Trust Board (business and risk)
Tuesday 27 July 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	**Paper/Verbal**	2	To receive
3.	9.03	**Minutes from previous Trust Board meeting held 29 June 2021**	Chair	**Paper**	2	To approve
4.	9.05	**Matters arising from previous Trust Board meeting held 29 June 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**	Interim Chief Executive	**Paper**	7	To receive
8.	9.30	**Risk and assurance**				
	9.30	8.1 Board Assurance Framework	Assistant Director of Corporate Governance, Performance and Risk	**Paper**	10	To receive

With **all of us** in mind.

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	9.40	8.2 Corporate / organisational risk register	Assistant Director of Corporate Governance, Performance and Risk	**Paper**	10	To receive
9.	**09.50**	**Business developments & collaborative partnership working**				
	09.50	9.1 Integrated Care System developments – white paper update	Director of Strategy	**Paper**	5	To receive
	09.55	9.2 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Interim Chief Executive and Director of Strategy	**Paper**	10	To receive
	10.05	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
	10.15	9.4 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive
	10.20	*Break*			*5*	
10.	**10.25**	**Performance reports**				
	10.25	10.1 Integrated Performance Report (IPR) month 3 2021/22	Director of Nursing & Quality/Assistant Director of Corporate Governance, Performance and Risk	**Paper**	45	To receive
	11.10	10.2 Focus on report - Service Demand	Director of Operations	**Paper**	10	To receive
	11.20	*Break*			*5*	
11.	**11.25**	**Governance matters**				

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	11.25	11.1 Motion to Amend the Trust Constitution	Chair	**Paper**	15	To approve
	11.40	11.2 Assessment against NHS Constitution	Assistant Director of Corporate Governance, Performance and Risk	**Paper**	5	To receive
	11.45	11.3 Committee Membership	Chair	**Paper**	5	To receive
	11.50	11.4 Quality Account update for 2020/21	Director of Nursing and Quality/Assistant Director of Corporate Governance, Performance and Risk	**Paper**	5	To approve
12.	**11.55**	**Assurance and receipt of minutes from Trust Board committees**	Chairs of committees	**Paper**	10	To receive
		- Audit Committee 13 July 2021				
		- Finance, Investment & Performance Committee 24 July 2021				
		- Workforce and Remuneration Committee 20 July 2021				
13.	**12.05**	**Trust Board work programme 2021/22**	Chair	**Paper**	3	To receive
14.	**12.08**	**Date of next meeting**	Chair	**Verbal item**	2	To note
		The next Trust Board meeting held in public will be held on 28 September 2021				
15.	**12.10**	**Questions from the public**	Chair	**Verbal item**	20	To receive
		(received in advance in writing)				
	12.30	*Close*				

Trust Board 27 July 2021
Agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Corporate Governance team on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the UK Corporate Governance Code, Monitor's (now NHS England / Improvement's) Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Any background papers/ previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality reviewed and scheduled for Board approval March 2021.
Executive summary:	**Declaration of interests** The Trust's Constitution and the NHS rules on corporate governance, the UK Corporate Governance Code and NHS England / Improvement require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Head of Corporate Governance (Company Secretary) so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution.

Non-Executive Director declaration of independence

Monitor's (now NHS England / Improvement) Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect.

Fit and proper person requirement

There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for Directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements.

The Head of Corporate Governance (Company Secretary) is responsible for administering the process on behalf of the Chief Executive of the Trust. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website.

In February 2017, NHS England released new guidance on Managing Conflicts of Interest in the NHS including a model policy which took effect from 1 June 2017. The Standards of Business Conduct Policy (conflict of interest policy) for staff was updated to align with the model policy and approved by Trust Board in March 2020.

The Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was reviewed in March 2021 with minor amendments to titles referenced within the policy, and remains compliant with the above.

Risk appetite

The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and

	independence process and the fit and proper person declaration undertaken annually support this.
Recommendation:	**Trust Board is asked to CONSIDER the attached updates, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

Trust Board 27 July 2021

**Updates to the register of interests of the directors (Trust Board)
From 1 May 2021 to 31 March 2022**

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by Monitor's (now NHS England / Improvement) Code of Governance, which requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following updates to the declarations of interest have been made by the Trust Board since the Annual update in March 2021:

Name	Declaration
Chair	
MONAGHAN, Angela Chair	Spouse is Associate Consultant with Project Rome. Consultancy projects may include NHS clients.
Non-Executive Directors	
Natalie McMillan Non-Executive Director (appointed 1 May 2021)	Director/owner of McMillan and Associates Ltd Chair of Kyra Women's Project, York

Minutes of the Trust Board meeting held on 29 June 2021
Microsoft Teams Meeting

Present:	Angela Monaghan (AM)	Chair
	Mike Ford (MF)	Non-Executive Director
	Chris Jones (CJ)	Deputy Chair / Senior Independent Director
	Erfana Mahmood (EM)	Non-Executive Director
	Natalie McMillan	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Tim Breedon (TB)	Director of Nursing and Quality / Deputy Chief Executive
	Mark Brooks (MB)	Director of Finance and Resources
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Dr.Subha Thiyagesh (ST)	Medical Director

Apologies:	<u>Members</u>
	Nil
	<u>Attendees</u>
	Nil

In attendance:	Carol Harris (CH)	Director of Operations
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
	Angie Balmer	Co- lead for Yorkshire & Humber Operational Delivery Network
	Chloe Dexter	Business Support Officer for Yorkshire & Humber Operational Delivery Network
	Catherine Horbury	Co- lead for Yorkshire & Humber Operational Delivery Network

Observers:	Three Trust governors
	Two members of the public

TB/21/48 Welcome, introduction and apologies (agenda item 1)

The Chair, Angela Monaghan (AM) welcomed everyone to the meeting. No apologies were noted, 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.

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A video of a poem was played from Carers' Week, read by "Ros".

AM thanked Ros for her poem and stated it was inspiring and a testament to all carers across the Trust and in our communities.

AM introduced Chiara DeBiase who is observing the Board on placement for six months with the Trust as part of the Insight programme, which is supported by GatenbySanderson. The Insight programme is to support people coming from non-traditional backgrounds into Non-Executive roles within the NHS.

Chiara introduced herself as the director of patient services at Anthony Nolan, a blood stem cell transplant organisation. Chiara is a physiotherapist by background specialising in cancer and palliative care and was the inpatient lead physiotherapist at St Bartholomew's Hospital in London for many years.

TB/21/49   Declarations of interests (agenda item 2)

Rob Webster (RW) declared an interest for item 9.4. No further declarations were made.

It was RESOLVED to NOTE the declaration of interest for item 9.4.

TB/21/50   Minutes from previous Trust Board meeting held 27 April 2021 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 27 April 2021 as a true and accurate record.

TB/21/51   Matters arising from previous Trust Board meeting held 27 April 2021 (agenda item 4)

The following items from the action log were reviewed:

TB/21/38 – Equality, Inclusion and Involvement (EII) Committee to review what the Trust is doing for people with learning disabilities, including staff, outside of Trust specialist services. Tim Breedon (TB) confirmed this action has been completed. To close.

TB/21/39b – in relation to Risk 1368 – Carol Harris (CH) has provided an update. To close.

TB/21/41a – IPR learning disabilities indicator - TB reported he had established it was incorrect. This has been amended. To close.

TB/21/41a – Mark Brooks (MB) confirmed this had been looked into and there was nothing untoward regarding the Dell invoices. To close.

TB/21/23a – Finance Investment and Performance (FIP) has agreed to use insight provided by the Benchmarking Group, and other committees to identify emerging performance risks for more detailed review. These will be built into the work programme as appropriate. To close.

TB/21/25a – Carbon emission offsetting – this will be considered as part of the Trust's final sustainability strategy. To close.

TB/21/25a – The Green Plan Equality Impact Assessment (EIA) is being finalised and will come to Board when complete. The sustainability strategy is in progress and work is ongoing with Staff side. There is to be a follow up meeting with the Chair. It will be coming to August strategic Board. Keep open until EIA received.

TB/21/25a - Reusable PPE. AM reported she had found a reusable PPE scheme based at the Royal Cornwall Trust. TB agreed he will make contact with the Royal Cornwall Trust.AM would also follow this up with the West Yorkshire and Humber climate change team. To close.

TB/21/08b – in relation to public health intelligence - MB noted working with public health is important. RW noted this was something that needs to be kept in view. Sean Rayner (SR) reported the Trust is linked into each district's health intelligence cell. Nat McMillan (NM) noted the need to keep this matter in view. Action date moved to September 2021.

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

TB/21/52 Service User/Staff Member/Carer Story (agenda item 5)

AM introduced the staff member story. Angie Balmer and Catherine Horbury are employed by the Trust as co-leads in the Yorkshire & Humber Operational Delivery Network (ODN). They work one day a week for the ODN and provide lived experience support. They are being supported today by Chloe Dexter their line manager, Business Operation Officer for the ODN.

Angie has autism and Catherine has a learning disability and the Board were reminded these are very different conditions. Both Angie and Catherine created pre-recorded videos that were played for the Board story item.

Angie introduced herself, where she is from and her domestic circumstances. Angie was diagnosed with autism in 2016 and has recently been diagnosed with Attention Deficit and Hyperactivity Disorder (ADHD). Her specialist interests are any disciplines that help to make people more predictable.

Angie's journey accessing diagnostic services was long and difficult, as a result of which she founded the charity the Society for Neuro Diversity (SAND) to help support others. Through this work she learned about the ODN vacancy.

Angie took up the role in December 2019 and works one day a week. Angie commented that the Trust's mandated training is not relevant to her post and takes her away from her work. Angie enjoys working for the ODN and her achievements so far have been expanding the network and participation in the co-production group.

Angie is passionate about amplifying the voice of people with autism and has achieved this by giving people a platform in the employment task and finish group to enable people to hear and learn from experiences about recruitment. The same opportunity will be offered through diagnosis work.

Angie explained the difficulties in attending the steering group, largely attended by NHS staff, due to the number of acronyms and clinical language. Since the pandemic Angie has accessed the steering group meetings through MS teams and can now ask questions in the chat. Chloe, Cath and Angie have de-briefs afterwards to aid understanding.

Angie said the team have been great in supporting her and Chloe has been able to get to know her, understand the barriers Angie faces and make adjustments to enable her to complete her best work.

Catherine introduced herself and reported she started the role of ODN co-lead in February. Catherine supports people with learning disabilities having lived experience of a learning disability herself. As part of her role she makes important documents available in easy read format and provides a voice for people with learning disabilities.

The role is very suitable for Catherine to work alongside the ODN and show them the skills she can bring to the team, across Yorkshire and the Humber, with lived experience of a learning disability.

Catherine reported it was a big achievement to get the job. She was sent an easy read application form and easy read interview questions letting her know how to fill in the application and what to expect in the interview.

When Catherine first started the job, Chloe brought her work laptop to her at home as she was shielding at the time. Chloe helped set up Catherine's computer and went through Catherine's outlook, folders and introduced her to MS Teams. Before the ODN meetings Chloe goes through the agenda so Catherine can ask any questions beforehand.

Catherine loves working as part of the ODN team and taking part in the Co-production and Employment meetings. Catherine has written a vaccine and lockdown story for people to read about her experiences.

Catherine does need support sometimes with things such as training courses, but not all the time. Sometimes she gets things wrong, but she knows people around her will support her when she needs it and Catherine loves her job.

AM thanked both Angie and Catherine for their presentations. AM asked for any questions to be sent to her or Andy Lister (company secretary) to be sent on to Catherine and Angie to allow them to consider their responses.

Board members thanked Angie and Catherine for their stories. The use of acronyms in meetings was highlighted and the presentations were noted to have reinforced the importance of listening to people with lived experience to improve services.

Angie's issues regarding mandatory training were highlighted and it was agreed to look at this outside of the meeting. Angie reported she has an idea as to how to improve this.

Action: Alan Davis

It was RESOLVED to NOTE the Staff Member Story.

TB/21/53   Chair's remarks (agenda item 6)

AM highlighted the following:

- Today is RW's last Board before his extended secondment to the West Yorkshire and Harrogate Health and Care Partnership, which the Board has agreed to support. RW has been an outstanding Chief Executive, recognised in his award from the Health Service Journal as top CEO in the country 2020.

  AM noted RW's unbending commitment to being values led. He is strongly committed to staff wellbeing and tackling racism and inequality. He believes in "leading from every seat" and empowering people.

  He has provided outstanding leadership to both the Trust and the Integrated Care System (ICS) throughout the pandemic. West Yorkshire and Harrogate Health Care Partnership (WYHHCP) is recognised as one of the most advanced in the country.

  AM thanked RW for his leadership of the Trust and wished him luck in his full-time role at the ICS. She invited TB and MB to comment.

- TB noted RW joined at a time when the Trust was responding to a Care Quality Commission (CQC) review. During his time at the Trust, the communications structure had changed, and people were better engaged and informed. RW had developed our values-driven culture, improved structure and process around Executive Management Team (EMT) systems and been visible across services. He will be missed but isn't far away as leader of the ICS.

- MB noted he joined the Trust within a couple of weeks of RW and noted RW's seemingly unapparelled encyclopedic knowledge of the everything in healthcare and system wide.

There has always been a high level of assurance and commitment in RW's leadership, he has a calm measured leadership approach that commands respect. RW has a strong interest in mental health, learning disabilities and autism and as such the voice for these will continue to be heard in the system.

It was RESOLVED to NOTE the Chair's remarks.

TB/21/54   Chief Executive's remarks (agenda item 7)

RW thanked Board members for their kind words. He noted you cannot deliver anything without teamwork and there is a great team at the Trust. It had been difficult to choose between the two roles, but he has received lots of support, professionally and personally.

RW asked that his report be taken as read and presented the following additional updates:

- There have been changes to government restrictions in relation to Covid-19 and an acceleration of the vaccination campaign for two jabs.
- Public health messaging – two jabs required for efficacy against the delta variant – has had a positive outcome.
- The new secretary of state for health and social care is confident restrictions will be lifted in July and the Trust needs to prepare for that.
- Due to the newly appointed secretary of state the reading of the bill in relation to the white paper has been delayed. This should be a short delay.
- Recruitment of the Chair for WYHHCP was due to start this week, this will now be delayed for a few days.
- The new secretary of state will need to sign off ICS Chief Executive and Chair appointments.
- There is a continuing focus on health inequalities. The Kings Fund has published a report this week which highlights inequalities and how it needs to feature in recovery, and noted the work carried out in WYHCCP.
- Prof Marios Adamou has been included in the Queen's birthday honours list, receiving an OBE, as have volunteers at Kirkwood hospice, who have been awarded The Queen's Award for Voluntary Service in recognition of their outstanding contribution to helping local people affected by life limiting illnesses across Kirklees.
- RW noted this is his last CEO report before extended secondment and substantive process to find a Chief Executive for the ICS. He thanked everyone for their support, commenting that we have fantastic leaders in the Trust and the Trust should be confident about the future.

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

TB/21/55   Performance reports (agenda item 8)
TB/21/55a   Integrated performance report month 2 2021/22 (agenda item 8.1)

TB noted the following:
Covid-19
- Infection Prevention and Control measures continue in the workplace.
- Personal Protective Equipment (PPE) is in good supply and asymptomatic testing continues at a good level.
- The command structure is now stood down with the Operational Management Group (OMG) and the Executive Management Team (EMT) picking up residual work. The Command Structure can step back up if required.

Quality
- Two consecutive months of lower friends and family test results are being reviewed.

- Under 18 admissions to adult wards remains concerning. The right safeguards are in place, but further review is being carried out and options for escalation being assessed
- Staffing pressures remain high.
- The Safe Care model (staffing software that matches staffing levels against patient acuity) is being piloted in the Unity centre.
- The safer staffing group is also looking at more meaningful metrics for safer staffing.
- Pressure ulcer enhanced training is taking place.
- Regarding Care Programme Approach (CPA) care plans, there are still recording issues. All separate care plans for an individual have to be closed for it to show as closed overall, and some service users have several. Work is continuing on this.
- FIRM Risk Assessment (Formulation Informed Risk Management) has had slower uptake than hoped. This doesn't include the Sainsbury's risk assessment which is still available.
- The FIRM assurance framework is being monitored through Clinical Governance Clinical Safety Committee (CGCSC) and the CQC has been updated with progress.
- Self-harm and suicide incidents continue to be closely monitored.
- Exception reporting around the CQC improvement plan is going through CGCSC.
- A huge amount of work is taking place behind the performance report to ensure quality standards are achieved.
- There are signs of increasing acuity and demand in the system that we need to monitor.

TB clarified that, in respect of the friends and family test, the internal review of information had been completed by the Quality Improvement Assurance Team (QIAT) and they will be liaising with Dawn Pearson and the engagement team. The outcome will therefore be reported into the next board meeting.

Action: Tim Breedon

TB clarified further that the enhanced pressure ulcer training had come from acknowledgement that some staff were not aware of the correct process for carrying out the 'Waterlow assessment'. This is critical in maintaining correct tissue viability. There had been a review over four months of the pressures in the system between the Trust, the Clinical Commissioning Group and Barnsley Hospital.

Carol Harris (CH) reported that work is taking place in CAMHS (Child and Adolescent Mental Health Services) to increase responses and look at different ways of asking questions. People engaged with CAMHS are often unhappy with the waiting time, but happy with the service they receive.

TB noted that the figures about FIRM were for measuring the movement from the Sainsbury's risk assessment to the FIRM risk assessment. The speed at which this is taking place needs looking at. This may be as a result of the pandemic. AM asked for a focus on this at the next CGCSC meeting.

Action: CGCS Committee

Out of area (OOA) beds were discussed. CH noted the pressure remained. Acuity has increased in the referrals received, and the two are linked. There is now a seven-day patient flow team, matrons working weekends and support into Intensive Home-Based Treatment Teams (IHBTT). These processes should help stabilise the position in the long term. There is an assumption this is pandemic related but this is being looked at. There is also work taking place across the WYH ICS to manage Psychiatric Intensive Care Unit (PICU) beds.

A discussion followed about risk assessment figures and risks associated with the current level of performance. Statistical Process Control (SPC) charts noted middle ground being achieved but it was questioned if the Trust is making any improvements.

TB noted the concern is that the risk assessment is not being used at the level we want. FIRM is a better quality risk assessment, but there are risk assessments for all patients even if they are not FIRM risk assessments. The pandemic has affected the roll out.

The unfilled shifts graph shows where shifts were planned but not filled. This has been added to the safer staffing report, along with lived experience information, to give a richer data set. There are no safety issues as a result of unfilled shifts, but leave from the ward may have been reduced. If staffing is deemed unsafe this would be flagged through the escalation system.

TB reported SPCs from his perspective were there to understand where the Trust might be an outlier against previous performance, hence it being introduced for incident reporting. The ambition to reduce harm remains a fundamental aim.

CJ commented the board development work that introduced SPCs was about improvement and this may not be how the Trust is consistently using them. We may be using them to ensure we don't decline, which is different.

AM summarised we need to look at the use of SPC charts through CGCSC and FIP and consider how we might use them differently.

Action: CGCSC and FIP

CH noted, in relation to the learning disability (LD) waiting times, the LD team is still working through the data, but there is pressure as they are above pre-pandemic referral levels. She added there are some data quality and reporting issues to resolve.

CH confirmed work is ongoing in relation to the recent Learning Disabilities Mortality (death) Review (LeDeR) report and TB reported this will feature later in the Board meeting. CH noted there are good practice examples in the LD communities and teams featured in the LeDeR report.

RW noted, in reference to the LD and LeDeR work in WYHHCP, once it became clear people with a learning disability were more likely to die from Covid-19 the Mental Health Learning Disability and Autism (MHLDA) collaborative did some work that showed we were in a better position locally than nationally, but the Board still considered the rate of premature death to be far too high.

Demand is significantly increasing across the health and care system. The Yorkshire Ambulance Service are receiving more calls than ever before about mental health. The Board needs to have a conversation about the Mental Health Investment Standard progress and impact it has had in terms of service user outcomes as well as the additional staff we need to employ to meet the requirements of the investment.

Action: Board agenda setting

SYo referenced complaints and noted the Trust isn't meeting targets.

TB stated the internal work is ongoing to respond to individuals rather than use the blanket 40-day response. This is as a result of conversations with complainants. We are behind on response times due to the capacity of investigators. From next month we will be able to report against the new timescales.

AM noted the dip in performance regarding cardio metabolic assessments and treatment on page 5. CH reported some of the performance issues are GP results that the Trust has not had back. Where there are delays in other parts of the system this affects our performance. We are looking to change how we record this.

AM noted a decline in recruitment of band 5 and above staff from BAME backgrounds. To be discussed at the next Equality, Inclusion and Involvement Committee (EII). This is one the Workforce Race Equality Standard (WRES) measures.

Action: EII Committee

National Metrics

MB noted these have been covered and there is nothing further to add. There were no comments raised.

Locality

Child and adolescent mental health services (CAMHS)
- Pressure remains in the ADHD and Autism Spectrum Disorder (ASD) services, particularly in Calderdale and Kirklees. Work with commissioners continues.
- There are continued improvements in the numbers of young people being treated within 18 weeks, but there is significant pressure in the system.
- Tier 4 bed access remains problematic and is leading to inappropriate stays in adult beds.
- There are some high-risk young people in Wetherby Youth Offenders Institute (YOI) because of a lack of specialist beds. This is being escalated.

Barnsley general community services
- The Yorkshire smoke free contract has been extended to 2022.
- There are increasing demands on services due to increased patient flow through the wider healthcare system.
- The FIP received a presentation this week showing how increased demand in the Barnsley system impacts on our community services.

Forensics, Learning Disability (LD), Autistic Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD)
- Forensic services are clinically very acute, Sandal, Bronte, Hepworth and Newhaven wards in particular.
- Staffing levels are under constant review and skill mixing has been taking place to manage demand and acuity.
- There remains a strong focus on staff wellbeing and staff retention.
- LD services have increased referrals.
- In LD services there are high numbers of locums, especially in Calderdale, and this is leading to delays in other areas of the service through the delay in seeing a doctor.
- In the Horizon centre the commissioned bed occupancy is at 83% and we are relying on temporary staffing to cover this, given current substantive staffing numbers. There is relatively high turnover of staff on Horizon and this is being reviewed.
- The reconfigured WY Assessment and Treatment Unit (ATU) service is due to start in October 2021.

Trust-wide Inpatient Services
- Patient flow and the impact on OOA bed usage is being monitored.
- Due to incidents in ward gardens, a blanket restriction has been put in place meaning no one can be in a garden unless supervised. There is a risk assessment process to cover this set of circumstances.

Trust-wide Community Mental Health Services
- Improving Access to Psychological Therapies (IAPT) referrals are showing sustained increase.
- A waiting list initiative is starting in Barnsley in July. There are some challenges in respect of the working environment and the need for social distancing.
- Demand into Single Point of Access (SPA) is increasing, self-referrals are increasing.
- Increases in demand aren't always numbers, they are sometimes related to acuity and there is a mixture of both at the moment.

Communications Engagement and Involvement

No additional points of note.

Finance and Contracts
MB highlighted the following points:
- There is additional funding due to Covid-19 currently, most of which is non-recurrent.
- Expenditure is currently lower than income received.
- The issue of higher acuity and increased demand is beginning to have an impact on our costs.
- There are no current issues for meeting our break-even target in the first half of the year.
- We have delivered a surplus of just over £1m in the first two months of the year.
- This will reduce over the next couple of months due to OOA beds and acuity pressures.
- Pay costs are similar to April 2021, £800k lower than planned, but we have significantly more people working in the Trust than we had 18 months ago.
- Cash is strong at over £60m.
- Second half of the year (H2) financial arrangements are expected to be similar to the first half with block contract arrangements, albeit with lower income.
- Our numbers are absorbed into the WYHCCP ICS and we have to ensure we contribute to ICS financial targets being met. We are likely to exceed our financial target and are discussing this with the ICS.

CJ reported FIP had discussed the pro and cons of an updated forecast. Current financial performance is solid and secure.

A conversation followed about staffing and pay. Mike Ford noted the Trust had more staff than last year, and an increasing level of turnover, it is £800k lower than budget and queried if this is a risk to achieving strategic objectives.

AGD reported there will always be a vacancy factor and explained there is a national shortage of doctors, nurses, and Allied Health Professionals (AHPs). The Trust is playing a leading role in pursuing international recruitment, and new roles are being developed. For example, AHPs can take on broader roles. There is a link to the safer staffing report. We are keeping things safe. Workforce risks are identified in the risk register.

AGD noted the need to be careful with monthly staff turnover figures as they are annualised. It was requested that both the monthly and rolling twelve-month figures should be presented.
Action: Alan Davis

Workforce
AGD highlighted the following points:
- In the future we need to learn to live with Covid-19.
- There are a number of ways people can now be vaccinated.
- Vaccination programmes are reducing but vaccine promotion continues.

- Boosters in the autumn potentially need to be considered.
- There are reports there is the potential of mandating vaccines for healthcare staff.
- We need to look at some of our areas e.g. how do we make inpatients a great place to work?

A discussion followed about staff turnover hotspots, how these are being managed and the use of exit interviews. Identified hotspots include adult acute wards and forensics. They are pressurised and stressful working environments. A lot of work has taken place in forensics and inpatient wards are now a priority programme.

AGD noted the Workforce and Remuneration Committee is taking place on 20 July 2021 and exit interviews could be reported into that meeting.
Action: Workforce and Remuneration Committee

Lateral flow testing was discussed and its use in mitigating the risk of Covid-19.

MF queried the vaccination programme and how the Trust is targeting individual staff.

AGD reported these dialogues and conversations are being conducted through line management and diversity networks. Voluntary uptake is the preference.

AGD confirmed the turnover figures represented staff that are exiting the organisation.

NM queried how can we be proactive around working from home and how it can benefit staff retention and reducing sickness.
Action: Workforce and Remuneration Committee

AM asked about reset and recovery in the priority programmes and noted it has three work streams, one of which is about working effectively. AM asked how NEDs will be involved in the strategic reset and recovery work. AM asked for a discussion outside of the Board meeting.
Action: Salma Yasmeen

Priority Programmes

SY updated that there is significant transformation funding starting to come through via integrated care systems. The community transformation programme has commenced, and the Trust is fully engaged in both ICSs with this work and all of our places. The aim is to join up care between primary care, secondary care and the voluntary sector.

SY reported a highlight report could be brought to a future Board meeting.
Action: Salma Yasmeen

SY confirmed that inpatient services is a priority programme, and this work is being progressed as an improvement programme through our quality improvement team.

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

TB/21/55b   Operating and Financial Plan Update (agenda item 8.2)
MB asked the paper to be taken as read and highlighted the following:
- The Trust has responded well to planning requests in the last 18 months
- We need to remain cognisant of the NHS long-term plan, ICS and place-based plans and ensure we align. Work on a medium-term Trust plan is re-starting.

It was RESOLVED to RECEIVE the update on the Operating and Financial Plan.

TB/21/56 Business developments (agenda item 9)
TB/21/56a Integrated Care System developments white paper update (agenda item 9.1)
SY introduced the item and highlighted the following points:
- RW had referenced the main developments in his brief earlier.
- The ICS design framework, while providing some clarity, has maintained a level of flexibility as hoped.
- This will help us to build on the work between the integrated care system and our places.

It was RESOLVED to NOTE the update on national policy and guidance and on the local ICS response to the White Paper.

TB/21/56b 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:
- There was commitment in the Health Executive Group that mental health, learning disability and autism does not fall off the radar despite pressure in the system.

Mental Health, Learning Disability and Autism Alliance
SY noted the development of the SYB Mental Health, Learning Disability and Autism Alliance continues. It is anticipated there will be a workshop for Chairs and Chief Executives in the coming weeks.

Barnsley
Following the joint agreement between primary care and community services in Barnsley, we have established a shared leadership group, which had a meeting this month. This will help to provide a joined-up response to the rise in demand in Barnsley.

As a system they have agreed that one of the first areas they will address around health inequalities is people with mental health difficulties who are also presenting with cardiovascular disease (CVD).

The formal agreement for the partnership agreement is being drawn up at the moment and will likely come to next public Board meeting.

RW thanked SY for the huge amount of strategic work that has taken place in Barnsley and the work from CH and her operational team.

It was resolved to NOTE the SYB ICS update, NOTE the MHLDA Alliance and programme update, and NOTE the Barnsley Partnership update.

TB/21/56c West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.3)
SY highlighted the following points:
- Significant work is happening to strengthen place-based arrangements and strong joint partnership working continues.
- Health inequalities and diversity leadership work is continuing, and the Trust has signed up to the ICS anti-racism campaign.
- Transformation programmes continue.

SR highlighted:

in Wakefield, the integrated care partnership board received a presentation from the co-clinical director of the five towns primary care network in May. All partners were asked to take it to their governing bodies for update. Dr Colin Spear leads this work and would give the presentation to Board if wanted.

- The Kirklees mental health alliance has reconvened.

A query was raised about WYHHCP progress against its ten big objectives. SY noted there is a System Oversight Assurance Group (SOAG) which has a focus on performance. They get an update on each of the programmes and the deliverables against which they are measured.

SR noted the purpose of bringing the Integrated Care Partnership presentation to governing bodies was for transparency. Questions on performance, improvements in health and health inequalities are all covered in detail through the agenda of the Board meeting.

RW noted the Wakefield partnership system is a beacon of good practice. There is lot of work going into new structures and we need to ask what impact they will have.

RW stated, in reference to the ten big ambitions, there is now a dashboard for West Yorkshire. It draws indicators against the ten big ambitions by place. This was discussed at the last SOAG meeting. This should come to the Board for assurance in future.

Action: Salma Yasmeen

AM noted the need for hard outcome measures for both integrated care systems to feature in the Trust IPR.

Action: Mark Brooks

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.

TB/21/56d   Confirmation of Chief Executive's extended secondment to West Yorkshire and Harrogate Health Care Partnership (agenda item 9.4)
AGD took the paper as read and reported this had been agreed in principle previously and was now being confirmed following agreement with all relevant partners.

It was RESOLVED to NOTE the confirmation of the secondment of Rob Webster to the role of Chief Executive West Yorkshire and Harrogate ICS on a full-time basis with effect from 5 July 2021.

TB/21/56e   Receipt of Partnership Board Minutes (agenda item 9.5)
AM asked for the paper to be taken as read.

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

TB/21/57   Strategies and Policies (agenda item 10)
TB/21/57a   Customer Services Policy (agenda item 10.1)
TB highlighted the following points:
- The policy has been updated in light of new guidance.
- New roles and responsibilities are reflected.
- New advice on how to manage persistent complainants is included.
- The policy may be reviewed earlier than three years dependent on changes in guidance.

TB confirmed internal audit had reviewed customer services two years ago and their recommendations were included in the policy.

TB reported customer services help operational teams respond to complaints and help them look at themes and how to change their practice and learn from them.

RW reminded the Board the Trust is accredited for customer service excellence and this would be due for further review in 12-months' time.

In response to a question, TB reported the update around persistent complainers was encouraged by the regulators and has been written in line with guidance.

It was RESOLVED to APPROVE the Customer Services policy updated as outlined above with the next review in 3 (three) years unless required earlier.

TB/21/58   Governance Matters (agenda item 11)

TB/21/58a   Compliance with NHS provider licence conditions and code of governance - self-certifications (agenda item 11.1)

MB asked to take the paper as read:
- Part 1 of the provider license self-certification was completed in March.
- Any adjustments in relation to our response to Covid-19 have been accounted for.

It was RESOLVED to NOTE the outcome of the self-assessments against the Trust's compliance with the terms of its Licence and with Monitor's Code of Governance and CONFIRM that it is able to make the required self-certifications in relation to the Corporate Governance Statement 2020/21 and the training for Governors 2020/21.

TB/21/58b Serious Incidents Annual report   (agenda item 11.2)

TB asked to take the paper as read and highlighted:
- The report has been reviewed at CGCSC.
- This report supports the work that takes place next for the learning journey and apparent suicide report, due in September 2021.
- Accreditation for the Trust serious investigation processes is now in place.

CJ queried if the Trust is getting better at the reporting of incidents and incident management and how can safety culture be improved.

TB noted the Trust is doing the right things. Work is being done about Freedom to Speak up Guardians and the importance of incident reporting. Incident data is being shared in a different way, so it is more available on a team by team/service by service basis.

RW noted 92% of incidents reported are low harm/no harm which is a sign of a positive reporting culture. RW explained the difference in view of different bodies on reporting figures. The CQC regard high levels of reporting as a potential concern whereas the health and safety executive regard high levels of reporting as a positive reporting culture.

RW reflected in a pandemic year we should ask questions about differences in reporting. The action plan on page 42 is for the executive and the teams.

We should be augmenting section 5 on page 42 to include what the Board might want to do to promote openness around incident reporting. TB noted the content of this report could be used to look at next steps for the Patient Safety Strategy.

Action: Tim Breedon

MF agreed to pick up some items with TB about the Serious Incident report outside of the Board. NM asked for comments from this discussion to go into CGCS agenda setting.

Action: Tim Breedon

It was RESOLVED to RECEIVE and comment on the annual report on incident management and to NOTE the next steps identified.

TB/21/58c   Health and Safety Annual report (agenda item 11.3)
AGD asked for the report to be taken as read:
- The report has been subject to detailed discussion at CGCSC.
- A training session for the Board is to be scheduled for December 2021.
- AGD noted the Health and Safety inspection in 2019/20 resulted in no actions for the Trust, which was a positive outcome.

It was RESOLVED to APPROVE the Annual Safety Services Report 2020/21.

TB/21/58d   Premises Assurance Model (agenda item 11.4)
AGD highlighted the following:
- This was initially an acute services model and it has been adapted for mental health services.
- It provides assurance our estates are safe and fit for purpose.
- It demonstrates the hard work the estates team have been doing despite the pandemic
- The document is likely to be further refined later in the year to include community services.

AGD confirmed the Trust has completed the sections of the model that are required for our services. The next iteration of the model will include mental health and community services.

RW noted the work that had gone into this given the capacity of the team during the pandemic. RW queried if this work could be integrated with PLACE (Patient Led Assessment of Care Environment) reviews and include the voice of service users.

AGD noted that governors are typically actively involved in PLACE reviews (these were paused during the pandemic). RW noted that PLACE reviews don't show that things are good or outstanding and if there is an opportunity to bring two things together it should be taken. AGD noted this could form part of the discussion about the Estates at the strategic Board meeting in August.

Action: Alan Davis

It was RESOLVED to APPROVE the PAM submission for 2021.

TB/21/58e Interim Governance Arrangements update (agenda item 11.5)
AM asked that the report be taken as read:
- MB noted, following the NHSE 'release the burden' letter in January 2021, the Board agreed a review would take place in June 2021.
- Committee chairs and lead executives should now review committee agendas and work plans to check they are working as they should be.
- AM queried if this is part of strategic reset and recovery priority programme.

RW noted the significant assurance outcome from the Trust internal auditor and the quality account is on track for submission in August. There has been no further input from the regulator.

It was RESOLVED to RECEIVE and NOTE the update to the interim governance arrangements.

TB/21/58f Changes to Board Committee Memberships (agenda item 11.6)
AM noted the changes are required due to RW's extended secondment.

- **It was RESOLVED to APPROVE the proposed updates to the memberships for the:**
    o **Audit Committee**
    o **Workforce and Remuneration Committee**
    o **Equality, Inclusion and Involvement Committee**
    o **Finance, Investment and Performance Committee**

TB/21/59 Assurance from Trust Board Committees and Members' Council (agenda item 12)

Audit Committee 18 June 2021
MF highlighted the following:
- Final approval of annual report and accounts.
- Head of Internal Audit Opinion was significant assurance for year 2020/21.

Clinical Governance and Clinical Safety Committee 8 June 2021 (approved minutes received from 6th April 2021)
NM highlighted the following:
- Alerts have come through on the IPR.
- The development of new Tier 4 CAMHS provision in West Yorkshire is a redistribution of existing national provision, rather than an increase, which has been noted as a risk.
- Drug and alcohol team attended committee and their hard work and achievements were noted,
- Annual incident report was received.
- The quality improvement strategy timescale of 12 months was agreed.

Equality, Inclusion and Involvement Committee 1 June 2021 (approved minutes received from 2nd March 2021)
AM highlighted the following:
- Slightly shortened agenda.
- A meeting of the full Committee was held with a lot of attendees. The meeting is very inclusive, with rich inputs from across the organisation.
- The new insight report is a systematic way of capturing all of the feedback coming into the organisation.

Finance, Investment and Performance Committee 24 May 2021 and 28 June 2021
- Agreed to recommend reducing the risk rating for the cash risk.
- Update the H1 forecast to the ICS with a surplus of £2m - £3m.
- Assurance on financial performance.
- Investment appraisals and bidding assurance.
- Assurance received around the implementation of Mental Health Investment Standard.
- Capital programme report received but could not conclude the committee was assured about delivery due to external factors, including contractor availability and cost of one major scheme.
- Latest update on adult secure lead provider collaborative and queries were raised about quality risks and quality management.

- Barnsley community services report was received, with some concerns expressed around the levels of engagement with digital interactions, which are being assessed.

Mental Health Act Committee 11 May 2021 (minutes received from 9th March 2021)
KQ highlighted the following:
- The Trust's support to the acute trusts was noted positively.
- Given the Committee's improvement and robust processes it is moving from an annual audit to a more business as usual quarterly report approach.

Workforce and Remuneration Committee 18 May 2021
- Board succession planning was the key agenda item.
- Remuneration for the two new interim Board posts was discussed and agreed.
- All other items were deferred to July.

West Yorkshire Mental Health, Learning Disability and Autism Committees in Common 11 June 2021 (minutes from 22 April 2021)
- In May a strategic meeting was held to review forthcoming work.
- 11 June NED and Governor event, a number of colleagues were present.

Members' Council 29 January 2021 (minutes received from 30 October 2020)
AM highlighted the following:
- Newly elected governors were welcomed.
- EM's reappointment was approved for a further three-year term.
- RW noted vacancies on the Members' Council. AM confirmed the election process would take place as normal later this year.

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

TB/21/60   Use of Trust Seal (agenda item 13)
AM asked to take the paper as read.

MB agreed to look at the way the Trust is using the Trust seal.

Action: Mark Brooks

It was RESOLVED to NOTE no use of the Trust Seal since the last report in March 2021.

TB/21/61   Trust Board work programme (agenda item 14)
AM gave an update on progress and reported work was ongoing into the redevelopment of the work programme.

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

TB/21/62   Date of next meeting (agenda item 13)
The next Trust Board meeting held in public will be held on 27 July 2021.

TB/20/63   Questions from the public (agenda item 14)

AM read out questions from a member of the public Jenny who had submitted questions in relation to the Serenity Integrated Monitoring (SIM) team – repeated verbatim below:

1. The Stop SIM website shows that SWYPFT launched its Serenity Integrated Monitoring team in Feb 2020. Is this correct?

2. If so, was SWYPFT aware at the time of <u>widespread concerns about the care model?</u> For example:

2.1 That the High Intensity Network's SIM model is based on dodgy data that Hampshire Police have disavowed in a Freedom of Information response.
2.2 That Serenity Integrated Monitoring is owned and run by a private company, High Intensity Network Ltd.
2.2 That SIM is an unacceptable step backwards in disability justice and has the effect of criminalising mental distress/illness.
2.3 That SIM claims that some of the most mentally unwell individuals in our communities, who frequently come into contact with emergency services while in crisis, are "High Intensity Users" who place an "unnecessary financial burden" on the NHS. (The <u>British Psychological Society says</u>: "Statistics and measures reported by the High Intensity Network and other organisations using SIM are centred mainly on producing savings and managing resource issues for the police and health services. There seems to be little consideration of what their use means for the service users involved.")
2.4 That individuals under SIM have "crisis response plans" that prevent them from accessing potentially life-saving treatment from the usual places that people are able to seek support during a crisis. This includes: ambulance services, A&E, mental health crisis services, community mental health teams and the police.
2.5 Additionally, the SIM model is heavily reliant on the "coercive" powers of the police to enforce "behavioural responsibility" and "behavioural management" on "High Intensity Users". "High Intensity Officers" are placed in mental health teams and have full access to the individual's medical records, with or without their consent. Messages such as: "We are responsible for the consequences of our actions and we need you to understand what the consequences of your actions will be if they continue" are "compassionately, but firmly reinforced over the course of several weeks/months."
2.6 The focus of SIM is on reducing service demand (how frequently people come into contact with emergency services), not the patients' well-being or experience. This program is likely to have the effect of re-traumatising individuals. SIM does not use any outcome measures (data that measures the success of the programme) that are commonly used in community mental health services to assess changes in the individuals mental well-being.
2.7 That SIM <u>appears to breach UK GDPR regulations</u>: SIM allows 'sensitive data' (information like medical records, ethnicity, religion, sexuality, gender reassignment and financial information) to be shared between services without the subject's consent (the subject is the person who the information is about)."

3. What, if any, is the relationship between the SWYPFT Serenity Integrated Monitoring Team and the High Intensity Network company?

4. Are South and West Yorkshire police officers members of community mental health teams, as " High Intensity Officers"? If so, do the Police hold any NHS contracts?

5. Is SWYPFT aware of the <u>Academic Health Science Network's commitment</u> to undertake an independent review to fully understand the circumstances surrounding the AHSN Network role in supporting providers to adopt the Serenity Integrated Monitoring model?[SEP]

6. How is SWYPFT responding to NHS England's ask of trust medical directors and directors of nursing, to review services for high intensity users so a full picture of the Serenity Integrated Monitoring model can be obtained, to enable NHS England to establish the full facts?

7. Is the <u>WY Adult Secure Lead Provider Collaborative</u> related to both Serenity Integrated Monitoring and the Vulnerability Support Service? (The April 2021 Minutes record that "The

West Yorkshire adult secure lead provider collaborative is to review options with NHS England about what a "go live" for 1st July 2021 may look like.")

8. According to athe WYH ICS webpage on the WY Adult Secure Lead Provider Collaborative, "There are three key areas of mobilisation: providing care closer to home, development of community models and diversification of hospital inpatient services within West Yorkshire.
"In the first 12 months the Lead Provider Collaborative will focus on those people who are currently supported in low and medium secure services who could instead be supported in the community. We have already identified who these people are and have engaged with their link workers to develop a plan to discuss the ways they could be supported by services."
Will patients who are moved out of low and medium secure services into the community come under the "care" of the Serenity Integrated Monitoring Team?

An overview response was provided by the Trust medical director Dr Subha Thiyagesh who noted the following points:
- The Wakefield model did not align directly to the national model.
- Consent was always sought from service users. One of the criticisms alleged of the SIM model was that it did not.
- The focus was on service user voice being heard.
- After national consultation with medical directors the Trust withdrew from the SIM scheme on 10 June 2021
- Since leaving the scheme, the Trust is looking to develop training for our staff in line with NICE guidance.

RW noted the Trust initially became aware of concerns on social media. AM noted concerns were also raised by a governor. On noting the issues, the Trust looked at them openly, honestly and transparently.

The Wakefield model was more patient and service user based than the national model and the service users who were to be part the scheme are still receiving appropriate support while we are reviewing our service offer.

A formal response will be sent to the questions by ST.

Action: Subha Thiyagesh

Signed: Date:

TRUST BOARD 29 JUNE 2021 – ACTION POINTS ARISING FROM THE MEETING

[ ] = completed actions

Actions from 29 June 2021

Min reference	Action	Lead	Timescale	Progress
TB/21/52	Angie Balmer raised within her Board Story that some of the Trust Mandatory training is not relevant to her role and had taken her away from her work. It was agreed to look at this issue outside of the Board meeting	Alan Davis	July 2021	All mandatory training is reviewed by the Specialist Adviser including which job roles it should apply to. Education and Training Governance Group reviews mandatory training requirements and any additions or subtractions are approved by the Executive Management Team.
TB/21/55	TB will bring the review of the recent low friends and family test results to the next Board meeting	Tim Breedon	July 2021	Narrative included in the FFT section of the IPR submitted to July board
TB/21/55	TB reported that the figures about FIRM were for measuring the movement from the Sainsburys risk assessment to the FIRM risk assessment. The speed at which this is taking place needs looking at. This may be as a result of the pandemic. AM asked for a focus on this at the next CGCS meeting.	Clinical Governance Clinical Safety Committee	September 2021	Included on agenda setting schedule
TB/21/55	To review the use of Statistical Process Charts CJ reported the board development work that introduced SPC's was about improvement and this may not be how the Trust is using them. We may be using them to ensure we don't decline, which is different. AM summarised we need to look at the use of SPC charts through CGCS and FIP and consider how we might use them differently.	Clinical Governance Clinical Safety Committee FIP	September 2021	Included on agenda setting schedule

With **all of us** in mind.

TB/21/55	Demand is significantly increasing across the health and care system. The Yorkshire Ambulance Service are receiving more calls than ever before about Mental Health. The Board needs to have a conversation about the Mental Health Investment Standard progress against the interventions we are going to invest in and staff we want to employ to help with pressures. Need a view of progress and risks.	Agenda Setting	July 2021	Discussed at Agenda setting and a focus on item is on July's agenda.
TB/21/55	AM noted a decline in recruitment of band 5 and above staff from BAME backgrounds. To be discussed at the next Equality, Inclusion and Involvement Committee (EII). This is one the Race Quality Standard measures.	EII Committee	September 2021	
TB/21/55	AGD noted the need to be careful with annual staff turnover figures in the IPR as they are annualised. We need to treat the figures with caution in the first two months as they represent the annual figure rather than the monthly figure. It was requested that both the monthly and annual figures should be presented.	Alan Davis	September 2021	
TB/21/55	A discussion followed about staff turnover hotspots, how these are being managed and the use of exit interviews. Identified hotspots are adult acute wards and forensics. They are pressurised and stressful working environments. A lot of work has taken place in forensics and inpatient wards are now a priority programme. AGD noted the Workforce and Remuneration Committee is taking place on 20 July 2021 and exit interviews could be reported into that meeting.	WRC Committee	September 2021	To be discussed at September's WRC meeting.

TB/21/55	AGD confirmed the turnover figures represented staff that are exiting the organisation. NM queried how can we be proactive around working from home and how it can benefit staff retention and reducing sickness.	WRC Committee	July 2021	Staff Turnover and Retention will be included in new Workforce Integrated Performance Reports from September 2021. Enabling Working Effective Task Group established including reviewing the benefits of home, hybrid and agile working.
TB/21/55	AM asked about reset and recovery in the priority programmes and noted it has three work streams, one of which is working effectively. AM asked how NEDs will be involved in the strategic reset and recovery work. AM asked for a discussion outside of the Board meeting.	Salma Yasmeen	July 2021	Involvement approach being developed and Governors and Board members to be included at key points.
TB/21/55	SY updated that there is significant transformation funding starting to come through. The community transformation programme has commenced, and the Trust is fully engaged in both ICS's with this work and all of our places. The aim is to join up care between primary care, secondary care and the voluntary sector. SY reported a highlight report could be brought to a future Board meeting.	Salma Yasmeen	September 2021	
TB/21/56c	RW noted the Wakefield partnership system is a beacon of good practice. There is lot of work going into new structures and we need to ask what impact they will have. In reference to the ten big ambitions there is now a dashboard for West Yorkshire. It draws indicators against the ten big ambitions by place. This was discussed at the last SOAG meeting. This should come to the Board for information.	Salma Yasmeen	July 2021	SOAG papers have been placed in private meeting partnerships section ICS level dashboards are being reviewed for relevant information to be included in our IPR.
TB/21/56	AM noted the need for hard outcome measures for both integrated care systems to feature in the Trust IPR.	Mark Brooks	September 2021	

TB/21/58b	RW reflected in a pandemic year we should ask questions about differences in reporting. The action plan on page 42 is for the executive and the teams. We should be augmenting section 5 on page 42 to include what the Board might want to do to promote openness around incident reporting. TB noted the content of this report could be used to look at next steps for the Patient Safety Strategy.	Tim Breedon	September 2021	
TB/21/58b	In relation to the Serious Incidents annual report MF agreed to pick up some items with TB about the Serious Incident report outside of the Board. NM asked for comments from this discussion to go into CGCS agenda setting.	Tim Breedon	September 2021	Included on agenda setting schedule
TB/21/58d	In reference to the Premises Assurance Model RW queried if this work could be integrated with PLACE reviews (Patient Led Assessment of Care Environment) and include the voice of service users. AGD noted governors are actively involved in PLACE reviews. RW noted that PLACE reviews don't show that things are good or outstanding and if there is an opportunity to bring two things together it should be taken. AGD noted this could form part of the discussion about the Estates at the strategic Board meeting in August.	Alan Davis	August 2021	
TB/21/60	MB offered to review the way in which the Trust seal is being used and make sure it is being used appropriately.	Mark Brooks	September 2021	
TB/21/61	Following a number of questions from a member of the public ST gave an overview response during the Board meeting. It was agreed that ST would provide a formal response to all questions.	Subha Thiyagesh	August 2021	

Actions from 27 April 2021

Min reference	Action	Lead	Timescale	Progress
TB/21/39a	RW noted the focus group for the workplan for the Board. They should look at scheduling the right conversations based on what the BAF is highlighting as areas of risks.	Board Workplan Focus Group	July 2021	New Board workplan in progress and draft created with a key that aligns items to strategic objectives.
TB/21/39a	The Board needs to consider if the Workforce strategy is mitigating the strategic workforce risks.	Trust Board	August 2021	
TB/21/41a	KQ raised autism friendly environments and it would useful to receive an update in relation to progress. AM asked for the next estates update to Board to include seclusion and autism friendly environments.	Alan Davis	August 2021	
TB/21/41a	AM noted today's discussions around a new priority programme to look at acuity.	Salma Yasmeen	August 2021	
TB/21/41a	SY noted the recovery and reset work is considering estate and the benefits it can bring. The reasons behind the low sickness levels need to be identified.	Alan Davis	September 2021	
TB/21/42a	Workforce Strategy EIA to be completed, go to WRC on 18th May 2021 and come back to Board for approval.	Alan Davis	September 2021	

Actions from 30 March 2021

Min reference	Action	Lead	Timescale	Progress

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	August 2021	To be discussed in Agenda setting for August Board.
TB/21/25a	AM reported we needed a group that drives the green and sustainability 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	July 2021	Nick Phillips, Head of Estates and Facilities, producing a paper on development of the Sustainability Strategy including resource implications. Sustainability and Estates Strategies to be included in August's Board Development session.
TB/21/25a	AM asked for an EIA to be completed for the Green Plan.	Alan Davis	August 2021	April Board update - EIA is being finalised and will be completed for by end of May 2021. To be returned to Board when complete. Verbal update required on sustainability strategy progress. EIA to August Board
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	October 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. Agreed at April to Board to form part of six-month Digital Strategy update in October.
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	October 2021	This work is being conducted currently and expected to be completed by the end of June. Agreed at April to Board to form part of six-month Digital Strategy update in October.

Min reference	Action	Lead	Timescale	Progress
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.	Sean Rayner	July 2021	April Board - Action allocated to Sean Rayner to progress. Discussions are in place and an update to follow.

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	September 2021	June Board update - Sean Rayner (SR) reported the Trust is linked into each districts health intelligence cell. Nat McMillan (NM) noted the need to keep sight on this matter. Action moved to September 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 | July 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.

26.06.21 There has been a national consultation on the recording of meetings through the company secretary network. The majority of Trusts are following our current practice of informing all parties the Board meeting is being recorded to support the minutes and will be deleted once the minutes are approved. The minutes are therefore the formal legal record of the Board meeting. It is recommended we continue with current practice at this time. |

Trust Board 27 July 2021
Agenda item 7

Title:	**Chief Executive's Report**
Paper prepared by:	Interim 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:	This report is being written on 19/07/21, the same date as the further easing of Covid-19 restrictions. Within the Trust we continue to operate with no change to restrictions in line with national guidance for healthcare settings and are reinforcing that message, along with one for continued personal responsibility in an environment in which confirmed cases of Covid-19 are escalating rapidly. This has brought the difference between home and work behaviours into sharp focus for all our staff. The Health and Care Bill was introduced on 06/07/21 and received a second reading on 14/07/21. Further updates on this Bill are provided below. The previously agreed interim leadership changes within the Trust are now in place. These have been extensively communicated along with the ongoing focus on our mission, values, objectives, and priorities. This report updates The Brief attached at **[ANNEX 1]** which itself outlines priorities and actions for all Trust staff. The Brief provides continuity of communications alongside The View, the weekly Coronavirus update and the virtual Chief Executive Huddle, which is open to all staff. Since publication of The Brief, we have seen: • **Confirmation of the Government's easing of restrictions.** These are effective from 19/07/21 although the requirement for use of PPE, social distancing and other infection prevention measures continues in the Trust and wider healthcare settings. There has also been a substantial increase in confirmed cases of Covid-19 nationally and in both West and South Yorkshire. NHS services are coming under increasing pressure as demand for both Covid-19 and other services increases. • **Various parts of the systems we work in are reinstating Command structures** in response to the increasing prevalence of the virus and other demand pressures**.** Within the Trust any need for reinstatement of internal Command structures is assessed regularly.

With **all of us** in mind.

- **The increased prevalence of Covid-19 has also had an impact on staff absence.** As of 18/07/21, 180 staff were absent due to Covid-19. This included staff or family members being symptomatic, staff working from home and those required to isolate.

- **Lateral flow testing.** Our Trust has been supporting front line and clinical staff to engage in a programme of regular lateral flow testing, which informs us of any positive coronavirus cases within our staff. Our compliance levels have been excellent, and this helps to ensure that we learn and respond quickly, supporting us to keep our wards and community teams COVID free. Up until now this has been coordinated internally in the Trust, however, from August this will transfer to the Government run national system. We are working to ensure staff are supported through the change, maintain their testing regimes, and that we are informed of any potential positive cases or issues which could impact on our service delivery.

- **The Health and Care Bill has commenced its process through parliament.** The majority of the Bill is in line with the White Paper and is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over national NHS bodies and local systems and Trusts. The Bill also introduces a two-part statutory ICS model, with an ICS in future comprising of an Integrated Care Board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS and an Integrated Care Partnership (ICP), bringing together a broad alliance of organisations related to improving health and care.

  Additionally, the Bill includes provisions which cumulatively amount to far-reaching powers for the secretary of state. This includes powers of direction over NHS England and the ability to intervene at any stage in local service reconfigurations. Other points relate to the potential to set capital spending limits, workforce planning responsibilities and local financial arrangements. The Health Service Safety Investigations Body (HSSIB) is also being placed on a statutory footing.

- **The government has commissioned Health Education England to produce a refreshed long-term workforce numbers plan.** This is on the back of the existing number of vacancies across the NHS and emerging evidence that some staff are leaving the service early given the impact of working through the pandemic.

- **It is very pleasing that the NHS has been awarded the George Cross by Her Majesty the Queen.** The award comes in recognition of 73 years of dedicated service, including for the courageous efforts of healthcare workers across the country battling the Covid-19 pandemic. The George Cross is the highest civilian gallantry award, equivalent to the Victoria Cross and has only been bestowed collectively twice before.

- **Funding arrangements and planning requirements for the second half of the year are likely to become clearer in September.** Indications are that similar financial arrangements to those used in the first half of the year will be used again with an increased focus on productivity and efficiency**.**

- **Anti-racism campaign.** The Trust is fully committed to the West Yorkshire and Harrogate anti-racism campaign, having been a part of the project group since its inception. We have worked with partners to devise the campaign images, messaging, and target audiences. We have signed up to the movement and campaign, and are actively promoting the messages in Trust communications, encouraging staff to sign up in a personal capacity also. The campaign officially launches in August and will be supported Trust-wide.

  Following the Euro 2020 football final a number of racist comments were directed towards members of the team. In response, the Trust produced an anti-racism statement which was distributed to all staff and placed on our website. The statement detailed our Trust-wide anti-racism aims, our commitment to promoting and ensuring diversity, inclusivity and equality for all staff and service users, and provided information on the support available for staff if they felt distressed by the coverage.

- **Recent research published in the BMJ has highlighted that people with learning disabilities** are five times more likely to be admitted to hospital and eight times more likely to die from Covid-19 than the general population. The researchers state prompt access to Covid-19 testing and healthcare is warranted and prioritisation for Covid-19 vaccination and other targeted preventive measures should be considered. This and the recent LeDeR underlines the importance of our work with partners, including primary care, acute and community colleagues, to reduce health inequalities for all vulnerable groups.

- A **mental health friendly/accreditation scheme** has been created named 'Moving Mental Health Forward'. This has the framework, brand and funding to be launched in July 2021. This is led by Barnsley Metropolitan Borough Council and Creative Minds on behalf of the Active in Barnsley Partnership.

- **The Lord Mayor of Wakefield marked the NHS birthday** and the Together Coalition's day of thanks by visiting the Drury Lane Health and Wellbeing Centre. While there she handed out certificates to teams to recognise their efforts in responding to the coronavirus pandemic, and in keeping services going during challenging times. You can see some of the photos from the day on our website.

- We have all been deeply shocked and saddened by the sudden death of Ruth Donoghue. Ruth was a community services manager in Barnsley. Having qualified as a nurse in 1996 Ruth went on to work in Barnsley community services for almost 21 years. Using the words of Sue Wing, our deputy director of operations 'She was a bright beacon in her professionalism, and her caring and love for her patients and all of you as

	individuals/ teams and colleagues shone throughout her work over the years. She was deeply loved and respected by all.'
	• **Trust leadership changes** – the initial changes in Trust leadership agreed by the Trust Board took effect on 05/07/21. This Board meeting will be the final one attended by Tim Breedon, Director of Nursing & Quality and Deputy Chief Executive before he retires. Tim has agreed to stay on in a part-time capacity as deputy Chief Executive to support the changes in leadership until the end of September, so will not be leaving the Trust until then. Tim has been an outstanding leader in the Trust and wider system and is hugely respected. His contribution to the Trust, its services and this Board has been immense. Darryl Thompson will formally become the Trust's Director of Nursing, Quality & Professions on 01/08/21 and we wish him every success. This is also the final Board meeting Sam Young will be attending as a Non-Executive Director. Sam has had a genuine and insightful impact whilst on our Board. We thank her for her positive contribution and wish her every success with her future endeavours.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

The Brief

1 July
2021

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

With **all of us** in mind.

Our mission and values

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

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Local carer from Calderdale, shared her poem of strength as part of last month's Carer's Week Trust celebrations. You can watch her read the poem on Twitter.

With **all of us** in mind.

Our priority areas 2021/2022

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Improve health

Understanding equality, and addressing inequality through inclusive involvement

- Play a full role in our Integrated Care Systems and associated places to contribute to outcomes in their 5 year plans
- Deliver improved integrated mental health community services with our partners in each of our places
- Deliver the changes required to be a high-quality lead provider of forensic services
- Continually improve and further integrate general community services in Barnsley
- Enhance creative, cultural and digital offers through Creative Minds and our recovery colleges

We deliver the targets agreed in our ICS strategies

Improve care

- Continually improve patient safety
- Safely deliver and restore inclusive services and support, locking in innovation
- Continually improve services for people who are acutely mentally unwell and improve the working environment for staff on our wards
- Transform our mental health wards for older people

We restore services, deliver our quality targets and improve our CQC ratings

Improve resources

- Integrate digital approaches to the way we work
- Spend money wisely and reduce waste

We deliver our financial duties and improve efficiency

Make this a great place to work

- Support the provision of a healthy, resilient and safe workforce
- Refresh and deliver our sustainability strategy and action plan

We improve our staff survey results and deliver our WRES/WDES indicators

#allofusimprove
and be outstanding

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

With **all of us** in mind.

The national, regional and local context

We are continuing to work with our partners in each of our places and ICS' areas to develop our response to the NHS White Paper, building on localised progress already made in the last few years.

West Yorkshire and Harrogate ICS has been working on a new delivery model for **Assessment and Treatment Units (ATUs)** for people with a learning disability. Following service user and carer engagement they are now in a position to confirm their plans. This involves providing the 16 inpatient beds from 2 units instead of the previous 3. These will be centred on Bradford and Fieldhead, and will be implemented from October 2021. You can find more details, including a link to the engagement report on the intranet.

West Yorkshire and Harrogate is one of 4 national creative health hubs which, in partnership with the **National Centre for Creative Health (NCCH),** will build on the work we have led with partners in Calderdale. This included a regional event held last month on creativity and health.

The South Yorkshire and Bassetlaw **QUIT** programme officially launched in May. The smoke prevention initiative could save up to 2,000 lives a year by supporting those in hospital to give up smoking. You can find more information along with training and resources on the QUIT website.

Barnsley 2030 also launched in May. It is about creating a shared vision and ambition for Barnsley, setting out what the Borough will be like by 2030. Our Trust is a part of plans and discussions.

We are taking part in a **CQC** South Yorkshire and Bassetlaw collaborative review, exploring the journeys of young people across Barnsley.

Coronavirus updates

NHS South West Yorkshire Partnership NHS Foundation Trust

As of 1 July there were **92** members of staff absent or working from home due to coronavirus, up from 24 in April.

The **Delta variant** of the coronavirus is becoming more prevalent and is more easily transmittable. The vaccine is so far effective against new variants and is the best way to protect you, your loved ones, colleagues and service users.

The Government has delayed the latest release of lockdown restrictions because of the rising infection rates and Delta variant. However some travel restrictions have been eased, with more countries now in the Green category. Please familarise yourself with the latest Trust guidance on travel before booking any trips abroad. You can find it on the intranet. To travel you also need a COVID passport, find out how to get one on the Government website.

Don't forget… **the vaccine is an important way to keep everyone safe.** Make sure you have both doses for maximum protection. Remember to tell us if you've had either dose of the vaccine outside of the Trust by emailing Business Intelligence.

Remember that as and when lockdown restrictions ease the rules in place across the Trust stay the same. The changes announced for wider society don't at this stage affect healthcare providers so even if restrictions are eased for social interactions for us in work they stay the same. So keep up with social distancing, hygiene measures, wearing of PPE, room occupancy levels, and all other IPC rules. It is what will keep us safe.

With **all of us** in mind.

Improving Health
Our performance in May

- **1** suicides for patients with an open referral
- **55.6%** of people completing IAPT treatment and moving into recovery
- **13.9%** of people accessing IAPT are from a BAME community
- **98.8%** of service users with a CPA followed up within 7 days of discharge
- **74%** of inpatients have been screened using the cardio metabolic assessment and treatment tool, **57%** have been screened in our early intervention services
- **86.8%** (provisional figure) of learning disability referrals have had a completed assessment, care package and commenced service delivery within 18 weeks

Staff member has been awarded an OBE in the Queen's Birthday Honours. Also his **ADHD team** have been invited by the Government of Iceland to present our ADHD pathway, linked to the A.I. Algorithm. This work is part of the grant application for which the Trust has received £39,000 this financial year.

The Trust's stop smoking service, **Yorkshire Smokefree**, has been awarded 'best poster presentation' at a national conference. The service presented the poster at the Smoking Cessation and Health Conference UK on their move from paper vouchers for stop smoking medication to more efficient e-vouchers.

Improving Care
Our performance in May
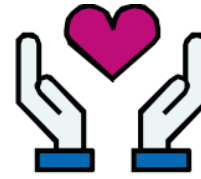
- **204** out of area bed days
- **3** young people under 18 admitted onto adult inpatient wards
- **93.2%** waiting list referral to assessment within 4 hours
- **94.6%** waiting list referral to assessment within 2 weeks
- **98.7%** waiting list assessment to treatment within 6 weeks
- **359** average contacts per day in mental health services
- **575** average contacts per day in general community services
- **174** average contacts per day in community learning disability services

96% of respondents in the friends and family test rated our general community services either good or very good; **78% in** our mental health services; and **69.1%** would recommend our CAMHS service.

Congratulations to *Staff Member* from our learning disability service, who has been nominated in the community nursing category of the Royal College of Nursing annual awards.

The Trust is carrying out a survey to find out what people who use our community mental health services think about their care. The survey closes at the end of July. More information can be found on our website.

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With **all of us** in mind.

Improving Care
Our performance in May

In May we had:

- 1,011 incidents – 645 rated green (no/low harm)
- 356 rated yellow or amber, 312 in April
- 10 rated as red, 9 in April
- 36.2% of incidents are recorded as either red, amber or yellow. Up from 32% in April.
- We had **9** self-harm incidents, **3** category 4 pressure ulcers, **1** slip, trip or fall, **1** medication incident, and **5** deaths awaiting confirmation of cause.

We had **106** restraint interventions in May, down from 157 in April. **100%** of prone restraints were of 3 minutes or less.

90.3% of people died in a place of their choosing.

DTOC (delayed transfer of care) was **1.1%** in May.

We had **39** falls in May, down from 50 last month. All falls are reviewed to identify measures required to prevent reoccurrence.

There were **8 confidentiality breaches** in May, slightly up from 7 in April.

All of us can help to reduce the number of patient data or sensitive information breaches at the Trust. If you are speaking to a patient remember to check you have the correct contact details and make any changes straight away. Double check preferred contact channels for patients and always make sure that the contact details you have are accurate and up to date before sending anything out.

Improving resources
Our finances in May

	Performance Indicator	Year to Date
1	**Surplus / Deficit**	£1.3m
2	**Agency Spend**	£1.1m
3	**Cash**	£61.3m
5	**Capital**	£0.3m
6	**Better Payment Practice Code**	97%

In May a surplus of £0.7m has been reported which is favourable to plan. We currently receive more income than normal to support the response to the pandemic. This is likely to change (reduce) in the second half of the year

Agency run rate continues to be in line with that from the previous financial year with spend of £0.6m.

We are seeing higher costs in our inpatient wards and for out of area beds

Cash in the bank continues to be positive although this is forecast to reduce in year due to the higher level of planned capital investment.

The capital programme for 2021/22 has been agreed as £9.6m. Spend to date is £0.3m as plans for the full year programme of work are developed.

97% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 11 days from receipt.

A great place to work
Our performance in May

#allofus
our wellbeing at work

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- **4.3%** sickness rate
- **2.8%** of absences are a result of stress, anxiety and MSK
- **14.7%** staff turnover

June was **PRIDE** month and our LGBT+ staff network supported teams across the Trust to celebrate and raise awareness. Our Barnsley Children's Therapy Group made cupcakes, the museum collected stories and art, Wakefield CAMHS held a number of activities, and many teams held awareness sessions with staff and service users.

If you haven't done so already don't forget to kick start your **appraisal** process on **WorkPAL** with the self assessment. Once you do this your line manager can start their assessment and book in your appraisal.

Our staff support group on **menopause** met virtually for the first time on 7 June. They meet every Monday afternoon. More details are on the intranet.

There is still time to order one of EyUp charity's **'Bee You'** journals which can help you support your health and wellbeing. This is being funded by NHS Charities Together.

Remember there is health and wellbeing support available for **#allofus**.

With **all of us** in mind.

#allofusimprove

![#allofusimprove and be outstanding]

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South West Yorkshire Partnership
NHS Foundation Trust

We use established QI (quality improvement) approaches for our improvement work.

The Trust has been nominated in the HPMA Awards in the Social Partnership Forum category, which celebrates partnership working between employers and trade unions.

EXCEL 2021
EXCELLENCE IN PEOPLE AWARDS
hpma

We have installed **electric vehicle** recharging points in Fieldhead and Kendray, with plans to extend this out to other areas when we can. This helps support our sustainability plans and commitment to the green agenda.

In June the Trust held the first in a series of **transgender awareness** events, held initially to coincide with PRIDE month. Due to the high demand two more sessions have already been arranged for July. Feedback has been great with one attendee saying it was the best training they had had in 20 years in the NHS!

