilising the most up to date evidence tool available which has been utilised in staff reviews to date and will be for the Trust-wide inpatient

establishment review. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.

4. What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?
   Managers are empowered to use a range of interventions (e.g. use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement. Specialist Advisor for Safer Staffing is available to offer advice and support as required.

5. How are the needs of Mental Health service users incorporated in staffing?
   Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.

6. What evidence is there that a multi-professional approach to staffing is being deployed across the organisations? How is the need to spend time simply engaging with and talking to the patients built into workload calculation?
   Service user and carer engagement and satisfaction tools assure us that service users and carers are largely satisfied with the care and treatment they receive. Where this is not the case, services and customer services respond promptly to try and resolve the issue as quickly as possible.

7. As well as staffing measures outlined by the NQB are there measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?
   Complex benchmarking and performance data is widely available throughout the organisation and drills down to team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.

8. How this ward staffing information might be presented differently within a Mental Health setting where the ward-based team is not the only important resource available? Monthly reporting on Trust website and safer staffing exception report shared with all services monthly and summary information provided in IPR

9. How are the challenges of filling specific Mental Health roles handled e.g. recruitment training etc.?
   We have very good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. We attend national recruitment events and are lead providers in a regional collaboration looking at international recruitment. Training needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.

10. How is the commissioner kept informed about best practice in Mental Health so that informed commissioning decisions are made?
    Local CCG Quality Boards receive updates on how the organisation is performing in relation to safer staffing.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 10.3

Title:	**Annual report on Safe Working Hours Doctors in Training (April 2020– March 2021)**
Paper prepared by:	Guardian of Safe Working
Purpose:	To provide assurance to the Board that we are meeting our responsibilities in relation to the monitoring of safe working hours within the new Doctors in Training contract. Trust Board is asked to note the report.
Mission/values:	The Trust is meeting its duties and requirement to have a Guardian of Safe Working. Caring for the wellbeing of our staff and provision of safe clinical care is essential to support the Trust's mission in helping people to reach their potential and live well in their communities. The training of the next generation of substantive psychiatrists is of strategic importance for not only the Trust's succession planning but to ensure provision of a highly trained medical workforce within the wider mental health system.
Any background papers/ previously considered by:	Briefing paper presented to Trust Board on 25 April 2017 2017 Quarterly reports presented to Trust Board 27 June 2017, 31 October 2017, 30 January 2017 and 24 April 2018 (within Integrated Performance Report) 2017/18 Annual report presented to Trust Board 24 April 2018 2018 Quarterly reports within Integrated Performance Reports 2018/19 Annual report presented to Trust Board 30 April 2019 2019 Quarterly reports within Integrated Performance Reports 2019/20 Annual report presented to Trust Board 28 April 2020 2020 Quarterly reports within Integrated Performance Reports
Executive summary:	The introduction of the 2016 contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. In order to protect the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training, the role of Guardian of Safe Working was established. The Guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board that doctors' working hours are safe.

	The Trust appointed Guardian of Safe Working is Dr Richard Marriott. The 2019/20 Annual Report highlights the following: • There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract. • Processes have been implemented trust-wide to ensure that trainees doing extra shifts have signed the EWTD waiver and that the number of shifts they do remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff. • The main concerns during this year has been the management of gaps on the rota, exacerbated by the pandemic. Rota coordinators and trainees have done fantastic work to maintain the service despite these challenges. • As described above, there have been very few ERs generated. This is not unusual compared to other Trusts providing mental health services and where issues arise, these have been directed to appropriate managers to address the difficulties.
Recommendation:	**Trust Board is asked to RECEIVE, REVIEW and CONFIRM their assurance that the Trust has met its statutory duties.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Annual Report on Safe Working Hours:
Doctors in Training (April 2020 - March 2021)

Introduction

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

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

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

This report outlines:

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

High level data

Number of doctors in training (total):	56
Amount of time available in job plan for Guardian to do the role:	1 Programmed Activity (PA)
Admin support provided to the Guardian:	Ad hoc
Amount of job-planned time for educational supervisors:	0.125 PAs per Trainee

Challenges

1) **Trainee and Clinical Supervisor Engagement**: There are varied levels of understanding about the contract amongst all grades of doctors, many of whom have expressed confusion regarding its implications. To introduce the Guardian role and Exception Reporting System, presentations have been undertaken at the Induction Programme for each cohort of new junior doctors. As well as the Junior Doctors' Forum, the GoSW attends the Medical Education Trust Action Group, which has oversight of all issues to do with Medical Education within the Trust. Medical Education Staff collect Personalised Work Schedules to ensure that these are being completed. The GoSW contacts clinical supervisors to support them in completing all reviews of ERs.

2) **Trainee concerns**: Trainee Surveys carried out by the GoSW in the past suggested that trainees were anxious about the exception reporting process. A number of Foundation trainees report that ERs completed in acute trusts have not been dealt with, reducing their faith in the system. The GoSW meets all the new trainees and describes how positively the trust views exception reporting and assures trainees that they will be supported if they complete ERs.

3) **Cost/Salary Implications**: The contract has been largely cost neutral for the trust but has resulted in considerable changes in salary for certain grades of doctor. There were slight increases in costs after the updates to the 2016 terms and conditions following the end to the dispute between the BMA and NHSE in 2019. These updates have all been implemented.

Junior Doctors' Forum

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

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

Few of the issues raised at the forum have related to hours of working. Where hours are raised, the main area of discussion tends to be non-resident on-call (NROC) rotas. Due to the variability of this work, it is hard to specify the workload. Clearly there will be busy nights and trainees have been encouraged repeatedly to complete ERs if they work beyond their contracted hours. Whilst there have been anecdotal reports that these rotas are becoming busier, there have been no related ERs.

The impact of seclusion reviews was increasingly a concern through 2019, especially for trainees on the Fieldhead site. There has been a review of the policy and anecdotal reports suggest that this has reduced the workload for the trainees and an audit is planned to ensure that this is the case.

The other key role of the forum over the last year has been to support and advise trainees as they struggled with the impact of COVID-19. This included practical issues relating to PPE and fit-testing but also addressing anxieties related to the Annual Review of Competence Progression (ARCP) process. The achievement of key competencies was affected by the pandemic, for example those regarding ECT and psychotherapy. Trainees that were shielding, were especially affected. The forum was able to advise and signpost trainees to potential sources of support and the majority of trainees were able to progress with training as expected.

Distribution of Trainee Doctors within SWYPFT

The Trust covers a wide geographical area and receives Trainees from a number of different rotational training schemes (Foundation Programme, General Practice Vocational Training Schemes, Psychiatry Core Training Schemes and Psychiatry Higher Training Schemes). Approximately half of the Trainees are employed by the Trust, with the remainder employed by other organisations.

Each locality (Barnsley, Calderdale, Kirklees and Wakefield) has a 1st on-call rota staffed by junior doctors. These are trainees from the local Core Psychiatry Scheme, the Foundation Year 2 Scheme or GP Vocational Training Scheme, although Barnsley's 1st on-call rota also includes non-training Specialty Doctors. The 2nd on-call rotas for each locality and at Newton Lodge are staffed partly

by Higher Trainees and partly by non-training Specialty Doctors, the latter whose contracts are subject to different terms and conditions.

Tables shown in the appendix demonstrate the breakdown of the different grades of Trainees in each locality, also noting the areas where there are vacancies. Recruitment to the Foundation and GP training programmes have been good and almost all posts have been filled. Recruitment to core training posts in Psychiatry has improved over the last year. The 3 training schemes in West Yorkshire have been merged as of August 2020. This already appears to have reduced the number of vacancies within SWYPFT, especially Calderdale and Kirklees. It has been reported that applications for Core Psychiatry Training for August 2021 are even better. We have also recently had confirmation of an expansion of training numbers with additional posts agreed in Barnsley and Kirklees.

The main current concern in recruitment relates to Higher Training with vacancies across most psychiatric specialties. This has an immediate impact on middle tier rotas but is also of concern for consultant recruitment over the next few years. Hopefully the improvement in Core Training recruitment will feed through to improve this over the next few years.

Exception Reports (with regard to working hours)

The Exception Reporting (ER) system is the main safeguard in the new junior contract that ensures junior doctors are not being forced to work excessive hours and are able to meet the training requirements of their contract. The hours and rest rules are complicated and a helpful factsheet covering the key features can be found at: http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20for%20guardians%20August%202016%20v2.pdf.

Each Trainee receives a work schedule prior to commencement of their post, which outlines the rota pattern, hours and pay arrangements for that post. If a Trainee is required to work beyond those hours, or if work commitments prevent them from attending required training, the Trainee is encouraged to complete an ER. This details the circumstances of the 'exception'. The report goes to the Trainee's clinical supervisor. If the clinical supervisor agrees an ER regarding additional hours, the options are for the Trainee to be given time off in lieu or to be paid for the extra time.

There have only been a few ERs completed in SWYPFT since the introduction of the new contract. This is to some extent reassuring, although there does appear to be a degree of reluctance amongst trainees to complete ERs. Most trainees state that this is because there had been nothing for them to report. However, others report various concerns; these include uncertainty as to how to complete the report or what would constitute an exception. Others were concerned that exception reporting would not achieve anything and might lead to them being seen as causing trouble. The GoSW has longer sessions with new trainees at induction and has produced more detailed information about exception reporting in their induction pack.

Exception Reports By Area				
Area/BDU	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	0	0	0
Calderdale	0	0	0	0
Kirklees	0	0	0	0
Wakefield	0	10*	10	0
Forensic	0	1	1	0
Total	0	11	11	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	3	3	0
F2	0	0	0	0
GPVTS	0	0	0	0
CT1-3	0	4	4	0
ST4-6	0	4*	4	0
Total	0	11	11	0

*1 ER related to work done 30.3.20 but was completed April 2020

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	2	1	0
F2	0	0	0	0
GPVTS	0	0	0	0
CT1-3	0	0	4	0
ST4-6	0	2	2	0
Total	0	4	7	0

For the exceptions noted in the tables above, the actions were:

1) For 1 the Trainee and Clinical Supervisor agreed that no additional payment or time off was required.
2) Higher trainees acting down (x3) were paid appropriately for extra work.
3) FYs and CTs working additional hours were given time off in lieu.

There were issues with response time, partly due to consultant annual leave and lack of familiarity with the IT system used. All clinical supervisors have addressed the ERs once prompted.

Historically, the response rate for rota monitoring exercises under the old contract has been poor. However, all higher trainees are to be included in a monitoring exercise for consultants and specialty doctors, planned for later this year.

Fines

Should certain of the hours and rest rules under the new contract be broken, a fine will be incurred, with a penalty hourly rate paid to the doctor and the remainder of the fine paid to the Guardian to use to improve training within the Trust. None of the ERs received so far have resulted in a fine. Despite no fines being levied at this stage, a decision has been made to identify an account and a member of finance personnel to support audit of any funds, should fines be levied.

Work schedule reviews

The new contract requires that generic work schedules detailing work patterns and pay be sent to trainees prior to commencement of the post and this was achieved. Following commencement of the post, the generic work schedule should be used to develop a personalised work schedule according to the doctor's learning needs and training opportunities within the post. The Work Schedule Review is the process whereby concerns about a doctor's working hours or access to training are reviewed. There were no work schedule reviews required during this period.

Rota gaps and cover arrangements

COVID-19 has had a significant impact on rotas. The combination of shielding and requirements for self-isolation have massively increased the number of gaps on rotas (nearly 70% increase in gaps and nearly 50% increase in hours / costs overall). This was especially stark in Barnsley where there was a 6-fold increase in gaps. Wakefield saw a doubling in gaps and Kirklees a 50% increase. However, there was positive data from Calderdale with nearly a 30% reduction in gaps, probably related to the reduced number of trainee vacancies there. The following table details rota gaps by area and how these have been covered. There were nearly 13 shifts where it was not possible to obtain junior doctor cover, a small reduction on last year.

Gaps by rota April 2020 – March 2021					
Rota	Number (%) of rota gaps	Number (%) covered by Medical Bank	Number (%) covered by agency / external	Number (%) covered by other trust staff	Number (%) vacant
Barnsley 1st	198 (27%)	197 (99%)	1 (1%)	0	0
Calderdale 1st	114 (16%)	109 (96%)	2 (2%)	0	3 (3%)
Kirklees 1st	101 (28%)	101 (100%)	0	0	0
Wakefield 1st	140 (19%)	133 (95%)	0	0	7 (5%)
Total 1st	553 (22%)	540 (97%)	3 (1%)	0	10 (2%)

Colleagues in Postgraduate Administration have been able to capture some information about the financial cost to the Trust of covering rota gaps. They have also tried to record the costs directly attributable to COVID-19 and most of the increase was directly related to covering gaps caused by shielding and self-isolation.

Costs of Gaps by rota April 2020 – March 2021				
1st On-Call Rotas	Shifts (Hours) Covered by Bank	Cost (£) of Shifts Covered by Bank	Costs Directly attributable to COVID-19	Shifts (Cost (£)) Covered by Agency
Barnsley	198 (1804)	62,140.00	12180	1 (720)
Calderdale	114 (1042.25)	36,522.25	2106.25	2 (1470)
Kirklees	101 (1848)	64,680.00	11646	0
Wakefield	140 (1322.25)	59,378.25	20306	0
Total	553 (4940.5)	174,423.25	46238.25	3 (2190)

Locum work carried out by Trainees / Medical Bank

The Trust is largely reliant on the current Trainees to do locum shifts to fill the gaps on the rota. However, a number of doctors who have worked with the trust previously have now joined the Medical Bank. It does appear that since this was set up, a greater number of shifts have been covered without the need to employ agency. This should be safer for patients as well as being slightly cheaper for the trust, given the higher hourly rate charged by agencies. Agency staff have been used 3 times to fill gaps. It is of concern that agencies have not been able to supply doctors to fill other unfilled vacancies.

Postgraduate administrators and the Medical Bank staff ensure that Trainees doing locum shifts, sign the European Working Time Directive (EWTD) waiver. This allows trainees to work up to an average of 56 hours a week instead of the usual 48 hours a week. Postgraduate administrators then monitor to ensure that individual doctors are not taking on excessive additional hours / shifts.

Issues of Concern

1) **COVID-19:** The pandemic clearly created significant challenges, not least with the cover of rotas where a number of staff were shielding, self-isolating or off-sick. In keeping with the joint statement regarding the rota-rules (included in the 2016 contract) released by NHS Employers and the BMA, the trust was able to maintain these in almost all situations. Flexibility was required at times with doctors taking annual leave or being released from day-time training duties to cover nights and weekends. “NHS Employers and the BMA agree that when not possible to implement, the working hours restrictions and rest requirements in the TCS will be suspended and that the Working Time Regulations 1998 (WTR) will be the fallback position for the duration of the pandemic.” It is a testament to the dedication of rota coordinators and the trainees, that the vast majority of shifts were covered. The Medical Education Bronze Groups continues to meet regularly to monitor the situation but data suggests a significant reduction in gaps over the last few weeks.

2) **Recruitment:** Recruitment to training posts, including core training posts in Psychiatry has been improving and the merger of the 3 training schemes in West Yorkshire from August 2020 appears to have reduced the number of vacancies within SWYPFT. A more pressing current concern is the poor recruitment to Higher Training in Psychiatry, affecting middle tier rotas and more worryingly, potential recruitment to consultant vacancies over the next few years. However, it is likely to continue to be the quality of the experience we offer to medical students and Foundation doctors that is most likely to lead to trainees choosing to train and work in Psychiatry in this trust in the long term.

Actions taken to resolve issues

There have been no significant actions arising out of trainees’ working hours. All ERs were dealt with appropriately and they did not require there to be fines or work schedule reviews. The planned audit following the update to the Seclusion policy will hopefully address some of the concerns raised previously.

Access to training experience in the assessment of patients presenting with self-harm, had to be put on hold due to the pandemic but plans are in place to restart this across the trust.

Recent feedback has suggested that the workload for trainees on the Wakefield site remains high. Discussions are taking place to explore the possibility of rota changes to increase the number of trainees available at evenings and weekends.

Summary

There is confidence that all generic work schedules include rota patterns that are compliant with the terms and conditions of the new junior doctors' contract.

The Postgraduate Medical Education Lead has implemented processes trust-wide to ensure that trainees doing extra shifts have signed the EWTD waiver and that the number of shifts they do remains within safe limits. The structures of the new contract offer an opportunity to develop better systems to ensure both patient safety and better training experiences for our junior medical staff.

The main concerns during this year has been the management of gaps on the rota, exacerbated by the pandemic. Rota coordinators and trainees have done fantastic work to maintain the service despite these challenges.

As described above, there have been very few ERs generated. This is not unusual compared to other Trusts providing mental health services and where issues arise, these have been directed to appropriate managers to address the difficulties.

Recommendation

Trust Board is asked to note this report. Any unresolved issues will be included in the next quarterly report.

Appendix – Trainee distribution as at March 2021

Distribution of Trainees by Locality

Barnsley

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	4	3	Sheffield Health and Social Care Trust
GP Trainee	1	0	Barnsley Hospital NHS Foundation Trust
LAS	N/A	1	South West Yorkshire Partnership NHS FT
CT1-3	5	5	Sheffield Health and Social Care Trust
FY2 FY1	1 1	1 1	Barnsley Hospital NHS Foundation Trust

Calderdale

Grade of Trainee	**Number Expected**	**Number in Post (WTE)**	**Employer**
ST4-6	2	2	South West Yorkshire Partnership NHS FT
GP Trainee	2	2.5	South West Yorkshire Partnership NHS FT
CT1-3	4	3	South West Yorkshire Partnership NHS FT
FY2 FY1	3 1	3 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

Kirklees

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	2	0.8	South West Yorkshire Partnership NHS FT
GP Trainee	3	3	South West Yorkshire Partnership NHS FT
CT1-3	6	5.1	South West Yorkshire Partnership NHS FT
LAS	N/A	2	
FY2 FY1	1 1	1 1	Calderdale and Huddersfield NHS FT Calderdale and Huddersfield NHS FT

Wakefield

Grade of Trainee	Number Expected	Number in post (WTE)	Employer
ST4-6	6	1*	South West Yorkshire Partnership NHS FT
GP Trainee	4	4	Mid Yorkshire NHS Trust
CT1-3	7	6.6	Leeds and York Partnership NHS FT
LAS	N/A	1	South West Yorkshire Partnership NHS FT
FY2 FY1	2 3	2 3	Mid Yorkshire NHS Trust Mid Yorkshire NHS Trust

*+ 1 on OOP

Forensic: Newton Lodge /Bretton /Newhaven

Grade of Trainee	Number	Employer
ST4-6	5	South West Yorkshire Partnership NHS FT
ST4-6	1	Sheffield Health and Social Trust

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 10.4

Title:	**Serious Incident Report Quarter 3 2020/21 (including Learning from healthcare deaths Quarter 3 2020/21)**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides information in relation to incidents in Quarter 3 and more detailed information in relation to serious incidents. It also provides assurance that learning from healthcare deaths arrangements are in place. The report provides cumulative data for 2020/2021 deaths. The learning from healthcare deaths report requires publication on the Trust website.
Mission/values:	• We are respectful, honest, open and transparent. • We put the person first and, in the centre. • We are always improving.
Any background papers/ previously considered by:	Previous quarterly reports which have been submitted to CGCSC, along with annual incident reports, Our learning journey reports. CGCSC has also received papers about the introduction of the national requirement for learning from healthcare deaths and the policy.
Executive summary:	• This report is produced by the patient safety support team and shows the data for incidents. Detailed Quarterly reports have been produced and shared with each Business Delivery Unit and all managers have access to Datix dashboards to interrogate data further. • This report has overall figures for incident reporting. Q3 had 3345 incidents; just slightly higher than the previous quarter (3342). • 83% of incidents are graded as “low” or “no harm” showing a positive culture of risk management (the more green incidents reported mean action taken proactively at an early stage before harm occurs). • “Physical aggression/threat (no physical contact): by patient” 330 incidents (9.9%) remains as the most reported category. • “Violence and Aggression” continues to be the highest reported incident type (30%) (1003) of all incidents reported in the quarter, consistent with the previous quarter) [fig 1]. • There have been no ‘Never Events’ reported in the Trust during Q3: the last Never Event reported was in 2010/11. • The total number of serious incidents reported through Strategic Executive Information System (STEIS) in Quarter 3 was 8; this is lower than what was reported in Quarter 2 20/21 (12). • In quarter 3, the highest category of serious incident is Suicide (incl apparent) - community team care - current episode (4). This is higher than quarter 2 which was 2 incidents. • All incidents that are graded red or amber are extracted from Datix for inclusion in a report that is reviewed at the weekly risk panel. • All deaths are reviewed in line with the learning from healthcare deaths policy. • We are implementing our Trust wide suicide prevention strategy, which includes conducting a deep dive analysis on hotspot areas and targeting clinical teams and service user groups where there is concern.

	• We have taken the lead on the West Yorkshire and Harrogate Health Care Partnership 5-year suicide prevention strategy, which has adopted an evidence-based approach to suicide prevention and zero suicide philosophy for targeted areas and hotspots. • A recent 360 Assurance audit of incident processes resulted in significant assurance. One of the improvement actions includes changes to Datix which came into effect during February 2021. • 12 serious incident investigations have been submitted to the Commissioner during the quarter and 13 previous serious incidents have been closed by Commissioners. • A number of investigations are outside the 60 working day target; during the Covid-19 period and to present, the 60 working days timescale has been suspended by NHS Improvement. • The Serious Incident Investigations team are currently working towards accreditation through the Royal College of Psychiatrists. **Learning from healthcare deaths** • The Learning from healthcare deaths report provides figures on the number of deaths reported, reviewed and the review processes. • Total number of deaths reported on Datix by staff between 1/10/2020 – 31/12/2020 (by reported date, not date of death) = 115, all of which have been reviewed. This is an increase on Q2 (77) but slightly lower than Q1 (132) • The report was scrutinised at the Clinical Governance & Clinical Safety Committee on the 9 February 2021 who commented as follows:- • The proportion of low/no harm incidents in Kirklees requires monitoring, to be included in the next report. • A potential trend in the reduction of green incidents and corresponding increase in yellow and amber was noted and requires further review, to be included in the next report • IG incidents in CAMHS remain high and requires ongoing attention • The importance of the suicide prevention programme was reiterated and the need for ongoing vigilance around our apparent suicide figures for any trends remains critical. **Risk appetite** • Risk identified – the Trust continues to have a good governance system of reporting and investigating incidents including serious incidents and of reporting, analysing and investigating healthcare deaths. • This report covers assurance for compliance risk for health and safety legislation and compliance with CQC standards for incident reporting. This meets the risk appetite –low and the risk target 1-6. • The clinical risk – risk to service user/public safety and risk to staff safety which is again low risk appetite and a risk target of 1-6. • The incident management process supports the drive to reduce harm and learn from incidents to reduce risk and prevent recurrence in the future.
Recommendation:	**Trust Board is asked to NOTE the comments of the Clinical Governance and Clinical Safety Committee and comment on the quarterly report.**

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 11.1

Title:	**Workforce Strategy 2021-2024**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates.
Purpose:	The workforce represents by far the largest investment the Trust makes and has the greatest impact on the delivery of safe, compassionate care and the effective use of resources. The Workforce Strategy is focused on making the Trust a great place to work which is a vital element of delivering outstanding services.
Mission/values:	The aim of the Workforce Strategy is to support the achievement of the Trust's Mission and embedding the Values into the development of the workforce. The model for the Workforce Strategy is built on the foundations of: 1. **Values Driven Human Resource Management** Ensuring the Trust's Values are embedded in the way we manage and develop staff 2. **Workforce Equality and Diversity** Commitment to equality and valuing diversity The strategic workforce objectives are aligned to supporting: • Improve Health • Improve Care • Improve the use of Resources • Making a Great Place to Work
Any background papers/ previously considered by:	The Trust Board, Workforce and Remuneration Committee and the Executive Management Team have been engaged in a number of development sessions on developing a new Workforce Strategy.
Executive summary:	The attached Workforce Strategy has been designed to be developed into a complete digital format which will be a live working document. The digital format will be designed for ease of access, to be a gateway to other linked strategies, plans and policies, be live with regular updates on implementation plans and performance measures. Supported by the Communications Team this approach will be used as a pathfinder for other strategies and plans. The focus of the Workforce Strategy is making the Trust a Great Place to Work. The Trust's response to the pandemic has demonstrated that great people deliver great services. The Strategy has been developed around the 5 essentials staff identified in what makes a Great Place to Work (GPTW). These are built on a foundation of the Trust values and Equality, Diversity and Inclusion.

	5 essentials of GTPW: • Feeling Safe • Being part of a Supportive Team • Keeping Fit and Well • Developing Potential • My Voice Counts **Foundations** • Our values guide how we lead, develop and manage staff • Equality, Diversity and Inclusion is central to everything we do The performance measures will continue to be developed, however, a large element will be feedback from staff. The quantitative measures will need to be reset in light of the pandemic. The Workforce and Remuneration Committee will agree the dates for the 12 month implementation programme and the performance measures in May 2021. The Trust Board is asked to consider the content and approach of the Workforce Strategy and support its development into a complete digital format. **Risk Appetite** The Workforce Strategy and the implementation is consistent with the Trust's risk appetite and supports the on-going reduction of risk levels in line with target.
Recommendation:	**The Trust Board is asked to APPROVE the Workforce Strategy 2021–2024 and its development into a digital format.**

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DRAFT

A Great Place To Work Workforce Strategy 2021-2024

With **all of us** in mind.

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Contents

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Introduction: Making a Great Place to Work

The NHS as a whole has been at the forefront of the nations response to the COVID-19 pandemic and at the heart of this has been a workforce who wanted to make a difference to peoples lives. The Trust has been able to continue to support communities and service users through the dedication, commitment and compassion of staff and by supporting their safety and wellbeing. The past year has demonstrated that great people deliver great services and deserve a Great Place To Work. A key strategic priority for the Trust is making South West Yorkshire Partnership NHS Foundation Trust a Great Place to Work and this is the essence of the Workforce Strategy for the next 3 years. The Workforce Strategy focuses on ensuring the organisation is an the employer of choice which attracts, retains, develops, supports, and motivates great people who live the Trust's Values and can deliver the Mission and Vision. Compassion, safety and wellbeing are at the core of being a Great Place To Work.

The Workforce Strategy has been developed using insight, gained through an engage and listen approach with staff, on what makes A Great Place To Work. It is built on a foundation of the Trust's Values and Workforce Equality, Diversity and Inclusion which must be part of everything we do. The Strategy recognises best practice and the learning from the impact of the pandemic on staff and their families. It is designed to align to the key initiatives within the NHS People Plan.

The context for the Workforce Strategy is being a strong partner and leader within a broader health and social care system and no less important is the need for the Strategy to support a sustainable future for our Staff, their families and communities.

Finally, it is everyone's responsibility in making SWYPFT a Great Place to Work

Our Trust Strategy: Making the Trust a Great Place to Work

The aim of the Workforce Strategy is to deliver the strategic objective of making the Trust a Great Place to Work as a key enabler to achieve the Trust's Vision and Mission.

Vision
We aim to provide outstanding physical, mental and social care in a modern health and care system.

Mission
We exist to help people reach their potential and live well in their communities.

To achieve the Trust's Vision and Mission 4 **Strategic Objectives** have been developed with the aim of:

- Improving Health
- Improving Care
- Improving Use of Resources
- Making the Trust a Great Place to Work

These are all built on a foundation of the **Trust 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

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Our Trust Strategy: Making the Trust a Great Place to Work

The Workforce Strategy is also designed to ensure we have the people to:

- Support the delivery of NHS Long Term Plan
- Implement the Mental Health Framework
- Support the Integrated Care Systems across West Yorkshire and Harrogate and South West Yorkshire and Bassetlaw.
- Support Place based health and wellbeing plans
- Support the Trust's and the systems approach Recovery and Reset following COVID-19.

The Workforce Strategy has been developed by:

- Using the insight from Staff on what they believe are the essentials of a Great Place to Work.
- Developing theses essentials into a series of pledges for a Great Place to Work built on a foundation of Values and Equality, Diversity and Inclusion.
- Use the pledges to identify a series of strategic workforce actions.
- Aligning the Great Place to Work with the NHS People Plan.
- Identify outcome and performance measures to progress and achievements.
- Commitment to annual Workforce Strategy implementation plans approved by the Trust Board.
- Integrate with associated Trust and System Strategies.

Staff Engagement on Making SWYPFT A Great Place To Work

The Trust engaged with more than half the workforce, including Staff Side organisations, to gain their insight in what they believe makes a great place to work. There were 5 key themes identified from the staff engagement and listening exercise on what people believe were the essentials of a Great Place to Work:

- Staff felt it was important to **Feel Safe at Work** by tackling violence, preventing bullying and harassment and having enough staff.
- Staff believed that it was important to be part of a **Supportive Team** with compassionate team leaders, effective team working and quality appraisal and supervision.
- Staff wanted support to **Keep Fit and Well** including being able to work flexibly and have a manageable workload.
- Staff wanted support to **Develop their Potential** with flexible career pathways, investment in their training and recognition of talent.
- Staff felt it was vital their **Voice Counts** and wanted to be listened to, engaged and involved in change.

These 5 essential have been developed into a series of organisational Pledges built on a foundation of Values and Equality, Diversity and Inclusion. The pledges have been developed into strategic actions which will remain consistent over the next 3 years. The milestones and key performance indicators will be reviewed and updated annually. The key performance are based on the NHS Staff Survey because as part of the NHS People Plan the survey will be developed to measure progress. The Trust will also being introducing a quarterly pulse survey which compliments the NHS Staff Survey to help measure a Great Pace to Work. Quantitative measures will need to be developed further as part of the reset after the pandemic.

