NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board (business and risk)
Tuesday 26 October 2021 at 9.00am
Virtual meeting held using Teams

AGENDA

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.00	**1. Welcome, introductions and apologies**	Chair	**Verbal item**	1	To receive
9.01	**2. Declarations of interest**	Chair	**Verbal item**	2	To receive
9.03	**3. Minutes from previous Trust Board meeting held 28 September 2021**	Chair	**Paper**	2	To approve
9.05	**4. Matters arising from previous Trust Board meeting held 28 September 2021 and board action log**	Chair	**Paper**	10	To receive
9.15	**5. Service User / Staff Member / Carer Story**	Director of Operations	**Verbal item**	10	To receive
9.25	**6. Chair's remarks**	Chair	**Verbal item**	3	To receive
9.28	**7. Chief Executive's report**	Interim Chief Executive	**Paper**	7	To receive

With **all of us** in mind.

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
9.35	**8. Risk and assurance**				
9.35	8.1 Board Assurance Framework	Interim Director of Finance and Resources	**Paper**	10	To receive
9.45	8.2 Corporate / organisational risk register	Interim Director of Finance and Resources	**Paper**	15	To receive
10.00	8.3 Risk Appetite Statement	Interim Director of Finance and Resources	**Paper**	5	To approve
10.05	8.4 Sustainability Annual report	Head of Estates and Facilities	**Paper**	5	To receive
10.10	8.5 Workforce Equality Standards	Director of HR and OD	**Paper**	5	To approve
10.15	8.6 Equality and Diversity Annual report	Director of Strategy	**Paper**	5	To approve
10.20	**9. Assurance and approved minutes from Trust Board committees and Members' Council** - Audit Committee 12 October 2021 - Equality, Inclusion and Involvement Committee 30 September 2021 - Finance, Investment and Performance Committee 25 October 2021 - Workforce and Remuneration Committee (terms of reference only)	Chairs of committees	**Paper**	15	To receive To approve

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	- West Yorkshire Mental Health, Learning Disability and Autism Collaborative Committees in Common 21 October 2021 Extraordinary Members' Council meeting 19 October 2021				
10.35	*Break*			5	
10.40	**10. Business developments and collaborative partnership working**				
10.40	10.1 Integrated Care System developments – update on national policy/legislation and local responses	Director of Strategy and Change	**Verbal item**	5	To receive
10.45	10.2 South Yorkshire & Bassetlaw Integrated Care System (SYBICS) including the Mental Health, Learning Disability and Autism Alliance and place-based partnerships update • Barnsley Place Agreement and Terms of Reference	Interim Chief Executive and Director of Strategy	**Paper** **Paper**	10	To receive
10.55	10.3 West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) including the Mental Health, Learning Disability and Autism Collaborative and place-based partnerships update • Adult secure lead provider collaborative and CAMHS Tier 4 provider collaborative update	Director of Strategy and Change and Director of Provider Development	**Paper** **Paper**	10	To receive
11.05	10.4 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
11.10	**11. Performance**				
11.10	11.1 Integrated Performance Report (IPR) month 6 2021/22	Interim Director of Finance and Resources/Director of Nursing	**Paper**	60	To receive
12.10	*Break*			5	
12.15	11.2 H2 2021/22 Financial and Operational Planning update	Interim Director of Finance and Resources	**Paper**	5	To receive
12.20	**12. Strategies and policies**				
12.20	12.1 Digital Strategy Update	Interim Director of Finance and Resources	**Paper**	5	To receive
12.25	**13. Governance**				
12.25	13.1 Revised Trust Constitution (including standing orders) scheme of delegation and Standing Financial Instructions	Interim Director of Finance and Resources	**Paper**	10	To approve
12.35	**14. Trust Board work programme 2021/22**	Chair	**Paper**	3	To approve
12.38	**15. Date of next meeting**	Chair	**Verbal**	2	To note

Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	The next Trust Board meeting held in public will be held on 30th November 2021		**item**		
12.40	**16. Questions from the public** *(received in advance in writing by e:mail to membership@swyt.nhs.uk)*	Chair	**Verbal item**	10	To receive
12.50	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 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 update, particularly in terms of any risk presented to the Trust as a result of the Chair'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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021

Updates to the register of interests of the directors (Trust Board)
From 22 August 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: • Trustee and Director - Park Avenue, Bradford Limited • Trustee and Director - Bradford District Community Foundation

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Trust Board meeting held on 28 September 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
	Mark Brooks (MB)	Interim Chief Executive
	Lindsay Jensen (LJ) (in attendance for Alan Davis)	Interim Director of Human Resources and OD
	James Sabin (JS)	Interim Director of Finance and Resources
	Dr.Subha Thiyagesh (ST)	Medical Director
	Darryl Thompson (DT)	Director of Nursing and Quality
Apologies:	Members	
	Alan Davis (AGD)	Director of HR, OD and Estates
	Attendees	
	Carol Harris (CH)	Director of Operations
In attendance:	Chris Lennox (in attendance for Carol Harris)	Deputy Director of Operations
	Nina Preston (item 5 only)	Principle Clinical Psychologist
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy and Change
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
Observers:	Insight Candidate	
	2 x public governors	

TB/21/79 Welcome, introduction and apologies (agenda item 1)

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

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

AM informed attendees the meeting was being recorded for administration purposes, to support minute taking, and once the minutes had been completed the recording would not be retained. Attendees of the meeting were advised they should not record the meeting unless they had been granted authority by the Trust prior to the meeting taking place.

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

TB/21/80 Declarations of interests (agenda item 2)

Nat McMillan (NM) reported her personal business is conducting work for the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) around their leadership and behaviour framework.

It was RESOLVED to NOTE no further declarations have been made since the last meeting.

TB/21/81 Minutes from previous Trust Board meeting held 27 July 2021 (agenda item 3)

AL reported he had identified the last two agenda item numbers were incorrect and had rectified this error.

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

TB/21/82 Matters arising from previous Trust Board meeting held 27 July 2021 (agenda item 4)

AM reported any items marked in blue (completed) or not due this month would not be discussed, unless Board members wished to make comment on them.

TB/21/73a – Priority programmes and digital interaction – Salma Yasmeen (SY) reported workstreams continue with clinical engagement to review the blended approach of working during the pandemic. Benchmarking data is being used to establish the Trust position compared to others. The team are looking at how to enhance virtual care safely but continue to give people choices. Agreed to close.

TB/21/73b – Bed numbers across WYHHCP - Chris Lennox (CL) reported the Trust is engaged in partnership work looking at psychiatric intensive care unit (PICU) beds with shared principles and approaches with clinical engagement. This is being received positively by partners. There is collaborative work taking place across the system to review occupancy levels and acuity and how any learning can be shared. The work is very positive and is benefitting from the partnership approach. Agreed to close.

TB/21/39a – New Board workplan – Andy Lister (AL) explained an updated draft is attached with this month's papers. Further work is required on the governance and assurance sections and further engagement will take place around whether the key, aligning agenda items to strategic objectives, is helpful. To remain open and move to October.

TB/21/08b – Access to public health intelligence to help plan Trust services effectively **–** Mark Brooks (MB) reported this is an iterative process and suggested it is closed as a Board action and monitored by Finance, Investment and Performance (FIP) Committee. Chris Jones (CJ), Chair of FIP, agreed. Agreed to close.

Sean Rayner (SR) provided an update on psychology commissioning. The West Yorkshire Mental Health Learning Disability and Autism Programme Board is to look at this as a collaborative issue. There is a proposal to create a workstream but there are a number of competing priorities. SR will update on this issue in future as part of the West Yorkshire update in the Business Developments section.

Action: Sean Rayner

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

TB/21/83 Service User/Staff Member/Carer Story (agenda item 5)

AM introduced Nina Preston (NP), a principal forensic psychologist with the Forensic Child and Adolescent Mental Health Service (FCAMHS).

CL commented that NP is going to explain how the service works in a trauma informed way, and this approach is in development across the Trust.

NP stated she is principal forensic psychologist with Forensic CAMHS service (Tier 4) and the service operates a hub and spoke model due to the size of the Yorkshire and Humber area. SWYPFT is the lead provider in partnership with Humber Teaching NHS Foundation Trust, Sheffield Children's NHS Foundation Trust and Tees, Esk and Wear Valleys NHS Foundation Trust.

The team works with children and adolescents under the age of 18 who present as high risk, high harm and high need. These children will have usually tried to access CAMHS services or lower tier services, but their risks and need require higher level input.