To celebrate **Carers Week** we held a number of engagement events across all of our areas, supported by our carers network and carer development team. The week culminated in a joint event for all areas, bringing them together to share stories and network.

Remember to use the I-Hub to share you learning and ideas for improvement.

i-hub
Share, innovate, collaborate and improve

Managing risk
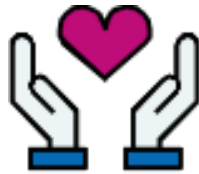
We continually monitor risk through our Operational Risk Register. This assesses clinical, commercial, compliance, financial and strategic risks and identifies mitigations on how we can reduce and remove risk.

In addition to COVID risks, the following are identified as major risks:

- Threats to our IT infrastructure from cyber crime and the dangers this presents to information security. IG and theft. **Our IM&T team is working to ensure our systems are up to date and secure. This includes online security, equipment and ensuring staff are aware of the dangers and skilled in what to do if problems arise.**
- Risk that care standards will be affected by lack of resources or service provision in partner organisations. **We are working with partners on place based localised approaches and in provider development initiatives that support cross organizational working.**
- Risk associated with becoming the lead provider in forensic services. **A collaborative partnership board is taking a lead on assessing all risks before 'go live' proceeds.**
- Risk that wards are not adequately staffed, impacting on quality of care. **Our safer staffing team is currently implementing appropriate action plans, focused on short, medium and longterm objectives.**
- Risk to confidence in services linked to long waiting lists. **Waiting lists are monitored, regular contact maintained, and alternative services offered as appropriate.**
- Risks associated with the availability of seclusion rooms if they become damaged or out of action. **A review of all seclusion facilities is currently being carried out.**

Leadership changes

Over the past couple of weeks we have told you about some changes to our leadership that will be coming up over the next few months. Despite these changes our core values and Trust culture remains strong. It comes from all of us, we all shape our culture, and we all have a part to play in ensuring we deliver safe, strong and effective care for our service users and their carers.

We have a strong leadership, led by our Trust Board and EMT, which largely stays the same. This will ensure a consistent approach to our direction, our strategic objectives, and our ongoing priority programmes. This will continue, led by EMT, and through Trust Board by our NEDs.

From 5 July, our chief executive will be going on secondment to the West Yorkshire and Harrogate ICS as their interim chief executive. Up until now he has worked as lead chief executive for the ICS on a part time basis, and this move means he will now take on the role full time. He is expected to stay in this role until the ICS roles are recruited to substantively, when he plans to apply.

Our Trust Chair, will be retiring this Autumn, after nearly 4 years in the role. A recruitment process will commence soon, with a new Chair appointed over the Summer.

Leadership changes

In addition to these changes some of our directors will be retiring over the next year. These changes have been planned for, with succession planning part of Trust Board's ongoing work.

As previously announced, our director of nursing, quality and professions will retire at the end of July. Our current deputy director will then take over the role from the current, following an open recruitment process. *Staff member* has agreed to support the Trust as deputy chief executive on a part-time basis until the end of September

Our director of HR, OD and estates will be retiring at the end of September after over 28 years working at our Trust. Our current deputy director of HR and OD will be acting up as director of HR and OD until a recruitment process is completed.

We will continue to have a strong core EMT and Trust Board, including *staff member* who will continue as our medical director, *staff member* our director of strategy and change, *staff member* our director of operations, and *staff member* our director of provider development. This will provide us with consistency throughout the upcoming period of change.

With **all of us** in mind.

Take home messages

NHS
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Leadership changes but our culture comes from all of us. Our focus on delivering quality care remains the same.

Safety comes first, always. Rising infection rates mean it is still important to maintain safety measures.

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

Remember if you haven't yet had your COVID vaccination there is still time to protect you and those around you.

Be extra careful when handling other people's information and data. Check all details before sending info out.

Take a look at the intranet and familiarise yourself with the HR guidance on travel.

Start your appraisal with your self assessment, and then book in your appraisal meeting.

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

Trust Board 27 July 2021
Agenda item 8.1

Title:	**Board Assurance Framework (BAF) Quarter 1 – 2021/22**
Paper prepared by:	Assistant director of corporate governance, performance and risk
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**

In April 2021, a comprehensive review of controls, assurances and target dates for actions took place.

Discussion at the Extended Management Team (EMT) meeting in July considered any change in circumstances which may impact the movement on strategic risk ratings.

With **all of us** in mind.

Typically, it was concluded that assurance levels have been maintained throughout the pandemic with strong mitigation against risks being demonstrated within the controls and assurances.

Although assurance levels have in the main, remained the same, controls and assurances have continually been updated providing evidence of mitigation and maintenance of assurance levels.

EMT also considered the impact of changes in Trust leadership on our strategic risks, reaching the view that strong mitigation is in place through pro-active Board succession planning.
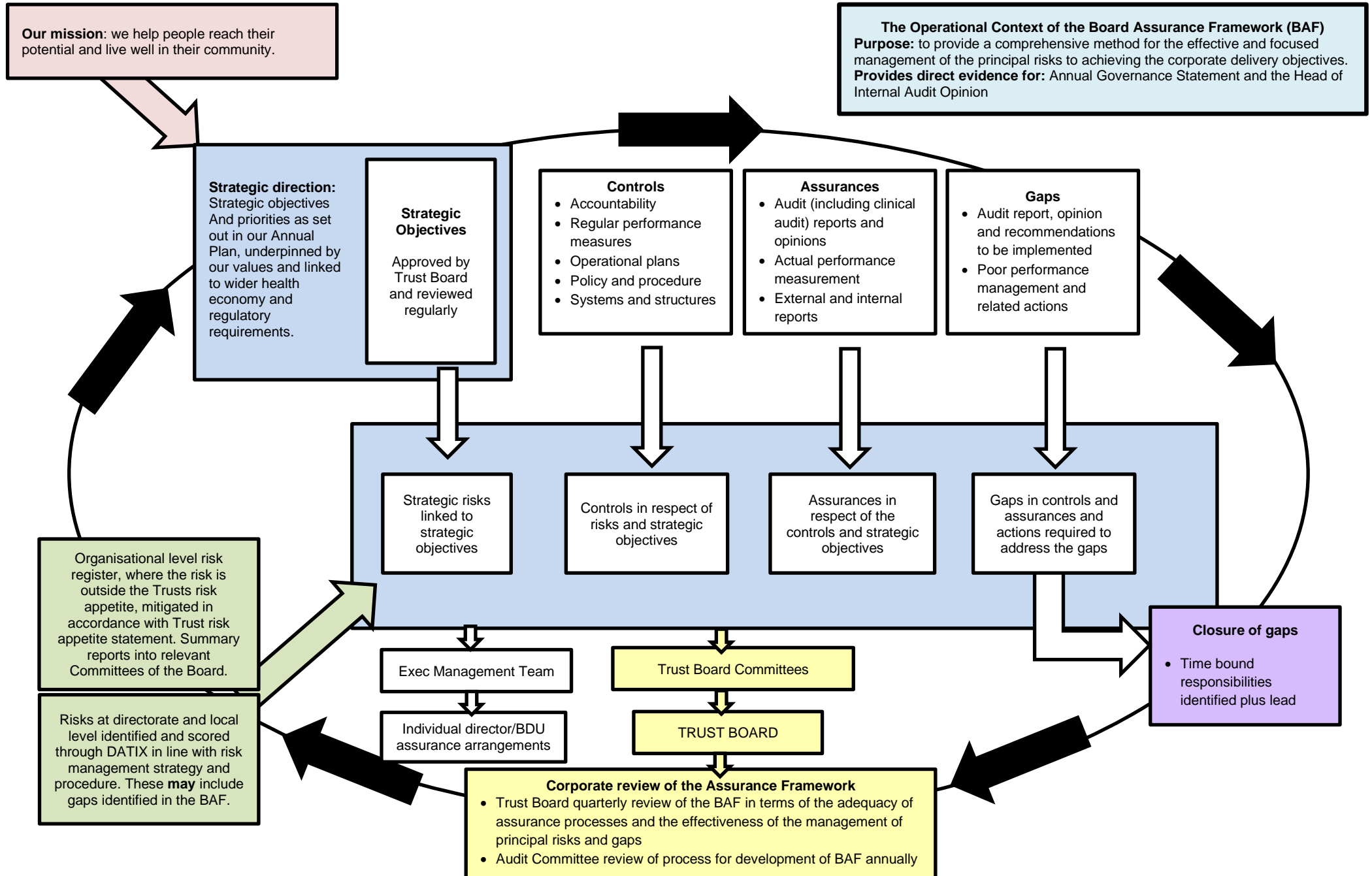
Executive Management Team have considered the scoring of each risk and at this time there are no recommended changes to assurance levels.

In reaching this conclusion key areas of focus included:

- Risk 1.1 – Acknowledgement that the development of the West Yorkshire & Harrogate integrated care system resulted in the Trust Chief Executive being seconded full-time to the ICS. During this period the director of finance and resources will be interim Chief Executive. The Trust remains engaged with it integrated care system developments in both West Yorkshire & Harrogate and South Yorkshire & Bassetlaw, and in all places including the development of mental health and wellbeing alliances and provider collaboratives. There remains a level of uncertainty. As such it is recommended the rating of amber remains
- Risk 1.2 - The planning process now needs to take a longer-term view, to ensure a less reactive approach. Work has re-commenced to develop longer term plans for the Trust. This will take into account such factors as the aims and intentions of the NHS long term plan, the development of integrated care systems, local place plans, workforce planning, financial sustainability, longer-term impact of pandemic including recovery and restoration, inequalities, capital planning and the potential impact of the White Paper.
- Risk 2.3 - The impact of the pandemic on mental health is not yet fully understood. The Business Intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting. The Trust has developed an intelligence tool which will enable us to map population against demand to support planning for future service and address inequalities when fully utilised.
- 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 – focus on available resources and capacity continues, particularly in light of leadership changes in the Trust, the impact of the pandemic on staff absence, and those changes anticipated through the Health and Care Bill.
- Risk 4.1 – the amber rating continues to bedriven by the availability of clinical workforce. A virtual international recruitment portal has been signed off by EMT and a work group has been established to look at the development of new clinical roles.

	• Risk 4.3 – it is recognised we provide a strong health & wellbeing offer for staff. Recovery and restoration planning considers the impact of the pandemic including long Covid on staff 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 DISCUSS this report and APPROVE the updates to the Board Assurance Framework**
Private session:	Not applicable.

BOARD ASSURANCE FRAMEWORK – STRUCTURE AND PROCESS

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	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	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	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	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	Y			
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.	23	G	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	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	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	Y			
	3.2 Failure to develop relationships with commissioners and other key partners to improve services and respond to local needs.	32	G	G	G			
	3.3 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.	35	Y	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	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	Y			
	4.3 Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.	41	Y	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**			
				Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Links to ORR (risk ID numbers): 275, 773, 812, 1077,1511, 1531		As noted below.	EMT, CGCS, MHA, Trust Board	Y	A	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. A recent decline in results is being investigated and will be reported into the next Board meeting, triangulating this with other feedback and insight, in particular Healthwatch.
• Strong and robust partnership working with local partners, through emerging integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield.

Rationale for current assurance level (strategic objective 1: improve health)

- Partnering provider collaborative development in West Yorkshire and lead provider for forensic provider collaborative.
- 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 are being monitored through the Equality Involvement 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 IPR Month 2: out of area beds – red, children and young people accommodated on an adult inpatient ward – 3 service users for a total of 22 days, seven day follow up – green, physical health – not reported, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – amber, 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			
				Q3	Q4	Q1	Q2	Q3	Q4
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	Y	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 and regularly reviewed as part of the Trust appraisal process. (Excellence awards paused during the Covid-19 pandemic)
- In the main, positive Friends and Family Test feedback from service users and staff. A recent decline in results is being investigated and will be reported into the next Board meeting, triangulating this with other feedback and insight, in particular Healthwatch.
- 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 Covid-19 vaccination programme and infection prevention and control response to Covid-19.
- Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting.
- Trust developing overarching operational data quality improvement plan which will be monitored by Improving Clinical Information Group (ICIG) and Operational Management Group (OMG)
- Focused information provided for out of area bed review to support findings and recommendations.
- Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 2 shows: Friends & Family (F&F) Test MH –red F&F Test Community –red, safer staff fill rates – green, IG confidentiality breaches – green.
- Programme of optimisation for SystmOne for mental health complete, however, ongoing development of the FIRM risk assessment tool and care planning continues. Waiting list management tool in SystmOne being prioritised for roll out. The second stage of benefits realisation assessment will take place Q4 2021/22.
- Testing and support for service users and staff in response to Covid-19
- Investment in IT and facility infrastructure.
- Bed occupancy and patient acuity 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 to continue to be utilised post pandemic.

Strategic objective 3: Improve resources		Lead Director(s)	Monitoring and assurance	Overall assurance level					
				2020/21		2021/22			
				Q3	Q4	Q1	Q2	Q3	Q4
Links to ORR (risk ID numbers): 275, 522, 695, 1076, 1077, 1114,1214, 1217, 1319, 1335, 1511, 1567		As noted below.	EMT, AC, WRC, Trust Board	Y	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)
• Interim financial arrangements in place for H1 2021/22.
• National funding arrangements are a key mitigation for this risk for H1 2021/22.
• A cumulative surplus of £1.3m has been recorded.
• . There has been a sustained increase in acuity and demand leading to an increase in out of area bed placements and costs
• 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 of c£60mand 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.
• 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, 1533, 1536		As noted below.	EMT, WRC, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
				Y	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.								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.								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.

Rationale for current assurance level (strategic objective 4: make this a great place to work)

- Staff sickness absence slightly lower than target on sickness, but lower than majority of other trusts in Yorkshire.
- Staff survey feedback average across the Trust, with some good areas and some hot spots.
- 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. A recent decline in results is being investigated and will be reported into the next Board meeting, triangulating this with other feedback and insight, in particular Healthwatch.
- 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 and post 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+.
- Full-time lead Freedom to Speak up Guardian in post
- Virtual international recruitment portal signed off by EMT.

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. New central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies.(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

	Controls (strategic risk 1.1)		
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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. There are no CQUIN schemes for H1 2021/22 (I, E)	DO	1.1, 1.4, 3.3
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
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 provision– actions identified on the Organisational Risk Register. (Linked to ORR risks 275 and 1077). Delayed transfers of care continue in 2021-22 Reviewed in June 2021 and new review date of September 2021 established.	To be reviewed by 30 September 2021	DO / DS

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 Integrated Care System initiatives – recognition that elements of this are not fully within our control, however we continue to play our part and help shape integrated care developments in all places including the development of mental health and wellbeing alliances, and working in partnership to reduce health inequalities in line with national guidance. (Linked to ORR Risk ID 812) Reviewed in June 2021 and new review date of January 2022	To be reviewed by 30 January 2022	DS / DPD
Clinical networks to be embedded across each pathway as part of the new operational leadership structure. Reviewed in June 2021 and projected date of completion is April 2022 following the impact of Covid-19.	April 2022	DO
Provider alliance / collaborative in South Yorkshire in development for mental health, learning disability and autism. This is still in development. Reviewed June 2021 for further review in September 2021.	September 2021	DS / DPD
Roles and views of primary care networks could differ by place and lead to inconsistent commissioning of services In partnership with the Barnsley Primary Care Network/GP Federation to develop the detail of the local transformation development plan. The proposal regarding a brief intervention service to support primary care (as part of additional roles reimbursement scheme) has been approved and scheduled for implementation in September 2021. Discussion with all primary care networks in each of our places is progressing in respect of the ARRS mental health practitioners. This is within the context of mental health community transformation in each place.	To be reviewed by 30 September 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 agreed at CG&CS Committee June 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

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)
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. 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, 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). The Trust has responded well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. The Trust has submitted a financial plan for a break-even position for the first six months of 2021/22. Work will now commence to agree longer term plans for the Trust. (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Kirklees and Barnsley for 21-22 expecting governing body approval for Calderdale imminently (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

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)**
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. Reviewed June 2021 in the development of our medium-term plan, we will ensure alignment to each ICS and place-based plan, in addition to giving consideration to key documents for example the Long Term Plan Implementation Guidance. Further review in September 2021.	September 2021	DS / DPD
Active member of place based / ICS integrated care governance arrangements in all areas. in the development of ICSs has resulted in the Trust Chief Executive being seconded full time to the ICS during which time the structure will be finalised. During this period the director of finance and resources will be interim Chief Executive. Reviewed in June 2021 to review further September 2021.	To be reviewed by 30 September 2021	DS
The planning process now needs to take a longer-term view, to ensure a less reactive approach. Work will commence to agree longer term plans for the Trust. This will take into account such factors as the aims and intentions of the NHS long term plan, the development of integrated care systems, local place plans, workforce planning, financial sustainability, longer-term impact of pandemic including recovery and restoration, inequalities, capital planning and the potential impact of the White Paper. Reviewed in June 2021 and review further in September 2021.	To be reviewed by 30 September 2021 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. New central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies.(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

Controls (strategic risk 1.2)				
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
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 agreed at CG&CS Committee June 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

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)
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. 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) annual and 5-year plans (P, N) (I). The Trust has responded well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. The Trust has submitted a financial plan for a break-even position for the first six months of 2021/22. Work will now commence to agree longer term plans for the Trust. (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
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

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)
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) There are no CQUIN schemes for H1 2021/22 (I, E)	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
The planning process now needs to take a longer-term view, to ensure a less reactive approach. Work will now commence to agree longer term plans for the Trust. This will take into account such factors as the aims and intentions of the NHS long term plan, the development of integrated care systems, local place plans, workforce planning, financial sustainability, longer-term impact of pandemic including recovery and restoration, inequalities, capital planning and the potential impact of the White Paper. Reviewed in June 2021 to be further reviewed in September 2021.	September 2021	DS
Active member of place based / ICS integrated care governance arrangements in all areas. in the development of ICSs has resulted in the Trust Chief Executive being seconded full time to the ICS during which time the structure will be finalised. In the interim the director of finance and resources is acting Chief Executive. Reviewed in June 2021 to review further September 2021.	To be reviewed by 30 September 2021	DS/DHR

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
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

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
C138	Trust wide Equality Impact Assessment together with the inequalities data developing systemic analysis and plans to address Trust inequality priorities (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 Integrated Care System initiatives – recognition that elements of this are out of our control, however we continue to play our part and help shape integrated care developments in all places including the development of mental health and wellbeing alliances and working in partnership to reduce health inequalities in line with national guidance. (Linked to ORR risk 812) Reviewed in June 2021 and new review date of September established.	To be reviewed by 30 September 2021	DS/DPD
Trust wide Equality Impact Assessment (EIA) – develop a Trust wide Equality Impact Assessment and intelligence data base to support planning. The EIA tools have been created, including the Trust wide EIA and literature. The intranet materials have been updated but an external delay in the intranet updates mean that the date for completion is delaying the availability of materials. It is anticipated that the intranet resources and update will be completed by August 2021.	August 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 agreed at CG&CS Committee June 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,	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)**
	identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.			
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.	Equality Standard (DES) reports and action plans. New equality, involvement, communication, and membership strategy approved by Trust Board in September 2020 with a suite of materials being developed to enable easy access. Equality, Involvement, Communication and Membership action plans being monitored by the EIIC. (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**
Although it is unclear of the full extent of the impact of Covid-19 on different populations the Trust has developed an intelligence tool which will start to enable us to map population against demand to support planning for future service. Reviewed in June 2021 and to be reviewed again in September 2021.	To be reviewed by 30 September 2021	DO/DS
Use of data and informatics together with insight from service users/carers, wider communities and stakeholders could be more comprehensive to support, involvement and engagement in service delivery.	To be reviewed by 30 September 2021	DPD
Trustwide Benchmarking Group established chaired by Director of Operations, reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. Reviewed in June 2021 to be reviewed further in September 2021.	To be reviewed by 30 September 2021	DO

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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.

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Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
	Controls (strategic risk 1.4)		
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. New central logs for clinical and corporate procedures developed and new procedure template added to the Policy on Policies.(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
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 There are no CQUIN schemes for H1 2021/22 (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

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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. The Trust has developed an intelligence tool which will start to enable us to map population against demand to support planning for future services, this includes equality information for our population. Reviewed in June 2021 to review further in September 2021.	To be reviewed by 30 September 2021	DS / DNQ
Use of data and informatics together with insight from service users/carers, wider communities and stakeholders could be more comprehensive to support, involvement and engagement in service delivery. Reviewed June 2021 to be reviewed further September 2021.	To be reviewed by 30 September 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

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)
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 2021/22 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. Use of data and informatics together with insight from service users/carers, wider communities and stakeholders could be more comprehensive to support, involvement and engagement in service delivery.	To be reviewed by 30 September 2021	DS
More granular level of reporting required of access to our services by protected characteristic compared to the demographics of the communities. The Trust has developed an intelligence tool which enables us to map population against demand to support planning for future service. This is being reviewed on monthly basis with Operational Management Group and every EIIC meeting. Reviewed in June 2021 and further review will take place in September 2021.	September 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

Controls (strategic risk 2.1)			
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
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 being implemented. Reviewed June 2021 to eb reviewed further in September 2021*	30 September 2021	DFR
Limited data on caseload, real time waiting list issues, face to face time. Working group established with senior operational and P and I staff to understand current waiting lists for all services. Waiting list management tool in SystmOne being prioritised for roll out. Reviewed June 2021 to be reviewed further in September 2021 Business Intelligence Group established as part of reset and restoration of services.	30 September 2021	DPD
Use of benchmarking information not fully embedded in the Trust. Benchmarking Group established chaired by Director of Operations, reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. Reviewed in June 2021 to be reviewed further in September 2021.	30 September 2021	DFR / DPD

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

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)**
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. Trust developing overarching operational data quality improvement plan which will be monitored by ICIG and OMG	30 December 2021	DFR
Process for reviewing internal benchmarking data is not applied consistently or fully embedded across the Trust. Benchmarking Group established chaired by Director of Operations, reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. Reviewed in June 2021 to be reviewed further in September 2021.	30 September 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

Controls (strategic risk 2.2)				
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	
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	
C139	Develop use of improvement case studies. Process established. Further developments to embed and effectively share are being led by the communications team and published on the website. (P,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. Monitoring system in place however action plan evidence challenge process not mature – to review October 2021.	31 October 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. Now included in restoration work programme and considered in quality strategy refresh process – update to CGCS in November 2021	30 November 2021	DNQ
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 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. Effective working group now established which is reviewing estate, new ways of working and development support. Reviewed in June 2021 and to be reviewed further in September 2021.	To be reviewed by 30 September 2021	DHR

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

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)
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 852) A new IG communications plan is being finalised, which will involve continued use of The Brief to publish case studies on the impact that personal data breaches have, raising awareness of the Freedom To Speak Up Guardians for staff to contact if they suspect inappropriate use of personal data is happening and communicate the need to ensure personal data is not stored in more than once place. Work using the Quality Improvement methodology continues to work through suggestions for improvement that were made during change improvement (CI) sessions that were run between November 2020 and January 2021. Reviewed in June 2021 for further review in September 2021	30 September 2021	DFR

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
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. Inpatient wards are now a priority programme. Reviewed in June 2021 for further review in September 2021.	Review by September 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/DPD	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/CEO/DPD	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
C69	Process to manage the CQC action plan. (I)	DNQ	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)
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 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
The impact of the pandemic on mental health is not yet fully understood. Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting. The Trust has developed an intelligence tool which will enable us to map population against demand to support planning for future service when fully utilised.	December 2021	DFR

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)
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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	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)**
		planned for 2021/22 with a report going to CG&CS Committee in February 2022. (P, N) (E		
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 2021/22 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. 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). An ICS review of the impact of the additional purchased PICU capacity is underway and will make recommendations for any similar strategies based on the learning. (August 2021). (ORR 1319) Reviewed in June 2021to be further reviewed by September 2021.	30 September 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. Negotiations of the resourcing for sustainable CAMHS neuro waiting list resources continue in Calderdale and Kirklees. Psychology recruitment and work to identify appropriate estate is being taken forward to mitigate against any potential issues caused by the time needed for the contacts to be established. • CAMHS Barnsley – internal development work being undertaken to enable production of reports for new access KPIs as well as establishing baseline. Plan timeframe changed to early September with intention to report on access KPIs from Q3 onwards (subject to commissioners agreement & sign-off via contractual routes). Reviewed in June 2021 to be reviewed further in September 2021.	To be reviewed by 30 September 2021	DO
The impact of the pandemic on mental health is not fully understood. Business intelligence development plan is being aligned to Trust strategic objectives and priority programmes including health intelligence data and reporting. The Trust has developed an intelligence tool which will enable us to map population against demand to support planning for future service when fully utilised. Review in June 2021 and further review in September 2021.	To be reviewed by 30 September 2021	DS

<table>
<tr><td colspan="2">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.</td></tr>
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	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. (linked to ORR1080) (I)	DFR	2.4
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. Reviewed June 2021 risk maintains to be further reviewed in September 2021	To be reviewed by 30 September2021	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

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)
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. Reviewed June 2021 next phishing exercise taking place July 2021.	30 September 2021	DFR
Cyber audits and penetration testing have highlighted some areas for improvements. Formal action plan in place to address.	September 2021	DFR
	September 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

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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	13.1, 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. H2 2021/22 contract negotiation process. (DFR) (Sept 2021) (Linked to ORR risks 1077, 1214).	30 September 2021	DFR
Trust has a history of not fully achieving its recurrent CIP targets (Linked to ORR risk 1076). *CIP delivery not required in 20/21 given the Covid-19 pandemic. Not required in half 1 of 21-22 in light of the pandemic.*	Annual target to be reviewed by 31 October 2021	DFR / DO
Impact on services as a result of local authority provision – actions identified on the Organisational Risk Register. (Linked to ORR risks 275 and 1077). Delayed transfers of care continue in 2021-22 Reviewed in June 2021 and new review date of September 2021 established.	To be reviewed by 30 September 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	Contracting risks, bids & tenders update standing item on delivery EMT agenda.	DO	1.1, 1.2, 3.1, 3.2

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)
	subject to delegated limits ensuring alignment with strategic direction and investment framework.	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)		
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). The Trust has responded well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. The Trust has submitted a financial plan for a break-even position for the first six months of 2021/22. Work will now commence to agree longer term plans for the Trust. (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Kirklees and Barnsley for 21-22 expecting governing body approval for Calderdale imminently (P) (I) (E)	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) There are no CQUIN schemes for H1 2021/22 (I, E)	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 3.1)				
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)**
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) A West Yorkshire & Harrogate ICS review of the impact of the additional purchased PICU capacity is underway and will make recommendations for any similar strategies based on the learning. (August 2021). Reviewed June 2021 and to be reviewed further in September 2021.	30 September 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
Financial plan for H2 2021/22 not yet developed. Timescale dependent on planning guidance availability	September 2021	DFR
A cumulative surplus of £1.3m has been recorded.. Reviewed in June 2021 and to be further review in September 2021 *Ongoing - Financial sustainability work is focusing on recurrent improvement opportunities.*	30 September 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

Controls (strategic risk 3.2)				
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**		**Director lead**	**Strategic risk(s)**
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 1077). Being addressed as part of the work on the LTP in each place, SY&B and WY&H.	31 January 2022	DFR/DS
Tendering activity taking place. (Linked to ORR risk 1214). Partnership and collaborative arrangements in each place being used to minimise this wherever possible. 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)	30 September 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
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. 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). The Trust has responded	DFR	1.1, 1.2, 3.1, 3.2, 3.3

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)**
		well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. The Trust has submitted a financial plan for a break-even position for the first six months of 2021/22. Work will now commence to agree longer term plans for the Trust. (E)		
A14	Mental Health Investment Standard income and reporting of performance.	Mental Health Investment Standard agreed with Wakefield, Kirklees and Barnsley for 21-22 expecting governing body approval for Calderdale imminently (P) (I) (E)	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. Impact of local place-based solutions and Integrated Care System initiatives – recognition that elements of this are out of our control, however we continue to play our part and help shape integrated care developments in all places including the development of mental health and wellbeing alliances, and working in partnership to reduce health inequalities in line with national guidance. (Linked to ORR risk 812) Use of data and informatics together with insight from service users/carers, wider communities and stakeholders could be more comprehensive to support, involvement and engagement in service delivery. Reviewed in June 2021 and new review date of September established.	To be reviewed by 30 September 2021	DS / DPD
The development of ICSs resulted in the Trust Chief Executive being seconded to the ICS full time during which time the structure will be finalised. In the interim the director of finance and resources is acting Chief Executive. Reviewed in June 2021 to review further September 2021.		DS/DHR

<table>
<tr><td colspan="3" align="center">**Strategic risk 3.3**
Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.</td></tr>
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<tr><td colspan="4" align="center">**Controls (strategic risk 3.3)**</td></tr>
<tr><td>**Control ref**</td><td>**Systems and processes – what are we currently doing about the strategic risk?**</td><td>**Director lead**</td><td>**Strategic risk(s)**</td></tr>
<tr><td>C09</td><td>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. There are no CQUIN schemes for H1 2021/22 . (I, E)</td><td>DO</td><td>1.1, 1.4, 3.3</td></tr>
<tr><td>C86</td><td>Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)</td><td>DO</td><td>3.1, 3.3</td></tr>
<tr><td>C87</td><td>Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)</td><td>DFR</td><td>3.1, 3.3</td></tr>
<tr><td>C94</td><td>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)</td><td>DHR</td><td>3.3</td></tr>
<tr><td>C95</td><td>Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)</td><td>CEO</td><td>3.3</td></tr>
<tr><td>C96</td><td>Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)</td><td>DS</td><td>3.3</td></tr>
<tr><td>C97</td><td>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)</td><td>DS</td><td>3.3</td></tr>
<tr><td>C98</td><td>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)</td><td>DFR</td><td>3.3</td></tr>
<tr><td>C99</td><td>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)</td><td>DS</td><td>3.3</td></tr>
<tr><td>C100</td><td>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)</td><td>DS</td><td>3.3</td></tr>
<tr><td>C134</td><td>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)</td><td>DHR</td><td>2.3, 3.3</td></tr>
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<table>
<tr><td>**Gaps in control – what do we need to do to address these and by when?**</td><td>**Date**</td><td>**Director lead**</td></tr>
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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). The Trust has responded well to the necessary short-term planning requirements both in 2020/21 and again in readiness for 2021/22. The Trust has submitted a financial plan for a break-even position for the first six months of 2021/22. Work will now commence to agree longer term plans for the Trust. (E)	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	DO	1.2, 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)**
		Trust Board. (P, N) (I) There are no CQUIN schemes for H1 2021/22		
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
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. in the development of ICSs resulted in the Trust Chief Executive being seconded to the ICS full time during which time the structure will be finalised. In the interim the director of finance and resources is acting Chief Executive. Reviewed in June 2021 to review further September 2021.	To be reviewed by 30 September 2021	DS/DHR
Additional demands being placed on Trust resource during the year over and above planning assumptions, particularly in respect of place-based developments. Reviewed in June 2021 and to be reviewed further in September 2021. 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 September 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

	Controls (strategic risk 4.1)		
Control ref	Systems and processes – what are we currently doing about the strategic risk?	Director lead	Strategic risk(s)
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
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. .At time of review in June 2021 this was still outstanding and therefore to be reviewed again in September 2021	To be reviewed by 30 September 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. Covid report has been maintained for July and the Committee will reintroduce broader workforce reporting from September 2021.	30 September 2021	DHR
• Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR 1151). Work ongoing around international recruitment and the development of new roles as part of increasing workforce supply. Virtual international recruitment portal signed off by EMT. Establishment of work group to look at development of new clinical roles.	To be reviewed by 30 September 2021	DHR

<table>
<tr><td colspan="2">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.</td></tr>
</table>

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. Pilot programme now completed with roll out across the organisation now being planned. Plan will be in place by 31st August 2021.	To be reviewed by 30 September2021	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

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)
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
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
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) position remains under review with further stocktake in August.	To be reviewed by 30 September 2021	DHR

Trust Board 27 July 2021
Agenda item 8.2

Title:	**Corporate / Organisational Risk Register Quarter 1 2021/22**
Paper prepared by:	Assistant Director of Corporate Governance, Performance and Risk
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 feedback is provided 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 resulted in a change in emphasis in some risks and the addition of 13 Covid-19 related risks in March 2020 (one of which is within risk appetite). The risk associated with the impact of long covid on our services and workforce is also being considered The full organisational risk register is reviewed on a regular basis by EMT.

With **all of us** in mind.

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

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

Risk ID	Description
New Risk	The current inconsistency in Speech and Language Therapy (SALT) provision could compromise the quality of care available in response to choking incident.
New Risk	Access to the roofs of single storey buildings could lead to a service user absconding and or serious harm

No risks have been merged in this period

Recommended for closure - Risk 1076 relating to cash resources has been recommended for closure by EMT and FIP in this period.

In addition, the risks specifically related to the Covid-19 pandemic are being reviewed. Some may need to be incorporated with existing risks, some potentially closed, and others may remain as separate risks. This work will take place during the remainder of quarter 2 and will involve Board committees.

This updated risk register was compiled prior to the significant increase in prevalence of Covid-19 and the associated impact on self-isolation and associated operational pressures within the Trust and wider system. The Trust is fully engaged with partners in all places and any impact on our risk register is being considered and developed

With regard to workforce risks discussion took place at the recent Workforce and Remuneration Committee. Associated updates will be incorporated in the next version of the organisational risk register.

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

Risk ID	Description	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.	- Phishing campaign being planned for and to be conducted during Q2 - Cyber security enhancements are under investigation.
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.	- Detailed planning exercise for remainder of 21/22 being undertaken - Focus on impact of increasing demand within restoration and recovery group.

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

Risks below 15 (outside risk appetite)

Risk ID	Description	Update (what changed, why, Assurance)
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	• Working on a plan through Operational Management Group in each place. • Contributing to the development of recovery plans in each place with partners.
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.	• Development of quality assurance processes and monitoring across the Collaborative is underway. • Development of governance structures including commissioning is underway. • Go live date deferred
905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	• New roles group established to develop broader range of options including AHP etc • New metrics under development to support improved reporting including staff lived experience
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	• A further review of resources has been undertaken and business case has now been submitted to address an increase in regular demand and with options to address historical waiting list pressures.
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	• Waiting list reports developed, further work required to ensure they are comprehensive. Additional reporting will be developed as part of SystmOne optimisation waiting list programme. • engaging with service users to ensure they are aware of the impact of the current ongoing NHS restrictions on delivery arrangements
1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	• Continue promoting smoking cessation services, strengthen the message of the impact on respiratory disease and the fact that it could affect recovery from Covid-19 via smoking cessation groups.

	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.	• Quality improvement network focus on patient safety improvement. commenced in Q1, and implementation plan reviewed in line with Covid-19 restoration.
	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 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 received a progress update
	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	• Continue discussions for use of mental health recovery funding
	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.	• Quality improvement project and action plan initiated: Data Quality report to Audit Committee in July
	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.	• External stakeholder engagement plans will be refreshed as part of the process to manage the change in the Trust leadership.
	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.	• Assess H2 2021/22 financial arrangements and planning guidance when received.
	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.	• Discussion taking place at Mental Health collaborative to look collectively developing new roles.
	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.	• There is a flexible workforce group being established as part of the implementation as a workforce strategy (Sept 2021)
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	• H2 2021/22 contract negotiation process.
	1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult	• Additional funding to support discharge packages during the current Covid-19 phase

		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.	has been made available. Teams will work with partners across the ICS to make best use of the available resources.
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	• Negotiation for use of mental health recovery monies
	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 and places additional pressure on staff when young people are cared for either on adult wards or in the secure CAMHS estate.	• Commissioners have agreed to additional resources to support young people in the secure estate who are waiting for a bed.
	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.	• Effective communication of Trust priorities to West & South Yorkshire partners
	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.	• An international recruitment portal has been agreed • 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 them and their families and therefore reducing the ability to provide safe and effective services.	• Review of physical health and wellbeing support being undertaken in light of Robertson Cooper survey result. (DHR)
	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.	• Review of how representative our decision-making groups are.
	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.	• Developing a more diverse and representative workforce where SWYPFT is seen as the employer of choice.

	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.	• Review of leadership and management pathway is underway and a programme of insight events are being held.

Risks within Risk Appetite

	695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	• Review and refresh of objectives and priorities in response to Covid-19 phases and recovery and reset plans
	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.	• Continue to play our part and help shape integrated care developments in all places including the development of mental health and wellbeing alliances and working in partnership to reduce health inequalities in line with national guidance.
	773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	• The Equality, Involvement, Communication and Membership strategy is in place with action plans agreed.
	New risk	The current inconsistency in SALT provision could compromise the quality of care available in response to choking incident.	• Associate of Director of Nursing and Quality is leading a review of SALT provision across all areas of the Trust
	New Risk	Inpatients areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury.	• We are following blanket restriction process at present, an assessment tool has been developed for roll-out in all areas
	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.	• Risk recommended for closure
	1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	• Continue to implement Quality strategy with integrated change application embedded. • Interim leadership arrangements in place

	1432	Risk of problems with succession planning / talent management.	• Key element of Trust Workforce Strategy.
		Covid Risks 15+	
	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.	• Detailed activity, workforce and finance planning for 2021/22 in light of increasing referral activity.
		Covid-19 related risks below 15 (outside risk appetite):	
	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.	• IPC BAF routine review and update into CG&CS Committee.
	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 has been added as a routine agenda item to allow OMG to review the OPEL levels and monitor the move from command structure to business as usual.
	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.	• Routine review of IPC guidance and horizon scanning.
	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.	• Developing a programme for potential Covid booster and flu vaccine programme
	1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	• National guidance on integrating learning from Covid-19 pandemic to be reviewed on receipt.
	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.	• Staff training plan to be initiated on use of translation and interpretation services.
	1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	• Review recent increase of referral data to understand to what extent this risk has been mitigated.

	1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**	• 8,284 patients responded positively to the consent request sent March 2021. Joint paper from the medical director, Trust CCIO and information governance lead on future arrangements post COPI drafted
	1567	Inability to meet the competing demand of responding to current waves of the pandemic, the regulatory reporting and restoration drives.	• Recovery and restoration work subject to routine review through performance reports to EMT • IPR review and triangulation providing early warning of emergent pressures and risks to delivery. (monthly 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.	• Effective ways of working group established
	1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	• Follow up on undertaking second vaccine to be completed by August 2021 • Link to the BAME staff equality network
	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.	• Targeted communication and engagement with staff network groups • Updating risk assessment including the impact of the vaccine.
	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	• Targeted communication and engagement with staff network groups continues • Engage with staff through individualised approaches to support informed decision making.

Covid-19 related risks within Risk Appetite

	1527	Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care.	• All Trust staff are transferring into the national lateral flow testing programme form August 2021 • This risk is to be reviewed within one month of handover to establish whether the national approach is effective and

	1611	adequate to support the Trust needs
		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.	• Engage with Trust-wide clinical safety and governance groups to identify any changes required in local processes.

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

In terms of risk profile, the consolidated risk score has remained similar, decreasing from 422 to 412 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.** • **AGREE to the removal or risk 1076 regarding cash resources being removed from the organisational risk register**
Private session:	Not applicable.

ORGANISATIONAL LEVEL RISK REPORT

NHS 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 (risk & assurance) 27 July 2021

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.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	• Ongoing capital programme to upgrade IT infrastructure in line with cyber security good practice during 2021/22. • 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 scheduled for Q4 . (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. • Remediation plans from the Penetration test conducted in January 2021. There remain two outstanding actions that are the responsibility of Estates & Facilities and further remediation plans	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	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

With all of us in mind.

- 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. - 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. - Capital programme completed to upgrade IT infrastructure – with some of the Cisco network equipment replaced during 2020/21. - Annual cyber survey conducted in January 2021. - Lightweight Directory Access Protocol (LDAP) has been amended to force any connection via LDAP to be authorised before allowing a connection to proceed. - Ongoing patching regime of SQL and non-security-based Microsoft Office updates - Microsoft Teams controls review completed in June 2021 - Backup solution has been further enhanced to include additional physical air-gap backups at both primary and			with revised timescales for resolution are in progress. (DFR) (Q2/Q3 2021) - Phishing campaign being planned for and to be conducted during the coming months. (Q2 2021) - Cyber security enhancements are being investigated that provide additional proactive countermeasures and advanced monitoring capabilities which will serve to reduce down the overall risk level, by reducing the likelihood and potentially the consequence also. These significant enhancements would facilitate an increased awareness, thus enabling a quicker remedial response, therefore potentially reducing the overall impact as a consequence. A separate paper is being readied to support the case for this significant investment (capital and recurrent revenue). (DFR) (Q4 2021/22)			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 conducted, this demonstrates significant progress and robust security controls are in place across the Trust's IT infrastructure.

			Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite							

| | | secondary data centre locations, for additional controls in relation to Ransomware. Completed June 2021 | | | | | | | | | | | |

Risk level <15 - risks outside the risk appetite

Risk ID	Description Of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
275	Risk of deterioration in quality of care 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 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (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 the Operational Management Group in each place. (DPD / DS) to review • Contributing to the development of recovery plans in each place with partners. (DS / DPD / DO)	DS	Ongoing risk given external influence outside our control	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performance report) Annual review of contracts and annual plan at EMT and Trust Board	6 Yellow /Moderate (4-6)	CG&CS FIP	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to business and risk Trust Board – July 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, and other risk to the Trust.	• 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. • 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'.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (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) • Further financial due diligence to be undertaken upon receipt of revised NHSE financial offer. (DFR) (July 2021) • 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) (July 2021)	DPD	August 2021	EMT (monthly)	4 Yellow / moderate (4-6)	FIP	Timescales for 'go live' of the collaborative is now August 2021.	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

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		• Learning from other Provider Collaboratives that have already gone live.					• 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) (August 2021) • Development of opportunities for financial efficiencies. (DPD) (August 2021) • Development of governance structures including commissioning (DPD) (August 2021)							
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. • Medical staff bank established. • 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.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Additional funding requests with commissioners will be maintained throughout contract negotiations for 2021/22. (DO / DFR) • Pandemic flu plan response including BCP stress testing. (DHR) • Business continuity planning included as a standard agenda item in OMG • 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 (DHR) (regular review throughout programme). • Monitoring the impact on staffing of emerging vaccination legislation and booster vaccinations. • 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 knowledge. Review completed and overtime continues to be available as an option within a range of temporary staffing measures and monitored by the flexible workforce group. (DO) • New roles group established to develop broader range of options including AHP etc (DNQ) • New metrics under development to support improved reporting including staff lived experience, both for IPR and safer staffing request.	DO / DNQ	Ongoing	EMT (monthly)	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review

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		• Staff redeployment process in place as part of business continuity planning (DHR) • Regular review of staff testing capacity through NQP business meeting to minimise staff absence with Covid-19 symptoms. (DNQ)												
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. • 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.	4 Major	2 Unlikely	8 Amber / High risk (8-12)	Minimal / low – Cautious / moderate (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). Discussion continues with commissioners to bring this to a satisfactory resolution. • 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) • A further review of resources has been undertaken June 2021 and business case has now been submitted to address an increase in regular demand and with options to address historical waiting list pressures. (DO) • Changes to delivery system have been made to manage recent increase in demand on crisis and eating disorder pathway to mitigate impact of additional pressure on waiting time for core CAMHS.	DO	Review every three months	Performance reporting to EMT - monthly Assurance report to Clinical Governance Committee Individual district performance reports reviewed by BDU	6 Yellow / moderate (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 and clinical risk.	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

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		• 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.												
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. • 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 – Cautious / moderate (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 July 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) further review required in August 2021 • Services are reviewing delivery methods and are engaging with service users to ensure they are aware of the impact of the current ongoing NHS restrictions on delivery arrangements.	DO	Ongoing	Performance reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performance reports reviewed by BDU.	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 Waiting list reporting has commenced in some areas but not all services in view	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review
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	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Smoking group established to review the smoking policy including the trial period for the use of e-cigarettes. (MD) 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) An update went to the CGCS committee in June 2021 reporting as follows: - Continue promoting smoking cessation services and strengthen the message of the impact on respiratory disease and the fact	DHR	Ongoing (Annual work programme to be reviewed in March each year.	EFM (weekly and monthly) Estates TAG (quarterly) OMG (monthly)	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 Note - A failure to effectively manage compliance	Every three months prior to business and risk Trust Board – July

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		Director of HR, OD and Estates been briefed and action undertaken accordingly. • Trust smoking policies with the use of e-cigarettes agreed for a trial period. • Compliance with the following regulations: o The allocation and definition of responsibilities and standards for the provision, installation, testing and planned maintenance of fire safety equipment, devices, alarm and extinguishing systems; o The identification of standards for the control of combustible, flammable or explosive materials; o The allocation of responsibilities for the implementation of fire emergency plans including evacuation procedures, first-aid firefighting, contacting the emergency services, emergency co-ordination and staff training; o The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures; o The development and delivery of suitable staff training in fire safety awareness; o Fire safety training compliance measured monthly at OMG with time constrained action plans required for non-compliant areas. o The development and implementation of emergency procedures to ensure early recovery from unforeseen incident involving fire in order to maximise safety, minimise problems and enable the core business structure to continue. • Use of sprinklers across all Trust buildings reviewed as part of the capital programme. • New inpatient builds and major developments fitted with sprinklers. • Reinforcement of rules and fire safety message in locations where additional oxygen could be used. • Temporary smoking arrangements introduced in response to Covid-19.			Amber / high	Minimal / low – Cautious /	that it could affect recovery from Covid-19 via smoking cessation groups. - Allow vaping in outdoor areas whilst risk factors of vaping indoors are confirmed. - Designate some outdoor areas for smoking subject to advice from pharmacy and the fire safety team. • Rollout programme of sprinkler system. Fire risk assessments completed. (DHR) (March 2022)						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.	2021 & weekly Covid-19 review
1424	Risk of serious harm occurring from known patient safety.	Clear policy & procedure in place providing framework for the identification and mitigation of risks in respect of: • Ligature assessment.	4 Major	2 Unlikely	8 Amber / high	Minimal / low – Cautious /	• Formulation of informed risk management (FIRM) assessment training has commenced, plan to risk assess process and outcome included in patient safety strategy. (DNQ)	DNQ MD	On going	Performance & monitoring via EMT,	6 Yellow /	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to

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	risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention • Restraint reduction • Covid-19.	• 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. • 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.			(8-12)	moder-ate (1 – 6)	• Internal and external regional work to ensure ECT offer remains in place. (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) commence in Q1 2021/22 and implementation plan reviewed in line with Covid-19 restoration. Clinical improvement strategy was reviewed at CGCS in June 2021.To be reviewed further in August 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 August 2021)			OMG & TB reports e.g. quarterly Patient Safety report & incident report	moder-ate (4-6)			busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review

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		• 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. • Restraint reduction accreditation • Additional support from legal team to provide timely response to clinicians in relation to MHA / MCA matters. (MD) • Additional pharmacy team support to clinicians to manage Covid-19 related matters. (MD) • Inpatient Covid-19 vaccination programme established and delivering to plan			12 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)					4 Yellow / moderate (1 – 6)			
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. • Incidents are monitored through risk panel with actions escalated as appropriate. • Completion of risk assessments for each individual case to determine whether	4 Major	3 Possible	12 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (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 received a progress update in June 2021. (DO / DHR) (October 2021) • Recent incident regarding the safety of the seclusion room will be reviewed and learning will be used to inform the review and a re-evaluation of the risk score in July 2021.	DO	Ongoing	EMT monthly	4 Yellow / moderate (1 – 6)	CG&CS		Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

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		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.												
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 H1 2021/22 • System wide funding provided on a fair shares basis for H1 2021/22.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• The Trust's 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 H2 contract negotiation process. (DFR) (September 2021 • Continue discussions for use of mental health recovery funding (DFR) (July 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 first half of 2021/22 have been agreed and are in line with those for H2 2021/21	Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	• Trust maintains access to information governance training for all staff and has track record of achieving the mandatory training target of 95%. • Trust employs appropriate skills and capacity to advise on policies, procedures and training for Information Governance. • Trust has appropriate policies and procedures that are compliant with GDPR. • Trust has good track record for recording incidents and all incidents are reviewed weekly with investigations carried out where needed and action plans put in place. • Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues. • Monthly report of IG issues to EMT.	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) • IG awareness raising sessions through an updated communications plan. (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 maintain comprehensive BDU 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)	DFR	ICO external monitori ng of progres s by external evidenc e / desk based reviews	Progress monitored through EMT and weekly risk scans	4 Yellow / moder ate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	

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		• 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. • Communications and awareness plan • Data protection impact assessment process • As part of the regular review of incidents. Those that that have taken place during the Covid-19 outbreak have been reviewed to identify if additional mitigations required is ongoing: review completed, no additional mitigations required (DFR) (June 2021) •					• Quality improvement project and action plan initiated: DQ report to Audit Committee July 2021 (DFR) (June 2021) accepted with an update on progress to be submitted to the October Meeting.							
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 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1	• 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 process to manage the change in the Trust leadership. (DS) (August 2021) • H2 2021/22 contract negotiation process. (DFR) (Sept 2021) • Current agenda item at Trust Board to cover ICS/ Health & Care Bill developments which includes how the Trust will engage with new commissioning arrangement in the local ICSs	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moderate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 1 & 3	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review
1114	Risk of financial unsustainability if the Trust is unable to	• Board and EMT oversight of progress made against transformation schemes.	3 Moderate	3 Possible	9	Minimal / low – Cauti-	• Implementation of longer term financial sustainability plan. (DFR)	DFR	Annual review	EMT (monthly)	4	FIP	Risk appetite: Financial risk target 1 – 6	Every three months

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
	meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	• 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. • . • Non-Executive Director led Finance, Investment & Performance Committee. • Confirmed block income in place for H1 2021/22 • Mental health investment standard. • System-wide funding provided on a fair shares basis. • Use of national and internal benchmarking information to support productivity improvements.			Amber / high (8-12)	ous / moder-ate (1 – 6)	• Increased use of service line management information by directorates. (DFR) • Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS) • Assess H2 2021/22 financial arrangements and planning guidance when received. (DFR) (September 2021)			Trust Board (quarterly)	Yellow /Moder ate (4-6)		Links to BAF, SO 3	prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
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. • Refresh of workforce plans as part of operational planning process. (DHR) (2021)	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• International recruitment portal implementation plan being developed (Sept 2021) • A new role working group established • Discussion taking place at Mental Health collaborative to look collectively developing new roles. (Sept 2021)	DHR	(linked to annual workforc e strategy action plan (April 2022)	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
1158	Risk of not having a flexible workforce leading to an over reliance on bank and	• Board self-assessment. • Reporting through IPR. • Safer Staffing Reports.	3 Moder ate	3 Possib le	9 Amber / High	Minimal / low – Cauti-ous /	• Business case for potential use of NHS Professionals underway. (DHR) (awaiting NHSP proposal) (delayed due to Covid-19)	DHR	Ongoing (Annual work program	EMT (monthly)	6 Yellow /	WRC	Risk appetite: Financial / commercial risk target	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
	agency staff which could impact on quality and / or finances.	• 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. • Implementation of new roles across 2020 including Nursing Associates and Advanced Clinical Practitioners.			(8-12)	moder-ate (1 – 6)	• Exit strategy for all agency locums has been requested from all clinical leads who refresh this on an ongoing basis. (MD) • There is a flexible workforce group being established as part of the implementation as a workforce strategy (Sept 2021)		me to be reviewe d in March each year.)	Board (monthly)	moder ate (4-6)		1 – 6 Links to BAF, SO2 & 3	busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
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)* • H2 2021/22 contract negotiation process. (DFR) (Sept 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 – July 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
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.	• Bed management process. • Critical to Quality map to identify priority change areas. • Joint action plan with commissioners. • Internal programme board. • Weekly oversight at OMG. • Agreed governance structure, with meetings in place, with commissioners in relation to the monitoring and management out of area cessation plans. • Workstreams in place to address specific areas as agreed following the SSG review. • Routine reviews of care whilst out of area are in place. • Pathway for people with trauma informed emotionally unstable personality disorder is in place with a programme of training ongoing.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (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) • An ICS review of the impact of the additional purchased PICU capacity is underway and will make recommendations for any similar strategies based on the learning. (August 2021) •	DO	Ongoing / monthly review	OMG	4 Yellow /Moderate (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 – July 2021 & weekly Covid-19 review
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	• Bed management process. • Joint action plan with commissioners. • Internal bed management programme board. • Weekly oversight at EMT and OMG. • In-depth financial reviews at OMG, EMT and Trust Board. • Temporary contract arrangements in place for the first half of 2021/22.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (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) • H2 2021/22 contract negotiation process. (DFR) (Sept 2021) • Negotiation for use of mental health recovery monies (DFR) (July 2021)	DO / DFR	Ongoing	OMG monthly EMT monthly Trust Board monthly	4 Yellow / moderate (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 recommendation.	Every three months prior to busi-ness and risk Trust Board – July 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	• 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.	4 Major	3 Possible	12 Amber / High (8-12)	Minimal / low – Cautious / moderate (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)	DO	Ongoing risk given external influence outside	EMT (monthly) CG&CS (regular)	4 Yellow /Moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 The Trust ensures children and	Every three months prior to busi-ness and

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
	requiring admission to hospital will be unable to access a CAMHS bed. This could result in quality of care being compromised and places additional pressure on staff when young people are cared for either on adult wards or in the secure CAMHS estate.	• 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 address delays in discharges of young people to release inpatient capacity.					• 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 / DnN) (July 2021) • Specific issues relating to the secure estate and access to medium secure beds for young people have been escalated to NHSE/I and at the request of the DoN in SWYPFT a risk meeting between providers has arranged to identify additional measures to maintain safety. Joint letter of escalation sent to HSE/I regarding access by LCH and YOI governor and Director of Nursing SWYPT (review July 2021) • Commissioners have agreed to additional resources to support young people in the secure estate who are waiting for a bed. These are in place where staff can be sourced (review July 2021) • Management and clinical supervision is in place to support and monitor the impact on CAMHS staff who are working with very high risk children in an unsuitable environment. (review July 2021)	our control		Trust Board (each meeting through integrated performance report)			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.	risk Trust Board – July 2021 & weekly Covid-19 review
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.	• Detailed internal capital planning and prioritisation process. • ICS capital allocation process. • Internal cash availability. • Approved updated digital strategy	3 Moderate	4 Likely	12 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)	• Updated estates strategy. (DHR) • Effective communication of Trust capital priorities to West and South Yorkshire ICS partners.	DFR		EMT (monthly)	4 Yellow / moderate (1 – 6)	FIP	2021/22 capital allocation to be confirmed by the ICS early April 2021.	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

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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. • Care, Education, Treatment Reviews (CETR) are in place for children with learning disability and autism. These help to prevent the need for admission. • International nurse recruitment funding bid awarded. (DHR)	3 Moderate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Proposal for On Boarding System to include recruitment Microsite. (DHR) (delayed due to Covid-19) • An international recruitment portal has been signed off by EMT (June 2021) • Establishment of work group to look at development of new clinical roles. (DNQ) (Sept 2021) • CAMHS teams are working to develop a multidisciplinary / multi-professional meeting for all children at the point of admission which will determine the actions required to avoid/shorten admission and support the child and their family. (Review September 2021)	DHR	Ongoing (Annual work programme to be reviewed in March each year.	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performance report)	6 Yellow / moderate (4-6)	CG&CS	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to business and risk Trust Board – July 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	• 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.	3 Moderate	4 Likely	12 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Developing a programme for Covid booster and flu vaccine programme • Review of physical health and wellbeing support being undertaken in light of Robertson Cooper survey result. (DHR)	DHR	Ongoing (Annual work programme to be reviewed in March each year.	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to business and risk Trust Board – July

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	therefore reducing the ability to provide safe and effective services.	• Core skills training on absence management. • 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. • Roll out of vaccination programme to all staff by end of January 2021												2021 & weekly 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	• 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.	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Review of how representative our decision making groups are. (DHR) (Sept 2021) • Introduction of internal review panel on disciplinary and grievance cases related to discrimination on the grounds of race. (DHR) August 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 business and risk Trust

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	meet the needs of the population served and fails to achieve national requirements linked to EDS2, WRES and WDES.	• Review of recruitment with staff networks complete. • Actions identified in the equality and diversity annual report 2017/18. • Establishment of staff disability network and LGBT network. • Links with Universities on widening access. • Framework for bullying and harassment between colleagues. • Action plan to tackle harassment and bullying from service users and families. • Appointment of WRES OD lead. • Full time freedom to speak up guardian appointed. • Delivery of WRES and EDS2 action plans. • Established BAME talent pool.												Board – July 2021 & weekly Covid-19 review
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.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)	Safety • Implementation of SafeCare linked to e.rostering system. (DNQ)) (Sept 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) (September 2021) New workforce supply • New internal group established to look further at the development of new roles. (DHR) (September 2021)	DHR		EMT (monthly)	6 Yellow / moderate (1 – 6)	WRC		Every three months prior to business and risk Trust Board – July 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
		• Working in partnership across West Yorkshire on international recruitment. • On-line job fairs programme. <u>New workforce supply</u> • 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. • Mutual aid arrangements with partners. • Health Care support worker targeted recruitment. (DHR) (April 2021)												
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.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)	<u>Feeling safe</u> • Roll out of equity guardians across the Trust. (DHR) (September 2021) • Tackling hate crime against staff. (DHR) (September 2021) <u>Supportive teams</u> • Review of leadership and management pathway. (DHR) (September2021) <u>Positive wellbeing</u> • Enhance Occupational Health Service linked to Long COVID. (DHR) (August2021) • Physical health plans. (DHR) (September 2021) • Appointment of staff dietician. (DHR) September 2021) <u>Personal & professional development</u> • Review of training provision. (DHR) (September 2021) <u>Everyone's voice counts</u> • New Freedom to Speak Up Strategy and Action Plan. (DHR) (September2021) • Programme of Insight events for 2021/22. (DHR) (September 2021) • Sustainability Strategy. (DHR) (December 2021)	DHR	Ongoing (Annual work programme to be reviewed in March each year.	EMT (monthly)	6 Yellow / moderate (1 – 6)	WRC		Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

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		• Study leave policy. • Establishment of BAME talent pool. • WRES and WDES action plan and KPIs. • Appointment of WRES OD Lead. • Talent and succession plans. Everyone's voice counts • Staff engagement and insight events. • Communications and engagement strategy. • Full-Time Freedom to Speak Up Guardian. • FTSUG network. • Board engagement programme. • 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) • Renew Great Place to Work Programme. (DHR) (June 2021) • Adapt the E-appraisal following feedback. (DHR) (June 2021) • Strengthen link to regional staff suicide prevention plan. (DHR) (review before July 2021) • Development of succession plan for second level post based on review directors. (DHR) (April 2021) • Support the BAME Fellowship Programme. (DHR) (April 2021) • Review social partnership model to include staff side involvement in decision making groups. (DHR) (June 2021) • Green plan approved by Trust Board (March 2021)												

Organisational level risks within the risk appetite

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
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	• OMG, Change and partnership board and EMT. • Service quality metrics in place highlighting potential hotspots and areas for action to be taken as appropriate. • Post implementation review process. • Active engagement in West Yorkshire and South Yorkshire Integrated Care	3 Moderate	2 Unlikely	6 Yellow/ moderate (4-6)	Minimal / low – Cautious / moder-ate (1 – 6)	• Active stakeholder management to create opportunities for partnership and collaboration which are reflected in corporate objectives. (DS / DPD / DO) • Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS)	DS	Ongoing risk given external influence outside	EMT (monthly) Transformation board (monthly)	6 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 3 Links to BAF, SO1 & 2	Every three months prior to busi-ness and risk

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		Systems/ CEO leads the West Yorkshire ICS. • Regular review and update of the strategy by Trust Board. • Review by the CG&CS Committee on QIAs and post implementation reviews updated at gateway review stages of the integrated change framework. • QIA process in place for all significant change. • EQIA trust wide in place for Covid-19 response. • EQIA processes in place for all service changes. • Recovery toolkit that includes EIA / EQIA in place for service recovery and reset. • Recovery group set up to co-ordinate the development of recovery plans for services and across the system and working in partnership to reduce health inequalities, in line with national guidance.					• Active engagement in place based plans. (DS / DPD / DO) • Place based plans that impact on clinical services will be governed and managed through the Trust-wide integrated change process at EMT and discussed at Trust Board. (DS / DPD / DO) • Focus on working towards the strategic ambitions of the Trust. (DS) • Close involvement in Barnsley plan to monitor potential impact and take measures to mitigate. (DS) • Review and refresh of objectives and priorities in response to Covid-19 phases and recovery and reset plans. (DS)	our control		OMG (weekly) Trust Board (quarterly)				Trust Board – July 2021 & weekly Covid-19 review
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.	• Progress on system and service transformation reviewed by Board and EMT. • Quality Impact Assessment process for CIP and QIPP savings in place. • Alignment of contracting and business development functions to support a pro-active approach to retention of contract income and growth of new income streams. • EMT monthly and Trust Board investment appraisal report. • Regular review and update of strategy by Trust Board. • Active engagement in West Yorkshire and South Yorkshire Integrated Care System (ICS) / CEO leads the West Yorkshire ICS. • Financial control process to maximise contribution. • New models of care boards established across the system. • Active commensurate role in strategic partnership working in each of our places, including West Yorkshire and South Yorkshire Integrated Care Systems, to plan and deliver stabilisation and recovery priorities.	3 Moderate	2 Unlikely	6 Yellow /moderate (4-6)	Open / High (8 - 12)	• Trusts pro-active involvement and influence in system transformation programmes, which are led by commissioners and includes new models of care. (DPD / DO) • Alignment of our plans with CCGs commissioning intentions. (DPD / DO) • Horizon scanning for new business opportunities. (DS / DFR) • Developing communications and engagement into a more systematic approach in stakeholder engagement. (DS) • Review of CQUIN income attainment by EMT & OMG with action plan to improve. (DFR) – temporary financial arrangements in place • Review of commissioning intentions by EMT and contract negotiation stances and meetings in place to progress agreements of contracts. (DFR) – contracting process for 2020/21 currently suspended • Place based plans and other system transformation programmes developing and ensuring Trust participation. (DS) • Internal groups established to co-ordinate contribution and involvement in each place in both West and South Yorkshire integrated care systems. Individuals identified supporting any key work streams from an operational perspective. (DS / DPD / DO) • Management process including additional skills building an increase in joint bids with partners. (DFR)	DS	Ongoing risk given external influence outside our control	EMT (monthly) Trust Board business and risk (half-yearly)	8 Amber / high (8-12)	CG&CS	Risk appetite: Commercial risk target 8 – 12 Links to BAF, SO 1 & 3 Nominated committee: AC	Every three months prior to business and risk Trust Board – July 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
							• Continue to play our part and help shape integrated care developments in all places including the development of mental health and wellbeing alliances and working in partnership to reduce health inequalities in line with national guidance. (DS / DPD)							
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	• Transformation projects required to include engagement with external partners to ensure alignment. • Use of workshops with external stakeholders to co-produce changes. • Communications through contract meetings and other working groups to ensure appropriate sharing of information. • Board – team-to-team meetings with commissioner organisations to ensure strategic alignment. • Quarterly Partnership Board meetings. • Active participation at all levels in ICSs and other place based planning initiatives. • Represented on place based integrated care partnerships or equivalent. • Equality, Involvement, Communication and Membership strategy. • Stakeholder plan developed with regular review through EMT • Trust prospectus used as part of ongoing engagement in place	3 Major	2 Unlikely	6 Yellow /moder ate (4-6)	Open / High (8 - 12)	• Proactive development of relationships with GP Federations to identify opportunities for collaboration and alignment. (DPD / DO) (ongoing) • For ongoing stronger links with national bodies to influence local and national systems thinking in relation to mental health and community services. (ALL) • Pro-active programme of discussion with OSCs regarding transformation proposals. (DS / DPD / DO) • Alignment of priorities through provider alliances and integrated care partnership (DPD / DS) • 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) • Alignment of Trust transformation and significant change plans for all services with commissioner's plans as set out in local ICS place based plans. (DS / DPD / DO) • The Equality, Involvement, Communication and Membership strategy is in place with action plans agreed. Delivery of key actions ongoing. (DS) • Development and implementation of interim executive leadership arrangements (July 2021) Associate of Director of Nursing and Quality	DS	Annual plan	Bi-monthly focus by EMT on transformati on. Trust Board reports as appropriate . Business cases approved by Calderdale, Kirklees and Wakefield commission ers.	6 Yellow /Moder ate (4-6)	CG&CS	Risk appetite - Commercial risk target: 8- 12 Nominated committee - CG&CS Links to BAF, SO 1 & 2	Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
New risk	The current inconsistency in SALT provision could compromise the quality of care available in response to choking incident.	• SBAR issued communicating importance of identifying choking risks and actions required • Choking awareness training slide pack produced and circulated • Systemic approach to MDT choking risk assessment for all inpatient areas established	3 Moder ate	3 Possibl e	9 Amber / high (8-12)		• Associate of Director of Nursing and Quality is leading a review of SALT provision across all areas of the Trust to report to OMG. • Agency SALT staff are in place in Forensics and Barnsley • Additional resources agreed in Barnsley to support recovery from COVID • Process and structure for risk assessment, an associated care plan and best interest guide for staff is being updated (August 2021) • Blue light alert on choking risk issued 5th July 2021 • E- learning programme under development • Referral to protected mealtimes arrangements initiated	DON MD		EMT (monthly)		CG&CS	Risk score reviewed and remains the same. The risk is being reviewed on an ongoing basis to ensure that actions remain appropriate subject to monthly review.	Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
New Risk	Inpatients areas with gardens that have access to single	• We have anticlimb measures in each garden worked through with esates _(need listing per garden)	4 Moder ate	3 Likely	12		• Currently adopted a blanket restriction pending a review of all areas • We are following blanket restriction process			EMT (monthly)		CG&CS	Risk score reviewed and	Every three months

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
	storey buildings present an increased risk of absconding and/or falling resulting in physical injury.	• Ward security checks • Induction / update for staff • FIRM risk assessments • Safe and supportive observation of patients at risk			Amber / high (8-12)		• Developed an assessment for roll out in all areas • Checking safety systems / alarms						remains the same. The risk is being reviewed on an ongoing basis to ensure that actions remain appropriate subject to monthly review.	prior to business and risk Trust Board – July 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 H1 2021/22 • Use of national and internal benchmarking to support productivity improvements.	4 Major	1 Rare	4 Yellow / moderate (4-6)	Minimal / low – Cautious / moderate (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 H2 2021/22 financial arrangements and planning guidance when received. (DFR) (September 2021) • Re-assess the financial sustainability plan in light of the impact of Covid-19. (DFR) (November 2021) • Estates strategy being updated. (DHR) (Aug 2021)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moderate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO3 The Trust has an internal requirement when considering its liquidity risk to have at least two months "cash in bank" to meet its payroll bill. As at 27th May 2021 the Trust has a cash balance in excess of £60m and is not forecasting that to significantly changing in year. This balance gives the Trust the ability to pay approximately 5 months payroll.	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review
1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	• Programme prioritisation processes. • Overall priority progress reports via monthly IPR. • Individual priority programmes via governance groups of change and partnership board, OMG and EMT. • Resources established aligned to programmes.	3 Moderate	3 Possible	9 Amber / high (8-12	Open / High (8 - 12)	• Agree resource availability to support system-wide programmes of work. (ALL) (annually in line with business planning and priority programme setting) • Integrated Change and Improvement Network established to develop critical mass across the organisation. (DS)	DS	Ongoing	Regular reports to transformation board, OMG and EMT	9 Amber / high (8-12)	AC	Nominated Committee - AC Risk appetite: Strategic risk 8 – 12	Every three months prior to business and risk