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Pledges on Making SWYPFT A Great Place To Work

Great Place to Work Essentials	Great Place To Work Pledges
Feeling Safe	We will tackle violence and bullying and harassment and ensure we have enough staff
Supportive Teams	We will develop team leaders at all levels, promote effective team working and ensure high quality supervision and appraisal
Keeping Fit and Well	We will provide support to keep staff physically and psychologically well, enabling them to work flexibly and ensure they have manageable workloads
Developing Potential	We will provide flexible career pathways, support personal and professional development plans and develop the talent and potential of all staff
My Voice Counts	We will effectively engage staff in service developments and improvements and ensure change is effectively managed
Foundations on which Great Place to Work is built	
• Our Values will guide how we lead, develop and manage staff • Equality, Diversity and Inclusion will be central to everything we do	

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Realising Great Place To Work: Strategic Objectives Summary on a page

Making SWYPFT A Great Place to Work (Great Place to Work Programme themes)	Realising Great Place To Work Pledges : Strategic 3 Year Objectives
Feeling Safe (Physical and Psychological Safety)	• Quality Improvement Project on Tackling Violence • Redesign of Bullying and Harassment approach based on civility and respect • Increase supply of Clinical Staff through development of new roles and international recruitment with a zero approach to vacancies
Supportive Teams (Healthy Teams)	• Great Place to Work Programme for Trio's and Immediate Managers • Development of a Trauma Informed organisation • Improve the Quality of Appraisal and Supervision through appreciative inquiry
Keeping Fit and Well (Staff Wellbeing)	• Enhance the Occupational Health Offer including focus on Creative and Physical Activities • Development of a Flexible Workforce Model supported by an active Staff Bank and effective approach to Agency Staff • Roll out of SafeCare and Safer Staffing in Community Services
Developing Potential (Investing in the future)	• Redesign of Leadership and Management Development Pathway • Investment in Personal and Professional Development Plans • Succession and Talent Management Plan for all staff
My Voice Counts (Engaging Staff)	• Staff engagement to be key element of Great Place to Work Programme for Trio's and Immediate Managers • Strengthen link with Quality Improvement Strategy • Development of clear change management process based on effective staff engagement

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Realising the Great Place to Work Pledges: Strategic Actions
Feeling Safe

	Key Milestones	Key Performance Indicators
Tackling Violence A long term quality improvement project with an initial focus in inpatients on reducing violence and effective support for staff. This will also include focus on race related violence and harassment through the clinically led Race Forward initiative.	• Project Plan Completed in Q1 21/22 • Start 3 month project in agreed inpatient setting Q2 21/22. • Project Report Completed Q3 21/22 • Rollout plan agreed for Trust Q4 21/22 • Trust wide rollout of tackling violence plan in inpatients Q1-Q4 22/23 • Pilot quality improvement project in Community Services Q1 –Q2 22/23	**21/22** • Reduction in Datix incidences on violence by 10% • Improvement in NHS Staff Survey Safe Environment Score and WRES **22/23** • Further 105 in Datix incidents on violence • NHS Staff Survey Safe Environment and WRES in upper quartile.
Preventing bullying and harassment The redesign of the Trust's Bullying and Harassment approach based on a model of civility and respect.	• Appointment of Civility and Respect Champions Q2 21/22 • Redesigned Bullying and Harassment Policy Q2 21/22 • Panel to Review all Race related Bullying and Harassment Q1 21 /22	**21/22** • Improvement in NHS Staff Survey Safe Environment • WRES and WDES Bullying and Harassment reduced by 10% **21/22** • Improvement in NHS Staff Survey Safe Environment • WRES and WDES Bullying and Harassment reduced by 10%
More staff Increasing the supply of clinical staff through introducing new roles and ethical international recruitment.	• Establish New Role Clinical Role Group Q1 21/22 • Commence ethical International Recruitment for Nursing Q2 21/22	**21/22** • Reduction in Clinical Vacancies by 10% (pre-covid rates) • First international recruits in place **22/23** • Further 10% reduction in Clinical Vacancies • 30 wte International Recruits

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Realising the Great Place to Work Pledges: Strategic Actions
Supportive Teams

	Key Milestones	Key Performance Indicators
Effective and compassionate leaders: A Great Place to Work (GPTW) immediate managers to support team leaders at all levels rolled out across the Trust.	• Pilot GPTW in Q1 21/22 • Start rollout of GPTW across Trust Q2 21/22 • GPTW programme rollout Trust wide Q2 21/22 • Design of GPTW Plus q4 21/22 • Complete rollout of GPTW Q3 22/23	**21/22** • Improvement in NHS Staff Survey Immediate Managers and Team Working Scores **22/23** • Improvement in NHS Staff Survey Immediate Managers and Team Working Scores to upper quartile
Supportive colleagues A trauma informed organisation approach to support effective team working	• Link to GPTW and Trauma Informed Organisation Rollout Q1 21/22 • Develop supportive Team model as part of Trauma Informed Organisation Q2 21/22	**21/22** • Improvement in NHS Staff Survey Immediate Managers, Health and Wellbeing and Team Working Scores **22/23** • Improvement in NHS Staff Survey Immediate Managers, Health and Wellbeing and Team Working Scores to upper quartile
Quality appraisal and supervision Continuous improvement of the appraisal and supervision with protected time.	• Redesign of E.Apprasial linked to initial evaluation and GPTW Q1 • Streamline appraisal process and develop link to an e.supervision Q2 • Annual review and action plan of Appraisal and Supervision Q4 21/22 • Uptake e.appraisal and supervision following review Q1 22/23	**21/22** • 95% Appraisal level for the Trust • NHS Staff Survey Quality of Appraisal above average • 80% target on clinical supervision **22/23** • 95% Appraisal level for the Trust • NHS Staff Survey Quality of Appraisal above average • 80% target on clinical supervision

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Realising the Great Place to Work Pledges: Strategic Actions
Keep Fit and Well

	Key Milestones	Key Performance Indicators
Enhanced Occupational Health Support Enhanced core Occupational Health supported by creativity and physical wellbeing offers.	• Enhanced Occupational Health offer linked to recovery and long covid Q1 21/22 • Appointment of Staff Dietitian as pilot Q2 21/22 • Pilot Creative Mind and Physical Wellbeing roles Q2 21/22 • Design of GPTW Plus q4 21/22 • Complete rollout of GPTW Q3 22/23	21/22 • Improvement in NHS Staff Survey Immediate Managers, Health and Wellbeing and Team Working Scores 22/23 • Improvement in NHS Staff Survey Immediate Managers, Health and Wellbeing and Team Working Scores to upper quartile
Flexible Working Developing a flexible workforce model giving more options for Staff to balance their personal and professional lives.	• Development of Flexible Workforce Model as part of the Workforce Plan Q3 21/22 • Rollout of Flexible Workforce as part of annual operational and workforce plans Q1 22/23	21/22 • Improvement in NHS Staff Survey Health and Wellbeing Scores • Reduction in Agency and Bank Spend (pre-covid) • Reduction in Turnover 22/23 • Improvement in NHS Staff Survey Health and Wellbeing Scores • Reduction in Agency and Bank Spend (pre-covid) • Reduction in Turnover
Manageable Workloads To ensure that Staff have time to care through the roll out SafeCare for inpatient services and a model of safer staffing for community services.	Link to Nursing Strategy	Link to Nursing Strategy

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Realising the Great Place to Work Pledges: Strategic Actions
Developing My Potential

	Key Milestones	Key Performance Indicators
Flexible career pathways The development of clear, flexible and supported career pathways across all professions and staff groups.	• Development of flexible access routes in the Trust roles which linked to being an employer of choice. Q3 21/22 • Career maps for all clinical professions Q3 21/22 • Career map for Health Care Support Worker roles Q4 21/22	21/22 • Improvement in retention rates • Improvement in Clinical Professions NHS Staff Survey Results including recommending as a place to work • Reduction in clinical vacancies by 10% 22/23 • Reduction in turnover by 10% from 21/22 • Further reduction in Clinical vacancies by 10% • Professions results in NHS Survey improved from 21/22
Supported personal and professional development plans Every member staff to have annual agreed personal development plans with a commitment for a continued investment in learning, development and education.	• Personal development for all staff who have completed appraisal Q2 21/22 • Learning needs analysis linked to personal development plans Q2 21/23	21/22 • 95% Staff have an appraisal and personal development plan
Recognising talent A succession and talent plan will be developed and implemented	• Update Board Succession Plan Q2 21/22 • Developed Trust Wide Succession and Talent Management Plan Q3 21/22 • BAME Talent Pool Q1 21/22 • Extension of Talent Pool Q4 21/22 • Shadow Board Programme Q2 21/22 • BAME Fellowship Programme Q1 21/22	21/22 • No Director vacancies • Increase in BAME representation at 8a and above

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Realising the Great Place to Work Pledges: Strategic Actions
My Voice Counts

	Key Milestones	Key Performance Indicators
Leaders engaging staff in change Staff engagement to be core to Great Place to Work Programme for immediate managers.	• Pilot GPTW Programme Q1 21/22 • Rollout of GPTW Q2 21/22-Q3 22/23	21/22 Increase in NHS Staff Survey Staff • Engagement • Immediate Manager • Quality of Care • Motivation 22/23 Above average in above
Engaged in service improvement Strengthen the link with Great Place to Work Programme and the Quality Improvement Strategy	• Pilot GPTW Programme Q1 21/22 • Rollout of GPTW Q2 21/22-Q3 22/23	21/22 Increase in NHS Staff Survey Staff • Engagement • Immediate Manager • Quality of Care • Motivation 22/23 Above average in above
Change managed effectively and fairly Redesign of the organisational change process with clear engagement standards	• Pilot GPTW Programme Q1 21/22 • Rollout of GPTW Q2 21/22-Q3 22/23	21/22 Increase in NHS Staff Survey • Engagement • Teamworking 22/23 Above average in above

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Pledges on Making SWYPFT A Great Place To Work: Foundations

Making SWYPFT A Great Place to Work	Foundation for Great Place To Work
Values **(Value Based Human Resource Management)**	• Strengthen the Social Partnership model linked into decision making arrangements • Resolution and learning approach to disciplinary and grievance • A culture of civility and respect where staff feel safe to speak up • Active Partner in Creating Sustainable Future for Staff, their families and the Communities served
Equality, Diversity and Inclusion	• Developing representative Leadership and Management Arrangements at all levels of the organisation • Role out and embedding Equity Guardians in clinical services. • Review and redesign of Recruitment and Selection Arrangements • Promotion and consolidation of staff equality networks • Positive action in the delivery of the WRES and the WDES including developing of local stretch targets

Alignment to the NHS People Plan

The NHS People Plan 2020/2021 sets out what NHS staff can expect from their leaders and from each other.

The focus of the People Plan:

- **Looking after our people**: keeping people safe, healthy and well.
- **Growing for the future**: expand and develop the workforce and retain existing staff.
- **New ways of working and delivering care**: effective use of the full range of people's skills and experience to deliver the best possible patient care.
- **Belonging in the NHS**: support and action needed to create an organisational culture where everyone feels they belong.

The plan is focused primarily on the immediate term (2020-21) but with an intention for the principles to create longer lasting change. The key focus of the NHS People Plan has been integrated through a workforce strategy framework to ensure alignment.

The NHS People Plan also includes 'Our People Promise,' which sets out ambitions for what people working in the NHS say about it by 2024. This has also been aligned to the five essentials of Great Place to Work.

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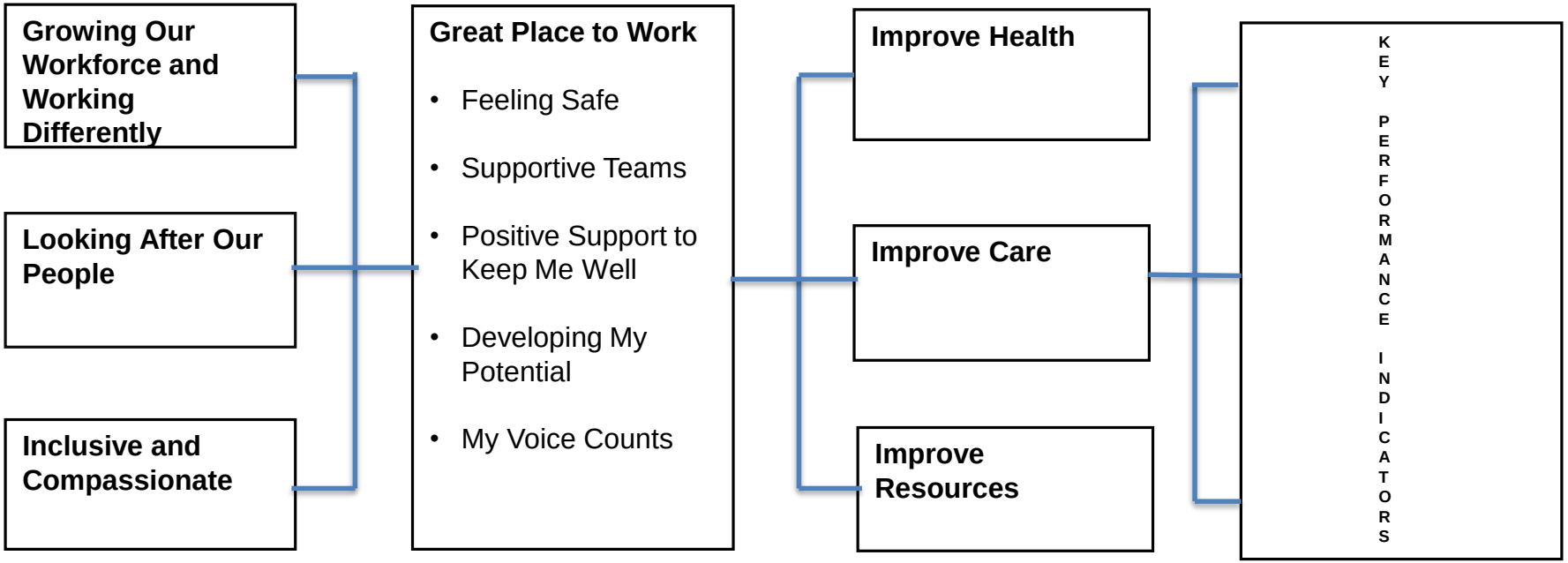
Model for Workforce Strategy Aligned to the NHS People Plan



Belonging to the NHS

- Value Based Human Resource Management
- Workforce Equality, Diversity and Inclusion

NHS People Plan: Our People Promise

The NHS People Promise is central to the People Plan and it has been developed to help embed a consistent and enduring offer to all staff. From 2021 the annual NHS Staff Survey will be redesigned to align with Our People Promise. The Great Place to Work essentials and the People Promise are very complimentary and enhance each other. The NHS Staff Survey will be used nationally to measure the People Promise.

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SWYPFT Great Place To Work and Our NHS People Promise

SWYPFT Great Place To Work	Our NHS People Promise
Felling Safe • Having Enough Staff • Tackling Violence • Preventing Bullying and Harassment	**We Are Safe And Healthy (1)**
Being Part Of A Supportive Team • Effective And Compassionate Team Leaders • Supportive Colleagues • Effective Supervision/Appraisal	**We Are A Team** **We Are Compassionate And Inclusive**
Positive Support to Keep Me Fit and Well • Positive Mental And Physical Health Wellbeing Support • Flexibility To Balance Work And Personal Lives • Manageable Workloads	**We Are Safe And Healthy (2)** **We Work Flexibility**
Developing My Potential • Career Development Opportunities • Personal And Professional Development Plans • Recognising And Supporting Talent	**We Are Always Learning (1)** **We Recognise And Reward**
My Voice Counts • Managers Listen And Respect My Views • Engaged In Improving My Service And Doing My Job Better • Being Part Of The Change Process	**We All Have A Voice That Counts** **We Are Always Learning (2)**
Built On A Foundation of Equality And Diversity	**Compassionate and Inclusive (2)**

NHS South West Yorkshire Partnership NHS Foundation Trust

Workforce Strategy 12 month Summary Action Plan

NHS People Plan		Making SWYPFT A Great Place To Work				
		Feeling Safe	**Being Part of a Supportive Team**	**Positive Health and Wellbeing**	**Developing My Potential**	**My Voice Counts**
NHS People Plan	**Growing Our Workforce and Working Differently**	• Ethical International Recruitment for Nursing and Medical Roles • Focus on recruitment into Health Care Support Clinical Roles	• Great Place to Work to be golden thread in appraisals • Wellbeing reviews completed	• Start to redesign core workforce: More Flexible Working and New Flexible Worker Roles supported by Bank and Agency • Flexible Working Policy Updated	• Clear workforce plan and commitment to developing New Clinical Roles • Learning needs analysis linked to additional Continuous Professional Development funds	• Engaging staff in service change/improvement at local level: GP2W • Effective staff engagement recovery programme
	Looking After Our People	• Developing Civility and Respect Model to prevent Bullying and Harassment: GP2W • Risk assessments updated	• Developing supportive teams which keep staff resilient: GP2W	Enhanced Wellbeing and Occupational Health Service including supporting long COVID	• Ensuring clear and progressive career pathways • Revised Managers and Leaders Development Pathway	• Service Level Action Plans which positively responds to the NHS Staff Survey
	Inclusive and Compassionate	Race Forward to review terms of reference and develop an action plan	Support for Managers and Team Leaders Wellbeing: GP2W	Supporting effective and efficient deployment of staff including manageable workloads through rollout of SafeCare	Development and implementation of Trust Talent Management Plan	Staff actively involved in development and implementation of Sustainability Strategy
		The Foundation To All That We do				
Belong to the NHS	**Equality and Diversity**	• Representative and Inclusive Leadership and Management Plan for all Decision Making Groups • BAME Talent Management Pool • Review and redesign of Recruitment and Selection Arrangements • Promotion and consolidation of staff equality networks • Review Panel for Disciplinary and Grievance cases related to race • Role out of Equity Guardians				
	Value Based HRM	• Review the role and function of the HR Directorate including on going development of the Workforce Support Hub • Social Partnership model linked into decision making arrangements • A culture of freedom to speak up • Resolution approach to Disciplinary and Grievance				

Measuring Performance of Great Place to Work

The commitment to Making SWYPFT a Great Place to Work will be tracked and measured using a variety of methods. The NHS Staff Survey supported by quarterly Staff Pulse Survey will be key measures of progress. The 4 levels for the measuring of progress:

1. Ambition to be Outstanding

Trusts who have been rated as Outstanding excel in 4 areas of the NHS Staff Survey:

- Staff Engagement
- Health and Wellbeing
- Immediate Managers
- Teamworking

The ambition that in these 4 themes from the Staff Survey we have 3 levels of improvements:

- 21/22 to show statistical improvement in all 4 of these areas in the Staff Survey
- 22/23 to be above average in all 4 areas
- 23/24 to be best in class in at least 1 of the areas and above average in the others

2. **Great Place to Work**

NHS Staff Survey Remaining Key Themes:

- 21/23 to show statistical improvement in at Equality and Diversity and Bullying and Harassment and no deterioration in other themes
- 22/23 to be above average in Equality and Diversity and Bullying Harassment and improvement in other areas
- 23/24 to be above in 80% of key themes

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Measuring Performance of Great Place to Work

3. **Key Performance Indicators**

GPTW	Key Performance Indicators
Feeling Safe	• Reduction in Violence in the Workplace reported on Datix • Reduction in Race and Disability related bullying and harassment from Service Users/Carers • Reduction in clinical vacancy rates
Supportive Team	• Number of staff completed GPTW immediate managers programme • Teamworking Score in NHS Staff Survey • 95% Completion of Appraisal and Supervision
Keep Fit and Well	• Reduction in absence due to stress and MSK • Reduction in turnover and increase in flexible working • Safer Staffing Report
Developing Potential	• Reduction in clinical vacancies • 95% staff have an agreed personal development programme • Senior roles vacant for more than 6 months
My Voice Counts	• NHS Staff Survey Engagement Score • NHS Staff Survey Immediate Managers Score • Staff recommending Trust as a place to work
Values	• Reduction in disciplinary and grievance cases • Freedom to Speak Up Index • Sustainability targets
Equality, Diversity and Inclusion	• WRES • WDES • Increase of BAME staff in 8a and above

Linked Strategies

The Workforce Strategy does not sit in isolation and the achievement of key objectives are linked to key associated strategies detailed below:

Associates Strategies

- Nursing Strategy
- Medical Workforce Strategy
- AHP Strategy
- Equality, Inclusion and Engagement Strategy
- Quality Improvement Strategy
- Sustainability Strategy and Green Plan
- WYH ICS Workforce Strategy
- NHS People Plan
- IMT Strategy
- Estates Strategy

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 12.1

Title:	**Draft Annual Governance Statement**
Paper prepared by:	Director of Finance and Resources
Purpose:	To enable the Trust Board to review and comment on the draft annual governance statement
Mission/values:	• Respectful, honest, open and transparent • Relevant today and ready for tomorrow
Any background papers/ previously considered by:	• Considered and approved by the Executive Management Team (EMT), Audit Committee and Trust Board annually • 2020/21 draft reviewed by EMT and Audit Committee
Executive summary:	• As part of the annual accounting and reporting requirements the accounting officer (Chief Executive) is required to provide an annual governance statement (AGS), which needs to be approved in line with other annual reporting requirements • The outline of the requirements of the AGS is provided in annual guidance by the regulator (Monitor/NHS Improvement) • Certain elements of the wording are prescriptive and in other sections there is clear guidance on what to include • At this stage it is a draft statement with elements of the wording only available on completion of the year-end • The draft document has been reviewed by EMT, Audit Committee and Chief Executive. Responses to some questions and points of clarification are in progress and are highlighted in the draft document. This enables Board members to be aware of those comments and questions already being addressed. • This report enables Trust Board members to have an early sight of the AGS and provide any feedback • It should be noted that the requirements of the AGS have been carefully reviewed by the Assistant Director of Corporate Governance, Performance & Information and Company Secretary to ensure the Trust's AGS complies with those requirements • Some additions to the standard wording have been included to reflect the impact of the Covid-19 pandemic on governance in 2020/21. • The final AGS will require approval by Trust Board in May along with other year-end reports, accounts and certifications
Recommendation:	**The Trust Board is asked to REVIEW the draft Annual Governance Statement and COMMENT accordingly**
Private session:	Not applicable

Annual Governance Statement 2020-21 amends v20

PLEASE NOTE GREY HIGHLIGHT CANNOT BE AMENDED

Annual Governance Statement 2020/21

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively.

I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

This Annual Governance Statement reflects the challenging context within which I deliver my responsibilities and demonstrates the complexity and diversity of the services the Trust provides across a broad geographical area. The Statement also reflects the unique circumstances and impact of the Covid-19 pandemic.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South West Yorkshire Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in South West Yorkshire Partnership NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Our Board has overall responsibility and accountability for setting the strategic direction of the Trust and ensuring there are sound systems in place for the management of risk. This includes responsibility for standards of public behaviour and accountability, for monitoring the organisation's performance against the Trust's strategy and objectives, and for ensuring corrective action is in place where necessary. The Trust Board's attitude to risk is based on appropriate tolerance to risk. The Board acknowledges that the services provided by the Trust cannot be without risk and ensures that, as far as is possible, risk is minimised and managed within a risk tolerance. This is set out in the Trust's Risk Strategy and Risk Appetite Statement.

The Board is supported and governed by an involved and proactive Members' Council, a key part of the Trust's governance arrangements. Since becoming a Foundation Trust in 2009, the Members' Council has become mature and well established in its role of holding Non-Executive Directors to account for the performance of the Trust Board. The agendas for Members' Council meetings, produced in partnership with the Members' Council Co-ordination Group, focus on its statutory duties, areas of risk for the Trust, and on the Trust's future

strategy. Training and development ensures governors have the skills and experience required to fulfil their duties.

The Board includes an Executive team with the day to day responsibility for managing risk. Over the last year, we have had continuity in the executive director team. There is a balance of directors with internally and externally focused roles. Director portfolios are regularly reviewed to ensure appropriate balance and capacity is in place to meet the needs of the Trust. This has been visible in the last year with the effectiveness of the Director of Provider Development and Director of Strategy roles in ensuring appropriate links into enhanced partnership arrangements; the development of an executive clinical/operational trio in securing a ward to board approach; and good support from other corporate directors. During the pandemic the Executive Directors have all been members of Gold Command, leading the Trust's response to the pandemic. The Director of Human Resources, Organisational Development and Estates has led the EPRR approach with very effective Silver and Bronze Command arrangements in place.

The Members' Council, Board and Executive team are operating in an environment of change and system pressure where risk is constant and at a heightened level. This has been impacted further by the Covid-19 pandemic and effective governance and management of risk has been a continuous feature throughout the year.

The Trust operates within a strategic framework that includes a Vvsion, mission and values, supported by four strategic objectives and a number of priority programmes. This approach is agreed and set by the Board and provides an effective underpinning of the Chief Executive objectives and the objectives of the Executive team determined in line with director accountabilities. I review these objectives on an on-going basis, with the full Executive and with individual directors with progress, issues and risks reflected in the Board Assurance Framework and corporate/organisational risk register.

This approach reflects the Trust's framework that devolves responsibility and accountability throughout the organisation by having robust delivery arrangements. Capacity for delivery is assured through business planning processes and control is executed through an appropriate scheme of delegation and standing financial instructions.

The Covid-19 pandemic has required reprioritisation of programmes and workload. This has been led by the Executive and governed and assured by the Board.

The Trust works in partnership with health economies predominantly in Barnsley, Calderdale, Kirklees, Wakefield, and the Integrated Care Systems of South Yorkshire & Bassetlaw and West Yorkshire & Harrogate. We identify and manage risk at those levels as well as at Trust level, as reflected in the roles and responsibilities of the Board, of Executives and of staff within the Trust. This is evident from the Board Assurance Framework and Trust risk registers.

The Trust continued to operate a strengthened risk management arrangement during 2020/21 with regular reviews of risk at Executive Management team (EMT) meetings, and the Trust Board, alongside the Committees of the Board. This recognises the dynamic nature of the environment in which we operate and the need to constantly focus, assess and manage risk. Throughout 2020/21, the level and nature of risk in the Trust has been significantly impacted by the Covid-19 pandemic and the risk register has been updated regularly to reflect the impact of the pandemic on the existing organisational level risks and new risks that have arisen.

Risk management training for the Trust Board is undertaken biennially. The training needs of staff are assessed through a formal training needs analysis which was completed in 2019/20.

All staff receive training appropriate to their authority and duties. The role of individual staff in managing risk is supported by a framework of policies and procedures that promote learning from experience and sharing of good practice. The risk management procedure was reviewed and updated in 2019 and the Risk Management Strategy was updated and approved by Trust Board in April 2019 (both next due for review in 2022). Guidance to support staff in the recording, reporting and management of risks was reviewed and refreshed in 2020.

Alongside this capacity, the Trust has effective internal audit arrangements, with an annual work plan that helps to manage strategic and business risk within the Trust. This is approved by the Audit Committee following engagement with Executive Directors.

The risk and control framework

The risk and control framework flows from the principles of good governance. It uses effective board and committee structures, supported by the Trust's Constitution (including standing orders) and scheme of delegation. The Risk Management Strategy describes in detail how risk is applied within this framework.

The Audit Committee assures the Board and Members' Council of the effectiveness of the governance structures through a cycle of audit, self-assessment and annual review. The latest annual review was received by the Board in April 2021.

The Audit Committee assessment was supported by the Trust internal auditors who conducted a survey of Trust Board members for the third consecutive year in relation to risk management, which again supports this assessment.

The cycle of Trust Board meetings continues to ensure that the Trust Board devotes sufficient time to setting and reviewing strategy and monitoring key risks. Within each quarterly cycle, there is one monthly meeting with a forward-looking focus centred on business risk and future performance, one meeting focusing on performance and monitoring, and one strategic development session. The Trust Board meetings relating to business risk and future performance, and performance and monitoring are held in public and the Chair encourages governors to attend each meeting.

Given the exceptional circumstances brought about by the Covid-19 pandemic, the Trust Board meetings have been held virtually. Minutes, papers and details of how governors and members of the public can join Board meetings held in public are available on the Trust website. The Trust also published guidance on how to join virtual meetings to ensure meetings are accessible. Regular reviews were made of the Board agenda during the course of the pandemic to ensure Board members were fully sighted on key issues, whilst simultaneously ensuring the Trust executive could focus its resources on the response to Covid-19. A regular briefing was provided to non-executive directors by me and the Director of Finance during the first four months of the pandemic, when uncertainty was at its height and knowledge of the progression and nature of the virus was emergent.

The Board has recognised the development of stronger partnerships across the geography in which we operate. Formal partnership Boards and committees have reports and minutes received by the Trust Board and there is appropriate consideration made in our risk register. This is informed by our presence of partners' Gold and Silver Command meetings.

The Committee in Common with West Yorkshire & Harrogate partners reports in line with other committees of the board.

The Trust's Risk Management Strategy sets out specific responsibilities and accountabilities for the identification, evaluation, recording, reporting and mitigation of

risk. The Trust's Risk Appetite Statement was defined in line with the *'Good Governance Institute risk appetite for NHS Organisations'* matrix aligned to the Trust's own risk assessment matrix. The Statement was approved by Trust Board in July 2016 and was further refined during 2018. It was confirmed in April 2019 when the Risk Management Strategy was updated and approved by the Board. The next review is due in 2022.

The Risk Appetite Statement sets out the Board's strategic approach to risk-taking by defining its specific boundaries and risk tolerance thresholds under four categories (strategic, clinical, financial or commercial, and compliance risks), and supports delivery of the Trust's Risk Management Strategy and procedures. All organisational level risks are aligned to and monitored by an appropriate Committee. Over 2020/21, further work has continued to review risk registers to consider where organisational risks scoring level 15 and below fall outside of their Risk Appetite. This ensures risks are managed within their tolerance where appropriate or escalated for further debate and action.

Risk reports are used at the relevant committees of the board setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level.

The Board Assurance Framework (BAF) describes the strategic risks that will continue to be managed by the Trust. The BAF is aligned to the four strategic objectives of the Trust. This ensures alignment between the business of the Trust and the risks we manage across the organisation and the system. The BAF is used to help shape the agenda of the Board and its sub-committees. In 2020/21, the Board made the decision to defer the annual review of strategic risks to later in the year to take account the impact of the Covid-19 pandemic. In quarter three, a comprehensive review of all strategic risks took place and an updated BAF considering the impact and influence of Covid-19 on the Trust's strategic objectives for 2020/21 and 2021/22 was reported to the Board in January 2021.

As Chief Executive and the Accounting Officer, my accountabilities are secured through delegated executive responsibility to the Executive Directors of the Trust for the delivery of the organisational objectives, ensuring there is a high standard of public accountability, probity and performance management. In 2020/21, personal objectives were set for each director and reflected in the Board Assurance Framework through the strategic objectives assigned to each Director. My objectives were discussed and agreed with the Chair and shared across the Trust, alongside a high-level summary of how Directors' objectives fit within this framework.

In support of the BAF, the Trust also has a corporate/organisational risk register in place which outlines the key risks for the organisation and actions identified to mitigate these risks. This is reviewed on a monthly basis by the EMT and quarterly by Trust Board, providing leadership for the risk management process. Risk registers are also developed at service delivery level within Business Delivery Units (BDUs) and within the corporate directorates. These are reviewed regularly at the Operational Management Group (OMG). The main risks at the end of 2020/21 have been separated into two sections. These are the risks that have been an area of focus for all or the majority of the year and the risks that are specific to the Covid-19 pandemic and its response.

The Trust's main risks at the end of 2020/21 that have been an area of focus for all or the majority of the year are shown below:

Area of focus	Sample of actions completed or underway

Data and information: cyber-crime and information governance (IG)	• The Trust has completed the rollout of Windows 10 across the full computer estate, additional email security and data loss prevention measures in place. • Identified activities have progressed to enhance our cyber security. • Cyber and IG awareness campaigns have been refreshed. • Targeted approach and advice / support provided to 'hot-spot' areas.
Workforce pressures	• Safer staffing project ongoing with regular reports to Board and commissioners. Bronze command staffing group established as part of Covid-19 response. • An organisational development plan for forensics services has been put into action • Refresh of workforce plans as part of operational planning process. • Dedicated recruitment resource to review and focus on target areas with the greatest recruitment issues / high agency use. • Implementation of new roles including nursing associates and advanced clinical practitioners. • Marketing the Trust as an employer of choice and a great place to work. • Enhanced health and wellbeing support for staff. • Delivery of Workforce Race / Disability Equality and EDS2 action plans Including staff disability and LGBT networks • Review of how representative Trust decision making groups are of our diverse workforce • Established BAME talent pool • Introduction of internal review panel on disciplinary and grievance cases related to discrimination on the grounds of race. • Established staff networks and Freedom to Speak Up Guardians, including one new substantive member of staff.
Quality of care / patient safety	• Child and Adolescent Mental Health Services (CAMHS) Improvement Group established with identified change leadership across each pathway. CAMHS performance dashboard for each district. • System-wide work to improve access to Autism Spectrum Disorder (ASD) services. Local plans in place to address backlog. • Quality improvement network. • Waiting lists reported through Business Delivery Unit (BDU) business meetings, alternative services offered as appropriate. Ethnicity monitoring in place to monitor any disproportionate impact.

	• Quality Improvement plans • Suicide prevention strategy. • Nursing Strategy • Allied Health Professionals policy • Patient safety strategy. • Review of seclusion facilities commissioned due to risk of reduced availability because of damage to existing rooms. • Reducing Restrictive Physical Interventions • Cohorting plans in reaction to any outbreaks of Covid-19 on our inpatient wards • Adherence to infection prevention and control guidance • Recent CQC communication around ligature risks reviewed by environmental safety group and recommendations being implemented. • The next phase of seclusion review work will include a review of all suites against the standards with an estate plan to address any gaps by October 2021.
Financial sustainability in a changing environment	• System wide funding provided on a fair shares basis for 2020/21. • Temporary financial arrangements in place across the NHS during 2020/21 • Financial sustainability plan (to be refreshed in light of Covid-19) in 2021/22. • Development of external engagement and links to priority programmes. • Engagement with West Yorkshire and South Yorkshire & Bassetlaw Integrated Care Systems. • Mental health investment standard has benefited income and service provision. • Updated Estates and Digital Strategies to inform Trust capital plan • Effective communication of Trust capital priorities to West and South Yorkshire ICS partners.
Out of area placements	• Bed management processes in place. • Additional Psychiatric Intensive Care Unit (PICU) capacity purchased during the pandemic. • Working across our ICSs to identify system-wide solutions and areas of best practice. • Work with commissioners to prioritise areas of investment
Partnership working	• Attendance and representation at partnership meetings. Active involvement in both our Integrated Care Systems. • Regular review of performance to identify any emerging issues.