The service is mainly operated on a consultation-based framework and we work with the system and professionals around the young person, and this is the focus of our resource. This supports service efficiency, but when required we provide direct input to service users and their families and offer assessments and interventions.

NP reported service user A (anonymised initial) was referred into service in December last year and has had extensive input through forensic CAMHS. This example highlights the work isn't just with the service user but equally weighted with family, the professional network including social care and the youth offending team, amongst others.

A and his parents felt they were struggling to get their voice heard, prior to engaging with Forensic CAMHS.

NP then played an audio clip of a phone call between herself and A's parents about their experience of the service.

A's parents described A's presentation and behaviours prior to his referral. A's parents reflected they had been given proper insight into A's behaviours and the reasons behind it and knew help was there if they needed it.

In future A's parents want to be able to do more activities with A and be given respite when they needed it, knowing A is with someone who is professional and understands A's needs and behaviours.

A's parents reported the service had been excellent and they had been given a full opportunity to share their concerns about their son's needs and would recommend Forensic CAMHS as a service to others.

NP then presented A's care plans reflecting what his expectations had been about the work he had undertaken with Forensic CAMHS, and his aspirations for the future and the next steps for his pathway of care.

MB thanked NP for her presentation and for the work that the team carry out. MB identified A's parents' issues about awareness of the Forensic CAMHS service within general practice

and the specialism our service can provide. He asked if the Trust should consider the promotion and awareness of the service to enable referrals and interventions to take place at an earlier stage.

NP agreed and reported the promotion of the service is on the agenda with the senior leadership team.

ST asked NP about transition pathways from the team, to make sure that all the good work the team had conducted continues into future care.

NP reported the transition pathways needed work, especially the transition from youth to adult services as this could be very impactive on future care and outcomes. The service is working on developing and improving transition pathways.

KQ stated she had heard excellent feedback about the service. KQ reflected on the benefits of earlier engagement with service users similar to A, to prevent escalation.

NP reported that historically the age range of referrals had been between thirteen and eighteen years of age. In the last year this had reduced to between the ages of eight and ten.
An early intervention service focussed on prevention could have a huge impact at such a developmental stage in a young person's life and could change the trajectory of children such as A. A service of this nature would require significant investment and resource.

AM thanked NP for presenting A's story and asked her to pass on thanks to A and his family for sharing their story with the Board today.

Sean Rayner reported transition arrangements to adult services had been the subject of a discussion yesterday afternoon led by Beate Wagner (Corporate Director of Children's Services) in Wakefield. Trust colleagues had presented the transition protocols that are in development for moving from CAMHS to adult mental health services. These were well received by other partners in the meeting.

AM noted SR's comments and suggested transition pathways may be something the Board may wish to consider for a future meeting.

Action: Andy Lister

It was RESOLVED to NOTE the Service User/Staff Member/Carer Story.

TB/21/84 Chair's remarks (agenda item 6)

AM highlighted the following points:

- Significant pressures continue to be present across all areas of the Trust and AM noted the fantastic leadership being provided by the Executive Management Team, especially with all the changes that have recently taken place.
  The difference between the relaxation of Covid-19 restrictions in wider society and the maintenance of restrictions in healthcare services is causing tensions in some areas.

It was RESOLVED to NOTE the Chair's remarks.

TB/21/85 Chief Executive's remarks (agenda item 7)

MB asked to take the report as read and highlighted the following points:

- This has been reported as the busiest summer ever in the NHS.
- There has been consistently high demand for services over the summer months and increasing acuity levels.

- There has been regular staff absence of between 100 and 180 due to Covid-19 since July.
- The Trust hasn't met all of its performance targets but is still performing well in a difficult environment.
- There have been some outbreaks of Covid-19 on our wards and infection, prevention and control measures have been reinforced.
- MB highlighted a report released concerning the death of three young adults with learning disabilities in Cawston Park in Norfolk. This is a report the Clinical Governance and Clinical Safety (CGCS) Committee may want to consider from a learning perspective

Action: CGCSC

- CO2 availability has been a recent reported issue. The estates team are working closely with suppliers and positive responses have been received.
- Fuel and energy shortages are a concern for Trust staff as 90% of Trust work is in the community CL and her team have been reviewing business continuity plans.
- Increased energy costs could lead to increased energy poverty in the winter, which could exacerbate inequalities.
- The abuse of NHS staff has been discussed in place-based meetings and there needs to be a collective zero tolerance response to both verbal and physical abuse of NHS staff.
- Consultation has commenced on the potential compulsory vaccination of NHS staff for flu and Covid.

A discussion took place around the fuel shortage and the impact on staff and services. At this time Trust services are unaffected, but this is being monitored closely.

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

TB/21/86 Performance reports (agenda item 8)

TB/21/86a Integrated performance report month 5 2021/22 (agenda item 8.1)

Strategic Objectives and Transformation

SY highlighted the following points:

Improving health:

- A strong focus remains on safety and quality.
- Work on transformation programmes continues to address longer term issues.
- Improving Access to Psychological Therapies (IAPT) - "moving to recovery" is an area of focus.
- The learning disabilities measure of having a completed assessment, care package and commenced service delivery within eighteen weeks is an area of challenge and work continues to improve performance.
- Work with partners in places in response to the national white paper is ongoing.
- Integrated community models of care to provide early help and support at a primary care level are in development.
- We are enhancing creative and cultural offers to people through our linked charities in places.

Improving care:

- The number of incidents is within normal range and tolerance.
- The CAMHS friends and family test has deteriorated in month and is being reviewed.
- Recovery and reset work continues.

Improving use of resources:

- finances are healthy at the moment, with further information about H2 planning to follow.
- Digital opportunities are continuing to be developed, and shared care records work continues and is being led by the integrated care systems (ICS).

Making SWYPFT a great place to work:

- Staff turnover is similar to last month and recruitment and retention work is ongoing
- Workforce-wellbeing and safety is a priority and the staff survey starts next month. Equity guardian roles have now been appointed to.

CJ acknowledged the current pressures but noted a number of metrics appear to be starting to deteriorate.

MB noted CJ's comments as a reasonable observation. The Trust dashboard contains some metrics that were selected to help achieve our objectives, and we are not meeting all of those. We continue to perform well against the majority of quality metrics, national metrics and finance metrics given the current pressures. The prevalence of Covid-19 continues to have an effect on the Trust and the performance against some metrics reflects this.

MB reported significant focus on maintaining safety, and recruitment and retention. These are key in order for the Trust to achieve its objectives. There are current national and regional shortages, and we need to improve on our ability to recruit into certain services.

CJ noted some improvement objectives have been set and the Board may wish to consider if these objectives remain achievable, or whether a review should take place given current circumstances.

MB stated there has been intense pressure in our inpatient units and the Trust has made conscious use of out of area (OOA) beds to reduce this pressure. The Trust's main priority is always safety, and some priority programmes have been slowed to allow the Trust to respond to the pandemic.

CL reported there is a need to balance the provision of safe, quality environments, with care as close to home as possible. The current workforce challenges are unprecedented both regionally and nationally. Acuity has been increasing for the last year. The prevalence of Covid-19 in the community is impacting on inpatient environments.

CL added that as part of our priority programmes, learning from Covid-19 is being utilised with skill mixing on shifts, and collaborative working across units to manage pressures. It is challenging and on occasions it feels like delivering services "under siege".

SY noted that, despite the pressures, credit has to be given to Trust staff that have managed to maintain progress in transformation of services, such as the integrated community transformation programme, which will help with pressure in the medium and long term.

Priority programmes continue and identifying which of these are critical is a priority. Inpatient services is one of these critical programmes and the integrated change team are providing support, in addition to operational solutions being identified.

SY noted further credit was due to the clinical and operational staff who are involved in integrated care developments in places.

ST agreed with the comments reporting high pressure on the front line. Staff continue to horizon scan and look at how they can fill the gaps. Staff are still focussing on how to change ways of working and to maintain innovation, despite the pressures.

<u>Covid-19</u>
<u>MB highlighted the following points:</u>

- There have been between one hundred and one hundred and eighty staff absent at any one time due to Covid-19 over the summer (through symptoms, household symptoms or test and trace).

- This is in addition to staff already absent for non-Covid related reasons.
- Personal Protective Equipment (PPE) provision is in good order.
- Staff vaccination rates have remained similar for the last eight weeks - 88% first dose - 87% second dose.
- The booster vaccination programme will be commencing shortly.
- We have reintroduced the command structure, due to the increasing prevalence of Covid-19. Silver command is meeting twice a week, Gold command once a week.
- A Bronze command meeting is being held to focus on inpatient services and staffing.
- We continue to follow all national guidance, keep this under review and feed into place-based arrangements.
- The Trust remains at OPEL 3 (operational pressures escalation level).
- The Trust continues to seek opportunity for improvements and learning.
- The Infection Prevention and Control team are working with the Communications team to improve accessible information for staff.