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		• Annual planning process. • Leadership framework to build capability and to include change competencies. • Quality strategy approved and implementation plan established.					• Review prioritisation and include stopping some activities based on risk assessment. (DS) (in line with quarterly review of programmes and capacity) • Build capability to enhance capacity through programmes including IHI, QSIR and other development programmes. (DS) (March 2021) • Priorities reviewed at each phase of Covid-19 response and recovery phases including management, capacity and resource required aligned to support priorities. (DS) • Continue to implement Quality strategy with integrated change application embedded. (DNQ / DS) (September 2021) • Development and implementation of interim executive leadership arrangements (July 2021)			Quality Strategy update to CG&CSC			Links to BAF, SO3	Trust Board – July 2021 & weekly Covid-19 review
1432	Risk of problems with succession planning / talent management.	• Workforce Plans to include succession planning and talent management. • Leadership and management framework in place. • Plans to develop coaching and mentoring. • Appraisal Policy reviewed in 2018. • Board succession plan paper discussed at Workforce and Remuneration Committee. • Development of succession plan for second level post based on review by directors. (DHR) (March 2021)	3 Moderate	2 Unlikely	6 Yellow /moderate (4-6)	Open / High (8 - 12)	• Key element of Trust Workforce Strategy. (DHR) (August 2021)	DHR	Trust board review quarterly	EMT monthly Trust Board quarterly	Yellow / Moderate (4-6)	WRC	Risk appetite: Commercial risk 8 – 12 Nominated committee - WRC	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

COVID-19 RISKS

Risk level 15+

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1530	Risk that Covid-19 leads to a significant increase in demand for our services (as anxiety and mental health issues increases in our populations) 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 in Wakefield, IPCG in Barnsley and ICHLB in Kirklees.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (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 business and risk Trust

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• Health and wellbeing boards. • Local stress testing exercise demonstrated strengths in business continuity systems. • Operational management group 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 Operational Management Group 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) position remains under review with further stocktake in August • Additional temporary staffing resources approved to respond to increased acuity, activity and environmental considerations						actions remain appropriate subject to monthly review.	Board – July 2021 & weekly Covid-19 review

Risk level <15 - risks outside the risk appetite

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
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	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• IPC BAF routine review and update into CG&CS Committee. (DNQ) (Sept 2021) • Inpatient vaccination programme is nearing completion. Ongoing second vaccination programme. (MD) (July 2021) • The scoring of this risk is subject to continual review against the status of the pandemic.	DNQ	Ongoing during Covid-19 pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to business and risk Trust Board – July 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
		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. • Risk assessments complete to determine if areas are Covid-19 secure. • Daily follow up of actions identified through OMG • Routine scan of national guidance as part of horizon scanning in OMG • 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. • Trust Covid-19 vaccination programme completed with over 87.7% of staff receiving initial doses and 78.1% of second doses to date. IPC to continue to monitor staff absence due to Covid-19. • Daily absence reports to executive directors and senior managers continue.												
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)	• Operational meetings manage the demand in the local service and review the needs of the service users on the caseload. (DO) • OMG continues to monitor performance and take appropriate actions to address areas of concern, with appropriate escalation to EMT. (DO) • Business continuity has been added as a routine agenda item to allow OMG to review the OPEL levels and monitor the move from command structure to business as usual. (review September 2021) • 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) • Grading to be reviewed in August 2021 in line with national and local demand	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 – July 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
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 – July 2021 & weekly Covid-19 review
1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.	• Safer staffing policies. • Increased supply of temporary labour through staff bank recruitment. • Ability to move staff between wards / teams. • Daily access to staff absent report by service. • Business continuity plans in place that relate to the deployment of staff towards critical (24/7) services. • Talent pool for the redeployment of staff from non-critical to critical roles. • Staff health and wellbeing offer. • Testing programme. • Retirees return and 'bring back' NHS staff programme. • New temporary register for NMC and HCPC. • Fast track recruitment process for essential roles in line with national guidance. • Staff testing arrangements in place. • Staff and managers advice line operating 7 days a week. • Integrated Health and Wellbeing support. • Reduction in mandatory refresher training to release headroom. • 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.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Developing a programme for Covid booster and flu vaccine programme	DHR / DO	Ongoing	EMT	8 Amber / high (8-12)	CG&CS		Every three months prior to business and risk Trust Board – July 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
		• 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. • 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 OMG and EMT to ensure that they reflect the current position and the impact is understood. (DHR / DNQ / DO) • Timely implementation of Covid-19 vaccination programme. (DHR), Trust Covid-19 vaccination programme completed with over 87.7% of staff receiving initial doses and 78.1% of second doses to 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.	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. (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) (August 2021) • Restoration and recovery programme – need for enhanced clinical leadership under review. (DNQ / DO / MD) (September 2021)	MD / DNQ	Ongoing	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review

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		• 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.			12 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)								
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. • 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.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cautious / moderate (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) • 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.	DNQ	Ongoing during Covid-19 pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	EIC		Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

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		o Equality Impact Assessment (EIA) quick decision tool and action log. o Trust wide Covid-19 EIA and process to embed at service level in place. o Improvements being made in data quality and data collection in line with national guidance.												
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) (August 2021)	DNQ / MD	Ongoing	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to business and risk Trust Board – July 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. • 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.	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. • 8,284 patients responded positively to the consent request sent March 2021. Joint paper from the medical director, Trust CCIO and information governance lead on future arrangements post COPI drafted (August 2021) • Reset and recovery of services. • Review of estates requirements. (DHR) (to be reviewed by September 2021) • Regular consideration of staff wellbeing offers. (DHR) (to be reviewed by August 2021)	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 – July 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
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 – Cautious / moderate (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 – July 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. • Effective ways of working group established	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Review of essential training provision being undertaken. (DHR) • Wellbeing plans developed for each BDU. (DHR) • Updating the risk assessment prior to return to work • Regional health and wellbeing hubs	DHR	Ongoing through out the pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	WRC		Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	• Occupational health service operating extended hours. • Coronavirus psychological support line for staff operating 7 days a week. • Support arrangements for shielded staff introduced. • Health and wellbeing support centre as part of the Workforce Support Hub. • Staff and managers advice line operating 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.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Follow up on undertaking second vaccine to be completed by August 2021 • Link to the BAME staff equality network to increase uptake amongst BAME colleagues (August 2021)	DHR	Ongoing through out the pandemic	Command structure of Gold, Silver, Bronze (daily) Trust Board through IPR (monthly) Safer staffing	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	Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19

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
		• 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. • Staff vaccination programme completed. (June 2021)								reports (monthly) WRC (as appropriate)			8 which remains outside the current risk appetite. Further reductions may require revision on the Business Continuity Plans.	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. • Ensure focus on ongoing robust use of IPC guidance including PPE and social distancing. (DNQ / DHR) • Continue to encourage staff from at risk populations to access vaccinations	3 Moderate	2	6 Amber / high (8 – 12)	Minimal / low – Cautious / moder-ate (1 – 6)	• Targeted communication and engagement with staff network groups. (DNQ) • Updating risk assessment including the impact of the vaccine. (DHR) (September 2021)	DHR	Ongoing through out the pandemic	EMT (monthly)	2 Green / low (1 – 6)	CG&CS OR EIC		Every three months prior to busi-ness and risk Trust Board – July 2021 & weekly Covid-19 review
1613	Insufficient numbers of staff receive the Covid-19 vaccination	• Trust Command structure • Real time reporting and monitoring of uptake	3 Moderate	3 Possible	9	Minimal / low – Cauti-	• Targeted communication and engagement with staff network groups continues (DNQ)	DHR	Ongoing out the	EMT (monthly)	2	CG&CS	This risk has been expanded to	Every three months

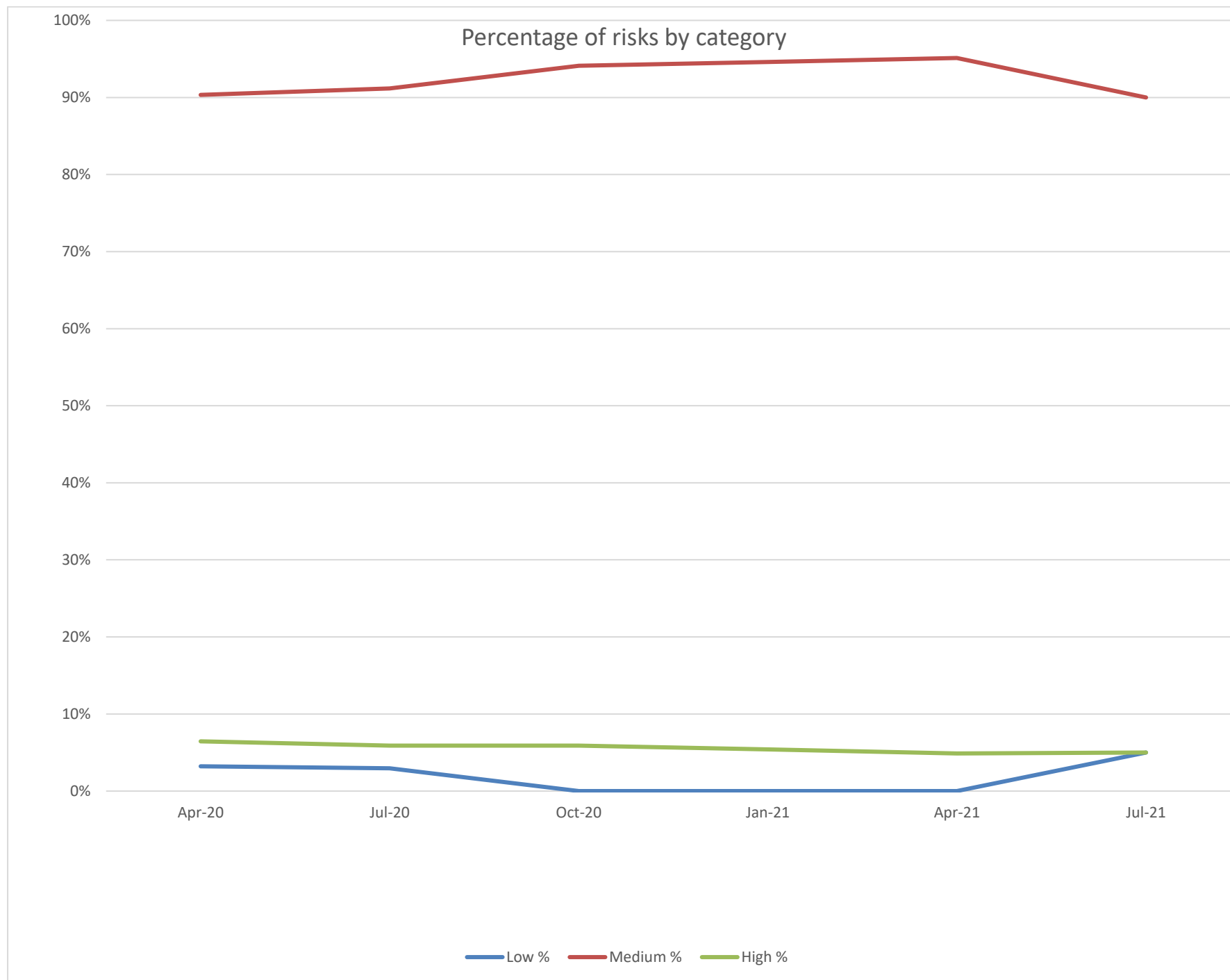|														
	leading to an increased risk of infection across the Trust workforce, service users, patients and carers	• Communications programme • Support and information available for all staff networks • BAME health & wellbeing taskforce • Daily analysis of vaccination uptake (DHR)			Amber / high (8 – 12)	ous / moder-ate (1 – 6)	• Engage with staff through individualised approaches to support informed decision making. (DHR)		pandemic		Green / low (1 – 6)	OR WRC	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.	prior to business and risk Trust Board – July 2021 & weekly Covid-19 review

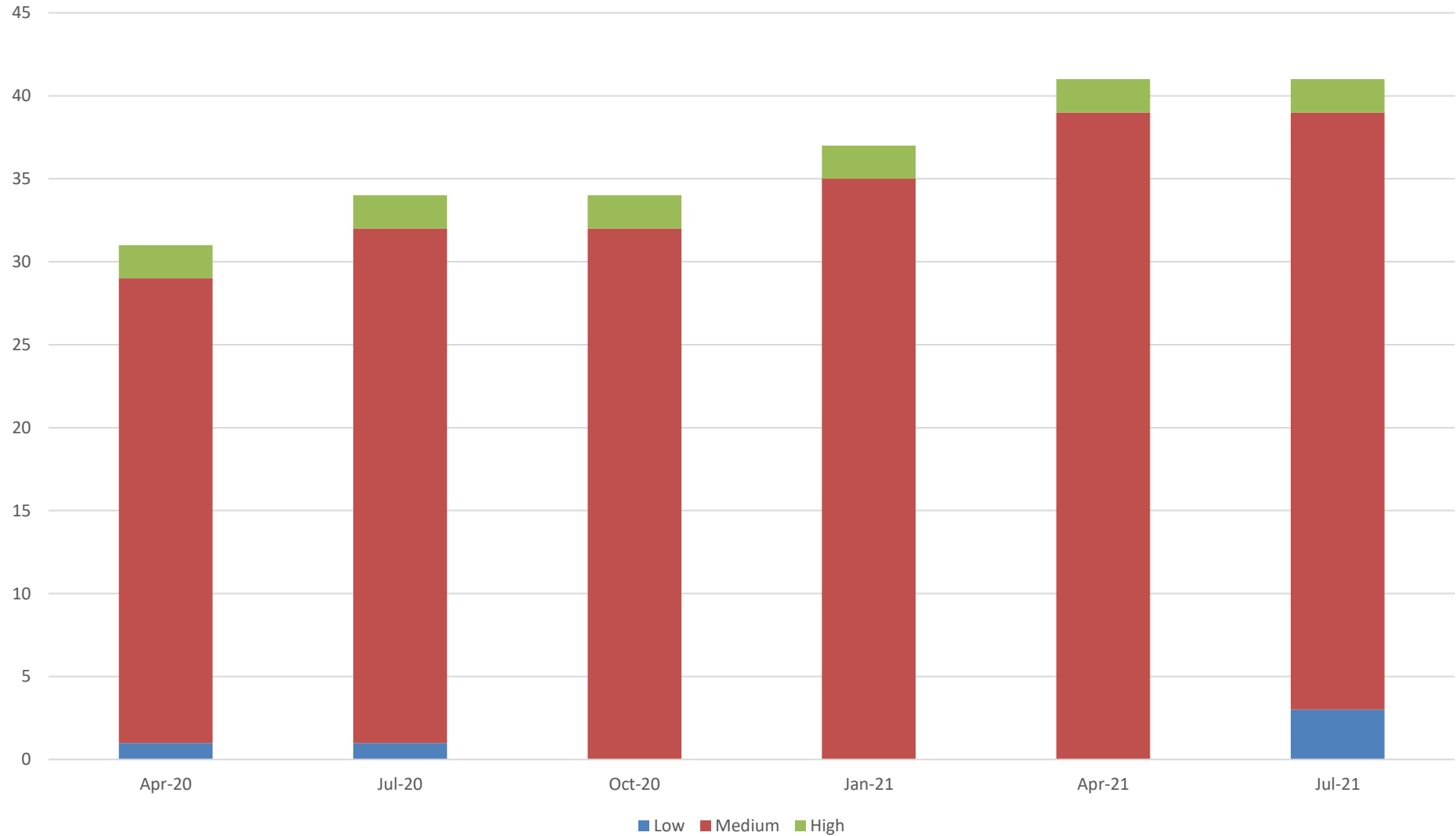## Risks within the risk appetite

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
1527	Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care.	• Staff trained to carry out testing. • Locations for testing established. • Part of regional testing arrangements for staff. • Protocol for testing service users in place. • Process for testing all staff established: symptomatic, asymptomatic and antibody.	3 Moderate	2 Unlikely	6 Yellow / moderate (4-6)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• All Trust staff are transferring into the national lateral flow testing programme form August 2021 • This risk is to be reviewed within once month of handover to establish whether the national is effective and adequate to support the Trust needs (September 2021)	DNQ		EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS	Risk score currently being considered given the testing regime in place	Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19 review
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	2 Unlikely	6 Yellow / moderate (4-6)	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 OMG. (DNQ) • Support the release of staff involved in the programme for training. (DO)	DHR	Ongoing through out the pandemic	EMT (monthly)	4 Yellow / moderate (1 – 6)	CG&CS		Every three months prior to business and risk Trust Board – July 2021 & weekly Covid-19

Risk ID	Description of risk	Risk review date	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
															review

Risk ID	Risk description	Apr-20	Jul-20	Oct-20	Jan-21	Apr-21	Jul-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	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	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	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	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	4	Risk recuced July 2021
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	9	
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	8	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	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	9	
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	12	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	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	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	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	9	
1158	Risk of over reliance on agency staff which could impact on quality and finances.	9	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	12	
1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	9	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	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	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	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	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	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	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	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	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	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	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	16	
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	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	9	
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.		12	12	12	9	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	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	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	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	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	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	6	Risk level decreased July 21
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	6	Reduced to 6 in July 21
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	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	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	9	
						422	412	

Percentage of risks by category

Low %   Medium %   High %

Number of risks by category and time period

| | Apr-20 | Jul-20 | Oct-20 | Jan-21 | Apr-21 | Jul-21 |

Legend: ■ Low ■ Medium ■ High

Title:	Update Integrated Care Systems and White Paper - Integration and Innovation: working together to improve health and social care for all
Paper prepared by:	Director of Strategy
Purpose:	1) To provide an update to Trust Board on national developments including the Health and Care Bill. 2) To provide an update on how the two Integrated Care Systems that the Trust is part of continue to develop their response to the white paper and NHSEI 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. Planning and 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 NHSEI 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 updates were provided to the March and April Trust Board, with a further update to Strategy Board in May 2021. An update on the NHSEI Integrated Care System Design Framework was also provided to Trust Board in June.
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, NHSEI set out proposals to further 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*. In June, NHSE/I published further guidance that was set out in the *Integrated Care System Design Framework*. Trust Board has considered and discussed the details set out in all these documents. The direction of travel is consistent with the Trust's strategy and ambitions and the

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work that we have been doing as partners in our local Integrated Care Systems.

National developments and update

The Health and Care Bill 2021-22 was introduced in the House of Commons on 6 July 2021 and the second reading took place on 14 July 2021.   It is anticipated that the bill will go through the committee stage in September.

The bill sets out how the Government intends to reform the delivery of health services and promote integration between health and care in England. This is the first major primary care legislation on health and care in England since the Health and Social Care Act 2012. The proposed reforms reflect the proposals set out in the white paper that was published in the spring and discussed at a previous Trust Board meeting.

The bill is structured in 6 parts and focuses largely on the detail on how a new health and care system based on integration rather than competition will be structured. This includes specifications on how integrated care systems are to be set up and the distinct statutory functions for the Integrated Care Board and Integrated Care Partnership.

The attached NHS Providers briefing summarises the key components set out in the proposed Health and Care Bill for Trust Board members to review and consider.

It is anticipated that it will take time for the bill to work through the full parliamentary process but is on course to pass into law by April 2022.

The Trust is part of two advanced ICSs and is also part of place-based partnerships and provider collaboratives.

WYH ICS has continued to develop the transition plan through the Future Design and Transition Group to oversee the transition and help make the right connections between the workstreams and a Chairs and Leaders Reference Group, which acts as a sounding board, has continued to meet.

As part of the preparation for the new statutory Integrated Care System (ICS) arrangements coming into force from April 2022, work has been progressed on the future design and ways of working of the NHS ICS statutory body structure and functions.

High level functions have been agreed through the System Leadership Executive and work is being progressed to develop a networked model under each of these functions, clarifying what will be done at ICS level and what will be done at place level building on the approach to date. The key functions will include:

- Strategy & Partnerships

	- Corporate - Finance - Planning & System Improvement - Clinical & Professional - People **SYB ICS** has also established an overarching Steering Group that draws on members from the 4 workstreams set out below. There is also a Change and Transition Programme Board that will provide oversight and support: - Place-based partnerships - Provider collaboratives - Commissioning changes - ICS operating model In addition, there are two enabling workstreams: - HR and people transition - ICS Financial framework 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. The 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 update on national policy/legislative update** - **Note update on local ICS response to the white paper**
Private session:	Not applicable.

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The Health and Care Bill

The government has today published the Health and Care Bill. This briefing sets out an overview of proposals, a summary of the key parts of the Bill as well as NHS Providers' view on these provisions. We have focused on the areas of particular interest to members and where we will seek to influence the Bill as it progresses through parliament. If you have any comments on the proposals that you would like to help inform our work on the Bill, please contact Cath Witcombe, public affairs manager, and Finola Kelly, senior legislation manager.

Overview

- The publication of the Health and Care Bill follows a limited set of proposals for legislative change originally brought forward by NHS England and NHS Improvement (NHSE/I) in autumn 2019 before the COVID-19 pandemic. These were further developed in the *Integrating Care* consultation with regard to system working and, most recently, in the Department of Health and Social Care's (DHSC's) Integration and Innovation white paper published in February this year. It also incorporates proposals for the Health Service Safety Investigations Body which were part of previous legislation which did not make it on to the statute book during a previous session of parliament.

- The majority of the Bill is focused on developing system working, with integrated care systems (ICSs) being put on a statutory footing. It also formally merges NHS England and NHS Improvement, and gives the secretary of state a range of powers of direction over the national NHS bodies and local systems and trusts. Other measures proposed include putting the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; a new legal power to make payments directly to social care providers; the development of a new procurement regime for the NHS; and a new duty on the secretary of state to report on workforce responsibilities.

- The government has stated that the Health and Care Bill will allow it to build and shape a health system that is better able to serve the people of England in a fast-changing world. Its intention is to create a system that is more accountable and responsive to the people that work in it and the people that use it. We support this direction of travel and the opportunity the Bill presents to design the right system architecture that will deliver sustainable high-quality care for the future. We believe there are a number of improvements that can be made which will make this the transformative piece of legislation the government wants it to be.

- The Bill introduces a two-part statutory ICS model, with an ICS in future comprising an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body) and an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership).
- The Bill includes provisions which cumulatively amount to far-reaching powers for the secretary of state. This includes powers of direction over NHS England and the ability to intervene at any stage in local service reconfigurations. We are concerned to ensure the NHS' clinical and operational independence and avoid the risk of political interference in the provision of services and will therefore seek appropriate safeguards to balance these powers.
- The Bill gives NHS England the power to set capital spending limits for foundation trusts. We will be seeking to amend the current proposals by asking parliament to consider adding a number of safeguards which were previously agreed between NHS Providers and NHSE/I in 2019.
- We welcome a new duty on the secretary of state to set out how workforce planning responsibilities are to be discharged, but believe that an additional duty should be added to the Bill to ensure the development of regular, public, annually updated, long-term workforce projections. There should also be a duty to regularly update parliament on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.
- The Bill also includes a number of changes to local financial arrangements. This includes setting requirements to meet financial objectives and balance, with NHS England having the ability to set additional and mandatory financial objectives specifically for NHS trusts. While we support greater integration within health services and across health and care, in the event that local organisations believe an impossible task has been set it is important that the legislation also establishes clear routes for recourse.
- We strongly support putting the Health Service Safety Investigations Body (HSSIB) on a statutory footing and setting out the framework for its conduct of safe space investigations so that the NHS can improve patient care and learn from when things go wrong. Nevertheless, we are keen to ensure that the Bill provisions genuinely enable the HSSIB's independence, which is crucial to its ability to carry out its intended systemic safety role, as well as protecting the integrity of safe space.
- As the country emerges from the pandemic, the NHS continues to face considerable challenges including in direct response to COVID-19; the backlog of care and restoration of elective care; persistent and severe pressures on the workforce; and the impact of prolonged under-investment. The impact of amending the legislative framework within which the NHS operates and the

additional burden this will create for the NHS and its staff should not be underestimated at this time.

- We will continue to work with the government, parliament and stakeholders as the Bill progresses, highlighting where we believe the legislation could be improved and amended. It will be vital for the government to continue listening to the views of those on the frontline to ensure the proposals best support the NHS and the patients and service users it cares for.

At 135 clauses and 16 schedules the Health and Care Bill is a long piece of legislation. It is divided into 6 parts covering the following areas:

Part 1 – Health service in England: integration, collaboration and other changes
Part 2 – Health and adult social care: information
Part 3 – Secretary of state's powers to transfer or delegate functions
Part 4 – The Health Services Safety Investigations Body
Parts 5 and 6 – Miscellaneous and general

Part 1 – Health service in England: integration, collaboration and other changes

NHS England (clauses 1-11; schedule 1)

Summary

These clauses made a number of provisions to NHS England and its ways of working. This includes:

- renaming the NHS Commissioning Board to NHS England
- giving the secretary of state the power to veto any proposal from NHS England on the commissioning of specialised services
- making it easier for the secretary of state to change the mandate in-year
- introducing a duty on NHS England to have regard to the likely effects of making any decision to exercise its functions on:
    - o the health and well-being of the people of England
    - o the quality of services provided, changes to prevention, diagnosis or treatment
    - o efficiency and sustainability across the NHS.

Further provisions include:

- Broadening the powers of NHS England to give assistance and support to any provider of NHS services or any body carrying out the functions of the NHS (this includes integrated care boards (ICBs) and non-NHS bodies providing NHS services).

- Enabling NHS England to give directions to one or more ICBs in respect of any of the ICB's functions and payments. Enabling NHS England to give directions to one or more ICBs in respect of any of the ICB's functions and payments. Regulations may be made limiting this power. The ICB becomes liable for any tort arising from the direction.
- Extending the right to be included in public involvement and consultation to carers and representatives.

In addition:
- NHS England will be subject to a duty to prepare consolidated accounts for NHS trusts and foundation trusts and submit them to the secretary of state, the comptroller and auditor general and submit them to parliament along with any report of the comptroller and auditor general upon them.
- The secretary of state will have the power to direct NHS England to use payments made to it for the purpose of integration and to direct how such payments may be used. NHS England will also have the right to make payments to ICBs in respect of integration.
- The power of the secretary of state to make regulations in respect of payments for quality will be removed and such payments will in future be able to be designated by direction.
- The right of NHS England to accept secondments from designated bodies is extended.

Key clauses and NHS Providers' view

Clause 3: NHS England mandate

This clause removes the requirement for a mandate to be set before the start of each financial year. Instead, a mandate can be set at any time and remain in force until is it replaced by a new mandate. The statutory link between the mandate and the annual financial cycle will be removed and the Bill proposes that NHS England's annual limits on capital and revenue resource be given statutory force through the financial directions.

NHS Providers' view

There is a logic to creating the potential for a longer running and more strategic mandate. However, there is also a need to maintain the link between the 'asks' of the NHS and the resourcing envelope available and to avoid a situation where priorities could change within a year (or any timeframe), and potentially be unfunded. These proposals will remove the duty to set NHS England's capital and revenue resource limits in the mandate itself. Instead, these limits will be set within the annual financial directions that are routinely published, and which will in future also be laid in parliament. There is a risk that disconnecting the mandate from financial planning could lead to inadequate funding, leaving the NHS unable to deliver on government priorities.

Clause 4: NHS England: wider effect of decisions

This clause places a duty on NHS England to have regard to the likely effects of making any decision to exercise its functions on the health and wellbeing of the people of England; the quality of services provided; changes to prevention, diagnosis or treatment; and efficiency and sustainability across the NHS. NHS England must produce guidance as to how it will exercise this duty.

NHS Providers' view

This clause requires NHS England to have regard to the 'triple aim' duty, which will also apply to ICBs, trusts, foundation trusts (see clauses 15, 43 and 56). This clause seeks to legislate for decision-making which balances health and wellbeing, the quality of services, and efficiency and sustainability within a constrained resource envelope. While in many ways this reflects the status quo, this clause does offer a new legal basis for decisions and could be used to justify greater expenditure on some services rather than others. Our expectation is that such decisions would always be clinically-led and evidence-based, but this may nevertheless be concerning for patient groups with rare diseases or for services which have been subject to local variation in the past. This clause may also become of greater concern should the clinical and operational independence of the NHS become diminished as a result of the proposed strengthened powers of direction for the secretary of state. We would welcome members' views on the practical impact of this clause, including how it may impact commissioning decisions and services.

Clause 9: Funding for service integration

This makes provision for a fund for the integration of care and support with health services, known as the Better Care Fund (BCF), and allows for the secretary of state to provide directions requiring NHS England to use a specified amount of this annual payment for purposes relating to service integration. Where the secretary of state has given a direction about the use by NHS England of the annual amount, NHS England may direct ICBs that a designated amount of the annual payment is to be used for purposes of service integration.

NHS Providers' view

We understand that this is a technical amendment to decouple the BCF from the NHS England mandate, rather than to fundamentally change the focus of the BCF.

Integrated care boards and Integrated care boards: functions (clauses 12-19; schedules 2 and 3)

Summary

Integrated care systems (ICSs) currently operate as health and care organisations working together as coalitions of the willing to coordinate, integrate and plan services, with a view to improving population health and tackling health inequalities. The Bill introduces a two-part statutory ICS model, with an ICS in future comprising:

- an integrated care board (ICB), bringing together the organisations that plan and deliver NHS services within the geographic area covered by the ICS (the white paper called this part the ICS NHS Body)
- an integrated care partnership (ICP), bringing together a broad alliance of organisations related to improving health and care (the white paper called this part the Health and Care Partnership).

This chapter of clauses and its schedules amend the National Health Service Act 2006 to describe the composition, constitution and functions of ICBs. The ICB will take on the commissioning functions and duties of clinical commissioning groups (CCGs), which will be abolished on the same day that ICBs are established as corporate bodies (clause 13). The CCG(s) within the system footprint must consult with relevant parties and propose the first ICB constitution, taking into account any guidance published by NHS England.

An ICB will have several duties (clauses 15 and 19), including but not limited to: improving the quality of services, reducing inequalities in access and outcomes; promoting integration between health, social care and wider services, and having regard to the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources. Further, ICBs must ensure patients and communities are involved in the planning and commissioning of services; NHS England must publish guidance for ICBs on the discharge of their functions; and ICBs must have regard to this guidance.

The composition of an ICB will, at a minimum, consist of a chair, chief executive and at least three other members. One of those members is nominated by NHS trusts and foundation trusts, one by general practice and one by local authorities (LAs) providing services within the ICB footprint. Beyond that, local systems will have the flexibility to determine any further membership. NHS England will appoint the ICB chair and have the power to remove them, with secretary of state approval in either instance. The ICB chief executive will be appointed by the chair, with NHS England approval. The chair will approve the appointment of ordinary members (that is, member other than the chair or chief executive). Each ICB must publish its constitution, which should set out how members are to be appointed and by whom, and the process for nominating ordinary members (schedule 2). The

constitution must also provide for committees or sub-committees of the ICB to be formed. NHS England will publish guidance in relation to the selection of candidates.

Clause 19 (along with schedule 2) further sets out that the ICB and its 'partner' trusts and foundation trusts must prepare a five-year plan (with regard to and in consultation with relevant Health and Wellbeing Boards [HWBs] and their strategies) setting out how they propose to exercise their functions. They must also create a joint capital plan for a period specified by secretary of state. The ICB must prepare accounts and create an annual report. NHS England will conduct a performance assessment of each ICB each financial year. If NHS England deems an ICB to be failing or at risk of failure, NHS England will have powers of direction over the ICB (including prohibiting or restricting the ICB from delegating functions) and may terminate the appointment of the chief executive and direct others to exercise the ICB's functions.

The Bill confers a duty on ICBs to commission primary care, and NHS England may direct an ICB to exercise any of NHS England's primary care functions (schedule 3).

NHS Providers' view

The national role in developing system working

We support the government's ambition to embed the success of collaboration and system working, as especially seen during the COVID-19 response. However, some trust leaders are increasingly concerned about a mismatch between the pace and scale of change, and the sector's capacity to carry out this major transformation at the same time as they are grappling with pandemic recovery. We urge flexibility around the timing of implementation, such as allowing for ICBs to take on functions when they judge themselves ready, enabling ICBs to exercise functions jointly with NHS England, and clarifying whether there will be a shadow implementation period.

We are keen to see an enabling, flexible legislative framework that accelerates the current direction of system working. While the narrative in the white paper aligned with this approach, we are concerned that the provisions in the Bill and accompanying guidance from NHSE/I and DHSC to date risk undermining this intention. For example, the level of detail around the ICB's membership, appointments and composition, alongside provision for an increased level of control and direction over ICBs from NHS England and secretary of state, indicates a shift further towards a tightly managed, centrally controlled NHS system architecture. Elsewhere in the Bill, for example, NHS England's and the secretary of state's duties to promote autonomy are removed (clause 62). This is framed in the context of greater collaboration, but we note with some concern that the explanatory notes position this removal as making way for the secretary of state's powers of direction over NHS

England. We are worried that this tendency to centralise and direct will be passed down to ICBs in their leadership and culture. This conflicts with the principle that locally designed systems will best improve patient care and is liable to forcing attention upwards, rather than promoting subsidiarity.

We are concerned that collective confidence in an ICB could be undermined by an excessively top-down approach, which could hinder the opportunity and ambition of system working:

- Schedule 2 states that an ICB chair will be appointed by NHS England with approval from the secretary of state and no involvement of the ICB members or wider system partners. This is concerning as the chair needs to have the confidence of the ICB and system partners. We urge the government to ensure a significant role for these bodies in the recruitment of the chair, even if powers of appointment lie elsewhere.
- The Bill provides for NHS England alone, with approval of the secretary of state, to remove the chair from office. However, it seems probable in the medium term, as local arrangements develop and get underway, that an ICB chair may lose the confidence of the ICB and/or the organisations within the system. Where this happens there must be a role for the ICB board in initiating the removal of the chair and this needs to be addressed in the constitution. If the ICB cannot initiate the removal of the chair, this will potentially lead to conflict, a stalemate and potential disruption to services.
- Schedule 2 makes the appointment of ordinary members subject to the chair's approval. We believe the whole board should approve the appointment of ordinary members (not the chair alone), to maintain the principle of collective responsibility that is central to good governance.

The role of the ICB and its relationship with local health and care bodies

There must be clarity on how the accountabilities of all parts of a local health and care system align without duplication, overlap or additional bureaucracy. For example, some of an ICB's duties as currently set out – such as the duty of quality improvement – risk overlapping with those of trusts. While we agree the board of an ICB will need to be formally accountable to parliament via DHSC and NHS England, the ICB should also see themselves as accountable to the communities they serve and the organisations within their footprint. There should be an obligation on NHS England in the Bill to set this out explicitly in future guidance. In addition, we see that the explanatory notes to the bill state that the ICB will be directly accountable for NHS spend and performance within the system. This does not appear to be explicit within the Bill, however, and we will seek clarity from the government as to the intentions here.

We are pleased to see the reference to ICBs and trusts and foundation trusts jointly developing the system's plan to meet the health needs of their population and jointly setting out how they will

exercise their functions to achieve that plan. We were clear in our discussions with DHSC and NHSE/I that this needed to be a joint endeavour, and we urge the government to extend the principle of co-production to the development of an ICB's composition and constitution. The consultation process for establishing an ICB and drafting an ICB constitution is currently framed as a CCG-led process, and therefore risks lacking appropriate consultation with trusts and wider system partners which would make it more robust. There needs to be a requirement in primary legislation for CCGs, trusts and wider partners to agree the composition and constitution of the ICB, as well as a statutory duty for the ICB to involve system partners in planning and commissioning decisions. There must be a requirement on NHS England to issue statutory guidance which ensures:

- each ICB has a mechanism which enables the views of all trusts to be heard as part of the ICB decision-making process
- each ICB has a robust process for agreeing the ordinary members
- each ICB has a challenge mechanism for trusts, in extremis, to raise concerns to NHS England about the ICB composition, constitution and plans.

We support the government's stated aim in the white paper to reduce the bureaucratic burden on the health and care system, but are concerned about the ever-increasing demands that system working places on trust leaders' time and moreover, that this will happen without any commensurate increase in resources. Taken together with the recent ICS design framework and system oversight framework, the statutory ICB risks creating an additional management and oversight tier rather than taking bureaucratic burden away. We are particularly concerned about how the relationship between trusts and ICBs is framed in the Bill. The clauses describe an ICB as a separate entity to its 'partners', rather than as a genuine partnership of all the organisations that contribute to health and care services and outcomes within the system. This model risks moving away from the founding spirit of partnership and the design principle of the ICS as a sum of its parts, and towards becoming a separate body managing those within it.

Finally, CCGs have largely been repurposed into ICBs. We are concerned that this 'lift and shift' approach to repurposing leaves them open to the charge that the government is simply recreating CCGs on a larger footprint, rather than developing them into a broader strategic, population health planning function. It is clear that the purchaser/provider split is not being fully removed in the Bill, so the link between providers and commissioners in an ICB needs to be sufficiently improved and strengthened by having robust provider input into ICB decision-making.

ICPs and Integrated care system: further amendments (clauses 20 and 25: schedule 4)

Summary

The Bill states that an ICB and relevant LAs must establish a statutory joint committee for the system – an ICP – which will bring together health, social care, public health and wider partners. The ICP membership will include one member appointed by the ICB, one member appointed by each of the relevant LAs, and any other members appointed by the ICP. The ICP will be able to determine its own procedures locally.

The ICP must prepare an 'integrated care strategy', building on the relevant joint strategic needs assessments (JSNAs) and considering the effectiveness of establishing section 75 arrangements. The ICP must have regard to guidance issued by the secretary of state. An ICP may include in this strategy a statement of its views on how the provision of health-related services could be more closely integrated with health and social care services. The strategy must detail how it will be delivered by the ICB, NHS England or LAs. There is a requirement for LAs and the ICB, in response and with regard to the integrated care strategy, to create a joint local health and wellbeing strategy.

NHS Providers' view

We support the lack of prescription around the membership of the ICP on the face of the Bill and the principle of the ICP being a partnership of equals. However, if all relevant LAs, who are already represented in the ICB by a 'partner' member, are each involved in setting up the ICP and represented by individual members, without additional provider representation, there will be an inappropriate imbalance when establishing the ICP which undermines the principle of equal partnership.

We support the creation of ICPs as joint committees rather than statutory organisations, and understand the rationale behind a separate body that brings the NHS in England, local government and wider partners together to focus on tackling health inequalities and the wider determinants of health. However, we note that this means an ICP's functions and duties, and the liabilities that accrue from them, will fall to individual members of an ICP. This may become problematic if an ICP's functions and duties conflict with the duties and liabilities of these individuals as directors, and there needs to be clarity as to where directors' duties lie. There also needs to be clarity as the accountability of an ICP and its members in agreeing that strategy.

Integrated care system: financial controls (clauses 21-24)

Summary

These clauses set out the financial responsibilities of NHS England and ICBs. Each ICB must exercise its functions with a view to breaking even. Furthermore, each ICB and its partner trusts and foundation trusts must seek to achieve financial objectives set by NHS England, and operate with a view to ensuring that local capital and revenue resource use does not exceed the limits specified by direction from NHS England in that financial year. NHS England may give directions to an ICB and its partner trusts and foundation trusts to ensure that they do not exceed these limits.

NHS Providers' view

Providers understand how the allocation and distribution of funding at ICB level can make a positive contribution towards the 'triple aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. The 'system first approach' to financial management driven by the response to COVID-19 appears to have been a largely positive experience.

However, it is important to reflect on what has worked well to date, and embed this in legislation (and guidance) to maximise the chances of the new financial regime being a success. As things stand, we are concerned that the Bill does not strike the right balance between embracing the opportunities presented by more collaborative working, and protecting ICBs, trusts and foundation trusts – and ultimately patients – when things do not go as planned. For example, in the event that an ICB, trust or foundation trust feels it has been given an impossible task – say if it is concerned that its funding envelope is insufficient to meet patients' needs, potentially putting outcomes, quality of care and patient safety at risk – it is important that clear routes to recourse exist.

It does not call into question the commitment of any of an ICB's partners to recognise that legislation needs to make provision for those difficult situations which, at times, will be unavoidable as much as partners may regret this. As such, we would welcome the opportunity to work with DHSC and NHS England to explore what a reasonable system of checks and balances might look like. We want to ensure that if and when tensions arise, they can be resolved quickly, fairly and transparently.

Furthermore, we urge the government to give careful consideration to the conditions needed to enable ICBs, and their partner trusts and foundation trusts, to collectively deliver financial balance. This will require an open and honest conversation ahead of the Comprehensive Spending Review

about the funding needed to fully recover from COVID-19, transform the NHS, and build greater resilience into the wider health and care system.

Merger of NHS bodies (clauses 26-32; schedule 5)

Summary

Clause 26 abolishes Monitor, with schedule 5 making consequential amendments relating to the transfer of Monitor's functions to NHS England. This fulfils the intention of DHSC to merge Monitor into NHS England to form a single body. Clause 27 places a duty on NHS England to minimise the risk of conflict between its regulatory and other functions, and managing any conflicts that arise. Clause 28 adds to current provisions to require an impact assessment before modification of standard licence conditions in all providers' licences or in licences of a particular description is allowed. Clause 29 transfers powers from the Trust Development Authority (TDA) to NHS England and abolishes the TDA.

NHS Providers' view

Overall, we support the move to merge Monitor and the TDA into NHS England and welcome the consistency and clarity it will offer. However, we note this raises a series of questions for the new NHS England as a single organisation that concurrently sets the national policy framework, supports improvement, and acts as a regulator. The merger removes the inherent tension deliberately created by the Health and Social Care Act 2012 which replicated a commissioner/provider split at a national level, and consolidates the direction of travel with NHS England seeking to operate as a more integrated body. However, while the Bill contains some useful provision for NHS England to manage conflicts of interest, this does not negate the fact that NHS England will be required to oversee and regulate the outcome of its own decisions. We will continue to work with DHSC and NHS England to understand the implications of this change in practice and what further safeguards may be needed to account for potential conflicts of interest between NHS England's various functions and powers.

Secretary of state's functions (clauses 33-38; schedule 6)

Summary

These clauses set out a number of powers of direction for the secretary of state, including in relation to public health, NHS England, safety investigations and reconfiguration. A duty on the secretary of state regarding publication of an assessment of the workforce needs of the health service in England is also set out.

Key clauses and NHS Providers' view

Clause 33: Report on assessing and meeting workforce needs

This clause sets out a duty on the secretary of state to publish, at least once every five years, a report describing the system for assessing and meeting the workforce needs of the health service in England. It also places a duty on Health Education England (HEE) and NHS England to assist the secretary of state in preparing the report, if asked by the secretary of state to do so.

NHS Providers' view

The intent of this clause is to add clarity and transparency on roles and responsibilities within the NHS on workforce planning. This is a welcome step forward and acknowledgement of the multiple bodies involved in this work. However, this duty will also essentially act to set out the status quo. The NHS desperately needs a long-term workforce numbers plan setting out the desired future shape and size of the workforce. We have called for an additional duty in the Bill to ensure the development of regular, public, long-term workforce projections drawing on input from all relevant NHS arm's length bodies, NHS frontline organisations such as ICBs and trusts, and expert bodies such as think tanks. These projections should set out, independently from ministers, on an arm's length basis, the size and shape of the future workforce needed to deliver safe, effective, high-quality care and the estimated cost of delivering this workforce. There should then be a duty on the secretary of state to regularly update parliament, more than once a parliament, on the government's strategy to deliver those long-term projections, including its approach to providing the required funding.

Clause 34: Arrangements for exercise of public health functions: arrangements; and clause 35: Power of direction: public health functions

Clause 34 allows for any of the secretary of state's public health functions to be exercised by NHS England, an ICB, a LA that has duties to improve public health, a combined authority, or any other body that is specified in regulations. Clause 35 allows the secretary of state to direct NHS England or an ICB to exercise any of the public health functions of the secretary of state, and provides for funding in relation to the functions to be exercised.

NHS Providers' view

Existing legislation enables the secretary of state to delegate public health functions by agreement. As part of this, NHS England currently commissions a range of services, including national immunisation and screening programmes. However, the secretary of state cannot require NHS England or any other NHS body to take on a delegated public health function, which may mean that the secretary of

state will be unable to deliver an aspect of their duties. The proposed clause in the Bill provides the secretary of state with greater flexibility as to which body carries out public health functions.

We support the introduction of flexibility for the secretary of state to direct NHS England to carry out delegated public health functions. We have previously highlighted the challenges associated with the LA commissioning of certain clinical public health services including health visiting, sexual health services and drug and alcohol services. Fragmentation and underfunding of services have undermined the ability of trusts, who are frequently commissioned to provide these services, to effectively deliver services and meet the needs of local communities. These services would be better placed to sit within the NHS and be commissioned alongside other clinical services, and so we welcome the opportunity for NHS England to play a greater role in commissioning services.

While we support this proposal, changes to the delegation of public health functions must not be considered as a cure-all for challenges faced by public health. Underfunding of services will continue to present challenges, regardless of who is delivering services. Should any future proposal be brought forward under this power, we would emphasise the need for it to be subject to full and wide consultation with a range of partners both within and outside the NHS.

Clause 36: Power of direction: investigation functions

Clause 36 enables the secretary of state to direct NHS England (if they consider it in the public interest) or any other public body to exercise any of the investigation functions which are specified in the direction. The 'investigation functions' here are those carried out by the Healthcare Safety Investigation Branch (HSIB) under ministerial directions relating to its investigative functions and its additional investigative functions in respect of maternity cases.

NHS Providers' view

Further clarity on this clause and how it works alongside Part 4 of the Bill and the work that the HSSIB would undertake would be welcome. In particular, it would be helpful to understand the intended approach to the maternity investigations currently undertaken by the HSIB. The HSIB has had a valuable role in identifying how NHS providers can sustainably and systematically improve the quality of their maternity investigations and then appropriately support those providers to make the required improvements. However, it remains important for these investigations to return to the NHS at an appropriate point to ensure proper accountability, to support a trust's relationships with the affected families and staff, and to avoid the loss of skill within the NHS in carrying out such investigations. We also note that the explanatory notes state, 'the Bill will establish a new statutory body which will largely replace the Investigation Branch', and we will seek clarification as to the intent there.

Clause 37: General power to direct NHS England

Clause 37 gives the secretary of state the power to direct NHS England in relation to their functions. There are exceptions to this power – the secretary of state cannot use the power in relation to the appointment of individuals by NHS England (including trusts and foundation trusts), individual clinical decisions, or in relation to drugs or treatments that the National Institute for Health and Care Excellence (NICE) have not recommended or issued guidance on as to clinical and cost effectiveness.

NHS Providers' view

This is a key provision to note as it appears to signal a recentralisation of power and to open up the possibility of ministers' involvement in aspects of the operational management of the health service. We are concerned that without appropriate safeguards in place, decisions might be reached based on political motivation rather than focused on the best interests of services and populations. The clinical and operational independence of the NHS must be maintained to ensure equity for patients within the service, best use of constrained funding, and clinical leadership with regard to prioritisation and patient care. We are concerned that there are no protections to mitigate against the involvement of the secretary of state in the day-to-day running of the NHS. This could arguably expose the government, any secretary of state, the service and patient care to undue, unmanaged risk.

The clause indicates that a direction must include a statement that the secretary of state considers the direction to be in the public interest and that this should be published as soon as is reasonably practicable. We are concerned that the way in which the 'public interest test' has been drafted is a subjective test, applied by the secretary of state. This could leave the secretary of state able to intervene in individual funding allocations. We believe there needs to be further discussion about whether such broad powers are necessary and proportionate, and would also encourage setting out specific criteria that must be met and a 'public interest test' for the deployment of these powers.

Clause 38: Reconfiguration of services: intervention powers; and schedule 6

Clause 38 gives the secretary of state intervention powers in relation to the reconfiguration of NHS services. Arrangements are detailed in schedule 7, which places a duty on an NHS commissioning body (that is, NHS England or an ICB) to notify the secretary of state when there is a proposal to reconfigure services. It also places a duty on an NHS commissioning body, NHS trust or foundation trust to notify the secretary of state when a reconfiguration is considered likely to be needed. The schedule gives the secretary of state power to give a direction calling in any proposal for the reconfiguration of services. The secretary of state can then take on the decision-making role of the NHS commissioning body concerned (for example, whether a proposal should proceed or not or whether the proposal should be modified). It also allows for the secretary of state to retake any

decision previously taken by the NHS commissioning body. When the secretary of state has made a decision, they must publish any decision made about a reconfiguration and notify the NHS commissioning body concerned of the decision.

NHS Providers' view

This gives wide ranging powers to the secretary of state to direct local service reconfigurations, and does so without appropriate safeguards. Decisions on local service reconfigurations are best taken locally by the organisations that are accountable for those services following meaningful engagement with local communities. While clarity and speed can be welcome in making such decisions, this should not be at the expense of local engagement and decision-making. The proposed powers risk undermining local accountability in the NHS, and local authority overview and scrutiny committees. They do not necessarily protect the best interests of patients and run the risk of political interference in the provision of local NHS services. In order to ensure that this power does not adversely affect services and patient care we believe that the following principles should be applied and set out on the face the Bill:

1. Any secretary of state involvement should be fully transparent, with the right of the affected parties to make appropriate representation and the secretary of state's intervention made against set, public, criteria
2. There is an appropriate role for an independent body like the Independent Reconfiguration Panel to provide independent advice on detailed issues including the validity and importance of the clinical case for change
3. There should be an appropriate threshold governing the level of reconfiguration where the secretary of state is involved
4. There should be an explicit test that use of the power must maintain or improve safety before it can be exercised.

NHS trusts (clauses 39-50; schedule 7)

Summary

A number of clauses in this chapter repeal redundant legislative sections, including some legislation which were never commenced – one example is provision in the Health and Social 2012 Act for the formal abolition of NHS trusts which was never commenced because the foundation trust pipeline was not completed as initially envisaged. This set of clauses also removes the power of the secretary of state to appoint trustees for an NHS trust to hold property on trust.

Clause 42 removes the exemption on NHS trusts to hold a licence from NHS England and requires NHS England to treat any new NHS trusts as if they had applied for a licence – effectively bringing the provider licence in line with the approach for foundation trusts.

Clause 43 sets out a new duty, which applies to ICBs, NHS England and foundation trusts and trusts in England (the 'relevant bodies'). This duty has been described by DHSC operationally as the 'triple aim' duty. ICBs and trusts will be under a duty when carrying out their functions, to have regard to all likely effects of their decisions on:
- the health and wellbeing of the people of England
- the quality of services provided or arranged by relevant bodies
- the efficiency and sustainability of resources used by the relevant bodies.

Decisions relating to services provided to a particular individual (for example individual clinical decisions or highly specialist commissioning decisions concerning an individual patient) are exempt from this duty.

Clauses 44 to 47 and clause 49 effectively give NHS England existing powers previously held by the TDA (and/or the secretary of state) over NHS trusts. Clause 49 gives NHS England the power to appoint the chair of an NHS trust, replacing the secretary of state's power here.

Clause 48 means that an application by an NHS trust to become a foundation trust no longer requires the support of the secretary of state. However, authorisation may only be given for foundation trust status if the secretary of state approves the authorisation and NHS England is satisfied. This clause also gives NHS England the power to dissolve a trust on the approval of the secretary of state and allows NHS England or the secretary of state to make the order for dissolution, if either consider it appropriate to do so. Neither the secretary of state nor NHS England may make a dissolution order until after the completion of a consultation unless as a matter of urgency or following the publication of a final report from a trust special administrator.

Clause 50 amends existing legislation such that NHS England, rather than the secretary of state with the consent of HM Treasury, may set financial objectives for trusts. As is the case now, trusts must achieve these objectives. Furthermore, objectives may apply to trusts generally, or to a particular trust or trusts of a particular description.

NHS Providers' view

For the most part, our understanding of this group of clauses is that it 'tidies up' existing legislation in line with the proposed direction of travel under a single, statutory NHS England – dealing in particular with the consequences of the merger of TDA with NHS England. It reinforces some degree of equalisation between trusts and foundation trusts in terms of the application of the provider licence.

We are interested to see that the legislation leaves open the potential for NHS trusts to seek and secure foundation trust status. While we understand this is more of a convenience within the Bill than a policy expectation, we will of course explore this further with DHSC and NHSE/I colleagues.

Trust leaders will be interested to review the proposed clauses on the new 'triple aim' duty which will apply to ICBs, trusts and the new NHS England. Our views are set out above (see clause 4), and we would welcome feedback on the anticipated practical impact of this clause on your trust and ICB. While the amendments to clause 50 are relatively minor, the clause needs to be viewed within the context of the wider changes to financial arrangements outlined in the bill (specifically clauses 21-24 on ICS financial controls, and clause 66 and schedule 10 on the NHS payment scheme). At this stage, it is unclear how the clause will be implemented in practice – for example, the consequences that will be associated with a trust's failure to achieve its financial objectives. This is something we are urgently seeking clarity on.

NHS foundation trusts (clauses 51-57)

Summary

Clause 52 gives NHS England the power to set a capital expenditure limit on a foundation trust. Therein, NHS England has the power to establish an order to set a capital expenditure limit on a foundation trust for a defined period for which the order relates. It places a duty on NHS England to consult with the foundation trust before the order is made and requires NHS England to publish the order. The clause further imposes a statutory duty on the foundation trust not to exceed the capital expenditure limit, and sets the definition for capital expenditure in line with how capital is reported in the foundation trusts annual accounts. NHS England must produce guidance on the use of its power to make orders, and NHS England is required to consult with the secretary of state before publication of such guidance. The guidance will set out information about the circumstances in which NHS England is likely to make an order to set a capital expenditure limit for a foundation trust and how it will establish the limit. NHS England must have regard to the guidance when deciding whether to issue any orders to limit capital expenditure by foundation trusts, and to keep the guidance under review.

Clause 54 will allow an NHS foundation trust to carry out its functions jointly with another organisation. The Bill will create a new legal mechanism that will allow ICBs and NHS providers to form joint committees, or two or more providers, to make joint arrangements and pool funds. Guidance will also be issued on joint appointments. Parallel measures in the Bill will also make it easier for ICBs to commission services collaboratively with other ICBs and other system partners by permitting a wider set of arrangements for joint commissioning, pooling of budgets and delegation of functions.

The other clauses here amend existing legislation in line with the creation of a single merged NHS England and seek to streamline licensing and parts of the transactions process. In summary:

- Clause 51 means NHS England can treat existing foundation trusts and new foundation trusts created via merger as having applied and been granted a licence
- Clause 53 means that foundation trusts will send their forward plans to NHS England rather than Monitor. Other amendments allow for greater flexibility on how accounts are to be prepared.
- Clauses 55 removes the requirement that an application to merge a foundation trust with an NHS trust must be supported by the secretary of state. This clause would also place a duty on NHS England to grant the application if it was satisfied that necessary steps have been taken to prepare for the dissolution and the establishment of the new trust and the secretary of state approves the grant of the application. An application to acquire a foundation trust or a trust similarly no longer requires the support of the secretary of state. This clause introduces a new duty on NHS England to grant the application if it is satisfied that necessary steps have been taken to prepare for acquisition and the secretary of state approves the grant of the application.
- Clause 56 removes the requirement for the grant of an application made by a foundation trust for dissolution to be based on the trust having no liabilities as currently set out in the National Health Service Act 2006. NHS England will also be required once the application for dissolution has been granted, to transfer, or provide for the transfer of, the property and liabilities (including criminal liabilities) to another foundation trust, a trust, or the secretary of state. It also imposes a duty on NHS England to include in the order a provision for the transfer of any employees of the dissolved foundation trust.
- Clause 57 reflects and reiterates the new 'triple aim duty'.

NHS Providers' view

We have significant concerns regarding the clause on capital spending limits for foundation trusts. The clause in the Bill does not mirror NHS England and NHS Improvement's September 2019

legislative proposal which was the result of detailed negotiations with NHS Providers on behalf of our foundation trust members. The clause also cuts across the Health and Social Care Committee's unequivocal position that the power to set capital spending limits for foundation trusts 'should be used only as a last resort'. We will ask parliament to consider adding the following safeguards to the Bill, which were agreed between NHS Providers and NHS England and NHS Improvement in 2019:

1. The power to set capital spending limits for foundation trusts should be circumscribed on the face of the Bill as a narrow reserve power;
2. Each use of the power should apply to a single named foundation trust individually;
3. Each foundation trust's capital spending limit should automatically cease at the end of the current financial year;
4. NHS England should be required to explain why use of the power was necessary, describe what steps it has taken to avoid requiring its use and include the response of the foundation trust when publishing each order; and
5. There should be a requirement for each order to be published in parliament, to ensure maximum transparency.

NHS trusts and NHS foundation trusts: transfer schemes between trusts (clause 58)

Summary

This allows for NHS England to make one or more schemes to transfer property, rights and liabilities from a relevant NHS body to another relevant NHS body, such as an NHS trust or an NHS foundation trust. The clause allows NHS England to set out what steps need to be taken before an application can be granted and what should be included in the scheme.

NHS trusts and NHS foundation trusts: Trust special administrators: (clause 59; schedule 8)

Summary

This outlines the changes to the process and authorisation for the appointment of trust special administrators, including reporting mechanisms.

Joint working and delegation of functions (clauses 60-61; schedule 9)

Summary

This enables NHS England, ICBs, trusts and foundation trusts to exercise their functions jointly with each other and/or local authorities. It also enables trusts and foundation trusts to establish joint committees and pooled funds with other trusts, foundation trusts, NHS England and ICB(s), and/or LAs. NHS England may publish guidance for NHS bodies in relation to joint working and delegation arrangements.

Collaborative working (clauses 62-65)

Summary

Clause 62 removes the secretary of state's and NHS England's duties to promote autonomy. NHS England will continue to function as an arm's length body. The removal of this duty is to allow for the introduction of clause 36 (directions to NHS England) which gives the secretary of state the ability to direct NHS England in regard to the exercise of its functions.

Clause 63 gives NHS England the ability to issue guidance concerning joint appointments between one or more NHS commissioner and one or more NHS providers; between one or more NHS body and one or more LA, or one or more NHS body and one or more combined authority. References here to NHS bodies mean NHS England, ICBs, trusts and foundation trusts. Ahead of publishing or revising any guidance, NHS England will be required to consult with appropriate organisations.

Clause 64 introduces a new power for the secretary of state to make guidance on how the duty imposed on NHS bodies to co-operate with each other is discharged. It also imposes a duty on NHS bodies, except for Welsh NHS bodies, to have regard to this guidance. This clause also creates new powers which will impose a duty on NHS bodies and LAs (including Welsh NHS bodies and Welsh LAs) to co-operate with one another in order to advance the health and welfare of the people of England and Wales. It also inserts a new power for the secretary of state to make guidance related to England, and imposes a duty on NHS bodies and local authorities, except for Welsh NHS bodies and Welsh local authorities, to have regard to this guidance.

Clause 65 amends the 2012 Act to specify the purposes for which Monitor (which this Bill proposes to merge with NHS England) may set or modify the conditions contained in the licences which any provider of health care services for the purposes of the NHS must hold. In light of the creation of the 'triple aim' duty for NHS England, ICBs, foundation trusts and trusts, a new purpose for which licence conditions may be set or modified is being created, namely that of ensuring that decisions are

made with regard to all of their likely wider effects on the three factors which are included in the new 'duty to have regard to the effect of decisions'.

NHS Providers' view

NHS Providers supported NHS England's initial proposal in 2019 for a new 'duty to collaborate' in support of the aims of system working. We will seek views from DHSC colleagues as to whether the current wording of a 'duty to co-operate' materially alters the intent of these clauses in any way.

We note that clause 62 explicitly removes duties on the secretary of state and on NHS England to 'promote autonomy'. This reflects proposals elsewhere in the Bill to alter the relationship between the secretary of state and NHS England. Our position on the need to place much greater safeguards around many of the proposals on new powers of direction for the secretary of state are made elsewhere in this briefing. However, it is also worth noting that clause 62 similarly removes NHS England's duty to promote autonomy. Although this is in line with the direction of travel for trusts and their partners as they embed more collaborative arrangements within local systems (and sits in contrast to the 2012 Act which actively promoted competition) we will continue to argue strongly for the need for clear lines of accountability within the system, including clear lines of accountability from trust boards for the quality of care they deliver, and as large employers. In our view organisational autonomy can exist alongside collaboration and co-operation.

NHS payment scheme (clause 66; schedule 10)

Summary

Clause 66 and schedule 10 replace the national tariff with the NHS payment scheme and make provisions relating to the new scheme. The scheme will be published by NHS England, which will consult with ICBs and relevant providers across the NHS and independent sector. The scheme will set rules around how commissioners establish prices to pay providers for healthcare services for the purposes of the NHS, or public health services commissioned by an ICB or NHS England, on behalf of the secretary of state. The intention is to give the NHS more flexibility in how prices and rules are set, in order to help support more integrated care at local levels.

Key clauses and NHS Providers' view

Schedule 10, paragraph 114D
Paragraph 114D deals with objections to the NHS payment scheme. The key difference to the existing statutory objection process for the national tariff is that the Competition and Markets Authority (CMA)

will no longer have a role in reviewing objections. Instead, NHS England will make its own decisions about how to proceed. If it decides to make amendments that are, in its opinion, significant and unfair to make without further consultation, it must consult ICBs and relevant providers again. If it decides not to make amendments, it may publish the NHS payment scheme alongside a notice stating that decision and setting out the reasons for it.

NHS Providers' view

The introduction of the NHS payment scheme represents a move away from mandatory national prices for many services to commissioners having a greater say over the prices they pay providers. Trusts generally support this direction of travel and welcome the opportunity to have more open conversations about the true cost of providing services. We are working with NHSE/I to ensure that trusts' views are properly considered in the design of the NHS payment scheme (and that the benefits associated with the national tariff are not lost).

At the same time, we are concerned that the changes proposed appear to represent a cumulative loss of independent oversight, particularly with the removal of the CMA as a route to recourse. This could potentially increase the risk of an unworkable NHS payment system being imposed on ICBs and their constituent organisations. We would welcome the opportunity to work with DHSC and NHSE/I to ensure that the right checks and balances are enshrined in law.

Patient choice and provider selection (clauses 67-69; schedule 11)

Summary

These clauses revoke existing procurement and competition requirements. They also strengthen the current rules around patient choice by making it mandatory for regulations to contain provisions about how NHS England and ICBs will allow patients to make choices about their care, and provide NHS England with new powers to enforce patient choice requirements. The intention is to pave the way for a new NHS provider selection regime that moves away from competitive retendering by default in favour of a more collaborative approach to planning and delivering services.

NHS Providers' view

We support the intention behind NHSE/I's proposals for a new NHS provider selection regime as we agree that the current rules for procuring healthcare services can unnecessarily disrupt the provision of high-quality local services and impede effective planning over the longer term. We understand why the legislative changes put forward in the Bill are necessary. However, more broadly, we have questions and concerns about how the regime will operate transparently and robustly in practice, and

believe that the inclusion of an appropriately defined challenge function would be beneficial. More detail can be found in our April 2021 response to NHSE/I's consultation. We are continuing to engage with NHSE/I as the regime develops and will keep members updated on our work in this area.

Competition (clauses 70-73; schedule 12)

Summary

Clause 70 proposes to require NHS England to give the CMA regulatory information that the CMA may need to exercise its functions, or which would assist it in carrying out its functions. This includes information held by NHS England relating to patient choice, and oversight and support and recommendations about restructuring.

Clause 71 introduces an exemption from Part 3 of the Enterprise Act 2002, removing CMA powers over trust mergers. Instead, NHS England, as the national body responsible for the NHS, will review mergers of NHS providers to ensure they are in the best interests of patients and the taxpayer.

Clause 72 also removes Monitor's competition duties ahead of the merger with NHS England to allow NHS England to focus more on improvement in the quality of care and use of NHS resources, and on the development of integrated care.

Clause 73 will remove Monitor's ability to refer contested licence conditions and tariff prices to the CMA. Instead, NHS England will make its own decisions on how to operate the licensing regime and the NHS payment scheme, in consultation with local leaders.

Miscellaneous (clauses 74-78)

Summary

Clause 75 sets out requirements for Special Health Authorities (SpHAs) in relation to their accounts and auditing. Clause 76 repeals the powers of the secretary of state in the 2012 Act to make a property transfer scheme or a staff transfer scheme in connection with the establishment or abolition of a body by the 2012 Act, or the modification of the functions of a body or other person by or under that Act.

Clause 77 abolishes Local Education and Training Boards (LETBs).

Clause 78 revokes section 74 of the Care Act 2014 and schedule 3 of the Care Act 2014. Schedule 3 in the 2014 Act deals with the planning of discharge of patients in England from NHS hospital care to LA care and support. In revoking schedule 3 here, the procedural requirements which require social care needs assessments to be carried out by the relevant LA before a patient is discharged from hospital are repealed. It also repeals provisions which enable the responsible NHS body to charge the relevant LA via a penalty notice, where a patient's discharge from hospital has been delayed due to a failure of the LA to arrange for a social care needs assessment, after having received an assessment and discharge notice for an individual from the relevant NHS body.

NHS Providers' view

The abolition of LETBs to an extent formalises existing practice given that they have been progressively reduced in number and in importance in recent years. LETBs have ceased to be used as the primary vehicle for collaborative conversations within areas and regions on local education and training needs, and workforce planning more generally. Their function has been partly replaced by the recent establishment of regional people boards, set up by HEE and NHSE/I. Most regional people boards are chaired by or have a significant representation of trust leaders, which should help to ensure the flow of local intelligence on workforce needs and planning into discussions. However, it remains to be seen how local and ICB and system level discussions around workforce planning are managed within and outside these forums. We also note the need for any local changes to be supported by a fully funded long-term workforce plan.

It is important that arrangements to replace the function of LETBs – including through the establishment of regional people boards – do not repeat the mistakes made by the Care Act's excessive centralisation of local workforce planning functions. The original rationale for establishing LETBs had been to "build a system that is responsive to the needs of employers, the public and the service at local level". It is important this remains the aim, with an emphasis placed on the ability of trusts and other local actors to provide the intelligence required for effective workforce planning and commissioning of education and training. Providers are best placed to identify current and future resource gaps, and their continuing and growing input here is vital to establishing a rigorous and realistic evidence base.

Part 2: Health and adult social care: information

Clauses 79-85

Summary

The data provisions in the Bill are intended to work collectively to enable increased sharing and more effective use of data across the health and adult social care system. The general duties of the Health and Social Care Information Centre (the Information Centre; known as NHS Digital) will be amended so that it may only share information for purposes connected with the provision of health care or adult social care or the promotion of health. The Information Centre will be able to require private providers of health services to provide any information it requires in order to comply with a direction from the secretary of state. Other provisions enable the secretary of state to require certain providers of adult social care services to provide information relating to themselves, their activities in connection with providing adult social care in England, or individuals they have provided adult social care to in England or, where those services are commissioned by a LA in England, or outside England. There are also powers to enforce information provisions against private providers, as well as provisions that confer a delegated power on the appropriate authority to make regulations providing for a system of information in relation to medicines to be established and operated by the Information Centre, and specifying the type of provision which can be included in the regulations.

NHS Providers' view

We welcome the ambitions behind the proposals to facilitate greater sharing of information across health and care providers. Any policy or legislative proposals that clarify data sharing parameters for people will undoubtedly improve the pace of change. Improving data quality, access and flows will underpin three core NHS long term plan aims: moving to population health management, progressing the prevention agenda, and tackling health inequalities. There will also be gains in terms of patient safety and improved efficiency.

We recognise that the response to the COVID-19 pandemic has accelerated digital ways of working but with this increased use of digital technologies comes a renewed focus on interoperability. Interoperable systems improve the delivery of health and care, ensuring that clinicians have access to the right information at the right time. Greater interoperability will also underpin the integrated care agenda and help deliver shared care records across integrated care systems.