	• Ongoing work regarding lead provider for forensic services in West Yorkshire with due diligence checks and process development underway. • Contribution to CAMHS and eating disorder lead provider collaborative processes in West Yorkshire • Working across both our Integrated Care Responses as part of the response to the Covid-19 pandemic
Fire safety	• The Fire safety function continues to be run effectively. Fire safety is a standing agenda item on the Trust Safety TAG. In addition, the Trust fire safety training figures are reviewed at OMG and action taken accordingly. • The Trust continues to monitor and manage compliance with the RRO (Regulatory Reform Order) and the relevant legislation. The compliance certificate for this has been considered at Estates TAG • All Fire Risk Assessments are up to date.

The Trust's main risks at the end of 2020/21 relating to the Covid-19 pandemic year can be summarised as follows:

Area of focus	**Sample of actions underway**
Risk of harm to staff, service users and carers whilst in our care	• Policies and procedures reviewed and revised to take account of Covid-19. • Regular publication of guidance and communications to all staff. • Provision of appropriate personal protective equipment (PPE) in line with emerging national guidance, which is monitored through bronze command and overseen by silver command. • Testing and vaccination programmes in place and successful. • High risk groups identified by clinical teams and treatment plans reviewed. • Risk assessment process undertaken including full risk assessment process for staff from a BAME background and all those shielding • Adherence to infection prevention and control guidance • Use of Command structure to manage the impact of and response to the Covid-19 pandemic
Impact on core Trust service provision	• Key partner in ICS recovery and reset plans. • Development of internal reset and restoration work stream • Command structure in place to support the immediate management of peaks in demand.

	• Detailed activity, workforce and finance planning taking place in light of increased referral activity. • Interim Clinical Ethics Advisory Group (CEAG) established to provide urgent ethical advice to clinical teams. • Performance management processes have remained in place during the pandemic
Staffing and workforce	• Increased support through recruitment of staff to the bank. • Comprehensive health and wellbeing support offer augmented by regional and national support. • Targeted support based on wellbeing survey conducted in pandemic. • Training and support readily available to staff required to work in a different way or with a different service. • Recruitment and retention plans have resulted in more staff being employed by the Trust compared to the previous year
Legal	• Process to receive, review and implement national guidance. • Decision logs and formal notes in place for the command structure. • Specific proactive task and finish group put in place to consider and monitor future Covid-19 related future legal risks.
Ability of staff to work remotely	• Provision of IT equipment and VPN access to allow staff to work remotely rolled out during the early stages of the pandemic. • Development of different IT platforms for clinical work delivered and evaluated, alongside associated good practice guidance

Given the strategic context within which we operate, the risks outlined above will continue into 2021/22 with mitigating actions in place. The current pathway out of lockdown, starting towards the end of 2020/21 is based on continued progress in four key areas. These are not guaranteed and the ongoing nature of the Covid-19 pandemic means that we are operating in a dynamic context for risk.

The instigation of command and control mechanisms through the Department of Health & Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) help to manage the risks of Covid-19. We play a full and active role in the aforementioned, through direct Emergency Planning Response and Resilience (EPRR) arrangements via NHS England/Improvement, and as a partner in Local Resilience Fora. The response to Covid-19 brings subsequent risks due to the withdrawal of personal freedoms and treatments to some members of the public.

The creation of Integrated Care Systems (ICS) across West Yorkshire & Harrogate and South Yorkshire & Bassetlaw provides a further mechanism for managing elements of some risks across organisations. Both of our ICS's have refocused their capacity and resources to ensure that actions to mitigate the impact of Covid-19 are prioritised. This includes critical care,

integrated community services and mutual aid on personal protective equipment (PPE), testing and staffing.

As the lead Chief Executive for the West Yorkshire & Harrogate Health and Care Partnership, I am able to ensure we are closely engaged in the leadership and delivery of these plans. The Director of Provider Development role means we have senior capacity working on the programmes that relate to the Trust, particularly in West Yorkshire & Harrogate. In parallel, we are an engaged partner in the South Yorkshire & Bassetlaw Integrated Care System, where I will ensure that the risks inherent in the move to an Integrated Care System are understood and mitigated.

The Board has kept my dual role, as Chief Executive of the Trust and lead Chief Executive of the West Yorkshire & Harrogate Health and Care Partnership, under regular review to ensure the arrangement continues to work in the interests of the Trust as well as the ICS.

Our Licence

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust continues to assess its compliance with CQC registration requirements on a regular basis through our Quality Assurance & Improvement Team. To support our assessment, we have developed a quality assurance and improvement 'self-governing' assessment model. This philosophy builds on our emphasis on self-governance and evaluation. As a series of methods and tools, this approach helps map the relationships between quality improvement and quality assurance and will provide a continual source of evidence for teams to inform how well they are performing against appropriate and helpful metrics for quality.

As part of this initiative, we have developed an accreditation scheme underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts. Although this was not launched as we had hoped due to the Covid-19 pandemic, two wards did take part in the programme during 2020/21.

There has not been a CQC inspection completed during 2020/21, however, the CQC rated our Trust as Good in 2019, recognising the improvements we have made since their last inspection in 2018 and the strength and quality of the services we provide. We delivered on the actions from the last report, which has led to four of the five overall domains now being rated as Good. We are also pleased that our mental health community services have improved and are now rated Good.

Overall, we are now rated Good for being responsive, caring, well led and effective, and Requires Improvement for being safe. This means that overall we have been rated Good as a Trust.

12 of our 14 core services are rated Good. Over **87%** of our individual domains have been rated as Good or Outstanding. In summary:

- The vast majority of our services are rated as Good or Outstanding.
- Our community based mental health services for working age adults have improved and are now rated Good.
- Acute wards for adults of working age and psychiatric care units have improved.
- We have improved and are now rated as Good for being Responsive.
- 93% of our services were rated as Caring and Responsive.
- Staff were kind and caring towards service users, with positive relationships that demonstrated we knew them well.

- The values of the organisation were understood and respected by both leaders and those working in core services.
- Our strategy, vision and values were all identified as being patient centred.

The Trust would normally assess itself annually against the NHS Constitution, in line with good practice. However, during the pandemic, the Government has advised that boards should ensure administrative burdens are reduced so that effort is focused on delivering services and responding to the pandemic. The Board agreed that the scheduled report would be deferred and will be presented in June 2021. This will set out how the Trust meets the rights and pledges of the NHS Constitution. At the time of writing, I believe that our risk register contains no material or substantial risk of significant breaches of the constitution.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months as required by the 'Managing Conflicts of interests in the NHS[23]) guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measure are in place to ensure that all the organisation's obligations under equality, diversity, and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has a sustainable development management plan in place which take account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Values Based Culture

The Trust works hard to provide the highest standards of healthcare to people. The promotion of a culture of openness is a pre-requisite to improving business resilience, patient safety and the quality of healthcare systems. Good governance and a risk aware culture are emphasised in the values of the Trust and reinforced through values-based recruitment, appraisal and induction.

Learning from incidents and the impact on risk management is embedded in the way we work. The Trust uses an e-based reporting system, DATIX, at directorate and service line level to capture incidents and risks, which can be input at source. Data can be interrogated through ward, team and locality processes. This encourages local ownership and accountability for incident and risk management. Data is interrogated regularly to ensure that any risks are identified and escalated at the appropriate level. Staff are assured they will be treated fairly and with openness and honesty when they report adverse incidents or mistakes, ensuring risks are reduced.

During the Covid-19 pandemic, the Trust has regularly reviewed incidents that cite Covid-19 as a factor.

The Trust works closely with safety teams in NHS England/Improvement and uses Root Cause Analysis (RCA) as a tool to undertake structured investigation to ensure learning from serious incidents. Our aim is to identify the contributory factors and potential root cause of serious incidents, to identify the learning and improvement actions necessary to minimise the opportunity of recurrence and to ensure that the Trust takes every opportunity to learn and develop from an incident and mitigate future risk.

The provision of mental health, learning disability and community services carries a significant inherent potential risk**.** Unfortunately, serious incidents do occur which require robust and well governed organisational controls. In 2020/21, there were 12,717 incidents reported (a 3.7% decrease on 2019/20), of which 92% resulted in low or no harm to patients and service users, recognising that the Trust has a risk based and good reporting culture.

During 2020/21, there were 34 serious incidents across the Trust compared to 47 in 2019/20. There were no 'Never Events' (as defined by the Department of Health) relating to serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Where harm has taken place, the Trust ensures that communication with staff, service users and families is open, honest and occurs as soon as possible following any patient safety event. Our Duty of Candour is an essential part of our culture, linked to our values of being open, honest, respectful and transparent. Staff understand their role in relation to Duty of Candour; they have the support required to comply with the duty and to raise concerns; the Duty of Candour is met through meaningful and sensitive engagement with relevant people; and all staff understand the consequences of non-compliance. This is monitored through a regular report to the Operational Management Group, the Executive Management Team and reported through the governance structures to Board. During 2020/21 the Trust has appointed a substantive Ambassador for Cultural Change and Freedom to Speak Up Guardian. There were 19 episodes of duty of candour during the year and there was one duty of candour breach recorded in the year. This was due to ….. and I can confirm lessons learned were identified and implemented.

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The Clinical Governance and Clinical Safety Committee has a leading role to play. It scrutinises and monitors quarterly serious incident reports and bi-annual reports on how and where lessons have been learnt and practice improved and/or changed. The Committee also monitors implementation of recommendations arising from external reviews and reports. In the last year, this has included the Trust's action plan in response to the CQC. This includes a review of arrangements for managing waiting lists for Child and Adolescent Mental Health Services (CAMHS), and quality improvement initiatives. The Committee routinely monitors infection, prevention and control, reducing restrictive practice interventions, safeguarding, patient safety, health and safety, quality impact assessments and issues identified at the drugs and therapeutic committee. The Committee oversees all work until actions have been completed and closed and it is satisfied that risks have been moderated.

The Clinical Risk Panel, chaired by the Director of Nursing and Quality, provides an organisational overview of the incident review, action planning and learning processes to improve patient safety. It also provides assurance on the performance management of the review process, associated learning, and subsequent impact within the organisation. The Panel takes place weekly and reports directly into the EMT at every meeting.

The key elements of the Trust's quality governance arrangements are as follows:

- The Trust's approach to quality reinforces its commitment to quality care that is well led, safe, caring, responsive, efficient and effective. The Quality Strategy outlines the responsibilities held by individuals, directorates, the EMT and Trust Board. The Trust

Board approved an updated Quality Strategy on 27 March 2018. This is due for review in 2021/22

- The Trust's Quality Strategy sets out our commitment to providing high quality care for all while achieving our organisational mission to help people to reach their potential and live well in their communities. It sets out what we mean by quality and provides a framework for how we assure and improve quality across the organisation. It also describes our Integrated Change Framework that supports innovation and improvement at all levels.
- This is supported by the Patient Safety Strategy to improve the safety culture throughout the organisation whilst supporting people on their recovery journey, to reduce the frequency and severity of harm resulting from patient safety incidents, to enhance the safety, effectiveness and positive experience of the services we provide, and to reduce the costs, both personal and financial, associated with patient safety incidents. The Strategy was reviewed in December 2019 and covers the period up to and including 31 March 2021.
- The Clinical Governance and Clinical Safety Committee is the lead Committee for quality governance.
- The Safeguarding Strategic Sub-Group provides assurance to our partners that we are compliant with national standards and adopt a quality improvement approach to developing our service offer
- Monthly compliance reporting against quality indicators sits within the Integrated Performance report. Trust Board also receives a quarterly report on complaints, concerns, comments and complements through a customer service report.
- CQC regulation leads monitor performance against CQC regulations and the Trust undertakes self-assessments.
- External validation, accreditation, assessment and quality schemes support self-assessment for example: accreditation of electroconvulsive therapy (ECT), Psychiatric Intensive Care Units (PICU) and Memory Services; CQC Mental Health Act Visits; and national surveys (staff and service user).
- Trust Action Groups provide organisational overview and performance monitoring against key areas of governance such as Serious Incidents, Infection Prevention and Control, Information Governance, Reducing Restrictive Practice Group, Drugs and Therapeutics and policy development. During the pandemic, these have continued to meet and/or have been strengthened by the development of groups within the command structure. For example, the IPC Bronze Command.
- Quality Impact assessments are carried out on all Trust cost improvement plans with Medical Director and Director of Nursing & Quality approval required before a scheme can proceed. Quality Impact Assessments (QIAs) can also be invoked in year where concerns trigger the requirement to do so. Given the temporary financial arrangements in place, with the suspension of cost improvement programmes during 2020/21 this process was not required during the year
- Measures are implemented and maintained to ensure individual practice, teams and services are reviewed and improvements identified and delivered. This includes the Trust's prioritised clinical audit and practice evaluation programme.
- The annual validation of the Trust's Corporate Governance Statements as required under NHS Foundation Trust conditions. The Board certified that it was satisfied with the risks and mitigating actions against each area of the required areas within the statement (as described in risk section on page 5).
- The Freedom to Speak Up Guardians ensure that where staff feel unable to raise concerns through the usual channels, there is a mechanism for doing so. The Trust has four Guardians, drawn from the staff governors and a representative of the BAME staff network. Over the year 19 concerns were raised through this mechanism and reporting was shared with the Office of the National Guardian. The arrangements surrounding the Guardians have been strengthened, with an Ambassador for cultural change and Freedom to speak up guardian appointed in December 2020. There is a specific slot on FTSU at

new staff induction, better administrative support, protected time allocated and clearer guidance available.
- The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensure that its obligations under the Climate Change Act and the Adaptation of reporting requirements are complied with. The Trust Board approved the Trust's Green Plan in March 2021.

The Trust continues to build on its engagement framework to enhance and increase understanding of the Trust's services, to demonstrate the quality of services and to show the actions taken in response to the feedback. A number of initiatives have been established to strengthen insight arrangements, including the following:

- Systematising the collection of service user and carer feedback, with a consistent approach to action planning and communication of the responses, including assessment against the Department of Health's Friends and Family Test.
- Insight events for Trust members, service users, patients, carers and the public.
- Ongoing facilitated engagement events for service users and carers, staff and stakeholders in support of the Trust's priority programmes. For example, the new mental health clinical record system optimisation programme for 2020/21 which included the implementation of a new electronic clinical risk tool, ensured that staff were fully engaged during both design and delivery phases. This has continued during the optimisation phase for the delivery of the new Mental Health Care Plan and risk assessments.
- Quantitative and qualitative local and national surveys undertaken on a regular basis and actions taken to address issues identified.
- The principle of co-production being promoted throughout the Trust, such as co-production of training in Recovery Colleges and new resources being secured to strengthen this further.

The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental and social care as part of a modern health and care system. This is backed by priority programmes and associated structures. The priority programmes help to address the strategic risk of having insufficient capacity and help to prioritise our efforts. During 2020/21 the Trust has employed an Assistant Director to lead on the physical healthcare agenda for learning disability and mental health service users within secondary services.

The Trust works hard to provide the highest standards of healthcare. through a culture of openness, good governance and a risk aware culture. This is reinforced through values based recruitment, appraisal and induction.

This has been further strengthened in 2020/21 with changes to the appraisal system to focus on objectives and values more explicitly. A successful E-Appraisal pilot was conducted with the aim to reduce the paperwork involved to allow staff and managers to focus on the conversation. This was rolled out in 2020/21, although at a slower pace due to the pandemic.

Equality, Involvement and Inclusion

The Trust believes that an integrated approach to equality, involvement, and communication (bolstered by our membership) will ensure we deliver on our inclusion agenda.

The Trust approved an Equality, Involvement, Communication and Membership strategy in 2020 which has supporting annual action plans to ensure an integrated approach. This is insight driven and will ensure:

- Every person living in the communities we serve will know our services are appropriate and reflect the population we serve;
- That our workforce reflects communities, ensuring our services are culturally appropriate and fit for purpose;
- Service users, carers and families receive timely and accessible information and communication, ensuring a person-centred approach to care;
- That our services are co-created and designed with our staff and communities

The Committee oversees the implementation of the Equality, Involvement, Communication and Membership Strategy to improve access, experience and outcomes for people from all backgrounds and communities. This includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.
The key approaches to support this work are set out below:

- The Equality, Involvement, Communication and Membership Strategy is supported by annual equality and involvement action plans. These plans set out our Trust wide approach to delivering strategic objectives and describe the Trust actions for the forthcoming year. The plans align existing internal resources, data and insight frameworks to ensure a systematic and integrated Trust wide approach.
- The effective use of insight and data underpins what we do. This includes robust equality monitoring. Data is used to identify who uses and works in services, highlighting areas of inequality that can be addressed through insight work and action planning.
- Equality Impact Assessments (EIA) are in place for all services, strategies and policies. This ensures that equality, diversity and human rights impacts are considered, recorded and action taken for every service. Action to mitigate impacts are taken through service level actions plans which are used to implement service improvements.
- A Trust wide equality impact assessment and approach was developed in direct response to the pandemic. This approach includes a Trust wide EIA that has regularly been updated and reviewed and signed off by E&I Committee and Trust Board and the development of a resource and research bank which is an internal resource of all literature published during this time. These tools have ensured that our public sector equality duty to advance equality of opportunity and consider impacts has been a core focus in response to the pandemic.
- A short form EIA has been introduced alongside this work to support rapid decisions specifically during the Covid-19 pandemic, ensuring the equality and diversity are considered and any impacts identified, and action taken.
- A number of involvement resources such as plans and reporting templates to record activity ensure that our approach is audited and in line with our legal obligations.
- The Trust have a clearly articulated approach to formal consultation, this includes a training pack, plan on a page and governance through EMT and E&I Committee who sign off the appropriate approach.
- The Trust wide change framework includes the process for involving people at each stage and a 'checklist' approach and dedicated inbox for involvement ensures that a systematic and considered approach to engagement, co-production and consultation is considered at the start of any new project or programme of work
- All involvement plans are driven by the Local Joint Strategic Needs Assessment and service level Equality Impact Assessment (EIA) data which describe the reach so that approaches consider equality and diversity by including a range of methods and approaches to support an inclusive involvement approach.
- A process is in place for working with our communities using stakeholder mapping to identify key stakeholders and contacts. Whilst working with community groups the routine collection of feedback and equality monitoring ensures we are listening to, recording and

reporting on the voice and views of a representative sample of the local population. Quarterly insight reports support this approach.

- A Trust wide survey toolkit to support the collection of patient experience and engagement intelligence ensures that the Trust has a clear approach for capturing views. The central collection of data provides an opportunity to use the feedback at both a service and Trust wide level.
- The Department of Health's Friends and Family Test in every service setting now has a short equality monitoring form. This ensures feedback is representative and that the information can be broken down by protected group to identify and address inequalities.
- The Trust assessed its performance regarding each of nationally identified eight urgent actions systems are required to take to reduce inequality and has measures in place to ensure it fully contributes to the achievement of these actions.
- The Trust publishes reports of findings from all our involvement activity to demonstrate the insight we are using to inform service improvements. The reports include an equality section, which includes who we have reached and how reflective the voice is of the local population. This will ensure the representation of voice is in line with and reflective of the population we serve.
- A dedicated programme of work to roll out of Peer support Workers and ensure lived experience is part of our approach has resulted in the development of a dedicated training programme and increase in internal posts to 11 members of staff.
- Staff networks are a significant part of our approach. The Black, Asian and minority ethnic (BAME) staff network was established to empower and support staff to achieve their potential and maximise their contribution in delivering the Trust's Mission, Values and Strategic Objectives. The Trust has an established a disability staff equality network and a Lesbian, Gay, Bisexual, Transgender, Queer plus (LGBTQ+) network using the same principles of self-determination and support. This year we have established a carers network to support staff in their caring role. The networks play an active role in a number of elements of Trust business, including recruitment to senior positions and the development of Freedom to Speak Up Guardians.
- The Trust has also established a clinical network, called Race Forward, to reduce bullying and harassment from service users and carers on staff from BAME backgrounds. The clinically managed network meets bi-monthly to support staff and liaises with the Police and other Trusts to tackle the issue and create positive change.
- The Board and Governors believe they should be reflective of communities and represent the workforce and population it serves. Over the last year a good level of diversity has been retained across the Board with a good balance of gender, age and ethnicity. Governors use a targeted approach to support recruitment from local communities.

The Trust has improved in all four WRES indicators published in the NHS Staff Survey and has plans identified to continue this improvement.

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During the year, the Trust published its gender pay gap audit as required by law, and in addition produced pay gap audits for ethnicity and disability. These showed there is a pay gap on gender but not on ethnicity or disability. An action plan has been agreed and published on the Trust's internet.

Commented [WR5]: Did we do this work in 2020/21?

Commented [LA6R5]: Will address for future version

The Trust has adopted the National EDS2 Framework and focussed on improving the following areas, working closely with service users, public and commissioners:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and well supported staff
4. Inclusive leadership at all levels

The Trust Board approved a Workforce Strategy, in March 2017 which includes objectives, linked to the EDS2 Framework and the NHS Workforce Race Equality Standards (WRES), to support a representative workforce. The Trust has a joint EDS2 and WRES action plan.

Building on listening events and feedback from staff during 2020/21 this resulted in a new organisational priority Making SWYPFT a great place to work which supports the provision of a healthy, resilient and safe workforce. This covers five key areas:

- Feeling safe
- Being part of a supportive team
- Positive health and wellbeing
- Developing my potential
- My voice counts

These key areas along with the People Promise commitment from the NHS People Plan have further informed the development of the Workforce Strategy which has been slightly delayed due to Covid 19 and will be implemented during 2021/22.

As part of making the Trust a Great Place to Work, a senior leadership forum was created involving senior managers, clinicians and corporate service to develop local actions plans in response to the key themes above in line with "Developing Workforce Standards" 2018.

In 2020/21, the Equality and Inclusion Committee received reports on the following:

- The approach, updates and progress to develop an integrated strategy for Equality, Involvement and Membership
- Covid-19 equality impact assessments and emerging research and evidence
- Progress against the Workforce Race Equality Standard (WRES) and Disability Equality Standard (DES) reports and action plans.
  - Equality Delivery System (EDS2) report and action plan
  - Equality Impact Assessments (EIAs) update.
  - The Trust's equality and diversity annual report.
  - Our inclusive leadership and development programmes.
  - Commitment to Carers.

Priority Programmes

The Trust continues to lay the foundations for its ambitious vision to provide outstanding physical, mental and social care in a modern health and care system. This is backed by priority programmes and associated structures. The priority programmes help to address the strategic risk of having insufficient capacity and help to prioritise our efforts.

For 20/21 the Trust Board agreed 13 priority areas of work, some of these are strategic developments ; others are priority programmes of change. Work takes place to ensure alignment with national guidance such as the NHS Long Term Plan and local system plan. The focus for many of these programmes during the year has been to respond and learn from the Covid 19 pandemic. In year, we have added one additional priority area. so by

As of January 2021 we had 14 priority programmes of change that provide the framework for driving improvements. These include:

- Working with our local system partners: in each of the places to join up care in our communities. This includes our four Districts where we provide services as well as the two integrated systems in South Yorkshire & Bassetlaw and West Yorkshire & Harrogate.
- Providing safe care every time in every service: focusing on programmes to develop and deliver safe, effective and high quality services, including the implementation of our patient

Commented [WR7]: Can we review this please? I presume we can say much more about the review we have been undertaking and the impact of Covid-19. See below!

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Commented [WR9]: Insert picture of programmes from the slide

Commented [LA10R9]: Will address for future version

safety strategy and the development of an integrated approach to quality improvement that equips our staff to make improvements for the benefits of our service users and carers.

- Programmes of work to improve our use of resources include making best use of digital technologies and covering reducing waste and improving productivity to support financial sustainability. We have also delivered a programme to provide all care as close to home as possible: focusing on improving patient flow through our systems and reducing the number of people who are placed outside our area.
- Making the Trust a great place to work: supporting staff wellbeing, improving staff engagement and reducing bullying and harassment.
- Understanding equality and addressing inequality through inclusive involvement

This is underpinned by our values and our approach to leadership with a culture of improvement and inclusive change. Each programme has a Director sponsor and clinical lead, and is supported by robust project and change management arrangements through the central integrated change team.

The Trust continues to develop and create additional capacity in the community and different models of delivery and support for service users and carers. This is through the development of a recovery approach with recovery colleges across our districts. Alongside this we host Altogether Better, a national initiative which supports development of community champions. This is all complemented by our charity EyUp! and linked charities Creative Minds, Spirit in Mind and the Mental Health Museum.

Commented [WR11]: Can we add any activity data on this?

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The Trust continues its commitment towards carbon reduction. We have undertaken risk assessments and Carbon Reduction Delivery Plans in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are met. During the year this has included further installation of energy efficient LED lighting across our estate and we have signed up to the NHS Single-Use Plastics Reduction Campaign which aims to eliminate avoidable single use plastics across the Trust. The Trust Board approved the Trust's Green Plan in March 2021.

Review of economy, efficiency and effectiveness of the use of resources

The governance framework of the Trust is determined by the Trust Board. It is described in the Trust's annual report and includes information on the terms of reference, membership and attendance at Trust Board and its Committees, including the Nominations Committee, which is a sub-committee of the Members' Council. The Trust complies with Monitor's (now NHS England/NHS Improvement) Code of Governance and further information is included in the Trust's annual report.

Financial monitoring, service performance, quality and workforce information is scrutinised at meetings of the Trust Board, Finance, Investment and Performance Committee, through Executive Management Team (EMT) meetings, the Operational Management Group (OMG), Finance & Performance reviews, BDU management teams and at various operational team meetings.

The EMT has a robust governance structure ensuring monitoring and control of the efficient and effective use of the Trust's resources. This is subject to oversight by the governance mechanisms described in the previous paragraph.

The Trust is a member of the NHS Benchmarking Network and participates in a number of benchmarking exercises annually. This information is used alongside reference cost and other benchmarking metrics, such as the Model Hospital, to review specific areas of service in an

attempt to target future efficiency savings. Work has continued with BDUs to implement and utilise service line reporting, including the use of bespoke performance dashboards. During the year enhanced reporting for the Covid-19 pandemic was developed and implemented. This includes live updating of staff absence, testing and vaccinations.

The Trust has a well-developed annual planning process which considers the resources required to deliver the organisation's service plans in support of the Trust's strategic objectives, local commissioning intentions and local health and wellbeing plans. Increasingly we are ensuring that Integrated Care Systems (ICS) inform our work. These annual plans detail the workforce and financial resources required to deliver service objectives and include the identification of cost savings.

The impact of Covid-19 is such that temporary financial arrangements were in place for the first half of 2020/21, which enabled trusts to break-even. For the second half of the year there was a return to a financial planning process, which resulted in the Trust having an agreed financial target to achieve. This target was agreed in liaison with other NHS organisations in the West Yorkshire & Harrogate ICS given the increased role of the system in operational and financial planning. The Trust also contributed to the plan for the Barnsley system within the South Yorkshire and Bassetlaw ICS.

A robust process is undertaken to assess the impact on quality and risks associated with cost improvements both prior to inclusion in the annual plan and during the year to ensure circumstances have not changed. The process and its effectiveness are monitored by the Clinical Governance and Clinical Safety Committee. QIAs take an objective view of the impact of cost improvements on the quality of services in relation to the CQC five domains of safe, caring, effective, responsive, and well led. The assessments are led by the Director of Nursing and Quality and the Medical Director with the Director of Operations, BDU Deputy Directors and senior BDU staff, particularly clinicians. Cost improvement planning was paused in in 2020/21 in to enable focus on our response to the Coronavirus pandemic.

As part of the annual accounts review, the Trust's efficiency and effectiveness of its use of resources in delivering clinical services are assessed by its external auditors and the auditor's opinion is published with the accounts.

The Trust delivered a position ahead of its financial control total. The control total was for a £2.1m deficit. On a like for like basis this position was improved by £6.3m to a surplus of £4.2m. Additional income has been provided to the Trust in support of a range of issues. These include carried forward annual leave, Covid-19, the Flower's legal settlement of enhanced holiday pay and compensation for reduced non-clinical income. The level of this additional income was above plan and has contributed significantly to the current financial position.

There are various levels of surplus and deficit and the following table provides reconciliation between the comprehensive income of £2.6m as shown in our accounts and the £4.2m surplus quoted above:

	£m
Total Comprehensive Income/(Expense)	3.0
Impairments and Revaluations	0.2
Net Impairments	1.4

Pre adjusted Surplus in our management accounts	4.6

As outlined above, work on delivering cost savings was suspended in 2020/21.

Information Governance

Information governance compliance is assured through a number of control measures to ensure that risks to data security are identified, managed and controlled. The Trust has put an information risk management process in place led by the Trust Senior Information Risk Owner (SIRO). Information asset owners cover the Trust's main systems and record stores, along with information held at team level. An annual information risk assessment is undertaken. All Trust laptops and memory sticks are encrypted and person identifiable information is required to be only held on secure Trust servers. The Trust more than achieved the target of 95% of staff completing training on information governance by 31 March 2021 with 98% of staff recorded as completing the training.

Information governance has had continued focus through 2020/21 through proactive monitoring of incidents, providing awareness raising sessions at all levels in the organisation, including senior level through Extended Executive Management Team, and offering advice and increasing availability of training for staff. Information governance had a continuous and high profile in the Brief, cascaded monthly to all staff.

Incidents and risks are reviewed by the Improving Clinical Information Group which informs policy changes and reminders to staff.

The Trust is required to report any information governance incidents scoring level 2 or above externally to the Information Commissioner's Office (ICO). Three incidents have been reported during 2020/21. Two involved allegations that staff members had shared sensitive data about Trust patients with other individuals, which was subsequently communicated to the patients, causing them harm. The ICO closed both incidents without taking further action and recommended that the responsible staff members were managed under processes and that the Trust raised awareness of the duty of confidentiality owed to patients and the need for a justified purpose when sharing personal data.

The third incident involved records that had been printed during processing of a subject access being sent by post to the wrong recipient, causing harm to the data subject. The ICO closed the incident without taking further action but recommended an investigation, which has been completed and all recommendations implemented.

Good information governance will continue to be a feature of the Trust in 2021/22. The Data Security and Protection Toolkit was submitted on time and is compliant with the standards.

Annual Quality Report

We have fully compiled our Annual Report with the updated guidance issued in response to the Covid-19 pandemic. The requirements for Quality Account reporting for 2020/21have been removed.

The following steps have been put in place to assure the Trust Board that appropriate controls are in place to ensure the accuracy of data, these are described below and demonstrate that

there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

Governance and leadership of quality reporting

- Quality metrics are reviewed monthly by Trust Board and the EMT, alongside the performance reviews undertaken by BDUs as part of their governance structures.
- The integrated performance report covers substantial quality and performance information and is reported to the Board and EMT. This is supplemented by detailed reports on specific elements of quality, such as incidents, complaints and patient experience.
- The Clinical Governance and Clinical Safety Committee oversee the development of the Quality Report and associated detailed reports.
- Corporate leadership of data quality through the Director of Finance & Resources, supported by the Director of Nursing and Quality.
- Data quality objectives that are linked to business objectives, supported by the Trust's Data Quality Policy and evidenced through the Trust's Information Assurance Framework.
- The commitment to, and responsibility for, data quality by all staff is clearly communicated through Trust induction, mandatory training for information governance and training for the Trust's clinical information systems.
- The SystmOne optimisation programme has been managed with input from the Improving Clinical Information and Information Governance Group (ICIG) and with significant governance via the programme board, and Executive Management Team.
- The Director of Nursing and Quality (Caldicott Guardian) and Director of Finance & Resources (SIRO) co-chair the Trust-wide Improving Clinical Information and Information Governance (ICIG) meeting. The group ensures there is a corporate framework for management and accountability of data quality, with a commitment to secure a culture of data quality throughout the organisation.
- The effectiveness of the Trust's arrangements is scrutinised by the Audit and Clinical Governance & Clinical Safety Committees.