Quality

Darryl Thompson highlighted the following points:

- Staff attitude is featuring as the third highest theme in our complaints. A lower number of complaints in total, means this is reflecting as a higher figure when presented as a percentage.
- Staff are the biggest factor in compliments received, but we are receiving a lower level of compliments.
- FIRM (Formulation Informed Risk Assessment) – data quality work is being carried out but the roll out is progressing slower than expected.
- Care plans – there are layers of nuance in the system. System improvements are being investigated to improve performance against this metric, but the issues are quite complicated.
- Staffing is the primary challenge, and safer staffing fill rates. We have a lower figure for registered staff and a higher figure for non-registered staff.
- Pressure ulcers - some are attributable but not avoidable meaning no declared problems in care within the Trust.
- Acuity in some wards has seen an increase in the number of restraints over three minutes.
- Fifty-six falls in July was a notable spike, this was largely attributable to two patients who have now been discharged and levels have returned to normal rates.
- People dying in a place of their choosing is showing some variance but remains above target.
- The number of children waiting for CAMHS has increased, which is expected. This hasn't impacted on our eighteen-week target yet.
- There is a subtle trend in the increase of bank staff and overtime.
- Friends and family test figures have gone down slightly, and this is being investigated.

KQ asked about Trust performance against the eighteen-week target for child and adolescent mental health services, especially in relation to eating disorders and crisis referrals, and queried, given the current national pressures, if more detail is required in the integrated performance report (IPR).

DT reported a number of these children are within our acute hospitals, and although not in a CAMHS inpatient bed they still require a CAMHS overview, which is putting pressure on CAMHS community teams.

Dr Subha Thiyagesh (ST) reported she and DT have some actions in relation to this issue. Conversations are taking place nationally with NHSE/I to escalate this issue, especially in

respect of eating disorders. There is additional pressure being placed on CAMHS community teams as they are having to provide an additional service through supporting acute services.

On the national medical directors call with the Royal College of Psychiatry (RCP), the RCP president did mention an increase in the budget for young people's social care. This will help.

AM suggested a review of CAMHS performance against the eighteen-week target in Clinical Governance and Clinical Safety Committee.

ACTION: CGCSC

MF raised the continuing red metrics for care plans and risk assessments in the quality section on the IPR. MF noted DT has reported the reality behind the data is more positive than figures suggest.

MB suggested a review of these metrics at the Finance, Investment & Performance Committee to see if there is an opportunity to present more balanced data reflecting the positives and negatives.

ACTION: Darryl Thompson

James Sabin (JS) reported, in relation to the care plan issue, operationally we have now identified some resource to conduct a manual review of the data quality issue and close down some care plans where clinically appropriate. This is expected to increase performance against this metric over the next few months.

NM noted the data on pressure ulcers, and the training that was to be put in place from a previous Board action. There is a notable downward trend which is good to see.

NM noted staff attitudes in the complaints data and suggested further analysis should take place given the Trust focus on values. This should be aligned with the work around complaints and desire around informal resolution. DT agreed to explore this with the customer services team. NM suggested further analysis of this through CGCSC.

ACTION: CGCSC

CJ noted unfilled shifts are now at 22% and asked for an explanation about what this data means and the impact on patient safety and quality of experience. CJ also asked for assurance around community staffing levels.

DT explained unfilled shifts data is where a request is made from the staff bank or overtime as a result of an increase in acuity or observations requiring additional staff on a ward. The data presented is the staff that have been requested in addition to those already on shift to cover higher acuity.

CJ suggested further narrative is required to support the explanation of this metric within the IPR. AM suggested in addition to further narrative, a trend indicator may be helpful.

Action: Darryl Thompson

CL noted the unfilled shift metric doesn't allow for skill mixing or migration of staff between wards but does show acuity.

CL reported there are gaps within the community teams and at present there isn't a safer staffing model for community teams, but work is being progressed on this.

Where agency staff are being used it is in a localised and specific way to address waiting times. The safer staffing modelling taking place in operations will help the modelling of the community teams and how they should be working.

SY reported the increase in prevalence of CAMHS eating disorders has been picked up by both West and South Yorkshire ICS Mental Health Learning Disability and Autism programme boards and emerging alliances.

SY reported a large amount of work had taken place within the Trust around the quality of risk assessments and has been part of the Trust's quality improvement (QI) work. This could be shown in a statistical process control (SPC) chart in the IPR and treated as a QI project to be taken into CGCSC for further review.

ACTION: Salma Yasmeen

EM noted safer staffing in the community teams and the creation of appropriate metrics has been a problem for some time.

DT reported there is a group to be established to look at community safer staffing. DT to report back to Board on the timeline for establishing a group to review community safer staffing.

ACTION: Darryl Thompson

National Metrics

JS reported performance against national metrics remains largely positive and highlighted:

- There have been two young adults on adult inpatient wards.
- IAPT treatment to recovery performance has deteriorated for the second month.
- OOA bed spend has increased but this is due to a conscious decision to reduce pressure on inpatient wards, and is being managed.

Locality

CL highlighted the following points:

Child and adolescent mental health services (CAMHS)

- The approved neuro-developmental assessment waiting list initiative will support improved diagnostic assessments in Calderdale and Kirklees.
- Services in Wakefield, Calderdale and Kirklees are under pressure from increased referrals.
- Increase in crisis referrals for eating disorders as already discussed.
- Tier 4 bed access and associated pressures continues.

Barnsley general community services

- Neighbourhood nursing is under significant pressure in terms of acuity and activity but the team are highly valued as partners in the wider system.
- The service has recently commenced the vaccination of twelve to fifteen-year-olds.

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

- Similar pressures are present in LD community teams as with other community teams in terms of staff vacancies.
- This is having an impact on the provision of speech and language therapy (SALT) and psychology.
- This is creating increased pressure in SALT provision generally from a mutual aid perspective.
- There have been improvements in medical staffing in the Horizon centre, but nursing staff vacancies continues to be an issue.
- There has been an increase in referrals into the Attention Deficit and Hyperactivity Disorder service (ADHD).
- Forensic service staffing vacancies remains an issue.

- The forensic service community team is helping to balance service user need in the community.
- A review of occupancy levels in Newhaven and Newton Lodge is taking place with a view on care closer to home in terms of clinical appropriateness and people in OOA forensic provision.

Trust-wide Inpatient Services

- Staffing challenges continue to be an issue as already discussed.
- We are trying to find the balance between acuity and demand.
- Fire safety - concordance with mandatory training is being addressed and reported into the operational management group (OMG).

Trust-wide Community Mental Health Services

- IAPT "moving to recovery" performance has been an area of high performance. National and regional forums suggest more people are leaving the service before they have progressed to recovery and as such performance appears to have dipped. We are linking into national work on this topic.
- This has been seen in Kirklees in August but less so in Calderdale where service provision is smaller. Work is ongoing to revert back to previous high performance.
- Wider community services continue to use a blended approach of virtual and face to face care based on individual need.
- Trust bases are being reviewed to expand group work and estates are assisting with this work.
- There is increased demand into Single Point of Access (SPA) teams.
- Working collaboratively in places continues.

System-wide monitoring

MB reported this work in progress and both ICSs are working on their performance dashboards.

Communications, Engagement and Involvement

- SY asked to take this as read.

Finance and Contracts

JS highlighted the following points:

- Finance remains in a strong position driven by vacancies and short-term workforce gaps caused by turnover.
- The current forecast is a £2.3m surplus for H1.
- The cash position remains strong at £63.3m and is expected to remain so for the rest of the year.
- Capital is slightly behind plan by £0.4m and is profiled in H2 and will be monitored.
- Better payment practice performance (to pay suppliers within 30 days) is at 95%, which is positive.

Workforce

LJ highlighted the following points:

- Workforce and Remuneration Committee (WRC) received two reports last week regarding Covid and non-Covid absence and recruitment and retention.
- The decision has been taken to no longer differentiate between Covid and Non-Covid absence.
- The current absence combined is 6.2% in total, and in inpatient services it is 10% and higher in some places. This is an area of focus through the Bronze command group.