However, we are concerned that these legislative proposals do not address the underlying issues of bureaucratic burden around data collections in the health and care system. Data requests and record

management are constantly cited as the primary bureaucratic burden on staff of all types. Data requests from regulators, commissioners and the national bodies should be proportionate and have a direct link to improving care. The proposals seem to increase the reporting burden on providers rather than decrease them as per the white paper intentions, and it will be important to ensure that reporting is not used as a command and control tool.

Many trusts as well as other health and care providers need investment to improve their technical infrastructure, as data is only as good as the technical flows an organisation's infrastructure is capable of. Consideration therefore needs to be given as to the support and investment required here and the implications for implementation. Moreover, we are concerned to ensure an aligned approach to the digital agenda.

Part 3: Secretary of state's powers to transfer or delegate functions

Clauses 86-92

Summary

These clauses give the secretary of state powers to make regulations to confer a function on a body; abolish a function of the body; change the purpose or objective for which the body exercises a function; and change the conditions under which the body exercises a function. The bodies in question here are HEE, the Information Centre, the Health Research Authority, the Human Fertilisation and Embryology Authority (HFEA), the Human Tissue Authority and NHS England.

NHS Providers' view

Of particular note here is clause 87, which would allow the secretary of state to transfer functions between bodies. The secretary of state may not change functions in a way so as to make NHS England redundant but they can abolish the other bodies by regulation. The power to abolish a body such as the HFEA, or the power to transfer the majority of their powers to other bodies, requires proper parliamentary scrutiny. We believe that such changes should require primary legislation.

Part 4: The Health Services Safety Investigations Body

Clauses 93-119; schedules 13, 14 and 15

Summary

Part 4 of the Bill puts the Health Services Safety Investigations Body (HSSIB) on a statutory footing. The organisation is currently established as the Healthcare Safety Investigation Branch (HSIB) under ministerial directions as part of the TDA and hosted by NHS Improvement. Schedule 13 describes the constitution of the HSSIB, including the appointment of the chief investigator and funding. Schedule 14 describes the exceptions to prohibition of disclosure of protected material. Schedule 15 contains consequential amendments relating to Part 4.

NHS Providers' view

NHS Providers strongly supports the principle of creating the HSSIB as an independent statutory entity and enabling it to conduct safe space investigations so that the NHS can improve patient care and learn from when things go wrong. Organisational cultures that support staff to speak up have higher levels of staff engagement and patient satisfaction and are associated with reduced errors in care and better safety. In 2019, the Health Service Safety Investigations Bill was published but did not progress through parliament. We are pleased to see a number of helpful revisions to those earlier provisions within this part of the Bill. Nevertheless, we are concerned to ensure that the Bill provisions genuinely enable the HSSIB's independence – crucial to its ability to carry out its intended systemic safety role – and protect the integrity of safe space.

Key clauses and NHS Providers' view

Clause 95: Deciding which incidents to investigate

Under Clause 95, the HSSIB determines which qualifying incidents it will investigate, but this is subject to the secretary of state's power to direct the HSSIB to carry out an investigation of a particular qualifying incident or qualifying incidents of a particular description. The secretary of state's directions must be in writing, and may be varied or revoked by subsequent directions, and they may provide for a person to exercise discretion in dealing with any matter.

NHS Providers' view

The parliamentary joint committee on the Draft Health Service Safety Investigations Bill in 2018 made clear the importance of the HSSIB's independence of judgement in deciding what investigations it undertakes. We note that a direction "may provide for a person to exercise discretion in dealing with any matter", but this does not seem to be a sufficiently strong safeguard. If the secretary of state is to

be able to direct the HSSIB to carry out an investigation, then three explicit balancing provisions are needed to maintain the HSSIB's independence. Firstly, it must be able to decline to carry out the investigation where there is reasonable justification. Secondly, adequate funding must be made available to the HSSIB to enable it to carry out such investigations in order to avoid compromising its ability to carry out its investigative function as the HSSIB would otherwise determine. Thirdly, the continuing independence of the HSSIB in how it carries out any such investigation and the independence of its consequent recommendations is paramount and should be explicitly protected.

Clause 106: Prohibition on disclosure of HSSIB material; clause 107: Exceptions to prohibition on disclosure; and schedule 14

Clause 106 sets out prohibitions on disclosure of HSSIB material. The HSSIB, or an individual connected with the HSSIB (past or present), must not disclose protected material to any person. "Protected material" means any information, document, equipment or other item which is held by the HSSIB or a connected individual for the purposes of the investigation function, and which relates to a qualifying incident, and which has not already been lawfully made public.

Clause 107 sets out exceptions to the prohibition on disclosure. Prohibitions do not apply to a disclosure which is required or authorised by schedule 14 (see below), other provisions within part four of the Bill, or regulations made by the secretary of state (for example, by reference to the kind of material, the matters to which it relates, the person from whom it was obtained, the purpose for which it was produced or is held, or the purpose for which it is disclosed). Regulations may provide for a person to exercise discretion in dealing with any matter.

Schedule 14 describes the exceptions to prohibition of disclosure of protected material. This includes the HSSIB disclosing protected material to a person if the chief investigator reasonably believes it necessary:
- for the purposes of the carrying out of the HSSIB's investigation function
- for the purposes of the prosecution or investigation of an offence relating to investigations or to unlawful disclosure
- to address a serious and continuing risk to the safety of any patient or to the public; if it is reasonably believed that the person is in a position to address the risk; and if the disclosure is only to the extent necessary to enable the person to take steps to address the risk.

A person may apply to the High Court for an order that any protected material be disclosed by the HSSIB to the person for the purposes specified in the application (which can include onward disclosure). The HSSIB may make representations to the High Court about any application. The High Court may make an order on an application only if it determines that the interests of justice served by

the disclosure outweigh (a) any adverse impact on current and future investigations by deterring persons from providing information for the purposes of investigations, and (b) any adverse impact on securing the improvement of the safety of health care services provided to patients in England. Similar provisions apply for senior coroners to make applications for disclosure and onward disclosure.

NHS Providers' view

There is a wide body of research that evidences the importance of work environments that offer 'psychological safety' for staff to discuss in a confidential setting the circumstances of an incident that has resulted in avoidable harm. It is through a robust application of a safe space that the HSSIB will be able to command the confidence of participants and best understand the safety risks present and make appropriate recommendations.

However, there seems to us a risk in the current drafting that the exceptions on prohibition of disclosure are wide ranging, discretionary and unreasonably open to external applications for access. For example, the impact assessment published for the previous HSSI Bill in 2019 noted that, "Litigation in healthcare is a more frequent occurrence than in other areas of accident investigation. It is therefore possible that lawyers representing patients or NHS staff involved in safety incidents that have been investigated by HSSIB, may make applications for disclosure of 'safe space' information hoping to uncover material of benefit to their clients". The High Court's balancing test seems liable to be intrinsically balanced towards considerations of legal justice rather than systemic patient safety or learning, not least as the ability of the High Court to consider disclosure as potentially deterring information provision is questionable given that the HSSIB has powers to compel interviews and information provisions. With multiple avenues of information and powers of investigation – as well as the HSSIB's final reports being available – other bodies do not need access to protected material simply thanks to the convenience of the HSSIB's existence. As the joint committee concluded: "We recommend that the draft Bill be amended to put beyond any possible doubt that the 'safe space' cannot be compromised save in the most exceptional circumstances, and therefore that the prohibition on disclosure applies equally to disclosure to coroners".

We will seek articulation during debates in Parliament as to how the government expects these provisions to work, with examples of where disclosure may take place and the level of where the bar is set in considering disclosure. We will also seek a tighter drawing of the boundaries of safe space to ensure its appropriate preservation and in turn support participants in playing their full role in an investigation. We would suggest for example that the tests for an application to disclose protected materials must be sufficiently strong to ensure that disclosure is only sought in extremis, that there is a clear and overriding public interest in any disclosure, that the anonymity, safety and privacy of

participants is respected without exception, and that current and future investigations are not jeopardised.

Part 5: Miscellaneous

Clauses 120-129; schedule 16

Summary

Part 5 covers a range of issues. Clause 120 sets out proposals on international healthcare arrangements intended to enable the government to implement more comprehensive reciprocal healthcare agreements with Rest of World countries, subject to negotiations. Also included is a new duty on the Care Quality Commission (CQC) to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care and providing financial assistance to social care services. Clauses here also enable changes to be made to the professional regulation system; restrict the advertising of certain food and drink products; set minimum standards for food and drink in hospital settings; make regulations regarding food information and labelling; and introduce powers for the secretary of state to introduce, terminate or vary water fluoridation schemes.

Key clauses and NHS Providers' view

Clause 121: Regulation of local authority functions relating to adult social care

Clause 121 clause sets out a duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care. The secretary of state will set objectives and priorities for CQC's assessments. Under the proposals, CQC would be required to set and publish indicators of quality to assess LAs' performance and prepare a statement setting out the frequency of reviews and a methodology for assessing LAs' performance, with flexibility to set different indicators, objectives and priorities for different cases. The secretary of state will have powers to direct CQC to revise its quality indicators, assessment framework, and frequency and methodology for different cases.

NHS Providers' view

We are broadly supportive of the duty for the CQC to conduct reviews, assess performance and publish reports on the exercise of regulated care functions by English LAs relating to adult social care. However, we note that this would involve the CQC becoming involved in assessing commissioning and administrative activity, potentially taking it away from its core remit of assessing the quality of services. In addition, we have questions around how the CQC would assess an LA's performance, how

they would define the link between an LA's activity and the quality of local services, and what impact these assessments would have on the quality of services being delivered.

Clause 122: Provision of social care services: financial assistance

Clause 122 enables the secretary of state to give financial assistance to bodies engaged in social care provision or connected services. The secretary of state may direct an NHS trust or an SpHA to exercise any of the functions of the secretary of state in relation to this financial assistance.

NHS Providers' view

This clause seeks to remove bureaucratic barriers to providing rapid financial support to a social care provider sector in exceptional circumstances, as seen during the COVID-19 pandemic. Currently, the secretary of state can only make such direct payments to not-for-profit bodies, so this clause expands existing powers to allow direct payments to be made to social care providers in England.

While we recognise the drivers behind the proposal in the Bill to provide financial support to the social care provider sector at speed in emergency scenarios, we do not think that the current Bill is the right legislative mechanism. We believe instead these powers should be incorporated into the relevant emergency legislation as temporary provisions with appropriate safeguards. We are concerned about the unintended consequences of establishing the secretary of state as a potential direct commissioner of social care providers. This risks undermining LAs' commissioning role and their knowledge of the local provider market. We are also concerned about the power it gives secretary of state to direct trusts and SpHAs to make payments to social care providers, and we do not support this approach and the implication that funding may be required from trusts.

Clause 123: Regulation of health care and associated professions

Clause 123 enables changes to be made through secondary legislation to the professional regulation system. It also permits a currently regulated profession to be removed from statutory regulation when the profession no longer requires regulation for the purpose of the protection of the public. The clause also provides an updated list of the legislation that regulates professions. There is a subsection in this clause which says that this may include senior managers and leaders.

NHS Providers' view

The intention of this clause to enable broader changes to the system of regulation for healthcare professionals is welcome, as we hope it will help create a more adaptable framework of rules and processes governing the professional activities of NHS staff. We have responded positively to the government's *Regulating healthcare professionals, protecting the public* consultation which, for the

most part, sets an encouraging direction of travel towards a proportionate and flexible system of regulation which will help to ensure patient safety while better supporting the future needs of trusts as employers, and the NHS workforce as a whole.

However, we note that statutory regulation of senior managers may not resolve the issue of concern (that is, the potential for a revolving door for 'poor leaders') and is, in practice, very difficult to make effective – it will not preclude the possibility that an individual with a good track record may make a mistake, nor can it prevent non-compliant behaviour. For these reasons, we have challenged proposals to introduce regulation of senior managers. If the regulation of NHS managers is going to be pursued, we would strongly suggest that the circumstances in which the measures could be brought into statutory regulation are fully consulted upon.

Clause 124: Medical examiners

This clause amends the Coroners and Justice Act 2009 in England and allows for NHS bodies, rather than LAs, to appoint medical examiners. This means that every death in England and Wales will be scrutinised either by a coroner or by a medical examiner. It also introduces a duty on the secretary of state for health and social care to ensure that enough medical examiners are appointed in the healthcare system in England, that enough funds and resources are made available to medical examiners to enable them to carry out their functions of scrutiny to identify and deter poor practice, and to ensure that their performance is monitored by reference to any standards or levels of performance that they are expected to attain. It also introduces a power for the secretary of state to give a direction to an English NHS body in order to: require the body to appoint one or more medical examiners, set out the funds or resources that should be made available to such employed medical examiner, set out the means and methods that may be employed to monitor performance of medical examiners. These clauses do not give any English NHS body any role in relation to the way in which medical examiners exercise their professional judgment as medical practitioners.

Clause 126: Hospital food standards

This proposes to give the secretary of state powers to adopt secondary legislation that will set minimum statutory standards for food and drink provided in hospital settings.

NHS Providers' view

We support the ambition to make food in hospitals safer, healthier and more sustainable, as it is an important factor in patient recovery and wellbeing. Trusts are already working hard to ensure they meet nutritional standards and provide good quality food. Arrangements for catering within trusts vary. Some do not have the kitchen facilities to be able cater on site for patients, and so they will have

links with national wholesale suppliers. Elsewhere, some trusts have been able to develop close links with local suppliers, and others have been able to maintain their own kitchens. These differences will have an impact on how quickly, and at what cost, individual trusts will be able to comply with any new nutritional requirements. Potential cost implications could include investment in additional workforce and facilities. There would also be costs associated with renegotiating and winding down contracts and arrangements with suppliers/outsourced caterers. There must therefore be a statutory period of consultation on any new nutritional requirements before they are made to avoid unintended consequences and unrealistic asks of trusts.

Part 6: General

Clauses 130-135

Summary

This chapter of clauses includes powers which allows the secretary of state, by regulations, to make provision that is consequential on this Bill. Where regulations modify primary legislation, the affirmative procedure must be used. Otherwise, the regulations can be made under the negative procedure. This provision may be used to amend primary legislation passed in any part of the United Kingdom. Where regulations are made under this Act, those regulations may make consequential, supplementary, incidental, transitional or saving provision. Provisions also sets out the territorial extent of the Bill, further financial provision necessary as a result of the Bill, and that this part of the Bill comes into force on the day that this Act is passed and that the short title of the Bill is 'The Health and Care Act 2021'.

NHS Providers' pre-legislative work

In recent months we have been working hard to influence the legislation which has been presented today. Member engagement over the last few months, underpinned by a new member reference group for the Bill, has been extremely valuable in helping to form our positions on key issues in the run up to today's publication of the Bill.

In January, following extensive member engagement, we responded to NHSE/I's *Integrating Care: Next steps to building strong and effective integrated care systems across England* consultation, welcoming the strategic direction of travel to integrate health and care at a local level through stronger collaboration and system working, but raising concerns that many significant questions regarding ICSs and their core purpose had been left unanswered. Our full response is available on our website.

In February, the government published *Integration and innovation: working together to improve health and social care for all*, setting out proposals for a Health and Care Bill. These further developed earlier proposals, as well as putting forward several new ones, as we examined in our on the day briefing. Alongside the publication of the government's White Paper, NHSE/I published five new recommendations for legislative change in regard to ICSs. Our on the day briefing is also available on our website.

We gave written and oral evidence to the Health and Social Care Select Committee inquiry on the White Paper, setting out priority issues for the committee to consider. We have engaged with politicians from all parties in the run up to Bill's publication and will continue to do so as the Bill progresses.

In the run up to the Bill's publication we pushed hard to secure small and focused stakeholder engagement groups with both DHSC and NHSE/I and played a key role in the discussions of these select groups in addition to ministerial meetings and regular bilateral meetings with senior decision makers across DHSC and NHSE/I.

Media statement

Bill signals way forward in fast changing health and care landscape

Responding to the publication of the Health and Care Bill, the chief executive of NHS Providers, Chris Hopson said:

"We welcome the publication of this Bill which will help provide clarity for trusts in a fast changing health and care landscape.

"Trusts have been at the forefront of the move towards closer collaboration and integration between health and care, a process that has accelerated in recent months to deal with the extraordinary pressures of the pandemic.

"The forthcoming legislation will formalise this process, so trusts and their partners can plan and cooperate more closely to help build healthier communities.

"We therefore think there is a lot to build on in the government's proposals, which herald the biggest reforms to the NHS in more than a decade.

"However we have been clear about key areas of concern for our members, which will need to be resolved as the Bill goes through parliament.

"It is very important to preserve the operational and clinical independence of the NHS so any new powers of direction for ministers do not impinge on issues such as procurement, treatment, drug funding and the hiring and firing of frontline NHS leaders.

"It's also important to ensure Ministers have appropriate powers in decisions over how local services are configured and that changes which improve quality and safety are not inappropriately blocked.

"There is no suggestion here that a publicly funded service like the NHS should not be held to account. Rather, that the strategic direction is the domain of politicians, who should then allow NHS leaders in operational and clinical roles - with day to day responsibility for supporting patient care - the space to deliver those strategic objectives without undue political pressure or interference.

"The new integrated care systems (ICSs) should develop to meet local needs, rather than being pushed into a one-size-fits-all approach.

"We are continuing to argue for a careful balance in how new potential controls on capital spending may be applied to foundation trusts in local systems.

"And it's vital that the legislation addresses the lack of a transparent, costed and funded long term workforce plan.

"We urge the government to continue to listen to the NHS frontline in shaping its proposals."

Trust Board 27 July 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:	Interim Chief Executive 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 partnership 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.
Executive summary:	**SYB ICS Update** **1. Coronavirus (COVID-19) Position** Like other parts of the country, South Yorkshire and Bassetlaw (SYB) is seeing a similar rapid increase in rates of Covid. This is linked to the increases in social mobility (back to pre-pandemic levels) and the Delta variant, now dominant throughout England. Cases of Covid are doubling in SYB, on average every seven days, which is a strong indication of how quickly infections are rising. The spread is largest among unvaccinated groups with the 20-24s and under 20s attributing to the latest surge in cases. In terms of vaccination progress, SYB is performing well and targeting new eligible age groups and improving access for greater numbers of our population. As of 6th June, 96% of cohorts 1-4 have had their first dose and 89.9% have had their second dose. For cohorts 5-9 this is 92% for the first dose and 87.1% for the second. In cohort 10, the first dose is 85.6% and second dose is 69.4%. For cohorts 11 and 12 (30 to 39-year-olds and 18 to 24-year-olds), the first dose drops to 68.5% and 24.2% for the second dose. This is not surprising given the vaccination offer has only recently been available to

cohort 12 and there is a minimum eight-week gap between doses.

2. QUIT Programme

The QUIT Programme, which has the potential to save up to 2,000 lives and 4,000 hospital re-admissions a year, has launched across SYB.

This ground-breaking stop smoking programme is being delivered by SYB ICS in partnership with Yorkshire Cancer Research, five local authorities and local Stop Smoking Services.

Based on evidence from successful smaller schemes in Ottawa and in Greater Manchester, QUIT is the largest project of its kind in the world and will transform the way smoking is tackled by the NHS in the region. Rather than seeing smoking as a lifestyle choice, hospital staff across the eight NHS Trusts in SYB now recognise it as tobacco addiction – a medical condition they have a responsibility to treat as part of patients' routine hospital care.

3. Health & Care Compact

Partners in the SYB ICS have developed a draft Health & Care Compact, Health & Care Partnership and Development Matrix. The Compact and Terms of Reference aim to enshrine the collaboration and principles of working together during the transition year of 2021-22. Whilst the Compact is not a legally binding document, it is intended to be a 'golden thread' and which, through members' engagement, partners can hold each other to account. The Place Development Matrix is a tool to support development across provider collaboratives and place-based partnerships and will continue to evolve through testing and self-assessment. These have been used to shape the place response to the white paper in Barnsley.

4. ICS Development Plan

Planning continues to take place regarding the development of the ICS with focus on readiness for becoming a statutory entity in April 2022. A development plan has been generated. Further guidance and policy are expected as the year progresses.

The first phase of work confirmed the key building blocks in the system of neighbourhoods, places, provider collaboratives and system and how the nature of commissioning will change and how this underpins the work.

The next stage of work focuses on a number of critical themes which will require working through, to ensure the statutory ICS operating model is successful including; a) ensuring the right functions and activities take place at the right level in the system, be that neighbourhoods and communities, whole place

populations or across the whole of SYB; b) incorporating clinical and professional leadership at all levels and across all activities, including transition of clinical and professional leadership; c) establishing clear and appropriate mechanisms for resource allocation, which builds on existing place-based pooled budgets and support development of provider collaboratives; and d) further developing proposals for governance including the ICS NHS Board and ICS NHS leadership arrangements, which supports the connections between neighbourhood, place and SYB working, which is building on the current proposals for the ICS Health and Care Compact and ICS Health and Care Partnership; e) setting out System Oversight arrangements in a Memorandum of Understanding (MoU).

Work continues on the development of provider collaboratives. A panel on the 13th August 2021 will discuss clinical model, commissioning intentions for each collaborative, operation of the hub, governance arrangements, progress on partnership agreement and risk share arrangements.

5. Children & Young People Transformation Programme

NHS England and Improvement (NHSEI) have asked each Integrated Care System (ICS) to develop a Children and Young People's Transformation Programme to improve health outcomes and reduce health inequalities for all those aged between 0 and 25. The programme was based on the commitment made in the NHS Long Term Plan, paused due to Covid-19, and restarted at the beginning of 2021. Within SYB it has been agreed to establish a children's and young people's (CYP) alliance to drive this transformation with two representatives from each locality. The Trust will work with partners in Barnsley to agree nominations for this alliance.

6. Service Delivery

There is sustained and exacerbated pressure across Child and Adolescent Mental Health Services (CAMHS), both across SYB and nationally, with a recognised national shortage of specialist Tier 4 placements.

A number of streams of work are now underway, at a national, regional and system level, to both develop both a strategic and tactical response.

An SYB task and finish group has been established led by Ruth Brown (Interim CEO, Sheffield Health & Social Care NHS Foundation Trust), with the objective of understanding the local challenge and potential actions to help support risk mitigation. Early work has focused on:

- capturing available capacity in SYB (both NHS and the Independent Sector)
- determining occupancy, waiting numbers and patient in-flows

	• establishing an operational group to track cases across SYB and support mitigation.
	7.Mental Health, Learning Disability and Autism Alliance
	Chief Executives from across the Alliance have continued to meet to oversee the progress of the provider collaboratives and agree approach to modelling mental health need as well as ensure the mental health, learning disability and autism priorities are being progressed through the programme board. Regular updates on the specific programmes that we are involved in are provided to Trust Board.
	8.Barnsley Integrated Care Partnership and Developments
	The Trust continues to work with partners to deliver the shared priorities in relation to Covid-19 response, vaccination programme, recovery and reset in addition to establishing our place response to the white paper through the development of shared governance arrangements.
	Partners through the Integrated Care Delivery group have continued to refresh the Barnsley health and care plan and priorities that were agreed at the June meeting.
	Discussions to develop deeper integration and provider collaboration have continued with partners.
	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.** • **Note the Barnsley Partnership update.**
Private session:	Not applicable.

Trust Board 27 July 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 and response to the national white paper. 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 June Trust Board.
Executive summary:	The Trust's strategy outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). The Trust has continued to work as a member of the partnership. **WYH 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. **WY&H Partnership response to the white paper** Work continues to develop the partnership governance arrangements in line with the establishment of the ICS as a statutory body from 1 April 2022. **Tackling health inequalities and achieving a diverse leadership and workforce**

Trust Board: 27 July 2021
West Yorkshire and Harrogate Health and Care Partnership
and Local Integrated Care Partnerships update

With **all of us** in mind.

	Progress continues to be made to address the recommendations set out in the review that was independently chaired by Professor Dame Donna Kinnair (DBE), including the co-production of an anti-racist campaign and social movement in collaboration with the violence reduction unit. The campaign will be launched in August and the Trust is a key partner and has signed up to the campaign. **Mental Health, Learning Disabilities and Autism Collaborative** An overview of key work streams and developments being progressed collaboratively are included in the paper. **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, develop plans to respond to system pressures and place-based governance to respond to the white paper. **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 July 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. WYH Covid-19 Response and Operational Priorities and System Pressures

The national Covid-19 infection rates continue to rise and the case rates remain higher in Yorkshire and the Humber. West Yorkshire organisations, including the NHS Trusts, are encouraging people to continue following existing Covid-19 guidance to help protect themselves and others; this includes continuing to wear masks in crowded indoor spaces, on public transport, in health and care settings and in other areas where it would help people feel safer or more comfortable. The bi-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 continued despite significant increased need and demand across all systems and places.

System pressures have continued across the region in all places and sectors. A&E departments across the region have seen significant increase in attendances driven by children and young adults (20-29). Partners across each of the places are working together to develop plans to respond to system pressures and increased need. The WYH strategic health coordination group has been re-established and the WYAAT gold command and escalation framework has been re-instated.

3. WY&H Partnership response to the white paper

Work has continued to develop the partnership governance and operating arrangements in line with the establishment of the ICS as a statutory body from 1 April 2022. The future governance arrangements and operating model are being developed and overseen through an established Design and Transition Group and Chairs and Leaders Reference Group and reported through the Partnership Group. **The Trust has continued to work with partners in each of its places to support the development of place-based arrangements in response to the white paper and the CEO and Chair are part of the oversight groups.**

4. Tackling health inequalities and achieving a diverse leadership and workforce

Progress continues to be made to address the recommendations set out in the review that was independently chaired by Professor Dame Donna Kinnair (DBE), including the formal launch of the anti-racism campaign and social movement in collaboration with the violence reduction unit. A workshop facilitated by the Partnership and Kings Fund on health inequalities was held in July. **The Trust is a key partner and formally signed up to the anti- racism campaign.   The ICS CEO, Rob Webster, wrote to all staff across the partnership following the England football match that resulted in several members of the national football team being subjected to racism.   The Trust's Interim CEO and Chair have also formally written a statement that has been shared publicly emphasising the Trust's commitment as an anti-racism organisation.**

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With **all of us** in mind.

5. Measuring delivery of our 10 Big Ambitions

Work has continued to develop supporting measures for the partnerships ten big ambitions set out in the strategy. A mixed approach including the use of hard data, which will allow the partnership to track numerical progress over time and key process measures which will make the biggest difference in delivering the objectives, will be used. **Key measures that the Trust is contributing to as part of the work that we do with partners in each of our places is being reviewed and considered as part of the ICS performance updates in our Integrated Performance Report.**

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

The Trust Board was appraised at the June meeting on the work that the 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 since the June meeting include:

West Yorkshire Adult Secure Lead Provider Collaborative:

The Collaborative 'go live' position has been confirmed with NHS England as 1 October 2021 at the earliest, subject to a satisfactory outcome of the financial offer discussions.

Further discussions have taken place with colleagues at Leeds and York Partnership NHS Trust (LYPFT) regarding the commissioning capacity requirements for West Yorkshire Collaboratives in the short term to achieve 'go live' and the requirements as we move towards a West Yorkshire Commissioning 'hub'. Interim capacity arrangements will be taken forward for the Adult Secure PC to ensure that the significant volume of work can be undertaken.

The Medical Clinical Lead, Dr Berry, has tendered his resignation with effect from 23 September 2021 as last working day. Options for interim and permanent arrangements to fill this role are being progressed urgently.

The Head of Commissioning for the West Yorkshire Provider Collaboratives has confirmed their intention not to continue in the role past September 2021. Recruitment to this role going forward will be progressed with LYPFT.

WY Mental Health, Learning Disabilities and Autism (MHLDA) Programme:

The July meeting of the WY MHLDA programme board covered a wide-ranging agenda.
There were presentations and papers on the progress of work programmes including: PICU programme; Development of a West Yorkshire children and young people Mental Health Plan by October 2021; Functions mapping work currently being undertaken; the launch of 'Night Owls', the overnight listening and advice service for children and young people, provided by Leeds survivor-led crisis service and the launch of the perinatal mental health campaign.

7. 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 as well as develop our place approach and response to the white paper.

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. A Transition Development Group has been established to develop the approach and governance arrangements that will be formally report to the emerging Integrated Care Partnership Board that is made up of health and care leaders including VCS partners.

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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 June Trust Board meeting on the work of the ICP.

The detailed workstreams on the next phase of the development of the ICP continue. Like other districts, the pressure on urgent care services has been significant, with attendances through Pinderfields Emergency Department being 898 on 14 July (as an example), with pre-Covid attendances for this time of year being approximately 750 or less on a single day. A significant increase in attendances is being experienced in the 0 – 9 years age cohort.   Multi-agency command arrangements have been reconvened in the light of the increase in service pressures.

Kirklees

The Kirklees Integrated Health and Care Leadership Board continues to meet monthly.   The most recent meeting took place on 1 July 2021.   The meeting focused on principles and issues that will be involved in the future when joint decisions on service investment/change are required.

The Kirklees ICP Design Team continues to meet frequently, with the establishment of several workstreams on which the Trust is represented.

Like other districts, due to increasing service pressures, particularly on the urgent care services, the multi-agency command arrangements have been reconvened.

Recommendations

- **Trust Board is asked to receive and note the update on the development of Integrated Care Systems and collaborations:**

    o **West Yorkshire and Harrogate Health and Care Partnership**
    o **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

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West Yorkshire and Harrogate Health and Care Partnership
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Agenda item 9.4 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Next meeting scheduled for 7 Oct 2021
Member	Chief Executive / Director of Strategy
Items discussed	
Minutes	Papers and draft minutes (when available): https://barnsleymbc.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=143

Calderdale Health and Wellbeing Board

Date	Next meeting scheduled for 12 August 2021
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	
Minutes	Papers and draft minutes are available at: Cald HWBB 08.07.21.docx 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	Next meeting scheduled for 30 September 2021
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	Next meeting scheduled for 15 July 2021
Member	Chief Executive / Director of Provider Development
Items discussed	• Focussed discussion – What we have learnt from Covid opportunities and challenges • Health and Wellbeing Board outcomes
Minutes	Papers and draft minutes are available at: Receipt of minutes of partnership board http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	Next meeting scheduled for 27 July 2021
Member	Director of Human Resources, Organisational Development and Estates / Director of Strategy
Items discussed	SYB ICS Update 1. Coronavirus (COVID-19) Position 2. QUIT Programme 3. Health & Care Compact 4. ICS Development Plan 5. Children & Young People Transformation Programme 6. Service Delivery 7. Mental Health, Learning Disability and Autism Alliance 8. Barnsley Integrated Care Partnership and Developments
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	Next meeting scheduled for 7 September 2021
Member	Chief Executive
Items discussed	
Further information:	Further information about the work of the Partnership Board is available at: https://www.wyhpartnership.co.uk/meetings/partnershipboard

Trust Board 27ᵗʰ July 2021
Agenda item

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 June 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 June is in line with developments agreed by the Trust Board, including a recently introduced section on monitoring progress against our strategic objectives. **Quality** - The majority of quality metrics continue to be maintained during the pandemic - The number of under 18 admissions to adult wards has continued and remains of concern - Staffing pressures remain present as acuity and demand rises - IPC training figures remain strong - Supervision levels decline is under review for appropriate action - Rising prevalence of covid-19 impacting on staffing, one positive case just identified in inpatients after long spell of zero cases. - There were 11 information governance breaches reported in June **NHSI Indicators** - Performance against national reported targets remains largely positive 3 young people under the age of 18 were on an adult ward in June, a total of 40 days, a deteriorating position - Inappropriate out of area bed usage decreased from May to 177 days **Locality** - Heightened levels of acuity are being experienced across many service lines, particularly ward-based - Staffing levels remain under constant review, with increased challenges associated with staff absence

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- ASD/ADHD services have seen a significant increase in referrals for assessment
- Works continues on the development of the regional (West Yorkshire and Barnsley) Assessment and Treatment Unit service for learning disabilities. New contractual arrangements will take effect from 1st October 2021.
- Waiting numbers for CAMHS neuro-developmental diagnostic assessment in Calderdale and Kirklees have significantly increased. Business cases have now been approved in Calderdale and Kirklees to support addressing waits and are moving to implementation.
- CAMHS referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield.
- A First Contact Physiotherapy (FCP) Service has commenced from our Musculo Skeletal Service (MSK) in Barnsley working with the Primary Care Network in GP practices

Priority Programmes

- Recruitment has progressed across the Community Mental Health Transformation programme, with the Project Manager post in place in Barnsley and due to commence in Wakefield.
- Work continues on the Adult Secure Lead Provider Collaborative with revised 'go live' date of 1st October 2021
- Work is underway in each place to review and further develop integrated care partnership arrangements in line with potential implications of NHSE/I proposals
- Progress continues to be made to address recommendations set out in the review independently chaired by Professor Dame Donna Kinnair (DBE) including co-production of an anti-racism campaign
- A work plan has been developed for 'Great Place to Work' themes

Finance

- A £0.4m surplus was recorded in the month, taking the cumulative position to a surplus of £1.7m. This is £1.7m favourable to our break-even plan.
- Income was lower than plan due to timing of the mental health investment standard income
- Pay costs were £1.3m lower than plan, partly due to recruitment to mental health investment standard and also due to a reduction in substantive and bank staff employed in June In total pay costs of £16.6m were in line with those incurred in April and May.
- Agency staffing costs increased by £0.2m in the month to £0.8m.
- £0.1m of costs were identified as being reasonably incurred as part of the Covid-19 response, mainly as a result of staffing requirements.

	- Out of area bed costs were £199k, which is a reduction compared to May. The number of bed days increased, but a high-cost placement ended during the month. Demand for beds remains high. - There also continues to be high spend on locked rehab placements in Barnsley (£0.3m) - The forecast for the first half of the year has been updated to a surplus of £2.3m - Capital expenditure of £0.6m, has been recorded to date. Further work is taking place on the costs and value for money associated with the proposed programme to provide en-suite facilities in the Bretton Centre - The cash balance remains positive at £60.8m **Workforce** - Non Covid- 19 sickness has stayed at 4.3% in June - Staff turnover decreased slightly to 13.1% in the month - As of July 22nd, there were 95 staff off work and not working Covid-19 related - Clinical supervision reduced to 74% in the quarter. This is being reviewed in more detail **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 - Lateral flow testing for staff continues - The Trust Opel level remains at 2 although some services are operating at a higher level e.g. inpatients - National guidance continues to be monitored, reviewed and adopted - A range of staff wellbeing support offers continue to be available and used - The Trust is responding to the recent increase in prevalence of the pandemic and operational pressures by engaging in system and place-based command meetings and is regularly assessing its own command arrangements
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

**Integrated Performance Report
Strategic Overview**

June 2021

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for June 2021. The development of the IPR will continue to evolve in the coming months following the discussion on targets and risks at the May Strategy Board session.

The majority 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 June month-end data. This will ensure that Trust Board can have a discussion on the most current position available as opposed to the position four weeks earlier. Given the fact different staff provide different sections of the report there may be some references to data from slightly different dates.

It is worth reminding the reader of the report of the Trust's four strategic objectives against which our performance metrics are designed to measure progress. These are:
• Improving health
• Improving care
• Improving resources
• Making SWYPFT a great place to work

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• Executive summary
• Covid-19 response
• Emergency Preparedness, Resilience and Response (EPRR)
• Quality
• National metrics
• Priority programmes
• Finance & contracting
• Workforce

It is likely additional metrics will be included at some stage of the year 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. The Trust is also keen to include data related to the West Yorkshire and Harrogate and South Yorkshire and Bassetlaw Partnerships – this is likely to be an iterative process as work is underway within the ICSs to determine how performance against their key objectives will be assessed and reported. Following an internal review of the IPR we are currently looking at which metrics could benefit from the addition of an SPC chart. We are waiting for sufficient data to implement these. 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 updates will be provided in future reports.

Improving health

Priority programme	Metrics	Threshold	Apr-21	May-21	Jun-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		3	1	3			
	2.Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks) *	55%	Q4 - 74.6% Q1 due August 2021					A weighted average is used given there are different targets in different places
	3.Proportion of people from BAME communities accessing IAPT		15.8%	13.9%	14.1%			BAME population 13%
Improve outcomes through our wellbeing services, physical health and services for people with mental health illnesses and learning disabilities	1a. Cardio metabolic assessment & treatment - Inpatient	80% screened 80% compliant	**93% screened 80% compliant	**74% screened 54% compliant	**80% screened 71% compliant			For current inpatients (as at 22nd July) 80% of applicable patients have been screened using the cardio metabolic screening tool and of those 71% have been screened across all 9 domains.
	1b. Cardio metabolic assessment & treatment - Community (Early Intervention services)	70% screened 70% compliant	**64% screened 51% compliant	**57% screened 37% compliant	**55% screened 41% compliant			For current patients (as at 22nd July) within early intervention services, 55% of applicable patients on caseload have been screened using the cardio metabolic assessment tool. Of those, 41% have been screened across all 9 domains, with alcohol and diabetes being two domains where screening and appropriate actions are not being undertaken. This in part can be related to the availability of blood tests and results within the community setting.
	2. IAPT - proportion of people completing treatment who move to recovery	50%	57.0%	55.6%	53.3%			June data is provisional and will be refreshed in August 2021
	3. % service users on CPA followed up within 7 days of discharge	95%	93/96 =96.8%	82/83 =98.8%	103/105 =98.1%			
	4. % of service users on CPA with a 12 month follow up recorded	95%	96.8%	95.1%	95.6%			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%	92.3%	87.5%	93.1%			Q1 total is 91.5%
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						Work taking place to define suitable metric

Notes:
* - quarterly data.
** - This metric identifies the number of current service users on CPA who have a diagnosis of psychosis that have been screened using the cardio metabolic assessment tool and the number of those screened that have all 9 elements of the tool recorded with appropriate action (smoking, diet, exercise, alcohol, substance misuse, weight, blood pressure, diabetes, cholesterol).

Glossary

BAME	Black, Asian and Minority Ethnic
IAPT	Improving access to psychological therapies
CPA	Care programme approach

Below we have set out progress against key milestones for areas of focus for those priority programmes that has taken place throughout June and progress towards milestones set for the next three months/Q2. 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.

Implementation deliverables

🟢	On Target to deliver within agreed timescales
🟡	On Trajectory but concerns on ability/confident to deliver within agreed timescales
🟠	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales
🔴	Action will not be delivered within agreed timescales
🔵	Action Complete

Improve health (Salma Yasmeen and Sean Rayner)

Key Milestones		Comments:
1. Creativity & Health: To develop a series of three regional/national public panel discussions/ Q&As bringing together the leaders from the Calderdale system with the National Centre for Creative Health, Culture Health and Wellbeing Alliance and representatives from Arts Council England by end July 2021.	🟩	**ICS and Partnership developments:** • An aggregated West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) level version of the operational and financial plan 21/22 was submitted to NHSE/I in June 2021. • Work is underway to develop the partnership governance arrangements and strategies in each Place and within the West Yorkshire Mental Health Learning Disability and Autism (WY MHLDA) Collaborative, in line with the establishment of the ICS as a statutory body from 1 April 2022.
2. Creativity & Health: Development of a Creativity & Health digital app with first stage research and development and proof of concept completed by end September 21. Three creativity courses produced by end of September 21 and testing and evaluation completed by end Nov 2021.	🟩	• Progress continues to be made to address the recommendations set out in the review that was independently chaired by Professor Dame Donna Kinnair (DBE), including the co-production of an anti-racist campaign and social movement in collaboration with the violence reduction unit. The campaign will be launched in August.
3. Creativity & Health: Partnership working with the National Centre Creativity & Health to map and analyse health sector investment in creative projects to inform sustainability plan by end Nov 2021.	🟩	• We continue to work with partners to develop and deliver joined-up Covid-19 response and vaccination programme in each of the places that we provide services. We have seen the national Covid-19 infection rates continue to rise and the case rates remain higher in Yorkshire and the Humber. The weekly system briefing meetings have continued and provide up to date information on partnership priorities and Covid-19 response plans.
4. Active Calderdale: integrating physical activity into systems and processes: develop and pilot a motivational interviewing learning and development programme for professionals with a physical activity focus by end August 2021.	🟩	• We also continue to contribute to place-based recovery and reset planning and place-based governance to respond to the white paper.
5. Active Calderdale: to hold a partnership event showcasing the work across SWYPFT in integrating physical activity into systems and processes by end October 2021.	🟩	**Community mental health transformation:** The project manager for Barnsley is already in post and Wakefield project manager will commence shortly. All project managers will be hosted by SWYPFT except in Kirklees, which will be CCG hosted.
6. Forensic Lead provider collaborative: Following discussions with NHS England the full year funding for the adult secure lead provider collaborative is not yet confirmed. As such the go-live has been deferred until October 1st 2021.	🟨	
7. Community mental health transformation: Recruitment into project/programme lead posts has now taken place and programme leads expected to be in post by August (Barnsley already in post and Wakefield project manager will commence shortly.). All programme leads will be hosted by SWYPFT except in Kirklees, which will be CCG hosted.	🟩	

Improve Care

Priority programme	Metrics	Threshold	Apr-21	May-21	Jun-21	Trend	Year end forecast	Notes
Continually improve patient safety	1. Incidents involving moderate or severe harm or death	Trend monitor	39	28	35			
	2. Number of c-diff avoidable cases	0	0	0	0			
	3. Number of pressure ulcers	Trend monitor	41	43	37			With regard to the recent reported increase in pressure ulcers, tissue viability nurses are providing additional training around Waterlow risk assessments and wound care management with the neighbourhood nursing teams. This is combined face to face/virtual, and they are also offering shadowing experience if required and where appropriate with the current Covid-19 restrictions. Each of the teams have set their own action plans around wound care management. Further focused work is being planned where necessary with individual teams.
	4. Safer staffing fill rates (%)	90%	118.9%	119.8%	118.5%			
	5. Number of children & young people in adult wards	0	3	3	3			Total of 40 days in June, which is a deteriorating position
	6. Staff absence due to Covid-19		0	0	0			No of staff still absent from work - Covid-19 positive
	7. Number of nosocomial incidences of Covid-19 in our inpatient units		139	139	140			Cumulative
Provide care as close to home as possible	1.Out of area bed placements (days)		122	204	177			Continued pressure and demand with the number of placements minimised. Targets being updated in light of the impact of the pandemic.
Deliver improvements particularly in CAMHS and forensic services	1.Numbers waiting over 4 weeks for assessment (CAMHS)		155	182	169			Some elements of the service seeing an increase in referrals and increase in numbers waiting as result of the additional demand
	2.Numbers waiting over 18 weeks for treatment (CAMHS)		140	128	139			
	3. Friends & Family test - CAMHS	80%	65.9%	69.1%	71.0%			69 responses in June
	4. Forensics staff sickness	<=5.4%	4.4%	4.3%	5.2%			
	5. Forensics staff turnover		Reporting commenced June 2021		13.2%			Registered nurses turnover
	6. Race related incidents in forensics		5	10	9			There were a total of 46 race related incidents against staff reported from 1 November 20 to 31 May 21, occurring in Forensic BDU. Of these incidents, 45 were patient against staff and 1 was other against staff.
Safely deliver and restore inclusive services locking in innovation	1a. Waiting lists - Referral to assessment within 2 weeks (external referrals)	75%	95.5%	94.6%	93.4%			This mostly relates to SPA, Core, Enhanced and other general community mental health services
	1b. Waiting lists - Assessment to treatment within 6 weeks (external referrals)	70%	92.5%	98.7%	94.6%			This mostly relates to SPA, Core, Enhanced and other general community mental health services
	1c. Waiting lists - Referral to assessment within 4 hours (external referrals)	90%	93.8%	93.2%	93.4%			This mostly relates to IHBT and liaison services
	2a. Average contacts per day - Core mental health		263	238	254			Pre Covid-19 - 240 (October 2019 which is representative of the following 6 months)
	2b. Average contacts per day - intensive home based treatment team		117	121	136			Pre Covid-19 - 154 (October 2019 which is representative of the following 6 months)
	2c. Average contacts per day - Learning disability community		155	174	162			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		592	575	585			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 August 21.

Glossary

CAMHS	Child and adolescent mental heatlh services
SPA	Single point of access
IHBT	Intensive home based treatment team
PICU	Psychiatric intensive care unit
CCG	Clinical commissioning group

NHS South West Yorkshire Partnership NHS Foundation Trust

Improve care (Carol Harris)

Key Milestones		Comments:
1. Recovery and stabilisation: identify and establish recovery workstreams with resources, work plans, structure, and governance in place to complete recovery activity for period May – September 2021.	🟩	**Recovery and stabilisation** • Enabling Working Effectively – Terms of reference and set of principles have been agreed. The programme of work is currently in the initiation phase and a case for change is being developed. Messages have been communicated to provide assurance that guidance remains as "work from home unless there is a clinical/business need". In development is a toolkit to support staff, and managers of staff, to safely return to/work from Trust or partner locations in readiness for when an NHS/organisational decision is made that it is the right time to do so. A set of classifications, to help staff and their managers identify their ways of working, is in development. The space governance framework is being refreshed and work has commenced on devising a coordinated staged approach to space utilisation (aligned to operational recovery and reset group work programme). A potential booking system has been identified and a trial of the system is being planned. Work has commenced on identifying services to test and evaluate the principles and models of ways of working and make recommendations for improvements to the group. • Operational Recovery and Reset - Work has commenced using intelligence and insight to identify the current blend and future blend, including setting of benchmark proxy measures, of face to face and non-face to face contact methods used in each mental health, learning disability and general community service. The support toolkit for recovery and reset of clinical services is being refreshed to aid services as they progress on the journey to achieving the 'to be position'. **Older People Inpatient Services Transformation** Following changes and improvements to our community systems, the recent focus of the Trust-wide transformation has been on the inpatient model. Over the Spring and Summer months, pre-consultation conversations have been taken forward with a range of partners and we are confident that we are now moving closer to a formal consultation on proposals. The scope of the work is specifically considering the case for separation of functional and organic wards and delivery of a more specialist inpatient service, to which there is wide agreement that there is a strong clinical case for. The current proposals and conversations taking place relate to the short to medium term solutions to resolve the clinical challenges of having mixed needs wards. Conversations with partners so far, including GP leads, have been positive and have supported us progressing work toward consultation and formal dialogue about the model. We are working with a small team of CCG engagement leads to develop the plan for this consultation process. We are also liaising with NHSE who are going to support us and help us navigate through the NHSEI service change assurance process as well as support an objective clinical review of the proposals. Work is now progressing towards the delivery of the outline business case for the proposals and the formal consultation. Various strands of information will be refreshed as part of this. **CAMHS** • Negotiations of the resourcing for sustainable CAMHS neuro waiting list resources are now progressing well. Securing estate and recruiting into the new service are the next priorities. **Improve Services for people acutely unwell and improve ward environment:** A high-level plan for activity across the wards already exists and activity is happening against the plan. Work is now being taken forward to map and agree the key priority activity across this programme and set up governance to oversee that activity. This work is being taken forward through July and further milestones will be established when the key priorities are agreed.
2. Recovery and stabilisation: Operational recovery and reset: Undertake 'as is' stocktake of current contact methods used and set 'proxy' measures for the future 'to be' state by September 2021.	🟩	
3. Recovery and stabilisation: Operational recovery and reset: Gather evidence to shape quality measurements and evaluation by November 2021.	🟩	
4. Recovery and stabilisation: Enabling Working Effectively: Case for change developed and approved by August 2021.	🟩	
5. Recovery and stabilisation: Enabling Working Effectively: Ways of working tested and agreed by October 2021.	🟩	
6. Recovery and stabilisation: Enabling Working Effectively: Room and desk booking system tested and procured by September 2021	🟩	
7. Care close to home: Gatekeeping analysis commence by end Apr and be taken forward through May and has now been completed. Plan to prioritise learning actions to be taken to the July steering group meeting for consideration.	🟩	
8. Care close to home: PICU dashboard live (Jul 2021)	🟩	
9. Care close to home: PICU standard operating procedure agreed and launched (end July / early August 2021)	🟩	
10. Improve Services for people acutely unwell and improve ward environment: scope and priority projects to be agreed (July - August 2021)	🟩	
11. Improve Services for people acutely unwell and improve ward environment: initial governance set up (July - August 2021).	🟩	
12. Older People Inpatient Services Transformation: Share draft consultation plan and collateral with the CCG and NHSE for comment and assurance – July 2021	🟩	
13. Older People Inpatient Services Transformation: Start the conversations with and share the consultation plan and collateral with the Overview and Scrutiny Committee. July – August 2021	🟩	
14. Older People Inpatient Services Transformation: Finalise the outline business case for change, considering resources required, the impact on travel and mitigations, and the equality impact assessment. Agree the business case through appropriate governance structures. (start Q2 2021, complete early Q3)	🟩	
15. Older People Inpatient Services Transformation: Develop collateral required to deliver formal consultation (start Autumn 2021, exact timing TBC)	🟩	
16. CAMHS improvement - Neuro waiting lists (Calderdale and Kirklees): Good progress on agreeing funding. Calderdale recurrent and non-recurrent funding now confirmed. Funding is available to deliver a sustainable service in Kirklees but some detail, including estates, still needs consideration. Due for completion now by end July 2021.	🟨	

Improve resources

Priority programme	Metrics	Threshold	Apr-21	May-21	Jun-21	Trend	Year end	Notes
Spend money wisely and reduce waste	1. Surplus/(deficit) vs target	In line with Plan	£636k	£675k	£426k		£2.3m	H1 forecast is favourable to plan.
	2. Underlying surplus/(deficit)							Not currently calculated due to interim financial arrangements
	3. Cash		£61.3m	£60.3m	£60.8m		£54.2m	Positive cash position
	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'		3.6%	3.7%	4.2%			
	2a. Percentage of video consultations		3.0%	3.1%	2.8%			Slightly lower than national averages
	2b. Percentage of telephone consultations		37.1%	36.8%	35.5%			
	2c. Percentage of face to face consultations		59.9%	60.1%	61.6%			
	3. Prescribing errors (EPMA) (development required)		Reporting to commence August 2021					Reporting to commence in August 2021 for medicine omissions as a proportion of doses due.

Improve resources (Mark Brooks)

Key Milestones		Comments:
1. Digital dictation: Development and approval of business case and specification for procurement of single supplier by 30.06.21 and completion of digital dictation tender and identification of preferred supplier by 30.09.21.	🟩	**Digital dictation:** Business case seeking approval to go out to tender has been prepared and will be submitted to EMT during July 2021. Trust Email platform accreditation (NHS Digital dependencies): Remains on track but timescales are dependent upon NHS Digital dependencies.
2. Trust Email platform accreditation (NHS Digital dependencies): Email accreditation penetration test completion June 2021, communications plan and review panel June/July2021 and accreditation achieved – July/August 2021.	🟩	**IT Services re-procurement:** Trust authority to proceed approved, detailed specification of requirements in development.
3. Microsoft Licencing annual review: licencing review - May/June 2021 completed.	🟦	**Information Sharing:** Development proposal for onboarding Viper360 portal to YHCR approved and work underway. Work ongoing to support the establishment of a minimum viable product (MVP) for a Barnsley Shared Care Record by 30 September 2021 – potentially utilising Viper360 together with existing capabilities available within SystmOne and ICE (results reporting) as used by partners across the place.
4. IT Services re-procurement: approach planning prior to procurement – Q1/Q2.	🟩	
5. Cyber Security: Annual Survey/Phishing Survey and evaluation of findings – Q2 and implementation of action plan – Q3	🟩	**Digital Inclusion:** Dr Abida Abbas, Trust CCIO developing proposal for digital inclusion survey for service users and to also establish mechanisms for collecting service user digital inclusion/preferences at relevant points of contact to be recorded in SystmOne.
6. Digital capital programme 21/22: detailed programme planning and mobilisation of planned expenditure. A review of HY1 underway and forecast for HY2.	🟩	**Mental Health Investment:** Confirmed for Barnsley, Kirklees and Wakefield. Awaiting governing body approval from Calderdale.
7. Electronic care records: Breathe Service SystmOne deployment – 1 July 2021. Service went live on 1 July 2021 as planned.	🟦	
8. Information Sharing: Yorkshire & Humber Care Record onboarding (utilising Trust clinical portal) – Q1/Q2.	🟩	
9. Business Intelligence & Performance Reporting • Development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available – ongoing • In support of Covid-19, Health inequalities reporting is established, and the outputs being further developed via Business Intelligence solution – June 2021 (ongoing) • Development work taking place for additional CQUIN metrics to support community schemes – schemes on hold and expected to take effect from Q3 21/22	🟩	
10. Digital Inclusion: Technical Feasibility (in collaboration with WY&H ICS).	🟩	
11. Finance: Confirmation of mental health investment standard (MHIS) monies and other investments by 30.06.21	🟩	
12. Financial Sustainability Plan: 3 year financial sustainability plan by 31.12.21 with review of previous financial sustainability plan scheduled to be completed by 31.08.21	🟩	

Make SWYPFT a great place to work

Priority programme	Metrics	Threshold	Apr-21	May-21	Jun-21	Trend	Year end forecast	Notes
Support the provision of a healthy, resilient & safe workforce	1. Sickness absence	4.5%	4.0%	4.3%	4.3%			Non Covid-19 sickness lower than previous years
	2. Staff turnover	10%	15.6%	14.7%	13.1%			Slight decrease in staff turnover in June.
	3a. Clinical supervision	>=80%	74.4%					Reduced performance reported this quarter
	3b. Appraisal	>=95%	Data currently unavailable					Suspended due to Covid-19
	4. Incidents of violence and aggression against staff	Trend monitor	58	67	54			
	5a. Staff survey - % staff recommending the Trust as a place to receive care and treatment	80%	Most recent survey - 71.8%					Increased from 65.6% in 2019
	5b. Staff survey - % staff recommending the Trust as a place to work	65%	Most recent survey - 69.0%					Increased from 61.5% in 2019
	6. Cases of bullying & harassment		2	1	0			Alternative metric being considered
	7. Absence due to stress & anxiety and MSK		2.3%	2.6%	2.3%			
	8. Relative likelihood of appointment to roles band 5 and above for people from BAME backgrounds		1.16	1.29	1.34			Based on rolling 12 months. The indicator is calculated using a count of shortlisted applicants split by white / BAME, then looks at the number appointed split by white / BAME, this then gives the relative likelihood of shortlisting/appointed and the difference between the two calculates the rate. A figure below "1" would indicate that BAME candidates are more likely than white candidates to be appointed from shortlisting.
	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.

Glossary

MSK	Musculoskeletal
GPTW	Great place to work

Make this a great place to work (Alan Davis)

Key Milestones		Comments:
1. Performance Indicators established for great place to work themes by September 2021	🟩	**Great Place to Work Themes:**
2. Feeling Safe (Physical and Psychological Safety): Preventing bullying and harassment - Appointment of Civility and Respect Champions Q2 21/22 – training commenced and likely to be in place ahead of schedule. - Redesigned Bullying and Harassment Policy Q2 21/22 - Panel to Review all Race related Bullying and Harassment Q2	🟩 🟨 🟨	Good progress has been made in developing the work plan, scheduling key milestones and establishing performance indicators for great place to work themes that underpin the Trusts workforce strategy. We are working in partnership to review Bullying and Harassment procedure. Progress on reviewing the early resolution process has been hampered owing to covid19 pandemic restrictions. Enhanced Occupational Health offer linked to recovery and long covid - a bid has been made for additional funding and is expected to be successfully received before Sept 2021.
3. Feeling Safe (Physical and Psychological Safety): More staff - Establish New Role Clinical Role Group Q1 21/22 - Commence ethical International Recruitment for Nursing Q2 21/2	🟦 🟩	Learning needs analysis has been drafted and submitted to Operation Management Group (OMG) for comment. Window for completion of appraisals has been extended to October owing to pressures resulting from Covid19 pandemic. BAME Talent Pool has been established and work continues to develop opportunities.
4. Supportive Teams (Healthy Teams): Effective and Compassionate Leaders - Pilot 'GPTW programme' in Q1 21/22 - Start rollout of 'GPTW programme' across Trust Q2 21/22 following successful pilot with senior leaders	🟦 🟩	BAME Fellowship Programme completed for this year with a fellow shortly commencing in the Trust. **Sustainability:** Sustainability action plan is in development and includes the identification of a range of reportable areas.
5. Supportive Teams (Healthy Teams): Quality appraisal and supervision - Redesign of E Appraisal linked to initial evaluation and GPTW Q1 - Streamline appraisal process and develop link to an e-supervision Q2	🟦 🟩	Agreement has been made on producing a monthly report for staff mileage and its carbon impact. The electric vehicle chargers are now in use at Fieldhead and Kendray hospitals and also all directly procured electricity for the Trust comes from renewable sources and more specifically Yorkshire wind farms.
6. Keeping Fit and Well (Staff Wellbeing): Enhanced Occupational Health Support Enhanced Occupational Health offer linked to recovery and long covid Q1 21/22	🟨	
7. Developing Potential (Investing in the future): Supported personal and professional development plans - Personal development for all staff who have completed appraisal Q2 21/22 - Learning needs analysis linked to personal development plans Q2 21/23	🟩	
8. Developing Potential (Investing in the future): Recognising talent - BAME Talent Pool Q1 21/22 - Shadow Board Programme Q2 21/22 - BAME Fellowship Programme Q1 21/22	🟦 🟩 🟦	
9. My Voice Counts (Engaging Staff): Leaders engaging staff in change and improvement - Included in 'GPTW Programme' in Q1 21/22 - Strengthen links with quality improvement strategy	🟦	
10. Sustainability: develop Trust wide action plan	🟩	

Lead Director:
• This section has been developed to demonstrate progress being made against the Trust objectives using a range of key metrics
• More detail is included in the relevant section of the Integrated Performance Report.

Quality
• The majority of quality metrics continue to be maintained during the pandemic
• The number of under 18 admissions to adult wards has continued and remains of concern
• Staffing pressures remain present as acuity and demand rises
• IPC training figures remain strong
• Supervision levels decline is under review for appropriate action
• Rising prevalence of covid-19 impacting on staffing, one positive case just identified in inpatients after long spell of zero cases.

NHSI Indicators
• Performance against national reported targets remains largely positive
• 3 young people under the age of 18 were on an adult ward in June, a total of 40 days, a deteriorating position
• Inappropriate out of area bed usage decreased from May to 177 days

Locality
• Heightened levels of acuity are being experienced across many service lines, particularly ward-based
• Staffing levels remain under constant review, with increased challenges associated with staff absence
• ASD/ADHD services have seen a significant increase in referrals for assessment
• Works continues on the development of the regional (West Yorkshire and Barnsley) Assessment and Treatment Unit service for learning disabilities. New contractual arrangements will take effect from 1st October 2021.
• Waiting numbers for CAMHS neuro-developmental diagnostic assessment in Calderdale and Kirklees have significantly increased. Business cases have now been approved in Calderdale and Kirklees to support addressing waits and are moving to implementation.
• CAMHS referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield.
• A First Contact Physiotherapy (FCP) Service has commenced from our Musculo Skeletal Service (MSK) in Barnsley working with the Primary Care Network in GP practices

Priority Programmes
• Recruitment has progressed across the Community Mental Health Transformation programme, with the Project Manager post in place in Barnsley and due to commence in Wakefield.
• Work continues on the Adult Secure Lead Provider Collaborative with revised 'go live' date of 1st October 2021
• Work is underway in each place to review and further develop integrated care partnership arrangements in line with potential implications of NHSE/I proposals
• Progress continues to be made to address recommendations set out in the review independently chaired by Professor Dame Donna Kinnair (DBE) including co-production of an anti-racism campaign
• A work plan has been developed for 'Great Place to Work' themes

Finance
• A £0.4m surplus was recorded in the month, taking the cumulative position to a surplus of £1.7m. This is £1.7m favourable to our break-even plan.
• Income was lower than plan due to timing of the mental health investment standard income
• Pay costs were £1.3m lower than plan, partly due to recruitment to mental health investment standard and also due to a reduction in substantive and bank staff employed in June In total pay costs of £16.6m were in line with those incurred in April and May.
• Agency staffing costs increased by £0.2m in the month to £0.8m.
• £0.1m of costs were identified as being reasonably incurred as part of the Covid-19 response, mainly as a result of staffing requirements.
• Out of area bed costs were £199k, which is a reduction compared to May. The number of bed days increased, but a high-cost placement ended during the month. Demand for beds remains high.
• There also continues to be high spend on locked rehab placements in Barnsley (£0.3m)
• The forecast for the first half of the year has been updated to a surplus of £2.3m
• Capital expenditure of £0.6m, has been recorded to date. Further work is taking place on the costs and value for money associated with the proposed programme to provide en-suite facilities in the Bretton Centre
• The cash balance remains positive at £60.8m

Workforce
• Non Covid- 19 sickness has stayed at 4.3% in June
• Staff turnover decreased slightly to 13.1% in June
• As of July 23rd, there were 95 staff off work and not working Covid-19 related
• Clinical supervision reduced to 74% in the quarter. This is being reviewed in more detail

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
• Lateral flow testing for staff continues
• The Trust Opel level remains at 2 although some services are operating at a higher level e.g. inpatients
• National guidance continues to be monitored, reviewed and adopted
• A range of staff wellbeing support offers continue to be available and used
• The Trust is responding to the recent increase in prevalence of the pandemic and operational pressures by engaging in system and place-based command meetings and is regularly assessing its own command arrangements

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
• Deliveries and stock levels remain good, ensuring sufficient supply to meet staff needs
• There has been a reduction is stock levels of surgical masks over the course of the last month, but there the amount held is still in excess of two weeks, which is the national threshold

PPE Levels	Approx days stock as at 13-Apr	Approx days stock as at 11-May	Approx days stock as at 15-Jun	Approx days stock as at 13-Jul
Surgical masks	31	42	42	22
Respirator masks	109	71	101	105
Aprons	23	19	20	19
Gowns	62	88	87	88
Gloves	22	18	20	19
Visors	46	46	33	36

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	As at 18th May 2021	As at 18th June 2021	As at 14th July 2021	Notes
No of service users tested (ward)	174	225	257	278	297	300	302	302	303	Symptomatic
No of service users tested positive (ward)	60	83	94	115	134	137	139	139	140	Cumulative
No of service users recovered	60	83	94	115	119	121	123	125	125	3 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. Last outbreak was in March 2021

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. The national lateral flow system is being implemented across the NHS from August and the Trust is currently undertaking an option appraisal for a safe exit from our internal system.

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
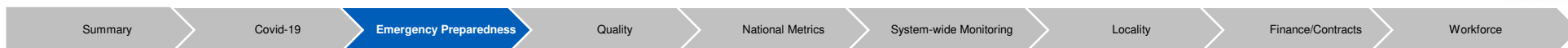
Emergency Preparedness

This section of the report identifies the Trust's repose to the Covid-19 pandemic.

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. As the prevalence of Covid-19 has increased recently the Trust has fully engaged with system command structure and other relevant meetings.
• 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
• A total of 4,520 staff have received their first vaccination (88%) and 4,024 staff have received their second vaccination (78%)
• Covid-19 vaccination programme has now closed, with staff offered vaccination routes into the national system. Report provided to EMT regarding the operation and lessons learned from the programme.
• In addition to providing vaccinations for our staff we have provided 969 first vaccinations and 894 second vaccinations for partner organisations.

Standing up services

Emergency prepardness, resilience and response (EPRR) update inc OPEL levels
• Gold, Silver and Bronze command meetings stood down, with new reporting structures for Covid-19 related issues being absorbed into the operational management group (OMG) & executive management team (EMT) to allow buisness as usual governance arrangements to manage the ongoing response and recovery. Further consideration being given to standing up the command structure given the recent increase in operational pressure caused by the pandemic.
• The Trust OPEL level remains at 2. Since the standdown of the command structure, this is now managed via weekly reports into the operational management group. Some services are operating with an OPEL level above 2.
• Attendance at regional learning events and preparation events for winter/Covid-19 2021 is underway.
• Strategic report regarding the response to Covid-19 and lessons learned being drafted.
• Consideration of planning for the flu vaccination and potential Covid-19 booster jab underway.
• Strategic debrief report written for distribution via Senior Management.
• Monitoring of staff absences ongoing following sharp increase, which reflects the position nationally.
• West Yorkshire and Humber Strategic meetings re-established with representation in place from the EPRR function.
• Regional silver calls continue with representation from across the Trust being maintained.

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	Improving Health	Responsive	CH	TBC	63.1%	63.1%	63.8%	66.9%	73.5%	73.1%	N/A
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	15% 4/27	7% 2/30	16% 7/43	11% 3/27	6% 2/35	19% 7/37	1
Service User	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	80%	80%	81%	81%	78%	81%	1
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	100%	95%	98%	95%	96%	97%	1
	Number of compliments received	Improving Health	Caring	TB	N/A	24	8	31	37	28	22	N/A
	Number of Duty of Candour applicable incidents 4	Improving Health	Caring	TB	trend monitor	36	24	35	31	34	Due August 2021	
	Duty of Candour - Number of Stage One exceptions 4	Improving Health	Caring	TB	trend monitor	4	4	4	3	1		N/A
	Duty of Candour - Number of Stage One breaches 4	Improving Health	Caring	TB	0	0	0	0	0	0		1
	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	41.3%	41.1%	40.4%	40.9%	41.8%	41.5%	2
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<12	12	13	13	7	8	11	2
	Delayed Transfers of Care 10	Improving Care	Effective	CH	3.5%	1.8%	1.6%	1.8%	1.2%	1.1%	1.3%	1
	Number of records with up to date risk assessment - Inpatient 11	Improving Care	Effective	CH	95%	55.5%	53.0%	53.2%	61.6%	68.3%	56.1%	N/A
Quality	Number of records with up to date risk assessment - Community 11	Improving Care	Effective	CH	95%	56.0%	63.2%	57.3%	51.8%	68.9%	68.9%	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	947	954	1168	1032	1038	1048	
	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	20	16	20	25	19	25	
	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	2	1	5	6	3	2	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	TB	trend monitor	5	8	4	8	6	8	
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	114.3%	116.2%	116.2%	118.9%	119.8%	118.5%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	88.9%	92.7%	92.9%	94.6%	94.9%	84.7%	
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	trend monitor	33	29	34	41	43	37	
	Number of pressure ulcers (avoidable) 2	Improving Care	Safety Domain	TB	0	0	3	2	1	3	1	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	Improving Care	Safety Domain	CH	90%	100%	90.0%	79.0%	93.7%	100%	93.8%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	47	44	40	50	39	41	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	166	185	179	157	106	170	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	82.8%	96.0%	100%	89.3%	90.3%	84.6%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	1
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	1
Improving Resource	Single Oversight Framework metric	Improving Resource			2	2	2	2	2	2	2	2
	CQC Quality Regulations (compliance breach)	Improving Resource			Green	Green	Green	Green	Green	Green	Green	Green

Note: Due August 2021 appears in Jun-21 column for "Number of Duty of Candour applicable incidents 4", "Duty of Candour - Number of Stage One exceptions 4", and "Duty of Candour - Number of Stage One breaches 4" rows.

* 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 (Category 2 and above) that has developed after 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 – Lapses in care - A pressure ulcer (Category 2 and above) that has developed after 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 damage3 - 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 becomes 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 June increased from 106 to 170. 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.

• Number of falls (inpatients) – Total number of falls was 41 in June, which is a slight increase compred to last month's data. 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 June

• % 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. Further work is underway also to review the way that this is recorded and reported with the emphasis on people having the conversation with service users about copies of the care plans.