Role of policies and plans in ensuring quality of care provided

- Good clinical record keeping is part of good clinical practice and provision of quality care to the people who use our services.
- There is comprehensive guidance for staff on data quality, collection, recording, analysis and reporting which meets the requirements of national standards, translating corporate commitment into consistent practice, through the Data Quality Policy and associated information management and technology policies.
- There are performance and information procedures for all internal and external reporting. Mechanisms are in place to ensure compliance through the ICIG with reports to the Audit and Clinical Governance and Clinical Safety Committees on data quality.

Commented [WR13]: Do we need to say anything about data quality audits?

Commented [LA14R13]: Will address for future version

Systems and processes

- There are systems and processes in place for the collection, recording, analysis and reporting of data which are accurate, valid, reliable, timely, relevant and complete through system documentation, guides, policies and training.
- Corporate security and recovery arrangements are in place with regular tests of business critical systems. These systems and processes are replicated Trust-wide.

Commented [WR15]: Do we need to say anything about cyber security and the steps we take on this?

Commented [LA16R15]: Will address for future version

People and skills

- Behaviours that reflect the Trust values and the necessary skills are essential elements of good data quality, recording and reporting and compliance with policy.
- Roles and responsibilities in relation to data quality are clearly defined and documented.
- There is a clear training plan for Information Governance and the Trust's clinical information systems (SystmOne and a small number of additional systems) with the

provision of targeted training and support to ensure responsible staff have the necessary capacity and skills.

Data use and reporting

- Data provision is reviewed regularly to ensure it is aligned to the internal and external needs of the Trust through the Executive Management Team meeting and Trust Board, with key performance indicators set at both service and Board level. This includes identification of any issues in relation to data collection and reporting and focussed action to address such issues

The Trust is committed to a continual improvement in the quality of its data in order to support improvement of the service it offers to users of its services and to meet its business needs. Regular reviews of the quality of the Trust's clinical data are undertaken by the ICIG and, where data quality standards are identified as a risk factor, these are reported to the Trust's Senior Information Risk Owner (SIRO) for further investigation.

A time limited group of the Trust Board reviewed the Integrated Performance Report (IPR) and made a number of recommendations to the Trust Board to streamline and improve it, which were agreed and were implemented from 30 March 2021.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the clinical governance and clinical safety committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The BAF provides evidence that the effectiveness of controls put in place to manage the risks to the organisation achieving its principal objectives have been reviewed. The BAF is approved by Trust Board on an annual basis and reviewed and updated on a quarterly basis throughout the year. There were no significant gaps identified in the BAF.

Directors' appraisals are conducted by me in my role as the Chief Executive with objectives reviewed regularly and monthly meetings on business delivery and progress. This has provided a good discipline and focus for Director performance. My appraisal is undertaken by the Chair. Non-Executive Director appraisals are undertaken by the Chair of the Trust. The Non-Executives' performance is collectively reviewed by the Members' Council. The appraisal of the Chair is led by the Senior Independent Director and reports to the Members' Council on the outcome.

The Trust has refined its values-based appraisal system for staff with a target for all staff in Bands 6 and above to have an appraisal in the first quarter of the year and the remainder of staff by the end of the second quarter. The Trust also uses values-based recruitment and selection. During 2019/20, approximately 95% of staff had an appraisal.

Commented [BM17]: Comment to be added in regarding approach for 2020/21

Commented [LA18R17]: Will address for future version

All Committees of Trust Board are chaired by Non-Executive Directors to reflect the need for independence and objectivity, ensuring that effective governance and controls are in place. The Committees have met regularly throughout the year and their minutes and annual reports are received by the Board. During the Covid-19 pandemic, some Committees have operated

with a reduced agenda. This is reported to the Board and reviewed regularly as part of the interim governance arrangements. Further information on Trust Board Committees is contained in the annual report and in the Trust's Risk Management Strategy.

The Audit Committee is charged with monitoring the effectiveness of internal control systems on behalf of the Board and has done so as part of its annual work programme. This was reported through its Annual Report to the Board. The Audit Committee was able to provide assurance that, in terms of the effectiveness and integration of risk committees, risk was effectively managed and mitigated. Assurance was provided that Committees met the requirements of their Terms of Reference, that Committee work programmes were aligned to the risks and objectives of the organisation, in the scope of their remit, and that Committees could demonstrate added value to the organisation. Areas of development identified in the last Audit Committee annual report have been acted upon.

The role of internal audit at the Trust is to provide an independent and objective opinion to the Trust, its managers and Trust Board on the system of control. It provides a Head of Internal Audit opinion each year. The opinion considers whether effective risk management, control and governance arrangements are in place in order to achieve the Trust's objectives. The work of internal audit is undertaken in compliance with the NHS Internal Audit Standards. The internal audit function within the Trust for 2020/21 was provided by 360Assurance.

The work undertaken by internal audit is contained in an annual audit plan approved by the Audit Committee. Development of the work programme involves pre-discussion with the EMT. It is based on an audit of core activity around areas such as financial management, corporate governance and Board assurance processes, and audit of other areas following assessment and evaluation of risks facing the Trust. This includes priority areas identified by the EMT focusing on risk and improvement areas. Internal audit provides the findings of its work to management, and action plans are agreed to address any identified weaknesses. Internal audit findings are also reported to the Audit Committee for consideration and further action if required. A follow up process is in place to ensure that agreed actions are implemented. Internal audit is required to identify any areas at the Audit Committee where it is felt that insufficient action is being taken to address risks and weaknesses.

In respect of the internal audit plan for 2020/21, 10 internal audit reviews have been conducted and presented to the Audit Committee. Of these, there were 5 significant assurance opinions, 3 were advisory audits with no rating provided and the other 2 provided limited assurance opinions.

Action plans are developed for all internal audit reports in response to the recommendations and the Audit Committee invites the lead Director for each 'limited' or 'no assurance' report to attend to provide assurance on actions taken to implement recommendations. For all 'limited' and 'no assurance' reports, a follow up audit is undertaken within twelve months. Completion of recommended actions is tracked by the Audit Committee and over the course of the year 79% of actions were completed within the original time frame specified and 98% of all recommendations have been completed

The Head of Internal Audit's overall opinion for 2020/21 provided **significant assurance**' that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Conclusion

I have reviewed the relevant evidence and assurances in respect of internal control. The Trust, its Board and members of the leadership and management structure are alert to their

accountabilities in respect of internal control. Throughout the year, the Trust has had processes in place to identify and manage risk.

The review confirms that the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives. I can confirm that my review has concluded no significant control issues have been identified. A small number of internal control issues outlined in this statement are not considered significant. I can confirm that those control issues have been or are being addressed.

Over the past year, the Trust has delivered its business in a context of significant change and challenges brought about by the Covid-19 pandemic. During this time, the system of internal control has remained robust and enabled change and risk to be managed effectively.

The Covid-19 outbreak meant changes to the operations of the Trust. These were conducted in line with the Trust constitution, its Standing Orders and Standing Financial Instructions. The system of governance was adhered to, with decision making always in line with powers of delegation and authority. Weekly assessments of the decision made through the Gold Command structure were appraised by non-executive members of the Board each week at the peak of the pandemic.

As we enter 2021/22, the Trust has therefore entered the recovery phase which will require ongoing monitoring for its impacts and risks in our systems. We will continue to ensure that the principles of good governance and effective controls are maintained throughout.

Rob Webster
Chief Executive Date:

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 12.2

Title:	**Going Concern Basis**
Paper prepared by:	Director of Finance and Resources
Purpose:	To enable the Board to make a decision that the 2020/21 accounts and financial statements are prepared on a going concern basis.
Mission / values:	Use of resources.
Any background papers / previously considered by:	Regular finance report provided at each Board meeting. Detailed finance and planning reports provided at the monthly Finance, Investment & Performance Committee.
Executive summary:	• There is a requirement for the directors of an organisation to confirm whether or not it is appropriate for the accounts of that organisation to be prepared on a "going concern" basis. • The auditors of the Trust are required to evaluate the management's adoption of the going concern basis and their assessment of any material uncertainties that may require disclosure. • For 2021/22 The Public Audit Forum has updated and simplified guidance on assessing going concern in its publication 'Practice note 10'. • It has been determined that 'Practice Note 10' applies to the NHS. This means that the anticipated continued provision of service is a sufficient basis for going concern. • This is supported in the newly updated NHS foundation trust annual reporting manual (FT ARM) and the HM Treasury Financial Reporting Manual (FReM). • This position is also confirmed in a letter received from NHSE/I on the 1st April 2021 from Adrian Snarr, Director of Financial Control. • The impact of this change is that the usual financial assurance will not be included in this paper. Instead, the focus will be on the evidence of an annual plan. • Despite delays in the process due to Covid-19, the Trust is currently developing plans for the next financial year, in collaboration with relevant NHS partners. It is therefore expecting to continue to provide services for the foreseeable future. • A separate paper has been provided on the financial plan for the first half of 2021/22 and Board members have had the opportunity to engage with the submission of the draft plan and ratify it • The draft financial plan for the first half of 2021/22 is for a break-even position, which looks achievable based on the assumptions made and recent financial performance

Recommendation:	**Trust Board is asked to APPROVE the preparation of the 2020/21 annual accounts and financial statements on a going concern basis by adopting the following statement:** ***'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'***
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Going Concern Basis

Introduction

There is a requirement for the directors of an organisation to confirm whether it is appropriate for the accounts of an organisation to be prepared on a "going concern" basis. The auditors of the Trust are expected to evaluate the management's adoption of the going concern basis and their assessment of any material uncertainties that may require disclosure.

For 2021/22 The Public Audit Forum has updated and simplified guidance on assessing going concern.

The basis for this change, as explained in the correspondence from Adrian Snarr, director of financial control at NHSE/I, is reproduced below.

"The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. Its publication 'Practice Note 10'1 was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern. This is the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation trust annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies."

The NHS foundation trust annual reporting manual has also been updated to reflect this change. The main point is captured in the quote below.

"An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the service it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise."

The (FT ARM) goes on to clarify that

"Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept."

For the reasons given above, the Trust no longer has to provide evidence regarding financial sustainability, as has been the case in previous years. This is covered in in risk disclosures and other performance reports. The section below, will instead, focus on the organisation's planning process.

The impact of Covid-19 has delayed the usual planning process, however the finance and operational teams of the organisation are currently engaged in developing a plan with internal and external NHS partners. The plan will be complete for submission by May 6th. For 2021/22 the Trust has initially been asked to develop a firm plan for the first half of the year and internally is developing an expenditure plan for the full year. There is no reason tom suggest that income in the second half of the year will be materially different from the first half. Indications are that there is likely to be a return to some level of efficiency requirement in the second half of the year (circa

1%). A separate paper is provided to Board members on this topic. This plan is based on the assumption that services provided by the Trust will continue for at least the next twelve months. This meets the condition, outlined above, that the organisation is expected to deliver services for the foreseeable future.

It is worth noting that the plan for the first half of 2021/22 is for a break-even position. This follows the generation of a surplus of £4.2m in 2020/21, with a cash balance at the end of March 2021 of just over £56m.

Directors should consider all available information about the future when concluding whether the company is a going concern at the date, they approve the financial statements. Their review should usually cover a period of at least twelve months from the date of approval of annual and half-yearly financial statements;

Directors should make balanced, proportionate and clear disclosures about going concern for the financial statements to give a true and fair view.

Directors should disclose if the period that they have reviewed is less than twelve months from the date of approval of annual and half-yearly financial statements and explain their justification for limiting their review.

It should be noted that as per section 2.1*3* of the foundation trust annual reporting manual there is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis, taking into account best estimates of future activity and cash flows.

Section 2.14 of the annual reporting manual does state 'The anticipated continuation of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.''

Recommendation

Given the above it is considered appropriate the Trust continues to report on a going concern basis. It is therefore recommended the Trust Board approves the following statement for inclusion in the 2020/21 annual report:

'***'After making enquires, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.'***

[1] https://www.public-audit-forum.org.uk with link to Practice Note 10 document at bottom of page

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 12.3

Title:	**Committee Membership changes for 2021/22**
Paper prepared by:	Chair
Purpose:	The purpose of this paper is: • To provide assurance to Trust Board that following changes to Board membership, its committees operate effectively and meet the requirements of their terms of reference. • This paper precedes the Audit Committee Annual Report and board members are asked to note the changes to committee membership as described in the documents attached.
Mission / values:	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals and maintain a sustainable and viable organisation.
Any background papers / previously considered by:	The proposals for each committee were considered at the following meetings: • Executive Management Team on the 15th April 2021 • Nominations Committee on the 6th April 2021
Executive summary:	Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board committees are required to produce an annual report and an annual work programme, undertake an annual self-assessment, and review their terms of reference for relevance and appropriateness. Following the above review, and due to the departure of two non-executive and one executive director over the next three months, the chair is proposing the revised memberships of the Board committees as per the attached documents from 1 May 2021 and 1 August 2021 respectively. At the EMT meeting it was identified that the Director of Nursing and Deputy Chief Executive currently attends five committee meetings and some thought is being given to determine if this can be reduced.

	Risk Appetite The committees are fulfilling their terms of reference; and integration between committees avoids duplication.

Recommendation:	**Trust Board is asked to:**
	• **RECEIVE the attached proposals from the Chair as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:**
	  ○ **committees meeting the requirements of their Terms of Reference;**
	• **APPROVE the update to the Membership for the:**
	  ○ **Audit Committee;**
	  ○ **Mental Health Act Committee;**
	  ○ **Clinical Governance and Clinical Safety Committee;**
	  ○ **Workforce and Remuneration Committee;**
	  ○ **Equality and Inclusion Committee;**
	  ○ **Finance, Investment & Performance Committee**

Private session:	Not applicable.

Trust Board and Corporate Trustee committee membership
(from 1 May 2021)

South West Yorkshire Partnership NHS Foundation Trust

	Audit Committee	Clinical Governance & Clinical Safety Committee	Equality & Inclusion Committee	Mental Health Act Committee	Workforce & Remuneration Committee	WYMHLDASC Committees in Common	Finance, Investment & Performance Committee	Charitable Funds Committee (committee of the Corporate Trustee)
Angela Monaghan		Member	**Chair**		Member	Member		Member
Natalie McMillan		**Chair**			Member		Attends	
Mike Ford	**Chair**		Member					Member
Chris Jones	Member		Member				**Chair**	
Erfana Mahmood			Member	Member				**Chair**
Kate Quail		Member		**Chair**			Member	
Samantha Young	Member				**Chair**		Member	
Rob Webster			Member		Member (NV)	Member **(LD)**	Member	
Tim Breedon		Member **(LD)**	Member	Member			Member	Member
Dr Subha Thiyagesh		Member		Member **(LD)**			-	
Mark Brooks	Attends **(LD)**						Member **(LD)**	
Alan Davis		Member	Member		Attends **(LD)**			
Carol Harris		Attends		Member			Attends	
Sean Rayner								
Salma Yasmeen			Member **(LD)**					Member **(LD)**
Andy Lister	Attends							
QUORUM	**2 NEDs**	**2 NEDs, LD & 1 ED**	**1/2 Members inc. 1 NED & 1 ED**	**2 NEDs, LD & 1 ED**	**2 NEDs**	**1 Member**	**2 NEDs & 2 EDs**	**3 Members**

Non-Executive Director (NED)
Executive Director
Executive Director (non-voting)
Company Secretary
LD Lead Director
NV Non-voting committee member

WYMHLDA SC – West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative

Members' Council, ICS/ICP and other Trust Board roles

NHS South West Yorkshire Partnership NHS Foundation Trust

	Members' Council	Members' Council Coordination Group	Members' Council Quality Group	Nominations' Committee	ICS/ICP and Other Trust Board Roles *(ICS/ICP roles shown in italics)*
Angela Monaghan	**Chair**	Member		**Chair**	*WYHHCP Partnership Board; SYBICS Collaborative Partnership Board; Barnsley Integrated Care Partnership Group; SYB MHLDA Alliance; WYH Climate Change Steering Group;*
~~Charlotte Dyson~~	~~Attends~~	~~Member~~			~~Patient Safety;~~
Natalie McMillan	Attends				Patient Safety;
Mike Ford	Attends				
Chris Jones	Attends	Member			Deputy Chair; Senior Independent Director; FTSUG Lead; MHPS investigations
Erfana Mahmood	Attends				
Kate Quail	Attends				
Samantha Young	Attends				Staff Wellbeing Lead
Rob Webster	Attends			Attends	
Tim Breedon	Attends		**Chair**		
Dr Subha Thiyagesh	Attends				
Mark Brooks	Attends				
Alan Davis	Attends			Attends	
Carol Harris	Attends				
Sean Rayner	Attends				
Salma Yasmeen	Attends				
Andy Lister	Attends	Attends		Attends	

Non-Executive Director (NED)
Executive Director
Executive Director (non-voting)
Company Secretary

Trust Board and Corporate Trustee committee membership
(from 1 August 2021)

South West Yorkshire Partnership NHS Foundation Trust

	Audit Committee	Clinical Governance & Clinical Safety Committee	Equality & Inclusion Committee	Mental Health Act Committee	Workforce & Remuneration Committee	WYMHLDASC Committees in Common	Finance, Investment & Performance Committee	Charitable Funds Committee (committee of the Corporate Trustee)
Angela Monaghan		Member	**Chair**		Member	Member		Member
Natalie McMillan		**Chair**			Member		Member	
Mike Ford	**Chair**		Member					Member
Chris Jones	Member		Member				**Chair**	
Erfana Mahmood			Member	Member				**Chair**
Kate Quail		Member		**Chair**			Member	
New NED	Member			Member	**Chair**			
Rob Webster			Member		Member (NV)	Member **(LD)**	Member	
Director of Nursing & Quality		Member **(LD)**	Member	Member			Member	Member
Dr Subha Thiyagesh		Member		Member **(LD)**			-	
Mark Brooks	Attends **(LD)**						Member **(LD)**	
Alan Davis		Member	Member		Attends **(LD)**			
Carol Harris		Attends		Member			Attends	
Sean Rayner								
Salma Yasmeen			Member **(LD)**					Member **(LD)**
Andy Lister	Attends							
QUORUM	**2 NEDs**	**2 NEDs, LD & 1 ED**	**1/2 Members inc. 1 NED & 1 ED**	**2 NEDs, LD & 1 ED**	**2 NEDs**	**1 Member**	**2 NEDs & 2 EDs**	**3 Members**

Non-Executive Director (NED)
Executive Director
Executive Director (non-voting)
Company Secretary
LD Lead Director
NV Non-voting committee member

WYMHLDA SC – West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative

Members' Council, ICS/ICP and other Trust Board roles

South West Yorkshire Partnership NHS Foundation Trust

	Members' Council	Members' Council Coordination Group	Members' Council Quality Group	Nominations' Committee	ICS/ICP and Other Trust Board Roles *(ICS/ICP roles shown in italics)*
Angela Monaghan	**Chair**	Member		**Chair**	*WYHHCP Partnership Board; SYBICS Collaborative Partnership Board; Barnsley Integrated Care Partnership Group; SYB MHLDA Alliance; WYH Climate Change Steering Group;*
Natalie McMillan	Attends				Patient Safety;
Mike Ford	Attends				
Chris Jones	Attends	Member			Deputy Chair; Senior Independent Director; FTSUG Lead; MHPS investigations
Erfana Mahmood	Attends				
Kate Quail	Attends				
~~Samantha Young~~	~~Attends~~				~~Staff Wellbeing Lead~~
New NED	Attends				Staff Wellbeing Lead
Rob Webster	Attends			Attends	
Tim Breedon	Attends		**Co-Chair**		
Dr Subha Thiyagesh	Attends				
Mark Brooks	Attends				
Alan Davis	Attends			Attends	
Carol Harris	Attends				
Sean Rayner	Attends				
Salma Yasmeen	Attends				
Andy Lister	Attends	Attends		Attends	

Non-Executive Director (NED)
Executive Director
Executive Director (non-voting)
Company Secretary

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 12.3

Title:	**Audit Committee Annual Report 2020/21 including updated Terms of Reference for Trust Board committees**
Paper prepared by:	Director of Finance & Resources
Purpose:	The purpose of this paper is: • To provide assurance to Trust Board that its committees operate effectively and meet the requirements of their terms of reference. • Make suggested improvement to Board and sub-committee arrangements. • Support the Annual Governance Statement of the Trust.
Mission / values:	A strong and effective Board and committee structure enables the Trust to achieve its vision and goals, and maintain a sustainable and viable organisation.
Any background papers / previously considered by:	The annual reports of each committee were considered at the following meetings: • Audit Committee 13 April 2021. • Clinical Governance & Clinical Safety Committee 9 February 2021 • Equality & Inclusion Committee 2 March 2021 • Finance, Investment & Performance Committee 22 March 2021 • Mental Health Act Committee 9 March 2021 • Workforce & Remuneration Committee 9 February 2021 The final annual reports of each committee were considered by the Audit Committee on 13 April 2021.
Executive summary:	The Audit Committee is required under its terms of reference to review other risk Committees' effectiveness and integration to provide assurance to Trust Board that: • risk is effectively managed and mitigated within the organisation; • Committees are fulfilling their terms of reference; and • integration between Committees avoids duplication. The Committee agreed to combine this process with the production of the Annual Governance Statement (AGS). Trust Board committees are responsible for scrutiny and providing assurance to Trust Board on key issues within their terms of reference. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met, and to address and mitigate risk. As part of this process of assurance to Trust Board and as part of development of the AGS annually, Trust Board committees are required to produce an annual report and an annual work

	programme, undertake an annual self-assessment, and review their terms of reference for relevance and appropriateness. The Audit Committee received the annual report, work programme, and updated Terms of Reference approved by each committee at its meeting in April. The reports were supported by each committee Chair and lead Director to provide assurance to in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees. A summary is contained within the Audit Committee annual report to Trust Board. Updated committee Terms of Reference are provided for the final approval of Trust Board The impact of Covid-19 on the operation of committees during 2020/21 was reported by each Committee and any revised governance arrangements, particularly during the early part of the year, were noted. The Audit Committee and Trust Board regularly received update reports regarding any revised governance arrangements during the course of the year. Reports on the effectiveness of the Charitable Funds Committee and West Yorkshire Mental Health, Learning Disability and Autism Committees in Common will be received later in the year. **Risk Appetite** The review of committees' effectiveness and integration to provide assurance to Trust Board that risk is effectively managed and mitigated within the organisation; committees are fulfilling their terms of reference; and integration between committees avoids duplication.

Recommendation:	**Trust Board is asked to:**
	• **RECEIVE the annual report from the Audit Committee as assurance of the effectiveness and integration of risk committees, and that risk is effectively managed and mitigated through:**
	  ○ **committees meeting the requirements of their Terms of Reference;**
	  ○ **committee work programmes are aligned to the risks and objectives of the organisation within the scope of their remit; and**
	  ○ **committees can demonstrate added value to the organisation.**
	• **APPROVE the update to the Terms of Reference for the:**
	  ○ **Audit Committee;**
	  ○ **Mental Health Act Committee;**
	  ○ **Clinical Governance and Clinical Safety Committee;**
	  ○ **Workforce and Remuneration Committee;**
	  ○ **Equality and Inclusion Committee;**
	  ○ **Finance, Investment & Performance Committee**

Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021

Audit Committee Annual Report 2020/21

1. Purpose of report

The purpose of the report is to provide a summary of the Audit Committee's activities during the financial year 2020/21, and to provide assurance and evidence to Trust Board of its effectiveness and impact through compliance with its Terms of Reference.

2. Terms of Reference and Audit Committee duties

The Audit Committee is a formal Committee of Trust Board, which provides the Board with assurance that the Trust is discharging its responsibilities in relation to the following.

- The establishment and maintenance of effective systems and processes that provide internal control within the organisation, particularly, review of all risk and control related disclosure statements, such as the Annual Governance Statement and value for money audit opinion.
- The effectiveness of the governance arrangements that cover evidence of achievement of corporate objectives and the adequacy of the assurance framework.
- The effectiveness of policies and processes to ensure compliance with regulatory frameworks, including Monitor's (referred to as NHS Improvement's) risk assessment framework.
- The effectiveness of systems of internal control for the management of risk including the risk strategy, risk management systems and the risk register.
- The effectiveness of policies and procedures to prevent and manage fraud and compliance with regulatory requirements monitored through the Counter Fraud and Security Management Service.
- Overview of the work of other Committees to provide Trust Board with assurance in relation to the overall effectiveness of governance arrangements through the committee structure.

Changes to Committee Terms of Reference

At its meeting on 13 April 2021, the Committee reviewed its Terms of Reference and any amendments were agreed and then recommended for final formal approval by the Trust Board on 27 April 2021.

Reporting to Trust Board

Under its terms of reference, the Audit Committee is required to produce a brief annual report on its activities, which is presented formally to Trust Board. The Committee's minutes are presented to the Trust Board once ratified.

Membership

The Committee is made up of Non-Executive Directors and members from 1 April 2019 to 31 March 2020 were as follows.

Name/role	Attendance 2020/21
Laurence Campbell, Non-Executive Director - Committee chair up to and including July Audit Committee meeting	3 / 3
Mike Ford, Non-Executive Director – Committee chair from the October Audit Committee meeting onwards	3 / 3
Chris Jones, Non-Executive Director	6 / 6
Sam Young, Non-Executive Director	4 / 6

The Director of Finance and Resources attends as lead Director.

3. Review of Audit Committee activities

The Audit Committee's activities during the year have been cross referenced to its Terms of Reference.

3.1 Governance, risk management and internal control

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation.

	Progress
Review all risk and control related disclosures, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances.	As part of its consideration of the annual report, and accounts, the Committee received and recommended for approval the Chief Executive's Annual Governance Statement for 2019/20. The Committee also received the statement from external audit for those with responsibility for governance in relation to 2019/20 and the Head of Internal Audit opinion.
Review underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principle risks and the appropriateness of the disclosure statements (above), including the fitness for purpose of the assurance framework.	The Committee was presented with the external audit plan in February 2020. Significant audit risks were outlined as follows. - Management override of controls - Revenue recognition of NHS revenue These were noted by the Committee and the Trust's annual report will specifically outline the management action to address these risks, explaining the mitigating action in place to address the risks or, where appropriate, an explanation as to why the Trust does not consider these to be risks, and explaining its tolerance of any residual risk. The Trust Board has agreed to conduct the full process to develop the Board Assurance Framework (BAF), which is presented quarterly to Trust Board. As such the fitness for purpose of the BAF is currently covered at Trust Board
Review policies and processes for ensuring compliance with relevant regulatory, legal or code of conduct requirements, including the Monitor risk assessment framework.	The Committee last reviewed and approved the Treasury Management Policy and Strategy in October 2019 as part of the two year cycle. An update is provided at each Committee meeting. The Committee last reviewed the Trust Scheme

	Progress
	of Delegation in January 2021, and Risk Management Strategy in April 2019 and supported their approval by Trust Board. Review of the Risk Management Strategy was deferred in 2020 as part of the response to Covid-19. They will next be due for review in 2022 and 2021 respectively. The Committee reviewed the Standing Financial Instructions in October 2019 and supported their approval by Trust Board. Review was deferred in 2020 as part of the response to Covid-19. They will next be due for review in 2021.
Review the systems for internal control, including the risk management strategy, risk management systems and the risk register.	Approval of the Trust's Risk Management Strategy is a matter reserved for Trust Board. It was last reviewed and approved by Trust Board in April 2019. The Committee receives a report at each meeting on the triangulation of risk, performance and governance, which provides assurance that all key strategic risks are captured by the risk management process, that risks are appropriately highlighted and managed through governance committees and operational meetings, and there is a clear link between risk management and identifying areas of poor performance by the cross-reference of performance reporting to the risk register. The Committee finds this report particularly helpful in supporting scrutiny of performance and risk through Trust Board. During the early stages on the Covid-19 pandemic this report was not considered at the Audit Committee to enable management to focus on the response to the pandemic and also due to the fact not all documents used in the triangulation have been fully updated during the pandemic. Reporting recommenced in October 2020. The corporate / organisational risk register is reviewed quarterly by Trust Board and risks aligned to the Committee are reviewed at each meeting.
Review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.	See section 3.3.
Review the work of other Committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.	See section 4.2.
Review the arrangements that allow Trust staff to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.	Updates in relation to 'whistleblowing' arrangements and Freedom to Speak Up Guardians are provided to the Clinical Governance and Clinical Safety Committee.

3.2 Internal Audit

The Committee shall consider the appointment of the internal auditor (for approval by Trust Board) and ensure that there is an effective internal audit function, established by management, that meets Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chair, Chief Executive and Trust Board.

	Progress
Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.	Through a procurement framework and tender process, 360Assurance was appointed as the Trust's internal auditor from 1 July 2017. Under the Public Sector Internal Audit Standards, all internal audit service providers are required to develop an internal audit charter, which is a formal document that defines the activities, purpose, authority and responsibilities of internal audit at the Trust. It also ensures the internal audit service provided to the Trust meets the requirements of both Professional Internal Auditing Standards and 360Assurance's own Internal Audit Manual. The contract with 360Assurance is for a maximum of five years, with a break clause after three years. The performance of 360Assurance was evaluated and the Committee agreed to continue to use them for the full five year duration of the contract.
Review and approval of the Internal Audit strategy and programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.	The Internal Audit Annual Plan for 2020/21 was presented to and approved by the Committee in April 2020. This followed a period of engagement with the Chair of the Audit Committee and Director of Finance. The plan provides a risk-based analysis of the Trust's operations, utilising the Trust Board assurance framework, reflecting the Trust's corporate objectives, priorities and areas identified for improvement. Progress against the plan is reviewed at every meeting and this includes reports on the Trust's progress against actions identified to address recommendations made by internal audit. Regular meetings are held between the Head of Internal Audit and Director of Finance to monitor progress against the work plan.
Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources.	The Audit Committee reviewed and received the Head of Internal Audit Opinion as part of the final accounts process for 2019/20. This provided significant assurance. The Audit Committee has reviewed and received phase 1,2 and draft final reports regarding the development of the Head of Internal Audit Opinion for 2020/21. The Committee receives audit reports and audit findings in line with the audit plan. The recommendations are followed up to ensure actions are taken in line with the action plans agreed. A number of audits have been deferred during the year given the organisational response to Covid-19. At the time of writing this initial draft report for the 2020/21 programme, 10 internal audit reports have been completed and presented to the Committee. Of these, there were:

	Progress
	- 5 'significant assurance' reports; - 3 'advisory' reports - 2 'limited assurance' reports Completion of a further 3 reports is expected during the year-end process and will be provided to the Audit Committee in May. Management action has been agreed for all recommendations. These are reported to the Committee and, where appropriate, progressed by 360Assurance. In the main, there are no significant outstanding actions. An additional bespoke piece of work has been conducted by internal audit and reported separately to a private session of the Audit Committee.
Ensure the Internal Audit function is adequately resourced and has appropriate standing in the organisation.	The ongoing adequacy of resources is assessed as part of the review of the internal audit plan and monitoring progress. No significant issues have been raised in-year.
An annual review of the effectiveness of internal audit.	Performance is reported to the Committee through the internal audit progress report at each meeting and a summary included in the internal audit annual report. In previous years the Committee and other relevant staff have also completed an established internal audit questionnaire to obtain feedback on the performance of internal audit. This exercise has not been conducted during 2020/21 due to the Covid-19 pandemic. During 2019/20 a more extensive review took place as part of the evaluation to determine whether the contract with 360Assurance should continue beyond the initial three years.