- Positive actions are being taken around the wellbeing offer, vaccinations and other support for staff.
- Turnover is increasing, focused work is taking place and a recruitment and retention report suggested a different approach may be required. Groups are being set up to look at options.
- We need to shine as on organisation, to attract new employees and a new website is being developed.
- International recruitment has provided twenty-seven nurses who will be going into forensic services initially.
- Virtual recruitment fairs are starting in partnership with Leeds and York Partnership and Bradford District Care Trusts.
- Exit questionnaires are going to be reviewed to help determine why people are leaving. A number of staff have retired this year following staying on to deal with Covid.

EM noted the workforce pressures and how they may be impacting on quality but there wasn't a sense of this on the dashboard. In the quality section of the IPR the workforce pressures can be seen to be impacting on quality of care, but this isn't reflected the same way in the workforce metrics. LJ to review this. MB suggested that many of the impacts of workforce pressures are likely to be seen in other performance metrics.

Action: Lindsay Jensen

CJ referenced calls to the occupational health (OH) helpline, which are at approximately 100 a month, and asked if we have got this service right.

LJ reported a spike in demand for counselling and the Trust is looking at extra investment in OH. There is a waiting list for counselling at the moment. The helpline is adding value. Demand is increasing and we need to ensure the system is being used effectively.

MB noted in reference to the workforce metrics the system oversight framework will introduce some slightly different metrics for us to report against, and this might change some of the messaging in the dashboard.

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

TB/21/86ai Community Transformation Plan update

AM asked to take the paper as read.

It was RESOLVED to RECEIVE and NOTE the progress and update on the Community Mental Health Transformation Programme.

TB/21/86b Serious Incident report quarter 1 2021/22 (agenda item 8.2)

DT asked to take the report as read and noted it had been presented to CGCSC. DT highlighted the following:

- Violence and aggression is the highest record incident category in the Trust.
- A higher rate of community suicides has been identified in Kirklees which is being investigated.

MB noted the support offer to staff who are subject to violence and aggression needs to be considered. Staff safety is a key component of the great place to work agenda.

Action: Darryl Thompson

CJ asked for some clarity around the numbers of incidents reported in relation to service and BDU (business delivery unit). CJ asked if the numbers of incidents reflected in the report are within expected tolerance and if there any areas of concern.

DT reported incident number are within the expected range and there no areas of concern have been raised at this time.

AM reported a discussion had been held in CGCSC and it was suggested to report serious incidents against 100,000 of population across the BDUs.

It was RESOLVED to RECEIVE the quarterly report on incident management.

TB/21/86c Financial Planning Arrangements 2021/22 H2 (agenda item 8.3)
JS reported:

- The final planning guidance for H2 has not been received as yet.
- Financial arrangements are continuing on a similar theme with block payments for H2.
- The efficiency saving is now expected to be 2% for trusts that aren't returning from an underlying deficit.
- Covid funding is going to be reduced by around 5%, which needs to be addressed through the ICS.
- The pay award is expected to be fully funded.
- Treasury are expected to negotiate a longer-term settlement regarding the capital funding available to the NHS to enable medium term planning in the longer term.
- Due to the H2 planning process being drawn out to November/December 2021 we are unlikely to get much clarity around the next financial year until late Q3/early Q4.
- Planning will be the focus of discussion at Finance, Investment and Performance (FIP) committee.

It was RESOLVED to RECEIVE the Financial Planning report.

TB/21/86d Emergency Preparedness Resilience and Response (EPRR) Core Standards (agenda item 8.4)
MB asked to take the report as read, this is an annual declaration, a self-certification and there are two standards we don't fully meet with an action plan in place. The report is produced in detail by the Estates team and has been reviewed by Executive Management Team (EMT).

MB recommended approval of the report and action plan.

It was RESOLVED to APPROVE the EPRR core standards compliance report and action plan.

TB/21/86e Reset and Recovery – demand and capacity modelling (agenda item 8.5)
Sean Rayner (SR) introduced the item and highlighted the following:

- The paper summarises the key points from the presentation taken to Strategic Board in August and highlights the demand modelling tool.
- Work is ongoing internally and in districts and the report shows the next steps.

It was RESOLVED to RECEIVE and NOTE the summary in this report of the key points relating to the Trust's work on service demand forecast and capacity modelling.

TB/21/87 Business developments (agenda item 9)

TB/21/87a Integrated Care System developments white paper update (agenda item 9.1)

SY introduced the item and highlighted the following points:

- The health and care bill is still going through the parliamentary processes.
- It is still on track to be implemented in April 2022.
- EMT have considered all of the guidance at a high level so that all work internally and externally with partners is in line with the guidance.
- The guidance is largely permissive and is aligned to Trust work that has been ongoing for two years.

EM queried if anything material in the constitution may need to be reviewed in light of the legislation.

AM noted the Trust constitution is under review and will be further reviewed once the ICS changes have taken place.

MB agreed with AM in respect of the Constitution and stated the developments over the following weeks and months will establish the responsibilities of the Integrated Care Board (ICB) and what it will delegate to place-based partnerships and how provider collaboratives will fit into these arrangements. MB assured the Board that the Trust is engaged in each place and has a voice and influence over how place arrangements will work.

A discussion followed about the position of integrated care partnerships (ICPs). SY explained ICPs are evolving in each place and their level of maturity is dependent on each place.

CJ stated this report now needs to be more evaluative of the impact of changes on the Trust. We will be a partner in an ICS to be a partner with an ICB, which will have an impact on relationships. At FIP last week it was reported there is increasing demand for information from the ICSs, and we need to support colleagues to prioritise workloads.

ACTION: Salma Yasmeen

SY commented that as the structure and the form of the arrangements takes shape, we need to review how it will affect the Trust.

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

TB/21/87b South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.2)

MB asked to take the paper as read and highlighted the following points:

- A transition plan is in place as Bassetlaw will move into the Nottingham and Nottinghamshire system on 1st April 2022.
- Bassetlaw pathways still have significant connections with South Yorkshire.
- South Yorkshire and Bassetlaw has appointed its designate chair – Pearse Butler.
- Key design work is taking place in readiness for 1st April 2022.
- Conversations took place at the Health Executive Group (HEG) leadership meeting regarding information sharing, which had been good during the pandemic, to establish what can continue to be shared taking data protection into account.
- There is commitment from the ICS for net zero carbon and plans are being developed to deliver this.
- A health and care compact has been agreed by the ICS partners (not legally binding) to establish shadow arrangements prior to April 2022.

SY highlighted the following points:

- The Mental Health, Learning Disability and Autism (MHLDA) alliance – Chairs and Chief Executives will be meeting in October to agree next steps.
- Work on the specialist provider collaboratives continues and we are part of the developments in South Yorkshire.
- In Barnsley specifically, work has now commenced with partners in primary care and community services to develop more formalised arrangements as a provider collaborative

AM noted the Barnsley place agreement is to be considered in the private Board session.

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

TB/21/87c West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.3)

SY highlighted the following

- The ICS is working in shadow form and working towards full status for 1 April 2022.
- Work on supporting winter planning, system pressures and place-based arrangements continues.
- 'Root Out Racism' movement was launched recently at Fieldhead.
- The Race Equality Awards take place this month.
- Developing trauma-informed care approaches across the ICS continues and the Trust is directly involved in this work.
- Readiness for places to work in more formalised partnership arrangements continues through design teams in Wakefield, Calderdale and Kirklees.
- Memorandums of understanding for these partnership arrangements will come through to Board in coming months.

SR highlighted:

- The adult secure lead provider collaborative business plan is being reviewed in private Board this afternoon.
- The Covid-19 command and control arrangements continue in places due to increases in pressure given the prevalence of Covid-19.

AM noted the appointment of the Chair of the West Yorkshire is in train and being considered by the Secretary of State.

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/21/87ci Wakefield Integrated Care Partnership Update

SR highlighted the following points:

- The paper has gone to all partnership governing bodies.
- In section four, it references the proposals to move to shadow arrangements in October 2021.
- Governance arrangements - there is a preference for there to be a committee of the ICB at Wakefield place, but this is still to be worked through in detail.
- Section 4.3: development of the provider collaborative in Wakefield - we have been testing ways of working, and the previous bi-lateral relationships we had with the Clinical Commissioning Group around business cases or significant service changes will now be largely in a provider collaborative context.

- One of the tests the partners are thinking about is what are the thresholds above which partners will need to bring proposals for either support or challenge in a collaborative context.

It was RESOLVED to NOTE the update on progress in Wakefield (in the context of progress across West Yorkshire) in mobilising the requirements of the NHS White Paper.

TB/21/87d Receipt of Partnership Board Minutes (agenda item 9.4)
AM asked for the paper to be taken as read.