• Number of pressure ulcers (avoidable) - there was 1 incidence of avoidable pressure ulcers to report during June. With regards to the recent reported increase in pressure ulcers, tissue viability nurses are providing additional training around Waterlow risk assessments and wound care management with the neighbourhood nursing teams. This is combined face to face/virtual, and they are also offering shadowing experience if required and where appropriate with the current Covid-19 restrictions. Each of the teams have set their own action plans around wound care management.   Further focused work is being planned where necessary with individual teams.

• Performance for CAMHS Referral to Treatment - The number of children waiting for CAMHS have increased. Although currently this has not had an impact on the 18 weeks performance, services have highlighted that sustained increases will negatively impact on the length of wait.

• As FIRM has not yet been in use for twelve months, assurance is provided through existing alternative risk assessments such as Sainsburys or those within medical care plans. The trajectory is 80% completion of FIRM by Q3 and 90% completion by Q4. Responsibility for the quality of FIRM sits within the BDU and will be monitored via audit and exceptions reported into the Clinical Governance Group for escalation to the Clinical Governance, Clinical safety Committee. Training sessions are available between August 2021 and May 2022 for new starters and refreshers.

NHS Improvement - the development of new programmes introduced in the NHS patient safety strategy are either continuing with amended timescales. 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/Improvement have identified 9 short to medium term priority areas to progress with. These are:

• Just culture – introducing NHS England's just culture guidance or other framework

• Implementation of Patient Safety Incident Management System (PSIMS) – will replace national reporting and learning system (NRLS) and STEIS

• Patient Safety alerts – ensuring effective processes are in place to manage alerts

• Improvement quality of Incident reporting – ensuring robust processes for reviewing and accessing data on NRLS

• Implementation of the New Patient Safety Incident Response Framework (PSIRF)

• Involving patients in patient safety (partners) – guidance issued 30/6/21

• Safety Improvement Programmes – number of programmes, active presently is for mental health for Reducing restrictive interventions

• Patient Safety education and training (curriculum) – curriculum published, e-learning for all staff expected to be available this summer

• COVID-19 recovery planning – ongoing work within organisation

The National priorities above are aligned with our patient safety strategy – more detail on the above has been added to the intranet . The Patient Safety Strategy group met on 30 June 2021 and reviewed the plan and received updates on the above. A briefing paper for Clinical Governance and Clinical Safety Committee is being prepared.

Work to map the patient safety specialist role against existing resources is ongoing, along with identifying operational leads for all areas of work.

Duty of Candour - the CQC have issued an update to the Duty of Candour guidance for providers. Guidance has been developed and circulated, intranet updated, and Q&A session arranged. Datix will be changed from 1 August 2021 to capture amendments.

Safety First

Summary of Incidents July 2020 - June 2021

Incidents may be subject to re-grading as more information becomes available
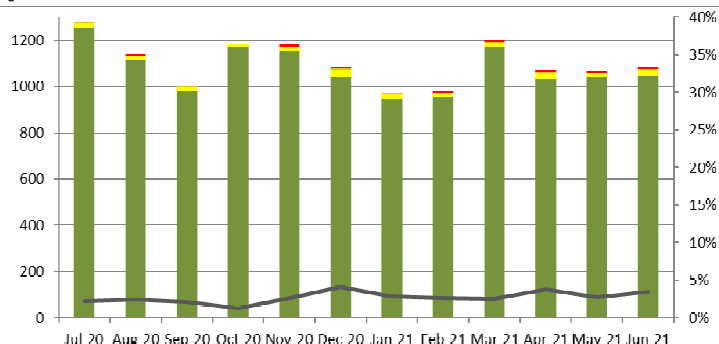
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Red (should not be compared with SIs)	4	6	2	2	8	7	5	8	4	8	6	8
Amber	3	2	1	1	2	6	2	1	5	6	3	2
Yellow	21	19	17	11	20	30	20	16	20	25	19	25
Green	1253	1114	981	1169	1150	1042	947	954	1168	1032	1038	1048
Total	1253	1114	981	1169	1149	1042	946	953	1166	1029	1011	1011
Percentage of total that are Red/Amber/Yellow *	2.2%	2.4%	2.0%	1.2%	2.6%	4.1%	2.9%	2.6%	2.5%	3.8%	2.8%	3.5%

Degree of harm analysis:

Degree of harm will be updated when more information emerges. Degree of harm is completed by the reporter of the incident. The reviewing manager will review and revise the degree of harm of the incident. The Patient Safety support team will do a final check before the incident is finally approved. This is a constantly changing position and the data was accurate at the time of extraction (9th July 2021).

Deaths: of the 8 deaths that were recorded for June 2021, there are 3 deaths that are classed as cause of death unknown/ unexplained/ awaiting confirmation. These are recorded 1 incident each at Core Team – Calderdale, Core Team South – Kirklees and Intensive Support Team - Calderdale (OPS.) There is 1 patient choking death incident recorded at Ward 18, Priestley Unit. There were 2 Suicide (incl apparent) - community team care - current episode incidents recorded 1 each at Core Team – Barnsley and Intensive Home Based Treatment Team (Kirklees). There was 2 Suicide (incl apparent) - community team care – discharged recorded at Assessment and Intensive Home Based Treatment Team / Crisis Team – Calderdale and Intensive Home Based Treatment Team (Kirklees).

Severe: of the 2 severe harm incidents recorded for the month of June 2021, there were 2 self harm (actual harm) with suicidal intent recorded 1 each at CAMHS Reach Team (Crisis Team), Wakefield and Early Intervention Service (Insight) - Kirklees

Moderate: of the 25 moderate harm incidents reported in June 2021, 12 Incidents were pressure ulcer category 3 incidents recorded across the neighbourhood teams in Barnsley.

There were also 9 self-harm incidents reported in the month of June. These were 2 incidents recorded at Stanley Ward, Wakefield, and 1 incident each at CAMHS (Barnsley), CAMHS Reach Team (Crisis Team), Wakefield, CMHT - North Kirklees (OPS), Early Intervention Service (Insight) – Kirklees, Intensive Support Team - Calderdale (OPS), Bronte Ward, Newton Lodge, Forensic, Clark Ward – Barnsley and Nostell Ward, Wakefield.

There was 1 Physical violence (contact made) against patient by patient recorded at Stanley Ward, Wakefield and 2 Slip trip and fall incident recorded 1 each at Beechdale Ward, The Dales Unit and Willow Ward – 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 June 2021 resulted in no harm or low harm or were not under the care of SWYPFT. 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. This is the same percentage figure of May 2021
• Reporting of deaths as red incidents in line with the Learning from Healthcare Deaths has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances.
• All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://www.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
• Risk panel 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.
• No never events reported in June 2021
• Patient safety alerts not completed by deadline of June 2021 - None

Following a decrease in incidents being reported in February 2021, the number of incidents reported in June 2021 is in line within the average range of reporting. In May 2021 there were 1038 incidents reported compared with June 2021 which was 1048 incidents were reported.

Mortality
Learning: Clinical mortality review group has been postponed due 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: The Regional Mortality Meeting was held on 6th July. Discussion took place around some examples of Learning from Deaths reports from around the region. Regional variation noted in how the data is presented – both for assurance purposes and quality improvement purposes. Noted that in some cases greater emphasis was on assurance with use of hospital mortality statistics and lesser emphasis on qualitative learning and subsequent action. Discussion about SJRs and how these are used in relation to sharing the learning.
Structured judgement reviews: allocations are on track.
Reporting: The Annual Incident report includes data on learning from healthcare deaths.
Training: Structured Judgement Reviewer training for Band 6 above took place on 12/7/21.

Total Number of Reported Incidents
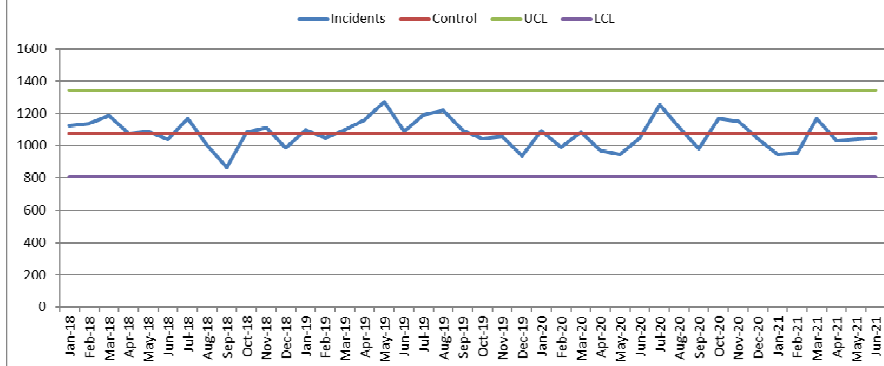
Number of Falls (inpatients)

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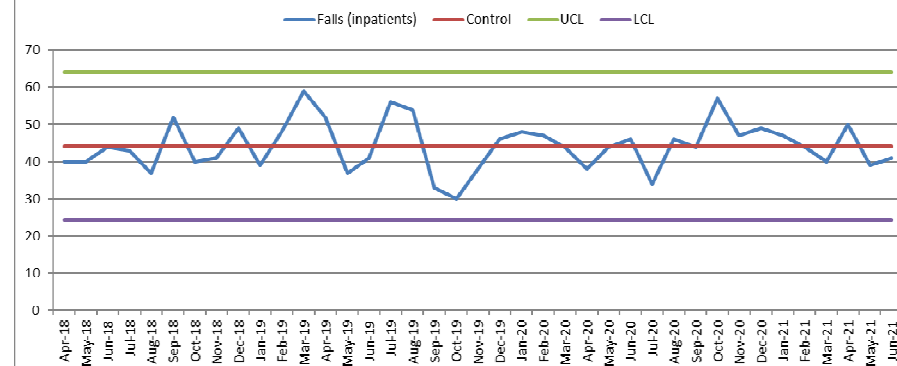
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Learning Library

The learning library has been developed as a way to gather and share examples of learning from experience.
Click here for further details of the examples http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

The Quality Improvement Toolkit is available here: http://nww.swyt.nhs.uk/quality-improvement-toolkit/Pages/default.aspx

http://nww.swyt.nhs.uk/learning-from-experiences/Pages/Learning-library.aspx

SBAR - specimen collection from urinary catheters

SBAR learning Choking

SBAR learning Covid 19 restraints

Bluelight alert 45 - 2 March 2021- Ligature risk from anti-ligature shower head

Bluelight alert 46 - 22 March 2021- Risks from fixed ligature light sliding windows

Bluelight alert 47 - 17 May 2021- Risks from nylon string, lace or cord

Patient Safety Alerts

Patient safety alerts received - June 2021

Alerts are issued by the Central Alerting System (CAS) which is a national web-based cascading system for issuing Patient Safety Alerts. Once received into the Trust, Patient Safety Alerts are sent to identified Trust clinical leads for reviewing safety alerts for a decision regarding whether it is applicable to the Trust or not, and if so, if it should be circulated. All alerts are entered on to Datix. If the alert is applicable to the Trust, the alert is circulated to Trios who then cascade to ward/team level managers via Datix. Responses are collated via Datix and Trios enter a final response for the service. Responses are monitored by the Patient Safety Support Team and reminders are sent via Datix to Trio's to ensure the Trust meet the deadlines set. Information is reported into the Medical Device and Safety Alert group on a monthly basis.

Reference	Title	Date issued by agency	Alert applicable?	Trust final response deadline	Alert closed on CAS
NatPSA/2021/003/NHSPS	Eliminating the risk of inadvertent connection to medical air via a flowmeter	16/06/2021	No - alert not applicable to trust	16/11/2021	16/06/2021
NatPSA/2021/005/MHRA	Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds	23/06/2021	Yes - circulated for information	17/12/2021	24/06/2021
NatPSA/2021/004/MHRA	Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd due to precautionary risk of causing overdose	16/06/2021	Yes - circulated for information	21/06/2021	16/06/2021

Safer Staffing Inpatients

We continue to experience a high demand on our inpatient services which can, and does, have an impact on the community service offer. This is for various reasons including ongoing vacancies, sickness, and a general increase in acuity/demand. This includes an increase in observation levels to provide a safe level of care.

Despite business continuity plans being in place and support being reallocated across the services there has been an added pressure with the track and trace self-isolation demands. As of the 22nd July, we currently have 161 staff absent through Covid related reasons.

The operalisation of the international recruitment processes continues with close collaboration across the 6 Tusts being led by SWYPFT. Recruitment continues to yield a mixture of experienced and newly qualified candidates although this is not enough to ease the pressures from vacancies.

The bank collaboration work across Bradford District Care NHS Foundation Trust, Leeds and York Partnership NHS foundation Trust and ourselves continues with the next stage being a short staff survey prior to going out to tender for a platform for booking shifts collaboratively.

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 because 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.

Again, no ward has fallen below the 90% overall fill rate threshold in June, which is consistent with the last four months.

Unfilled shifts:

An unfilled shift is a shift that has been requested of the bank office, flexible staffing, and could not be covered by bank staff, agency or Over Time. Although not exclusive, there are two main reasons for the creation of these shifts, and they are:

1-Shifts that are vacant through short- or long-term sickness, annual leave, vacancies, or other reasons that impact on the duty rosters.

2-Acuity and demand of the Service Users within our services including levels of observation and safety concerns.

From next month we will be able to provide a more in-depth trend analysis. In the meantime the table below shows the figures for the BDUs over the previous three months (April, May and June 2021).
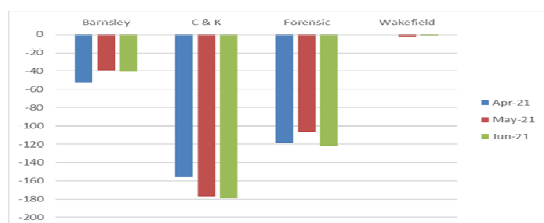
This shows demand for flexible staffing continues to fluctuate slightly. However, the overall demand has not diminished over the previous three months.

In June 2021, without the overtime fill rate, the requested sum of additional shifts, indictive of acuity including sickness absence, increased by 338 shifts to 4,496 (997 RN and 3,499 HCA) shifts with 3,778 (84.71%) being filled.

This meant that there was an overall increase on spend on inpatient staffing, see table below, of £112k for the month of June 2021. This included a reduction of bank and overtime spend of £79k and £3k respectively whilst agency spend rose by £116k.
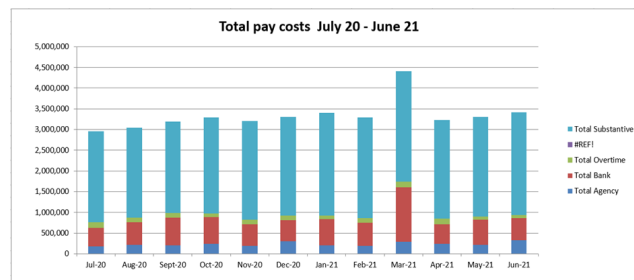
Although safe and effective staffing is a priority in all our teams, the main areas of focus for the flexible staffing resources have remained unchanged in Ward 18 within the Priestley Unit in Kirklees, The Oakwell Mental Health Unit with Kendray Hospital in Barnsley and Newton Lodge within the forensic BDU. There have been supportive measures put in place in these particular areas including block booking staff to provide consistency and continuity, placing bespoke recruitment adverts and ensuring that additional resources are placed at their disposal. The Oakwell Centre in Barnsley is our main priority to support.

Information Governance

11 data breaches were reported during June, which is slightly higher than during April and May but continues to be lower than any month during the previous financial year.

Incidents involving information being disclosed in error continues to be the highest reported category. 8 such incidents were reported during June, involving such breaches as letters and emails being sent to the wrong recipients, other individuals' personal data being sent with patient letters, letters being addressed incorrectly and mail being delivered to the wrong department and opened before being redirected.

One incident was escalated to the Caldicott Guardian and Senior Information Risk Owner.

A new IG communications plan will be launched in late July 2021, which involves posters and screensavers based on real life scenarios and continued use of The Brief to raise awareness.

The Trust did not report any incidents to the Information Commissioner's Office (ICO) during June but a service user has made a complaint to the ICO that a letter sent by the Trust was incorrectly addressed, which allowed another party to access it. The complaint is being investigated and a response will be provided.

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.

Total Number of IG Breaches
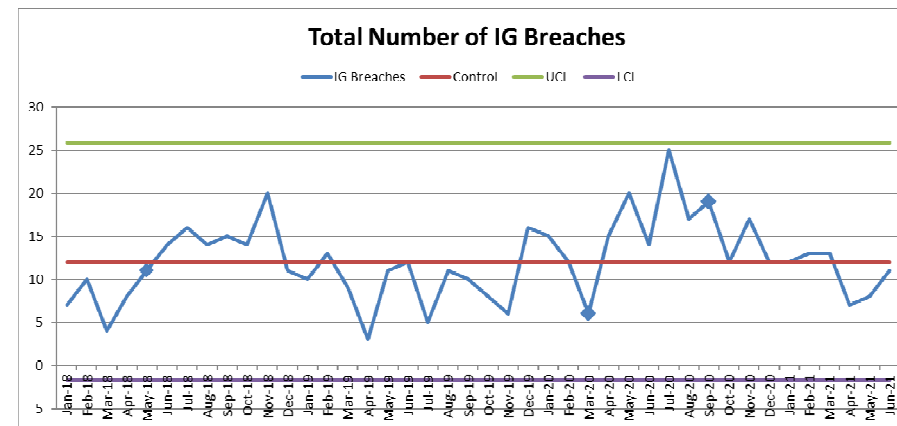
Commissioning for Quality and Innovation (CQUIN)

Schemes for 20/21 were suspended during the Covid-19 pandemic period. Similarly there are no CQUIN schemes for Q1 2021/22.

Patient Experience

Friends and family test shows

- 97% would recommend community services.
- 81% would recommend mental health services

Mental Health Services

Mental Health **81%/ n=635**

Community Services

Community **97%/ n=115**
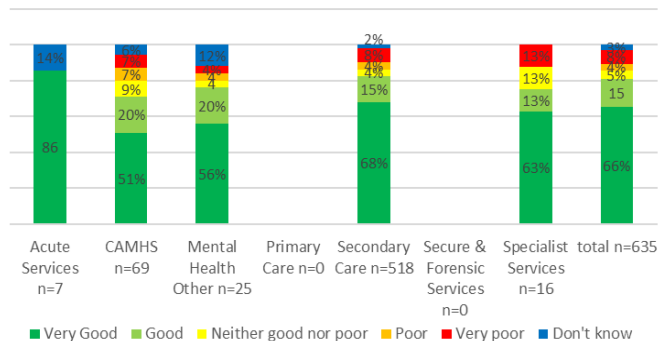
- 83% (741) of respondents felt that their experience of services had been very good or good across Trust services.
- 97% (n=106) of respondents felt that their experience had been very good or good across community services.
- 81% (n=635) of respondents felt that their experience had been very good or good across mental health services.
  - Work is being undertaken with CAMHS to improve Friends and Family Test responses and identify areas of improvement.
  - Forensic services are now collecting Friends and Family Test feedback to identify areas for improvement.
- The text messaging service provided 67% (511/741) of responses for June.
  - The Trust is adapting how the Friends and Family Test question is asked via text message. This is in a response to the low number of free text comments provided. A URL will be sent by text to encourage respondents to provide accompanying comments to their ratings.
- A Friends and Family Test Question and Answer session was held with service managers to discuss Friends and Family Test, the reporting and how this can be used to help support quality improvement for services A session is being held for practice governance coaches, quality governance leads and matrons this month.

In response to the previous board query regarding CAMHS figures;
We are receiving a significant amount of responses from CAMHS and Forensics who generally have lower satisfaction scores. We know that this is due to the nature of the forensic service (being detained) and for CAMHS waiting to be seen. The QIAT are leading a piece of work with CAMHS to improve accessibility to giving feedback for children and young people, and ensuring CAMHS staff are listening and acting upon feedback.
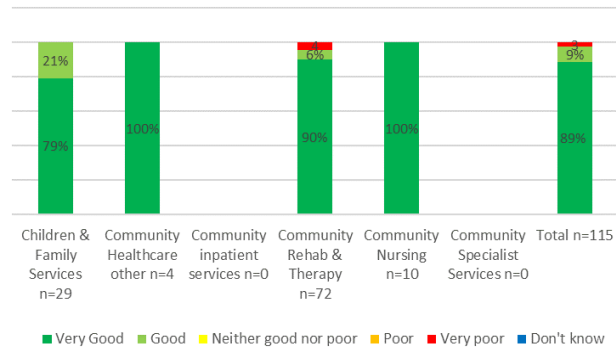
Safeguarding

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. Levels 1 and 2 have been accessed via e-learning with all mandatory courses (including PREVENT) reported above the 80% mandatory training target. Following the findings from a few external investigations the team are continuing to deliver the impact of parental mental illness training, this was also delivered at the West Yorkshire Safeguarding week. The safeguarding team have delivered mandatory training to volunteers and for the Care Certificate. Support has also been given to the head of forensic social work team with re-establishing the face to face child visits and child contact training.

The Policy for adult and children visiting to inpatients in hospitals (including handling of non-patient visitors to the Trust) has been updated and approved at the Executive Management Team (EMT).

All members of the team have attended virtual webinars and or training sessions to ensure that their practice, the training material, and advice provided is up to date and relevant. The Safeguarding team have attended: psychological first aid and fuel poverty training.

The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections. The All external information gathering requests have been responded to in a timely manner.

The safeguarding team supported managers and practitioners at a learning event that was organised by the Calderdale safeguarding children partnership in response to the child safeguarding practice review (CSPR) of a baby who suffered abusive head trauma.

Infection Prevention Control (IPC)

Ongoing work for COVD19 pandemic, with reset, restoration and recovery

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

Mandatory training figures are healthy:

Hand Hygiene-Trust wide Total –95%
Infection Prevention and Control- Trust wide Total –94%

Policies and procedures are up to date.

Complaints

There were 37 new formal complaints in June 2021. Of these 1 has a timescales start date and 33 are awaiting consent/questions. We have closed 3 due to no contact/consent.
19% of new formal complaints (n=7) have staff attitude as a primary subject which is a significant increase from May where this was 6%
22 compliments were received
12 formal complaints were closed in June and under the 40 working day target, 58% (n=7) exceeded this. Under the revised targets 67% (n=8) exceeded this.

Reducing Restrictive Physical Intervention (RRPI)

There were 170 reported incidents of Reducing Restrictive Physical Interventions used in June 2021 this is an increase of 64 (60.4%) incidents since May 2021 which stood at 106 incidents.

Of the different restraint positions used in the 170 incidents, standing position was used most often 84 (49.4%) followed by seated at 46 (27%).

Prone restraint was reported 16 (9.4% of total restraints) times in June 2021, this is a decrease of 2 (11%) from last month. All the prone restraints were directly linked to seclusion (16) or medication (10) events.

Incidents where prone descent immediately turned into a supine position were recorded at 14 (8.2%) this is a separate entity to prone restraint.

Wakefield recorded 9 prone Restraints; Kirklees 3, Calderdale and Barnsley both reported 2, learning disabilities and Forensics reported no prone restraints in this period

The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised. In June the percentage of prone restraints lasting under 3 minutes was 93.75% which is a reduction of 6.25%. Each incident of prone restraint has been reviewed by a member of the RRPI team and an explanation can be found further in the report.

The use of seclusion has remained static at 48. One incident of seclusion has been attributed to Covid themes in June.

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.

The refresher courses were re-introduced in May this year with update periods extended by 12 months from March 2020. Supplementary to this we commenced a period of workplace competency assessments from April 2021.

Discussions regarding the planning for the reintroduction of training has occurred within the Mandatory and Essential to Job Role Training Group, 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.
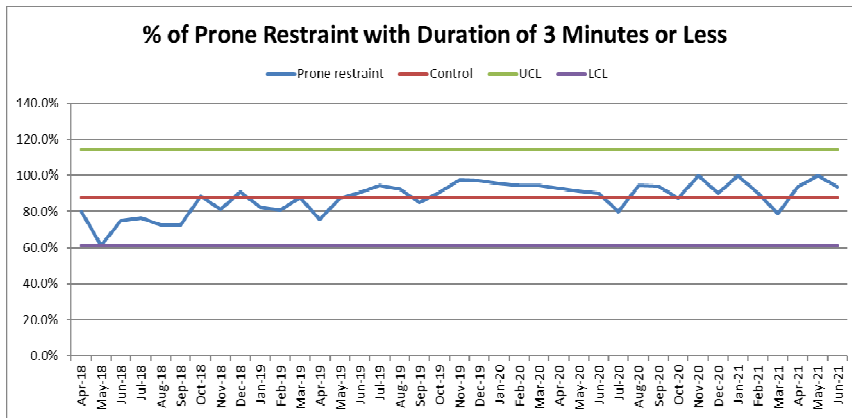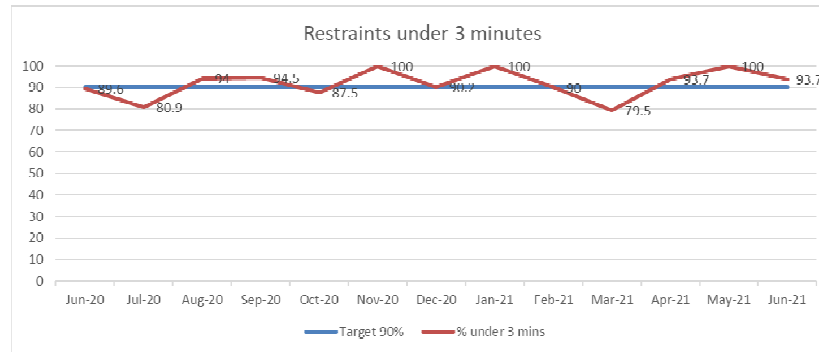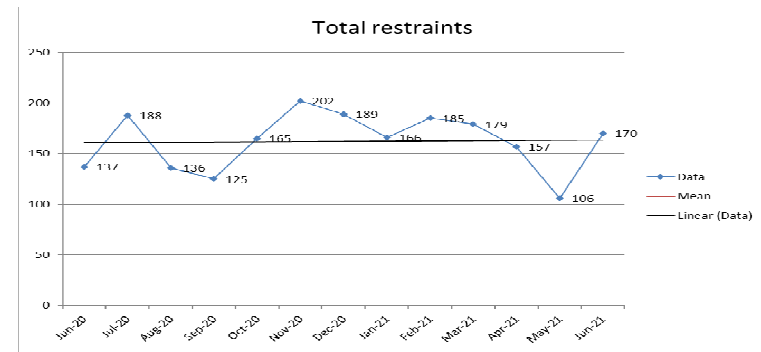
Total restraints

Restraints under 3 minutes

% of Prone Restraint with Duration of 3 Minutes or Less

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.

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.
The NHS System Oversight Framework for 2021/22 replaces the NHS Oversight Framework for 2019/20, which brought together arrangements for provider and CCG oversight in a single document. A single set of oversight metrics, applicable to ICSs, CCGs and trusts, will be used to flag potential issues and prompt further investigation of support needs with ICSs, place-based systems and/or individual trusts and commissioners.
These metrics align to the five national themes of the System Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. There are potentially 41 indicators that are applicable to the Trust in the 21/22 framework. It is anticipated that the majority of these metrics will be taken from existing data flows and sources that are already in operation. The systems oversight guidance refers to the use of in year monthly or quarterly collections – it is not entirely clear which collections this relates to, SWYPFT will try to clarify this, to ensure local systems are in place to monitor performance and a further update will be included in next month's report. A detailed report is being taken to the Finance, Investment and Performance Committee

NHS Improvement - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Data quality rating 8	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	98.7%	99.2%	99.9%	100%	99.6%	99.9%	100%	100%	100%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	43.8%	56.8%	97.8%	100%	74.3%	97.8%	98.7%	100%	100%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	96.1%	98.7%	99.4%	99.7%	99.1%	100%	100%	100%	99.1%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	300/302 =99.3%	301/302 =99.7%	277/281 =98.6%	278/284 =97.9%	90/90 =100%	98/101 =97.0%	93/96 =96.8%	82/83 =98.8%	103/105 =98.1%		
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.7%	98.8%	98.8%	99.1%	98.9%	98.3%	99.1%	99.1%	99.1%		
Out of area bed days 5	Improving Care	Responsive	CH		737	316	251	374	78	82	122	204	177		
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	52.7%	56.3%	53.4%	55.3%	53.4%	53.7%	57.0%	55.6%	53.3%		
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	92.8%	96.5%	98.8%	98.7%	99.0%	98.7%	99.1%	98.6%	98.5%		
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	95%	99.1%	99.9%	99.9%	99.9%	100%	100%	100%	100%	99.8%		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	87.0%	94.4%	91.5%	90.5%	90.6%	91.9%	87.0%	89.7%	96.8%		
% clients in settled accommodation	Improving Health	Responsive	CH	60%	91.1%	91.7%	92.1%	92.4%	92.2%	92.2%	92.3%	92.4%	92.4%	⚠️	
% clients in employment 6	Improving Health	Responsive	CH	10%	12.6%	12.5%	12.5%	12.8%	12.4%	12.6%	12.7%	12.9%	12.8%	⚠️	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Feb-21	Mar-21	Apr-21	May-21	Jun-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	34	10	70	47	6	6	25	22	40		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	TBC	6	2	13	7	1	3	3	3	3		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	Trend Monitor	205	210	189	217	189		217				
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	Trend Monitor	13.7%	18.1%	19.0%	19.8%	19.0%		19.8%				

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Feb-21	Mar-21	Apr-21	May-21	Jun-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%	99.8%	99.5%	99.4%	99.1%	99.4%	98.9%	98.9%	99.6%	98.7%		
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%	100.0%	99.9%	100.0%	99.9%	99.9%		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	98.4%	98.0%	98.1%	98.2%	98.2%	98.1%	98.3%	98.3%	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 100%
- The percentage of service users seen for a diagnostic appointment within 6 weeks has improvedto 100% and is now above target, which represents excellent recovery from the impact of the pandemic.
- Inappropriate out of area bed placements amounted to 177 days in June. This is a decrease from 204 in May.
- During June 2021, there were 3 service users aged under 18 years placed in an adult inpatient ward for a total of 40 days. This is a deteriorating and concerning position. 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 19.0% to 19.8% 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 May the following data quality issues have been identified in the reporting:
- The reporting for employment and accommodation for June shows 15.4% of records have an unknown or missing employment and/or accommodation status, this is an increase from May which showed 14.0% 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
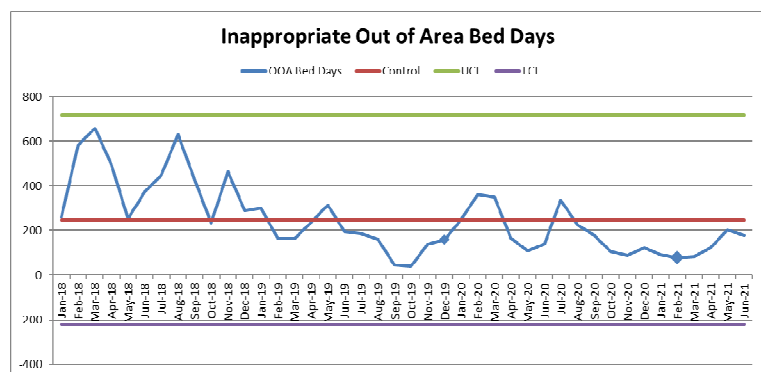
Inappropriate Out of Area Bed Days

SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data points in December 2019 and February 2021 have been highlighted for this reason.

Total Bed Days of CYP on Adult Wards
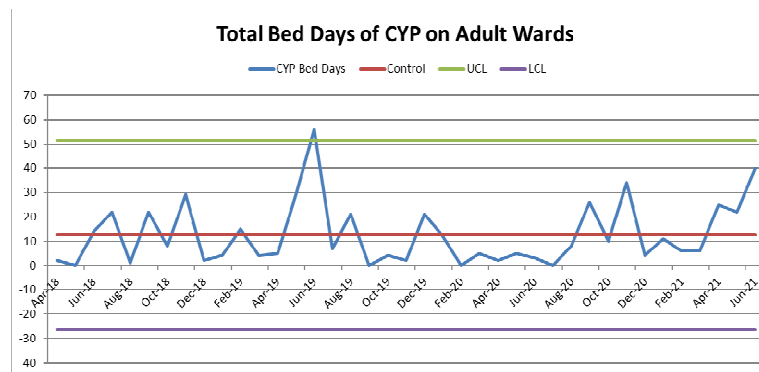
The majority of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported bed days are within the expected range with the exception of Jun-19.

System wide monitoring

Integrated care systems (ICSs) are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Since 2018, they have been deepening the relationship in many areas between the NHS, local councils and other important strategic partners such as the voluntary, community and social enterprise sector. They have developed better and more convenient services, invested in keeping people healthy and out of hospital and set shared priorities for the future.
The Trust sits within 2 ICS foot prints, West Yorkshire & Harrogate and South Yorkshire and Bassetlaw.

This section of the report outlines the metrics that are in place across both ICS footprints along with system performance.

West Yorkshire & Harrogate Partnership

The Partnership finalised and published its five year strategy in March 2020. This document included 10 'big ambitions' – 10 measures that reflect what is important to the Partnership, and by which progress will be measured. These 10 items are:

1 - Increase the years of life that people live in good health in West Yorkshire and Harrogate compared to the rest of England. We will reduce the gap in life expectancy by 5% (six months of life for men and 5 months of life for women) between the people living in the most deprived communities compared with the least deprived communities by 2024.

2 - We will achieve 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 by 2024 (approx 220,000 people). In doing this, we will focus on early support for children and young people.

3 - We will address the health inequality gap for children living in households with the lowest incomes. This will be central for our approach to improving outcomes for 2024. This will include halting the trend in childhood obesity, including those living in poverty.

4 - By 2024 we will have increased our early diagnosis rates for cancer, ensuring at least 1000 more people will have the chance of curative treatment.

5 - We will reduce suicide by 10% across West Yorkshire and Harrogate 2020/21 and achieve a 75% reduction in targeted areas by 2022.

6 - We will achieve at least 10% reduction in anti-microbial resistance infections by 2024, by for example reducing antibiotic use by 15%

7 - We will achieve a 50% reduction in still births, neonatal deaths, brain injuries and a reduction in maternity morbidity and mortality by 2025.

8 - We will have a more diverse leadership that better reflects the broad range of talent in West Yorkshire and Harrogate, helping to ensure that the poor experiences in the workplace that are particularly high for black, Asian and minority ethnic (BAME) staff will become a thing of the past.

9 - We will aspire to become a global leader in responding to the climate emergency through increased mitigation, investment and culture change throughout our system.

10 - We will strengthen local economic growth by reducing health inequalities and improving skills, increasing productivity and the earning power of people and our region as a whole.

The Partnership have recently outlined an approach to measurement and quantification and it is anticipated that this will be finalised in September 2021. A further update as to progress will be provided in the IPR produced in September.

South Yorkshire & Bassetlaw Partnership

The Trust will work with the partnership to gather relevant information and update this section of the report in August 2021.

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
• The Trust is in discussion with Primary Care Network/GP Federation to develop detail of the local transformation development plan. A proposal regarding a brief intervention service to support primary care (as part of Additional Roles Reimbursement Scheme) has been approved.
• Progress is being made with regards to the system-wide mental health strategy, led by the Clinical Commissioning Group (CCG) Stakeholder consultation is expected in September 2021.
• Service resilience has been maintained. Contacts continue to be delivered by telephone/video link where practicable with face to face support offered as necessary.
• Improving access to psychological therapies (IAPT) waiting list has commenced with focus on evidence-based group interventions.

Areas of focus
• Increased referrals and acuity have been seen, with associated increase in caseloads across Core, Enhanced and Intensive Home-Based Treatment services.
• % service users on care programme approach (CPA) with a formal review within the previous 12 months has been improving with ongoing attention on recording
• Non-recurrent recovery investment has been made available by the CCG. Plans have been submitted to support caseload pressure in the Single Point of Access and Core and Enhanced teams, and we are awaiting approval.
• Focus on staff wellbeing/resilience has been maintained

CAMHS
Strengths
• Business continuity plans have to date been effective.
• Waiting numbers/times from referral to treatment being maintained in Barnsley

Areas of focus
• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased. Business cases now approved in Calderdale and Kirklees to support addressing waits and are moving to implementation
• Referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield. The medium term trajectory is unclear. % treated within 18 weeks is unlikely to be maintained given the increase in demand.
• Crisis referrals – particularly in relation to eating disorders – are high. Tier 4 bed access remains problematic, leading to inappropriate stays for children and young people in acute or Trust mental health beds.
• There have been staffing capacity issues across eating disorder pathway, and proactive discussion with CCG's regarding additional investment
• There has been a focus on maintaining staffing levels in in Wetherby Young Offenders Institute.
• Focus on staff wellbeing/resilience has been maintained

CAMHS Referral to Treatment Waiting Times
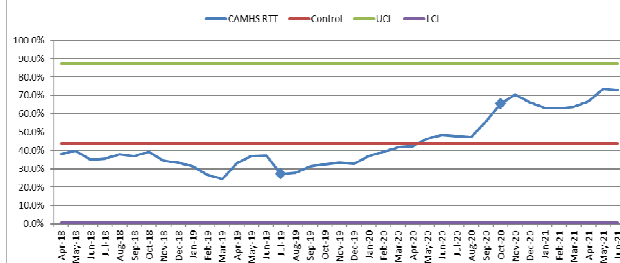
The data point in July 2019 has been highlighted as the neurodevelopmental teams have been excluded from this point onwards.
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in October 2020 has been highlighted for this reason.

Barnsley general community services

Key Issues
• The Yorkshire Smoke Free (YSF) Wakefield bid was submitted in May 2021 with outcome expected in November 2021.
• There is a national problem with the supply of Champix (drug used to aid smoking cessation) which could potentially impact on service performance (Key Performance Indicators). Our commissioners have been made aware of the issue and an action plan is in place to ensure provision of alternative treatment.
• The Urban House Health Integration Team (HIT) service is nurse-led and currently has only one Nurse Prescriber in the team. A Nurse Prescriber post has been offered and is going through employment checks to relieve the operational issues this causes.

Strengths
• Positive feedback has been received from the staff who have joined SWYPFT following successful bid for the Breathe Service in relation to their welcome and introduction to SWYPFT.
• A First Contact Physiotherapy (FCP) Service has commenced from our Musculo Skeletal Service (MSK) working with the Primary Care Network in GP practices. Clinicians appointed to the roles have begun integrating into the practices, promoting the role of FCPs.
• All areas of the Health and Wellbeing / Children's Services are performing well.

Challenges
• Services are continuing to restore and recover service provision. Covid-related absence rates have increased across services. Staff fatigue as a result of the pandemic is having an impact in some areas.

Areas of Focus
• A key area of focus has been continuation of the organisational change programme across the Neighbourhood Teams

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
• OPEL Level remains at level 2.
• Work on the Adult Secure Provider Collaborative continues with a revised go live date of 1st October 2021.
• Staffing levels remain under constant review, with registered nurse vacancies a particular area of focus.
• Absence levels (due to Covid and non-Covid reasons) is over 12%.
• Recruitment to Psychology has been successful, and the service will be fully staffed by October 2021 for this discipline.
• Occupancy levels in Newhaven and Newton Lodge are below target. Plans are in place to re-assess Out of Area patients with a view to repatriate wherever clinically appropriate and possible.
• The service have seen an increase in safeguarding concerns which are being investigated, and appropriate safeguards are in place.
• Staff supervision levels are at 81% in medium secure, 89% in low secure and 88% in Newhaven with ongoing work to ensure they reach target.
• Staff well-being remains a focus, with the service utilising recent NHS survey results to modify plans.
• Focus on recruitment and retention continues. Data from the recent survey has informed the action plan.

Learning Disability services
Community:
• Referral rates continue to be 20-30% higher than throughout 20/21 and are roughly at the level seen pre-pandemic.
• Face to face contacts continue to represent about 50% of total activity, with other contacts mostly via telephone.
• Staff are continuing to work in a 'blended' way (working from home and in base) but spending increasing time in our learning disability hubs.
• Covid- 19 vaccine clinics specifically for people with learning disabilities continue to encourage vaccination and additional time/support for those that previously declined vaccination and have been very successful
• Targeted work with specific community leads continues to manage individual discipline waiting lists
• Barnsley community team will move to new premises (Mapplewell Health Centre) on 2nd August 2021
Inpatients:
• Supervision is currently 82%
• Medical cover across all LD services is a key concern with short-term plans in place, but medium and longer term this will present challenges and is being discussed with the Medical Director.
Assessment and Treatment Unit (ATU):
• Development of the West Yorkshire ATU continues with significant progress being made on the workforce profile.
• High bank/agency use continues though is being supported by safer staffing team with block bookings.
• There has been significant turn-over of substantive staff (leavers and new-starters) and vacancies are being actively recruited to.
• Work is progressing well with Bradford District Care Trust in relation to the Assessment and Treatment Unit collaboration.

ASD/ADHD
• The service is operating fully without any operational challenges due to Covid-19.
• There has been a surge in referrals for assessment
• Supervision is currently 88%
• Performance metrics all green.
• The Service has a identified a number of new business opportunities/developments to explore further.
• The Trust has requested support to undertake a service review from the Royal College of Psychiatry.

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Trustwide Acute Inpatients:
• Maintaining patient flow and facilitating sufficient ward capacity has been challenging. Whilst use of acute beds out of area has been kept to a minimum, there have been acute out of area placements particularly in response to demand for male admissions. The use of Psychiatric Intensive Care Unit (PICU) out of area beds is mainly attributable to gender specific and safeguarding clinical reasons, although bed availability has become a factor. High demand for inpatient beds continues. Concerted work on optimising patient flow is continuing and the service is now fully recruited and is providing a 7 day a week service.
• Following two incidents which occurred within unsupervised garden areas on the working age adult wards, a decision was taken to restrict all garden access to supervised access only. This was until a more detailed risk assessment of the garden areas and process for risk assessing unsupervised access to outdoor areas could be undertaken through the implementation of a risk assessment tool developed in conjunction with Health and Safety. The tool is currently being used to review the garden access for each ward and blanket restrictions are being removed where appropriate and it is safe to do so.
• 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, 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 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. 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. A gatekeeping review of admissions has taken place to inform learning and planning around community alternatives to inpatient care and the learning from this is currently being collated and embedded across the system. We have currently strengthened our discharge coordination offer on the wards to complement this.
• 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.
• There has been an impact on prevalence rates for IAPT as a consequence of the COVID-19 period. IAPT access has been lower over the last year as a consequence of limitations on access to primary care, as the main referral method into the service is GP directed self-referrals. However referral figures for recent months are showing a sustained increase and demand is now growing.
• Demand into Single Point of Access (SPA) continues to increase leading to significant pressure in the service and necessitating the use of additional staff and sessions for assessment slots. We are seeing a notable growth in self referrals. SPA is prioritising risk screening all referrals to ensure any urgent demand is met within 24 hours but routine triage and assessment is now at risk of being delayed. The situation is being kept under close review by General Managers and teams and all mitigations are in place.

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
• Coronavirus update sent out weekly to all staff and governors
• Coronavirus sections on the intranet and website maintained and updated.
• Sharing of staff and service user good news stories, internally, externally and through social media channels
• Coronavirus vaccination comms, general focused and targeted.
• Communication on Trust leadership changes, both internally and to partners
• Continued promotion of 'Choose Well for Mental Health' guide; internally, on social media channels and with partners, alongside award submissions
• Staff wellbeing initiatives promoted
• Design and print of materials continuing for services and corporate functions
• Awareness days and weeks supported on social media and in internal communication channels.
• Information governance campaign supported
• Nhs.net removal and Trust email accreditation comms
• Forensic improvement programme - continued support
• Support provided to EyUp Charity, Creative Minds, Spirit in Mind and Mental Health Museum
• New intranet development project supported – migration of information and site development.
• Promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS' initiatives and campaigns.

Engagement, Equality and volunteering update
• Equality Impact Assessment (EIA) process and forms reviewed and now approved by EMT, the next steps will be to roll out the new way of working across the Trust. In parallel, a review of the number of policy EIAs the Trust will take place.
• Resources to support the EIAs are available for the intranet. Due to delays we are awaiting an opportunity to upload the resources which includes links to BI intelligence and local authority needs assessments.
• Website material is also ready for upload once the platform is in place following work to improve.
• Virtual Visitor is now called 'CHATpad' and devices have been updated and leaflets and instructions reissued. The new version includes links to advocacy and access to our survey tool 'Healthcare Comms'.
• Work is still progressing to launch the equality data improvement campaign – the Trust will use a previous campaign and re-focus. This is now being shared with staff side, staff networks, the Operational Management Group and clinical teams to identify ideas for a campaign for EMT to view, agree and approve
• Awareness raising training planned for specific groups starting with Transgender Awareness, which has been well received and more sessions arranged.
• The draft easy read strategy has also been reviewed and will be shared for comment with staff and service users a revised version will be tested next month.
• Work continues to support recovery planning using insight and intelligence to inform decision making.
• A quarterly insight report has now been developed and the format agreed. The report has been shared at equality, inclusions and involvement committee (EIIC) and through to Governors who contribute to the report. The report was well received at Committee and Healthwatch provided positive feedback on the format. The report will continue to be developed each quarter and the insight to form a 'you told us, we responded' approach
• A programme update on the strategy action plans has been agreed by EIIC and a workshop to develop KPIs took place this month. KPIs will be reviewed in line with Trust indicators and these will be agreed at EIIC in September
• Support for Older People's Services Transformation consultation in partnership with CCGs has continued and development of a plan, timeline and governance and a review by NHSEI of the gateway to assure the approach.
• A training bid has been developed to identify funding to refresh mandatory equality training and create short films to support the online EIA toolkit. This has now been approved and progress to secure the work are underway. This work has also been linked to learning and development and is in line with mandatory training and the core skills framework.
• Work with Voluntary and Community Sector VCS umbrella organisations to support the mapping of local groups and allocation of small grant fund opportunities is part of our planned approach to engaging communities, and this work is ongoing with Kirklees showcasing their work to us in August along with over 80 interested groups who would like to work with our Trust.
• An update on the Trust response to the 8 actions to address inequalities was provided at the June EIIC and to Wakefield Inequalities Leaders network who were very impressed with our approach
• Our approach to equality was presented at WYHP ICS which was well received
• We are working on the addressing inequalities agenda in Calderdale and leading on a composite report of insight to inform the approach
• Working in Barnsley to support the development of an engagement and communication approach which includes developing a shared set of principles
• Working closely with the Mental Health Alliance to support a partnership approach to involvement which includes a development session and plan to support the programme of work for mental health. The development session was led by our Trust in partnership with the CCG and Healthwatch.
• Process to support SEQUIN submission for secure services continues, with monthly updates forming part of core work and plans to work closely with the regional team to align further and identify ways to embed equality and address inequality.
• Carers Lead now in post following a successful charitable funds application and the work to identify and support carers continues.
• Payment for involvement policy now being looked at and a draft will be circulated for comment by EMT in the next month.
• Community Reporter 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 has delivered a staff event and the action plan for the forthcoming year is in development. A co-designed training package and resources for peer workers is being delivered initially in Recovery Colleges and the feedback on the work has been really positive
• Draft strategy for volunteering developed and ready to be approved, this includes a framework to support volunteers in each place. The strategy has been reviewed by Trust staff and volunteers. The volunteer policy has been updated in line with the strategy and was recently approved at EMT.
• Volunteers are starting to return with support and guidance. The return of volunteers will be supported by training and DBS refresh and an online welcome back event is planned for September

Overall Financial Performance 2021/22

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast 2021/22	Narrative
1	**Surplus / Deficit**	£1.7m	£2.3m (H1 21/22)	In June a surplus of £0.4m has been reported which is favourable to plan. The forecast position for the first half of the year is currently for a surplus of £2.3m. This will continue to be re-assessed.
2	**Agency Spend**	£1.9m		Agency run rate continues to be in line with that from the previous financial year with spend of £0.8m. There has been an increase in unregistered nursing usage in month to support both backfill of vacancies and safer staffing requirements.
3	**Cash**	£60.8m	£54.2m	Cash in the bank continues to be positive although this is forecast to reduce in year due to the higher level of planned capital investment.
5	**Capital**	£0.6m	£9.6m	Capital spend to date is £0.6m which is £0.1m ahead of plan. Tendering, procurement and finalising of business cases continue and the full £9.6m programme is currently forecast to be spent in year, with ongoing assessment of major programmes currently taking place.
6	**Better Payment Practice Code**	94%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 94% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 10 days from receipt.

Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	4.0%	4.0%	3.9%	4.0%	4.3%	4.3%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.0%	4.0%	3.9%	4.0%	4.3%	4.3%
Staff Turnover (registered nurses)	Improving Resources	Well Led	AD	10%	8.4%	9.1%	8.9%	9.3%	9.3%	9.9%	10.0%	10.0%	10.3%	15.6%	14.7%	13.1%
Gross Vacancies	Improving Resources	Well Led	AD	-	Reporting Commenced April 2021									10.8%	5.5%	7.9%
Net Vacancies	Improving Resources	Well Led	AD	-										2.9%	0.6%	3.2%
Aggression Management	Improving Care	Well Led	AD	>=80%	85.5%	86.5%	86.0%	86.3%	85.4%	85.1%	84.1%	84.1%	82.3%	80.7%	79.95%	85.1%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80%	89.4%	90.3%	89.4%	88.7%	88.2%	86.2%	85.2%	84.5%	81.7%	78.8%	77.7%	76.27%
Clinical Risk	Improving Care	Well Led	AD	>=80%	93.7%	93.8%	93.6%	93.3%	93.2%	94.1%	93.3%	93.1%	93.5%	94.6%	94.9%	94.7%
Equality and Diversity	Improving Health	Well Led	AD	>=80%	95.2%	95.7%	95.7%	95.6%	95.7%	95.5%	95.5%	95.6%	95.5%	95.6%	95.5%	95.2%
Fire Safety	Improving Care	Well Led	AD	>=80%	93.7%	93.9%	93.4%	92.8%	91.8%	87.9%	86.9%	87.6%	86.2%	85.9%	84.3%	84.6%
Food Safety	Improving Care	Well Led	AD	>=80%	76.9%	78.3%	76.7%	76.8%	76.5%	75.8%	74.8%	75.9%	75.3%	76.3%	77.2%	79.60%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	95.8%	96.2%	96.0%	96.1%	96.0%	95.6%	95.0%	94.7%	94.3%	94.0%	94.2%	92.7%
Information Governance	Improving Care	Well Led	AD	>=95%	98.2%	98.8%	98.8%	98.9%	98.8%	98.5%	97.5%	97.8%	97.9%	96.6%	95.7%	94.67%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	95.0%	95.5%	95.6%	95.5%	95.1%	95.0%	95.0%	95.1%	94.9%	95.1%	95.7%	96.3%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80%	93.3%	94.6%	94.3%	94.8%	94.9%	95.0%	94.6%	93.9%	91.0%	90.8%	88.9%	87.7%
Mental Health Act	Improving Care	Well Led	AD	>=80%	89.5%	91.2%	90.8%	91.4%	91.4%	92.1%	91.3%	90.5%	85.0%	85.1%	82.0%	80.7%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	79.3%			80.6%			81.3%			74.4%		
Prevent	Improving Care	Well Led	AD	>=80%	93.2%	94.6%	94.6%	94.4%	95.3%	95.7%	95.6%	95.6%	95.6%	95.6%	95.3%	95.4%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	96.2%	92.8%	92.8%	93.0%	92.8%	93.9%	94.0%	94.2%	94.0%	94.7%	94.7%	94.7%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	92.4%	93.6%	93.6%	92.8%	93.2%	93.4%	93.4%	93.5%	93.3%	93.4%	93.1%	
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	96.9%	96.8%	96.8%	No longer used								
Bank Cost	Improving Resources	Well Led	AD	-	£687k	£778k	£907k	£915k	£889k	£944k	£946k	£682k	£1,120k	£803k	£911k	£795k
Agency Cost	Improving Resources	Effective	AD	-	£558k	£606k	£588k	£604k	£573k	£686k	£587k	£562k	£760k	£583k	£560k	£794k
Overtime Costs	Improving Resources	Effective	AD	-	£257k	£276k	£213k	Data unavailable at the time of producing this report								
Additional Hours Costs	Improving Resources	Effective	AD	-	£71k	£59k	£53k									
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£408k	£411k	£387k									
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-	208.9	205.9	234.0									
Business Miles	Improving Resources	Effective	AD	-	164k	166k	147k									

Health & Safety

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-		3			14			7			4	

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	As at 20th May 2021	As at 22nd June 2021	As at 23rd July 2021	Trend	Notes
No of staff off sick - Covid-19 not working 7		154	204	112	48	26	82	108	161	81	159	91	89	33	15	32	95		
Shielding		54	59	52	37	0	0	0	29	0	48	42	50	1	0	0	1		
Symptomatic		69	118	46	5	14	31	57	51	45	64	29	19	16	2	8	33		
House hold symptoms		26	24	13	4	7	29	31	25	10	19	4	10	5	3	6	28		
OH Advised Isolation		5	1	0	0	1	1	2	2	0	0	1	1	1	0	0	4		
Test & Trace Isolation		0	0	0	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	10	18	29		
No of staff working from home - Covid-19 related 8		125	136	107	90	7	53	79	147	35	84	78	88	16	8	21	66		
Shielding		76	78	72	71	0	0	0	77	0	49	54	74	8	0	0	1		
Symptomatic	N/A	13	28	13	5	1	14	29	16	8	9	4	3	2	2	3	15		
House hold symptoms		29	23	13	1	0	26	21	33	14	6	10	4	1	3	8	28		
OH Advised Isolation		7	6	7	3	0	1	5	1	1	4	2	2	1	1	0	0		
Test & Trace Isolation		0	0	0	7	0	0	0	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	2	10	22		
Number of staff tested 9		89	783	1798	2038	2162	2294	2498	2917	3098	3241	3353	3386	3386	3386	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	610	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 =90.6%	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%	2813/2836 =99.2%	2828/2882 =98.1%	2888/3054 =94.6%		
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%	1885/1905 =99.0%	1890/1928 =98.0%	1913/2034 =94.1%		
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	0	0	0		
Additional number of staff enabled to work from home		900	900	937	1003	1024	1043	1069	1095	1168	1175	1306	1369	1281	1271	1223	1350		Cumulative
Calls to occupational health healthline		178	576	921	1230	1450	1536	1780	1967	2109	2274	2451	2565	2655	2713	2798	2911		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 staff bank capacity in light of recent increase in recruitment
• Continue to follow government guidance e.g. social distancing, wearing of masks, working from home where possible
• Assessing the impact of updates self-isolation guidance for some NHS Staff

Staff Health & Well Being

• 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.
• We continue to provide and use lateral flow tests for many of our staff.

Workforce Issues

• As at 23rd July, 95 staff off work Covid-19 related, not working which compares to 32 one month earlier. A further 66 were working from home.
• 3386 staff tested for Covid-19 as at 23rd July.
• 610 staff have tested positive for Covid-19, none of which tested positive within the last month.
• Staff turnover decreased to 13.1% in June.
• Non-Covid sickness absence remained at 4.3% in June.

SPC Charts

Trust Sickness Absence

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 points in January 2020 and September 2020 have been highlighted for this reason.

Trust Staff Turnover

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 October 2020 has been highlighted for this reason. Turnover has been lower since the onset of the Covid-19 pandemic.

Trust Agency Spend

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

Sickness reporting

As at 23rd July, the Trust has 162 staff absent or working from home due to Covid-19. This makes up 3.1% of the workforce. Of those absent, 30.2% are symptomatic and 34.6% have household symptoms. The business delivery unit (BDU) with the biggest impact is Forensic with 6.9% of staff impacted
• 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 7.7 days in June.

Sick/Absent % by BDU/Service/Cost Centre (excludes Trust Bank/Pastoral Care)
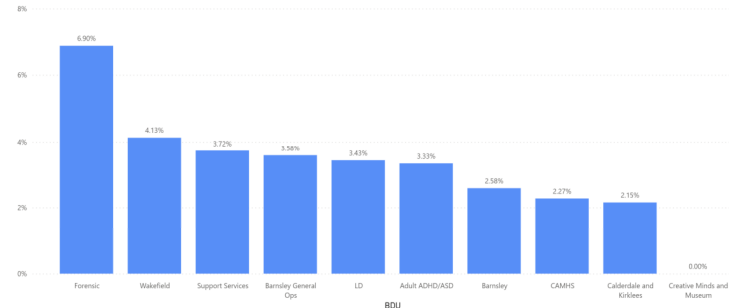
Absence by BDU and Reason for absence
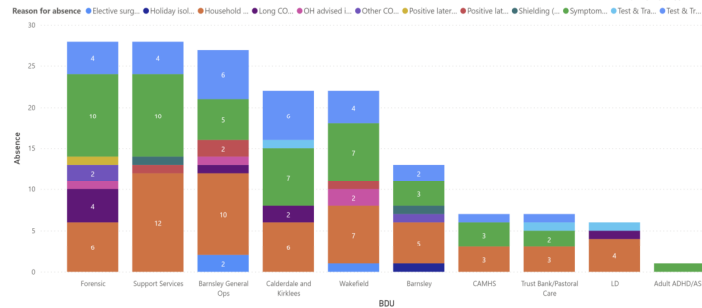
Publication Summary

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

Community services statistics for children, young people and adults: March 2021

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

Provisional monthly hospital episode statistics for admitted patient care, outpatient and accident and emergency data: April to May 2021

NHS sickness absence rates: February 2021, provisional statistics

NHS workforce statistics: March 2021 (including selected provisional statistics for April 2021)

Learning disability services monthly statistics; Assuring Transformation: June 2021, Mental Health Services Data Set: April 2021 final

Finance Report

Month 3
(2021 / 22)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0	Executive Summary / Key Performance Indicators			
	Performance Indicator	**Year to Date**	**Forecast 2021 / 22**	**Narrative**
1	**Surplus / (Deficit)**	£1.7m	£2.3m (H1 21/22)	In June a surplus of £0.4m has been reported which is favourable to plan. The forecast position for the first half of the year is currently for a surplus of £2.3m. This will continue to be re-assessed.
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5	**Better Payment Practice Code**	94%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 94% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 10 days from receipt.

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Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

Budget Staff WTE	Actual worked WTE	Variance WTE	%	This Month Budget £k	This Month Actual £k	This Month Variance £k	Description	Year to Date Draft Budget £k	Year to Date Actual £k	Year to Date Variance £k	Budget M1 - M6 £k	Forecast M1 - M6 £k	Forecast Variance £k
				21,616	20,039	(1,577)	Clinical Revenue	63,038	61,442	(1,596)	126,386	123,524	(2,862)
				21,616	**20,039**	**(1,577)**	**Total Clinical Revenue**	**63,038**	**61,442**	**(1,596)**	**126,386**	**123,524**	**(2,862)**
				1,028	1,494	466	Other Operating Revenue	3,103	3,784	680	6,349	7,154	804
				22,644	**21,533**	**(1,111)**	**Total Revenue**	**66,142**	**65,226**	**(916)**	**132,736**	**130,678**	**(2,058)**
4,774	4,396	(378)	7.9%	(17,922)	(16,637)	1,284	Pay Costs	(52,571)	(49,888)	2,683	(105,449)	(100,626)	4,823
				(3,987)	(3,712)	275	Non Pay Costs	(11,325)	(11,329)	(4)	(22,796)	(23,208)	(412)
4,774	4,396	(378)	7.9%	**(21,909)**	**(20,350)**	**1,560**	**Total Operating Expenses**	**(63,896)**	**(61,217)**	**2,679**	**(128,245)**	**(123,834)**	**4,411**
4,774	4,396	(378)	7.9%	**735**	**1,184**	**449**	**EBITDA**	**2,245**	**4,009**	**1,763**	**4,491**	**6,844**	**2,353**
				(537)	(545)	(9)	Depreciation	(1,610)	(1,636)	(26)	(3,220)	(3,272)	(52)
				(212)	(212)	(0)	PDC Paid	(635)	(636)	(1)	(1,271)	(1,272)	(1)
				0	0	0	Interest Received	0	0	0	0	0	0
4,774	4,396	(378)	7.9%	**(14)**	**426**	**440**	**Surplus / (Deficit)**	**0**	**1,737**	**1,737**	**0**	**2,300**	**2,300**
				0	1,137	1,137	Gain / (loss) on disposal	0	1,137	1,137	0	1,137	1,137
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,774	4,396	(378)	7.9%	**(14)**	**1,563**	**1,577**	**Surplus / (Deficit)**	**0**	**2,874**	**2,874**	**0**	**3,437**	**3,437**

The Trust's financial plan, in line with national guidance, covers the period H1 2021 / 22 (April to September 2021) only. The forecast shown similarly reflects this period only. The forecast has been assessed and a surplus of £2.3m, excluding exceptional items, is reported. Development of the H2, and longer term plan, continues with a focus on recurrent and non recurrent run rates.

Trust Monthly I & E Profile
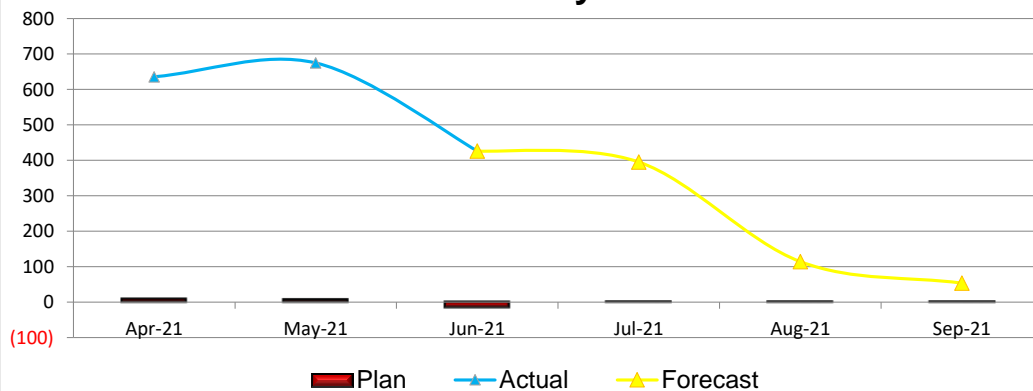
Trust Cumulative I & E Profile
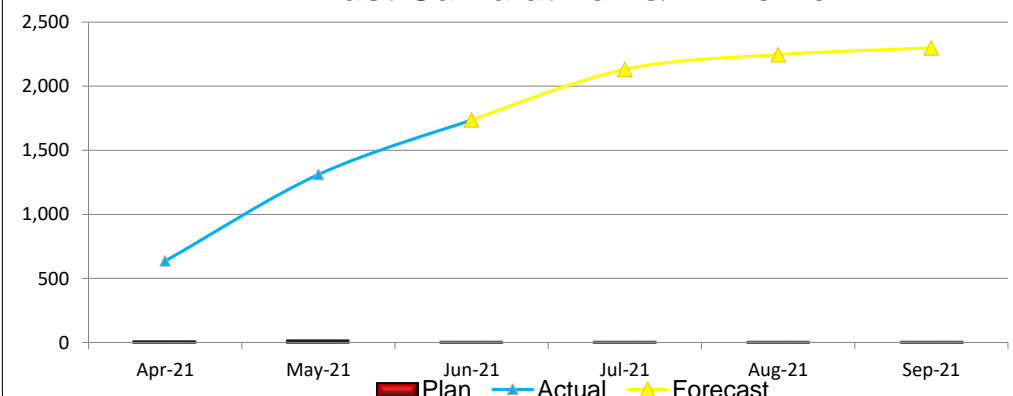
Income & Expenditure Position 2021 / 22

For the period April to June 2021 a surplus of £1.7m has been forecast. Expenditure is forecast to increase resulting in a H1 forecast of £2.3m surplus.

For April to September 2021 the Trust has an operational plan to deliver a breakeven position. It was based on estimated expenditure run rates and updated funding available. This includes non recurrent funding allocated through the Integrated Care System (ICS). Actual and forecast spend continue to be reviewed monthly with the current position reflected in a revised forecast position. This has been discussed with the relevant ICS contacts.

Income

The vast majority of income continues to be received as a singular block payments from each commissioner. These are based upon national funding principles and includes 2020 / 21 Mental Health Investment Standard (MHIS) funding. Initial funding for 2021 / 22 MHIS has been agreed with Barnsley and Wakefield commissioners and the cash payments are being finalised.

Funding from Kirklees and Calderdale commissioners will be included once formally agreed; good progress has been made with all parties to ensure that MHIS is being fully utilised within the system.

Other income streams, such as local authorities, continue as normal with standard contracting arrangements in place.

In June income received from these contracts was £20.0m and reflects the income received to date. This is less than plan due to the timing and part year effect of receipt of MHIS funding.

Pay

Pay Spend in June 2021 is £16.6m. This is the same as April and May 2021 and is approximately £0.3m higher than the run rate in Q4 2020 / 21, although the overall WTE is the same as Q4, partially linked to the point below and the premium rates of pay for agency staff. Further analysis has been included in the pay information section to highlight the variations by staff group and service line.

Utilisation of temporary workforce options, including bank, agency and overtime payments has continued. Bank and agency accounted for 9.3% of overall pay expenditure. The headlines behind this request are covered within the pay analysis section.

Non Pay

Non pay expenditure continues to have specific areas of variability. These are subject to focus later in the report and include out of area bed placements and the purchase of locked rehab beds. Covid-19 response spend continues to be closely monitored; it has been confirmed that national supply of PPE will continue for 2021 / 22.

Covid-19 Financial Impact

Covid-19 continues to have an impact on our financial position and the table below highlights 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.

In line with the principles established in H2 20/21 funding for additional covid-19 costs has been provided prospectively through the West Yorkshire ICS. Reporting continues via the monthly NHS Improvement financial return with the expenditure summarised below.

Costs are reviewed and agreed through the Trust Operational Management Group to ensure that expenditure continues to provide the best possible service and value for money. This also ensures that the approach is joined up and consistent across the Trust.

Heading	Description	Apr-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Total £k
Staffing - backfill	Additional staff costs to support Trust workforce response. Includes acting up and backfill arrangements	22	51	37				110
Staffing - vaccination	Additional staff costs to support vaccination programme (including overtime)	33	62	19				114
Staffing - Isolation	Isolation, shielding and backfill for covid absence	56	15	31				102
Total – Pay		**110**	**128**	**87**	**0**	**0**	**0**	**325**
Lateral Flow Testing	Distribution of kits to staff	7	2	12				21
Laundry & Scrubs	Purchase of scrubs for staff and associated laundry costs	2	1	1				4
IT	Purchase of equipment and agile working enabling costs (VPN)	0	35	3				38
OOA Placements	Out of area bed placements required to covid issues	0	6	12				18
Staffing - security	External security costs to support vaccination	0	0	8				8
Misc / other	Other general non pay not captured in the headings above	0	15	8				23
Total – Non Pay		8	59	44	0	0	0	111
Total cost recovery		119	187	131	0	0	0	436

Within the Trust Income and Expenditure position clinical revenue is separately identified. This is income received through contracts to provide clinical services. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income.

The financial arrangements have been set for April to September 2021 (H1 2021 / 22). These are the same as H2 2020 / 21 with income received via block contracts from our main commissioners. The block is a combination of national calculation and agreed locally funding for the Mental Health Investment Standard (MHIS) in 2020 / 21. Additional MHIS funding for 2021 / 22 will be added as and when confirmed with commissioners.

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

The arrangements for October 2021 to March 2022 are yet to be confirmed.