3.3 Counter Fraud

The Committee shall review the policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service. The Committee shall also review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Counter Fraud Authority Standards for Providers and as required by the NHS Counter Fraud Authority.

	Progress
Consideration of the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal.	Through a procurement framework and tender process, Audit Yorkshire was appointed as the Trust's Local Counter Fraud Specialist from 1 July 2017.
Review the proposed work plan of the Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures.	Audit Yorkshire presented a programme of work to the Committee in May 2020, which was approved. The Committee receives a Counter Fraud update report at each meeting to identify progress and any significant issues for action.
Receive and review the annual report prepared	The Committee received a progress report from

	Progress
by the Local Counter Fraud Specialist.	the Local Counter Fraud Specialist at each meeting during 2020/21
Receive update reports on any investigations that are being undertaken.	These are included in the progress reports to the Committee.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to their work.

	Progress
Consideration of the appointment and performance of the External Auditor, as far as Monitor's rules permit.	Following a re-procurement exercise during 2020, the Members' Council approved a proposal to re-appoint Deloitte as the Trust's external auditor from 1 October 2020 for an initial period of three years with the ability to extend to up to five years. Members of the Audit Committee and the Deputy Lead Governor for the Members' Council were involved in the tender process.
Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Audit Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy.	The Audit Committee has received and approved the Annual Audit Plan in February 2021. Progress against the plan is monitored, where appropriate, at each meeting.
Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.	The fee for Deloitte was approved as part of the re-appointment process in 2020. A formal audit plan was presented to and approved by the Committee in February 2021. This included an evaluation of risk, which is summarised under section 3.1 above.
Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.	The Audit Committee received and approved: - the statement for those with responsibility for governance in relation to 2019/20 accounts; - final reports and recommendations as scheduled in the annual plan.
Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.	Deloitte has not been engaged to provide any non-audit services during 2020/21.

3.5 Financial reporting

	Progress
The Committee has responsibility for approving accounting policies.	The Committee considered and approved changes to accounting policies at its meeting in January 2021. These changes were supported by the Trust's external auditor. For 2020/21, changes are very minimal. Further guidance may be provided before the year-end, which will be communicated to the Audit Committee when available. The adoption of the changes included in IFRS 16 – accounting for leases has been deferred for a further year
The Committee has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and charitable Funds, and the Quality Accounts/Report and to make a recommendation	The Committee recommended to the Trust Board for approval the annual report and accounts for 2019/20 at its meeting in June 2020 prior to submission to NHS Improvement (Monitor). As part of the consideration of the auditor's

	Progress
to the Chair, Chief Executive and Director of Finance on the signing of the accounts and associated documents prior to submission.	report, the Committee received and reviewed the Use of Resources Assessment for 2019/20. Revised arrangements were put in place for the Quality Account in 2020/21 and these were reviewed and recommended for approval by the Clinical Governance and Clinical Safety Committee. The Committee also recommended for approval the stand-alone annual report and accounts for charitable funds in October 2020.
The Committee also ensures that the systems for, and content of, financial reporting to Trust Board are subject to review so as to be assured of the completeness and accuracy of the information provided.	The internal audit programme includes routine testing of the Trust's financial reporting systems; however, financial reporting and scrutiny remains with Trust Board and Finance, Investment and Performance Committee, including any review of the adequacy of reporting. The Committee reviewed and approved the Treasury Management Policy and Strategy in October 2019 and supported its approval by Trust Board. An update is provided at each Committee meeting. The next review and approval of the Policy and Strategy is scheduled for 2021. The Committee also receives a detailed report on procurement activity at each meeting, which monitors non-pay spend and progress on tenders, the use of single tender waivers, and progress against the Procurement Strategy and associated cost improvement programme. The Committee is also required, on behalf of Trust Board, to approve the methodology for determining the Trust's reference cost submission. The Committee received and reviewed the Use of Resources Assessment for 2019/20.
The Committee also: - reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation; - examines circumstances associated with each occasion Standing Orders are waived; - reviews the schedules of losses and compensations on behalf of Trust Board.	The Committee last reviewed the Standing Financial Instructions in October 2019 and supported their approval by Trust Board. They have not been reviewed during 2020 due to the Covid-19 pandemic and will instead be updated and reviewed during 2021. Changes to the Trust's Scheme of Delegation were considered by the Committee in January 2021 and it supported their approval by the Trust Board They will next be due for review in 2022. There were no occasions when Standing Orders were waived in 2020/21. The losses and special payments report is received by the Committee at each meeting.

4. Review of Audit Committee administrative arrangements

The Committee met the requirement for the number of meetings in the year and has been quorate at each meeting. An additional meeting was held in February 2021 to review and approve the external audit plan for 2020/21. Given the impact of Covid-19 all meetings were held virtually during the year. Agendas were reviewed regularly by the Chair of the Committee and Director of Finance. A small number of items were deferred in the early part of the year in response to the Covid-19 pandemic, but typically the work plan for the year has been fully adhered to.

The requirement to send papers out five working days prior to the meeting has been met throughout the year.

5. Audit Committee self-assessment

In line with the Terms of Reference, the Audit Committee has an agreed self-assessment process. The proforma used is that recommended by the Audit Committee Handbook. The self-assessment has eight sections:

- Composition, establishment and duties;
- Compliance with the law and regulations governing the NHS;
- Internal control and risk management;
- Internal audit;
- External audit;
- Annual accounts;
- Administrative arrangements
- Other issues

The self-assessment survey was completed by all three members of the Audit Committee and no significant issues were raised within it. Potential areas for future consideration raised in the survey included:

- Develop an understanding of how the internal quality assurance process works with the internal auditors
- Separate meeting for all Audit Committee members with internal and external auditors (currently just with the Committee Chair)
- Play a larger role in risk management and oversight of number of risks

The Terms of Reference have been approved by the Chair of the Committee and lead director. A small number of changes are recommended based on discussions with Internal Audit. These relate to attendance requirements of counter fraud, areas of focus for financial reporting and other assurance functions. The work programme for 2021/22 has been updated and agreed by the Chair of the Committee and lead director. This will be subject to regular review given the ongoing impact of the Covid-19 pandemic.

6. Governance assurance

6.1 Review of committee effectiveness

Each Committee has Terms of Reference and is required to produce an annual report outlining achievements against objectives and compliance with Terms of Reference. The annual reports, work programmes and updated terms of reference were provided to the Audit Committee to provide assurance to Trust Board.

6.2 Audit Committee review of the effectiveness of Trust Board committees

In April 2010, the Audit Committee agreed an approach and process to fulfilling its role to provide oversight and assurance to Trust Board on the effectiveness of the other sub-committees of the Board.

The committees assumed within scope of the Audit Committee review are:

- Clinical Governance and Clinical Safety Committee;
- Equality and Inclusion Committee;
- Mental Health Act Committee;
- Workforce and Remuneration Committee;

- Finance, Investment and Performance Committee; and
- West Yorkshire Mental Health, Learning Disability and Autism Committees in Common

The Equality and Inclusion Committee was established as a formal Board Committee during 2019, having previously operated as a forum. Its first meeting as a Committee was in April 2019.

In 2019 the Trust added a Finance, Investment and Performance Committee, which first met in October 2019.

The West Yorkshire Mental Health, Learning Disability and Autism (MHLDA) Committees in Common has conducted a significant review of its terms of reference and memorandum of understanding in the past twelve months. Both documents have been presented to Trust Board.

The Committee's future focus is to ultimately prepare an annual report for the whole MHLDA programme across the ICS, which will encompass the work of the Committee in Common and those pieces of work that sit outside of its remit, and to build this into the future mechanics of the programme and will likely be produced at the end of the financial year.

The draft annual report, annual work programme and the outcome of self-assessments for these committees was provided to the Audit Committee on 13 April 2021 for 2020/21. The purpose of the review is for the Audit Committee to provide assurance to Trust Board that:

- each meets the requirements of its Terms of Reference;
- each work programme is aligned to the risks and objectives of the organisation, which are in the scope of its remit;
- each can demonstrate added value to the organisation.

The review is undertaken as part of formal Audit Committee business with committee chairs and lead Directors invited to present to provide assurance to the Audit Committee on the assurance each committee has provided to Trust Board in terms of meeting its terms of reference, in identifying and mitigating risk, and in integrating with other committees.

The Charitable Funds Committee has agreed it will conduct its effectiveness annual report and review of terms of reference and workplan at the same time as it conducts its annual report and accounts for Charitable Funds. This will be presented to the Corporate Trustee for Charitable Funds for sign off in September 2021.

<u>Audit Committee</u>
Chair – Mike Ford; Lead Director – Mark Brooks

Key areas highlighted for 2020/21 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 including cyber security
- 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
- Oversight of Board and Committee governance arrangements given the Trust response to Covid-19

- Approved the internal audit and counter fraud plans for 2020/21
- Regular review of organisational risks allocated to the Committee by the Trust Board

Clinical Governance and Clinical Safety Committee
Chair – Charlotte Dyson; Lead Director – Tim Breedon

Key areas highlighted for 2020/21 are:

- Delivering and adapting workplan during covid-19 pandemic and meeting via virtual means
- Review and action to ensure appropriate response to quality impact of covid-19 pandemic
- Oversight of the Care Quality Commission (CQC) improvement plan and the shift to a quality improvement approach
- Review and comment on the Quality Account
- Review and comment upon Infection Prevention Control board assurance framework
- Quarterly review of the serious incidents report and the annual incident report
- Review of key issues and reports 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 Information Group).
- Review the development of the Clinical Ethics advisory group to support the covid-19 response
- 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 across Trust services and integration with the Equality impact assessment process.
- Review of feedback and action plans in relation to Care Quality Commission MHA virtual visits.
- Review and scrutiny of Internal audit reports, with particular focus on customer services.
- Review of key clinical risks and allocated risk register entries.
- Receive updates on the progress being made in relation to the Patient Safety Strategy with a focus upon the suicide prevention plan
- Receipt and review of safer staffing report.
- Monitor and review of waiting lists in psychology services.
- Reviewed the learning disability mortality review

Equality & Inclusion Committee
Chair – Angela Monaghan; Lead Director – Tim Breedon

Key areas highlighted for 2020/21 are:

- Standing items on the agenda during the year were:
    - review of risks aligned to the Committee.
    - performance dashboard looking at a basket of key indicators for equality, diversity and inclusion. This is still in development and evolving.
    - review of progress made against the Workforce Race Equality Standards (WRES), Workforce Disability Equality Standards (WDES) and NHS Equality Delivery System (EDS2).
    - review of status on Trust equality impact assessments for services and policies.
    - verbal feedback from our four staff equality networks and business delivery unit (BDU) equality forums.

- updates on our inclusive leadership and development programmes.
- horizon scanning - update on relevant national, regional and local policy developments for context.

- The committee adapted its agenda during the year to meet the demands resulting from the Covid-19 pandemic, which meant that some of the standing items were shortened or deferred.
- The committee also:
  - received an update on progress against the previous Equality Strategy action plan.
  - supported the development of and then recommended the new 2020-2023 Equality, Involvement, Communication and Membership Strategy for approval by the Board.
  - following approval of the strategy by the Board, considered and approved the associated action plans for 2020-2022.
  - received an annual report on the Trust's Commitment to Carers.
  - considered equality and inclusion aspects of learning from the Trust's NHS staff survey and well-being at work survey.
  - received a report on the Trust's equality, inclusion and engagement review prior to adoption of the new strategy.
  - Reviewed our Equality and Diversity annual report prior to submission to the Trust Board.
- The Committee met all requirements set out in its terms of reference, including completing the annual self-assessment and report.
- In addition to the Committee members, meetings are regularly attended by representatives from the Trust's staff equality networks, staff side, Trust BDU equality forums, an elected governor, and staff from our equality and engagement team.

<u>Finance, Investment & Performance</u>
Chair – Chris Jones; Lead Director – Mark Brooks

Key areas highlighted for 2020/21 are:

- Regular review of financial performance and forecast within the temporary financial arrangements being used in 2020/21 as part of the response to the Covid-19 pandemic
- Received reports on the updates to financial arrangements for 20/21 and how they impact on Trust financial performance
- As part of the regular reporting mechanism reviewed the appropriateness of costs reclaimed as part of the Covid-19 response
- Received the service line financial reports for 2019/20
- Received a presentation on the development of the Trust data warehouse and internal dashboard that can be used for performance monitoring and benchmarking purposes
- Reviewed and approved the business case for the SBS financial and procurement ledger system and received regular reports on the progress of the implementation
- Reviewed the financial due diligence for the work being carried out for the adult secure lead provider collaborative
- Regularly reviewed the organisational risks allocated to the Committee by Trust Board
- Reviewed the progress being made on the development of the H.2 financial plan for the Trust to enable assurance to be provided to the Trust Board
- As part of regular reporting and forecasting reviewed the Trust's capital expenditure plans
- Received an in-depth review of CAMHS performance

Mental Health Act Committee
Chair – Kate Quail; Lead Director – Dr Subha Thiyagesh

Key areas highlighted for 2020/21 are:

- Mental Health Act monitoring reports, including mandatory Mental Health Act and Mental Capacity Act training compliance; Complaints compliments and concerns.
- Care Quality Commission Mental Health Act visit reports and action plans.
- Receipt of update reports from the work of the independent associate Hospital Managers and scrutiny of the processes and outcome of appeals and tribunals
- Hospital Managers' Forum.
- Local authority and acute hospital trust updates.
- 'The Act in Practice': 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
- Legal update and horizon scanning.
- Consideration of organisational risk register and MHAC Risk Register.
- Receipt and scrutiny of quarterly monitoring information and exception reports.
- Two new MHAC duties were agreed by Trust Board in September 2020, as part of the MHAC focus on reducing health inequalities and delivering person- centred care
- Consideration of the impact of Covid-19
- Oversight of Quality Improvement (QI) approaches
- Feedback and assurance from the MHA/ MCA Code of Practice Oversight Group on:
    a) 136 MHA policy b) Leave implementation group c) Seclusion and segregation

Workforce and Remuneration Committee (previously the Remuneration and Terms of Service Committee)
Chair – Sam Young; Lead Director – Alan Davis

Key areas highlighted for 2020/21 are:

- Regular Integrated Performance Reports including absence, bank and agency spend, recruitment and retention.
- COVID Integrated Performance Report including COVID and Non COVID Absence and actions, Vaccination Programmes for Flu and COVID.
- Review of the Workforce Support Hub in response to the pandemic.
- Staff Risk Assessments related to COVID including updates and roll out. Including the support for BAME Colleagues, appointment of BAME Health and Wellbeing Practitioner and appointment of Workforce Race Equality Standards Organisational Development Lead.
- Ratification of the Consultants Clinical Excellence Awards in line with national guidance in response to the pandemic.
- Regular review of the Workforce Risks and updating for COVID.
- Development sessions on the new Workforce Strategy including the link to Making South West Yorkshire Partnership NHS FT a Great Place to Work.
- Development of Board Succession Plan which was discussed by the Trust Board.
- Staff Wellbeing Report including results of the Trusts Wellbeing Survey undertaken in partnership with Robertson Cooper and actions in response.
- Review of the Trust's Disciplinary Procedure in line with national guidance.
- Agreed recruitment process for the Director of Nursing and Quality.
- Review of NHS Staff Survey Results and Actions.
- Review of Directors Objectives for 2021/2022.

- Annual report of Off Payroll Staff.
- Considered Draft Workforce Strategy 2021/2024.

The Audit Committee reviewed the documents and presentation on the work of the committees and considered if it was sufficient to enable the Chair of the Audit Committee to support an assurance to Trust Board that the integrated governance arrangements in the Trust were operating effectively and that committees:

- had met the requirements of their Terms of Reference;
- had followed a workplan aligned to the risks and objectives of the organisation, within the scope of each committee's remit; and
- could demonstrate added value to the organisation.

6.3 Independent review of the Trust's governance arrangements

In 2014, Monitor (now known as NHS England & Improvement) stated its expectation that all foundation trust boards would carry out an external review of their governance arrangements every three years. Monitor issued guidance to support Trusts in ensuring they are 'well-led,' which supported the NHS response to the Francis Report and was aligned with the assessment the Care Quality Commission (CQC) makes on whether a foundation trust was well-led as part of its revised inspection regime. In 2015/16, Deloitte undertook an independent review in line with the framework which included interviews and focus groups with Trust Board, key stakeholders, the Members' Council and staff. There were no 'material governance concerns' arising from the review, with a number of developmental areas recommended further work and an action plan developed. In 2016, an internal audit review of the action implementation as part of an audit on corporate governance arrangements received 'significant assurance'. In 2017, NHS Improvement aligned its well-led review to the CQC well-led key lines of enquiry. In April 2018, the CQC undertook a well-led review of the Trust which with the well-led domain rated as 'GOOD'.

In 2018/19, an internal audit review of governance was conducted to provide independent assurance of the robustness and effectiveness of the governance arrangements in place at Trust Board committee level; and undertake a deep dive of the Clinical Governance and Clinical Safety Committee which received 'significant assurance'.

In June 2019, CQC undertook a further well-led review and was rated as 'GOOD'.

Given the impact of the Covid-19 pandemic the CQC has not undertaken any well led reviews during 2020/21.

7. Conclusion

In summary, the Annual Report of the Audit Committee will be used as evidence the Committee has discharged its responsibilities in relation to its statutory obligations and Terms of Reference. This includes providing the Trust Board with assurance on the effectiveness of other committees which is part of the Audit Committee role in supporting integrated governance.

South West Yorkshire Partnership NHS Foundation Trust

AUDIT COMMITTEE
Terms of Reference
To be approved by Trust Board 27 April 2021

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Audit Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Audit Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Audit Committee's prime purpose is to keep an overview of the systems and processes that provide controls assurance and governance within the organisation as described in the Annual Governance Statement on behalf of Trust Board and that these systems and processes used to produce information taken to Trust Board are sound, valid and complete. This includes ensuring independent verification on systems for risk management and scrutiny of the management of finance. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
Taking guidance from Monitor (referred to as NHS England & Improvement) and the Department of Health into consideration, neither the Chair of the Trust or the Chief Executive attends this Committee unless invited to do so. The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors.

Membership as at 1 April 2021
Chair – Non-Executive Director – Mike Ford
Non-Executive Director - Chris Jones;
Non-Executive Director - Sam Young.

Attendance
The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Company Secretary also attends meetings. Representatives of internal and external audit are also invited and expected to attend. The local counter fraud specialist is required to attend a minimum of two meetings a year.

The Chair of the Trust, the Chief Executive, other Directors, and relevant officers attend the Audit Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Finance and Resources

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect best practice. The Chair of the Committee, External Auditor or Head of Internal Audit may request a meeting if they consider one is necessary. There will also be an additional meeting to approve the annual report, accounts and Quality Accounts.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation, and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain external legal or other independent professional advice and to secure the attendance of external bodies or individuals with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

<u>Governance, risk management and internal control</u>

The Committee shall review the establishment and maintenance of effective systems and processes that provide internal control within the organisation. In particular, the Committee will review the adequacy of:

- All risk and control related disclosure statements, in particular, the Annual Governance Statement and declarations of compliance with value for money assessments together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by Trust Board.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of management of principal risks and the appropriateness of the above disclosure statements. This includes assessing the fitness for purpose of the assurance framework including risk appetite and providing assurance that action plans are in place to address significant control issues.

- The policies and processes for ensuring compliance with relevant regulatory, legal and code of conduct requirements, including the NHS England & Improvement risk assessment framework.
- The systems for internal control including the risk management strategy, risk management systems and the risk register.
- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State's directions and as required by the Counter Fraud and Security Management Service.
- The work of other committees whose work can provide relevant assurance regarding the effectiveness of controls and governance arrangements.

In carrying out its work, the Committee will primarily utilise the work of Internal and External Audit; however, it will not be limited to these audit functions. It will also seek reports and assurances from Directors and managers concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. The Committee will use the Trust's Assurance Framework to guide its work and that of the audit and assurance functions reporting to it.

The Committee will also review arrangements that allow Trust staff (and other individuals where relevant) to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Committee will ensure that:

- Arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
- Ensure safeguards for those who raise concerns are in place and that these safeguards operate effectively.
- Such processes enable individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations and to ensure valid concerns are promptly addressed.
- These processes reassure individuals raising concerns that they will be protected from potential negative repercussions.

<u>Internal Audit</u>

The Committee shall consider the appointment of the Internal Auditor (for approval by Trust Board) and ensure there is an effective internal audit function established by management that meets Public Sector Internal Audit Standards, that provides appropriate independent assurance to the Audit Committee, Chief Executive, Chair and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation or dismissal.
- Review and approval of the Internal Audit approach, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework.
- Consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between internal and external auditors to optimise audit resources.
- Ensure the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- Annual review of the effectiveness of internal audit.

External audit

The Committee shall review the work and findings of the External Auditor appointed by the Members' Council and consider the implications and management's responses to its work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as NHS England & Improvement's rules permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the annual audit plan and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the External Auditors of its local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review of External Audit reports, including agreement of the annual audit letter before submission to Trust Board and any work carried on outside of the annual audit plan, together with the appropriateness of management responses.
- Review of each individual provision of non-audit services by the External Auditor in respect of its effect on the appropriate balance between audit and non-audit services.

The Committee will also advise the Members' Council with regard to the appointment and removal of the Trust's external auditors and, to inform this advice, carry out a market testing exercise for the appointment of the external auditor at least every five years.

Counter fraud

The Committee shall review the work and findings of the Local Counter Fraud Specialist as set out in the NHS Counter Fraud Authority Standards for Providers and as required by the NHS Counter Fraud Authority. In particular:

- Consider the appointment of the Trust's Local Counter Fraud Specialist, the fee and any questions of resignation or dismissal;
- Review the proposed work plan of the Trust's Local Counter Fraud Specialist ensuring that it promotes a pro-active approach to counter fraud measures;
- Receive and review the annual report prepared by the Local Counter Fraud Specialist;
- Receive update reports on any investigations that are being undertaken.

Financial reporting

The Committee has responsibility for approving accounting policies. It also has delegated authority from Trust Board to review the annual report and financial statements, both for the Trust and for charitable funds, and the Quality Accounts/Report on its behalf and to make a recommendation to the Chair and Chief Executive on the signing of the accounts and associated documents prior to submission to NHS England & Improvement, Trust Board and the Members' Council.

In particular, the Committee shall focus on:

- Changes in, and compliance with, accounting policies and practices.
- Major judgemental areas.
- Significant adjustments arising from the annual audit.
- The wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee.
- Unadjusted misstatements in the financial statements.
- Letters of representations.
- Explanations of significance variances.

The Committee also ensures that the systems for, and content of, financial reporting to Trust Board, including those of and for budgetary control, are subject to review so as be assured of the completeness and accuracy of the information provided to Trust Board.

The Committee also:

- Reviews proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation before these are laid before Trust Board;
- Examines the circumstances associated with each occasion Standing Orders are waived.
- Reviews schedules of losses and compensations on behalf of Trust Board.

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include any reviews by the Department of Health and Social Care, arms-length bodies, or regulators/inspectors (e.g. Care Quality Commission and NHS Improvement, NHS Resolution, etc) professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)

Relationship with the Members' Council

To reflect best practice and NHS England & Improvement's Code of Governance, Trust Board will consult with the Members' Council annually on the Audit Committee's terms of reference. At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either

through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

To be approved by Trust Board: 27 April 2021
Next review due: April 2022

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

CLINICAL GOVERNANCE AND CLINICAL SAFETY COMMITTEE
Terms of Reference
To be Approved by Trust Board 27 April 2021

All Trust Board Committees are responsible for scrutinising and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Clinical Governance and Clinical Safety Committee provides assurance to Trust Board on service quality and the application of controls assurance in relation to clinical services. It scrutinises the systems in place for effective care co-ordination and evidence-based practice and focuses on quality improvement to ensure a co-ordinated holistic approach to clinical risk management and clinical governance is in place, protecting standards of clinical and professional practice. On behalf of the Trust Board, it will have an oversight of clinical risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Clinical Governance and Clinical Safety Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors (NED) also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 1 April 2021:
Chair - Non-Executive Director - Charlotte Dyson (Deputy Chair / Senior Independent Director)
Non-Executive Director - Angela Monaghan (Chair of the Trust)
Non-Executive Director - Kate Quail
Lead Director - Director of Nursing and Quality – Tim Breedon
Medical Director - Dr Subha Thiyagesh
Director of Human Resources, Organisational Development and Estates - Alan Davis

Attendance
The Director of Operations and the Deputy Director of Nursing and Quality are in attendance at each meeting. Clinical representatives and relevant Trust officers are invited to meetings as appropriate to ensure the remit of the Committee is adequately covered. The Chief Executive, other Directors, and relevant officers attend the Clinical Governance and Clinical Safety Committee by invitation. Administrative support is provided by the Personal Assistant to the Director of Nursing and Quality.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of six times per year.

It is the responsibility of the lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Health and Safety;
- Drugs and Therapeutics (Medicines Management);
- Safeguarding (vulnerable adults and children);
- Infection Prevention and Control;
- Managing Aggression and Violence;
- Quality Network Improvement Group;
- Patient Safety Strategy Group;
- Clinical Ethics Advisory Group and
- Improving Clinical Information Group.

Duties

The Committee provides assurance to Trust Board on service quality, practice effectiveness and the application of controls assurance in relation to clinical services and ensures the Trust is discharging its responsibilities with regard to clinical governance and clinical safety.

<u>Strategy and policy</u>

1. To approve relevant strategies and policies on behalf of the Trust Board
2. To monitor implementation of strategic objectives relevant to clinical governance, care delivery and practice effectiveness, such as implementation of care management processes and clinical information management, providing assurance to Trust Board that these are appropriately managed and resourced.

Clinical governance

3. To provide assurance to Trust Board that appropriate and effective clinical governance arrangements are in place throughout the organisation through receipt of exception reports from relevant Directors to demonstrate that they have discharge their accountability for parts of their portfolios relating to clinical governance. This covers the areas of practice effectiveness, drugs and therapeutics, infection prevention and control, diversity, information governance and clinical documentation, managing violence and aggression, medical education, safeguarding children, research and development, compliance, and health and safety.
4. To provide assurance to Trust Board that the Trust is meeting national requirements for clinical governance and clinical safety.
5. To assure Trust Board that the Executive Management Team and Business Delivery Units have systems in place that encourage and foster greater awareness of clinical governance and clinical safety throughout the organisation, at all levels.

Compliance

6. To monitor, scrutinise and provide assurance to Trust Board on the Trust's compliance with national standards, including the Care Quality Commission, the quality elements relating to NHS Improvement (NHSI) and NICE guidance.
7. To provide assurance to the Trust Board that the Trust is compliant with relevant legislation.
8. To provide assurance that the Trust has effective arrangements for the prevention and control of infection, safeguarding adults and children, information governance and records management, and the safety elements covered by the Health and Safety TAG.

Clinical safety management

9. To provide assurance to the Trust Board that environmental risks, including those identified as a result of PLACE inspections or environmental audit, are addressed and monitor appropriate action plans to mitigate these risks.
10. To provide assurance to the Trust Board that robust arrangements are in place for the proactive management of complaints, adverse events and incidents, including scrutiny of quarterly and annual reports on incidents and complaints and implementation of action plans.
11. To provide assurance to Trust Board that there are robust systems for learning lessons from complaints, adverse events and incidents, and action is being taken to minimise the risk of occurrence of adverse events.
12. As delegated by Trust Board, to monitor implementation of action plans relating to reviews of complaints by the Health Service Ombudsman and of action plans identified through independent inquiry reports relating to the Trust.

Public and service user experience

13. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users and carers, and clinicians to shape service delivery.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting wherever practical. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees. When a new Committee is formed it is incumbent upon all Committees to ensure that there are clear lines of accountability and that workplans / responsibilities are aligned and work is not duplicated. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

Reports being received as per the internet meetings governance framework

Ensure that the terms of reference template allows for the clear capture of information required by and reporting requirements into each committee

Approved by Trust Board: 27 April 2021
Next review due: April 2021

NHS
South West Yorkshire Partnership
NHS Foundation Trust

EQUALITY AND INCLUSION COMMITTEE
Terms of Reference
To be Approved by Trust Board 27 April 2021

The Committee is a Committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by the Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Equality and Inclusion Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity. The Committee will develop and oversee a strategy, including an approach to positive action, to improve access, experience and outcomes for people from all backgrounds and communities, including people who work and volunteer for the organisation, those who use Trust services and their families, and those who work in partnership with the Trust to improve the health and well-being of local communities.

Membership
The Equality and Inclusion Committee is chaired by a Non-Executive Director. At least one other Non-Executive Director also sits on the Forum as well as relevant Directors of the Trust.

Membership as at 1 April 2021
Chair – Chair of the Trust – Angela Monaghan
Non-Executive Director – Chris Jones
Non-Executive Director – Erfana Mahmood
Non-Executive Director – Mike Ford
Chief Executive – Rob Webster
Lead Director – Director of Nursing and Quality – Tim Breedon – To transfer to Salma Yasmeen – Director of Strategy from 31 March 2021.
Director of Human Resources, Organisational Development and Estates – Alan Davis

Attendance
Technical support is provided by Human Resources Managers and Equality and Engagement Development Managers, who are in attendance. A Governor (appointed by the Members' Council), the staff side representative with lead for equality and diversity, a representative from each of the staff equality networks, and a representative for each BDU equality forum, is also invited to attend meetings. Other directors and relevant officers attend the Committee by invitation. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum

The quorum will be half of the membership which must include one Non-Executive Director and one Director; however, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year and be reviewed every twelve months.

Duties

- To promote the values of inclusivity, mainstreaming equality, diversity and inclusion across the Trust.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust has a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers, staff and Members' Council.
- To monitor and provide assurance to Trust Board that the Trust is embedding diversity and inclusion in all its activities and functions.
- To monitor, scrutinise and provide assurance to Trust Board that the Trust is compliant with legal and national guidance, including Equality Delivery System (EDS2), the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES).
- To agree an annual work plan that links to the Trust's strategic direction, workforce plan and the wider priority programmes and to monitor progress.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the approved minutes of Committee at the next Trust Board meeting following the Committee meeting at which they are approved. The Committee will also report to the Board annually on its work (see above).

All Trust Board committees have a responsibility to ensure they foster and maintain relationships and links between the Forums / Committees and Trust Board. Each committee also has a responsibility to ensure actions identified and agreed are placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Reporting requirements into the Committee

The Equality and Inclusion Committee received regular performance reports on Equality Standards, Equality Delivery System and Equality Impact Assessments., plus feedback from staff networks and development programmes.

The Committee receives the annual reports on equality and diversity, Workforce Disability Equality Standard and Workforce Race Equality Standard before submission to Trust Board.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

To be approved by Trust Board: 27 April 2021
Next review due: April 2021

South West Yorkshire Partnership NHS Foundation Trust

FINANCE, INVESTMENT & PERFORMANCE COMMITTEE
Terms of Reference
To be approved by Trust Board 27 April 2021

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Finance, Investment & Performance Committee was established in 2019. The Terms of Reference of the Committee will be reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. The Finance, Investment & Performance Committee is a committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Finance, Investment & Performance Committee's prime purpose is to provide oversight and challenge of the Trust's financial performance and financial plans to ensure the Trust and the services it provides remain financially sustainable. It will also review capital plans with particular focus on the scrutiny of major investments, including post evaluation reviews. The committee will also review the overall performance metrics of the Trust to identify key trends and issues. This may result in direction being given to other committees of the Board to carry out more detailed review and determine where corrective action needs to be taken. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership
The Committee is always chaired by a Non-Executive Director of the Trust and the membership consists of a minimum of two other Non-Executive Directors and three executive Directors.