SR reported the Wakefield meeting on 23rd September 2021 was cancelled due to Covid-19.

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

TB/21/88 Strategies and Policies (agenda item 10)

TB/21/88a Quality Strategy Update (agenda item 10.1)
DT asked to take the paper as read and highlighted the following points:

- We are taking a quality improvement approach to the strategy and work is underway.

It was RESOLVED to RECEIVE the Quality Strategy update.

TB/21/88b Workforce Strategy Equality Impact Assessment (EIA) (agenda item 10.2)
LJ highlighted the following points:

- The workforce strategy was approved in April at Trust Board.
- The EIA is based on the equality workforce monitoring annual report.

AM noted the EIA had been considered at Workforce and Remuneration Committee (WRC) and Executive Management Team (EMT).

MF noted some yes or no fields had been left blank and queried is it right for the sexual orientation assessment to exactly match the transgender assessment as these are different agendas.

AM agreed there should either be a yes or a no in each box.

LJ reported this was the subject of discussion at WRC and it was deemed it is not a straight yes or no answer, and something we might want to review.

MF suggested “possible” or “partial” may be better.

LJ reported she would go back to the staff networks group around the sexual orientation and transgender assessments, this document has not been to Equality Inclusion and Involvement Committee (EIIC) yet and she will consult with the staff networks at EIIC.

Action: Lindsay Jensen.

NM noted the Trust engagement with half the workforce and asked if the narrative could be strengthened around this.

Action: Lindsay Jensen

SY supported MF’s comments and noted the EIA will be a live document as the strategy is implemented. If we are to update as items as “yes”, “no” or “partial” we should document how

we are going to mitigate against the risks of any protected characteristics being adversely affected.

Action: Lindsay Jensen

LJ reported when the strategy and EIA were written we didn't believe it would have a negative impact on staff, and we still don't think there will be a negative impact, but we need to review this as we continue.

AM summarised the EIA needs to be complete for the Board to approve this document. It was agreed all boxes would now be completed with "no". Mitigations and actions will be monitored in the workforce implementation plan updates which will be presented quarterly to EIIC. WRC will also review on an annual basis.

It was RESOLVED to APPROVE the Equality Impact Assessment for the 2021-2024 Workforce Strategy with the noted amendments.

TB/21/88c Green Plan EIA (agenda item 10.3)

MB highlighted the following points:

- The EIA has identified where there may be potential impacts, these have been considered.
- An example would be people with a disability if we change transport arrangements.
- Mitigating actions are noted in the EIA.

AM noted she liked the EIA, it is thoughtful and detailed noting the potential impacts.

CJ reported he didn't feel the EIA was grounded to the plan due to the number of actions.

AM noted the wider sustainability strategy is still being developed.

SY reported this has been produced with the broader agenda of the sustainability strategy in mind. The EIA documents are meant to be live documents to be used as the strategies progress.

MF noted even where it says no, we are going to continue monitor progress against these areas and adjust as it progresses.

AM summarised the Board will take the EIA with the wider sustainability strategy ambitions in development. The Board will want to return to this as the sustainability strategy develops.

It was RESOLVED to APPROVE the Green Plan EIA

TB/21/89 Governance Matters (agenda item 11)

TB/21/89a Quality Account (agenda item 11.1)

DT asked to take the paper as read and highlighted the following points:

- The Quality Account has been out to consultation with external partners and has been approved by the Interim Chief Executive and Chair.

AM thanked all partners for putting in such thoughtful reflections and comments, and everybody who had worked so hard to produce the report.

It was RESOLVED to RECEIVE the Quality Account 2020/21.

TB/21/89b Medical appraisal/revalidation annual report (agenda item 11.2)

ST asked to take the paper as read and highlighted the following:

- The purpose of the paper is to inform the Board of the progress against achieving a satisfactory medical appraisal and revalidation for our doctors.
- 68.2% of 152 doctors have completed the appraisal process. This is a drop from last year, but is a result of Covid-19.
- 31st March 2020 – September 2020 all appraisal and revalidation processes were paused but the governance process continued.
- Wellbeing data will be reviewed in the future.
- There is also a requirement for more appraisal trainers next year.
- The General Medical Council are looking at methods of easing and helping online feedback.
- The statement of compliance report provides evidence of compliance to the Trust's medical governance process, which satisfies the Care Quality Commission and GMC requirements.

AM noted CGCSC have reviewed the report, that it was good and recommended it for approval by Trust Board.

MB asked for ST to explain the process and timeline for the 32% of appraisals that have been postponed with agreement. ST reported they had all been postponed for 12 months. Work is ongoing to make sure that all appraisals are completed. The Trust has 32 appraisers now compared to 17 last year which helps.

AM noted appraisers have time in their job plan to carry out this function.

It was RESOLVED to RECEIVE this report noting that it will be shared with NHSE/I and to recognise that the resource implications of medical revalidation are likely to continue to increase year on year, and APPROVE the NHSE Designated Body Annual Board Report Statement of Compliance, attached as Annex D of this report, confirming that the Trust, as a Designated Body, is in compliance with the regulations.

TB/21/89c Patient Experience Annual report (agenda item 11.3)

DT asked for the report to be taken as read and highlighted the following points:

- The report provides an overview of complaints, how they are assessed and how the Trust responds to them.
- The report was reviewed in depth at a CGCSC assurance meeting.
- Equality data is being considered to see if it can be reported differently. Currently the data relate to the complainant, rather than the affected service user, who may not be the same.
- Equality data aims to identify under/over representation of complaints from any particular protected characteristic groups and how we might benchmark against this.
- A trial of response times has been taking place and will be reviewed shortly.
- There has been an increase of formal vs informal complaints which is being reviewed to see if there are any links to Covid-19.
- Values and behaviours are now at number three in the top five complaint categories, which links to discussions held earlier on in today's Board meeting.

CJ commented that it is a good report but queried the name of the report "patient experience". Is the complaint data being triangulated with other information such as Healthwatch information?

DT reported historically the report was about complaints, but we are looking at how patient experience can be reported on in the broader sense.

SY explained that Dawn Pearson and her team have been working with customer services to triangulate data from EIIC and the insight report and any intelligence from our change programmes.

It was agreed to review the substance and scope of the patient experience report and consider the frequency of reporting into Board or a relevant Committee, and why the word "patient" is used instead of "service user".

Action: Darryl Thompson/Salma Yasmeen

LJ offered to assist DT in relation to the values and behaviours work to see if 360 degree feedback could be used to triangulate the data.

It was RESOLVED to NOTE the comments of the Clinical Governance and Clinical Safety Committee and APPROVE the Patient Experience Annual report.

TB/21/90 Assurance from Trust Board Committees and Members' Council (agenda item 12)

Clinical Governance and Clinical Safety Committee 14 September 2021 (approved minutes received from 8th June 2021)

NM highlighted the following:

- Risk 905 (Ward staffing) and 1522 (Risk of harm to service users/staff from Covid- 19) were reviewed and scores are to remain the same but will continue to be monitored
- Fire training compliance is being closely monitored and a report is due back to CGCSC on 9th November 2021. CGCSC will report back to Trust Board.

CL reported there are firm plans to improve fire safety training up to the Trust's high internal target. An update is going to OMG tomorrow and it is expected there will be considerable improvement in the next two weeks. Isolated hotspots have been identified and individuals are being taken through the training. Fire drill exercises have been repeated and improvements have been seen.

Finance, Investment and Performance Committee 23 August and 22 September 2021 (approved minutes from 29th June and 26th July 2021)

CJ updated:

- No items to alert the Board to but the Adult Secure Lead Provider Collaborative and Bretton Centre business plans are going to the private session.
- Received news of the deliberate decision to extend the use of OOA, and the Committee was happy with the decision from a finance perspective to ease pressure on the wards.
- Further work has been requested to strengthen waiting time data.
- H2 planning arrangements were expected but have been delayed.
- Continue to review risks allocated to the Committee in light of forthcoming planning guidance and the formulation of the ICB.
- The delivery of the capital programme could be a challenge.
- We are on target to deliver the surplus for the first half of the year.

Mental Health Act Committee 17 August 2021 (minutes received from 11th May 2021)

KQ highlighted the following:

- Mental Health Act reform and liberty protection safeguards renewal will require significant work from the Trust and partners.
- Quality improvement – we have formally registered advanced care planning as a Quality Improvement (QI) project.
- An input was received from perinatal colleagues and use of the MHA.

- Two compliance reports were received, one on Section 132 patient rights and the other on advocacy.
- The Committee noted the positive level of scrutiny being maintained in relation to action plans for assurance around the codes of practice.
- Risk discussions were held around staffing and pressures in the Trust.