	Apr-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Oct-21 £k	Nov-21 £k	Dec-21 £k	Jan-22 £k	Feb-22 £k	Mar-22 £k	Total £k	Total 20/21 £k
CCG	15,365	15,341	14,558	15,425	15,425	15,425							91,538	177,447
ICS / System	1,737	1,737	1,737	1,737	1,737	1,737							10,421	9,917
Specialist Commissioner	2,475	2,471	2,473	2,473	2,473	2,473							14,837	28,281
Local Authority	404	490	402	416	416	416							2,543	5,025
Partnerships	657	636	654	624	624	624							3,820	7,514
Top Up / ERF	0	0	169	0	0	(77)							92	5,458
Other	41	50	46	46	46	46							274	4,815
Total	20,679	20,725	20,039	20,720	20,720	20,643	0	0	0	0	0	0	123,524	238,457
20/21	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	

Trust Income Profile (Plan, Actual, Forecast)
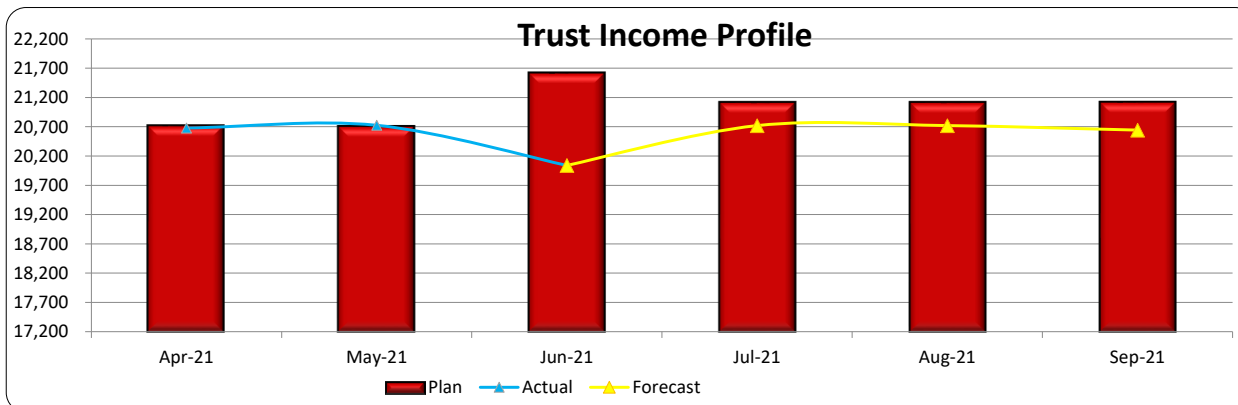
As agreed within the ICS, additional income has been shown on the Top Up / ERF (Elective Recovery Fund) line in June. This reflects additional income for increased activity, and associated increased costs, within Barnsley community services. Guidance on this fund has been revised post month end and the updated impact will be reported next month.

The increase in budget in June 2021 reflects the agreed initial 21/22 MHIS funding for Barnsley and Wakefield commissioners although the physical cash flows have yet to be processed.

Further non recurrent funding proposals have been submitted to all commissioners outlining how this could be utilised as part of the reset and recovery programme. These will also be added when agreed.

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 80% of our budgeted total expenditure. Trust priorities include a focus on the health and wellbeing of this workforce.

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-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Oct-21 £k	Nov-21 £k	Dec-21 £k	Jan-22 £k	Feb-22 £k	Mar-22 £k	Total £k
Substantive	15,224	15,171	15,089										45,484
Bank & Locum	803	911	795										2,508
Agency	583	560	754										1,897
Total	16,610	16,641	16,637	0	0	0	0	0	0	0	0	0	49,888
20/21	15,142	16,019	15,709	15,501	15,912	16,205	15,969	16,313	16,199	16,273	16,245	18,087	168,476

Bank as %	4.8%	5.5%	4.8%										5.0%
Agency as %	3.5%	3.4%	4.5%										3.8%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,100	4,076	4,049										4,075
Bank & Locum	255	263	218										245
Agency	107	115	128										117
Total	4,461	4,454	4,396	0	0	0	0	0	0	0	0	0	4,437
20/21	4,171	4,332	4,302	4,312	4,357	4,283	4,661	4,634	4,678	4,424	4,407	4,472	4,419

Pay Expenditure Profile

Legend: 21/22 budget — 20/21
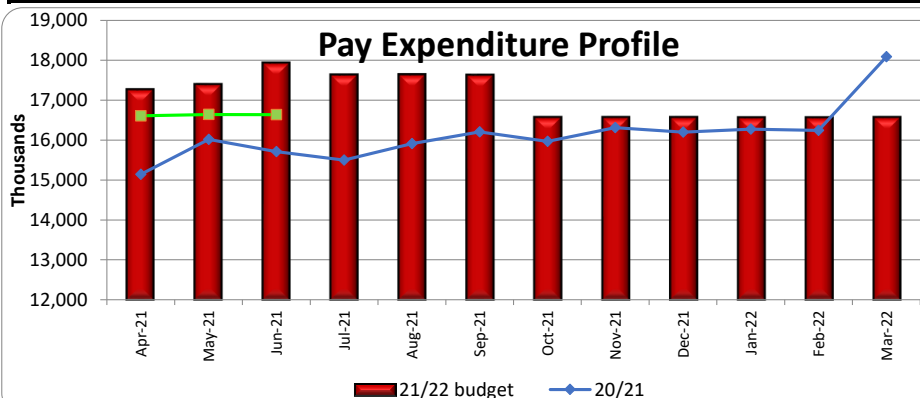
Pay expenditure run rate for quarter 1 has remained flat at £16.6m per month.

Increases for incremental pay rises are included in both the actuals and plan but no pay award assumption has been included yet for 2021 / 22 in line with guidance.

Similar to last month there has been a small reduction in substantive staff in month and there has also been a reduction in bank and locum used. This has partially been offset by agency staff.

Covid continues to have an impact on staffing levels in work with increased levels of isolation during June. As a result both bank and agency are expected to increase next month.

The overall Trust pay expenditure position includes different types of staffing and a wide variety of service lines and as a single value includes both under and overspends. This additional analysis provides a further level of detail and an indication of focussed action areas within the Trust.

Year to Date Budget v Actual - by staff group

Staff Group	Budget £k	Substantive £k	Bank / Locum £k	Agency £k	Total £k	Variance £k
Medical	6,420	5,754	153	765	6,672	252
Nursing Registered	20,501	15,071	828	221	16,121	(4,380)
Nursing Unregistered	6,340	5,233	1,235	683	7,151	811
Other	14,247	12,169	121	218	12,509	(1,738)
Corporate Admin	4,167	3,907	72	10	3,989	(177)
BDU Admin	3,428	3,348	98	0	3,447	18
Vacancy Factor	(2,531)				0	2,531
Total	52,571	45,484	2,508	1,897	49,888	(2,683)

WTE In month Budget v Actual - by staff group

Staff Group	Budget WTE	Substantive WTE	Bank / Locum WTE	Agency WTE	Total WTE	Variance WTE
Medical	227	181	1	16	198	(28)
Nursing Registered	1,481	1,220	57	17	1,293	(188)
Nursing Unregistered	870	710	134	82	927	57
Other	1,367	1,184	9	13	1,207	(161)
Corporate Admin	352	323	18	0	341	(11)
BDU Admin	476	430	0	0	430	(47)
Total	4,774	4,049	218	128	4,396	(378)

By staff group the key elements to highlight are:

Underspending against budget for unregistered nurses has increased in month through both a reduction in substantive staff in post and delays in recruiting for new investment. This continues to be supported by the use of bank shifts and overtime. Some backfill of the gaps are supported by additional unregistered staffing which shows as an overspend above.

Work continues to increase the number of registered nurses including overseas recruitment and additional substantive recruitment.

The financial plan includes a value relating to expected staff vacancies and posts not back filled. This value, shown seperately in these tables as Vacancy Factor, is a planning assumption and no posts are actively held. This is due to natural timing gaps in recruitment both for new investments and existing substantive posts.

Year to date Budget v Actual - by service

	Budget £k	Substantive £k	Bank / Locum £k	Agency £k	Total £k	Variance £k
MH Community	22,599	19,313	514	949	20,775	(1,823)
Inpatient	11,685	9,963	1,637	851	12,451	766
BDU Support	3,193	1,873	93	8	1,974	(1,219)
Community	7,177	6,072	111	27	6,211	(967)
Corporate	10,448	8,262	153	63	8,478	(1,971)
Vacancy Factor	(2,531)				0	2,531
Total	52,571	45,484	2,508	1,897	49,888	(2,683)

In month Budget v Actual - by service

	Budget WTE	Substantive WTE	Bank / Locum WTE	Agency WTE	Total WTE	Variance WTE
MH Community	1,848	1,595	31	27	1,652	(196)
Inpatient	1,141	956	159	91	1,207	66
BDU Support	356	211	5	0	216	(140)
Community	739	625	10	3	638	(102)
Corporate	689	663	12	7	682	(6)
Vacancy Factor					0	
Total	4,774	4,049	218	128	4,395	(378)

With the exception of Inpatient areas, which includes adult acute, older peoples and Forensics, all service groups are underspending and have unfilled posts. The corporate service line includes covid-19 spend which, as demonstrated earlier in the paper, is less than previously.

This information continues to inform the Trust workforce and recruitment strategy and the overall financial planning process.

Agency spend is £754k in June.

Agency costs continue to remain a focus for the NHS nationally and for the Trust. As such separate analysis of agency trends is presented below.

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

NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.

Due to covid 19 there is currently no agency cap for 2021/22, 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.

June spend has increased from an average of £0.6m in April and May. This increase is within the unregistered nursing agency workforce which is supporting the acute inpatient and forensic inpatient requirements.

Triangulation continues to compare agency spend with substantive staff and bank staff payments.

Agency Expenditure Trends (£m)

Legend: Consultants, Other Medical, Nursing, Other Clinical, A & C, Other
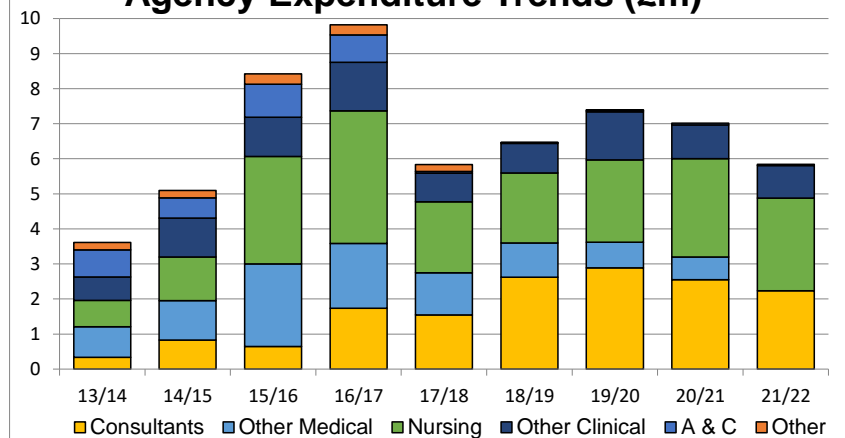
Agency and bank expenditure trend

Legend: Bank, Agency
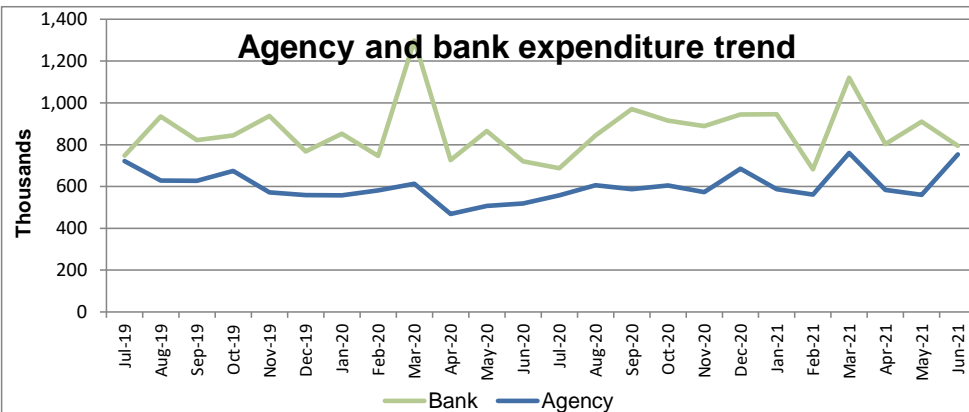
Agency Spend By Month

Legend: 18/19, 19/20, 20/21, 21/22
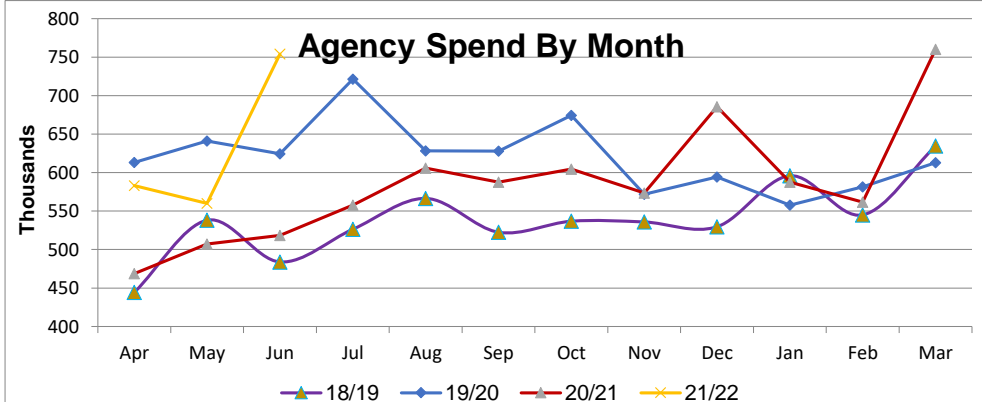
Whilst pay expenditure represents approximately 80% of all Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the BDUs and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position.

	Apr-21 £k	May-21 £k	Jun-21 £k	Jul-21 £k	Aug-21 £k	Sep-21 £k	Oct-21 £k	Nov-21 £k	Dec-21 £k	Jan-22 £k	Feb-22 £k	Mar-22 £k	Total £k
2021/22	3,834	3,783	3,712										11,329
2020/21	3,900	2,811	3,236	3,906	3,821	3,857	4,090	3,772	3,925	3,707	3,628	5,921	46,574

Non Pay Category	Budget Year to date £k	Actual Year to date £k	Variance £k
Drugs	929	914	(15)
Establishment	1,857	1,825	(33)
Lease & Property Rental	1,914	1,988	74
Premises (inc. rates)	1,440	1,618	179
Purchase of Healthcare	1,672	1,806	133
Travel & vehicles	1,055	939	(116)
Supplies & Services	1,700	1,467	(233)
Training & Education	173	177	5
Clinical Negligence & Insurance	218	322	105
Other non pay	367	272	(95)
Total	11,325	11,329	4
Total Excl OOA and Drugs	8,724	8,610	(115)
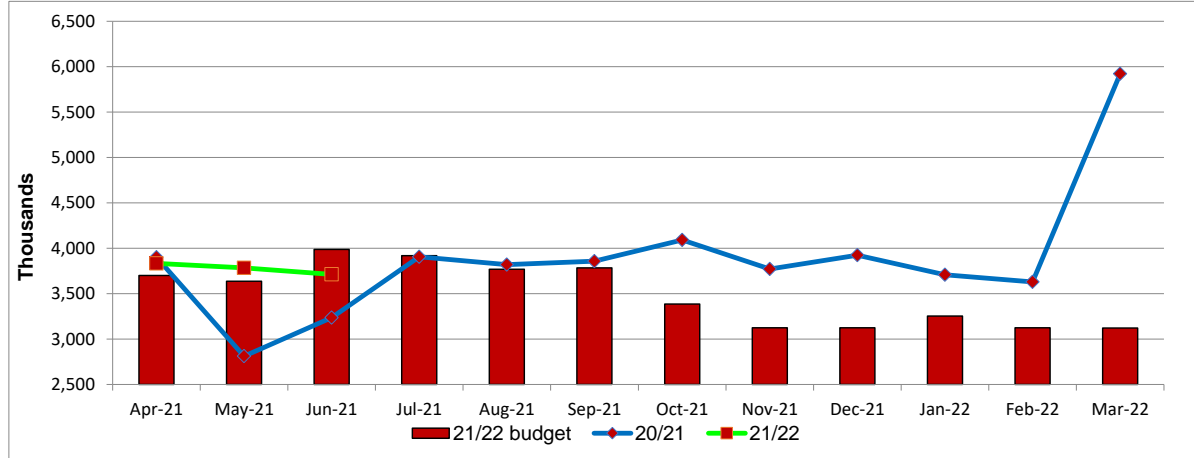
Key Messages

Non pay pressures continue within the purchase of healthcare section. This includes both out of area bed placements and the purchase of locked rehab beds. These are specifically reviewed on the out of area focus page.

Premises costs are currently higher than planned. Review has confirmed that this is the timing of purchases being earlier than originally assumed.

Supplies and services continue to be less than planned. Elements of this are also timing related with additional spend forecast later in the year.

The heading of purchase of healthcare within the non pay analysis includes a number of different services; both the purchase of services from other NHS trusts or organisations for services which we do not provide (mental health locked rehab, pathology tests) or to provider additional capacity for services which we do.

Due to it's volatile, and potentially expensive nature, the focus has been on out of area bed expenditure. In this context this 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.

Breakdown of Purchase of Healthcare

	Budget	Actual	Variance
	Year to date	Year to date	
Heading	**£k**	**£k**	**£k**
Locked Rehab	571	684	113
Out of Area			
Acute	313	48	(265)
PICU	190	48	(142)
Other Services	599	1,026	427
Total	**1,672**	**1,806**	**133**

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
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**
21/22	195	251	199										**645**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
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**
21/22	221	314	328										**863**

Bed Day Information 2021 / 2022 (by category)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
PICU	203	236	245										**684**
Acute	18	78	83										**179**
Total	221	314	328	0	0	0	0	0	0	0	0	0	**863**

Out of Area Expenditure - monthly

Legend: 17/18, 18/19, 19/20, 20/21, 21/22
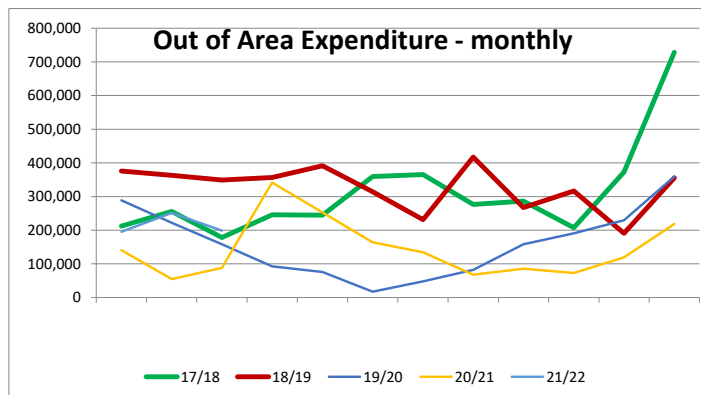
The overall delivery of activity remains a challenge for the Trust and, to date performance has been exceptional in ensuring that as many people as possible are supported within the Trust bed base especially considering the impact that covid has had.

Spend of £199k in 2021 brings monthly expenditure back in line with March and April 2021 and is a reduction from May 2021.

The response to Covid-19 continues to impact on demand and specific placements have been charged against the covid allocation. High levels of acuity have also been experienced adding to the pressure on inpatient wards.

The bed numbers of June 2021 also includes 54 bed days which are paid directly by the ICS. There is no cost included within the Trust financial position.

Balance Sheet 2021 / 2022

	2020 / 2021 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	104,978	102,429	Pg 14
Current Assets			
Inventories & Work in Progress	173	173	
NHS Trade Receivables (Debtors)	1,173	409	1
Non NHS Trade Receivables (Debtors)	1,828	977	1
Prepayments	2,867	3,078	2
Accrued Income	3,090	4,352	3
Cash and Cash Equivalents	56,648	60,774	Pg 16
Total Current Assets	**65,781**	**69,764**	
Current Liabilities			
Trade Payables (Creditors)	(1,182)	(814)	4
Capital Payables (Creditors)	(585)	(487)	
Tax, NI, Pension Payables, PDC	(5,920)	(7,026)	
Accruals	(24,112)	(23,197)	5
Deferred Income	(3,981)	(4,036)	6
Total Current Liabilities	**(35,779)**	**(35,559)**	
Net Current Assets/Liabilities	**30,001**	**34,204**	
Total Assets less Current Liabilities	**134,980**	**136,633**	
Provisions for Liabilities	(7,348)	(7,252)	
Total Net Assets/(Liabilities)	**127,632**	**129,381**	
Taxpayers' Equity			
Public Dividend Capital	45,384	45,384	
Revaluation Reserve	11,721	10,596	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	65,307	68,181	7
Total Taxpayers' Equity	**127,632**	**129,381**	

The Balance Sheet analysis compares the current month end position to that at 31st March 2021.

1. Both NHS and Non-NHS Debtors are low, 85% of this value is less than 30 days, and action is taken on all debtors over 30 days.

2. Prepayments are currently higher as a number of contracts start at the beginning of the year, this includes software licences and the car insurance for the Trust.

3. Accrued income remains high primarily due to additional income forecast from NHS England in March 2021 (£2.1m) relating to Flowers and annual leave payments. This is scheduled to be received in August 2021. We are still chasing local authorities for outstanding purchase orders and will invoice once received.

4. Creditors, invoices outstanding for the Trust to pay, continues to be closely reviewed alongside Better Payment Practice Code (page 17) performance. 95% of aged creditors are less than 30 days old.

5. Accruals continue to be at a higher level than historically. Work continues to chase invoices etc to reduce this value.

6. Deferred income has increased from year end due to receipt of Q1 training and education in April 2021.

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

Capital Programme 2021 / 2022

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Major Capital Schemes							
En Suite	2,000	0	0	0	2,000	0	
OPS transformation	578	0	0	0	578	0	
Maintenance (Minor) Capital							
Routine Maintenance	3,194	324	253	(71)	3,275	81	
Fire Safety	160	0	0	0	160	0	
Plant & Machinery	455	10	0	(10)	455	0	
Equipment	100	10	0	(10)	100	0	
Fixtures & Fittings	45	0	0	0	45	0	
Other	643	42	291	249	435	(208)	
IM & T							
Clinical Systems	275	8	0	(8)	275	0	
Hardware	200	0	0	0	200	0	
Cybersecurity, Infrastructure	200	0	12	12	327	127	
Software	600	0	0	0	600	0	
Other	1,140	0	0	0	1,140	0	
VAT Refunds						0	
TOTALS	**9,590**	**394**	**556**	**162**	**9,590**	**(0)**	
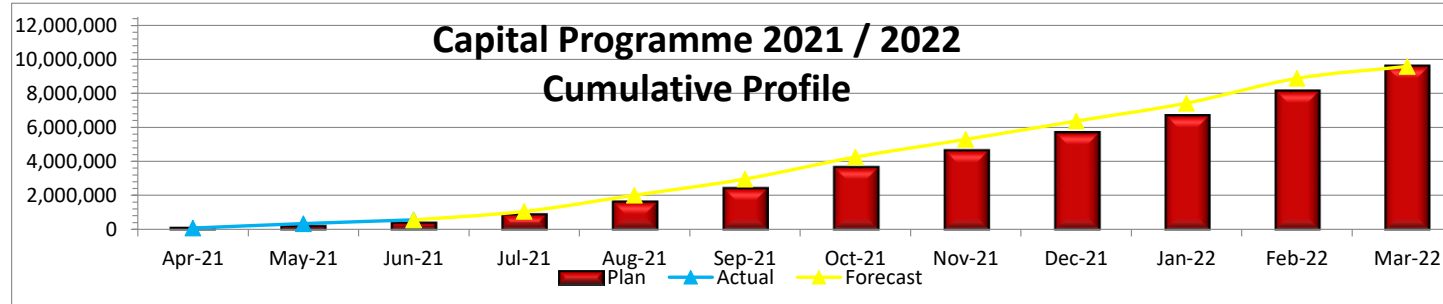
Capital Expenditure 2021 / 22

The Trust capital programme forms part of the overall West Yorkshire & Harrogate ICS capital plan. For 2021 / 22 the Trust component is £9.59m.

Minimal spend was planned for Q1 21//2 but preparatory work is continuing internally. This work has highlighted current increased costs and availability issue for resources. This is linked to Covid-19, Brexit, the Suez canal blockage and general demand.

Schemes are contuinually assessed against evolving safety and service requirements and continue to be assessed to ensure they are value for money in the current climate.

Spend to date is mainly a new scheme required to enable relocation of services within Barnsley and work at the Priestley Unit.

Further work is taking place to fully understand the costs and value for money associated with the proposed Bretton centre en-suite scheme.

Capital Programme 2021 / 2022 Cumulative Profile
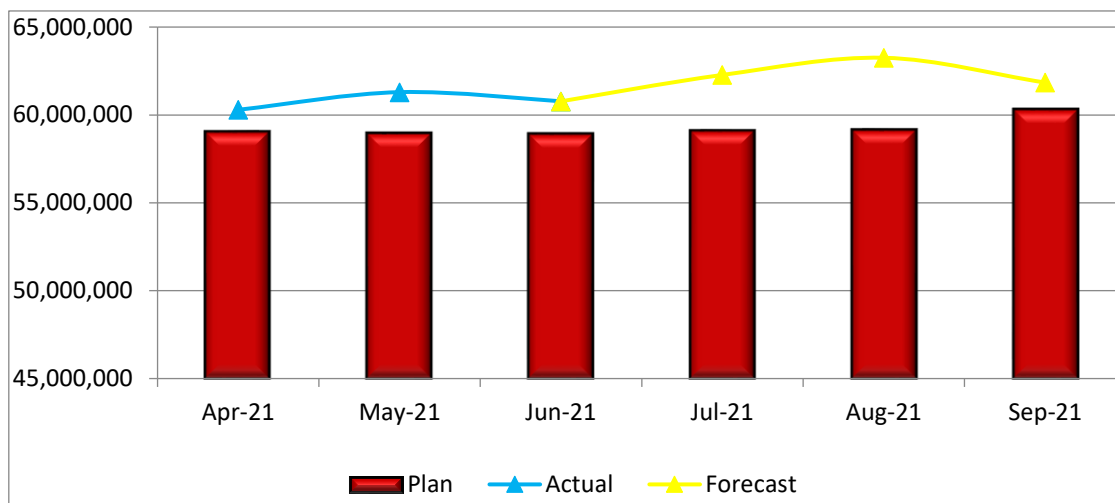
	Plan £k	Actual £k	Variance £k
Opening Balance	56,648	56,648	
Closing Balance	58,927	60,774	1,847
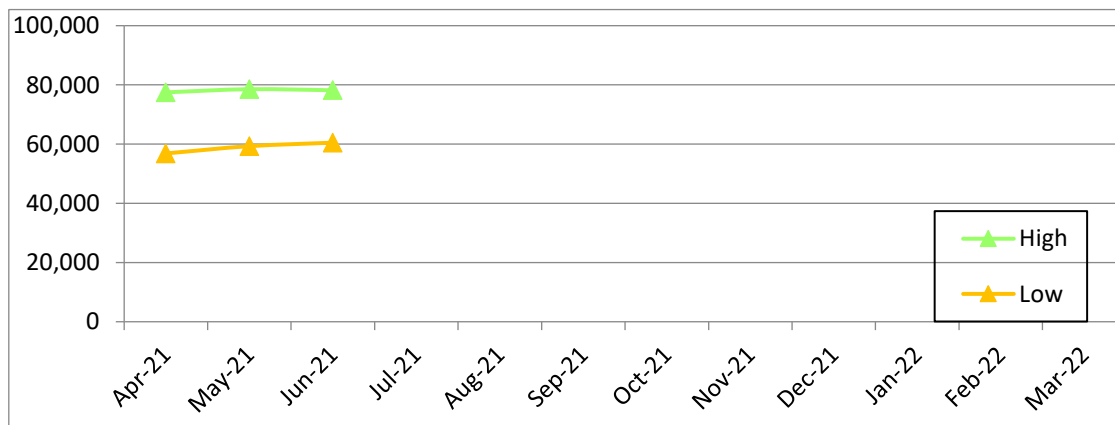
Cash remains positive. This helps to enable continued investment in the Trust capital programme.

An internal cash plan has been developed for 2021 / 22 showing an expected maintenance of cash levels.

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

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

The highest balance is: £78.2m
The lowest balance is: £60.5m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Note
Opening Balances	**56,648**	**56,648**	
Surplus / Deficit (Exc. non-cash items & revaluation)	1,636	4,009	
Movement in working capital:			
Inventories & Work in Progress	0	0	
Receivables (Debtors)	300	143	
Accrued Income / Prepayments	0	0	
Trade Payables (Creditors)	1,110	(601)	
Other Payables (Creditors)	0	(157)	
Accruals & Deferred income	(14)		
Provisions & Liabilities	0	(96)	
Movement in LT Receivables:			
Capital expenditure & capital creditors	(754)	(654)	
Cash receipts from asset sales	0	1,482	
PDC Dividends paid	0	0	
PDC Dividends received			
Interest (paid)/ received	0	0	
Closing Balances	**58,927**	**60,774**	

Cash Bridge 2021 / 2022
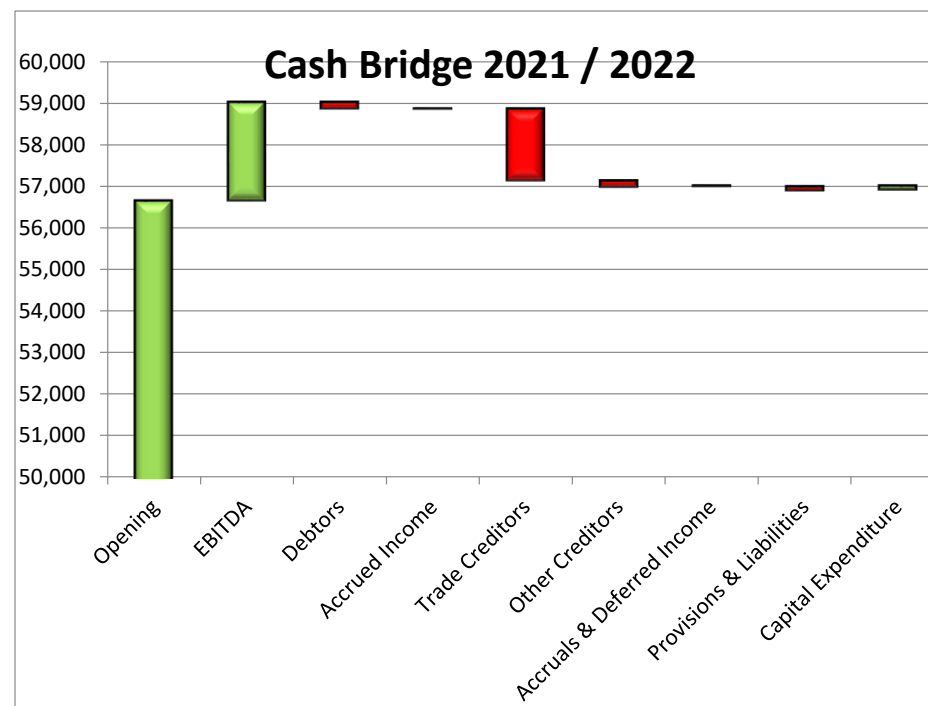
The table above summarises the reasons for the movement in the Trust cash position during 2021 / 2022. This is also presented graphically within the cash bridge.

The surplus / deficit movement is the Trust I & E position adjusted for depreciation which is non cash and adding back in PDC as this only generates a cash impact on a 6 monthly basis and is shown separately.

The current main driver is the overall Income and Expenditure position which is better than breakeven and the receipt of £1.5m from the sale of Mount Vernon.

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.

We continue to optimise the finance and procurement system which was implemented in October 2020. This includes a regular review of outstanding invoices, and working with SBS to resolve any issues.

Performance in June has seen 95% of volume and 92% by value paid within the Trust payment terms of 30 days. The team continue to work with internal stakeholders and customers to ensure that the purchase to pay service runs as smoothly as possible.

NHS	Number %	Value %
In Month	100%	100%
Cumulative Year to Date	89%	96%
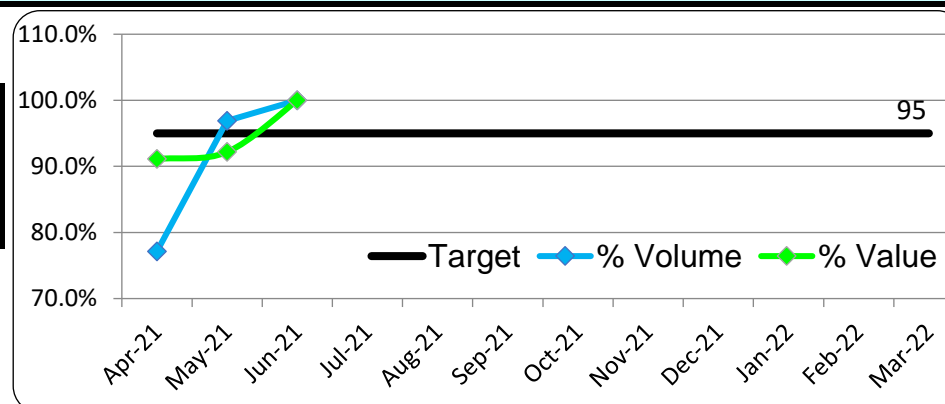
Non NHS	Number %	Value %
In Month	97%	93%
Cumulative Year to Date	98%	96%

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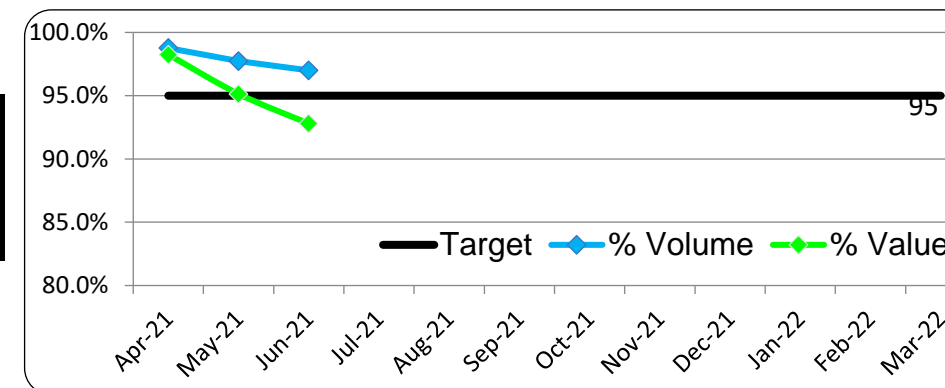
As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

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

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

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

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
02-Jun-21	Computer Licences	Trustwide	Trustmarque Solutions Ltd	2320304	972,466
02-Jun-21	Computer Licences	Trustwide	Trustmarque Solutions Ltd	2320302	133,045
02-Jun-21	Computer Licences	Trustwide	Phoenix Partnership (Leeds) Ltd	12734	124,306
01-Jun-21	Rent	Wakefield	Bradbury Investments Ltd	1569	118,518
16-Jun-21	Computer Licences	Trustwide	Datix Ltd	SIN016448	92,582
03-Jun-21	IT Services	Trustwide	Daisy Corporate Services	3I472273	90,250
30-Apr-21	Drugs	Trustwide	Lloyds Pharmacy Ltd	99692	77,578
01-Jun-21	Computer Licences	Trustwide	Thirsty Horses Ltd	INV0393	64,260
31-May-21	Drugs	Trustwide	Lloyds Pharmacy Ltd	100615	63,367
29-Apr-21	Rent	Barnsley	Dr A D Mellor And Partners	GHP92021	60,192
22-Mar-21	Training	Trustwide	University Of Sheffield	1800209316	57,500
02-Jun-21	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	995524	55,602
28-May-21	Staff Safety	Trustwide	Lone Worker Solutions Ltd	163810	55,181
28-May-21	Staff Safety	Trustwide	Lone Worker Solutions Ltd	163811	55,181
22-Feb-21	Telecoms	Trustwide	Virgin Media Ltd	60044852	48,791
01-Jun-21	Telecoms	Trustwide	Virgin Media Business Ltd	927686105	45,215
17-May-21	Drugs	Trustwide	Nhs Business Services Authority	1000069271	42,294
21-Jun-21	Public Health	Wakefield	Wakefield Metropolitan District Council	91313448108	39,231
18-May-21	Insurance	Trustwide	Willis Ltd	10958GP21000001PRM	37,186
02-Jun-21	Staff Recharge	Trustwide	Leeds & York Partnership Nhs Foundation Trust	995524	33,404
14-Jun-21	Recruitment	Trustwide	Friday Ad Ltd	IN230925	32,399
31-May-21	Advocacy	Forensics	Cloverleaf Advocacy 2000 Ltd	10170	32,358
09-Jun-21	Rent	Barnsley	Chapelfield Medical Centre	279	31,599
12-May-21	Telecoms	Trustwide	Vodafone Ltd	98001753	31,577
12-Jun-21	Telecoms	Trustwide	Vodafone Ltd	98272750	31,562
02-Jun-21	Computer Licences	Trustwide	Trustmarque Solutions Ltd	2320307	30,397
21-Apr-21	Utilities	Trustwide	Edf Energy Customers Ltd	000009612868	29,719
04-May-21	Utilities	Trustwide	Edf Energy Customers Ltd	000009656774	29,719
01-Jun-21	Rent	Kirklees	Bradbury Investments Ltd	1570	27,758
10-Jun-21	Healthcare	Forensics	Humber Nhs Foundation Trust	59889925	27,150
02-Jun-21	Utilities	Trustwide	Edf Energy	000009862517	26,917
11-Jun-21	Photocopiers	Trustwide	Kyocera Document Solutions (Uk) Ltd	1238908	25,365
11-Jun-21	Photocopiers	Trustwide	Kyocera Document Solutions (Uk) Ltd	1238905	25,365
11-Jun-21	Photocopiers	Trustwide	Kyocera Document Solutions (Uk) Ltd	1238920	25,365

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.

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.3%	4.2%	4.2%	4.2%	4.3%	4.2%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.0%	3.8%	3.9%	4.2%	4.3%	4.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.7%	84.5%	82.0%	78.8%	79.4%	88.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.2%	86.8%	84.2%	82.5%	82.5%	79.5%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.8%	96.1%	96.4%	95.7%	96.1%	94.3%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.9%	97.7%	97.2%	97.3%	96.9%	96.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.4%	89.2%	87.0%	86.4%	82.7%	83.6%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.1%	77.3%	75.5%	75.9%	77.7%	79.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	96.4%	95.9%	95.7%	95.7%	95.6%	93.9%
Information Governance	Resources	Well Led	AD	>=95%	97.2%	97.3%	97.7%	96.9%	96.0%	95.2%
Moving and Handling	Resources	Well Led	AD	>=80%	89.8%	90.1%	89.9%	90.0%	91.6%	93.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.6%	94.0%	93.1%	91.8%	90.2%	87.0%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	95.5%	95.6%	93.4%	90.7%	86.8%	78.9%
Prevent	Improving Care	Well Led	AD	>=80%	96.1%	96.2%	95.5%	95.6%	96.0%	96.0%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.6%	94.8%	94.1%	94.5%	94.4%	94.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	95.3%	95.2%	94.8%	94.1%	93.9%	93.4%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD		Data unavailable at the time of producing this report					
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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.1%	3.2%	3.2%	4.2%	5.7%	4.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.8%	3.3%	3.0%	4.2%	5.1%	4.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.6%	83.2%	82.2%	80.7%	80.1%	85.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	83.6%	83.5%	82.7%	78.8%	78.0%	79.5%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.4%	94.0%	94.9%	95.3%	96.8%	96.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	96.6%	97.3%	97.8%	98.1%	97.3%	97.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.6%	89.2%	87.6%	86.9%	87.2%	85.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.2%	78.3%	76.1%	76.9%	79.4%	85.2%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	95.6%	95.6%	95.3%	95.5%	95.3%	94.2%
Information Governance	Resources	Well Led	AD	>=95%	98.6%	99.0%	99.3%	97.5%	96.8%	95.6%
Moving and Handling	Resources	Well Led	AD	>=80%	94.1%	94.5%	94.7%	94.7%	95.0%	95.8%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	95.7%	94.9%	91.1%	90.3%	83.6%	84.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	93.3%	92.7%	87.9%	87.2%	79.6%	80.7%
Prevent	Improving Care	Well Led	AD	>=80%	96.0%	96.1%	95.9%	96.1%	95.8%	94.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.5%	93.8%	94.2%	95.0%	94.9%	94.7%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.0%	94.4%	94.5%	94.5%	94.7%	93.9%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD		Data unavailable at the time of producing this report					
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.6%	5.6%	5.5%	4.4%	4.2%	4.6%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	6.0%	4.5%	4.1%	4.4%	4.3%	5.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.8%	83.7%	80.4%	79.9%	80.6%	80.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.3%	87.4%	81.8%	86.8%	73.2%	73.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	93.7%	93.0%	91.6%	94.4%	93.4%	93.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.6%	94.6%	94.3%	94.1%	94.9%	95.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.2%	88.3%	86.6%	86.4%	85.8%	84.5%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	65.9%	65.3%	64.3%	64.8%	65.4%	69.1%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	94.6%	93.9%	92.7%	92.8%	93.3%	92.4%
Information Governance	Resources	Well Led	AD	>=95%	97.2%	97.2%	96.9%	95.1%	93.3%	93.0%
Moving and Handling	Resources	Well Led	AD	>=80%	97.3%	97.3%	96.7%	97.4%	97.9%	98.0%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.4%	90.1%	85.7%	87.5%	87.1%	87.3%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.1%	86.1%	78.3%	80.1%	79.7%	81.2%
Prevent	Improving Care	Well Led	AD	>=80%	93.1%	92.9%	93.3%	92.3%	92.4%	93.4%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.2%	92.4%	92.5%	93.9%	94.2%	94.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	89.2%	89.6%	90.4%	90.2%	91.2%	91.4%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD		Data unavailable at the time of producing this report					
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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.7%	2.6%	2.6%	2.6%	2.8%	2.7%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	1.9%	2.2%	2.3%	2.6%	2.7%	2.6%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	75.4%	77.0%	76.9%	74.8%	72.2%	81.6%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	75.2%	74.9%	72.6%	71.3%	71.4%	67.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.5%	94.0%	93.1%	94.5%	95.0%	95.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.5%	93.8%	95.5%	95.5%	96.5%	96.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.6%	88.2%	89.3%	81.2%	79.8%	83.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	33.3%	28.6%	28.6%	20.0%	20.0%	33.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.5%	92.5%	93.9%	93.6%	93.9%	93.6%
Information Governance	Resources	Well Led	AD	>=95%	95.7%	96.7%	97.7%	95.5%	94.9%	91.7%
Moving and Handling	Resources	Well Led	AD	>=80%	97.1%	97.7%	98.1%	98.4%	98.7%	98.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.8%	92.1%	83.2%	83.7%	84.0%	81.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	88.3%	88.7%	79.8%	81.2%	81.0%	79.1%
Prevent	Improving Care	Well Led	AD	>=80%	92.0%	92.3%	92.8%	93.5%	94.1%	94.8%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	90.5%	90.2%	91.3%	91.7%	92.6%	94.2%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.5%	90.9%	92.2%	93.0%	94.2%	95.5%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD		Data unavailable at the time of producing this report					
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.3%	3.3%	3.2%	2.6%	3.0%	3.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.5%	3.5%	3.2%	2.6%	2.8%	3.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	92.5%	90.5%	89.3%	89.9%	86.5%	94.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	90.0%	90.0%	89.7%	93.1%	83.3%	83.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	80.0%	80.0%	80.0%	100%	100%	100%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.1%	90.5%	80.2%	89.3%	89.9%	88.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.1%	80.9%	80.6%	86.9%	84.2%	85.3%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	97.8%	97.8%	97.8%	99.3%	98.5%	98.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.3%	92.3%	91.5%	90.3%	91.1%	89.4%
Information Governance	Resources	Well Led	AD	>=95%	97.6%	97.6%	97.6%	96.1%	96.0%	95.2%
Moving and Handling	Resources	Well Led	AD	>=80%	98.9%	99.0%	99.0%	99.2%	99.3%	98.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.7%	98.6%	98.6%	98.2%	98.2%	97.7%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	90.5%	86.4%	77.3%	68.2%	78.3%	72.7%
Prevent	Improving Care	Well Led	AD	>=80%	98.3%	98.2%	98.7%	98.7%	97.2%	97.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.6%	97.5%	97.2%	97.4%	97.5%	97.1%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	97.4%	97.5%	97.6%	96.9%	97.6%	97.0%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD			Data unavailable at the time of producing this report				
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	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	3.3%	3.4%	3.4%	3.4%	4.1%	3.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.4%	4.2%	3.8%	3.4%	3.7%	3.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	87.6%	85.5%	82.4%	80.8%	84.1%	86.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.3%	83.1%	79.1%	76.5%	75.6%	69.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.1%	90.4%	92.8%	94.0%	93.6%	93.6%
Equality and Diversity	Resources	Well Led	AD	>=80%	96.1%	96.9%	97.2%	96.9%	96.4%	96.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	87.6%	88.2%	87.9%	86.7%	85.6%	88.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	71.3%	76.3%	82.5%	84.3%	84.2%	85.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.1%	94.3%	94.1%	93.6%	94.4%	91.9%
Information Governance	Resources	Well Led	AD	>=95%	98.2%	98.7%	98.4%	98.0%	95.9%	95.2%
Moving and Handling	Resources	Well Led	AD	>=80%	96.4%	95.9%	93.6%	93.9%	93.6%	95.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.8%	92.5%	88.1%	89.8%	89.5%	84.4%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.4%	91.2%	85.4%	87.0%	86.1%	80.6%
Prevent	Improving Care	Well Led	AD	>=80%	95.6%	95.8%	96.1%	95.9%	95.4%	95.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.3%	94.3%	93.5%	94.6%	95.1%	95.9%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	91.2%	93.1%	91.8%	92.4%	91.1%	90.1%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD			Data unavailable at the time of producing this report				
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							

Inpatient Service

Month	Objective	CQC Domain	Owner	Threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.0%	5.0%	5.1%	6.4%	7.5%	7.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.4%	5.9%	6.2%	6.4%	7.0%	7.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.7%	85.8%	84.7%	82.3%	79.2%	84.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.2%	84.0%	81.1%	78.2%	77.1%	77.3%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	90.3%	87.7%	88.4%	90.4%	89.7%	92.1%
Equality and Diversity	Resources	Well Led	AD	>=80%	97.3%	96.9%	96.7%	97.8%	97.8%	97.0%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	89.4%	89.4%	86.1%	81.5%	82.0%	82.4%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.5%	77.3%	76.2%	78.3%	79.0%	79.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	97.3%	97.2%	95.8%	95.0%	94.9%	92.5%
Information Governance	Resources	Well Led	AD	>=95%	97.3%	97.5%	97.2%	96.7%	95.8%	94.6%
Moving and Handling	Resources	Well Led	AD	>=80%	98.1%	98.1%	98.1%	98.3%	98.6%	97.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	92.6%	90.8%	88.1%	88.3%	87.1%	87.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	90.6%	88.7%	85.2%	85.4%	83.5%	83.3%
Prevent	Improving Care	Well Led	AD	>=80%	94.8%	94.2%	94.5%	95.3%	94.7%	94.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	92.0%	92.5%	92.5%	93.0%	91.8%	91.0%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	86.8%	88.6%	87.5%	87.4%	86.0%	87.3%
Bank Cost	Resources	Well Led	AD							
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD			Data unavailable at the time of producing this report				
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	HEE	Health Education England	NICE	National Institute for Clinical Excellence
ADHD	Attention deficit hyperactivity disorder	HONOS	Health of the Nation Outcome Scales	NK	North Kirklees
AQP	Any Qualified Provider	HR	Human Resources	NMoC	New Models of Care
ASD	Autism spectrum disorder	HSJ	Health Service Journal	OOA	Out of Area
AWA	Adults of Working Age	HSCIC	Health and Social Care Information Centre	OPS	Older People's Services
AWOL	Absent Without Leave	HV	Health Visiting	ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield	IAPT	Improving Access to Psychological Therapies	PbR	Payment by Results
BDU	Business Delivery Unit	IBCF	Improved Better Care Fund	PCT	Primary Care Trust
C&K	Calderdale & Kirklees	ICD10	International Statistical Classification of Diseases and Related Health Problems	PICU	Psychiatric Intensive Care Unit
C. Diff	Clostridium difficile	ICO	Information Commissioner's Office	PREM	Patient Reported Experience Measures
CAMHS	Child and Adolescent Mental Health Services	IG	Information Governance	PROM	Patient Reported Outcome Measures
CAPA	Choice and Partnership Approach	IHBT	Intensive Home Based Treatment	PSA	Public Service Agreement
CCG	Clinical Commissioning Group	IM&T	Information Management & Technology	PTS	Post Traumatic Stress
CGCSC	Clinical Governance Clinical Safety Committee	Inf Prevent	Infection Prevention	QIA	Quality Impact Assessment
CIP	Cost Improvement Programme	IPC	Infection Prevention Control	QIPP	Quality, Innovation, Productivity and Prevention
CPA	Care Programme Approach	IWMS	Integrated Weight Management Service	QTD	Quarter to Date
CPPP	Care Packages and Pathways Project	JAPS	Joint academic psychiatric seminar	RAG	Red, Amber, Green
CQC	Care Quality Commission	KPIs	Key Performance Indicators	RiO	Trusts Mental Health Clinical Information System
CQUIN	Commissioning for Quality and Innovation	LA	Local Authority	SIs	Serious Incidents
CROM	Clinician Rated Outcome Measure	LD	Learning Disability	S BDU	Specialist Services Business Delivery Unit
CRS	Crisis Resolution Service	MARAC	Multi Agency Risk Assessment Conference	SK	South Kirklees
CTLD	Community Team Learning Disability	Mgt	Management	SMU	Substance Misuse Unit
DoV	Deed of Variation	MAV	Management of Aggression and Violence	SRO	Senior Responsible Officer
DoC	Duty of Candour	MBC	Metropolitan Borough Council	STP	Sustainability and Transformation Plans
DQ	Data Quality	MH	Mental Health	SU	Service Users
DTOC	Delayed Transfers of Care	MHCT	Mental Health Clustering Tool	SWYFT	South West Yorkshire Foundation Trust
EIA	Equality Impact Assessment	MRSA	Methicillin-resistant Staphylococcus Aureus	SYBAT	South Yorkshire and Bassetlaw local area team
EIP/EIS	Early Intervention in Psychosis Service	MSK	Musculoskeletal	TB	Tuberculosis
EMT	Executive Management Team	MT	Mandatory Training	TBD	To Be Decided/Determined
FOI	Freedom of Information	NCI	National Confidential Inquiries	WTE	Whole Time Equivalent
FOT	Forecast Outturn	NHS TDA	National Health Service Trust Development Authority	Y&H	Yorkshire & Humber
FT	Foundation Trust	NHSE	National Health Service England	YHAHSN	Yorkshire and Humber Academic Health Science
FYFV	Five Year Forward View	NHSI	NHS Improvement	YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
1	On-target to deliver actions within agreed timeframes.
2	Off trajectory but ability/confident can deliver actions within agreed time frames.
3	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
4	Actions/targets will not be delivered
	Action Complete

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to align with the NHSI rating system.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

Title:	Service Demand
Paper prepared by:	Carol Harris, Director of Operations
Purpose:	The paper is to highlight where increases in demand are currently or may in the future impact service delivery. It is intended as preparation for a discussion on managing demand in a future strategic board meeting.
Mission/values:	Understanding and managing demand will ensure that the Trust is able to achieve its mission, continue to work within its values and meet the strategic objectives.
Any background papers/ previously considered by:	Information on activity and performance is provided in the integrated performance report to board each month. The locality section also provides narrative that includes service pressures.
Executive summary:	After experiencing lower levels of demand during the original onset of the Covid-19 pandemic there has been a sustained increase in demand since the various stages of the easing of restrictions during 2021. The level of demand has been exacerbated by increasing acuity and illness of service users and patients when they present. This paper summarises the current position, the measures the Trust has in place to manage the demand and sets the scene for a more detailed discussion at the Board strategy meeting in August. Board is asked to note that increases in demand are easy to see when activity numbers increase. Increases in acuity, levels of distress and need are not as straightforward to measure and often have a bigger impact on the people involved. This will need further exploration
Recommendation:	**Trust Board is asked to** • **Note the information and actions set out in the report.** • **Determine the further information required for the detailed discussion in the Strategy Board in August 2021**

With **all of us** in mind.

Service Demand

July 2021 / Carol Harris

With **all of us** in mind.

Introduction

After typically experiencing lower levels of demand during the original onset of the Covid-19 (Covid) pandemic there has been a sustained increase in demand since the various stages of the easing of restrictions during 2021. The level of demand has been exacerbated by increasing acuity and illness of service users and patients when they present. The purpose of this paper is to summarise the current position, the measures the Trust has in place to manage the demand and to set the scene for a more detailed discussion at the Board strategy meeting in August. A number of examples are provided in this paper to illustrate where and how demand is increasing.

Demand increases are easy to see when activity numbers increase. Increases in acuity, levels of distress and need are not as straightforward to measure and often have a bigger impact on the people involved.

Adult Mental Health Inpatient Services

A detailed presentation and discussion took place at the May Finance, Investment and Performance Committee meeting, focusing on adult inpatient wards. Summary points included:

- High levels of occupancy on all wards
- Complex service user presentation including some on a low secure pathway
- Increasing numbers of incidents of violence/aggression and hate incidents
- Rise in observation levels e.g. 1:1, 2:1
- Increase in seclusion: episodes and length of stay
- Section 136 demand consistently high
- Covid outbreaks place additional challenges on use of estate and staffing

In recent years there has been national and local focus to increasingly move to providing interventions and care in the community. As such there has been minimal commissioner investment in inpatient services. Consideration needs to be given to funding in both the short and medium term.

The heightened and type of demand on our inpatient wards has a number of risks attached, including the health and wellbeing of staff, staff turnover and quality of care.

Having the right staff in place helps to minimise risks to quality and safety. Maintaining safer staffing levels in context of absences due to Covid, combined with supporting people to use their annual leave during the summer holiday period is challenging.   Actions to address this include:

- Use of temporary staffing to cover gaps
- Local leadership to oversee staffing deployment in a timely way, over a 7 day period, using SafeCare as a tool where this is available
- Close working across inpatient, learning disability and forensic BDUs to share resources
- Business continuity plans in place to support the redeployment of staff from community services, noting that this has an impact on delivery across community services and intensive home-based treatment
- Rapid response to new guidance regarding fully vaccinated staff quarantine arrangements

Longer term work continues to consider new roles and innovative recruitment. Work has commenced on the inpatient priority programme.

Barnsley Community Services

Barnsley community services have continued to be provided during the pandemic. There have been differences to the nature and timing of some referrals and service provision. By nature of the services provided many have continued to be face-to-face, although other means have been used when appropriate. The demand in the acute hospital has a direct impact on demand into community services, especially when there is greater need to discharge into a community setting. Barnsley hospital has recently moved to Opel level 4 and as such our services are feeling the effect of higher demand in the system.

The numbers in the activity data cannot accurately represent the increase in acuity.

Unit		Referral Month																	
		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Barnsley Intermediate Care Crisis Response		134	94	113	115	118	109	99	87	116	104	117	110	124	93	98	95	86	54
Barnsley Intermediate Care Neighbourhood Rehabilitation		155	145	167	165	131	166	173	133	169	175	171	154	150	140	170	132	154	165
Neighbourhood Teams		2221	2038	2235	2250	3927	3908	2844	2265	2263	2568	2360	2135	2303	2206	2377	2030	2006	2257
Grand Total		2510	2277	2515	2530	4176	4183	3116	2485	2548	2847	2648	2399	2577	2439	2645	2257	2246	2476

Covid measures have placed additional pressures on the physical environment due to cleaning regimes and/or social distancing. This has had an impact on the appointments available. Services requiring physical intervention such as MSK now have longer waiting lists which need to be addressed. It should also be noted that home visits take longer than prior to the pandemic given the infection prevention and control measures that need to be adhered to.

Measures taken to address the increases in demand include:
- Use of business continuity measures as appropriate to prioritise visits
- Increase in the use of telephone (11.1%) and video consultations (34%) over a 12-month period with the offer continuing post-pandemic to address demand
- Flexible use of the available estate
- Additional temporary resources agreed for a number of services including MSK, tissue viability, dietetics and adult speech and language therapy to support the management of demand
- Integrated working and excellent partnership across the Barnsley system

Recruitment remains challenging in some areas and new ways of working or post redesign are being considered.

CAMHS

Demand for CAMHS fluctuated during the pandemic and has seen a notable increase since the return to school. Of particular note are the number of children and young people presenting in crisis and with an eating disorder.

The below data shows the number of urgent and crisis referrals received for CAMHS services by locality, by month for the last 18 months. Demand dipped in May 20 and then saw a general month on month increase to Dec 20. Demand for the last 4 months has been higher than pre-covid levels.

CAMHS Emergency and Urgent Crisis Referrals Month by Month by Locality

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Barnsley	28	33	36	19	17	20	23	30	41	22	27	18	15	19	24	32	53	34
Calderdale	33	26	33	11	15	22	17	16	23	27	36	17	18	18	36	30	32	36
Kirklees	50	45	45	30	31	34	34	30	36	39	48	36	38	33	54	68	68	73
Wakefield	72	64	58	48	36	38	55	47	67	69	55	49	61	44	78	70	64	64
Total	183	168	172	108	99	114	129	123	167	157	166	120	132	114	192	200	217	207

CAMHS Emergency and Urgent Crisis Referrals
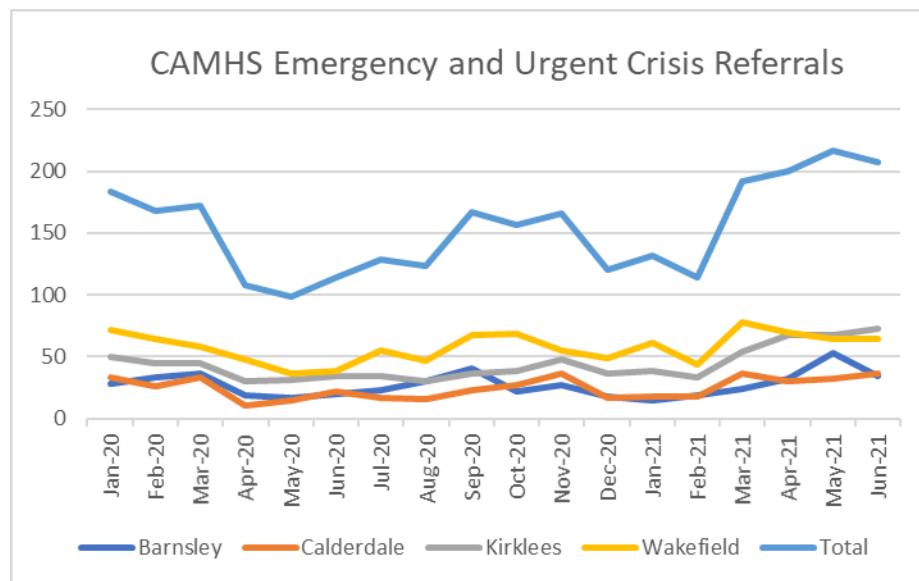
The below data shows the number of referrals for children with an eating disorder received for CAMHS services by locality, by month for the last 18 months. The Trust has an increase in demand since November 20 with spikes in December 20 and March 21.

CAMHS Eating Disorder Referrals Month by Month by Locality

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Barnsley	8	2	4	5	3	6	6	1	3	4	1	10	6	4	8	8	5	7
Calderdale	2	2	7	1		6	4	5	3	5	2	8	6	1	9	4	5	9
Kirklees	5	1	2	3	5	2	4	9	5	3	8	12	4	8	14	6	12	13
Wakefield	8	11	7	3	3	7	5	6	8	5	4	7	4	9	18	8	11	13
Grand Total	23	16	20	12	11	21	19	21	19	17	15	37	20	22	49	26	33	42

CAMHS Eating Disorder Referrals
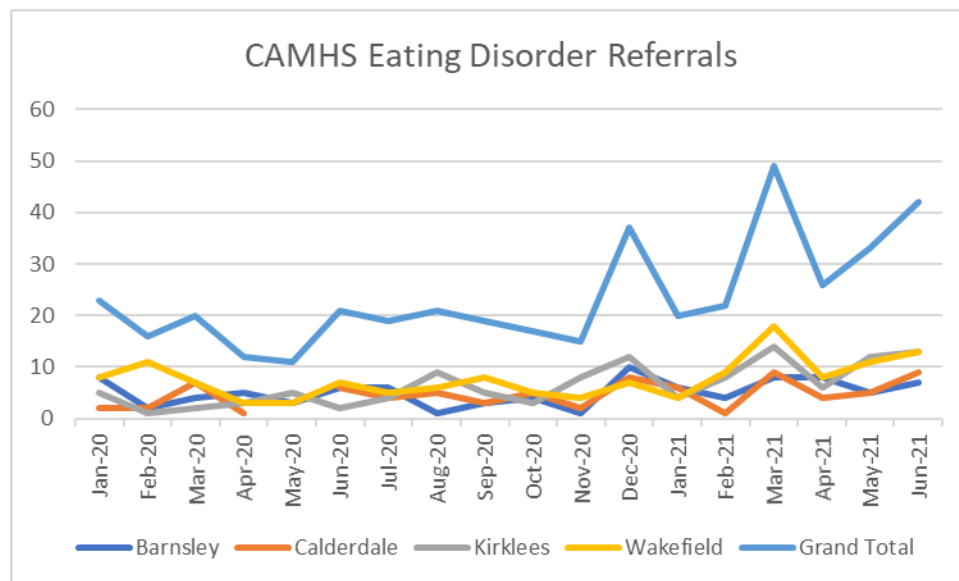
To ensure that children presenting with urgent need are prioritised, resources have been redeployed from core CAMHS. Although the data below is still showing positive performance, services have warned that this is placing pressure on the 18 weeks waiting times and a dip in performance may be seen soon.

KPI	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks	35.6%	38.1%	40.8%	42.3%	46.5%	48.8%	47.9%	47.4%	55.7%	65.4%	70.6%	66.4%	63.0%	63.2%	63.2%	66.3%	72.9%

Children needing assessment for a neurodevelopmental disorder in Calderdale and Kirklees had increased beyond the commissioned service levels prior to the pandemic. As the diagnostic assessment involves direct observation of the child at school, assessments were also delayed.   Work is taking place with commissioners to address the historic backlog and the future demand. Restrictions on estate availability in line with Covid measures, to provide safe face to face work is a further frustration in meeting the needs of this group of children.

The below table shows the number of referrals waiting for treatment at the end of each month which shows an increasing picture across the board.

Referrals waiting for treatment

	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21
Calderdale Neuro	30	37	52	62	82	99	120	126	142	156	171	195
Kirklees Neuro	696	699	699	714	712	745	770	769	783	774	782	792

Other services

Forensic services and learning disability (Horizon) experience pressures like those faced in inpatient services in relation to staffing and acuity.   Further activity that is related to the new care collaboratives impacts the staff probably more so in Horizon where staff are directly involved in discussions about the new model. Very early into the pandemic the learning disability unit at Leeds was closed and Horizon has worked with Bradford District Care Trust to provide inpatient services across West Yorkshire.

There has been pressure on the consultant psychiatrist resource in learning disability services which is not Covid related but has occurred at the same time. Business continuity measures are in place to use cross cover and a flexible approach to locum recruitment has been taken, considering, for example, using adult consultant psychiatrists with support from other learning disability consultants in the Trust.

Mental health services that are provided in the community such as IAPT, core and enhanced teams and early intervention teams experience a different level of pressure. The single point of access services (SPA) are seeing an increase in referrals after a lull during the pandemic, with teams reporting an increase in self referrals being particularly noticeable.

Team Referrals

Number of team referrals in the selected period

TeamName	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Barnsley SPA - NEW	422	488	495	472	423	446	495	429	383	441	459	385
Calderdale & Kirklees SPA Triage	659	803	726	777	622	737	797	785	659	803	715	678
Wakefield SPA	148	178	173	153	121	119	132	111	100	481	410	430

Team Referrals

Number of team referrals in the selected period

TeamName	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Barnsley SPA - NEW	202	275	383	378	367	378	426	382	354	365	356	463
Calderdale & Kirklees SPA Triage	354	479	658	810	755	813	808	795	757	771	773	899
Wakefield SPA	228	292	418	445	367	424	448	405	397	378	446	537

Team Referrals

Number of team referrals in the selected period

TeamName	Apr 21	May 21	Jun 21	Jul 21
Barnsley SPA - NEW	355	364	434	262
Calderdale & Kirklees SPA Triage	737	772	920	591
Wakefield SPA	426	392	474	255

Face to face, digital and telephone appointments can be facilitated with guidance in place to support staff to make decisions on the type of appointment to offer. Whilst numbers of digital appointments in community mental health teams are not high, the teams benchmark really well against other trusts in the number of face to face appointments.   The below charts are taken from the last monthly benchmarking return and show the Trusts monthly position (COV089) against the national position for digital contacts (chart 1) and total clinical contacts (chart 2).
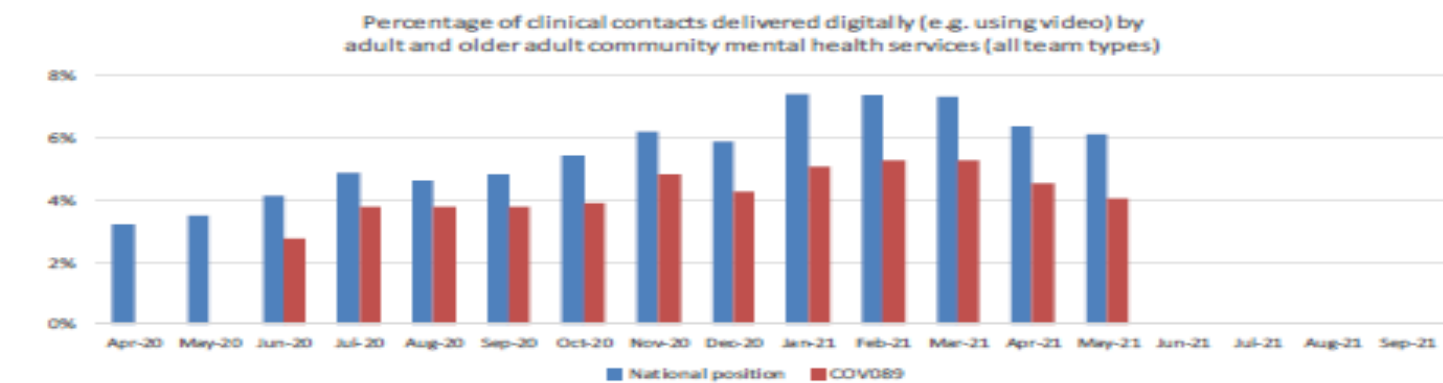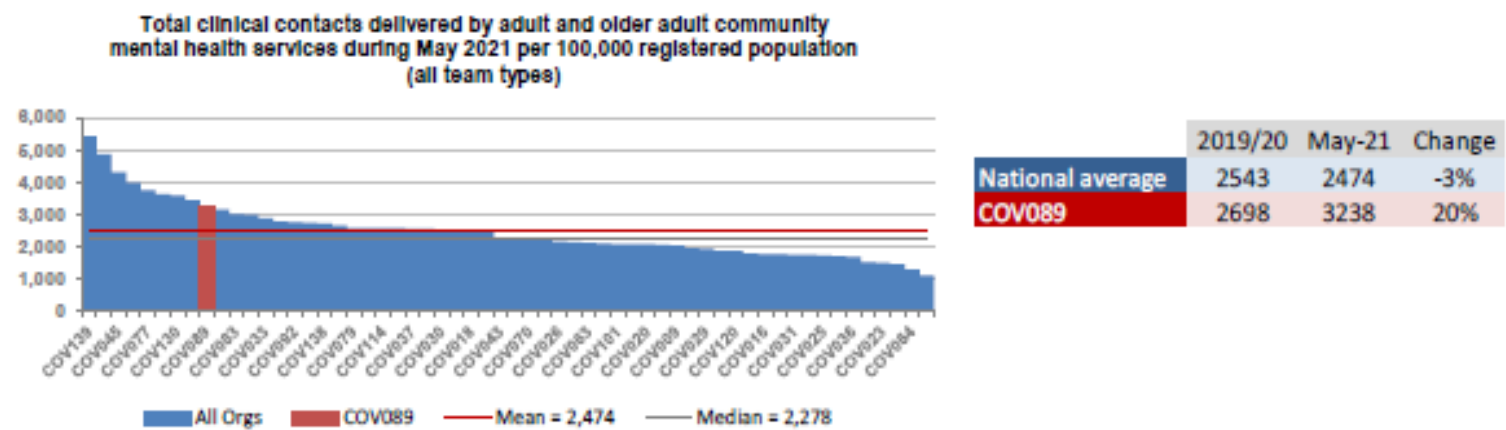
Chart 1

Percentage of clinical contacts delivered digitally (e.g. using video) by adult and older adult community mental health services (all team types)

Chart 2

Total clinical contacts delivered by adult and older adult community mental health services during May 2021 per 100,000 registered population (all team types)

	2019/20	May-21	Change
National average	2543	2474	-3%
COV089	2698	3238	20%

Challenges

The level and type of demand being experienced currently provides a number of challenges and potential risks. In summary these cover:

- Staff health and wellbeing – sustained pressure during the course of the pandemic is having an impact on the health and wellbeing of some staff. This is notable in inpatient services, where there is higher staff turnover and sickness absence
- The quality of care could be compromised given the acuity levels of some service users. For example, lower levels of meaningful activity could be provided and there may be reduced familiarity with staff where there is regular use of different temporary staffing
- The focus on managing sustained demand with higher acuity would adversely impact on improvement work the Trust is undertaking

Mitigations

The Trust has previously identified on its organisational risk register that demand was likely to increase and mitigations have been identified and progressed. These include:

- Learning from Covid being captured as it becomes available so that we can continue to adapt our services to work in different ways. We are using strategies created for the pandemic to now help us manage the resulting increases in demand, for example changing the service model to a blended offer of virtual and face to face.
- Working with partners in each place to understand the emerging impact, need and demand and building service planning together
- Prioritising service delivery to meet need, manage risk and promote safety with cross service and BDU support in place
- Prioritising building use for clinical services
- Ensuring robust business continuity plans are in place and informed by learning
- Providing additional temporary staffing resources to key areas
- Creating ways to better understand how we measure, monitor and manage demand so that adjustments to delivery can be made more proactively

Next Steps

Business continuity measures are regularly refreshed and will continue to support operational delivery throughout the next phase.