Membership as at 22 March 2021
Chair – Non-Executive Director – Chris Jones
Non-Executive Director – Sam Young
Non-Executive Director – Kate Quail

Lead Director – Director of Finance & Resources – Mark Brooks
Chief Executive – Rob Webster
Director of Nursing & Quality / Deputy Chief Executive – Tim Breedon

Attendee as at 22 March 2021
Director of Operations – Carol Harris

Attendance

The Director of Finance and Resources is in attendance (as lead Director) at meetings. The Chair of the Trust, other Directors, and relevant officers attend the Finance, Investment and Performance Committee by invitation. Administrative support is provided by the Personal Assistant to the Lead Director.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

For the first twelve months of its existence the Committee met on a monthly basis given the focus on the ongoing development and implementation of the financial sustainability plan.

The frequency of the meetings will continue to be reviewed by the Chair of the Committee and lead director, particularly in light of the response to the Covid-19 pandemic. The initial plan for 2021/22 is that meetings will be held monthly with the middle meeting in each quarter focusing on a specific area of performance.

It is the responsibility of the Chair to work with the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed by Trust Board to co-operate with any request made by the Committee.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees.

Duties

<u>Finance</u>

The Committee will focus on the following in respect of the financial affairs of the Trust:

- Oversee and evaluate financial strategy;
- Seek assurance on delivery of financial and operational targets (through the integrated performance report);
- Consider forecasts for financial and operational information;
- Assess risks and seek assurance on mitigating action;
- Review proposed annual financial plan;
- Review proposed three and five year financial plans;
- Seek assurance on delivery of the cost improvement programmes (CIPs);
- Oversee delivery of the financial sustainability plan;
- Review Trust's service line financial reporting; and
- Consider the Trust's performance using benchmarking information including that included in the model hospital.

Investment
The Committee will focus on the following in respect of Trust investments:

- Approve business cases as required by Trust Standard Financial Instructions (SFIs) and oversee the post implementation review process for these; and
- Review the annual, three year and five year capital plans for the Trust.

Performance
The Committee will focus on the following in respect of Trust performance:

- Review the integrated performance report and identify key trends and issues across the Trust;
- Provide information to other Trust committees on these key trends and issues which may require corrective action to be taken; and
- Receive and review NHS benchmarking reports.

In carrying out its work, the Committee will primarily utilise internal expertise. Where required it will seek reports and assurances from Directors and managers concentrating on the delivery of financial plans, investment criteria and over-arching Trust performance.

Relationship with the Members' Council

At the discretion of the Chair of the Committee and/or the Chair of the Trust, governors may be invited to attend meetings of the Committee to support the Members' Council in meeting its duty to hold Non-Executive Directors to account for the performance of the Board.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the Trust Board meeting following the Committee meeting. The Committee will also report to the Board annually on its work and include commentary on its support of the Annual Governance Statement, the effectiveness of assurance systems, the work of internal and external audit and the annual accounting process.

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups.

Approved by Trust Board: 27 April 2021
Next review due: April 2022

NHS
South West Yorkshire Partnership
NHS Foundation Trust

MENTAL HEALTH ACT COMMITTEE
DRAFT Terms of Reference

To be approved by Trust Board 27 April 2021

All Trust Board Committees are responsible for scrutiny and providing assurance to Trust Board on key issues allocated to them by the Board. Agendas are set to enable Trust Board to be assured that scrutiny processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Committee was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role, any changes to other committees and revised membership. It is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose

The Mental Health Act Committee is responsible for ensuring the organisation is working within the legal requirements of the Mental Health Act (1983), as amended by the 2007 Act and Mental Capacity Act 2005, and with reference to guiding principles as set out in the Code of Practice and associated legislation as it applies to the Mental Health Act, the Mental Capacity Act and Deprivation of Liberty. On behalf of the Trust Board, it will have an oversight of related risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.

Membership

The Mental Health Act Committee is chaired by a Non-Executive Director. Two other Non-Executive Directors also sit on the Committee as well as relevant Directors of the Trust.

Membership as at 1 April 2021
Chair – Non-Executive Director - Kate Quail
Non-Executive Director - Charlotte Dyson
Non-Executive Director - Erfana Mahmood
Lead Director - Medical Director - Dr Subha Thiyagesh
Director of Nursing and Quality - Tim Breedon
Director of Operations - Carol Harris

Attendance

Representatives of the four local authorities, a representative from each of the three acute trusts covering the Trust's geography, and one Associate Hospital Manager (the Chair of the Hospital Managers' Forum), are invited to attend meetings. The Committee also has scope to invite other external individuals on an ad-hoc basis where it is felt expertise or specialist advice is required. The Deputy Director of Operations, Assistant Director of Legal Services; and Clinical Legislation Manager are in attendance at meetings.

The Chief Executive, other Directors, and relevant officers attend the Mental Health Act Committee by invitation. Administrative support is provided by the Personal Assistant to the Medical Director.

Quorum

The quorum will be two Non-Executive Director members and the lead Director (or nominated Director) plus one other Director. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of executive Director members, deputies are permitted to attend, however they will not form part of the quorum.

Frequency of meetings

The Committee will meet a minimum of four times per year to reflect availability of quarterly reports.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees and reporting requirements into the Committee

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-groups including but not limited to:

- Associate Hospital Managers' Forum
- MHA/MCA Code of Practice Oversight Group – workstreams include: 136 MHA Policy; Leave implementation group; Seclusion and Segregation and Reducing Restrictive Practice; and Section 132/132a and 131 patients' rights

The Committee receives regular reports on risk and assurance including statistical information on the use of the MHA 1983 and MCA 2005 in the form of the quarterly performance report.

Duties

1. To monitor the Trust's implementation of, and compliance with, current mental health legislation and proposed changes to such legislation, in particular the Mental Health Act 1983 and the Mental Capacity Act 2005, within the Trust taking into account best practice.
2. To consider the implication of any changes to legislation and regulations within a local context.
3. To receive reports from Associate 'Hospital Managers' in their role of hearing appeals and to scrutinise the processes for and outcome of appeals and tribunals.
4. To ensure there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role.

5. To monitor trends in the application of the Mental Health Act 1983 (and any new Mental Health Acts or revisions to the existing Act) within the Trust and make recommendations where necessary.
6. To receive reports following Care Quality Commission (CQC) Mental Health Act visits for information and comment and to ensure appropriate action is agreed and implemented within the organisation.
7. To scrutinise delivery against the Trust's action plan developed as a result of the Care Quality Commission's Annual Report as instructed by Trust Board.
8. To receive Trust policies relating to the Mental Health Act and Mental Capacity Act which have been approved by the Executive Management Team.
9. To receive policies reviewed/updated by the Trust's Policy Group.
10. To scrutinise the application of these policies throughout the Trust.
11. To address training issues in terms of delegation of responsibilities under the Mental Health Act 1983.
12. To address quality issues in terms of delegation of responsibilities under the Mental Health Act 1983.
13. To manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.
14. To request specific reports relevant to the application of the Mental Health Act.
15. To undertake duties relevant to the Committee set out in the 'Duties of Hospital Managers' Policy.
16. To provide assurance that there are appropriate systems in place to enable the views and experiences of service users, carers and clinicians to shape service delivery in relation to the Mental Health Act 1983 and the Mental Capacity Act 2005.
17. To consider, in all its functions, the experience and views of service users, carers and families, with a particular focus on those from vulnerable groups, Black Asian and Minority Ethnic communities and all those who have protected characteristics.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting at which the minutes are ratified, wherever practical.
The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal working groups.

To be approved by Trust Board: 27 April 2021
Next review due: April 2022

NHS
South West Yorkshire Partnership
NHS Foundation Trust

WORKFORCE AND REMUNERATION COMMITTEE
Terms of Reference
To be approved by Trust Board 27 April 2021

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Workforce and Remuneration Committee (formerly known as Remuneration and Terms of Service Committee) was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose
The Workforce and Remuneration Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate that actively contribute to the achievement of the Trust's aims and objectives. The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

Membership
Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

Membership as at 1 April 2020
Chair – Non-Executive Director - Sam Young;
Non-Executive Director - Angela Monaghan (Chair of the Trust);
Non-Executive Director - Charlotte Dyson (Deputy Chair of the Trust / Senior Independent Director);
Chief Executive (non-voting Committee member) - Rob Webster.

Attendance

The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Director of Human Resources, Organisational Development and Estates is also in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Director of Human Resources, Organisational Development and Estates.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of the Chief Executive, the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend as a non-voting member.

Frequency of meetings

The Committee will meet no less than four times per year.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

Duties

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:
   a) determine the remuneration and terms of service for the Chief Executive;
   b) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
   c) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;

d) to ratify remuneration arrangements for senior management posts;
e) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;
f) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
g) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.

2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
4. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
5. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
6. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
7. To consider future national developments which could impact on the Trust's strategic workforce objectives.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the private session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

To be approved by Trust Board: 27 April 2021
Next review due: April 2022

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021
Agenda item 12.4

Title:	**Trust Board self-certification (G6/CoS7) – compliance with NHS provider licence conditions**
Paper prepared by:	Director of Finance and Resources
Purpose:	To provide assurance to Trust Board that it is able to make the required self-certifications that the Trust complies with the conditions of the NHS provider license.
Mission / values:	Good governance supports the Trust to deliver its mission and adhere to its values.
Any background papers / previously considered by:	Trust Board and Finance, Investment & Performance Committee has received updates on the development of the 2021/22 operational plan, most recently at the Trust Board meeting held on 23 February 2021. The attached document is reviewed and updated annually. A further self-certification will come to Trust Board on 29 June 2021.
Executive summary:	**Background** NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. As part of the annual planning arrangements, NHS England & Improvement (NHSE&I) requires the Trust to make a number of governance declarations. Trust Board is required to make self-certifications (G6/CoS7) in relation to: • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (as required by condition G6(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions); and • If providing commissioner requested services (CRS), the provider has a reasonable expectation that required resources will be available to deliver the designated service (as required by condition CoS7(3) of the NHS Provider Licence) (appendix 1 – NHS provider licence conditions). It is expected a further self-certification (FT4) is required by 30 June 2021 and this will come to the Trust Board meeting on 29 June 2021: • The provider has complied with required governance arrangements (as required by condition FT4(8) of the NHS Provider Licence); and • The training of Governors (as required by s151(5) of the Health and Social Care Act 2012).

	Self-certification - part one (G6/CoS7) Trust compliance with its Licence The Licence is a requirement of the Health and Social Care Act 2012 and is the mechanism by which NHS Improvement/Monitor regulates providers of NHS services, both NHS and non-NHS. The provider licence is split into six sections, which apply to different types of providers. From 1 April 2013, all foundation trusts were automatically issued with a licence as the Health and Social Care Act 2012 specified that foundation trusts were to be treated as having met all the licence criteria. In the main, the licence requires the Trust to adhere to (and provide evidence that it has done so) certain conditions, which it does as part of its existing governance and reporting arrangements. The attached paper (appendix 1) provides assurance to Trust Board that the Trust meets the conditions of its Licence and identifies potential areas of risk. Reference is made to the impact of and response to the Cocid-19 pandemic in the accompanying paper. From the assurance provided, Trust Board is asked to certify that "***the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution***". Providing commissioner requested services (CRS) CRS designation is not simply a standard contract with a commissioner to provide services. CRS are services that commissioners consider should continue to be provided locally, even if a provider is at risk of failing financially and which will be subject to regulation by NHSE&I. Providers can be designated as providing CRS because: • there is no alternative provider close enough • removing the services would increase health inequalities • removing the services would make other related services unviable. The attached paper (appendix 1) sets out the way the Trust complies with the continuity of services conditions in the NHS provider licence. From the assurance provided, Trust Board is asked to certify that *"****the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking into account distributions which might reasonably be expected to be declared or paid for the period of 12 months****".*
Recommendation:	**Trust Board is asked to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to compliance with the conditions of its Licence.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 27 April 2021

NHS provider licence

This paper is intended to provide assurance that the Trust complies with the terms of its licence and sets out a broad outline of the licence conditions and any issues for Trust Board to note.

The provider licence is split into six sections, which apply to different types of providers.

1. **General conditions (G)** – general requirements applying to all licensed providers.
2. Obligations about **pricing (F)** – obliges providers to record pricing information, check data for accuracy and, where required, charge commissioners in line with tariff. Applies to all licensed providers who provide services covered by national tariff.
3. Obligations around **choice and competition (C)** – obliges providers to help patients make the right choice of provider, where appropriate, and prohibits anti-competitive behaviour where against patients' interests. This applies to all licensed providers.
4. Obligations to enable **integrated care (IC)** – enables the provision of integrated services and applies to all licensed providers.
5. Conditions to support **continuity of services (CoS)** – allows Monitor/NHS Improvement to assess whether there is a risk to services and to set out how services will be protected if a provider gets into financial difficulty. Applies to providers of commissioner requested services (CRS) only.
6. Governance licence **conditions for Foundation Trusts (FT)** – provides obligations for Foundation Trusts around appropriate standards of governance. Applies to Foundation Trusts only.

Condition	Provision	Comments
Section 1 - General conditions (G)		
G1: Provision of information	Obligation to provide Monitor (referred to as NHS England & Improvement – abbreviated to NHSE&I) with any information it requires for its licensing functions.	The Trust is currently obliged to provide NHSE&I with any information it requires and, within reasonable parameters, to publish any information NHSE&I requires it to. We have systems in place to identify and respond to routine and ad-hoc requests. Formal articulation of this Condition, therefore, does not present any issues for the Trust. Conditions are broad, so there is a risk of increased burden in the future
G2: Publication of information	Obligation to publish such information as NHSE&I may require.	
G3: Payment of fees to Monitor	Gives NHSE&I the ability to charge fees and for licence holders to pay them.	There are currently no plans to charge a fee to Licence holders. Trust Board should note that

Condition	Provision	Comments
		there is currently no provision in the budget for additional fees and this would, therefore, become a cost pressure.
G4: Fit and proper persons	Prevents licences from allowing unfit persons to become or continue as governors or directors.	The Care Quality Commission (CQC) published the fit and proper person requirements to take effect from 1 October 2014. The Trust has included the requirement for members of Trust Board to make a declaration against the requirements on an annual basis to the Trust Board and has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Trust Board declaration and register of fit and proper persons, interests and independence policy was last reviewed and approved by Trust Board on 30 March 2021. The declarations are published on the Trust's website. All governors of the Members' Council are required to make a declaration of interest on commencement and on an annual basis which is reported to the Members' Council. The Members' Council declaration and register of interests, gifts and hospitality policy was last reviewed and approved by Members' Council on 27 April 2018, and is going to Members' Council for approval on 11th May 2021. The declarations are published on the Trust's website. All governors of the Members' Council are required to sign a Code of Conduct for Governors on commencement.
G5: Monitor guidance	Requires licensees to have regard to Monitor guidance.	The Trust responds to guidance issued by NHSE&I. Submissions and information provided to NHSE&I are approved through relevant and appropriate authorisation processes.
G6: Systems for compliance with licence conditions and related obligations	Requires providers to take reasonable precautions against risk of failure to comply with the licence.	The Trust has systems and processes in place to ensure it complies with its Licence and this is co-ordinated by the Director of Finance & Resources.

Condition	Provision	Comments
G7: Registration with the Care Quality Commission	Requires providers to be registered with the CQC and to notify NHSE&I if their registration is cancelled.	The Trust is registered with the CQC.
G8: Patient eligibility and selection criteria	Requires licence holders to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.	The Trust's website sets out the service directories for each Business Delivery Unit (BDU) and the relevant access criteria for the services.
G9: Application of section 5 (which relates to continuity of services)	Sets out the conditions under which a service will be designated as a CRS	Covers all services which the licensee has contracted with a Commissioner to provide as a Commission Requested Service (CRS). See CoS1.
Section 2 - Pricing conditions (P)		
P1: Recording of information	Obligation of licensees to record information, particularly about costs.	The Trust responds to guidance and requests from NHSE&I. Information provided is approved through the relevant and appropriate authorisation processes. The Trust's accounting systems and processes ensure appropriate recording of cost information. The Trust's accounts are subject to external audit each year and its controls and processes are subject to both internal and external audit each year
P2: Provision of information	Obligation to submit the above to Monitor.	
P3: Assurance report on submissions to Monitor	Obliges licensees to submit an assurance report confirming that the information provided is accurate.	
P4: Compliance with the National Tariff	Obliges licensees to charge for NHS health care services in line with national tariff.	All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance. The Trust has worked within the temporary financial and contracting arrangements put in place by NHSE/I for 2020/21 that were put in place in response to the Covid-19 pandemic.
P5: Constructive engagement concerning local tariff modifications	Requires licence holders to engage constructively with commissioner and to reach agreement locally before applying to Monitor/NHS Improvement for a modification.	All contracts are agreed annually and are in line with the national tariff. The Trust continues to work with its commissioners on the requirement to develop a local tariff within the terms of national guidance. see C2. The Trust has worked within the temporary contracting arrangements put in place by NHSE/I for 2020/21 that were put in place in response to

Condition	Provision	Comments
		the Covid-19 pandemic
Section 3 - Choice and competition (C)		
C1: Patient choice	Protects patients' rights to choose between providers by obliging providers to make information available and act in a fair way where patients have a choice of provider.	The Trust has in place a service directory setting out the services available. Commissioners monitor the Trust's compliance with the legal right of choice as part of contract monitoring in line with NHS Standard Contract requirements.
C2: Competition oversight	Prevents providers from entering into or maintaining agreements that have the effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	Trust Board has reviewed its position and considers that it has no arrangements that could be perceived as having the effect of preventing, restricting or distorting competition in the provision of health services. The Trust is aware of the requirements of competition in the health sector and would seek legal and/or specialist advice should Trust Board and Members' Council decide to consider any structural changes, such mergers or joint ventures. The Trust Board and Finance Committee receive updates of tenders and service developments being undertaken.
Section 4 - Integrated care condition (IC)		
IC1: Provision of integrated care	Requires Licensee to act in the interests of people who use healthcare services by facilitating the development and maintenance of integrated services.	The Trust actively works with its partners, through formal and informal mechanisms to foster and enable integrated care and is involved in several collaboratives which are developing new ways of working and new models of delivery. A number of services are provided through partnership working with local stakeholders. The Trust plays an active role in Integrated Care Systems in West Yorkshire and South Yorkshire & Bassetlaw, and is a signatory to a Memorandum of Understanding with both.
Section 5 - Continuity of service (CoS)		
CoS1: Continuing provision of commissioner requested services (CRS)	Prevents licensees from ceasing to provide CRS or from changing the way in which they provide CRS without the agreement of relevant commissioners.	As part of contract negotiations, the Trust has agreed CRS with commissioners, with the exception of Barnsley, that all mental health services will be considered as CRS. Barnsley

Condition	Provision	Comments
		Clinical Commissioning Group has reviewed the guidance and has determined that services provided under their contract will not be designated as essential or CRS.
CoS2: Restriction on the disposal of assets	Licensees must keep an up-to-date register of relevant assets used in commissioner requested services (CRS) and to seek NHSE&I's consent before disposing of these assets if NHSE&I has concerns about the licensee continuing as a going concern.	The majority of Trust services are classed as CRS and all assets associated with these services are classed as restricted and can be identified by the Trust. Any changes to estate and the asset base are discussed with commissioners in relation to the provision of services. The Trust has an asset register in place. The Trust is only required to seek NHSE&I's consent for disposal of assets if NHSE&I is concerned about its ability to continue as a going concern. The Trust Board reviews and approves a going concern statement with appropriate rationale provided by the Director of Finance & Resources on an annual basis.
CoS3: Standards of corporate governance and financial management (Monitor/NHS Improvement risk rating)	Licensees are required to adopt and apply systems and standards of corporate governance and management, which would be seen as appropriate for a provider of NHS services and enable the Trust to continue as a going concern.	The Trust has robust and comprehensive corporate and financial governance arrangements in place. Due to the Covid-19 pandemic there have been a number of adjustments made to governance arrangements in 2020/21 as interim measures. These adjustments have been approved through Trust Board periodically during the year. Corporate and Financial governance arrangements remain subject to both internal and external audit annually. All audit plans are agreed by the Audit Committee and similarly all audit reports are received and reviewed at the Audit Committee
CoS4: Undertaking from the ultimate controller	Requires licensees to put a legally enforceable agreement in place to stop the ultimate controller from taking action that would cause the licensee to breach its licensing conditions.	Does not apply to the Trust.
CoS5: Risk pool levy	Obliges licensees to contribute to the funding of the 'risk pool' (insurance mechanism to pay for	There is currently no risk pool levy in place.

Condition	Provision	Comments
	vital services if a provider fails).	
CoS6: Co-operation in the event of financial stress	Applies when a licensee fails a test of sound finances and obliges the licensee to co-operate with NHSE&I.	The Trust is aware it would need to co-operate with NHSE&I in such circumstances. The Trust submits periodic financial returns to NHSE&I, participates in a Quarterly Review Meeting (QRM) with NHSE&I and liaises extensively on financial matters. Quarterly Review Meetings did not take place during 2020/21 as part of the response to the Covid-19 pandemic.
CoS7: Availability of resources	Requires licensees to act in a way that secures resources to operate commissioner requested services (CRS).	The Trust has sound and robust processes and systems in place to ensure it has the resources necessary to deliver CRS.
Section 6 - Foundation Trust conditions (FT)		
FT1: Information to update the register of NHS foundation trusts	Obliges foundation trusts to provide information to NHSE&I.	See G1. The Trust is currently obliged to provide NHSE&I with any information it requires, including information to update its entry on the register of NHS foundation trusts and has processes in place to ensure it complies with such requirements
FT2: Payment to NHSE&I in respect of registration and related costs	The Trust would be required to pay any fees set by NHSE&I.	NHSE&I has undertaken not to levy any registration fees on foundation trusts without further consultation.
FT3: Provision of information to advisory panel	NHSE&I has established an independent advisory panel to consider questions brought by governors. Foundation trusts are obliged to provide information requested by the panel.	The independent advisory panel was established by Monitor in April 2013 and the Trust provided a briefing on the Panel to the Members' Council. This Panel has since been disbanded by NHSE&I.
FT4: NHS Foundation Trust governance arrangements	Gives NHSE&I continued oversight of the governance of foundation trusts.	The Trust has sound governance processes in place and reviews of these arrangements are a core part of the internal audit annual work programme. This has been evidenced in the outcome of the well-led reviews carried out by the CQC in both 2018 and 2019. As stated in CoS3 a number of interim changes to governance structures were made during 2020/21 due to the Covid-19 pandemic. All changes were subject of scrutiny by Trust Board.

NHS
South West
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NHS Foundation Trust

Trust Board 27 April 2021
agenda item 12.6

Title:	**Data Security & Protection Toolkit**
Paper prepared by:	Director of Finance & Resources
Purpose:	To provide information to support the approval of the submission of the Data Security and Protection Toolkit (DSPT)
Mission / values / objectives:	All Trust objectives.
Any background papers / previously considered by:	• An annual report is made to the Trust Board • Internal audit provides regular updates to the Audit Committee • Regular updates at the Improving Clinical Information & Information Governance Group (ICIG)
Executive summary:	The current Data Security & Protection Toolkit (DSPT) was released on 1 December 2020. An interim submission was required by 28 February 2021 to assess the position at that time, and the final submission deadline is 30 June 2021. The DSPT allows organisations to self-assess their performance against the ten data security standards recommended by the National Data Guardian. To ensure this self-assessment is considered and evidenced the final assessment submission is subject to review by internal audit. Internal audit undertook remote fieldwork between December 2020 and March 2021 to assist the Trust with action planning to achieve full compliance as well as ensuring the self-assessment is based on robust and evidenced grounds. For the current DSPT assessment the data security standards are broken down into 42 assertions, which are further divided into 111 mandatory evidence items. 34 evidence items have an exemption as the Trust has achieved Cyber Essentials+ (CE+) accreditation. Internal audit reviewed evidence for 41 evidence items, 13 of which were immediately validated as they are within the scope of the CE+ exemption. A comprehensive evidence collation and review process is undertaken The parameters for assessing and auditing the evidence are quite specific The overall classification for each of the assertions is **substantial**.

	The overall risk assessment across all ten data security standards is **substantial** and the confidence level in the veracity of the self-assessment is **high**. The Trust has made excellent progress in its completion of the DSPT and has evidence of full compliance with all mandatory standards plus a number of non-mandatory standards.
Recommendation:	**It is recommended that the Trust Board APPROVES the Trust submits the final assessment of the DSPT of "standards exceeded".**
Private session:	Not applicable

Data Security & Protection Toolkit 2020/21

1. Introduction

The current Data Security & Protection Toolkit (DSPT) was released on 1 December 2020. An interim submission was required by 28 February 2021 to assess the position at that time, and the final submission deadline is 30 June 2021.

The DSPT allows organisations to self-assess their performance against the ten data security standards recommended by the National Data Guardian. To ensure this self-assessment is considered and evidenced the final assessment submission is subject to review by internal audit. Internal audit undertook remote fieldwork between December 2020 and March 2021 to assist the Trust with action planning to achieve full compliance as well as ensuring the self-assessment is based on robust and evidenced grounds.

The standards are clustered under three leadership obligations to enable peer support and cascade lessons learned:

- **Leadership obligation 1: People**
  Ensure staff are equipped to handle data respectfully and safely, according to the Caldicott Principles.

  Data Security Standard 1: Confidential, person-identifiable data
  All staff ensure personal, confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is only shared for lawful and appropriate purposes.

  Data Security Standard 2: Staff responsibilities
  All staff understand their responsibilities under the National Data Guardian's Data Security Standards including their obligation to handle data responsibly and their personal accountability for deliberate or avoidable breaches.

  Data Security Standard 3: Training
  All staff complete appropriate annual data security and protection training and pass a mandatory test, that is linked to the current DSPT.

- **Leadership obligation 2: Process**
  Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses.

  Data Security Standard 4: Data access management
  Personal, confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All access to personal, confidential data on IT systems can be attributed to individuals.

Data Security Standard 5: Process reviews
Processes are reviewed at least annually to identify and improve processes that have caused breaches or near misses, or, which have forced staff to use workarounds that compromise data security.

Data Security Standard 6: Incident responses
Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken immediately following a data breach or near miss, with a report made to senior management within 12 hours of detection.

Data Security Standard 7: Continuity planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum with a report to senior management.

- **Leadership obligation 3: Technology**
  Ensure technology is secure and up to date.

  Data Security Standard 8: Unsupported systems
  No unsupported operating systems, software or internet browsers are used within the IT estate.

  Data Security Standard 9: IT security
  A strategy is in place for protecting IT systems from cyber threats, which is based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.

  Data Security Standard 10: Accountable suppliers
  IT suppliers are held accountable via contracts for protecting the personal confidential data they process and meeting the National Data Guardian's Data Security Standards.

For the current DSPT assessment the data security standards are broken down into 42 assertions, which are further divided into 111 mandatory evidence items.

34 evidence items have an exemption as the Trust has achieved Cyber Essentials+ (CE+) accreditation.

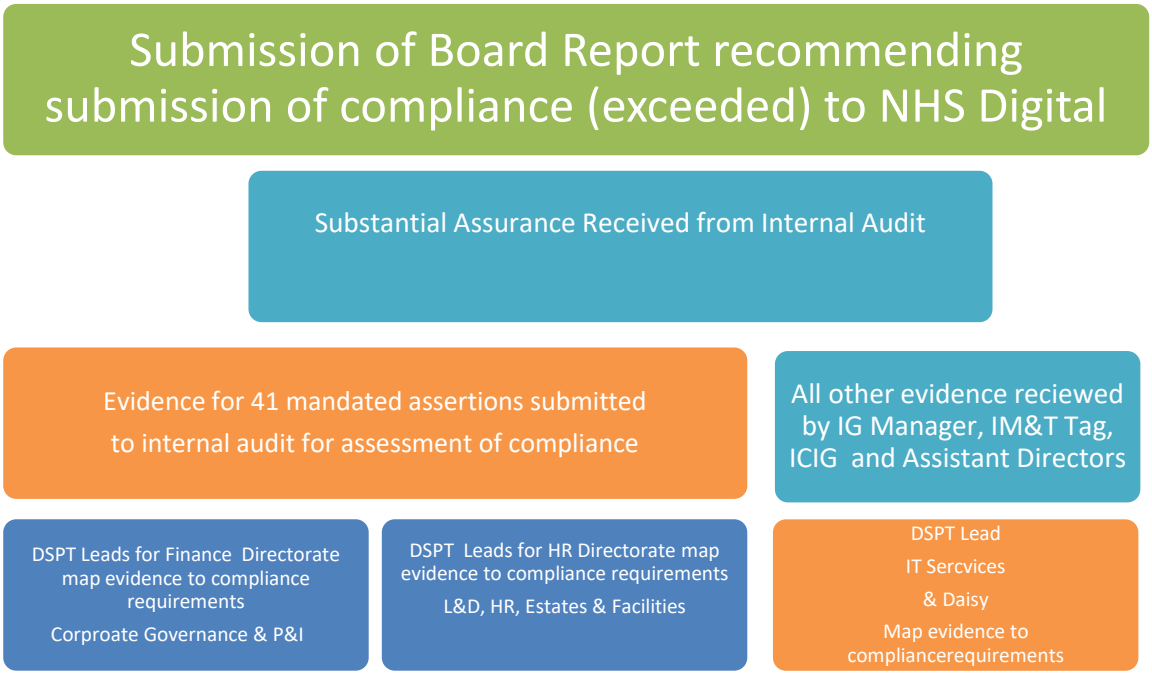
Internal audit reviewed evidence for 41 evidence items, 13 of which were immediately validated as they are within the scope of the CE+ exemption.

It should be noted that, whilst it has been approved for use by NHS Digital, the DSPT is a beta release and is subject to ongoing review and development

2. Evidence gathering

Documents provided as evidence to the Information Governance Manager were overseen by the appropriate assistant director or head of service

The full structure for evidence provision, assessment and sign off is below. This is a comprehensive and robust structure that provides strong assurance that the evidence compiled is solid and subject to review by the right people across the organisation.



3. Internal audit reviews

The draft internal audit report was issued on 14 April 2021 and subsequently approved by the Assistant Director of Corporate Governance, Performance & Information and the Assistant Director of IT Services & Systems Development.

The overall classification for each of the assertions is **substantial**.

The overall risk assessment across all ten data security standards is **substantial** and the confidence level in the veracity of the self-assessment is **high**.

It should be noted that the criteria for assessment of evidence is very specific and does not provide any real margin for interpretation. One low risk finding was identified in respect of user accounts audits as the review did not identify evidence to demonstrate the Trust performs secondary checks on leavers at the Active Directory level, which creates a risk that staff may retain access and continue to access systems and data.

No key issues on governance, risk management and control were identified.

4. Action Plan

The finding in respect of user accounts audit is low risk and relates to a strengthening of existing processes rather than a failure to meet the standard. Internal audit confirmed it can be marked as complete in the DSPT so will not prevent the final submission being made. IT Services have commenced taking appropriate action and the 30 June 2021 deadline for completion will be met.

Aside from the evidence items within scope of the CE+ exemption and those in scope of the audit, all other evidence items are complete.

5. Final Reviews

A summary report was presented at the Improving Clinical Information Group on 14 April 2021.

The Information Governance Manager and Assistant Director of Corporate Governance, Performance & Information met on 15 April 2021 and reviewed each evidence item and completed each assertion. Following this exercise, if the submission was to be made, it was confirmed that the standards would be exceeded.

Approval to make the submission was given by the Director or Finance & Resources.

Conclusion and Recommendation

The Trust has made excellent progress in its completion of the DSPT and has evidence of full compliance with all mandatory standards plus a number of non-mandatory standards.

It is recommended that the Trust submits the final assessment of the DSPT of “standards exceeded”.