Workforce and Remuneration Committee 21 September 2021 (approved minutes from 20th July 2021)

- The Chief Executive's extended secondment was discussed.
- Terms of Reference (TOR) for the committee need to be presented to the next Board meeting.

Action: Andy Lister

- There was a review of staff absence.
- Pay framework - the Trust will follow national guidance not to increase executive directors' pay. The Committee was disappointed it was having to make this decision and wished it to be noted the Executive Director team's leadership and hard work is very much appreciated.
- The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports were reviewed, which will go to EIIC prior to coming to Board next month.
- A review of mandatory training for bank and agency staff took place and it was noted these staff are compliant.
- The compulsory vaccination of Trust staff going into care homes was discussed and no immediate concerns have been identified.
- Risks allocated to the Committee were discussed and, in particular, if the new broader consolidated risks will be effective. These will be reviewed in six months' time.
- Mandy Griffin will be taking over as chair of the committee from 1st October 2021.

Members' Council 17 August 2021 (minutes received from 11th May 2021)

AM highlighted the following:

- Extraordinary Members' Council meeting to be held on 19th October 2021 to appoint the new chair.

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

TB/21/91 Use of Trust Seal (agenda item 13)

AM asked to take the paper as read noting the following use of the Trust seal:

- Deed of surrender for the Keresforth Centre, Barnsley. The Keresforth Centre was deemed surplus to requirements for the Trust in January 2015 and contacts are exchanged for the sale of the site for a new academy school set to open in September 2023.
- Deed of variation and early works licence for the Keresforth Centre, Barnsley. The purchaser wishes to demolish buildings on site in advance of completion of the sale. -In order to allow this work to go ahead a licence is required in advance of the sale and the sale contract requires variation. The cost of the demolition will be funded by the purchaser and subtracted for the gross sale price in line with normal practice
- The lease of Unit 9, Agbrigg and Belle Vue Community Centre, Montague Street, Wakefield. - This is to renew the lease for occupation at the above community centre by the Health Integration team providing TB services to Wakefield.

It was RESOLVED to NOTE the use of the Trust Seal since the last report in June 2021.

TB/21/92 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. By October Board this should be finalised.

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

TB/21/93 Date of next meeting (agenda item 15)

The next Trust Board meeting held in public will be held on 26 October 2021.

TB/20/94 Questions from the public (agenda item 16)

Signed: Date:

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 28 September 2021 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 28 September 2021 (draft)

Min reference	Action	Lead	Timescale	Progress
TB/21/82	Sean Rayner (SR) provided an update on psychology commissioning. The Mental Health Learning Disability and Autism Programme Board is to look at this as a collaborative issue. There is a proposal to create a workstream but there are a number of competing priorities. SR will update on this issue as part of the West Yorkshire update in Business Developments item	Sean Rayner	November 2021	
TB/21/83	AM noted SR comments and suggested transitions pathways may be something the Board may wish to consider for a future meeting.	Andy Lister	November 2021	
TB/21/85	MB highlighted a report released concerning the death of three people with learning disabilities in Cawston Park in Norfolk. This is a report the Clinical Governance and Clinical Safety (CGCS) Committee may want to consider from a learning perspective	Clinical Governance Clinical Safety Committee	November 2021	
TB/21/86	CAMHS performance against the eighteen-week referral to treatment target with a focus on eating disorders and crisis referrals to be reviewed in Clinical Governance Clinical Safety Committee.	Clinical Governance Clinical Safety Committee	November 2021	

TB/21/86	MF raised the continuing red metrics for care plans and risk assessments in the quality section on the IPR. DT reported the data behind this is more positive. MB suggested a review of the metrics to see if there is an opportunity to present more balanced data reflecting positives and negatives.	Darryl Thompson	November 2021	
TB/21/ 86	NM noted staff attitudes in the complaints data and suggested further analysis should take place given the Trust focus on values. This should be aligned with the work around complaints and informal resolution. DT agreed to explore this with the customer services team.	Clinical Governance Clinical Safety Committee	November 2021	
TB/21/86	CJ suggested further narrative was required around the unfilled shifts data so that the context of the data was clearer to understand	Darryl Thompson	November 2021	
TB/21/86	SY noted that a significant amount of work has taken place in respect of risk assessments, including quality improvement work. This should be reflected in the IPR and maybe some SPC charts to go to CGCS	Darryl Thompson	November 2021	
TB/21/86	DT to report back to Board on the timeline for establishing a group to review community safer staffing.	Darryl Thompson	November 2021	
TB/21/86	EM noted workforce pressures and how they may be impacting on quality. In the quality section of the IPR the workforce pressures can be seen to be impacting on quality of care but this isn't reflected the same way in the workforce metrics. LJ to review. MB suggested that many of the impacts of workforce pressures are likely to be seen in other performance metrics.	Lindsay Jensen	November 2021	A review of Workforce KPIs will be agreed at WRC in November.
TB/21/86b	MB noted the support offer to staff who are subject to violence and aggression needs to be considered. Staff safety is a key component of the great place to work agenda.	Darryl Thompson/Lindsay Jensen	November 2021	Occupational Health provide support to staff affected by serious incidents through trained counsellors. LJ will pick up with DB if there are any gaps in our support offer

TB/21/87a	CJ noted the Integrated Care System developments white paper item needs to be clearer on what the impact of new arrangements will be on the Trust as things develop.	Salma Yasmeen	November 2021	Board will continue to receive updates as they emerge as the legislation progresses including any potential impact on the Trust.
TB/21/88b	In reference to the Workforce Strategy EIA LJ reported she would go back to the staff networks group around the sexual orientation and transgender assessments, this document has been to Equality Inclusion and Involvement Committee (EIIC) yet and she will consult with the staff networks at EIIC. NM noted the Trust engagement was with half the workforce and asked if the narrative could be strengthened around this.	Lindsay Jensen	November 2021	The EIA has been updated and shared with the LGBT+ network.
TB/21/88b	In relation to the Workforce Strategy EIA, SY supported MF's comments and noted the EIA will be a live document as the strategy is implemented. If we are to update as items as "yes", "no" or "partial" we should document how we are going to mitigate against the risks of any protected characteristics being adversely affected.	Lindsay Jensen	November 2021	The EIA has been updated and No has been included against each protected characteristic as the actions set out the mitigation.
TB/21/89c	It was agreed to review the substance and scope of the patient experience report and consider the frequency of reporting into Board or a relevant Committee and why the word "patient" is used instead of "service user".	Darryl Thompson/Salma Yasmeen	November 2021	
TB/21/90	Workforce and Remuneration Committee renewed terms of reference to come back to Board.	Andy Lister	October 2021	Included in October papers

Actions from 27 July 2021

Min reference	Action	Lead	Timescale	Progress

TB/21/71a	MB noted the BAF contained strategic risks, and different services are experiencing different demands, which may not affect all services in the same way. The Board needs to consider what specifically would need to happen for the assurance level to change to red for risk 2.3.	Julie Williams	October 2021	Review of risk 2.3 included in October's BAF paper
TB/21/71a	In relation to the BAF the Board asked consideration to the given to risks 1.4, 2.3 and 4.3. Mike Ford (MF) noted 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). MF reported the gaps in assurance look fairly small, and asked could this move from amber to yellow? Does the Board need to reflect on the changes in leadership in relation to 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)?	Julie Williams/Andy Lister	October 2021	All risk scores have been fully considered by lead directors and subject of detailed discussion in EMT and any changes are documented in the report submitted to Board
TB/21/71b	AGD and SYo reported that WRC risks were in the process of being consolidated and the Board needed to scrutinise the next iteration of workforce risks when they return to Board in October	Trust Board	October 2021	Complete and included in the October ORR report following discussion at WRC and EMT
TB/21/71b	When a risk is added to the Organisational Risk Register the front sheet should include the rationale as to why.	Julie Williams	October 2021	Included in the October report
TB/21/71b	Committee chairs to review their allocated risks and consider the level of movement in their risks	Julie Williams	October 2021	Complete
TB/21/71b	SYo reflected on "aged vacancies" where there has been a vacancy for a long time. Long term vacancies in individual roles need looking at in WRC and the associated risks then need escalating into the Board report.	Workforce and Remuneration Committee	November 2021	Further work is required on identifying long term vacant post and will be discussed at the November 2021 WRC.

TB/21/72b	Further to the decision that Bassetlaw will no longer be part of this ICS, any implications for the Trust will need to be considered by the Board separately.	Andy Lister	October 2021	This will not come into effect until April 2022.