Work with partners in each place will continue. Recent stepping up of business continuity measures in Barnsley, Calderdale and Kirklees have been supported with our services reviewing the measures we have in place to prioritise flow through the acute system.

The Trust has created a demand tool that has been adopted across West Yorkshire. Work is taking place to bring together data from the forecast demand and the actual activity. This will support operational understanding of how services may need to respond for the future.

A further focus on rising acuity and meeting demand within inpatient areas is required and will be built into the priority programme

Summary and Recommendations

Where the demand can be met through increasing the available resource and/or changing the service offer work is in place to address this either internally or through discussions at place.
Challenges present where resources are not easily available and existing resources are under threat. The most notable being inpatient services where levels of distress and acuity impact upon staff wellbeing and morale and recruitment does not match turnover. The priority programme for inpatient services must progress at pace to address these issues.

Trust Board are asked to
- Note the information and actions set out in the report.
- Determine the further information required for the detailed discussion in the Strategy Board in August 2021

Title:	**Proposed Change to Trust Constitution**
Paper prepared by:	Assistant Director of Corporate Governance, Performance and Risk
Purpose:	The purpose of this report is to put forward a motion to amend our constitutional boundaries.
Mission / values:	Robust governance arrangements are essential for the Trust to remain legally constituted, financially viable and sustainable as a Foundation Trust and to continue to meet its obligations under its Constitution.
Any background papers / previously considered by:	The Trust Constitution is based on the NHS Foundation Trust Model Core Constitution (2013). The last amendments to the Trust Constitution were submitted to the Trust Board for approval in December 2019. It was submitted to the Members' Council meeting and ratified on the 31st January 2020, and subsequently submitted to the Trust Board on the 31st March 2020 for information.
Executive summary:	**Background**
	The Trust is required to have a Constitution in place that sets out:
	- how it is accountable to local people - who can become a member? - the role of the Members' Council - how Trust Board and the Members' Council are structured - how Trust Board works with the Members' Council - how the Chair and Non-Executive Directors are appointed - how public and staff governors are elected.
	Proposed amendments to the Constitution (including Standing Orders)
	The Trust currently has a public constitution of "Rest of Yorkshire & the Humber", this includes the areas covered by the following:
	Bradford Council – City of York Council – Doncaster Council – East Riding of Yorkshire Council – Hull City Council –

Leeds City Council –
North East Lincolnshire Council –
North Lincolnshire Council –
North Yorkshire County Council –
Rotherham Metropolitan Borough Council –
Sheffield City Council –

Membership is currently open to anyone living in Yorkshire and the Humber. Once a member is accepted, they then have the opportunity to apply to become a Non-Executive Director of the Trust or stand for election as a Trust Governor.

The Board will also be aware that a recruitment process has commenced to appoint a new Chair of the Trust. At the Trust Nominations Committee meeting on Tuesday the 13th July 2021 the progress and next steps for recruitment were discussed.

During this discussion the current restraints of our constitutional boundaries were considered, and the impact on our ability to attract the best chair candidates from as wide an area as possible.

Following discussion, the Nominations Committee agreed to put forward the following motion for consideration:

- To amend Annex 1 (the public constituencies), (1.5) to extend the constituency currently known as Rest of Yorkshire & the Humber, to include *adjacent counties* adding the specific counties *Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire.*

This motion was supported by the full Nominations Committee (comprising the lead governor, deputy lead governor, publicly elected governor and Chair of the Trust) to be taken forward for consultation. Following this decision, a letter was sent by the lead governor to all council members detailing the motion and next steps following this presentation for the motion to the trust Board.

Board members should note that this change, if agreed, would broaden the catchment area for members, and would mean that the publicly elected governor for this constituency could be drawn from anywhere within the wider geography at future elections. The governor role for this constituency is currently vacant.

	Amendments to the constitution need to be approved by both the Trust Board and the Members' Council. Governors and members of the public will have the opportunity to ask questions of the Board, submitted in writing, in the public Q&A at the end of the meeting. **Next steps** If the motion is approved by Trust Board, we will then hold a Q&A session for Governors prior to the Members' Council meeting on the 17th August 2021, to discuss the motion further and enable governors to raise any questions or concerns before the motion is taken to the Members' Council meeting for a decision. It should be noted that, in order to continue with the recruitment of the Chair, potential candidates drawn from the proposed amended constituencies will be invited to apply, whilst noting that a constitutional change is in the process of being considered. However, if the change to the constitution is not agreed at the Members' Council meeting on the 17th August, any candidates that have applied from outside our current boundaries would be notified they were ineligible. **Risk appetite** The delivery of the Trust's Constitution supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to approve the motion for the extension of our constitutional boundaries as described above.**
Private session:	Not applicable.

Title:	Assessment against NHS Constitution
Paper prepared by:	Assistant Director of Corporate Governance, Performance and Risk
Purpose:	To provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the NHS Constitution in delivering, planning and developing its services.
Mission/values:	Meeting the rights and pledges in the NHS Constitution supports the Trust to adhere to its mission and values.
Any background papers/ previously considered by:	Annual reports to the Trust Board. A full copy of the NHS Constitution can be found on the Department of Health website at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england. The attached assurance document was reviewed and updated as appropriate by the Executive Management Team (EMT).
Executive summary:	The NHS Constitution was published in January 2009, following an extensive public consultation. It established the principles and values for the NHS in England and set out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieving, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required, by law, to take account of the NHS Constitution in their decisions and actions. The NHS Constitution also applies to public health services, which are now the responsibility of local authorities. The Government has committed to renewing the NHS Constitution every ten years with the full involvement of patients who use the NHS, the public who fund it and the staff who work in it. The first review took place in early 2012 and a further review was undertaken following the publication of the second Francis Report, which was published in March 2013. In July 2015, the Constitution was updated to reflect a limited package of changes. These included:

- Reflecting recommendations made by Sir Robert Francis QC in his Inquiry Report on Mid- Staffordshire NHS Foundation Trust.
- Incorporating a series of fundamental standards, below which standards of care should never fall.

	- Highlighting the importance of transparency and accountability within the NHS. - Giving greater prominence to mental health, through reflecting a parity of esteem between mental and physical health problems. - Making reference to the Armed Forces Covenant. In January 2021 the NHS Constitution was updated to reflect that from 1 January 2021, the rules had changed regarding UK residents' access to healthcare in the EU, Norway, Iceland, Liechtenstein and Switzerland following the UK's exit from the EU. The Trust meets the rights and pledges of the NHS Constitution with the rationale as to why this conclusion has been reached outlined in the detailed paper attached. The impact of Covid-19 has been reflected throughout the document, however, the Board should note that our compliance with the NHS Constitution has been maintained during 2020/21, taking account of all acts of parliament, temporary measures and guidance during the pandemic, for example, the control of patient information (COPI) notice. **Risk appetite** The delivery of the NHS Constitution rights and pledges supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.**
Private session:	Not applicable.

The NHS Constitution – patients and the public
How the Trust meets its obligations
Trust Board 27 July 2021

Heading	Compliance	Evidence	Lead
• R1 You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	Yes	Core services are commissioned by clinical commissioning groups covering the areas the Trust covers in Barnsley, Calderdale, Kirklees and Wakefield local authority areas, and NHS England (via the Specialist Commissioning Team). Annual contracts and service specifications are evidenced through annual contract negotiations. **Impact of Covid-19** Revised financial and contracting arrangements were implemented in response to the Covid-19 pandemic to provide certainty for all organisations providing NHS-funded services under the NHS Standard Contract that they will continue to be paid and to minimise the burden of formal contract documentation and contract management processes. Block payment arrangements remain in place for relationships between NHS commissioners (comprising NHS England and CCGs) and NHS providers (comprising NHS foundation trusts and NHS trusts) and signed contracts between NHS commissioners and NHS providers not required for the H1 2021/22 period.	Director of Finance & Resources
• R2 You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right. **Impact of Covid-19** Business continuity plans are in place across all areas.	Director of Finance & Resources

With **all of us** in mind.

Heading	Compliance	Evidence	Lead
		The Trust has taken steps to ensure that services remain as accessible as possible during the pandemic. We have not closed beds in order to create covid areas and managed our resources flexibly to maximise access. Clinical staff have been issued with guidance to support decision making regarding face to face or virtual appointments. Estate changes have been made to facilitate safer group working. Covid measures such as social distancing and cleaning regimes have led to delay in some treatments and waiting lists are monitored through the Trust's governance processes.	
• R3 You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right.	Director of Finance & Resources
• R4 You have the right to expect your local NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary and, in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.	Yes	The Trust does assess the health needs of the local community in the development of its operational and strategic plans and, as part of the development of its transformation programmes. The Trust is working with commissioners, stakeholders, service users and carers, and local people to transform its services and develop new models and pathways of care that meet people's needs. As part of two integrated care systems the Trust works with partners in each place it provides services to understand the needs of local populations and design service provision accordingly. The Trust is a member of the local Health & Wellbeing Boards who have a statutory duty to do this. The Trust uses Joint Strategic Needs Assessment data available in each place to inform and shape strategic and service change priorities.	Director of Strategy
• R5 You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available to you through your NHS commissioner.	N/A	N/A to the Trust. This is determined by commissioners. This section of the NHS Constitution has now been amended to state: You have the right to authorisation for planned treatment in the EU under the UK EU Trade and Cooperation Agreement where you meet the relevant requirements. You also have the right to authorisation for planned treatment in the EU, Norway, Iceland, Lichtenstein or Switzerland if you are covered by the Withdrawal	N/A

Heading	Compliance	Evidence	Lead
		Agreement and you meet the relevant requirements.	
• R6 You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	Yes	The Trust complies with appropriate legislation relating to discrimination and has an Equality, Involvement, Communication and Membership Strategy in place (approved by Trust Board September 2020) with the prime aims of respecting and valuing difference and promoting a fairer organisation. The Trust has committed to implementing the NHS Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) in accordance with the NHS Standard Contract. The Trust Board has an Equality Involvement and Inclusion Committee. The Trust established a Black, Asian, and minority ethnic (BAME) staff network in 2017/18 and a disability staff network and LGBT+ staff network in 2019/20. The Trust uses Equality Impact Assessments (EIA) to evaluate the effect of its strategies and policies on its service users and the communities it serves. The Trust implemented the Equality Delivery System 2 (EDS2) and Trust Board agrees for each of the four EDS2 goals to focus on one key outcome area assessed by service users and staff. The Trust has been graded as achieving EDS2. **Impact of Covid-19** The Trust utilised all available equality data to ensure equity of access to services for the communities the Trust serves, including video consultations and treatment sessions, improved communication through use of social communication tools e.g., SystmOne messaging tool.	Director of Nursing & Quality / Director of HR, OD & Estates
• R7 You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described	Yes	The Trust does provides some services subject to waiting times as outlined in the Handbook to the NHS Constitution which are reported monthly to the Trust Board under the national metrics in the Integrated Performance Report: • Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral. • A maximum seven day wait for follow-up after discharge from psychiatric in-patient care for people under adult	Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
in the Handbook to the NHS Constitution.		mental illness specialties on Care Programme Approach. • There is a right for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral and for the NHS to take all reasonable steps to offer a range of alternatives if this is not possible. There are further waiting times which are not currently subject to the NHS Constitution that are monitored by the Board and Committees. **Impact of Covid-19** Performance continues to be monitored through the integrated performance report to Board. 6 week waits for paediatric audiology were breached at the outset of the pandemic as assessments could not be undertaken. Actions were taken to restore performance once assessments recommenced. Performance has been maintained regarding follow up from hospital care. Pressure is building in relation to 18 week waits particularly in psychology for people with a learning disability and in CAMHS where an increase in referrals for crisis and support for children with eating disorders are now impacting the capacity to respond. This is monitored through the Clinical Governance Clinical Safety Committee.	
• P1 The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the Constitution.	Yes	As part of its contractual requirement through the service specification with commissioners, the Trust is required to report on local waiting times in relation to improving access to psychological therapies (IAPT) and psychological therapies, referral and treatment times in relation to the Barnsley BDU musculoskeletal service (MSK). The Trust meets the required timescale. The Trust has a history of regularly meeting national targets for access to IAPT and when there is an issue in terms of meeting any local targets action plans are put in place to address. Access is one of the Trust's quality priorities set out in its Quality Accounts and performance is monitored and reported on a quarterly basis.	Director of Finance & Resources / Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
		The Trust has local Commissioning for Quality and Innovation (CQUIN) targets in relation to waiting times for mental health services, which were paused during 2020/21. Temporary national contracting arrangements were put in place. **Impact of Covid-19** IAPT adopted a telephone / virtual appointment system to maintain access and performance through the pandemic. Some impact on waits was noted as some people needed/preferred face to face appointments which were not available for the first 3 months of the pandemic. Estate work is taking place to increase the space available to conduct group work. MSK services are impacted in particular.	
• P2 The NHS commits to make decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered.	Yes	The Board meets in public and papers and minutes for public Trust Board meetings are published on the Trust's website. Minutes from Board Committee meetings are included in the public Board papers. The Trust holds an Annual Members' Meeting and usually holds regular public events throughout the year (reduced number of events during Covid-19 pandemic). The Trust has a Members' Council in place comprising of elected public and staff governors and appointed stakeholder representatives. Meetings are held in public and papers and minutes are published on the Trust's website. The Trust's Equality, Involvement, Communication and Membership Strategy outlines its approach to involvement and engagement. Service users and carers are involved in planning and designing Trust services, including the transformational service change programme. The Trust's services have individual service user groups. A description of the Trust's service offer is available on the Trust's website. **Impact of Covid-19** The Trust utilised all available equality data to ensure equity of access to services for the communities the Trust serves,	Director of Finance & Resources / Company Secretary

Heading	Compliance	Evidence	Lead
		including video consultations and treatment sessions, improved communication through use of social communication tools e.g., SystmOne messaging tool. From March 2020 all Trust Board and Members' Council meetings were held virtually and meeting links shared on the Trust website and through social media to enable members of the public to attend meetings virtually and ask questions prior to meetings taking place. The Trust Annual Members' Meeting was also held virtually in September 2020 showcasing work that was taking place within the Trust during the pandemic.	
• P3 The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them.	Yes	The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness may make this inappropriate. Care planning is a priority area for the Trust QI programme in 2019/20. The Trust has improved systems and processes to ensure that all service users have a care plan in place and that they know who is responsible for their care. The Care Programme Approach (CPA) and standard care standards demonstrate the Trust's commitment to put service users at the centre of care planning. Service user and their carers' perceptions of the Trust are regularly reviewed through national and local surveys. The Trust is committed to system wide improvement of services and interagency protocols through the Integrated Care Systems (ICSs) and local partnership arrangements. The Trust has transition arrangements in place between services to ensure that handovers are as smooth as possible. **Impact of Covid-19** Engaging with service users on their care planning has remained a priority throughout the pandemic.	Director of Operations / Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
		Development work on transitions has not taken place due to the focus being on engaging with service users to determine the best way to deliver their immediate care.	
• R8 You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	Yes	The Trust introduced a revised Carers Charter during 2019/20. The Trust has in place strong and robust processes for the employment, appraisal and re-validation of medical staff. The Trust ensures all appropriate staff are registered with the Health and Care Professions Council (HCPC). There can often be a need to utilise temporary staffing. When this is required the Trust endeavours to use bank staff where appropriate. In circumstances, where it has to use agency staff, these are from approved suppliers to ensure the quality, skills and experience of staffing is maintained. The Trust has an e-rostering system for all inpatient areas with agreed establishment levels for registered and non-registered staff. The Trust is registered with no conditions with the Care Quality Commission (CQC). The Trust is licensed by Monitor with no conditions and continues to comply with licencing requirements. The Trust is compliant with relevant National Institute for Health and Care Excellence (NICE) guidelines. The Trust has a robust system in place to undertake appropriate employment checks for its entire staff. The Trust has an ongoing Continuous Professional Development (CPD) approach. A Human Resources and Workforce Development Strategy, including mandatory training plan, is in place. The Trust's Patient Safety Strategy brings all aspects of patient safety together in one document. The Trust has an unannounced visits programme in place (visits deferred due to Covid-19 pandemic). Safer staffing reports are included within the monthly Integrated Performance Report and the Board requires a safer staffing and workforce report every six months.	Director of Nursing & Quality / Director HR, OD & Estates / Medical Director

Heading	Compliance	Evidence	Lead
		The Trust undertakes a robust workforce planning process each year linked to service and financial plans. **Impact of Covid-19** During 2020/21 a command structure was established and included a bronze workforce group who met, (daily when required), to review staffing levels. A staff redeployment programme was established for non-clinical staff to be rostered as appropriate into clinical shifts and/or to cover clinical administration duties. This included professionally registered staff to be redeployed to cover registered absence. In addition to the bronze group, operational teams continued to meet daily and to report staffing issues into the command structure.	
• R9 You have the right to be cared for in a clean, safe, secure and suitable environment.	Yes	The Trust has an Estates Strategy to support and meet the needs of services. Development of the Estates Strategy included a detailed six-facet survey of Trust estate. The Trust is compliant with Fire and Occupational Health & Safety (OHS) legislation. In light of the Grenfell fire in 2017/18, a review was undertaken of all inpatient areas and these were shown to be fully compliant. The latest round of Patient-led assessments of the care environment (PLACE) visits of the Trust continue to result in a positive outcome. Infection prevention and control advisers and specialist advisers in place with regular programme of audits in place. The Trust undertakes an annual Health and Safety Monitoring Audit. The Trust approves an annual Health and Safety action plan. **Impact of Covid-19** Individual and organisational risk assessments have been completed in order to determine if areas are Covid-19 secure. These risk assessments are subject to review to ensure they encompass all the latest guidance, personal protective	Director HR, OD & Estates / Director of Operations

Heading	Compliance	Evidence	Lead
		equipment available and testing process established for staff and service users. The Trust continued to assess its Estate use on a short-term basis in order to respond to the immediate issues surrounding the pandemic. At the same time the new Estate Strategy is being revised with a new round of engagement with all parties.	
• R10 You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Yes	The Trust's approach is based on the key areas included in the Department of Health Food Standards in relation to nutritional care, healthier eating for the whole hospital community and sustainable procurement of food and catering services. In all areas, the Trust works with its dieticians to create a balanced nutritional and healthy menu to cover the Trust's diverse patient base and also cooks to request for special diets. Work is continuing with procurement to raise awareness of the standards and the role the Trust plays with suppliers. Nursing and medical staff are also aware of their role within the process. These processes are capture within the Trust's Food Policy which was updated to include the latest guidelines including the latest guidance on allergens. **Impact of Covid-19** Food safety training had to be adapted in order to allow staff to complete mandatory safety training in a virtual environment. The Trust canteens remained operational for patients, visitors and staff adhering to all Covid requirements. Hydration points were also placed in all inpatient wards.	Director HR, OD & Estates
• R11 You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	Yes	The Trust publishes an annual Quality Account describing performance against key quality priorities and plan for improvement. The Trust's performance management processes include summary statistics on service activity data to enable comparisons of Trust outcomes with the 'what good looks like' and health needs assessment intelligence to support local decision-making to ensure continuous improvement. The Trust Board and its Committees receive performance and other reports. Trust Board reports are publicly available on the	Director of Finance & Resources / Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
		Trust's website. The Trust maintained the vast majority of reporting metrics throughout the pandemic and the clinical governance and clinical safety committee delivered on its workplan. The Trust has an ongoing change programme in place including engagement and involvement. Programmes of improvement are reviewed and prioritised on a regular basis. Dedicated website pages supported by and strategic plans. Trust's own programme of visits to all in-patient locations and a range of community teams registered with the Care Quality Commission (CQC) where compliance with essential standards is reviewed. The Trust continues to work towards the delivery of the action plan agreed with the CQC following unannounced visits and has processes in place to learn from the outcome of previous visits to the Trust. The Trust has a programme of PLACE visits undertaken annually, which have achieved positive results (deferred in 2020 due to Covid-19). **Impact of Covid-19** The Quality Account was delayed in 2020 due to the pandemic and was published in September 2020 in line with guidance from the Department of Health and Social Care. Physical Quality monitoring visits were also paused in line with IPC guidance and replaced with virtual quality monitoring visits taking place in early 2021.	
• P4 The NHS commits to identify and share best practice in quality of care and treatments.	Yes	The Trust has a leadership and clinical management structure, including Practice Governance Coaches whose role is to ensure best practice is being followed and effective clinical governance is maintained and developed. The Trust has quality improvement and patient safety strategies with implementation plans in place and formal systems in place to share good practice through the Quality Improvement Group. Accreditation for Trust services, such as Electroconvulsive Therapy (ECT), memory services in Barnsley, Calderdale,	Executive Management Team

Heading	Compliance	Evidence	Lead
		Kirklees and Wakefield, and secure services peer review undertaken annually. Living our values and values into excellence introduced in 2014 for staff. Trust quality monitoring visits programme in place. Clinical network for forensic services with providers as part of Allied Health Services Network members and the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP). Annual staff Excellence Awards which celebrate the difference that our staff and teams make to the lives of local people (event deferred in 2020 due to Covid-19 pandemic). (also see R11) The Trust has processes in place to learn from incidents and cross-Trust learning has been strengthened over the course of 2019/20. The leadership structure for operational leadership includes clinical networks which ensures the spread of best practice across pathways trust-wide, and the matron role (implemented in 2019) in acute inpatient areas. The matron role leads on quality, best practice and standards of care. Clinical Ethics Advisory Group (CEAG) was established in 2020. **Impact of Covid-19** CEAG was established to ensure that operational decisions being made in response to the pandemic were reviewed, interrogated, and agreed as clinically ethical. Quality monitoring visits were put on hold until spring 2021 in order to support the services to focus on managing the pandemic. These have been reinstated. The executive trio has met virtually with staff groups. Clinical network development was paused and is being re-started in August 2021. The matrons have been key leaders throughout and play a key role in sharing good practice and learning. The command structure supported immediate roll out of learning and best practice.	

Heading	Compliance	Evidence	Lead
• R12 You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if you doctor says they are clinically appropriate for you.	Yes	The Trust is compliant with relevant NICE guidelines. The Trust has a policy and procedures in place with timelines to implement NICE guidance. The Trust has a robust procedure in place for the approval and oversight of medical treatments within the Drug and Therapeutic sub-committee.	Director of Nursing & Quality / Medical Director
• R13 You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain the decision to you.	N/A	N/A	
• R14 You have the right to receive vaccinations that the Joint Committee on Vaccinations and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.	N/A	The Trust is commissioned by NHS England to provide school age children (5-19) vaccination and immunisation programme including flu in Barnsley. A comprehensive service for immunisation and vaccination to the 0-19 population of Barnsley is delivered by Barnsley Council Public Health following re-commissioning arrangements October 2016. The Trust, in partnership, upholds the principles, values pledges and responsibilities as a significant partner in providing sign-posting arrangements and every contact counts capability in demonstrating partnership working. Pharmacy support continues to be provided by the Trust. Work ongoing in 2020 on the roll out of the Covid-19 vaccination for staff and service users. **Impact of Covid -19** A programme group was formed as the Covid-19 Vaccination Bronze Command group on 26th November 2020 and a reporting and governance structure put in place. This included structured and timely reports to both Silver and Gold Command, as a key part of the governance of the programme.	Director of Operations

Heading	Compliance	Evidence	Lead
		On 18th December the decision to also include the vaccination of inpatients included in the priority groupings was agreed and approved by the West Yorkshire & Harrogate ICS. Also achieved was the objective of vaccinating the majority of substantive SWYPFT staff to protect workers at high risk of exposure who may also expose vulnerable individuals whilst providing care. In addition, all inpatient service users during their stay at SWYPFT were offered a vaccination during the programme.	
• P5 The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.	N/A	Where appropriate, all national screening programmes are in place and managed through the Screening Advisory Committee for South Yorkshire in respect of screening services provided by Barnsley BDU.	Director of Operations
• R15 You have the right to be treated with dignity and respect, in accordance with your human rights.	Yes	Staff work to professional codes of conduct, Trust policies and CPA standards. The Trust's Equality, Involvement, Communication and Membership Strategy sets out how the Trust accords to an individual's human rights. Living our values and values into excellence were introduced in 2014 for staff. The Trust has values-based recruitment and induction programme. The Trust has a strong pastoral care function to support service users and their carers, and staff. The Trust has a contractual duty of candour and has arrangements in place to ensure it meets the extended legal duties of candour introduced by the CQC. Regular reporting has been established at BDU, Executive Management Team (EMT) and Board level.	Director of Operations / Medical Director / Director of Nursing & Quality
• R16 You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Yes	The Trust has a robust policy and arrangements in place through its approaches to safeguarding vulnerable adults and children and is an active member of local safeguarding boards.	Director of Nursing & Quality / Director of

Heading	Compliance	Evidence	Lead
			Operations
• R17 You have the right to accept or refuse treatment that is offered to you, and not be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests. (NB different rules apply for patients detained in hospital or on supervised community treatment under the Mental Health Act 1983.)	Yes	The Trust has a Consent Policy in place. The Trust has clear policies, procedures and guidance in place for the administration of the Mental Health Act (MHA), Mental Capacity Act (MCA) and for Deprivation of Liberty Standards. The Trust works in partnership with advocacy services provided by local authorities to provide support for service users and carers. The Trust's complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right. The Trust introduced an updated training plan for Mental Health Act / Mental Capacity Act compliance and is meeting revised targets. **Impact of Covid-19** During the pandemic the secretary of state for health and social care issued a control of patient information (COPI) notice to enforce the requirement for NHS organisations to process and disseminate confidential patient information for the purposes of protecting health in relation to Covid-19.	Medical Director / Director of Nursing & Quality
• R18 You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Yes	The Trust has medicine information leaflets including translation into other languages if required and utilises information available from NHS Choices. Service user information leaflets, which set out service user rights. Service users are given copies of their care plans. Service users and carers are part of developing Trust approach to care planning. Ongoing engagement with service users and carers, particularly around CPA. The Trust met the Accessible Information Standard in 2020/21 and was rated as good. **Impact of Covid-19**	Medical Director / Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
		Any information used by the Trust were sent electronically via e-mail, social media and displayed in inpatient areas where possible to minimise the spread of infection.	
• R19 You have the right of access to your own health records and to have any factual inaccuracies corrected.	Yes	The Trust has a Patient Identifiable Information Policy – service user access and a Freedom of Information Policy. The Trust complies with requirements of Data Protection & Security Toolkit (DPST), CQC registration and Monitor's Licence conditions.	Director of Finance & Resources / Director of Nursing & Quality
• R20 You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure	Yes	Trust meets Department of Health privacy and dignity guidance and has made an annual declaration of compliance to its regulator and to service users regarding elimination of mixed sex accommodation. The Trust has a Service User Confidentiality and Data Protection Policy, incorporating Information Sharing and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. When breaches do occur they are thoroughly investigated with learning identified and notification to our commissioners or the Information Commissioner where appropriate. **The impact of Covid-19** Acute inpatient areas developed a cohorting standard operating procedure that supports the safe management of isolation and quarantine. Forensic services created a cohort facility due to the lack of en-suite accommodation in low secure. The female ward patients moved to a decant ward. This was done in collaboration with them, but after a period of time, they reported concerns about the environment and requested to return to their own ward.	Director of Nursing & Quality Director of Finance & Resources
• R21 You have the right to be informed about how your information is used.	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the	Director of Finance & Resources /

Heading	Compliance	Evidence	Lead
		requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. **Impact of Covid-19** During the pandemic the secretary of state for health and social care issued a control of patient information (COPI) notice to enforce the requirement for NHS organisations to process and disseminate confidential patient information for the purposes of protecting health in relation to Covid-19.	Director of Nursing & Quality
• R22 You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and, where you wishes cannot be followed, to be told the reasons, including the legal basis.	Yes	Patient Identifiable Information Policy – service user access. Freedom of Information Policy. The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area.	Director of Finance & Resources / Director of Nursing & Quality
• P6 The NHS commits to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively.	Yes	The Trust has one main clinical information system (SystmOne) across its Business Delivery Units (BDUs). The Trust is also working with partners to ensure interoperability between systems, such as those used by local authorities, to make accessing information on care easier for staff working in integrated teams. Information sharing protocols in place with partners as appropriate. **Impact of Covid-19** During the pandemic the secretary of state for health and social care issued a control of patient information (COPI) notice to enforce the requirement for NHS organisations to process and disseminate confidential patient information for the purposes of protecting health in relation to Covid-19.	Director of Finance & Resources
• P7 The NHS commits that, if you are admitted to hospital, you will not have to share sleeping	Yes	The Trust is able to make a declaration that it complies with the national standard in relation to Eliminating Mixed Sex Accommodation.	Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution.			
• P8 The NHS commits to anonymise the information collected during the course of your treatment and use it to support research and improve care for others.	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Data Protection & Security Toolkit and Department of Health requirements to train staff in this area. When breaches do occur they are thoroughly investigated with learning identified and notification to the Commissioner where appropriate. The Trust has robust governance arrangements in place to cover its research and development work. **Impact of Covid-19** Policies are monitored for compliance as part of the self-assessment for the Data Security & Protection Toolkit submission, which is subject to audit. Where necessary, policies were amended to include the requirement to share records to manage and mitigate the covid-19 pandemic (COPI notice).	Director of Finance & Resources Medical Director
• P9 The NHS commits, where identifiable information is used, to give you the chance to object wherever possible.	Yes	**Impact of Covid-19** During the pandemic the secretary of state for health and social care issued a control of patient information (COPI) notice to enforce the requirement for NHS organisations to process and disseminate confidential patient information for the purposes of protecting health in relation to Covid-19.	Director of Finance & Resources
• P10 The NHS commits to inform you of research studies in which you may eligible to participate.	Yes	The Trust has an in-house research and development department that manages, facilitates and governs all research to ensure it reflects services and the geographical area the Trust serves. Support is available to staff, patients / service users and carers who would like to become more involved in research as well as those who are established researchers. Advice and information is available on NHS research approval, ethics, the research passport, letters of access, training and funding	Medical Director

Heading	Compliance	Evidence	Lead
		opportunities, patient / service user and carer involvement in research and dissemination.	
• P11 The NHS commits to share with you any letters sent between clinicians about your care.	Yes	All service users have access to their clinical records (Patient Identifiable Information Policy – service user access). Service users are offered a copy of their care plan and are able to receive a copy of any correspondence between clinicians about them unless there is a specific risk identified to their physical and/or mental wellbeing.	Director of Nursing & Quality / Director of Finance & Resources / Director of Operations
• R23 You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	N/A	N/A	N/A
• R24 You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply.	N/A	N/A	N/A
• R25 You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.	N/A	N/A	N/A
• R26 You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs.	N/A	N/A	N/A

Heading	Compliance	Evidence	Lead
• P12 The NHS commits to inform you about the healthcare services available to you, locally and nationally.	Yes	Information is available on the Trust's website and in information leaflets. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams. The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents. **Impact of Covid-19** Any information used by the Trust was sent electronically via e-mail, social media and displayed in inpatient areas where possible to minimise the spread of infection.	Director of Nursing & Quality / Director of Operations
• P13 The NHS commits to offer you easily accessible, reliable and relevant information in a form you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.	Yes	Information available on Trust's website, in information leaflets and the Trust's Quality Accounts. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams. Information on mental health conditions is included on the Trust's website. Service user survey findings are displayed on wards and units. Feedback mechanisms are in place for service users and their carers, including 'real time' collection of customer experience feedback. Advocacy information is available on wards and in patient information. The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents. **Impact of Covid-19** Any information used by the Trust were sent electronically via e-mail, social media and displayed in inpatient areas where possible to minimise the spread of infection.	Director of Operations / Director of Nursing & Quality
• R27 You have the right to be involved in planning and making decisions about your health and	Yes	As above (see R18, P12, P13). The Trust offers and has available interpreter / translation services either face-to-face or by telephone.	Director of Operations / Director of

Heading	Compliance	Evidence	Lead
care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.		An agreed end-of-life care pathway involving all agencies involved in end-of-life care is in place.	Nursing & Quality
• R28 You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	Yes	The Trust has a Duty of Candour policy in place supported by robust processes for complaints and redress. The Trust monitors compliance with the policy which is reviewed by the Clinical Governance & Clinical Safety Committee and Board.	Director of Nursing & Quality
• R29 You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in the decisions to be made affecting the operation of those services.	Yes	Patients, services users and their carers can be involved in the Trust through the Members' Council, Trust membership and volunteering. Equality, Involvement, Communication and Membership Strategy in place. The Trust is continuing to engage with service users and carer groups to ensure all teams and wards will have the ability to involve, listen and respond to feedback from people who use Trust services at all levels of the organisation. Trust service users / carers on local partnership boards. Information provided to local HealthWatch.	Director of Nursing & Quality / Director of Strategy
• P14 The NHS commits to provide you with the information and support you need to influence and	Yes	As above (see P2, P3, R29).	Director of Nursing & Quality

Heading	Compliance	Evidence	Lead
scrutinise the planning and delivery of NHS services.			
• P15 The NHS commits to work in partnership with you, your family, carers and representatives.	Yes	As above (see P2, P3).	Director of Operations / Director of Nursing & Quality
• P16 The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.	Yes	Service users are offered a copy of their care plan. Care Plans are coproduced with service users wherever possible. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness makes this inappropriate.	Director of Operations / Director of Nursing & Quality / Medical Director
• P17 The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services.	Yes	The Trust welcomes feedback from service users and carers and actively encourages people to comment on its services. The Trust uses this information to inform service development and improvement. The Trust is working towards real time service user feedback through the Friends and Family service user test. Service user surveys are undertaken as part of our commitment to learn and improve across all of our BDUs. Public engagement events held throughout the year (deferred during 2020 due to the Covid-19 pandemic). Feedback facility on the Trust's website. Feedback is provided through the Customer Services Team, which is reported to Trust Board quarterly and annually. **Impact of Covid-19** The Trust has continued to collect, analyse, report and act upon patient feedback throughout the pandemic. This includes work to explore the views of people that use our services, on new ways of working e.g. video consultation.	Director of Nursing & Quality
• R30 You have the right to have any complaint you make about	Yes	Customer Services Policy and Customer Service Team structure with quarterly reports to Trust Board.	Director of Nursing &

Heading	Compliance	Evidence	Lead
NHS services acknowledged within three working days and to have it properly investigated.		Performance measures in place. Complaints acknowledged within three working days and investigated appropriately.	Quality
• R31 You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.	Yes	As above. The Trust encourages face to face meetings to discuss complaints as the first act of resolution. Formal complaints always involve the offer of a further face to face meeting. In 20/21 the complaints process undertook a review and new timescale processes were proposed to meet the needs of complainants. **Impact of Covid-19** At the height of the pandemic local resolution meetings were suspended. Once clinical services resumed offering appointments the Complaints team offered digital appointments through MS teams and telephone conference calls.	Director of Nursing & Quality
• R32 You have the right to be kept informed of the progress and to know the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.	Yes	Customer Services Policy and Customer Service Team structure. All responses are shared with complainants and personally signed by the Deputy Chief Executive including actions to be taken as a result. Learnings are discussed by the Trust Board.	Director of Nursing & Quality
• R33 You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman if you are not satisfied with the way your complaint has been dealt with by the NHS.	Yes	This is referenced in all correspondence around complaints. Everything possible is done to prevent this. During 2019/20, the Trust received six requests for information from the Ombudsman – two of the cases are closed and the Trust is awaiting the outcome of four cases. At the end of 2018/19, the Trust had five open cases – three of those have since been partially upheld and two are now closed. This is also reflected in the Customer Services Policy and Customer Service Team structure.	Director of Nursing & Quality
• R34 You have the right to make a	Yes	Customer Services Policy and information on the Trust's website.	Director of

Heading	Compliance	Evidence	Lead
claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.			Nursing & Quality
• R35 You have the right to compensation where you have been harmed by negligent treatment.	Yes	Claims Management Policy.	Medical Director
• P18 The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint and the fact that you have complained will not adversely affect your future treatment.	Yes	Customer Services Policy and Customer Service Team structure. **Impact of Covid-19** At the height of the pandemic local resolution meetings were suspended. Once clinical services resumed offering appointments the complaints team offered digital appointments through Microsoft teams and telephone conference calls.	Director of Nursing & Quality
• P19 The NHS commits to ensure that, when mistakes happen or if you are harmed while receiving health care, you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. Arrangements in place to ensure the Trust and its staff meet the Trust's Duty of Candour responsibilities.	Director of Nursing & Quality
• P20 The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. Quality Improvement Group established to share learning between and across BDUs. Learning lessons reports are reviewed by the Clinical Governance and Clinical Safety Committee. Post investigation meetings are held at a local level.	Director of Nursing & Quality / Medical Director

The NHS Constitution also sets out nine responsibilities of patients and the public.

- Please recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.
- Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.
- Please treat NHS staff and other patients with respect and recognise that violence or the causing nuisance or disturbance on NHS premises could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
- Please provide accurate information about your health, condition and status.
- Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.
- Please participate in important public health programmes such as vaccination.
- Please ensure that those closest to you are aware of your wishes about organ donation.
- You should give feedback – both positive and negative – about your experience and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

Heading	Compliance	Evidence	Lead
The rights are there to help ensure staff:			
• have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives	Yes	Workforce Strategy agreed which includes workforce development, and staff engagement and wellbeing as key priority areas Human Resources (HR) policies and procedures on annual leave, sickness absence, flexible working, carer leave, adoption rights and benefits, age retirement, equal opportunities in employment, job share, paternity leave, maternity leave, special leave, stress, etc. Harassment and Bullying Policy and Grievance Policy and Procedures in place. Friends and Family Test for staff. Wellbeing survey / national staff survey. Occupational health policy and service in place including Musculoskeletal and staff counselling services. Values-based recruitment, induction and appraisal policies in place. **Impact of Covid-19** Support for staff was made available during Covid-19 pandemic, including provision of equipment allowing and enabling staff to work from home, Occupational Health support and helplines, and staff risk assessments.	Director HR, OD & Estates
• have a fair pay and contract framework	Yes	Workforce strategy agreed by the Trust Board. Trust pay structure based on Agenda for Change and Trust follows guidance issued by National Pay Bodies as appropriate. HR Policies and Procedures as above. Workforce Strategy sets out Trust approach to pay. Support to the concept of Living Wage. Ethnic pay audit recently completed. Gender pay audit recently completed. Disability pay audit recently completed.	Director HR, OD & Estates
• can be involved and represented in the workplace	Yes	Workforce strategy agreed by the Trust Board includes staff engagement as key priority area. Disciplinary Policy and Procedures. Grievance Policy and Procedures.	Director HR, OD & Estates

Heading	Compliance	Evidence	Lead
		Set out in the Social Partnership Agreement between the Trust and staff side organisations. Staff engagement strategy. Staff engagement events. Annual staff survey. BAME, Disability and LGBT+ Staff Networks established. Elected staff governors on the Members' Council. Substantive lead Freedom to Speak up Guardian in place. Regular staff network meetings with Trust Board. During the height of the pandemic weekly meetings were implemented with Staff side Staff side were engaged in bronze and silver command arrangements during the pandemic.	
• have healthy and safe working conditions and an environment free from harassment, bullying or violence	Yes	HR policies and procedures. Staff survey. Health and Safety Policy. Health and Safety Steering Group. Health and Safety annual audit and work programme. Occupational health service. Risk assessments of workplace. Managing Aggression and Violence lead in place with supporting Management of Violence and Aggression Trust Action Group (MAV TAG).	Director HR, OD & Estates
• are treated fairly, equally and free from discrimination	Yes	HR policies and procedures. Equality and Inclusion Committee, of the Trust Board in place. Trust staff are required to undertake mandatory equality training. Equality networks, annual workforce equality impact assessment. Equality impact assessment of all policies and procedures BAME, Disability and LGBT+ Staff Networks established. WRES, WDES and EDS2 action plans agreed. Substantive lead Freedom to Speak up Guardian in place.	Director HR, OD & Estates
• can, in certain circumstances, take a complaint about their employer to an Employment Tribunal	Yes	Disciplinary and Grievance Policies and Procedures. Trust staff advised of their rights following disciplinary action. Substantive lead Freedom to Speak up Guardian in place.	Director HR, OD & Estates
• can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.	Yes	HR Policies and Procedures. Information given to staff and Trust welcome events include information for staff. New Raising Concerns / Freedom to Speak Up (Whistleblowing) Policy	Director HR, OD & Estates

Heading	Compliance	Evidence	Lead
		agreed with Staff Side in Consultation and the Freedom to Speak Up Guardian Whistleblowing report taken to Clinical Governance & Clinical Safety Committee every six months. Raising concerns leaflet widely available. Posters on Freedom to Speak Up widely distributed. Network of Freedom to Speak Up Guardian established Intranet site for staff on raising concerns in place. Freedom to Speak Up Guardians have regular meetings with Director of HR, OD and Estates and Deputy Chair. Substantive lead Freedom to Speak up Guardian in place.	

The NHS Constitution also sets out seven staff pledges, which, although not legally binding, represent a commitment by the NHS to provide high-quality working environments for staff.

- The NHS commits to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.
- The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
- The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
- The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
- The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
- The NHS commits to have a process for staff to raise an internal grievance.
- The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

The NHS Constitution also sets out six existing legal duties that staff must observe. (This list is not meant to be exhaustive.)

- To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.

- To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.
- To act in accordance with the express and implied terms of your contract of employment.
- Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
- To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm.
- To be honest and truthful in applying for a job and in carrying out that job.

The Constitution also sets out how staff should play their part in ensuring the success of the NHS.

- You should aim to provide all patients with safe care, and to do all you can to protect patients from avoidable harm.
- You should follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers.
- You should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.
- You should aim to find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving basic care to meet their needs).
- You should aim to take up training and development opportunities provided over and above those legally required of your post.
- You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities.
- You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity.
- You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment.
- You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.
- You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made.
- You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.
- You should aim to take every appropriate opportunity to encourage and support patients and colleagues improve their health and wellbeing.
- You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access and outcomes between differing groups or sections of society requiring health care.
- You should aim to inform patients about the use of their confidential information and to record their objections, consent or dissent.
- You should aim to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

Trust Board 27 July 2021
Agenda item 11.3

Title:	Committee Membership changes for 2021/22
Presented by: Paper prepared by:	Chair Company Secretary
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.
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:	Committee memberships for 2021/22 were previously considered at the following meetings: • Nominations' Committee on 6 April 2021 • Trust Board on 27 April 2021 • Executive Management Team on 17 June 2021 • Trust Board on 29 June 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. The previous update provided to Trust Board on 29th June 2021 reported that Mark Brooks will be the interim Chief Executive, whilst Rob Webster is on secondment to the West Yorkshire and Harrogate Health Care Partnership, and the relevant Committee membership changes that followed. Due to further changes in Board membership, the Chair is proposing the revised memberships of the Board committees as per the attached document from 2nd August 2021. Those Board changes are: • James Sabin will start as the interim Finance Director with the Trust on 11th August 2021. • Darryl Thompson will start as the Director of Nursing and Quality on 1st August 2021. • Sam Young will leave the Trust on 2nd August 2021, at the end of her term of office, and her replacement will begin on 1st October 2021 if the nomination for the role is approved by the Members' Council on 17th August 2021.

With **all of us** in mind.

	It was previously agreed by the Board, on 27 April 2021, that the newly appointed NED replacing Sam Young will chair the Workforce and Remuneration Committee, and become a member of the Audit Committee, and the Mental Health Act Committee, on taking up their appointment. This was expected to take effect on 2 August 2021 but will now take place from 1 October 2021, subject to approval of their appointment. It was also previously agreed that Natalie McMillan will become a member of the Finance, Investment and Performance Committee from 2 August, and this change is reflected in the attached document. The chair has reviewed attendance at all committee meetings scheduled to take place between 2 August and 1 October and confirms that they are expected to be quorate. On agreement by Trust Board, Committee Terms of Reference will be updated to reflect the changes in membership. **Risk Appetite** The committees are fulfilling their terms of reference; and integration between committees avoids duplication.

Recommendation:	**Trust Board is asked to:**
	• **NOTE the proposed change in appointment date for the new Non-Executive Director; and**
	• **APPROVE the changes to the Membership for the:**
	   o **Mental Health Act Committee;**
	   o **Equality, Inclusion and Involvement Committee;**
	   o **Finance, Investment and Performance Committee**

Private session:	Not applicable.

Trust Board and Corporate Trustee committee membership
(from 2 August 2021)

	Audit Committee	Clinical Governance & Clinical Safety Committee	Equality Involvement & 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	
~~Samantha Young~~	~~Member~~				~~Chair~~		~~Member~~	
New NED (from 01/10/21)	Member			Member	**Chair**			
Mark Brooks			Member		Member (NV)	Member **(LD)**	Member	
Mark Sabin (11/8/21)	Attends **(LD)**						Member **(LD)**	
Darryl Thompson		Member **(LD)**	Member	Member			Member	Member
Dr Subha Thiyagesh		Member		Member **(LD)**				
Alan Davis		Member	Member		Attends **(LD)**			
Carol Harris		Attends		Member			Attends	
Sean Rayner								Member
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**

Legend:
- 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;*
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 (from 1/10/21)	Attends				Staff Wellbeing Lead
Mark Brooks	Attends			Attends	
James Sabin	Attends				
Darryl Thompson	Attends		**Co-Chair**		
Dr Subha Thiyagesh	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 27 July 2021
Agenda Item 11.4

Title:	**Quality Account update for 2020/21**
Paper prepared by:	Director of Nursing & Quality / Assistant Director of Corporate Governance and Risk.
Purpose:	The quality account report is an annual report that focuses on how we perform against a set of quality priorities that we set for ourselves and a range of mandated items as identified by NHSI. The purpose of this paper is to describe the revised quality account proposal taking account of national guidance.
Mission / values:	All of the quality priorities we set in the quality account process are in line with our mission and values.
Any background papers / previously considered by:	Previous quality account report annual submission
Executive summary:	At the Private Board meeting on 25th May 2021, it was agreed, following discussion, that the Quality Account for 2020/21 would be submitted after the deadline of June 2021.
	This followed guidance from NHS Providers that the submission deadline in 2021 would be December, as was the case in 2020, due to the response to the pandemic.
	A submission deadline of August 2021 was agreed to allow the Quality Account to be produced, go through our internal governance framework and provide sufficient time to consult with stakeholders.
	It was noted in the May meeting that the August Board is strategic meeting, not a decision-making meeting, and a sign off process would need to be established.
	Update
	The Quality Account has been written and is currently with external stakeholders who have been asked to return by 16 August 2021. The Trust website has been updated to this effect.
	An update on the progress of the Quality Account is being presented to the public meeting of the Members Council on 17th August 2021.

With **all of us** in mind.

	Members of the Members Council Quality group will receive the Quality Account electronically to comment on, as will members of the Clinical Governance and Clinical Safety Committee in line with normal practice.
	Due to the timescales involved, and in order to achieve the completion deadline of 31st August 2021, Trust Board is asked to delegate authority to the Chair and Interim Chief Executive for final approval of the Trusts Quality Account for 2020/21.
	On approval, the Quality Account will be submitted to NHSE/I to be publicly presented on their website, in line with guidance, and will be presented to the Public Trust Board meeting on 29 September 2021 for receipt.
	Risk appetite
	The trust continues to have a good governance system for monitoring and reporting against the actions that are required to support the quality account process.
	This report covers assurance for compliance risk legislation. This meets the risk appetite –low and the risk target 1-6.
Recommendation:	**Trust Board is asked to NOTE the update provided in this report and to DELEGATE approval of the final QUALITY ACCOUNT to the Chair and Interim Chief Executive.**
Private session	N/A

Trust Board 27 July 2021
Agenda item 12 – Assurance from Trust Board Committees
Audit Committee

Date	13 July 2021
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	

Alert:
- The Committee were briefed on the process for the update of the Trust's Constitution which is due for ratification by the Members' Council in November 2021 following review by the Trust Board. (Note – at the same time the Trust's Standard Financial Instructions will be updated)   - Internal Audit report on Pay Expenditure reported a finding of limited assurance specific to weaknesses in anti-fraud controls regarding changes to employee bank accounts; recommendations to address have already been implemented (Note – significant assurance received re rest of payroll control environment)

Advise:
- The Committee reviewed the plans to address previously identified areas for improvement regarding data quality. Progress report to be received at future meetings   - A first draft update to the Trust's Procurement Strategy was presented; comments being provided offline and revised version to be brought back to October Committee.

Assure:
- The Committee reviewed the status of the risks assigned to it and were assured that the current risk levels were appropriate   - Assurance was received regarding the process for Reference Cost submissions for 20/21   - Positive update received re staff Declarations of Interest process   - The results of a post implementation review into the new financial system was received. There are a small number of recommendations to be implemented but in general the conclusion was that the implementation had been very successful and the staff involved are to be thanked for all their efforts.   - Significant assurance received from external review (EY) of 19/20 healthcare costing standards   - Progress report received from Internal Audit – significant assurance received on 3 of the 4 audits completed – see above.

Risks discussed:
N/A – covered above

New risks identified:
N/A – covered above

Approved Minutes of previous meeting/s	Minutes of the meeting on 13th April 2021 and 18th June 2021.

With **all of us** in mind.

for receiving	

Finance, Investment & Performance Committee

Date	26 July 2021
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Verbal update to be provided during the Board meeting.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting on 22 March 2021 and 23 April 2021.

Workforce & Remuneration Committee

Date	20 July 2021
Presented by	Sam Young, Non-Executive Director (Chair of Committee)

Key items to raise at Trust Board	➤ Freedom to Speak Up Guardians update:
	  - Receive a report from the lead Freedom to Speak Up Guardian.
	  - Recognised the importance of the Board in supporting a culture of feeling safe to speak up and all Directors were ask to undertake the FTSU training.
	  - Discussed the low numbers in terms of reporting and the FTSU Index and agreed to undertake further work to understand the reasons staff reporting maybe low when compared to other organisations.
	➤ Vaccinations – discussed vaccination levels and work to continue to increase uptake particularly in BAME colleagues, discussed potential COVID Booster and position on self-isolation for NHS Staff.
	➤ Workforce Strategy – WRC discussed importance of staff engagement, internal communication and asked for strengthening around My Voice Counts area in terms of actions and in terms of the metrics.
	➤ Horizon Scanning – New Treasury guidance for Trusts on settlement agreements relating to termination of employment and Flowers case.
	➤ Risk Register – highlight significant proposed changes through WRC and Board to note the changes.

Approved Minutes of previous meeting/s for receiving	Minutes of the meetings on 16th March 2021, 18th May 2021 and 29th June 2021.

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

Minutes of the Audit Committee held on 13 April 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

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
	Caroline Jamieson	Senior Manager, Deloitte
	Leanne Hawkes	Deputy Director, 360 Assurance
	Andy Lister	Head of Corporate Governance
	Lianne Richards	Client Manager, 360 Assurance
	Alan Davis	Director of HR, OD and Estates (for agenda item 8)
	Tim Breedon	Director of Nursing and Quality (for agenda item 8)
	Kate Quail	Non-Executive Director (for agenda item 8)

AC/21/30 Welcome, introduction, and apologies (agenda item 1)
The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting.
No apologies were received.

It was noted that the meeting was quorate.

AC/21/31 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 2021 or subsequently.

AC/21/32 Review other committee effectiveness and integration (agenda item 8)

Clinical Governance and Clinical Safety Committee
Tim Breedon (TB) introduced the paper and referred the Committee to highlights identified in the report. In particular, he noted the need to adapt the Committee's agenda in response to the Covid-19 pandemic. Despite this the work plan was delivered with adjustments made to the timing of some items and reports. He was pleased to note the continuation of improvement work during the year including the CQC improvement plan. The introduction of the Clinical Ethics Advisory Group to support the Trust through the pandemic was also noted. Finally, there was continued work around the patient safety strategy and suicide prevention work.

MF referred to the annual survey process and asked if there was anything to be drawn out from this process. TB confirmed it was discussed at the last Clinical Governance and Clinical Safety Committee (CGCS) and there were no major points arising from it. A lower response rate than normal was noted and put down to the pressures caused by the pandemic.

With **all of us** in mind.

MF thanked TB and the Committee members for carrying out impressive work during the year.

Equality and Inclusion Committee
TB introduced the paper and noted the main highlights of introducing the new equality and involvement strategy with its associated work plan, ongoing development of a performance dashboard which will prove to be very helpful, and the continued involvement of all the networks in the Trust.

MF highlighted the need for committees to review risks attributed to it for overview and asked how this was working in the Committee. TB confirmed this process is working well. MF commented his name needs adding to the members of this Committee in this report.

Action: Andy Lister

Finance, Investment & Performance Committee
CJ discussed the annual report for this committee. Key highlights include oversight of Covid-19 costs, monitoring performance against the 7-day payment target for suppliers, developing a financial plan for the second half of the year and putting in place monitoring arrangements, and oversight of performance against the capital expenditure plan. There has been less focus on tenders and cost efficiencies given the financial arrangements in the year. The Committee has continued to monitor the financial due diligence regarding the forensics lead provider collaborative. There has been less focus on performance, although there was an in-depth review of CAMHS and a review of the development of performance information available within the Trust.

Focus has been applied to risks allocated to the committee and emerging risks given national financial arrangements.

MF asked if there were any issues identified by the survey. CJ responded by stating there were no major issues identified, although the response rate was low. MF asked if the use of surveys was appropriate. MB commented that in previous years these have been responded to well and he felt that as directors of the Trust we should ensure we complete them. MF agreed with this. SY added that in the Workforce & Remuneration Committee the questions in the survey were discussed at the meeting. MB added that if committee chairs and director leads felt that as a result of lower than normal survey responses then alternative approaches could be looked at during the year.

Action: Mike Ford and Andy Lister to consider how this issue is raised with Trust Board

MF asked if the Terms of Reference for the Committee required any changes. CJ explained that this was the first full year the Committee has been in operation and that no changes are recommended at this stage.

Mental Health Act Committee
KQ referred to the key points highlighted in the report and confirmed the Committee has a number of standing agenda items including oversight of compliance with the Mental Health Act. KQ explained service user rights and services have been upheld despite the impact of the pandemic and the Committee did adjust its agendas accordingly in response to the pandemic, particularly in its early stages. KQ explained about the focus on improvement including section 17 leave and highlighted two responsibilities picked up during the year involving service user feedback with a particular focus on inequalities. No key issues were

identified as part of the survey, which was responded to well. KQ explained one issue was raised relating to committee independence and one return suggested it wasn't independent as executive directors sat on the Committee.

No changes to the Terms of Reference have been recommended.   KQ noted the Committee does not have any risks allocated to it by the Board, but there is a committee risk register

MF asked if executive directors were members of the Committee or if committee membership was restricted to non-executive directors. MB and AD explained that only the Audit Committee and Workforce and Remuneration Committee membership consisted exclusively of non-executive directors. MB added that our approach follows the norm in the NHS. We may wish to consider how we phrase this question in the survey in future.

Workforce and Remuneration Committee
SY explained she had added some highlights form the year in the chat function which will be incorporated in the Board paper. SY commented that this committee was stood down during the early stages of the pandemic as the workforce issues were covered by the Trust Board in its entirety. It did still meet its minimum number of meetings for the year and focused on our staff and the Covid-19 response including performance and vaccinations. Keen interest was shown on the impact of absence and actions relating to the OD strategy. The requirements of Terms of Reference have been met.

Each question of the survey was discussed at the Committee

CJ added that reading the reports and listening to the discussion he felt that the work conducted by the Board committees given the circumstances was quite extraordinary. SY and MF agreed with this.

The Audit Committee resolved to receive the annual reports from each committee and confirmed they meet the requirements of their Terms of Reference, that work programmes are aligned to the risks and objectives of the organisation and that they demonstrate added value to the Trust

AL added that the paper provided notes the position regarding the Mental Health, Learning Disability and Autism Committee in Common, and Charitable Funds Committee annual reports which will be available later in the year.

TB, AD and KQ left the meeting at this point

AC/21/33   Audit Committee Annual Report and Review of Effectiveness (agenda item 9)

MF noted some minor changes to the Terms of Reference and that he felt the Committee had met its Terms of Reference, covering off risks on a regular basis.

MB added that the Audit Committee did not fundamentally change its agenda during the pandemic.

The workplan for the year was reviewed and agreed.

It was RESOLVED to RECEIVE the annual Audit Committee report, RECOMMEND the terms of reference for approval and APPROVED the annual workplan

AC/21/34 Draft Annual Governance Statement (agenda item 12)

AL introduced this item and explained the requirement for the Chief Executive to provide an annual governance statement. He further explained that guidance is received from the regulator regarding the required content of the annual governance statement and that certain wording is prescribed. This is highlighted in the paper. AL noted this version is a draft as some information is only available on completion of the year-end accounts. He also confirmed he has reviewed the guidance in detail to ensure our format and information included is in line with that guidance.

Several comments in the report have been left in so committee members can see what information is outstanding. The draft report has been to the Executive Management Team (EMT).

MB explained the final sign off is at the Trust Board meeting in May following recommendation by the Audit Committee. MF asked PH if this statement is audited. PH confirmed the Annual Governance Statement is subject to audit.

MF asked how the document compared to previous years. AL responded by stating it is in line with previous years, updated for current guidance and current year information.

MF also noted the appearance of the risks included in the report. A more detailed discussion took place regarding how the risks should be presented in the governance statement. CJ queried whether we should use the risks on the Board Assurance Framework, whilst understanding the need to summarise. It was concluded that the guidance would be reviewed in further detail and the issue discussed with the Chief Executive, who has yet to review the governance statement. It will also be raised with Board members.

Action: Mark Brooks

MF will forward specific points and questions he has on the governance statement to AL

It was RESOLVED to RECEIVE the draft annual governance statement

AC/21/35 Review of annual accounts progress (agenda item 7)

RA provided an update of the progress being made on the year-end and development of the annual accounts. He commented that good progress was made especially considering the implementation of a new system part way through the year, remote working of the team and a range of additional guidance issued towards the end of the year. He expects an agreement of the year-end position to be made imminently, meaning we can start development of the annual accounts.

It was RESOLVED to RECEIVE the update of the year-end accounting process

AC/21/36 Draft accounts timetable and plans (agenda item 17)

PH commented that planning work is largely done, discussions have taken place regarding year-end judgements, and a more detailed discussion with MB has taken place regarding the new value for money requirements. The audit will commence in April.

MF sought clarification of the Deloitte year-end partner shadow arrangements. PH explained this is a requirement given it is the final year of him being involved in the Trust's audit how this would work in practice. This individual will be distant from the Trust and only challenge the audit team.

MF asked if it was agreed who the new partner will be to replace PH. PH believes Nicola Wright will be taking over this role and, once confirmed and the year-end is complete, will introduce her to the Trust.

AC/21/37   Internal audit progress report including head of internal audit opinion (agenda item 15)

LR introduced the progress report. Five reports have been issued recently as well as terms of reference for the equality and inclusion audit. Final reports are in progress for the audits on payroll, data security & protection and BDU governance and risk management. Follow up of recommendations at the year-end is 98% overall

Recent audits completed include a review of the digital strategy which provided significant assurance. The internal audit on data quality for information provided to commissioners gave limited assurance. The sample of metrics was chosen by the Trust. Some controls could be strengthened and some inaccuracies in reported data were identified.

The audit on accounts receivable provided significant assurance with some actions identified. LR understands that all actions have already been completed.

An in-year audit on remote consultations was agreed and this is an advisory audit looking at the roll out of remote consultations since the onset of the pandemic.

Significant assurance was also provided on financial ledger controls and systems

Focused discussion took place on the data quality audit. MF asked if there are wider implications than the scope of this audit. MB responded and noted that the Trust did ask for this audit to be completed given some feedback from commissioners in 2019/20. He added that he felt the Trust took a mature approach to audit by considering areas of risk so that learning, and improvement could take place.

MB added for context that there has been a data quality audit of some type carried out most years and the assurance provided has typically been good. His personal view is that for metrics reviewed at Board and Committee there is greater focus and assurance around data quality. He acknowledged that there are clearly some areas for improvement and whilst the Trust has been stretched with the response to Covid-19, data quality needs to be an area of continuous focus.

MF asked about MB's views on wider data quality. MB suggested that it would be helpful to re-visit if SystmOne is used consistently and effectively across the Trust in terms of what data is entered, what fields are used, user knowledge etc.

MF asked if the recommendations identified would resolve this issue. MB responded by stating that in his view the actions identified will be progressed as the Trust has a strong track record in doing this, which will resolve the specific issues identified in the audit. He added that in his view there needs to be a wider change in culture to address data quality consistently. We need to ensure the importance of data completeness and accuracy is recognised at all levels and in all services across the Trust. Local ownership and responsibility are also key. A measured and considered approach is required to identify how we can make the best difference.

CJ agreed the most important aspect of data quality is clarification of who owns the data. CJ also raised the point regarding system optimisation and wanted to ensure that it is re-considered. He also asked about the level of assurance that can be taken from the wider range of data sources the Trust is using such as the SWIFT dashboards and benchmarking data.

SY added that she feels the key point to address is process quality as data is usually a consequence of a process followed. The data and improvement culture in each team is key and this is an important point to address from her perspective. SY wondered if the Finance, Investment & Performance Committee could undertake a piece of work to ascertain where the Trust has data quality concerns.

MF asked MB about the wider actions required. MB suggested fuller consideration is given over the course of this quarter with a proposal being available by the end of June. MB added a brief description of the role of the Improving Clinical Information Group (ICIG) in the Trust. MF requested that as part of any proposal thought is given to where a more detailed review and monitoring of data quality needs to take place.

Action: Mark Brooks

CJ asked a further question regarding remote consultations, following review of benchmarking data which suggested the Trust has lower levels of video consultations than other trusts. He asked where this is being reviewed and how that fact aligns with the internal audit report. MB explained the purpose of the audit, given the rapid use of remote consultations in response to Covid-19, was to ensure we had good controls in determining the appropriateness of using them. Is there a good process in place? The issue is being overseen and considered by the reset and recovery group. Feedback has included the need to consider appropriateness by service, and that different managers may have different views. Each service is conducting its own review. CJ emphasised the need to develop a plan.

LH introduced the draft Head of Internal Audit Opinion. LH explained that it is a draft report at this stage, which provides significant assurance. LH did note that there are some recommendations regarding the Board Assurance Framework, which have been agreed by AL.

MF asked what the prior year assurance level was. LH stated that the Trust has received significant assurance for each of the past three years. MF asked how the Trust could receive substantial assurance. LH responded they have never given any organisation substantial assurance, other than for individual elements of the opinion. She agreed the costs of achieving a substantial opinion would be high.

It was RESOLVED to NOTE the internal audit progress update and draft head of internal audit opinion

AC/21/38   Update of actions taken following the internal audit on service users' property and money (agenda item 11)

MB summarised by stating the actions identified have been completed. A plan has been agreed for completion of spot checks. These have not taken place yet and will be conducted when restrictions change, and Trust guidance is that it is safe to do so. MF agreed that this item would only be brought back to the Committee by exception. LR confirmed their follow up has been completed and no further work is planned.

It was RESOLVED to NOTE the update of actions taken following the internal audit on service users' property and money

AC/21/39   Internal Audit Plan (agenda item 10)

LH introduced the internal audit plan for 2021/22. LH explained that discussion has taken place with MB, who in turn has discussed and reviewed with the exec team. In addition, she has discussed the draft plan with MF and taken feedback into account. LH pointed out areas considered for inclusion that were not prioritised this year.

MB provided further confirmation that following a discussion with Tim Breedon the audit on patient safety should be planned in for Q3. Regarding the audit to be identified Tim has suggested an audit of the roll out of FIRM risk assessments would be most appropriate. The other option being national guidance on ligatures. The other question related to payroll. Given the timescale associated with the 200/21 audit and depending on the outcome of it, a more bespoke audit could take place such as approval of timesheets, which could cover agency staffing as well as bank and overtime.

MF asked about the system-working audit and whether it would cover the move to ICS arrangements. MB explained that the White Paper introduction is expected to become effective from April 2022, with planning for it taking place this year. The intent of the audit is to cover the partnership arrangements within the Wakefield Mental Health Alliance, which has now been operational for two years. LH explained that across internal audit providers in the North East and Yorkshire preliminary discussions have taken place on how assurance can be provided across this wider footprint. They are considering how to engage with Audit Committee chairs in this respect.

MF asked about those audits not included in the plan including information governance and whether it would be covered elsewhere. MB explained this has been subject to regular audit in recent years, including the implementation of GDPR. The data security and protection toolkit also covers information governance to some degree. MF similarly asked about sustainability. Progress is likely to be monitored in 2022/23 or 2023/24.