NHS
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Trust Board 27 April 2021
Agenda item 13 – Assurance from Trust Board Committees

Audit Committee

Date	13 April 2021
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Action** "Limited Assurance" Internal Audit received re Data Quality: Reporting to Commissioners. Recommendations to be implemented **Alert and advise** • Update provided on progress with year-end and external timetable • Annual Internal Audit and Counter Fraud plans for 21/22 presented and approved • The Committee reviewed the draft Annual Governance Statement in preparation for April Board **Assure** • The Committee received the annual effectiveness reports from other committees – covered by separate paper • Audit Committee annual effectiveness report received • Internal Audit presented their draft annual Head of Internal Audit Opinion "Significant Assurance" provided re framework of governance, risk management and control • Risks from ORR assigned to Audit Committee reviewed – no matters to report • No issues identified in reports presented on procurement, treasury & special losses
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 26 February 2021 attached. Audit Committee minutes - Feb 2021.

Clinical Governance & Clinical Safety Committee

Date	6 April 2021
Presented by	Charlotte Dyson, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	**Action** None **Alert and advise** • CQC Improvement Plan - Focus on quality improvement approach going forward with progress reports on care planning and risk assessment into Committee. Monitoring to encompasses a range of measures to ensure triangulation and a sustained and embedded improvement. Action DT • Safer Staffing - Assurance received around meeting national safer staffing requirements. Recognition of significant work around staffing and recruitment. Committee wanted a greater understanding of the impact of staffing and mix on individual wards, particularly on the impact on staff. Action: EMT to review and consider as an item for future strategy board discussion. • Mental Health User Survey – Received. Agreed that there were some significant findings and that some priorities for focus needed to be agreed – Action DT • CAHMS - update on commissioning of C+K services. Increase in demand for services following schools going back noted. Issue around tier 4 services and capacity discussed (Specifically admission of 14 year old). Action: Risk description and level to be reviewed at EMT • FTSUG - National move to create a culture where staff feel safe to speak up. EM new title Ambassador for Cultural Change and FTSUG. Action: Agreed FTSUG annual Report and Strategy to go to WARK / Board (May/June). • RRPI TAG - Benchmarking report identifies us an outlier on prone restraint. Review paper being provided into benchmarking group in first instance – outcome to be reported into CGCS. **Assurance** • Safety and resilience annual report - Received. Recognition of significant work achieved and action plan for 2021/2 noted
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 9 February 2021 attached.  Item 3 Minutes 09.02.2021 CD TB C(

Finance, Investment & Performance Committee

Date	23 April 2021
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Verbal update to be given at meeting.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 25 January 2021 attached.

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	22 April 2021
Presented by	Chris Jones, Deputy Chair who attended on behalf of Angela Monaghan, Chair.
Key items to raise at Trust Board	• Verbal update to be given at meeting.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on January 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 26 February 2021 (Virtual meeting, via Microsoft Teams)

Present:	Mike Ford	Non-Executive Director (Chair of the Committee)
	Chris Jones	Non-Executive Director
	Sam Young	Non-Executive Director
Apologies:	None	
In attendance:	Rob Adamson	Deputy Director of Finance
	Mark Brooks	Director of Finance and Resources (lead Director)
	Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
	Paul Hewitson	Director, Deloitte
	Leanne Hawkes	Deputy Director, 360 Assurance
	Andy Lister	Head of Corporate Governance
Apologies:	Lianne Richards	Client Manager, 360 Assurance

AC/21/21 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting.

It was noted that the meeting was quorate.

AC/21/22 Declaration of interests (agenda item 2)

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

AC/21/23 Minutes from the meeting held on 5th January 2021 (agenda item 3)

It was RESOLVED to APPROVE the Minutes from the meeting held on 5th January 2021

AC/21/24 Matters arising from the meetings held on 5th January 2020 (agenda item 4)

It was agreed that given the specific reason for this additional Audit Committee meeting that progress against the action log would form part of the agenda at the April meeting.

Action log

Andy Lister (AL) did note that the effectiveness review for the Mental Health Committees in Common will be conducted by Keir Shillaker, programme director. The timescale for completion is likely to be during the summer months.

AC/21/25 Consideration of external audit plan for 2020/21 (agenda item 5)

Paul Hewitson (PH) introduced the audit plan noting that the value for money scope has changed this year and the implementation of IFRS16 – lease accounting has been deferred again.

The proposed materiality threshold is slightly over £5m at 2% of turnover and the triviality threshold of reporting errors to the Audit Committee has been assumed at £250k in line with recent years. The Audit Committee were asked to consider these thresholds and following discussion both were agreed.

PH noted that the audit plan has been adapted to ensure appropriate consideration of the impact of Covid-19. Regarding the audit of the Quality Account, this is not mandated again this year, so is not included in the plan.

PH explained that in terms of significant risks that auditing standards require a risk relating to the revenue cycle. PH added that given the unusual circumstances and the financial arrangements in place for 2020/21 it is difficult to see where this risk is likely to materialise. This will be considered further once the draft accounts have been completed and the audit commenced. The risk of management override of controls is also a required risk Deloitte need to consider as part of their audit. Last year there was a recommendation regarding journal approvals, which will be tested again this year to confirm if management has taken appropriate actions to address.

PH added there will be attention on the transfer to the new financial ledger system during the year. The scope on value for money has changed with revised audit guidance in place. This year Deloitte is required to provide a view on arrangements to secure financial sustainability, financial governance and use of resources. Any significant weaknesses will need to be referred to in the audit opinion. An information gathering template is being shared with management to enable preparation ahead of the audit. PH explained there is recognition that this year is not the best year to introduce the new arrangements given the impact of Covid-19 so plans are being developed to make it less cumbersome and burdensome. A separate narrative report will be provided on value for money.

MF questioned how the Audit Committee gains insight during the year on the Trust's controls and processes for securing value for money. Mark Brooks (MB) explained the Trust has a range of controls and processes in place which have been positively taken as assurance in previous years. PH suggested that if there are issues identified from the audit report the Audit Committee may wish to receive update reports on progress being made to address them.

PF noted that there are new auditing standards regarding going concern and financial sustainability. There will also be increased audit work on key estimates and judgements, which will likely mean the Trust needing to provide increased written rationale regarding these estimates and judgements.

Audit fees are quoted in the plan. This excludes the additional value for money work which will be discussed and agreed once the final scope of the work is clear. Costs associated with the quality account and IFRS 16 implementation have also been excluded. MF asked MB to confirm he is in agreement with the fees quoted, and MB responded by stating they were in line with the fees included in the recent tender process.

MF asked if there was a significant risk in the Trust relating to asset valuation. PH responded that he did not expect there to be a major issue this year.

MB asked PH if there would be any focus on treatment of such items as non-NHS income, holiday pay or the Flowers adjudication. PH explained that Deloitte technical team are involved with national discussions and he would update in readiness for the audit. MB will provide PH with some specific questions.

It was RESOLVED to APPROVE the materiality and trivial threshold limits and to AGREE the external audit plan for 2020/21.

AC/21/26 Internal Timetable for the Year-End (agenda item 6)

Rob Adamson (RA) introduced this paper. Updated national guidance has been received since the January Audit Committee meeting. A contingency date has been allowed for in case of slippage, which he hoped would not need to be used. Both Trust management and Deloitte agreed not to apply for an extension to completion. The requirement for review by a second partner may add some time into the process, which may result in the contingency being required.

It was RESOLVED to NOTE the paper provided and timescales included within it.

AC/21/27 Internal Audit Update (agenda item 7)

Leanne Hawkes (LH) provided an update on the Head of Internal Audit Opinion and other matters pertaining to this year's internal audit programme. LH explained the stage 1 report on the development of the Head of Internal Audit Opinion has already been provided to the Audit Committee and the report in the meeting papers provides the stage 2 report. This includes the results of the Board survey regarding management of governance and risk. Eight responses were received this year, which was lower than normal, but expected given the impact of the pandemic. Responses were positive. No specific recommendations have been made.

LH commented that it is key the progress against the internal audit plan is strong in the final quarter. The disruption caused by the response to Covid-19 is acknowledged, but completion of nine audits is currently outstanding, five of which are core to the opinion. All are resourced with plans in place to complete by the end of the financial year. Any concerns in terms of receipt of information from Trust officers will be raised with MB.

MF queried the level of response to the survey. LH stated that in previous years response rates have been close to 100% and this year they have deliberately not sent reminders given the known pressures. MB added that response rates to committee effectiveness surveys have also been quite low this year.

MF questioned what the single oversight framework related to. MB provided a response and offered to discuss with MF outside the meeting. LH explained that other party assurances are considered in the overall Head of Internal Audit Opinion.

It was RESOLVED to NOTE the internal audit update report including the stage 2 Head of Internal Audit Opinion.

AC/21/28 Any Other Business (agenda item 8)

Shaun Fleming (SF) explained that new counter fraud standards are expected to be in place by April 2021. Given the timing SF believes that for some standards most NHS trusts will be classified as either amber or red. There is recognition of this timing issue nationally. SF will circulate a briefing paper developed by Steve Moss of Audit Yorkshire. SF commented there will be a reduced number of broader standards.

Action: Shaun Fleming to circulate the briefing paper regarding the new counter fraud standards.

AC/21/29 Date of next meeting (agenda item 22)

The next meeting of the Committee will be held on Tuesday 13th April 2021 at 2.00pm.

Minutes of Clinical Governance and Clinical Safety Committee held on 9 February 2021
Via MS Teams
(COVID -19)

Present:	Angela Monaghan (AM)	Chair of the Trust
	Charlotte Dyson (CD)	Non Executive Director (Chair of the Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Kate Quail (KQ)	Non-Executive Director (*part apologies for the meeting*)
	Dr Subha Thiyagesh (SThi)	Medical Director
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Carol Harris (CH)	Director of Operations
In attendance:	Darryl Thompson (DT)	Deputy Director of Nursing and Quality
	Sarah Harrison (SH)	PA to Director of Nursing and Quality (author)
	Yvonne French (YF)	Assistant Director of Legal Services
Apologies:	Sue Barton (SB)	Deputy Director of Strategy and Change

CG/21/01 Welcome, introductions and apologies (agenda item 1)

The Chair Charlotte Dyson (CD) welcomed everyone to the meeting and advised that due to the pandemic, these meetings would continue to be held via Microsoft Teams until further notice. The revised agenda was also acknowledged due to Covid-19 and that due notice had been given for the preparation of the papers. It was noted that the meeting was quorate and that it would be recorded for note taking purposes. The Committee agreed. The Committee wanted to thank those who had prepared papers given the current pressures.

CG/21/02 Declaration of interest (agenda item 2)

The Committee
noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2020 or subsequently.

CG/21/03 Minutes of previous meeting held on 10 November 2020 (agenda item 3)

Notes approved as an accurate record.

It was RESOLVED to APPROVE the minutes of the meeting held on 10 November 2020

CG/21/04 Matters Arising (agenda item 4)

The Committee discussed and noted the completed actions and updated the action log accordingly.

CG/20/125 – Risk ID 1530 and Risk ID 1525 – it was noted that these risks had been reviewed at Trust Board in January and updated accordingly – Complete

CG/20/138 – Consideration of Clinical Supervisor Role – Improvements have been noticed in all areas and it was agreed there was no need for the role at this time. This is being monitored through the Operational Management Group (OMG) – Complete

CG/20/140 CAMHS – Carol Harris (CH) informed the Committee that the increase in incidents are now levelling off and that OMG are monitoring the situation – Complete

CG/20/201 CAMHS – 2 local incidents – CH informed the Committee that these had been tied to the Board action plan and a briefing dispatched.

CG/21/05 Consideration of items from the organisational risk register relevant to the remit of the Clinical Governance and Clinical Safety Committee (agenda item 5)

CD informed the Committee that the risks had already been discussed at Board however there were a couple that needed focus as a Committee.

1. Risk ID 1568 – IPC Board assurance. Tim Breedon (TB) informed the Committee that this is a new risk around availability of a seclusion room when it is needed. This has been identified due to increased acuity as well as damage that has been caused to a room that is awaiting safe repairs. CH informed that across the ICS there are similar concerns.

The committee noted a review of actions for February 2021 and queried whether this had been completed. CH informed that this is in progress and expected by the end of February 2021.

AM queried if the Trust has mutual aid arrangements in place and if so, does the Trust have to call on this. CH informed that systems are in place to discuss any urgent need and there are also options available to manage situations inhouse by potentially using other rooms in ward areas.

TB highlighted to the Committee that it was helpful making sure the actions are logged against the changes.

CD asked if the Committee felt that the Covid-19 risks were sufficiently identified with the right controls in place. CD queried if long Covid was on the risk register and TB informed that this will be picked up within RISK ID 1522 and Subha Thiyagesh (SThi) noted that Risk ID 1530 could also be part of the long Covid risk but that this was to be discussed by the Trio.

Action: Trio

CD queried what the impact of the new Covid 19 variants and the length of lockdown might have on the Trust. TB noted the need for a more sufficient profile in relation to these risks and these would be picked up by the Trio.

Action: Trio

AM raised a query in relation to Risk ID 1524 – PPE. With emerging evidence regarding the transmission of Covid-19 through the air and masks not being as effective, AM asked what is taking place nationally around this and whether the Trust is in a position to respond. SThi informed that there was a paper from the ICS in Harrogate and discussions had taken place with the Medical Director and Nursing networks. It was noted that the virus was airborne and there was a need for good air flow etc but current guidance remained valid at this time. TB noted that further guidance is expected through the nursing and medical director networks over the next few weeks.

CD asked if the Committee felt assured that the right measures and controls were in place and the Committee agreed.

It was RESOLVED to NOTE that the items on the ORR relevant to the CGCS have been considered and the Committee satisfied themselves that they are assured that the current risk level, although above risk appetite given the current environment is appropriate. The Committee noted the work to date in mitigating the Covid-19 risks.

CG/21/06 Quality Accounts (agenda item 6)

CD informed that this item had been read and noted.

TB advised the Committee that the update was the same as the last meeting but with two caveats. 1. The Trust is still waiting for formal notification that there will be an extension for submission to December 2021. 2. Darryl Thompson (DT) will ensure a clear understanding between the quality account and the quality reports.

The Committee noted the update and the 2 caveats.

The Committee NOTED the update of the Quality Account

CG/21/07 Care Quality Commission Improvement Plan (agenda item 7)

DT gave a brief update to the Committee. DT informed that the Trust are continuing to receive updates and that 33 out of 38 “should do” actions have now been completed and 7 out of the 12 “must do” actions have also been completed.

DT informed that there are themes and noted that some actions are unrated and work is underway to address this, particularly around risk assessment. DT noted the move from Sainsburys to the FIRM model of risk assessment and queried whether there is a need for the action to be aligned to the FIRM model.

Kate Quail (KQ) raised a query in relation to the psychology issue and whether there was anything else that the Trust should be doing. KQ queried if funding was available and whether this should be taken to Board to progress. CH noted that this had been escalated to commissioners but was not sure of the progress at the moment. CH will check this point.

Action: CH – and to bring back

KQ queried the format of the reports in relation to no outcomes. It was noted that actions can be seen to have been done but we need to ensure the outcomes have been achieved.

DT informed the Committee that he will take this back to the team to discuss

TB highlighted the challenges of reporting against milestones rather than the rag rated system and suggested there is an opportunity to update the style of the plan to enhance understanding of progress and compliance. To be considered and a verbal update provided to the next meeting.

AM queried what SWYPT's relationship was like with the CQC. AM had seen that the CQC were pursing prosecutions and wondered how the Trust was fairing. TB informed the Committee that there is still scheduled engagement meetings and conversations are good. The Trust continues to have ongoing dialogue with the CQC and keep them up to date. Routine conversations with Catherine Beynon Pinder also take place and TB informed that he will be having a stock take call with Jo Walkinshaw this coming Friday. There is an increasing interest from the CQC within the London area. The Trust relationship with the CQC is strong and takes an open and honest approach.

TB noted that generally around this agenda there is a need to ensure alignment with the CQC and informed that this had been done and the CQC have supported this.

TB did not know when the Trust should anticipate formal physical visits by the CQC will recommence.

The CQC improvement plan was discussed and AM highlighted the need to keep a focus on risk assessments and there was a need to err on the side of caution until the Trust have a clear picture on improvement.

The Clinical Governance and Clinical Safety Committee NOTED the latest CQC Improvement plan, and how we are responding to changing CQC guidance and maintaining effective engagement with them

CG/21/08 Trust Achievements (deferred) (agenda item 8)

CG/21/09 Waiting List Improvement Plan (agenda item 9)

CH gave an update to the Committee and noted that whilst the activity and usual reporting format had not been prioritised for the February Committee, it was important to note that ensuring access to our services remains a clinical priority. This was noted by the committee.

CH had supplied some slides for the Committee and updated the key issues for each service.

Wakefield Core Psychology
CH noted that there had been an increase in the waiting times. Face to face therapy had initially halted in lockdown and a number of service users had chosen not to take up digital therapy options which had led to a longer wait for those individuals.

Staffing challenges including long term sickness and maternity leave was impacting on waits. There had been successful recruitment in the West and new staff are now in post which is beginning to have a positive impact on the numbers of people waiting.

Calderdale & Kirklees Core Psychology
Waits have decreased and new staff have been recruited and some staff have returned.

IPAT Performance Calderdale & Kirklees

Demand pressures continue and discussions with the CCG are taking place in relation to how they commission the services.

Psychological therapists are reporting a supressing effect of lockdown on service users' recovery as they are unable to consolidate their psychological learning through usual means such as attending external groups increasing psychological distress.

It was noted that Access figures were similar across all providers.

All wait time KPI's have been achieved for all localities.

Barnsley Core Psychology
Waiting times have increased October to December 2020.

It was noted that Barnsley IAPT was in a similar position to Kirklees.

Barnsley General Community Services
MSK –waiting lists cleared as of October 2020.

AM raised a query in relation to the equipment and adaptation service regarding the 6 month waiting time. The service is working to recruit increased staff profile with social services service under review by joint commissioning. CH to check if any groups are impacted more than others.

Action: CH

CD reiterated the actions from this item for the next update:-

- Continued focus on the big issues impacting on waiting times and how this was being managed
- Planning and contracting to be included in the report and assurance on hidden waits across the services
- Calderdale Core Psychology Waits – 36 months waits was noted to be a significant issue and the Committee would like to receive some further assurance on the action plan.

Action: CH

The Committee RECEIVED the update

CG/21/10 Patient Safety (deferred) (agenda item 10)

CG/21/11 Update on Covid-19 Response (agenda item 11)

11.1 National Issues / Phase 3 Letter / NHS Providers Briefing

TB informed the Committee that there had been no further update since Members Council but wanted to just note two things.

1. The need to remain alert to new variants and to be in a position to respond as quickly as possible.
2. Monitoring of nosocomial infection rates as the Trust's localities are now high in the region.

CD and AM queried how the Trust knows what the level of nosocomial infection is within the Trust, if any. Also, if there were any RIDDOR reports and the thresholds. CD raised a query in relation to how we manage the risk around staff potentially infecting patients. TB noted that a patient case would be classed as a nosocomial infection after they had been with us for more than 8 days and guidance is awaited in relation to recording. Any outbreak would also be investigated through the IPC team who would seek further advice if necessary.

The Committee NOTED the update

CG/21/12 Workforce Update with response to Covid-19 (agenda item 12)

12.1 Safer Staffing

A brief overview was given from TB and noted that overall staffing is very pressured and very busy. Fatigued staff is a daily challenge, however staff remain resilient considering the situation.

DT highlighted what has been stood down during the third wave and the move to SafeCare training to enable a more sensitive and live view of the staffing requirements. This will enable meaningful movement across Trust wards.

CD noted that the Workforce & Renumeration Committee had discussed the high levels of sickness in forensics and inpatient services and the impact this was having on safe staffing levels. TB informed the committee of the systems in place to manage this to ensure we remain flexible and meet the service need.
CH noted that Datix reports are being completed if, for example, a nurse in preceptorship has been left in charge of a ward, and management plans are in place.

AM queried if the same applied across medical staffing issues and SThi confirmed that this is the case.

12.2 Outbreak and Testing Management

The Committee had read the update on the Outbreak and Testing Management and CD raised a query in relation to the two outbreaks on Ashdale and whether there was anything specific that had occurred to cause these. DT informed that there is a consistent challenge around patients socially distancing and also around testing. Testing was, however, now detecting more infections due to the regularity and need for this on a mental health ward. Themes are also being considered at all times.

The Committee NOTED the update

CG/21/13 Delivery of Clinical Services (agenda item 13)

Update on impact on all clinical areas

CD informed that the slides that had been provided in advance, been noted and read.

CD wanted assurance around the Barnsley Community Service which has been under significant pressure. It was noted that whilst pressure remains the good work the service has done has been noted by our partners.

TB noted that in particular the Health and Wellbeing Boards have all had positive comments on the services that the Trust have been providing.

KQ made a small reference in relation to LD that the phrasing and tones could be described better.

The Committee NOTED the update

CG/21/14 Patient Safety (agenda item 14)

14.1 Incident Trends

DT gave a brief overview and noted from December 2019 to December 2020 incidents are holding steady with a slight increase in yellow incidents which is moderate. Strong recording cultures of low impact risks remains.

The Committee NOTED the analysis of suicide and self-harm incidents during the Covid-19 pandemic

14.2 PPE Arrangements

TB informed the committee that the Trust remains in a good position in terms of supply and no challenges have arisen. DT noted that PPE is now reported to the Silver command meeting fortnightly. Any issues would be escalated.

The Committee NOTED the update

CG/21/15 Issues arising from Integrated Performance Report, not covered on the agenda (agenda item 15)

CD raised a query from Mike Ford in relation to moving red rag rated items into the IPR and how this will be done across the board. This is to be looked at by EMT.

The Committee RECEIVED and NOTED the update

CG/21/16 Child and Adolescent Mental Health Services including Wetherby and Adel Beck (agenda item 16)

CH briefly reported the CAMHS update to the Committee.

CH noted that the positive waiting times for Barnsley and Wakefield continue. There is still a rise in referrals but not to pre Covid-19 levels.

Formal notification of the contract extension at Wetherby and Abel Beck is to end in March 2025. The performance notice is still in place but it is hoped that this will be removed very soon.

In relation to Tier 4 admissions there was a more positive position and the partnership board had met and agreed joint work with Leeds (LYPFT) to address the blockages and discharge some of the beds. Work is still ongoing with Calderdale and Kirklees in relation to neuro development pathways and the work is included within the CAMHS service improvement plan.

CD asked for an update on Tier 4 bed availability. CH reported that it would still be some months but progress is being made.

CD raised a query around the improvement plan in terms of the neuro development and the green rag rating. CH informed the committee that it was rated green as all the actions were on target.

CH informed the Committee that the Trio undertook service visits with Barnsley and Wakefield CAMHS and reported that the teams were enthusiastic and motivated and wanted to share this with the Committee. The good work of the teams was noted.

The Committee RECEIVED and NOTED the update

CG/21/17 Quality Impact Assessment (agenda item 17) deferred

CG/21/18 Serious Incident Quarterly Report Q3 (agenda item 18)

CD noted that the report would be taken as read and received by the Committee and comments were as follows:-

DT gave a brief outline and highlighted that the 360° audit resulted in significant assurance and that the Serious Incident (SI) team are working towards accreditation through the Royal College of Psychiatrists.

KQ noted on page 7 of the report the Kirklees figure of 70% and not 81% of low or no harm and queried whether this is an issue and if there is a threshold. DT noted that there was a lower proportion within community services but higher within inpatients. DT confirmed that this will be monitored.

The committee discussed the reporting rates noting that there was a reduction in green incidents but it was not clear if this was a trend and that yellow and amber rates were rising. Clarity on this was requested.
AM noted that there was a discrepancy with the figures from the front sheet and the paper of 83% or 81%.

TB reported that:-

1. Individual BDU reports provide the information which is considered separately and also considered through the clinical risk report that goes through OMG to highlight any trends or concerns.
2. The cycle of the quarterly reports pick out the position over the quarter.
3. The annual report looks at trends and themes over a longer period.

TB informed the committee that the report was an amalgamated position of the individual reports which are considered within BDU's. TB also noted the review of trends within the clinical risk panel.

DT will consider how the Trust monitors and presents trends in regard to the rate and the denominator and pick up on the points raised above.

TB confirmed that the annual report includes benchmarking data.

AM queried page 164 of the report in relation to type and category of incidents and the number of information governance incidents within CAMHS which seemed to be significantly higher than other teams. AM also raised a query in relation to suicide rates which AM stated are in line overall but is aware that they are the highest in Yorkshire. AM has a particular concern in relation to rising suicides in Barnsley.

AM also wanted to pick up serious incident investigations where risk assessments are shown as top place and queried whether this would change with the introduction of Safe Care. DT highlighted that this question is being raised in Trusts across the country. The Safe Care approach had been welcomed and staff are finding it helpful, the Trust are in a good place and have a good foundation to move forward from.

It was noted that there were a number of queries that had been raised and these would be looked at and a timeline developed.

Action: DT

Clinical Governance and Clinical Safety Committee NOTED the quarterly report on incident management

CG/21/19 Committee Annual Report (agenda item 19)
The Committee had read and received the annual report and comments were as follows:-

KQ would like some emphasis on the QI focus and also Covid-19 to be noted in the activities section.

It was noted that only 3 people had completed the survey.

Any further comments to be fed to CD and TB

Action: All

CG/21/20 Internal Audit Report –Policy Governance Report (to receive) (agenda item 20)
Received and noted

The Committee RECEIVED and NOTED the report

CG/21/21 Nurse Revalidation Report (agenda item 21)
Committee noted the positive report and the working system.

The Committee RECEIVED and NOTED the update

CG/21/22 Freedon to Speak up Guardians Report (deferred) (agenda item 22)

CG/21/23 Smoking Policy Update (agenda item 23)
Update was given for the action log at item 4.

The Committee NOTED the update

CG/21/24 IPC BAF (agenda item 24)

The Committee received and noted the IPC BAF update.

TB noted that the Covid-19 pathway contains evidence that relates to the report and also the Committee have received the annual report on IPC BAF.

The Committee RECEIVED and NOTED the update

CG/21/25 Sub-groups – exception reporting (agenda item 25)

Drug & Therapeutic

Report received and noted. KQ queried if the TAG could look at the STOMP initiative. SThi confirmed that this was on the action plan. SThi also noted that the electronic prescribing system is now live.

It was RESOLVED to NOTE the report

Safety and Resilience

Report received and noted. It was noted that there was a lot of activity around general health and safety as well as Covid-19 and the TAG continues to support all aspects.

It was RESOLVED to NOTE the report

Infection Prevention and Control and IPC BAF

Report received and noted. Reinforcement that all outbreaks are investigated and tracked.

It was RESOLVED to NOTE the report

Safeguarding adults and children and Ockenden

Report received and noted.

It was RESOLVED to NOTE the report

Reducing Restrictive Physical Interventions Group

Report received and noted. Training numbers are down and are at 80% and this is being monitored.

It was RESOLVED to NOTE the report

Improving Clinical Information Governance Group

Report received and noted. Information governance incidents remain an issue. In view of the increased need to share patient information to support safety we remain prepared for any new or increase in data sharing agreements being requested.

It was RESOLVED to NOTE the report

Physical Health
Report received and noted. 4512 staff vaccinations have taken place so far.

It was RESOLVED to NOTE the report

Clinical Ethics Advisory Group
Report received and noted. To note that AM's name is against the item on the agenda.

It was RESOLVED to NOTE the report

CG/21/26 Serious Incidents Update (agenda item 26)
TB noted no change from the previous updates from Trust Board.

TB noted the interim 25 day report from Clark ward and the interim actions.

TB noted the sad death in Newhaven and confirmed that the Trust are working closely with the police and are awaiting a post-mortem. The family have been informed and are being supported and all reporting is in hand.

CG/21/27 Issues and items to bring to the attention of Trust Board and other Committees (agenda item 27)
SThi noted that the issue of remote Mental Health Act assessments will being taken to the Mental Health Act Committee (MHAC) for discussion before going to Board. This follows an update of advice from the Department of Health.

Alert
CQC improvement plan - Progress being made on action plan. Discussion around reporting / Risk assessment / Relationship with CQC
Waiting list improvement plan - Access to services remains a clinical priority despite significant pressures. 36 month waits in Calderdale Core Psychology
Covid-19 risks - Assurance on Workforce / Delivery of clinical services / Patient safety

Assurance
Received and discussed **Q3 Serious incident report**
Received update on **Nurse revalidation**
Received Internal Audit Repot – **Policy Management** - Significant assurance
Received and discussed **CGCS Annual report**

Committees
As above re MHAC

CG/21/28 Consideration of any changes from the organisational risk register relevant to the remit of the Clinical Governance and Clinical Safety Committee (agenda item 28)

- Nil

CG/21/29 Work Programme (agenda item 29)

Work programme received and noted that a revision is planned.

Committee Presentation
TB shared with the Committee the presentation in relation to the Committee's plans to achieve better use of time dealing with pressures in the system and essentially a suggestion with a slightly different agenda focus. TB suggested that a focus on improvement would be a way forward.

AM asked where health inequalities would sit within the work plan and TB noted this would be under improvement.

Comments to be sent to TB and CD.