Actions from 29 June 2021

Min reference	Action	Lead	Timescale	Progress
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	October 2021	EII committee deferred to 30.09.21
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	November 2021	Workforce and Remuneration Committee considered a detailed paper on Recruitment and Retention and Staff Absence together with actions. The 6 month Exit Interview data will be included in the Workforce and Remuneration Committee meeting in November 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	October 2021	New Board workplan in progress and draft created with a key that aligns items to strategic objectives. AL updated a draft is attached with this months papers. Further work is required on the governance and assurance sections and further engagement will take place around whether the key aligning agenda items to strategic objectives is helpful. New workplan to October Board.

Actions from 30 March 2021

Min reference	Action	Lead	Timescale	Progress
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. September Update - The infographic is complete and has been shared with EMT - just making a few final tweaks to the full strategy. It was requested that we change some of the images. October – both the strategy and infographic are complete.

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. On October's agenda

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 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:	Since the previous report to Trust Board **the number of daily positive Covid cases has remained high**. Across both South and West Yorkshire, the rate has typically fluctuated at between 300 – 400 per 100,000 of population, very much driven by the younger age groups. It has been reported that approximately one fifth of critically ill Covid patients are unvaccinated pregnant women. Staff absence in the Trust due to Covid has remained at 120 – 150 at any one time. **Pressure on meeting demand remains relentless for many services** with these pressures exacerbated by increasing referral numbers, system-wide pressures, high acuity, and staff absence and vacancy levels. Following a number of Covid outbreaks on inpatient wards there has been renewed focus on the actions we can take internally to reduce the risk of an outbreak. Existing measures have been re-emphasised and are regularly communicated, and a number of supplementary actions have been put in place following agreement by the Trust's Command structure. **The Government has set out its aims to sustain the progress made against the pandemic** and prepare the country for future challenges, while ensuring the NHS does not come under unsustainable pressure during autumn and winter. Plans to achieve this are identified as being by: • Building our defences through pharmaceutical interventions: vaccines, antivirals and disease modifying therapeutics. • Identifying and isolating positive cases to limit transmission: Test, Trace and Isolate. • Supporting the NHS and social care: managing pressures and recovering services. • Advising people on how to protect themselves and others: clear guidance and communications.

	• Pursuing an international approach: helping to vaccinate the world and managing risks at the border. There are a number of variables including: levels of vaccination; the extent to which immunity wanes over time; how quickly, and how widely social contact returns to pre-pandemic levels as schools return and offices reopen; and whether a new variant emerges which fundamentally changes the Government's assessment of the risk We are working across each of our places and ICSs regarding our own winter planning. **2021/22 priorities and operational planning guidance for the second half of the year has now been published**. A more detailed paper is included in the Board agenda and the Trust is actively engaged with each place and ICS in providing robust plans. **The recent Connected on Inclusion event in West Yorkshire was very successful and highlighted some excellent work taking place**. The Trust was well represented and recognised with award winners and highly commended nominations (Alan Davis, Cherill Watterston and Aboo Bhana). We also had many other staff and teams nominated and my thanks go to all of those nominated and involved for the work they are doing and difference they are making. **A virtual recruitment fair has taken place to promote opportunities to work in mental health services**. This is being carried out with our partners across the West Yorkshire ICS and there are further events planned in the coming months as we aim to address staffing shortfalls in the sector. **The annual State of the Adult Social Care Sector and Workforce in England report has commented that more jobs in the sector are unfilled than before the coronavirus pandemic**. Skills for Care found that employers couldn't fill 8% of posts before the start of the pandemic, a proportion that had fallen to 6% by June 2021, before rising to 8.2% by August - the equivalent of more than 100,000 jobs. There have been reports nationally that this is having an impact on discharge from hospital beds. The impact of staff requiring Covid vaccinations is yet to be seen and we need to continue to work closely with partners to understand and plan for any impact this may have on the services we provide. **The Care Quality Commission (CQC) is developing its new regulatory model**. An updated framework is being developed for making judgements about the quality of care based on a set of quality statements. These will replace the current Key Lines of Enquiry (KLOE). These statements will inform what good and outstanding person-centred care looks like. There is also an intention to develop more real-time information to review information received more frequently. As this work develops we will continue to review and understand so that it informs our approach.

	The development of integrated care systems (ICS) continues and is highlighted in greater detail in the ICS update papers. The Trust remains fully engaged in the development of ICSs, associated place-based partnerships and provider collaboratives. There has been significant focus on the development of provider collaboratives and we have contributed to a consultation exercise regarding the extension of transferring of commissioning responsibilities for a wider range of mental health services. **Cathy Elliott has been appointed new chair designate for the new NHS West Yorkshire Integrated Care Board** when it takes on statutory responsibilities as anticipated from April 2022. Cathy is currently the Chair at Bradford District Care NHS Foundation Trust and we look forward to working with her. The process for recruitment of a chief executive for both West and South Yorkshire ICSs is expected to be completed by the end of October. **There is concern nationally that a flu outbreak could be more prevalent this year** and our flu vaccination programme is making good progress. 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.
Recommendation:	**Trust Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

The Brief

30 September 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

NHS
South West Yorkshire Partnership
NHS Foundation Trust

During challenging times is it important we focus on our values.

We exist to help people reach their potential and live well in their community.

To achieve our mission we have a strong set of values:

- We put people first and in the centre and know that families and carers matter
- We're respectful, honest, open and transparent
- We constantly improve and aim to be outstanding so that we're relevant today and ready for tomorrow

As part of the #MoveMoreSWYFTly project Mo Navsarka held an online fitness session, attended by many members of staff and partners. Following which our CEX Mark Brooks spoke about the importance of physical health to personal wellbeing.

With **all of us** in mind.

Our priority areas 2021/2022

NHS
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NHS Foundation Trust

Understanding equality, and addressing inequality through inclusive involvement

Improve health	Play a full role in our Integrated Care Systems and associated places to contribute to outcomes in their 5 year plans	We deliver the targets agreed in our ICS strategies
	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	
Improve care	Continually improve patient safety	We restore services, deliver our quality targets and improve our CQC ratings
	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	
Improve resources	Integrate digital approaches to the way we work	We deliver our financial duties and improve efficiency
	Spend money wisely and reduce waste	
Make this a great place to work	Support the provision of a healthy, resilient and safe workforce	We improve our staff survey results and deliver our WRES/WDES indicators
	Refresh and deliver our sustainability strategy and action plan	

#allofusimprove and be outstanding

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

With **all of us** in mind.

The national, regional and local context

NHS
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NHS Foundation Trust

We are continuing to work with our partners in each of our places and ICSs to develop our response to the NHS White Paper, building on the local progress we have already made.

The **Health and Care Bill,** called Integration and innovation: working together to improve health and social care for all is progressing through Parliament. In all of our local areas work is progressing to develop the structures that will need to sit under the ICS, and will replace CCGs. These will provide local leadership and involvement in health and care decisions.

West Yorkshire and Harrogate Health and Care Partnership is hosting a week-long **inclusion and diversity** celebration from Monday 4 to Friday 8 October. The week will showcase the work taking place across the area to connect on inclusion, whilst celebrating diversity within our workforce, learning from others, and highlighting the positive difference made when all come together.

In **Barnsley** our children's immunisation team is supporting the COVID vaccination roll out for young people aged 12-15. They are being helped by volunteers from across our Trust. Barnsley has over 11,000 young people eligible for COVID vaccinatation.

In South Yorkshire we are a part of the **QUIT programme**, which offers support to inpatients to quit smoking. QUIT will be officially launched in October. Keep an eye out for the intranet for details.

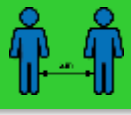
On 30 Sept we are taking part in a West Yorkshire wide **virtual recruitment event** to attract future staff and volunteers.

Coronavirus updates

NHS
South West Yorkshire Partnership
NHS Foundation Trust

As of 29 Sept there were **129** members of staff absent or working from home due to coronavirus. This is an 18% increase from the previous week. Of those absent 44% are symptomatic.

Remember for us in healthcare restrictions are still in place. So make sure you follow all IPC guidance, practice social distancing, don't exceed room occupancy, and work from home if you can.