MF asked about assurance for those other audit areas not being covered. LH explained the internal audits have been prioritised by the Trust and there is nothing to stop the Audit Committee assessing what internal assurance it requires on any of these.

CJ suggested that whilst not necessarily subject to audit SystmOne optimisation should be an agenda item at some stage.

Action: Mark Brooks

CJ questioned the prioritisation given to the Freedom to Speak Up Guardian audit, but also recognised the role of management in developing priorities. CJ would also like at some point some assurance regarding capital planning. He also asked about discharge arrangements, following conversation with governors. These items should be covered in some other way if not through internal audit.

Action: Mark Brooks

SY asked whether the forensics lead provider needs to be picked up in some way. A review took place on the governance of the project in 2020/21 and the collaborative is likely to go live on July 1st. MF suggested Q1 2022/23 might be an appropriate timescale. LH offered to include this for consideration when preparing the 2022/23 plan.

It was RESOLVED to APPROVE the internal audit plan for 2021/22

LH left the meeting at this point

AC/21/40   Counter Fraud progress report and 2021/22 plan (agenda item 16)

SF introduced the report. He noted that since the last Audit Committee work has continued to meet the plan. He noted alerts for salary diversion and mandate frauds. SF explained about the national fraud initiative. To date no fraud issues have been identified on the work that has taken place.

SF provided an update on the passport investigation. The process has been delayed because of Covid-19. The court case is now scheduled for July 1st. There was an intention to seek recompense via the Proceeds of Crime Act. Following a police case review this has been discontinued.

SF also referred to an investigation into a member of staff working elsewhere whilst on sick leave. Covid-19 has also impacted this investigation. Following discussion with MB based on proportionality and discussion with the Counter Fraud Authority this will not proceed to an investigation. SG suggested resources are better directed to understanding any system weaknesses and rolling out learning via staff training.

There was also a successful salary diversion in January, when a member of staff working for an organisation the Trust provides payroll services to alerted the Trust that they had not been paid. A change in bank details had been provided and they had been updated. Mistakes were made at both organisations. Remedial actions have already been put in place. A criminal investigation is unlikely to be successful given the threshold and evidence available. SF expressed disappointment the fraud had been successful despite the provision of fraud alerts.

An update has been provided on the new counter fraud standards. The standard was finalised in February and there are thirteen components in the new standards. Some component areas are very new and as such there are three components no trusts will be able to achieve in the first year. This has been recognised nationally. SF confirmed that the paper written by Steve Moss has been circulated as requested at the previous meeting. Only a limited inspection regime is expected in the first year and we therefore have a year to prepare to fully comply.

MF stated the introduction of standards that trusts cannot comply with feels to be an odd way of working. He asked what the resource implications are to meet the new standards. SF responded by stating he did not think they would be significant. The most notable point will be the metrics that will require producing and this will become evident as the year progresses.

SF introduced the counter fraud plan for 2021/22 which is based on the requirements of the new standards. MF asked about the likelihood of the organisation being selected for assessment. SF responded by stating this is expected to be limited in the first year. MF also asked about the fraud risk assessment. SF noted a new template is expected to be released and he will bring it to the Audit Committee when it is available

Action: Shaun Fleming

It was resolved to RECEIVE the counter fraud update and APPROVE the counter fraud plan for 2021/22

SF left the meeting at this point

AC/21/41 Procurement report (agenda item 13)

MB introduced the paper and suggested it was taken as read. MB and MF to discuss the context of some of the numbers in the report outside of the meeting.

Action: Mark Brooks/Mike Ford

The Audit Committee RESOLVED to RECEIVE the procurement report.

AC/21/42 Treasury Report (agenda item 14)

RA introduced the paper and again suggested it was taken as read. There are no notable updates since the previous Audit Committee report. No interest is currently being received.

It was RESOLVED to RECEIVE the Treasury report

AC/21/43 Losses and Special Payments (agenda item 18)

RA provided this update and again suggested the paper was taken as read. Only minor payments have been required in the most recent quarter

It was RESOLVED to RECEIVE the losses and special payments report

AC/21/44 Minutes from the meetings held on 5 January 2021 and 26 February 2021 (agenda item 3)

The minutes received from the two meetings highlighted above were approved

It was RESOLVED to APPROVE the minutes from the meetings held on 5 January 2021 and 26 February 2021

AC/21/45 Matters arising from the meetings held on 5 January 2021 and 26 February 2021 (agenda item 4)

MF noted the majority of actions have now been implemented. It was confirmed that given the approval of the internal audit plan at the meeting, the timescales for the next phishing exercise can now be planned.

It was RESOLVED to NOTE and RECEIVE the updates against the matters

AC/21/46 Consideration of items from the Organisational Risk register allocated to the Audit Committee (agenda item 5)

MB introduced the paper. He noted very limited change since the previous meeting. There is a recommendation that the risk regarding provision of IT equipment to staff to enable them to work remotely is closed. A report on cyber controls was received by the Audit Committee at the January

meeting. He added that the information governance risk has had controls and actions added regarding the Covid-19 vaccination programme. MB also noted that regarding the legal risk the COPI (control of patient information notice) has been extended.

CJ asked if regarding the capacity risk if EMT is considering the impact of planned leadership changes at executive level and their impact for the next six to twelve months. MB responded not directly as part of the risk and he would ensure this is raised at the next EMT risk meeting. It was acknowledged the experience of replacements would be key.

It was RESOLVED to NOTE and RECEIVE update to items from the organisational risk register allocated to the committee.

SY left the meeting at this point

AC/21/47   Triangulation of risk, performance, and governance (agenda item 6)

AL introduced this paper. In summary no notable exceptions have been identified through undertaking the triangulation exercise. MF asked where red rated performance metrics are picked up and sited the example of service users on care programme approach (CPA) receiving a copy of their care plan. MB suggested it would be expected to be reviewed at the CGCS, but that it is worth checking.

Action: Andy Lister

It was RESOLVED to NOTE and RECEIVE the triangulation of risk, performance, and governance

AC/21/48   Any Other Business (agenda item 19)

MF asked PH if there was any update regarding the Redmond Paper. PH has not received any further update since the last meeting. PH explained there is a degree of nervousness that fewer audit firms are tendering for NHS audit work

AC/21/49   Items to report to Trust Board (agenda item 20)

MF summarised he would report back on the following to Trust Board:

Review of the annual reports from the other Board committees
Annual governance statement will be received as a separate paper at the April Trust Board
Head of internal audit opinion
Approval of 2021/22 internal audit and counter fraud plans
Data quality internal audit

AC/20/98   Date of next meeting (agenda item 22)

The next meeting of the Committee will be held on Thursday 25th May 2021 at 8.30am.
A contingency date of June 1st has been provided given the timescales associated with the year-end audit

Minutes of the Audit Committee held on 18 June 2021
(Virtual meeting, via Microsoft Teams)

Present:	Mike Ford	Non-Executive Director (Chair of the Committee)
	Chris Jones	Non-Executive Director

In attendance:	Rob Adamson	Deputy Director of Finance
	Mark Brooks	Director of Finance and Resources (Lead Director)
	Caroline Jamieson	Senior Manager, Deloitte
	Leanne Hawkes	Deputy Director, 360 Assurance
	Andy Lister	Head of Corporate Governance
	Lianne Richards	Client Manager, 360 Assurance
	Julie Williams	Assistant Director of Corporate Governance, Performance and Risk

Apologies:	Sam Young	Non-Executive Director
	Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
	Paul Hewitson	Director, Deloitte

AC/21/51   Welcome, introduction, and apologies (agenda item 1)
The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting.
Apologies were received as identified above.

It was noted that the meeting was quorate.

AC/21/52   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 2021 or subsequently.

AC/21/53   Consideration of the Annual Accounts for the period 1 April 2020 to 31 March 2021 (agenda item 3)

Mark Brooks (MB) introduced this section with an overview of the year. He highlighted the impact Covid-19 and revised financial arrangements have had on the completion of the accounts and the year in general. He noted there was impact on staff who have prepared the accounts and annual report, and that staff from all areas of his directorate responded to the pandemic including provision of PPE, Covid-19 testing, the vaccination programme and other duties to support the Trust. He also noted that some of the financial guidance for the year-end was only made clear towards the end of the year. Mike Ford (MF) recognised and concurred with everything MB said.

MF stated the fact the accounts and reports have been completed is a huge testament to

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staff. He asked for a formal note of thanks to be recorded in the minutes.

<u>Agenda Item 3.1 - ISA 260 Audit of Accounts 2020/21 report to those charged with governance</u>

Caroline Jamieson (CJa) introduced this item and recognised it has been a difficult process given the circumstances MB highlighted and added her thanks to the finance team. MB stated that significant efforts have also been required by Deloitte to complete the audit, and thanked CJa and her team for this. CJa stated the audit was now complete other than final clearance on page numbering which she expected on June 23rd.
CJa took the Committee through the report and work completed. She explained to Committee members that following review of the accounts the final risk area selected for audit was that of accruals. This was seen across the NHS. Materiality was also updated by circa £100k based on the final outturn position.

The value for money work is ongoing, and CJa noted no significant issues have been identified during the work completed to date. She explained that national deadline for completion of this work is September 20th. She did explain that as part of this work the Quality Account for 2019/20 had been reviewed and some areas of non-compliance had been identified. The Trust has recognised this and put in processes to ensure compliance for 2020/21 and will also update its website to point readers in the direction of the integrated performance report to access those metrics not included in the 2019/20 Quality Account.

CJa explain the work that has taken place regarding management override of controls. One classification error only between accruals and provisions was highlighted. CJa also spoke about management review of journals. Off line of journals review took place whilst agresso was being used. The move to using Oracle has enabled a strengthening in controls in this area providing greater assurance for audit purposes.

In terms of the validity of accruals two errors were identified. One was a classification error between accruals and trade creditors. The second related to 8 smaller errors totalling £92k. Three recommendations have been identified following the audit work. The first related to implementing a threshold for reviews, the second to ensure there is greater written evidence for accrual review and the third related to central accruals and segregation of duties. MF asked if MB accepted the recommendations. MB stated that he recognised the points raised and on the central accruals recommendation some consideration needs to be given to the relatively small size of the finance team. He noted the use of retrospective compensatory controls within the Trust. Rob Adamson (RA) commented that we need to consider how the recommendations can be implemented effectively in the team.

Action: Rob Adamson to provide a management response to the audit recommendations.

A discussion took place regarding the use of extrapolation. RA clarified the fact accruals tend to be estimates so some margin of difference is inevitable.

CJa spoke about the replacement of the general ledger during the year. The audit demonstrated a good level of comfort with the process.

CJa explained about further recommendations. One relates to the service auditor reports. Both received (from SBS and ESR) were qualified in the year for fairly minor issues. There is a recommendation these are reviewed for any potential mitigating action required. The

next relates to the revenue changes during the year. The revised arrangements during the year have made this difficult to audit, so further reconciliations and evidence would be beneficial. The final recommendation relates to a physical check of assets for asset valuation where there have been any major changes. This will be picked up in the annual audit planning meeting that takes place with the District Valuer.

MF asked MB for his views on the recommendations. MB again confirmed recognition, again noting some of the practical difficulties faced due to Covid-19 restrictions and revised financial and contracting arrangements.

CJa highlighted the error schedule above the clearly trivial threshold. There is a regular item given the timing of the asset revaluation and also the accruals issues previously raised. These will not be changed in the accounts given the materiality of the points. MB noted there is a challenge in how these relatively small issues are communicated to non-accountants.

It was resolved to note and accept the ISA 260 report

Agenda Item 3.2 - Report from the Director of Finance on the Accounts

MB introduced this paper which provided an overview of the accounts. He again emphasised the unusual nature of some of the income this year largely due to the Covid-19 response. Additional costs were incurred through PPE, holiday pay accruals and the Flowers adjudication. A reconciliation was included in the paper to explain the differences between different classifications of profit. A strong cash position is also evident. He also noted the increase in employee numbers to meet the investments made in our services. MB suggested that the additional costs incurred during the year have been appropriately reimbursed.

Chris Jones (CJ) added that he was pleased that good financial control has been maintained during the year.

Agenda Item 3.3 - Internal Audit Annual Report 2020/21 including Head of Internal Audit Opinion

Leanne Hawkes (LH) introduced this paper. LH noted the Head of Internal Audit Opinion was approved at the previous meeting. An additional high risk has been included relating to how bank changes are processed following an issue the Trust identified earlier in the year. The recommendation made has already been implemented. The internal audit has only just been completed so will come to the July meeting.

MB explained that the standard payroll audit was conducted as normal and provided significant assurance. Following a specific incident 360 were asked to carry out work specific to bank changes and the high risk recommendation relates to that incident. Improvements in controls have been implemented following the identification of the issue and the recommendation from 360. He noted the issue related to services provided to another organisation. Issues in control were identified at both organisations.

LH also referred to the annual report and noted the full plan was delivered despite the impact of the pandemic.

It was resolved to note and accept the internal audit annual report

Agenda Item 3.4 – Letter of Representation

MB suggested the paper was taken as read unless there were any questions. He noted it is a standard letter that is provided annually. CJ and MF confirmed their approval of the letter of representation.

It was resolved to approve the letter of representation

Agenda Item 3.4 – Annual Accounts and Trust Accounts Consolidation Schedules

RA introduced this paper. It was noted that the accounts presented were fundamentally the same as the draft provided earlier in the process. He explained both CJ and MF had commented on the draft version and responses were provided and where appropriate changes made. RA highlighted the changes since the draft, primarily relating to national wording for policies.

RA agreed to send MF a separate list of changes made since the draft version.

Action Rob Adamson

RA noted an additional disclosure was made for related parties regarding national related parties following further guidance provided. A change was also made relating to the Mount Vernon valuation following discussion of accounting treatment with Deloitte. MF asked about post balance sheet events and changes in leadership. MB confirmed a comment has been made to this effect in the annual report.

It was resolved the recommend the 2020/21 annual accounts for approval

AC/21/54   Consideration of the Annual Report for the period 1 April 2020 to 31 March 2021 (agenda item 4)

Julie Williams (JW) explained the minor changes to the report following the most recent draft circulated to Trust Board members. These relate to the leadership changes above and an update of internal audits completed. It was acknowledged that Trust Board members have received several versions of the draft annual report and had the opportunity to comment.

It was resolved the recommend the 2020/21 annual report for approval

AC/21/55 Timescale for the approval of the Quality Account 2020/21 (agenda item 5)

MB commented that the paper confirmed what has already been agreed at Trust Board. To ensure good engagement and feedback the Trust will aim to submit the Quality Account by the end of August.

The revised timescales for completion of the Quality Account for 2020/21 were noted

AC/21/56 Any Other Business (agenda item 6)

MB introduced one item of any other business relating to when the annual accounts and report can be laid before parliament. Recent national guidance indicates this will be when the final audit certificate is provided, which he understands can only be issued on completion of the value for money work. This would mean submission in September as opposed to June or July which is the normal position. Focus has been applied to risks allocated to the committee and emerging risks given national financial arrangements.

CJa agreed to discuss within Deloitte and provide clarification. CJo checked the Trust and auditors sign the accounts at the same time. MB confirmed this.

Action Caroline Jamieson

AC/21/57   Items to report to Trust Board (agenda item 7)
MF summarised he would report back on the following to Trust Board:

Recommendation to approve the annual report and accounts to Trust Board for approval (noting delegated authority provided)
Receipt of the ISA 260 external audit report

AC/21/58   Date of next meeting (agenda item 8)
The next meeting of the Committee will be held on Tuesday 13th July 2021 at 14.00.

Finance, Investment & Performance Committee (FIPC) – Monday 22 March 2021
Virtual meeting, via Microsoft Teams

Members Mark Brooks (MB) Carol Harris (CH)	Chris Jones (CJ) (Chair) Kate Quail (KQ) Sam Young (SY) Rob Webster (RW)	**Present** Lucy Auld (LA) (Note taker)	**Apologies** Tim Breedon (TB)

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting 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 25 January were approved.	CJ	
4.	Review of progress against agreed actions and matters arising	Action 044: Action closed as item covered on the agenda today. Action 043: Action closed as item covered on the agenda today Action 042: Update to be provided on 23.04.21, Carol Harris (CH) to discuss with Chris Lennox.	CJ	
5.	Review of committee related risks and any exception reports as required.	MB noted that planning guidance is expected imminently and that the Committee risks have been updated to recognise the current expectations of the guidance, subject to review once received. • MB highlighted the new capital regime risk (1585) requiring approval following EMT review. The risk reflects the current context, national and system capital arrangements, and potential restrictions on the amount the Trust can spend in any one year • MB highlighted the Forensic Lead Provider risk (1511) as being significant at this stage, adding that given the income for 2021/22 is not yet known, it is difficult to quantify at this stage what is a predominantly a financial risk to the Trust. **The Committee reviewed and approved the risk relating to capital regime (1585) and were satisfied with the risk appetite.**	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
6.	Current year financial performance and forecast			
6.1	Month 11 finance performance report	MB provided month 11 key performance highlights: • The Trust recorded a strong surplus of £0.5m. • Year to date surplus is £2.7m. MB explained this is higher than expected and has been achieved due to the following: - Excellent operational management in relation to out of area (OOA) beds with current performance exceeding expectations. - Although we have successfully recruited into some Mental Health Investment Standard (MHIS) posts, the pay report shows figures have remained static at £16.2m for the last 5 months. This indicates that a proportion have been internal appointments, therefore the net position of additional MHIS income is unchanged. Turnover of staff has also started to increase from the very low levels witnessed at the start of the pandemic - A high cash balance driven by early payments plus low capital expenditure has resulted in a public dividend capital (PDC) saving of approx. £700k. The Trust has also made savings in estates and on training partly due to the impact of Covid-19 restrictions. - Capital expenditure is currently much lower than plan, although there has been a considerable increase in orders during quarters three and four - Payment to suppliers now stands at an average of within 13 days, continuing the positive trajectory. The 7-day payment requirement has now elapsed and is no longer required within the national guidance. • CJ noted the need to understand the full impact of the capital issues and that focus would be given to this later on the agenda. He highlighted the large cash balance the Trust will have at the end of the year, noting the more limited ability to spend on capital in 2021/22 given the capital limits placed on the ICS'. • RW added that the cash balance position at the end of 2019/20 was £36m compared to the forecast position of over £50m by the end of 2020/21, noting an increase of c£15m feels substantial. • MB acknowledged that a prior year transaction with Calderdale & Huddersfield Foundation Trust (CHFT) contributed £1.6m towards our total, that together with the 2019/20 PSF payment and underspend on capital has contributed to this increase. Also delivering a surplus has generated cash. MB added that our cash balance is above average when compared across West Yorkshire (WY). **The Committee discussed and commented on the report as above.**	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
6.2	Full year forecast including risks and possible upsides	MB provided the key forecast highlights: • MB clarified that the performance discussion in item 6.1 worked on a 'like for like' basis of the Trust's current surplus against the projections made in August. • In month 11 the Trust was informed it will receive up to £1.164m as an additional unanticipated sum of money to cover the loss of non-NHS income. The previous planning forecast was based on non-NHS income levels returning to normal, however this hasn't been the case due to the high prevalence of Covid-19 and continued restrictions. It is estimated that the Trust has lost circa £700k in relation to non-NHS income in 2020. There may yet be a requirement to not retain this payment, dependent on the national year-end guidance. RW agreed that if the Trust does not need the payment discussions should be held with the ICS and NHSE&I to offer it back. • MB noted that overall monthly pay costs haven't increased since September and this has resulted in some services struggling to spend monies as projected. MB explained that some transactions are recognised at the end of the year when there is more certainty on the costs e.g. holiday pay accrual. • MB noted the Board have previously agreed to submit a £1m surplus, advising that this figure should potentially be increased. A balance is required that both meets with accounting standard requirements and ensuring accruals are such they do not leave the Trust exposed. • MB noted a need to better understand Covid-19 expenditure across the Trust in further detail and the finance team is completing a piece of work on this. MB outlined the further technical adjustments affecting the forecast in addition to non-NHS income: • PPE: It is expected a transaction will occur whereby the Trust is asked to count and recognise stock levels and will receive income and cost sales adjustments to cover PPE costs. • Holiday pay: A set number of days is to be paid to each organisation, likely to be up to 5. Current annual leave accrual calculations indicate the Trust is at the low end of the scale compared to other West Yorkshire organisations. This additional funding will lead to an upside to our surplus position of circa £600k. • Flowers: Income will be paid to the Trust or an adjustment made that will likely increase the forecast position. MB concluded that taking all of this into account, the Trust is in a position to deliver a surplus of between £2m and £5m. • CJ commented that in a complex year it appears the Trust has had a good and secure year financially for all of the reasons articulated thus far. He offered particular thanks to the teams involved in managing the OOA beds both financially and operationally. • RW added that he agreed with MB that the organisation should not 'profit' financially from accounting arrangements driven by Covid-19 and this approach was supported by the Committee.	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• CJ acknowledged that the overall position appears similar across the ICS. RW added to this that the West Yorkshire & Harrogate ICS (WY&H) System Oversight and Assurance Group discussed last week a projected total ICS surplus of between £0-£40m. • Sam Young (SY and Kate Quail (KQ) confirmed support for the proposed position. • KQ queried the specific provision for Flowers, holiday pay and clinical pensions. MB explained an adjustment is made to the accounts in terms of the clinical pensions and we should receive partial funding for Flowers and holiday pay. • KQ also asked for clarity regarding the Altogether Better provision. MB explained that Altogether Better did not receive any income in the first half of the year and therefore the Trust covered their costs following the principle that no organisation should suffer a reduction in reserves as a consequence of Covid-19.. **The Committee reviewed and commented on the paper as above, noting the forecast submitted to the ICS of £1m and ratifying the improved forecast outturn of between £2m and £5m. The Committee authorised MB to manage accordingly in line with national guidance and accounting standards to ensure the best outcome for the Trust and the system.**		
7.	Operating Plan 2021/2022 and Horizon scanning	MB highlighted the key points: • Of the two options referred to, the preferred approach within WY&H ICS is to roll forward the H2 2020/21 plans. • In terms of income flow, the expectation is that system monies will be allocated via the ICS with nationally calculated block contracts, this will be confirmed when the guidance arrives. • MB is keen that the mental health recovery (demand surge) monies are deployed into services where high demand is expected to ensure safeguarding of those services. • Additional monies are being made available nationally for Community Mental Health Transformation. • Leeds & York Partnership Trust (LYPFT) are leading on the CAMHS provider collaborative. SWYPFT will need to understand the baseline finances and risk share arrangements in this regard. FIP will oversee this process and provide recommendation to Trust Board in due course. • Confirmation of the final financial arrangements regarding the WY Learning Disability (LD) re-configuration is required. For example, LYPFT no longer provide inpatient services but in effect continue to receive funding for it given the current financial arrangements. Commissioner engagement and agreement to the funding approach is key. Further work will be required financially and contractually to manage this effectively across the ICS. • In response to the recent ICS White Paper the WY&H ICS Finance Forum has been asked to contribute to six work streams considering the potential impact of the proposed legislation on such matters as financial resources and planning. • Clarification is required regarding whether the Covid-19 response monies will continue in 2021/22 and if so at what level. This will depend on the Covid-19 prevalence and restrictions as the Trust could incur further costs depending on the rate of recovery.	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• Rob Webster (RW) noted the ongoing work on future commissioning models is looking at how commissioners can work together across WY to ensure there is a single manageable approach. The LD services referred to above are an example of where we should be seeking leverage to ensure a consistent view, although there will be a number of similar opportunities that could put us in a better position with commissioners to work through tactics collaboratively. • KQ added that this should be made easier once the ICS is in control of the commissioning function. RW explained that this is not yet the case adding that Helen Hirst is the lead commissioner on mental health, and the work being led on commissioning futures is pushing mental health and LD services as being areas in which change can be made to happen. The difficulty will be in the transition from chief executive authorisation into operating managers driving this forward. • CH noted the need to ensure that services are levelled up. Good services should be replicated across the ICS rather than shared as this will inevitably reduce the quality of some of outstanding services. CJ highlighted that conflict may arise as a result of balancing maintaining consistency across the ICSs and ensuring place-based decision making takes place. This will need to be resolved. • CJ noted that the CAMHS and LD projects will need to be reviewed by FIP in due course in addition to the Lead Forensic Provider as the Trust will need to sign off risk agreements and governance arrangements for these with recommendations from this Committee. • MB confirmed resources within the finance team will be tight in terms of completing all of the necessary work in the next couple of months. CJ confirmed support from the Committee to lessen the demand on MB and the team if required. **The Committee noted the paper and commented as above.**		
8.	Financial Plan	MB presented the key highlights: • The expectation is that current financial arrangements will be rolled over into Q1 of 2021/22 and potentially Q2 with some adjustments. Internally the Trust has conducted financial planning to focus on the baseline spend and contract income position. This process entailed understanding the key cost movements between 2019/20 and 2020/21 by BDU and corporate service and taking a view on what will change next year, whilst also taking into account original 2020/21 budgets. The planning guidance will confirm arrangements when received. • RW queried the historical operating cost figures noting in 2019/20 the figure was £222.4m and in 2020/21 it is £223.8, rationalised against the statement that the Trust has 200 more staff. MB agreed to provide supporting information on a like for like basis. **MB and the team to complete a further piece of work to establish a true comparison between income and operating costs.**	MB	**Action: MB**

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• CJ noted the anticipated stability of acute inpatients. MB suggested that whilst there is limited growth next year in inpatient cost projections this is likely to be because there has been such pronounced growth this year. If there is reduced Covid-19 prevalence and sickness absence costs could be expected to reduce. • RW noted the placeholder in the paper relating to the Workforce Plan and triangulation, and the cost associated risks that will need to be considered in relation to the pay increase when this information is available. He added that the Trust has benefited from having staff stay on, with less turnover, higher attendance and lower sickness rates, however this is not guaranteed to continue as we move into the next phase. It will therefore be critical for the Committee to look at the Workforce Plan and triangulation in detail when this is available. • SY queried if from an operational point of view the overtime figures noted can realistically be maintained, particularly in areas such as forensics and CAMHS, noting further assurance is required regarding this from a safety perspective. MB added that the equivalent heads worked in forensics in 2020/21 is substantially higher than in previous years and that CH is conducting a review of the effectiveness of overtime in forensics • RW noted that the benchmarking data will be important in developing the Trust strategic response to any risks. • CJ queried whether there is any underlying assumption regarding vacancy levels. MB explained the position is not yet clear however suggested that the base assumption should be similar to this year. • CJ commended the excellent baseline planning that has taken place in anticipation of the planning guidance. **The Committee noted the paper and commented as above.**		
9.	National Mental Health Benchmarking Report	MB noted thanks to the P&I team for their input in pulling this report together given the substantial pressure the team has been under. The aim will be to complete a benchmarking analysis report every 1-2 months depending on capacity. The report highlights the Trust as being higher than national averages in the following key areas: • Adult acute prone restraint per 10,000 bed days • Adult acute cost per bed • Medium secure length of stay (opportunities presented here as Lead Provider) • Community contacts • Referrals and activity in early intervention • Use of restraint in older adult acute and PICU And lower than national averages in relation to: • Lower than national averages for older adult team caseloads per 100,000 population. • Lower than national averages for older adult bed occupancy.	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action

		MB noted a Benchmarking Group has been established as a sub-group of OMG. CH informed the group met for the first time, with CJ attending, and a ToR has been established. The Group will regularly report to OMG as a line of oversight. The Group reviewed this report in addition to the Monthly Covid Tracker data and a presentation delivered to the North East Yorkshire & Humber (NEYH) chief executives.
		
		The key areas below were drawn out as requiring further consideration and will form the basis of the agenda for the next Benchmarking Group which will in turn feed into FIP in terms or areas for further drill down:
		  - Bed occupancy, this will be followed up through the care closer to home (CC2H) work
		  - More detailed work on the ethnic distribution of our service users to ensure the Trust is reaching all demographics
		  - Community caseloads are lower than our partners. Further understanding of caseload size and distribution is required to ensure that the Trust is offering the right services as appropriate.
		  - Assurance in relation to performance on restraints.
		  - Further understanding as to why CAMHS referrals are at a higher rate of acceptance, with a lower rate of referral
		
		• RW noted there is a different narrative to support each of the different areas highlighted above. The data cleanse of the community caseloads for example could explain the low numbers in that regard, and assurance regarding the prone restraints should be sought from the Clinical Governance and Clinical Safety Committee (CGCS).
		• RW added that the benchmarking work should lead us to be in a better position to be able to demonstrate assurances, tackle challenges and be aware of opportunities.
		• KQ provided an overarching comment that the Benchmarking Group should be mindful of where the Trust is in the middle of the national averages and not focus entirely on the high and low figures, aiming to be outstanding wherever possible through further intelligence and initiative. She noted that the learning from the data should be considered in addition to the resulting actions so that good practice can be shared and replicated. KQ would also welcome an update on the work completed at Nostell and any plans to roll-out the learning from this. CH added that there are opportunities to work with colleagues in Leeds and Bradford to share best practice identified in the benchmarking reports, to understand where each organisation does well and to learn from each other.
		• RW noted the team behind the presentation to NEYH chief executives do offer to present to Boards or Committees and we may wish to take up this opportunity. They presented learning disability benchmarking data at the NEYH meeting and the Trust stood out as being one of the top performing in terms of contacts in the last month and digital advancement. We continue to perform highly and should share this good practice. RW would welcome the LD benchmarking report to be reviewed by FIP. CJ confirmed this will be scheduled.
		• SY reminded of the need to use the intelligence within the benchmarking report whilst not losing sight of our services being delivered in the right way for us and our communities.		

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		• CJ noted that the report does not identify trends and this may be useful in deciding where FIP should focus its energy. There is a definite need to drill down into each service by 'place' as performance differs within each of our services. • CJ added that the Trust is noted as using digital technology less than other organisations overall and it would be useful to look at this in more detail to understand the reasons for this and whether it impacts services in a positive or negative way. • CJ also commented that the Trust has a less rich workforce in acute services in terms of registered and unregistered staff. CH explained the split has is now 40% registered staff, having flipped from being 40% unregistered. Issues with availability of staff have affected this. RW added that the Trust is exploring the need to maintain a well-blended team. Following the above discussion FIP considered the role of this Committee in the benchmarking process and agreed: - To refer the restraint item to CGCS to pick up and consider against national guidance. **KQ to escalate as a member of both committees and CJ to raise with Charlotte Dyson.** - To refer the workforce and skills mix issues to the Workforce & Remuneration Committee. **SY to pick this up through the Flexible Working Group.** - To pick up the issues relating to occupancy and caseloads through FIPC. • CJ noted it would be pertinent for FIP to receive a regular update from the Benchmarking Group to maintain oversight and insight. • CJ commented that readmission rates appear high in the report and this has not yet been picked up by the benchmarking group. **CH to ensure this is picked up through the OOA Steering Group**, with a view to tackling the causes of this indicator. • RW agreed that the key themes have been identified and suggested this now needs to be moulded around the quality and efficiency agenda. Once matured, we should reach a point of being able to identify productivity across specific teams and services to safeguard efficiency, and this is a prime objective of the benchmarking work. • KQ noted the need to be mindful of the links to the inequality agenda throughout the benchmarking work. MB confirmed this is being picked up by the Equality and Inclusion Committee. CJ noted that the benchmarking analysis should sits alongside the planning work and asked **CH to confirm a list of additional topics for FIP to consider in depth as a result of the work of the benchmarking group.** **The Committee noted the report and commented as above and sent some of the things to other committees, note.**		**Action: KQ/CJ** **Action: SY** **Action: CH** **Action: CH**

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
10.	Capital Plan 2021/2022	MB provided the key headlines: • The majority of the programme for 2021/22 is split between estates minor works, IT (both partnership working and cyber protection), and specific money set aside for the Bretton centre en-suite facilities and Older Peoples Services transformation works. Much of the planned estates work relates to safety, anti-ligature and statutory requirements. • MB noted it is likely the Trust will receive 90-95% of the £10m it submitted as an initial plan. Allocation is through the WY&H ICS. A meeting is taking place next week to discuss the allocations for each organisation. • RW noted a conversation has taken place this morning amongst executive directors regarding taking an early risk-based approach to spending the money in particularly regarding some of the early priorities as there may be some competition for staff and contractors over the coming period. • CJ enquired what impact, if any, will be apparent in terms of patient safety, quality and productivity given some capital programmes have not been realised this year. MB confirmed that these projects will all roll over into next year, and that the draft plan includes this. Three sizeable projects were deferred from 2020/21 due to various reason - **MB to provide details of these programmes for completeness.** • CJ queried the Trust's plans to guarantee that the monies can be spent in 2021/22 given the difficulty to spend this year, and asked if any consideration has been given towards supporting a feasible business case for grandeur reorganisation of the Trust's services as this was raised by the Members' Council. MB confirmed this was considered as an opportunity but was deemed not be the correct time in terms of adding the most value. The Trust's aim over the next two-five years is to move out of The Dales and the Priestley Unit and develop our own replacement merged ward. Nick Phillips and Alan Davis have attended a meeting with NHSE/I regarding early sight of this as we may require some level of support from them as well as the WY ICS recognising this as a priority. The process has therefore begun but is in the early stages. • CJ asked if the green and sustainability strategy should be recognised as a project type in addition to those highlighted. MB acknowledged the work that has already been done on this agenda in terms of our green spend and that many of the schemes we carry out are completed to the most up-to-date green standards. Recognition of this together with ensuring the Green Plan is recognised as a priority. We will work towards capturing this and it would be useful to flag any Green concerns as we move forward. It is noted in the paper that there is money built into the capital regime for this and it needs to be balanced with safety being paramount. • KQ asked how closely linked clinical staff are to the capital programme. MB confirmed each BDU provides its own priorities for the forthcoming year. The Estates TAG brings together BDU reps, estates reps, and IT reps and it is here that time is spent assessing the range of priorities. This is then taken through OMG for approval followed by EMT, with clinical reps at every level of the process.	MB	**Action: MB**

With all of us in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		The Committee noted the report and commented as above. **The Committee confirmed agreement with the process undertaken to date and confirm any future prioritisation will be completed on a risk-based approach.**		
11.	Forensic Lead Provider update	MB noted the position has not significantly changed since the last meeting of the Committee and provided key highlights: • MB wrote to NHSE/I as approved by FIP in January, a standard response was received offering enhanced support to those organisations wishing to defer go live until1 July 2021, the nature of which has not yet been confirmed. The Trust would benefit from confirmation of income levels and the imminent planning guidance will hopefully provide this. • Activity levels have not decreased across WY and the £2.4m income the Trust has requested reinstating relating a baseline forensics learning disability adjustment is critical to supporting financial sustainability of these services • There will be a substantial amount of contracting work to be done once conditions are confirmed, with the role of the Trust changing as we become the commissioner as well as provider • CJ noted broad support from the Committee and Board for clarity adding that the baseline funding should be a requirement and not a request. **The Committee noted the report.**	MB	
12.	Review of Committee Effectiveness, Annual Report, Terms of Reference and Annual Work Plan	CJ noted the work programme has previously been flexed to suit the needs of the Committee and will continue to do so. CJ queried where the governance of the Lead Forensic Provider should sit in terms of Committees within the Trust. MB noted that Izzy Worswick is currently working on a paper detailing the complex governance flow and processes surrounding this. The Mental Health, Learning Disability and Autism Programme Board will play a role, however it is understood that the statutory responsibility sits with the Trust. FIP appears the most practical Committee to oversee this and this should therefore influence the work programme. RW added that the Audit Committee and Committees in Common could also play a role in terms of overseeing the governance. **The Committee reviewed and approved the Annual Report 2020/21, confirming it as an accurate reflection of the work of the Committee.** **The Committee recommended the updated Terms of Reference for approval by the Trust Board and confirmed support for the 2020/21 Work Programme whilst recognising it will remain flexible to suit the needs of the Committee.**	CJ	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
13	Items to be brought to the attention of the Trust Board / Committees	• The outstanding performance in relation to OOA beds • The degree of uncertainty regarding the final surplus for the year and noted it is likely to be more positive than £0.5m previously approved by Board. Authority has been delegated to MB to manage the position which is now likely to be between £2m and £5m. • The planning guidance is yet to be received for 2021/22, acknowledging the good work the Trust is doing to understand the baseline cost position to put us in a better place once the plans emerge. • The capital priorities for 2021/22 whilst awaiting final confirmation of what the capital allocation will be. • Review of the detail of the MH benchmarking and referred some themes to other committees and to this committee for a more detailed review. • Approved the 2020/21 Annual Report, revised ToR and 2021/22 Work Programme.		
14	The next meeting date of the Committee	The Committee noted the next FIPC meeting will take place via MS Teams on Friday 23 April 2021.		

With **all of us** in mind.

Finance, Investment & Performance Committee (FIP) – Friday 23 April 2021
Virtual meeting, via Microsoft Teams

Members	Sam Young (SY)	Present	Apologies
Mark Brooks (MB)	Rob Webster (RW)	Carol Harris (CH)	Tim Breedon (TB)
Chris Jones (CJ) (Chair)			
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 22 March were approved.	CJ	
4.	Review of progress against agreed actions and matters arising	Action 046: CJ confirmed he has written to TB and Charlotte Dyson and the restraint issues will be picked up by the Clinical Governance & Clinical Safety Committee (CGCS) and is therefore now closed Action 047: SY will speak with Alan Davis regarding this action. The action will be kept open to confirm the outcome at the next FIP meeting in May. Action 048: CH confirmed the out of area steering group is reviewing re-admission rates and receives a separate report on re-admissions. The action will be left open so feedback from the steering group can be received. Action 049: CH has sent CJ a lengthy list of areas to potentially review. CJ,CH & TB to discuss how these can best be prioritised outside of the meeting. CH expressed her preference to initially prioritise areas where information is readily available. In addition, CH suggested a need to review incidents of violence and aggression on inpatient wards, but is uncertain if this is an issue for CGCS or FIP. RW suggested triangulation with risk including use of benchmarking data to support prioritisation Action051: Feedback from the internal benchmarking group has now been added to the work plan.	CJ	
5.	Review of committee related risks and any	MB introduced this item, noting there is limited change since the previous meeting. He noted there is a separate paper regarding the forensics lead provider collaborative and that financial risks have been updated to reflect the latest information	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
	exception reports as required.	regarding 2021/22 financial planning. MB noted there is increased use of out of area bed placements currently and that the new risk relating to the capital regime was agreed at the previous meeting. **The Committee reviewed and noted the updates to the risks allocated to the Committee.**		
6.	Current year financial performance and forecast			
6.1	Month 11 finance performance report	MB provided month 12 key performance highlights and noted there was confirmation of a number of items of national funding arrangements during the latter weeks of the financial year. • The Trust recorded a surplus of £4.6m, which arose through a number of reasons compared to the original plan generated in September 2020. These included the impact of the second and third waves of Covid-19 on our ability to spend, good operational performance on such items as out of area bed placements, additional funding provided, the pace of recruitment into new investments, and a saving on public dividend capital as a result of higher cash balances. • MB added that the Trust received approximately an additional net £2m of income that was not included in the original plan. Compared to prior years there has been a notable increase in income, and it is unlikely this will be sustained into 2021/22 and beyond to the same extent given the non-recurrent nature of some of this income. In effect both income and costs have increased compared to 2020/21 as a result of the response to the pandemic and service investments. • Cash ended the year strongly and capital expenditure closed at £4.9m, which was within £0.1m of the revised forecast CJ noted that capital spend was broadly in line with forecast, although much of the spend was in the latter part of the year. He asked if the Committee should have a tighter assurance and monitoring process regarding capital planning during the course of the year. MB commented that the Committee should recognise the capital programme was compressed into five to six months of the year given the impact of lockdowns on the construction industry, staff absence, access to sites and product/service lead times. Notwithstanding this, it may be appropriate to have greater assurance on the delivery of the plan regularly during the year. CJ asked if the risk relating to spend of capital monies given greater scrutiny by systems needs to be managed in a different way. SY recognised the fact 2020/21 was an exceptional year, but that it might be helpful to have greater visibility on the timing of spend and any risks that have been identified. SY asked if the delivery of a £4.6m surplus would have any consequences on future funding or savings targets. MB responded by stating that future financial arrangements are not yet clear, and that he expected systems to recognise the unique circumstances of the finances during 2020/21 RW added that it is important to ensure we have a good understanding of our underlying cost base and to be able to explain variances as we have done in the report.	MB	Action: MB

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		MB reiterated that the cost base in the Trust has increased year on year, with in excess of 200 more substantive staff in place. CJ noted the challenge will be to understand the affordability of the additional costs when the income and financial arrangements return to a more normal basis. **The Committee discussed and commented on the report as above.**		
7	Operating and Financial Plan	MB introduced the paper by reminding Committee members of the discussion that had taken place and paper provided to all Board members on April 16th, which recommended the Trust plan for a break-even position in the first six months of 2021/22. MB explained that the ICS needs to make a final submission on May 6th and the Trust is working on a number of actions to validate the assumptions made including working with commissioners to confirm funding assumptions, and re-visiting cost assumptions with BDUs and support services. MB stated he did not expect the final plan to vary from the draft submission based on the work that has taken place to date and assumptions made. MB explained that the workforce template requirements by place are proving more challenging with information requested at short notice and not necessarily using the same classification of workforce we have used in the past or on ESR. We are working with each place and ICS to confirm what information can be provided and by when. We have also provided narrative to each place. MB commented that in discussions with each place there is a financial challenge in Barnsley and likely to be a similar challenge in Wakefield in the second half of the year. The capital expenditure budget has been confirmed at £9.5m. MB commented that it will be interesting to understand the impact of having different targets in the first and second half of the year. This will need careful consideration. One challenge for the second half of the year could be any reduction in monies allocated via the system such as the Covid-19 response monies. Planning work needs to start now to consider how we have spent and intend to spend these monies, and what will be required when the prevalence of Covid-19 reduces. KQ asked if the ICS role in finance meant the Trust had additional resource and capacity implications and whether there is a separate financial report. MB stated that he summarises ICS financial information in his finance reports and that typically the ICS is using financial information already in existence. He added that what it does do is add an additional tier into reporting and as the ICS needs to consolidate and understand the whole system's financial position, the timescales are more compressed than if reporting purely into the regulator. The full impact of financial reporting into two different ICSs remains to be seen. CJ followed up about the issue regarding operating with different targets in the two halves of the year. MB commented that one challenge we have is to ensure we have resources in place to spend transformational and investment monies provided over the course of the next six to twelve months. RW added that given the financial deal for this year including further investment in mental health services combined with our spend run rates he felt that we should be able to achieve our financial targets this year and he concurred with MB that we	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		should aim to ensure where we have been given investment we should aim to spend in a manner that will make a difference to our services. CJ asked about arrangements for risk share in the ICS. MB confirmed the risk share for the first six months of the year will remain the same as last year. The risk share arrangements for the second half of the year will be partly dependent on what financial arrangements are agreed for that period of time. **The Committee reviewed and commented on the paper as above**		
7.	Community Services Benchmarking Report	MB introduced this report noting that given the impact of Covid-19 the scope of the exercise and number of participants reduced for the 2019/20 community services benchmarking report. He also noted the basis of population figures used for the exercise changed this year. This possibly had an impact on the results. Some key points were highlighted in the report. MB suggested the report be reviewed by the internal benchmarking group and they can determine if there are any areas for further understanding and investigation. CH confirmed this is being reviewed at the next benchmarking meeting. RW commented that it was important to ensure a consistent understanding of the information between the Trust and wider stakeholders including commissioners. KQ noted an issue regarding recruitment of physios. CH will check if that relates to the same services included in the report. RW commented on the positive results relating to end of life care and less positive results regarding speech and language therapy. CH responded by stating this is an area for internal review as there are recruitment challenges for these posts across the organisation. **The Committee noted the paper and agreed that CH would report back following review at the internal benchmarking meeting**	MB	
9.	2021/22 contracting	MB introduced the report which explained the approach being taken to contracting in 2021/22 including the use of updated block arrangements for the first half of 2021/22, the mental health investment standard and mental health recovery funding. MB noted we are using the NHS standard contract for these first six months and that there is flexibility to negotiate mental health investment standard funding locally. CJ asked for clarification of what proposals were funded by the mental health investment standard and what proposals were business cases for additional funding. MB explained there is a distinction between the two and that separate conversations have taken place where there are demand pressures such as the impact of increased demand and acuity in inpatient wards.	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		CJ commented that he felt the paper was very helpful and clear. RW added the discussions taking place regarding how the mental health recovery monies are used are important and the fact discussions with the regulator have been pragmatic is encouraging. CJ asked if the Committee should spend some more time on how investment monies are used and spent. MB confirmed that this information exists and is reviewed regularly at Finance & Performance reviews, so could look to bring to the Committee when required. RW agreed this would be helpful and similarly we may wish to consider financial reviews of some of the priority programmes such as inpatients and older people's services. CJ asked about investment in learning disability services. MB explained that the mental health investment standard funding excludes learning disabilities, so needs to be subject to separate business cases and negotiations. He added the re-configuration of assessment and treatment units across West Yorkshire has resulted in some focused attention on the finances associated with these services and that whilst there may be fewer inpatient wards and beds before we need to ensure the community model is structured and funded to support care in the community. RW agreed with this and emphasised the ethos of the transforming care agenda is to provide improved care in the community so fewer beds need to be used. RW noted there is some limited national funding available for learning disabilities. **The committee noted the paper and commented as above.**		**Action: MB**
10.	Forensics lead provider collaborative update	MB suggested that an alternative approach may be required in order to go live on July 1st. The regional specialist commissioner does not know its allocated income beyond the first six months of the year yet, which means it cannot fully respond to the requirements laid out in our letter to them specifying the funding the lead provider collaborative needs. This may require the existing financial mechanisms need to remain in place as at July 1st until such time formal recurrent funding can be confirmed. MB added that discussions are taking place to finesse the role of strategic and transactional commissioning roles for the three lead provider collaboratives in West Yorkshire. This will determine the role of the commissioning hub and what is carried out by the lead provider. He further added the structure to manage the lead provider collaborative arrangements has been updated by Sean Rayner and Izzy Worswick. **The Committee noted the report and commented as above**	MB	
11.	Perintatal mental health performance	CH introduced the paper noting the information provided is specifically available to the service. This is reported in the BDU, which is then reported into OMG. As such it is very detailed service information. This has been summarised into a powerpoint presentation for ease of reading, given the volume of data that exists. In summary the information provided	MB	

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		demonstrates the team is achieving what they are expected to do and that the number of referrals is increasing again following a reduction at the outset of the pandemic. The use of video contacts is being assessed. Planned appointments, waiting times, 'did not attends' are all routinely monitored. There is also standard information provided such as supervision, sickness absence etc. which all show favourable performance. CJ thanked CH for pulling this report together at short notice. KQ echoed these thanks. She stated she is keen to ensure teams report on their strengths. In terms of development she asked about secondary preventions. For example, this might mean women known to us, but currently well and if they can be supported. Also how do we target women more likely to end up in our service and do we track the children as part of prevention. CH agreed to feedback and ask the service and noted the aims of the community mental health transformation work which include helping people stay well. KQ had a further question about attrition rates and what the definition is. Do we understand by age, ethnicity, condition etc.? CH will ask the team RW re-emphasised what a great service this is. He suggested KQ may wish to have a separate conversation with the perinatal team. He also asked the committee if they felt the information provided has met their requirements. Can the committee give the Board assurance there is a cascade of information? CJ commented that it is also in the terms of reference to review detailed performance and the perinatal report is a good start. Some more information on access and quality e.g. wait times, service user feedback etc. would be helpful. Also is there more information that can be applied relating to inequality? Finally, can more service insight be provided? RW responded by stating the ultimate goal is having a golden thread of reporting. We also need a risk or investment -based approach to determine which services we review. He re-emphasised the need not to create a significant burden for services already under pressure. CJ noted the report has provoked a good discussion and that the benchmarking work will support the risk-based approach. He suggested this be led by CH. An alternative method could be to use the four Trust objectives and determine what each service is doing to contribute towards achievement of them, recognising though that this could cause additional work. CH confirmed our information is not currently constructed in this manner. CH explained that her and MB do review service dashboard with BDUs on a monthly basis and it might be helpful to bring one of those to the Committee. The inpatient data could be reviewed at the next meeting and Chris Lennox could attend to discuss in greater detail. SY asked if we can incorporate how service users feel as part of performance reporting, depending on what information already exists.		**Action: CH** **Action MB/CH**

With **all of us** in mind.

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		KQ asked about information triangulation and consider how patient experience reports are used. This could be picked up in CGCS. RW acknowledged the need for us all to challenge each other especially when it comes to quality.

CJ summarised by noting the assurance received on perinatal services and the achievements highlighted in the performance report.CH and CJ will review the outcomes from the benchmarking group to identify any services that it may be appropriate to review at FIP. He also reinforced the need to use existing information.

The Committee noted the report and commented as above. | | |
| 12. | Horizon scanning | MB provided a brief update. A key consideration is to plan for H2 financials when the Covid-19 monies potentially reduce. This will be carried out during Q1 and Q2. RW added that there is a focus on ensuring the mental health investment standard and long-term plan priorities are met, along with ensuring we use mental health recovery monies effectively to meet demand. There is also increased focus being placed on eliminating out of area bed placements, leading to increased pressure on performance. This will be a stretch for most parts of the country. MB felt it was important to recognise the progress made on out of area bed elimination over the last three years.

RW added there is increased demand for CAMHS locally and nationally and further national funding could be made available.

CJ asked about the approach required for efficiency savings. MB suggested we need to prepare for efficiency requirements during H1 in readiness for H2 and beyond. The scale of this will depend on what level of funding is provided

The Committee noted the report. | MB | |
| 13 | Items to be brought to the attention of the Trust Board / Committees | • Full year financial performance
• Receipt of the community services benchmarking report which will be reviewed further by the benchmarking group
• Receipt of contracting paper including mental health investment plans
• Receipt of perinatal performance report and agreed approach to reviewing service performance. | | |
| 14 | The next meeting date of the Committee | The Committee noted the next FIPC meeting will take place via MS Teams on Monday 24 May 2021. | | |

With **all of us** in mind.

(Draft) Trust Board annual work programme 2021-22

Colour	Category
Red	Business and risk
Green	Performance and monitoring
Amber	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.

		1	2	3	4	5	6	7	8	9	10	11	12
🟪🟧	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							✖					
🟩	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)*				✖										
Estates strategy *(July 2022) (in draft prior to sign off) (private)*														✖
Learning from Healthcare Deaths Policy (January 2022)											✖			

Trust Board work programme 2021/22

		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)
- 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))*

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NHS
South West
Yorkshire Partnership
NHS Foundation Trust

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**Minutes of the Workforce and Remuneration Committee
held on 16 March 2021**

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Present:	Sam Young	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Charlotte Dyson	Non-Executive Director (Vice-Chair)
In attendance:	Alan Davis	Director of HR, OD and Estates
	Janice White	PA to Director of HR, OD and Estates (author)
	Lindsay Jensen	Deputy Director of HR and OD
Apologies:	Rob Webster	Chief Executive

WRC/21/31 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Sam Young (SY) welcomed everyone to the meeting.   An apology was received
from Rob Webster.

It was noted that the meeting was quorate and could proceed.

WRC/21/32 Declaration of Interests (verbal item) (agenda item 2)
There were no declarations over and above those made in the annual return to the Trust Board
in March 2021 or subsequently.

WRC/21/33 Minutes of the meeting held on 9 February 2021(agenda item 3)
The Committee confirmed that these were an accurate reflection.

**The Committee RESOLVED to APPROVE the minutes of the meeting held on 9
February 2021.**

WRC/21/34 Matters arising (agenda item 4)

(a)   WRC/21/04 - BAME risk assessment survey (agenda item 4)
AGD confirmed that it has been agreed a question on vaccination will be included in
the updated BAME and vulnerable staff risk assessment survey. The Committee
agreed that this action can now be closed.

<div align="right">**Action: AGD**</div>

**(b)   <u>WRC/21/22 Review of workforce performance indicators during the pandemic–
RIDDOR reporting in relation to Covid Infections (agenda item 5)</u>**

AM had asked about assurance that we are meeting all the statutory requirements
around RIDDOR reporting in relation to Covid infections and said she had received a
response from Nick Phillips who confirmed we are acting in line with the national
guidance.

AGD said what might be a growing issue is staff vaccinations and expectation from service users and the government. CD asked if this is on the organisational risk register. AGD said he will pick this up and take this into the next EMT where they are reviewing the risk register.

Action: AGD

AM said she is happy to send the response from Nick Phillips to Janice White as an update for this action.

Action: AM

The Committee confirmed that they are assured that we are complying with the Health and Safety Executive (HSE) requirements in relation to RIDDOR reporting.

The Committee discussed safety issues and staff responsibility to continue to follow the appropriate safety guidance, particularly on PPE and AGD said this would be continued to be emphasised through Silver Command. It was agreed the issue of breaches in PPE guidance should be considered by the Clinical Governance and Clinical Safety Committee.

Action: AGD and CD

The Committee NOTED the actions from the meeting held on 9ᵗʰ February 2020 and COMMENTED as above.

WRC/21/35 Covid Workforce Performance Report (agenda item 5)

LJ informed the Committee that the COVID Workforce Performance Report is a weekly report produced for the Bronze Workforce and Staffing Group, which includes Staff Side and operational staff. She said the main headlines around the Covid position are:

- There has been an increase in staff shielding with the widening of the definition of Clinically Extremely Vulnerable. Managers are continuing to offer support to shielded staff through one to one conversations. The biggest impact of shielding has been in the Forensic BDU.
- Although no guidance on what will happen when shielding ends the Trust will continue with the practice that no one will return to work without an updated Risk Assessment.
- There has been a reduction in staff absence due to symptoms or isolation.
- BAME health and wellbeing continues to be a priority area given the adverse impact of COVID on the BAME communities.
- Vaccination programme is progressing very well, with 87% of staff receiving the first vaccine, although there is a lower uptake by BAME colleagues, which reflects a national position.
- Targeted support and communications have been developed for BAME Staff to build trust and confidence in the vaccine and increase uptake. The BAME Staff Equality Network have been involved and active in trying to increase uptake of the vaccine.
- A survey has been sent to staff who have not had the vaccine to gain further insight into how best to support them to be vaccinated. Staff will continue to be offered the opportunity to receive the vaccine at any point.
- The survey did highlight worries from carers, concerns about potential impact on fertility and staff unsure about possible side effects. In response we are engaging with the Carers Network, running further sessions on the safety of the vaccine, and offering the opportunity for staff to have a confidential one to one conversation with pharmacy and/or peers and/or a staff equality network member. Subha and Tim are also writing to registered clinical staff to emphasise the importance from a professional aspect of being vaccinated.

- Managers have been asked to meet with staff not vaccinated to offer support and build trust. Guidance has been produced to support these conversations.
- More local clinics are being planned at Laura Mitchell, Folly Hall and Priestley in addition to clinics at Fieldhead and Kendray.
- Work continues around support and information for BAME colleagues to increase uptake.
- COVID and Non COVID absence is lower than the same period last year, however, stress absence proportionately has increased.

LJ also told the Committee that the Bronze Workforce Group met with a couple of people from the Forensic BDU who are health and wellbeing champions to hear about some of the great work they have been doing on staff wellbeing.

CD asked about support for staff shielding as this could be quite a traumatic time for them, also in Forensics are we still meeting safer staffing levels and finally whether in terms of BAME staff vaccine uptake, are our figures similar to other Trusts. LJ said managers have guidance on support to shielding staff including regular contact, induction on return and updating risk assessments as appropriate. She said managing staffing pressures in Forensics is difficult and there is a lot of on-going work to support the service. It was noted in terms of Safer Staffing the Trust Board report provides more detail. LJ responded that it appears BAME Staff vaccination, based on information from ICS HR networks, we are higher than a lot of other Trusts.

AM mentioned the current position on BAME staff absence and vaccination was a cause for concern. LJ said around the uptake from BAME colleagues, Dawn Pearson, Head of Engagement and Communications has been going out talking to some of the BAME communities and speaking to some of the faith leaders to try and gain more insight into this and she brought this into the Workforce Group. It appears some of the reasons for the lower uptake are around the fake news, lack of confidence in the vaccine given past experiences and access to clinics.

LJ said in response to the query on comparisons on BAME staff absence, this was also discussed at the Bronze Workforce Group, the numbers were very small numbers across the Trust and therefore it was difficult to draw any meaningful conclusions at this time but the group is keeping a watching brief on this.

The Committee discussed the impact of the pandemic on Bank Staff and LJ said there has been regular communication with them and they have been included in all the arrangements for vaccination. LJ confirmed that bank staff are included in the one to one conversations.

AGD said there is a 19% gap between take up of the vaccine by White colleagues compared to and the Communications Department are relooking at what more can be done to build trust and confidence as mentioned earlier. The Committee wanted to take the opportunity to thank everyone involved in the vaccination programme for their tremendous efforts.

The Committee NOTED and COMMENTED on the Staff Covid Vaccination Report.

WRC/21/36: Workforce Strategy 2021-2024 (agenda item 6)

AGD updated the Committee on the Workforce Strategy and action plan and said that this was being discussed at the Executive Management Team (EMT) time-out taking place on Thursday, particularly considering the NHS Staff Survey. Whilst for the second consecutive year the Trust has improved or stayed the same in the 10 key themes, which is a good sign, it still leaves the Trust at average which is not where we want to be. AGD said in terms of the presentation on the Workforce Strategy it has been made clearer its purpose is about Making SWYPFT A Great Place to Work, there is now a stronger link to the sustainability and a sustainable future and the NHS Staff Survey has been used to identify best practice. It also emphasises that the five elements of a Great Place to Work came from an engage

and listen process with over half the staff and is built on the foundation of the Trust's values and equality.

AGD said looking at the NHS Staff Survey results of the similar Trusts who have been rated as Outstanding by the CQC, there were four of the key themes which they all excelled at: health and well-being, immediate managers, staff engagement and teamworking. The Workforce Strategy has set out ambitions to excel in these four areas over the next three years.

AM mentioned the listening exercise which identified the five Great Place to Work elements and asked if we would be doing this again. AGD said that we have continued to engage and listen to staff by using the Robertson Cooper survey which are followed by a series of staff engagement events based on these five elements. He said the five great place to work themes have stood the test of time and feels that the listening and engagement exercise was successful and a strength that we cannot lose. AM asked if we had thought about regular pulse surveys. AGD said he has mixed feelings about this, however, we are exploring with Robertson-Cooper the feasibility of more regular surveys.

CD said the two areas she would like to see an emphasis on is developing and supporting middle management and reducing bullying and harassment. AGD said that the Great Place to Work Programme will have an initial focus on supporting and developing immediate managers/team leaders and Trios. AGD said that there could be a greater emphasis around Race Forward and the different approaches around tackling bullying and harassment in the final version. SY said it is really good and agrees it is best to do a few things really well. She mentioned deciding what language we use and to be consistent and use the same language. AGD said he has tried to simplify the strategy and wanted it to be a more public facing document.

The Committee support the additions to the Workforce Strategy and noted it would go to the Trust Board in April.

Action: Alan Davis

The Committee NOTED the update.

WRC/21/37: Recruitment to the Post of Director of Nursing and Quality (agenda item 7)

AGD updated the Committee that the Director of Nursing post is out to advertise with the final interview date of 29th April 2021. There is an option of first round of interviews of 14th April 2021.

The Committee NOTED the update.

WRC/21/38: NHS Staff Survey 2020 (agenda item 8)

AGD referred to earlier discussions and felt it was important to get local ownership of the action plans in response to the NHS Staff Survey. Business Development Units (BDUs) are developing their own local action plans with engagement of staff and staff side.

AM said Staff Survey confirms what was discussed earlier that we need a focus around middle management and bullying and harassment but felt it was also important to recognise that there is really positive news on the areas that we have focussed on. SY said she found the comparative tables that were included very helpful.

The Committee noted that the key issues from the survey were being addressed in the Workforce Strategy but acknowledged it was vital we kept a focus on both the development of immediate managers and preventing bullying and harassment.

The Committee NOTED and COMMENTED on the update.

WRC/21/39 Directors Objectives 2021/2022 (agenda item 9)

AGD said that this was for the Committee to note and that RW will be giving updates on progress every six months. The Committee commented that it felt that it would be good to link the Directors Objectives into a future Strategic Board meeting.

Action: AGD

The Committee NOTED the update.

WRC/21/40 Off Payroll Staff Annual Report (agenda item 10)

AGD informed the Committee that Mark Brooks had produced this report, which is an update from the report produced for the Board, following a request from the Committee to ensure there is an oversight of this sensitive area of expenditure. It was noted an anonymised report on highly paid consultants is as part of the annual accounts. AGD suggested that a more detailed report on those highly paid consultants should come back to this Committee after the annual accounts are agreed, perhaps in July, given this can be a contentious area.

Action: AGD

The Committee NOTED the report.

WRC/21/41 Workforce Risk Register (agenda item 11)

AGD said that following discussions at previous meetings there had been a comprehensive review of the risks as requested resulting in proposed changes to the risk register. He said that some of the risks have been combined and some risks have been broadened. The EMT have looked at the collective risks which were brought to a previous WRC meeting and discussed whether if they were more Board Assurance Framework BAF than risk and the EMT are looking at that.   The Committee commented that the previous discussions at this Committee on risks had been incorporated into the risk register and supported the proposed changes.

AM suggested given the significant amount of potential organisational change that is arising from the White Paper, consideration should be given to the risk of a negative impact on staff morale. AGD said he will pick this up and discuss with EMT colleagues.

Action: AGD

CD mentioned that under 2, risk of potential loss of knowledge and skills, did not feel clear. AGD clarified that there are three issues, firstly is that after the pandemic there is a concern that staff may be exhausted and want to leave, secondly there is an ageing workforce able to retire and thirdly when we come out of the pandemic there will be increased competition with other organisations for staff. AGD said he will look at the wording to see if it can be made clearer.

Action: AGD

The Committee DISCUSSED and COMMENTED on the Workforce Risk Register

WRC/21/42 Annual Work Programme 2021/2022 (agenda item 12)

AM said that recruitment and retention is not explicit in the programme and this is normally discussed at the Committee. AGD said this would usually be part of the Integrated Workforce Performance Report. The Committee prior to the Covid-19 had agreed to re-look at the way the Integrated Performance Report was produced for the Committee and that this would resume for the meeting in July.

AGD suggested that we use the July meeting to bring a prototype report so we could ensure it is developed to cover the key responsibilities of the Committee including recruitment and

retention, bullying and harassment, middle management training and the Workforce Strategy.

AM mentioned WDES and WRES actions which is also discussed at the Equality and Inclusion Committee and asked if we are duplicating this information. AGD said this spans both groups and whilst we try not to duplicate there will inevitably be a degree of overlap given the strong link to the Workforce Strategy.

Action: AGD

The Committee DISCUSSED and COMMENTED on the Annual Work Programme.

WRC/21/43 Committee Annual Report 2020/2021(agenda item 13)

(a)   Annual Report 2019/20

The Committee had no comments on the Annual Report for 2019/20.

(b)   Terms of Reference

The Committee had no comments on the draft Terms of Reference.

(c)   Annual Work Programme 2019/2020

The Committee commented on the draft Annual Work Programme at agenda item 12.

(d)   Self-Assessment

The Committee discussed the self-assessment and made the following comments:

Q13 Status: Has the Committee formally assessed whether there is a need for the support of a 'Company Secretary' role or its equivalent?

The Committee agreed that they have got the relevant support required.

Question 21: Does the Committee effectively monitor the implementation of management action arising from audit reports referred to it.

It was agreed that anything that has a workforce element that fits into this Committee's remit does come to the Committee.

It was RESOLVED to APPROVE the Committees Annual Report 2020/21.

WRC/21/44 Matters to report to the Trust Board and other Committees (agenda item 14)

The key points to report to Trust Board and other Committees are as follows:
➢   Request for Clinical Governance and Clinical Safety Committee to review breaches in the use of PPE and whether different approaches need to be adopted in their management.
➢   Vaccination update – had a good discussion around vaccination uptake within different groups.
➢   The Committee noted the continuing pressure in Forensics and In-patient services.
➢   The Committee reviewed workforce risks and recommended several changes for consideration by EMT.
➢   The Committee received an update on the Workforce Strategy and agreed that it will go to the Trust Board in April 2021.
➢   Directors Objectives – the Committee felt that it would be good to link the Directors Objectives into a future Strategic Board meeting.

WRC/21/45 Any other Business (agenda item 15)
There was no any other business.

WRC/21/46 Date and Time of next meeting
The next meeting will be held on 18 May 2021, at 11.30am, Microsoft Teams Meeting.

**Minutes of the Workforce and Remuneration Committee
held on 18 May 2021**

Present:	Sam Young	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Natalie McMillan	Non-Executive Director
	Rob Webster	Chief Executive

In attendance:	Alan Davis	Director of HR, OD and Estates (author)

The Committee agreed given the significance of the Board Succession Planning Paper and urgency of agreeing the Director of Nursing, Quality and Profession starting salary to only consider these two items and defer the remaining items on the agenda.

WRC/21/47 Board Succession Planning

AGD said that the paper circulated to the Committee was the initial draft of the Trust Board paper and was here for discussion and further development prior to going to the private section of the Board on the 25 May 2021. The paper is in the same format as the previous ones and has been updated to reflect appointments made for Tim's and Charlotte's replacements, the decisions of Sam not to seek reappointment for a second term and Angela to retire at the end of November. In addition, the paper includes the issues and options in regard to the notional secondment of RW to the full-time role of Chief Executive for West Yorkshire and Harrogate Integrated Care System.

The Committee recognised that it was important all the issues, options and risks on the potential secondment of the Chief Executive from his current dual role to full-time ICS Chief Executive were fully explored and carefully considered. To help the discussion RW was asked to give the context and his personal position on the full-time ICS Chief Executive role.

RW left the meeting at that point.

The Committee carefully considered the implications of allowing RW to undertake the ICS Chief Executive role including RW's own preference. The Committee accepted that the dual role was no longer tenable for the Trust, the ICS and RW.

The Committee felt that the paper needs to be strengthened before it goes to the Trust Board and the options developed further to include the pros and cons as well as the risks. AGD to update the paper taking account of the Committee's discussion prior to the private Board meeting on 25 May 2021.

Action: Alan Davis

WRC/21/48 Director of Nursing, Quality and Professions

The Committee considered the paper recommending the starting salary of Darryl Thompson following his appointment to Director of Nursing, Quality and Professions with effect from 1 August 2021. The Committee agreed the recommendation for DT's starting salary. It was agreed that the Trust should undertake a review of executive directors remuneration at the September's meeting.

Action: Alan Davis

WRC/21/49 Date and Time of next meeting
The next meeting will be held on 29 June 2021 at 8.30am, Microsoft Teams Meeting.

**Minutes of the Workforce and Remuneration Committee
held on 29 June 2021**

Present:	Sam Young	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Natalie McMillan	Non-Executive Director
In attendance:	Alan Davis	Director of HR, OD and Estates (author)
Apologies:	Rob Webster	Chief Executive

The Committee met to consider a single item which were the salaries for the Acting Chief Executive and interim Director of Finance and Resources.

WRC/21/50 Interim Leadership and Management Arrangements: Starting Salaries

The Committee considered the paper recommending the starting salary for the Acting Chief Executive and Interim Director of Finance and Resources. AGD confirmed that the two individuals had been consulted on the proposal and both felt they were appropriate.

The Committee approved the recommendations as detailed in the paper. It was noted that there will be a review of executive directors remuneration at the September's meeting.

Action: Alan Davis

WRC/21/51 Date and Time of next meeting
The next meeting will be held on 20 July 2021 at 10.00am, Microsoft Teams Meeting.