Action: All

CG/21/30 Date of next meeting (agenda item 30)

The next meeting will be held on 6 April 2021 between 2.00-5.00 pm via MS Teams

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

South West Yorkshire Partnership NHS Foundation Trust

Finance, Investment & Performance Committee (FIPC) – Monday 25 January 2021
Virtual meeting, via Microsoft Teams

Members	**Present**	**Apologies**
Tim Breedon (TB) Mark Brooks (MB) Carol Harris (CH) Chris Jones (CJ) (Chair) Sam Young (SY)	Lucy Auld (LA) (Note taker)	Rob Webster (RW) Kate Quail (KQ)

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting and noted apologies. Mark Brooks (MB) advised that the meeting was quorate.	CJ	
2.	Declarations of interest	There were no declarations of interest	CJ	
3.	Minutes from previous meeting	The minutes from the FIPC meeting held on 24 November were approved.	CJ	
4.	Review of progress against agreed actions and matters arising	Action 043 – Capital regime Capital regime issues need to be kept in focus and will be discussed at the meeting today, a further update will report into the next FIP meeting. **MB agreed to work up the risk surrounding the capital regime.** Action 042 - Safer Staffing reporting MB/Carol Harris (CH) to agree a date for review, an update will be given at the next meeting.	CJ	**Action: MB**
5.	Review of committee related risks and any exception reports as required.	MB provided a brief synopsis of the report as follows: • Adult Secure lead provider (1511): There has been substantial progress on this since the last Committee meeting. The NHSE/I assessment panel has taken place and was largely positive, with a few areas for improvement highlighted. A lot of work has been undertaken on the potential benefits, financial and otherwise in the intervening period. This will be discussed in detail at item 10. • National funding (522): MB noted it is important to recognise that funding mechanisms for this year are not representative of long-term funding as they are based on nationally determined block payments and system allocations of some non-recurrent monies. The scope of the national funding arrangements is not yet known for Q1	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		21/22, but the Trust is currently in a positive position in terms of cash balances and this provides some short-term security. • Cash/CIPs (1076): This is low risk for the current year as the cash balance is high and the Trust does not currently have notable efficiency targets given the interim financial arrangements. • Out of area beds (1335): MB noted CH and the team have managed the position very effectively and numbers are being kept low however the risk remains the same. • Local authorities (275): CH identified there are different issues across each of the 'places' with learning disability (LD) placements being an area of concern, this being due to staffing issues across the system leading to slower discharges and challenges to ensure the safe running of services. • Sam Young (SY) queried the absence of reference to the vaccination risks in the paper, noting this was perhaps due to timing. MB confirmed that reference to the vaccine risks is included in the Board papers for tomorrow. • SY also noted that in general the higher score risks relate to factors not in our full control and more in our influence. She also sought assurance regarding how external relationships and influences are being managed given current competing pressures. • MB confirmed partnership working continues more than ever, with the ongoing pandemic uniting partners around a common issue. Tim Breedon (TB) added that formal contact with other organisations through the command structure has enhanced dialogue and system working, although the risk is that the subject matter is focussed primarily on a few issues rather than a broader spectrum as previously. Sean Rayner (SR), Salma Yasmeen (SYa) and CH are all heavily involved in relationship building across the ICSs. The increase in partnership working has not notably affected capacity internally, it has become more embedded into ways of working. • CJ queried the focus on the new risk (1567). CH clarified the risk relates to the Trust's ability to service internal business demands through operational teams focusing on the day to day delivery of servicing, working closely with corporate teams to support this delivery. TB added that this risk was created to ensure resources are targeted in the right place and the Trust is able to satisfy regulatory demands in the absence of a letter from the centre indicating a reduction in the burden of governance.		
6.	Current year financial performance and forecast			
6.1	Month 9 finance report	MB provided month 9 key highlights: • Caution is required when looking at the 20/21 finances in isolation as the level of funding we are receiving is not necessarily representative of the level received previously. Based on current performance some or our assumptions earlier in the year have been shown to be prudent, for example not all staff have been recruited for the Mental Health investments, out of area bed usage is lower than expected, and the level of the Covid-19 response spend is lower than we originally predicted.	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• In addition to this the Trust has received additional monies throughout the year, leading to a healthy financial position of 600k surplus in month 9, despite incurring some heavy premiums in supporting the Christmas working incentive scheme and the voucher issued to all staff as an additional health and wellbeing gesture. • MB highlighted that we mustn't lose sight of the fact we are spending more this year than in previous years, and that capital expenditure is not where it should be. • The new arrangements with SBS are improving each month and on average suppliers are currently being paid within 15 days. • CJ noted that the Covid-19 costs are substantial and could still be necessary for a longer period of time given the longevity of the pandemic, therefore this is something to keep in mind in terms of financial planning for next year.		
6.2	Full year forecast including risks and possible upsides	MB provided the key highlights in terms of forecast: • All organisations in West Yorkshire (WY) have been asked to submit a revised forecast in early February with some risks identified across the ICS, given that the plans were set in September 2020 and the significant changes to the Covid-19 response since then. Much will depend on which of these risks are considered allowable e.g. holiday pay, non-NHS income, Flowers • Year to date performance reports a surplus of £1.3m against the projection of a deficit after 3 months. • BDUs regularly update their forecasts with monthly review meetings taking place with the director of finance and director of operations as usual. • Testing on holiday pay assumptions shows the projections remain realistic. • More guidance is expected on the Flowers judgement towards the end of February. • The Trust differs slightly from other organisations in West Yorkshire given that we need to consider two systems, those being the Barnsley system and the West Yorkshire system. We need to ensure we support both. • MB proposed a revised forecast submission of between £0.5m deficit and £0.5m surplus, noting that as a minimum the Trust should reach £1.5m better than planned. • TB queried whether acute trusts are generally in a similar or better position in terms of forecast. MB explained that from a system position it appears that many of the risks identified in September are reducing, although the impact of the pandemic on the Yorkshire Ambulance Service (YAS) is resulting in additional financial pressures. MB is participating in a call this afternoon with West Yorkshire finance directors to look at how this £3m risk can be addressed. • At this point in time, it is important to state that going back to the original assumptions, which exclude any incremental Flowers adjustments etc, the WY system should not face significant issues in achieving its forecast. • SY indicated agreement in the necessity to support both the West Yorkshire and Barnsley systems in tandem. • SY queried how the Committee would be sighted on the caveat noted in the papers of 'subject to any notable issues arising'. MB confirmed this caveat is in place to protect us from any national issues that could arise given the current climate.	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• CJ noted the overall position is similar to last year. We should be seen to be supporting the system and maintaining good relationships with partners whilst maintaining the financial integrity of the Trust and its ability to deliver our services. We should understand our cost base and manage it as effectively as possible in the current unstable environment, preparing for next year as well as focusing on this year's outturn position **The Committee supported the recommendation to Board to submit a revised forecast of between £0.5m deficit and £0.5m surplus.**		
7.	Financial risk share – West Yorkshire ICS 20/21	• MB highlighted that the proposed recommendation is endorsed by all finance directors across West Yorkshire and is for 2020/21 only, given the financial arrangements are not yet known beyond this. A risk share agreement may be required for 2021/22 and if so, this would need to be a revised version given how the funding streams may work. • It is recognised that substantial additional monies have been received across the system due to the Covid-19 pandemic and that some organisations may spend more or less than others • MB has written to Jonathan Webb to confirm that the Trust will improve its year-end outturn compared to the original plan. • The risk share arrangements as proposed relate to £8.9m which the ICS considers to be the net risk after national adjustments are made for technical and other factors largely outside its control. If the £8.9m is not delivered, each organisation will be asked to take a fair share of the risk by 'place'. This is in line with the principle of 'place' having leadership and priority within the system. • The only potential risk currently relates to YAS as previously identified and is expected to be covered by improved positions across each of the places in West Yorkshire. • It is important to recognise the principle of the agreement as a way of working across the ICS as this type of approach may be required in the future and appears a pragmatic solution for the potential £8.9m deficit. • SY noted that the agreement appears to be relevant for next year and that if an agreement is required next year this version could be built upon rather than anything taken away. • MB agreed and again noted the need to support the Barnsley system if required. • CJ noted the model as described and added that the principles seem reasonable but will not be fully put to test until under pressure. He reiterated that the arrangements would need to be reviewed further if a similar agreement in 21/22 is to be effective, in particular in relation to the apparent unlimited indemnity, where a cap would add security for the organisations involved. The agreement relies on honest relationships between partners in terms of financial positions in order to manage the risks effectively and proactively. Overall, the principle is firm and these are practical issues arising that will be worked out in practice. • MB confirmed arrangements in South Yorkshire & Bassetlaw (SY&B) ICS and the Barnsley system will continue to be monitored in terms of our involvement should a similar situation arise there. We have strong relationships in Barnsley and as a Trust we are well-placed to be involved in these discussions moving forward.	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		The Committee confirmed and approved the financial risk share arrangements in West Yorkshire for 2020/21, noting that a refreshed agreement would be required for 2021/22.		
8.	Capital Expenditure forecast	MB presented the key challenges: • The Trust has an agreed capital budget of £6.6m for 2020/21. The forecast was reduced to £5.6m and now the recommendation is to reduce further to £5m leaving us circa £1m to spend in each of the last three months of Q4. • Large projects to account for this reduction in forecast include: - Work on Willow Ward of circa £200k: The tender process is now complete with returns received of much higher values than expected, therefore producing debate as to whether to continue ahead with the developments on this basis. Nick Phillips will review the tender specifications and take appropriate action. - Beachdale Gardens: The contractual arrangements are taking longer to determine given the PFI implication. - Covid-19 has affected the sign off of the harm audits, as resources have been focussed on the Covid-19 and vaccine response, so these are likely to be deferred until next year. IM&T resources have also been affected given the change in organisational priorities for this year. • Current orders suggest a minimum spend of £4.4m and with additional work the target of £5m should be achievable. • MB informed following a high-level ICS exercise capital spend requirements in West Yorkshire could exceed capital available by circa £50m. • MB highlighted the two asks as being: - Recognition of the reduction in the capital expenditure forecast - Recognition that the change in capital regime could impact on our ability to spend money, and therefore complete all the projects we wish to in 21/22 • CJ confirmed support for the revised forecast given the assurances from MB that there is no detriment to the Trust should we land at £4.4m rather than the aspired £5m. • MB confirmed we will not be seeking any notable single waiver tenders in March given the £4.4m orders already in place. CJ agreed, noting that the Trust should not be seen to be seeking these as it would not reflect the substantial planning that has gone into the process of demonstrating value for money on our capital expenditure programme.. **The Committee agreed to endorse a capital expenditure forecast of £5.0m for 2020/21.**	MB	
9.	2021/22 planning update	MB highlighted the key points to note: • Further to the letter received by the Trust in December 2020 outlining key priorities for 2020/21 and principles relating to the operating and financial plan for 2021/22, it has now been communicated that given the national Covid-19	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		position, there will not be a formal planning and contracting process carried out in readiness for Q1 of 2021/22. Instead the existing financial arrangements will be carried over although the financial values are not yet determined • Internally, work is ongoing across the BDUs and corporate services to establish our baseline cost profile for 2021/22. This involves understanding cost movements between 2019/20 and 2020/21 forecast, and the original plan for 2020/21 against the 2020/21 forecast. From this, a baseline for 2021/22 can be established. • Understanding this will enable us to make reasonable working assumptions for our run rate cost base. The new head of financial planning, Louise King, started at the Trust last week and is assisting the management of this process. An exercise has also been conducted with Clinical Commissioning Groups (CCGs) to support baseline income assumptions. • MB commented that, the direction of travel is likely to go back to what the Long Term Plan says in terms of investment in mental health, with some levels of adjustment for cost efficiencies. There will also be £500m national monies made available from April 2021 to invest in the surge in demand expected as a result of the pandemic. • MB highlighted that the internal planning process is ongoing using a small, core team. The Trust is striving to get into a good position looking at the triangulation of finance and workforce. • CJ noted the financial planning arrangements are a fluid and evolving process. Given the level of control we have in terms of the national picture, the work MB and the team have done and continue to do is a good piece of planning work and he is fully supportive of the process, recognising that the more accurate this is will aid the process in the future. • TB noted the difficulty in distinguishing between the Covid-19 response monies against that identified as the normal core business monies, and what it means for the Trust when the pandemic is over in terms of the overall financial envelope for the Trust. • CJ added that the political and economic context here is significant ahead of the budget in March. **The Committee noted the report and agreed that it is useful for the Committee to see and be kept up to date outside of the meetings.**		
10.	Forensics Lead Provider – financial position	MB provided key headlines outlining the main risks and next steps: • A huge amount of work has been progressed by the Collaborative to look at the historical financial performance of these services and validating the information received from NHSE/I in terms of activity. • This recognised a sizeable deficit across the three NHS organisations for the provision of these services of circa £4.5m, that has been happening over a number of years. The Collaborative will have responsibility for operating the whole financial picture in future years including the commissioning monies.	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• NHSE/I have provided a baseline calculation of income for each provider and the collaborative in total, with a series of assumptions and calculations being made to develop the financial plan, this has identified some risks. • Particularly of note, due to the transforming care agenda for people with LD the aim has been to focus on reducing the number of people in beds, and numbers have reduced over the last few years. This has resulted in a £180k per annum income reduction to the Collaborative per each LD bed no longer commissioned. SWYPFT has previously agreed with the specialist commissioner that the reduction in LD beds would be offset by an increase in medium secure male beds. MB does not believe that the £2.4m reduction in baseline income to the Collaborative is appropriate given additional activity in other pathways. • Following discussion with partners MB proposes to write to NHSE/I with a number of requests as set out below to enable the Collaborative to have better financial assurance in order to go live. - The FTA adjustment of £2.4m is not applied given the fact total activity levels have not notably changed. - The collaborative bears no risk in the first year for exceptional packages of care over and above recent levels - The additional 1.4% tariff provided in 2020/21 is not withdrawn in 2021/22 - Given the recent announcement that planning and contracting arrangements are deferred for a quarter it is recommended that the collaborative request that the financial arrangements for the first quarter of 2021/22 remain in line with those currently in place • MB talked through the costing table on page 2 of the paper, highlighting the potential financial efficiencies and holistic financial projections that have been identified based on solid assumptions, with some contingency identified. MB noted that taking all of the available information into account the Collaborative would be in deficit, albeit at a reducing level ranging between £1.9m to £3.0m. • CJ clarified the position to be that if we are successful in re-instating the £2.4m in relation to LD this would put us in a more reasonable position and enable us to manage some financial risk • MB noted the small upside shown in relation to the £1.1m for 2 years to identify whether a working community model can work. Other provider collaboratives in the country have gone live with this and are starting to see the benefits of the lower costs of managing LD within the community, however this will need to be monitored closely to ensure it is cost effective for us. • MB highlighted that we cannot lose sight of the fact that the three NHS providers current incur deficits in providing these services, so we need some focus on improving these positions. • Longer term opportunities to improve on this position have been identified including greater ambition for service user repatriation, establishment of new service pathways in the region with the potential use of the Gaskell ward, sharing of best practice and reduced length of stay. The details of these opportunities are yet to be worked out in detail.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• The Committee and Board also need to consider the level of risk appetite for the Trust. We should be cognisant of the national direction that provider collaboratives are the expected future way of working, but we must also ensure the deal that we agree to is the best possible and is achievable in delivering the best results for our services. • There are a small number of other actions to be completed in to enable the submission of a financial plan including working on the bed planning and potential risk sharing scenarios in line with the above. MB opened the discussion up for questions: • TB highlighted the fundamental benefit of having input from Dr Adrian Berry given his understanding of the complex clinical system and model in addition to the financial position. • TB also added the longer test will be in terms of the community model, through-put and the real impact this has on the reduction of bed numbers. This will affect the through-put across other services. • CH agreed and added that the repatriation of beds is a really important factor and the use of Gaskell Ward in assisting with this should compensate. • CJ queried whether the Collaborative has the capacity to fulfil the repatriation as proposed, given challenges with staffing. MB clarified that given current safer staffing models in place in forensics, in theory this should be manageable with the risk not being any worse than is currently being managed, CH confirmed the level of challenge would remain as it is now, however the potential use of Gaskell Ward in future could be difficult to staff if this leads to a further staffing model due to a revised service offer. • SY confirmed support for the proposal, highlighting the risks previously discussed and querying the operational benefits of taking on the financial risks. MB/CH agreed that the clinical risks of this model are no more of a risk than the Trust currently manages, but there are definite upsides in terms of control over pathways between low, medium and secure services, and the benefits in terms of services we do not currently provide including: Males with a personality disorder; women in forensic care; and keeping overall care pathways within West Yorkshire for people in West Yorkshire, with definite greater opportunities to improve across the area. • The role of this Committee is to look at the financial risks, with the role of Board being to look at the overall picture. • The Committee asked that the points raised in MB's proposed letter regarding funding and financial safeguards are requirements, not requests. CJ summarised that provider collaboratives appear to be the future direction nationally. The Trust can benefit from leading this collaborative well and despite the risks in taking it on, there is also a risk of not doing so, therefore the overall risk appears marginal and is worth taking given the potential service benefits.		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		The Committee approved the recommended approach for the financial plan ahead of the Board discussion tomorrow. The Committee also approved the proposed formal communication to NHS England outlining the points raised above.		
11.	Horizon scanning	MB noted this agenda item has been covered within the preceding updates.	MB	
12.	Annual work plan and meeting frequency	• CJ noted the Committee has covered finances diligently but queried if performance issues have been discussed adequately within the Committee remit. • MB indicated a work programme has been drawn up with a bi-monthly schedule, recognising the need for the Committee to be flexible and in some cases reactive in the current climate. He sought a level of consensus from the Committee regarding the timetable and opened up for discussion leading to agreement of the following: • FIP deemed it was not necessary to hold a Committee meeting in February, given that the financial context is unlikely to change substantially. The next meeting will be held in March to focus on year-end and 2021/22 arrangements. • FIP agreed to hold a substantial Committee meeting bi-monthly and have a shorter 'focus on' performance meeting every other month to give an opportunity for involved discussion on specific issues to be agreed by the Committee. **TB/CH to discuss and recommend a number of performance items that would benefit from a focused review at FIP, for consideration and scheduling onto the workplan at the next meeting in March.**	CJ	**Action: TB/CH**
13	Items to be brought to the attention of the Trust Board / Committees	• FIP noted the current year financial performance and forecast is better than originally planned and supported the recommendation to Board to submit a revised forecast of between £0.5m deficit and £0.5m surplus. • FIP agreed to approve the proposed financial risk share arrangements for WY&H ICS in 2020/21. • FIP agreed to endorse the revised capital expenditure forecast of £5m for 2020/21, whilst noting some concerns regarding its deliverability. • FIP approved the approach to the financial planning for the forensic lead provider collaborative and; • Approved the substance of the proposed formal communication to be sent to NHSE/I from MB. • FIP agreed to meet again in March given there should be no substantial change to the financial position in Feb, with a view to holding monthly meetings with a full FIPC agenda bi-monthly, interspersed with a shorter performance focused meeting. • **Action agreed – To work up the risk surrounding the capital regime.** • **Action agreed – CH/TB to agree 3-4 performance areas for focus at FIP on a bi-monthly basis.**		
	The next meeting date of the Committee	The Committee agreed the next meeting will be held in March 2021, date TBC.		

Minutes of the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Thursday 21st January 2021, 10.00 – 11.20am

Virtually by Microsoft Teams

Present:

Angela Monaghan (AM) – Chair, South West Yorkshire Partnership NHS Foundation Trust
Cathy Elliott (Chair) (CE) – Chair, Bradford District Care NHS Foundation Trust
Keir Shillaker (KS)- Programme Director, West Yorkshire and Harrogate Health and Care Partnership
Paul Hogg (PH) – Company Secretary, Bradford District Care NHS Foundation Trust
Sara Munro (SM) – Chief Executive Officer, Leeds & York Partnership NHS Foundation Trust
Sue Proctor (SP) - Chair, Leeds & York Partnership NHS Foundation Trust
Thea Stein (TS) – Chief Executive Officer, Leeds Community Healthcare NHS Trust
Therese Patten (TP) - Chief Executive Officer, Bradford District Care NHS Foundation Trust
Rob Webster (RW) – Chief Executive Officer, South West Yorkshire Partnership NHS Foundation Trust

In attendance:

Lucy Rushworth (minutes) (LR) – Project Support Officer, West Yorkshire and Harrogate Health and Care Partnership
Salma Yasmeen (SY) – Strategy Director, South West Yorkshire Partnership NHS Foundation Trust

Apologies:

None received.

Glossary of acronyms in this document can be found on page 5.

Item	Discussion / Actions	By whom
1	**Introductions:** Cathy Elliott (CE) welcomed the group, there were no apologies other than Thea Stein (TS) joining the meeting at 10.00am and Rob Webster (RW) leaving the meeting at 10.45am.	
2	**Declaration of Interests Matrix / Conflict of Interest:** The Declaration of Interest Matrix will be updated with the following: <u>Removal</u> of Patrick Scott as Interim Chief Executive Officer for Bradford District Care NHS Foundation Trust (BDCFT). <u>Removal</u> of Angela Monaghan (AM) spouse declared interest due to retirement. <u>Add</u> Therese Pattern (TP) as Chief Executive Officer (CEO) for BDCFT.	
3a	**Review of Previous Minutes:** The minutes from the 22nd October 2020 were reviewed by the meeting group and were accepted as an accurate record.	
3b	**Actions log and matters arising:** The matters arising were discussed as follows: The successful West Yorkshire and Harrogate Health and Care Partnership (WY&HHCP) Mental Health, Learning Disabilities and Autism (MHLDA) Non-Executive Director (NED) and Governor virtual event, which was well received and attended with good engagement. The next event has been held in diaries for the 11th June 2021. The CEOs aim to be proactive in capital planning and requirements into 2021/2022, there is a national indication that the Integrated Care System (ICS) will be having more of a control over this,	

Item	Discussion / Actions	By whom
	and this will require a shared view and strategy going forward. It was agreed for capital planning to be on a future Committees-in-Common (CinC) meeting agenda. The main and strategic meeting action logs were reviewed by the meeting **AGREED** It was agreed by CinC to continue with the additional strategic planning sessions, following the productive first meeting in September 2020. The next one in February 2021 will be rescheduled to 17 May due to the third phase of the pandemic, and suggested strategic topics were shared by attendees to note for the next session. Keir Shillaker (KS) updated the group on a proposed formal 'Gateway' process which will see wider discussions amongst provider collaborative executives of agenda items prior to MHLDA programme boards. There was a conversation about the MHLDA strategy which should continue to form the framework for what we cover at strategic meetings, but to also include the Black, Asian and Minority Ethnicity (BAME) review and the and Learning Disability (LD) review. Agreed best practice by the collaborative should be continually captured, and can be shared regionally and nationally for those that are in the beginning of their collaborative journey.	
	Governance	
4	**Reviewing the Memorandum of Understanding (MoU)** Paul Hogg (PH) presented highlights of the MoU which has been reviewed with the collaborative's respective Chairs and Company Secretaries during December 2020 and January 2021 which asked the CinC to: a) Consider the proposed changes to the draft MoU at Appendix 1; b) Discuss the recommendation to allow Deputy Chairs/NEDs to observe Committees-in-Common meetings, but not Governors; c) Approve the draft summary of the purpose and work of the CinC at Appendix 2 for use on the Mental Health, Learning Disabilities and Autism Collaborative website and with external partners; d) Approve the new assurance Triple-A report format at Appendix 3. There was an additional point raised by PH in relation to identifying the public and private CinC minutes. The meeting discussed and supported the proposed Triple-A reporting in addition to the public minutes being circulated to respective Boards in the collaborative for consistency in reporting. It was agreed that NEDs could attend CinC for specific development purposes or with regard to specific discussion items. Discussion was held about the need to ensure more visibility of joint working through the collaborative via the MHLDA webpages and potential creation of an annual report. The CinC thanked the Company Secretaries for this piece of work. A final request was to ensure that Directors of Finance (DoF) were content with the content of section 5 before ratifying through	

Item	Discussion / Actions	By whom
	organisational boards. Noted: That the Terms of Reference (ToR) were approved previously. **ACTION** PH and KS to meet and discuss the balance of public and private minutes for the CinC. **ACTION 1/01** Create a circulation list of key stakeholders for updates on work of the CinC and explore possible website presence for this work. **ACTION 2/01** Company Secretaries to gain final comments from the DOFs in relation to section 5. **Action 3/01** PH to send final MoU to Lucy Rushworth (LR) to circulate by email to the CinC. **ACTION 4/01** All to take the final MoU to their Board for approval in February and no later than March and each report how the MoU is working in principle and in practice at future CinC meetings. **ACTION 5/01** **AGREED** The CinC principally agree to the subjected changes discussed and proposed. *TS joined at this point in the meeting.*	**PH/KS** **KS/LR** **Co-Secs** **PH** **ALL**
	Assurance	
5	**Programme Update** <u>Response to the LeDer Review</u> The programme is taking a proposal paper to the Senior Leadership Executive Group (SLEG) to outline the national and regional evidence on the impact of COVID 19 on learning disability deaths. The purpose of the SLEG discussion is to set collective responsibility as a partnership for addressing this inequality with expectations for all partners in the ICS to commit to it. The CinC welcomed the approach as outlined and discussed possible links with the work of the Operational Delivery Network. Further discussion centred around current Covid19 (C19) vaccination prioritisation which does not feature this cohort, however there could be an opportunity to put people with a Learning Disability (LD) and their carers higher up on the 'other conditions' category once the first four priority groups have received their vaccinations. SM offered to present to the Chairs network to raise awareness across the ICS and influence leaders. **ACTION** RW & Sara Munro (SM) to explore the prioritisation of vaccines for people with LD in the sector leads meeting. **ACTION 6/01** <u>Complex Rehab</u> The CinC were asked to be aware of timescales as presented.	**RW/SM**

Item	Discussion / Actions	By whom
	MH & Wellbeing Hub The hub has now commenced, led by a psychology leadership team that will identify needs, coordinate services and provide triage for complex cases. There was a request for this item to be placed on the next CinC agenda. Transformation Funding There are large volumes of funding being discharged through the programme, including the Community Mental Health Transformation Bid of £5.2million which was submitted to NHS England (NHSE) on the 20/01/2021. KS thanked the Trusts and their teams that have been able to contribute. Adult Secure A verbal Board update will be provided for each organisation in January 2021 and the business case will be scheduled for Boards in February 2021.	
6	**Focus on: ATU** RW shared that there is positive work into the clinical models and shared working, the completion timescale has changed from April to July 2021. TP added that there may be some programme support required for resourcing the model which will be discussed with KS. There will be some changes to the MH Act due to the current White Paper from which there will be implications to the service to be worked through. Joint Health Overview and Scrutiny Committee (JHOSC) will firstly be sighted on the engagement work undertaken to date. *RW left the meeting at this point.* The engagement process includes people who have attended/worked in ATU with this process being extended multiple times due to C19, and CinC noted a clear narrative to explain that the engagement has been carried out completely and properly given the circumstances. Examples of engagement and consultation on service provision during C19 were invited to be shared with KS. **ACTIONS** TP to meet with KS to discuss programme support for resourcing the ATU model. **ACTION 7/01** ATU transformation plan to be on the next CinC agenda. **ACTION 8/01** ATU transformation plans to be reported to respective Boards by February 2021. A Private Board update can be provided before February Board meetings, noting today's CinC Lead Provider decisions in private today. **ACTION 9/01**	**TP** **CinC** **CinC**
7	**Update: Prevention & Management of Violence & Aggression (PMVA)** There has been progress made from the working group which is looking at ways in which the collaborative is working together consistently in restraint and de-escalation techniques with the aim to share staff across CinC services and assist in joint working (e.g. ATU).	

Item	Discussion / Actions	By whom
	Guidance from National Institute for Health and Care Excellence (NICE) and the restraint reduction network has given the group a broad framework of principles, although there is a shared ambition to have more engagement with service users to measure impact. Reflections on the two main differences were shared which is currently a focus for the working group which are risk assessments for individuals and interventional holds. Each organisation has taken part in virtual workshops and there are scheduled dates in place for a simulation day to look at the specific differences in the holds to help understand the next steps for this work. It is hoped that we can modify existing curricula sufficiently to create consistency, although the simulation day taking place is dependent on reduced COVID restrictions. Should curricula not be modifiable it may mean that LYPFT (as a subscriber to the GSA curriculum) consider coming out of their current arrangements to help facilitate a collaborative approach. CinC had comments around the level of work needed to proceed with this outcome, with the added difficulty of having a real-life scenario compared to textbook. The data on when restraint is used would be welcomed in the next report to understand frequency of occurrence. **ACTION** KS to add where possible the data metrics into future PMVA papers. **ACTION 10/01**	**KS**
	Problem Solving	
8	Tracking MH demand will be placed on the next strategic meeting agenda, especially noting the collaborative seeing an increase in demand for MH services due to the pandemic and need to future plan models of care, following the impact of the pandemic.	
	Agreement of Outputs	
9	**The following will be reported at the respective Boards of CinC:** <u>January 2021:</u> Adult Secure financial planning (verbal update). <u>February 2021:</u> ATU Provision; MoU; Adult Secure (Business Case). The LeDer review is also to be shared with the Chairs network.	
10	**Any Other Business** MH Legislation committee and officers are to meet and have a joint discussion about the impact of the MH Act White Paper consultation. The deadline for the consultation is 21st April 2021. **ACTION** Lucy Rushworth (LR) to arrange a meeting for the MH committee and officers regarding the impact of the MH Act consultation. **ACTION 11/01** CE summarised the meeting, including items for the new Triple-A style reporting on which to Alert and Assure respective Boards which were supported. CE thanked attendees for their contributions to the meeting.	**LR**

Item	Discussion / Actions	By whom
	Date and Time of Next Meeting: Thursday 22nd April 2021, 10.00am-12:30pm	
	Glossary	

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
C-In-C	Committees in Common
CCG	Clinical Commissioning Group
DTOC	Delayed Transfers of Care
ICS	Integrated Care System
LD	Learning Disabilities
LCH	Leeds Community Healthcare NHS Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MHLDA	Mental Health, Learning Disabilities and Autism
MoU	Memorandum of Understanding
NCM	New Care Model
NED	Non-Executive Director
NHSE/I	National Health Service England / Improvement
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
TCP	Transforming Care Programme
VCH	Voluntary and Community Sector
WY&H	West Yorkshire & Harrogate
WY&H HCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H ICS	West Yorkshire & Harrogate Integrated Care System (internal reference to WY&H HCP)
WYMHSC C-In-C	West Yorkshire Mental Health Services Collaborative Committees in Common

South West Yorkshire Partnership NHS Foundation Trust

(Draft) Trust Board annual work programme 2021-22

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item previously deferred due to Covid-19

Note that some items may be verbal

SO	Agenda item / issue	27 Apr	25 May	29 June	27 July	24 Aug	28 Sept	26 Oct	30 Nov	21 Dec	25 Jan	22 Feb	29 Mar
	Standing items												
	Declarations of interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
	Minutes of previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
	Chair and Chief Executive's report	✘		✘	✘		✘	✘	✘		✘		✘
	Business developments	✘		✘	✘		✘	✘	✘		✘		✘
	ICS developments	✘		✘	✘		✘	✘	✘		✘		✘
	Integrated performance report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
	Serious Incidents (private session) - verbal	✘		✘	✘		✘	✘	✘		✘		✘
	Assurance from Trust Board committees and Members Council	✘		✘	✘		✘	✘	✘		✘		✘
	Receipt of minutes of partnership boards	✘		✘	✘		✘	✘	✘		✘		✘

With **all of us** in mind.

SO	Agenda item / issue	27 Apr	25 May	29 June	27 July	24 Aug	28 Sept	26 Oct	30 Nov	21 Dec	25 Jan	22 Feb	29 Mar
	Questions from the public (to receive in writing during Covid-19 pandemic)	✘		✘	✘		✘	✘	✘		✘		✘
	Quarterly items												
	Corporate / organisational risk register	✘			✘			✘			✘		
	Board assurance framework	✘			✘			✘			✘		
	Serious incidents quarterly report	✘		✘			✘		✘				✘
	Use of Trust Seal			✘			✘		✘				✘
	Half yearly items												
	Safer staffing report	✘						✘					
	Digital strategy (including IMT) update							✘					
	Estates strategy update				✘						✘		
	Annual items												
	Strategic overview of business and associated risks									✘			
	Investment appraisal framework (private session)							✘					
	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 working hours	✘											
	Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	✘											
	Review of Risk Appetite Statement							✘					

SO	Agenda item / issue	27 Apr	25 May	29 June	27 July	24 Aug	28 Sept	26 Oct	30 Nov	21 Dec	25 Jan	22 Feb	29 Mar
	Health and safety annual report			✘									
	Patient Experience annual report			✘									
	Serious incidents annual report			✘									
	Equality and diversity annual report							✘					
	Medical appraisal / revalidation annual report				✘								
	Sustainability annual report						✘						
	Workforce Equality Standards						✘						
	Assessment against NHS Constitution			✘					✘				
	Data Security and Protection toolkit	✘										✘	
	Strategic objectives												✘
	Trust Board annual work programme											✘ (draft)	✘
	Operational plan										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
	Five year plan (for review in November 2023)												
	Strategic Board (headings to be considered)												
	Board Development		✘			✘				✘		✘	
	Covid-19 Reflections												
	Horizon Scanning												
	Policies and strategies												
	Constitution (including Standing Orders) and Scheme of Delegation *(January 2020) (deferred to June 2021)*			✘									
	Customer Services policy *(May 2021)*		✘										

SO	Agenda item / issue	27 Apr	25 May	29 June	27 July	24 Aug	28 Sept	26 Oct	30 Nov	21 Dec	25 Jan	22 Feb	29 Mar
	Estates strategy *(July 2022) (in draft prior to sign off) (private)*												✘
	Learning from Healthcare Deaths Policy (January 2022)										✘		
	Sustainability strategy *(June 2020)*			✘									
	Organisational Development Strategy *(June 2020)*				✘								
	Procurement Strategy (June 2021)			✘									
	Workforce strategy *(March 2020)*	✘											
	Quality strategy *(September 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 (deferred to await ICS development changes) (Scheme of Delegation may need to come back in 2021/22 for further update)
- Digital Strategy (March 2024)
- Equality, Involvement, Communication and Membership Strategy (October 2023)
- Customer Services Policy *(next due for review in June 2020, extended to October 2020 now due May 2021)*
- Digital Strategy *(next due for review in March 2024)*
- Estates Strategy *(next due for review in July 2022)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2022)*
- 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) (amendment version June 2021) *(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 2024)*
- Workforce Strategy *(next due for review in March 2023 (if approved at Board March 2020))*