The **coronavirus vaccine booster** programme has now started nationwide, with the focus initially being on offering immunity reinforcing vaccination to those people identified as clinically at risk, or at increased risk of exposure and transmission. Anyone identified as being eligible will be contacted directly by the NHS and asked to book a booster vaccine. It's believed that the first and second dose of the vaccine should provide most people with ongoing immunity over the winter, and therefore the immunity booster vaccine is currently only being offered to those considered at higher risk from the virus. Front line health and care workers are eligible to receive a booster vaccine. This is due to the risk of exposure and transmission of the virus in their roles. More information can be found on the intranet.

88% of staff have now had their first dose of the coronavirus vaccine; with **85.6%** reporting they have also had their second. If you have had either dose and haven't told us email businessintelligence@swyt,nhs.uk so we can ensure our records are up to date.

With **all of us** in mind.

Managing risk

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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.

Our services continue to be challenged by coronavirus, leading to this being a major risk for the Trust this month. Staff absence has increased and we have a number of outbreaks on our inpatient wards and in other services. Unchecked this could have an impact on our ability to maintain our services, which will ultimately affect our staff, service users and carers.

Please remember to do everything you can to limit transmission of the virus:

- Follow IPC guidelines and rules at all times
- Wear PPE and face masks wherever you need to
- Maintain social distancing
- Don’t exceed room occupancy numbers
- Work from home if you can

Please remember to act responsibly, when in and out of work, to keep yourselves and your loved ones safe and well. And as always, be kind.

We continue to do everything we can to mitigate all our risks. This includes supporting staff and enabling everyone to find ways to maintain quality of care while improving services.

With **all of us** in mind.

Improving Health
Our performance in August

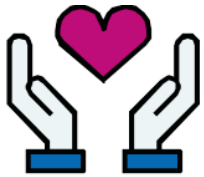
NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **43.6%** of people completing IAPT treatment and moving into recovery
- **14.3%** of people accessing IAPT are from a BAME community
- **99.1%** of service users with a CPA followed up within 7 days of discharge
- **60.3%** records with up-to-date risk assessment in inpatient and **54.7%** in community
- **85.9%** of learning disability referrals have had a completed assessment, care package and commenced service delivery within 18 weeks
- **87.1%** of people died in a place of their choosing
- **2.9%** delayed transfer of care
- **74.4%** clinical supervision for quarter 1

Join our improvement network by signing up for an **IHI Certificate in Quality and Safety**. It is an online, module based course which will help you to support improvements in your service. We currently have a number of licences still available with a completion deadline of the end of March 22 - if you are interested please get in touch with Vicki Whyte.

Please display a community mental health survey poster. This survey poster must be displayed in patient-facing areas from 1 September 2021 to 30 November 2021 to ensure that eligible service users know about the upcoming 2022 survey and have an opportunity to opt out. For more information, please contact Suzie Barton.

Improving Care
Our performance in August



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NHS Foundation Trust

- **165** out of area bed days
- **2** young people under 18 admitted onto adult inpatient wards for a total of 41 days
- **96.3%** waiting list referral to assessment within 4 hours
- **96.3%** waiting list referral to assessment within 2 weeks
- **95.2%** waiting list assessment to treatment within 6 weeks
- **335** average contacts per day in mental health services
- **590** average contacts per day in general community services
- **119** 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; **82% in** our mental health services; and **66%** would recommend our CAMHS service.

Join the monthly **FIRM risk assessment** and formulation training sessions to find out more about FIRM or to brush up on your knowledge. Simply book yourself onto a session via ESR. Find out more on the intranet.

Prepare for changes to NHS.net emails and the sending of secure emails at the Trust. We've been working with NHS Digital to make sure our Trust emails (swyt.nhs.uk) meet all criteria to be accredited as secure enough to share personal and sensitive information. There are things you can do to prepare for these changes, and we will share more information once we have full accreditation.

With **all of us** in mind.

Improving Care Incidents in August

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In August we reported:

- **1,006** incidents – 649 rated green (no/low harm)
- **319** were rated yellow and 30 rated amber
- **8** rated as red, it was 9 in July
- **3.8%** of incidents are recorded as either red or amber.
- **18** patient safety incidents that resulted in moderate harm, severe harm or death were: **3** apparent suicides, **3** self harm, **6** category 3 pressure ulcers, **2** tissue viability incidents, **2** inappropriate sexual behaviour incidents, and **2** relating to safeguarding adults

There were 2 apparent suicides amongst patients with an open referral to Trust services.

We had **136** restraint interventions in August, down from 161 in July. **85%** of prone restraints were 3 minutes or less.

We had **43** falls in August, down from 56 last month. All falls are reviewed to identify measures required to prevent reoccurrence.

There were **8 confidentiality breaches** in August, down from 11 in July.

All of us can reduce the number of patient data or sensitive information breaches at the Trust. Help us protect the people we care for by printing and displaying our IG campaign posters. The posters feature real-life service user stories on how Trust data breaches have impacted their lives.

Think. Check. Share.

Improving resources
Our finances in August

NHS South West Yorkshire Partnership NHS Foundation Trust

Performance Indicator	Year to Date	Forecast 2021/22
Surplus / Deficit	£2.2m	£2.3m
Agency Spend	£3.4m	
Cash	£63.3m	£64.6m
Capital	£1.2m	£9.6m
Better Payment Practice Code	96%	

In August a surplus of £0.1m has been reported which is favourable to plan. The forecast position for the first half of the year remains a surplus of £2.3m.

Agency expenditure in August was £0.7m.Internal staffing costs increased in August.

Cash in the bank continues to be positive and enables us to spend money on improving our estate and digital solutions

The forecast remains that the full £9.6m capital programme will be utilised in year. A business case for the Bretton Centre development has been drafted and this is currently being assessed. Year to date spend is £1.2m which is £0.4m less than planned.

96% 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.

We await final details of the financial arrangements and our income for H2

A great place to work

Our performance in August

- **4.6%** sickness rate (excluding Covid related absence)
- **2.2%** of sickness absence is due to stress, anxiety and MSK
- **14.6%** staff turnover

Protect yourself and others with your flu jab. Due to us receiving batches of the vaccine in stages, we will be offering our first delivery to frontline staff in frequent contact with service users. Look out for an email from VaccinationTrack to book a clinic, or if you're ward based speak to your local peer vaccinator about our drop in clinics.

Please ensure you complete your **mandatory training**, especially **fire safety** which is currently showing low compliance.

After 29 years working for our Trust Alan Davis, our director of HR, OD and estates retired. Lindsay Jensen, our current deputy director, will be taking over as interim director of HR and OD. Make sure you display our new EMT posters in all areas.

Sign up to the EyUp! Lottery for your chance to win £1,000. Register for the Lottery by 10 Nov in time for the 'Big Christmas draw'. Winners will be drawn on 1 Dec 2021.

The pay award and arrears has now been applied to staff on agenda for change terms and conditions and to senior medical staff. Further details can be found on NHS Employer's website. The new agenda for changes rates of pay are shown on this poster.

Keep an eye out for the **NHS Staff Survey** which will be launching in late Sept or early October. The survey is an important tool to give insights into staff experience, where this is working well, and where we can improve.

A great place to work
Equity guardians

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We want the Trust to be a great place to work. However, we know from listening to our frontline colleagues that clinical staff experience racism from service users whilst they are providing care. We also know from our data that colleagues from racially minority groups are more likely to experience abuse that their white counterparts.

Examples of racist abuse include:

- Racist comments
- Threats or threatening behaviour
- Actual physical contact – grabbing of clothing or hair; punches, strikes or kicks; spitting and/or scratching
- Abusive remarks including excessive foul language
- Malicious allegations regarding staff, other patients or visitors.

The Trust will not tolerate any incidents of racist abuse and has created a network of equity guardians who provide support and advice to frontline colleagues that are effected by racism. A robust process of personal and clinical support has been created to safeguard staff who experience racist abuse during their work in a clinical role. If you are concerned, contact one of the guardians.

Our equity guardians are:

- Jacob Agoro
- Toni Burns
- Rachel Chislett
- Jon Millard
- Donna Somers
- Richard Watterston

If you are interested in working as a guardian or want to know more contact Cherill Watterston.

With **all of us** in mind.

A great place to work
Civility and respect champions

#allofus
our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Our civility and respect champions have recently been launched in the organisation. They are there to listen to your concerns about any issues relating to civility and respect across our Trust. It is about being treated fair and right.

You can contact any of the civility and respect champions for an informal discussion about any concerns you have about a lack of civility or respect in the workplace.

They can support you to consider different options for dealing with your concerns.

If the matter is not resolved they will help signpost you to further support, including trade union and HR representatives or freedom to speak up guardians

Contact details for the civility and respect champions can be found here.

With **all of us** in mind.

A great place to work

Freedom to Speak Up Guardian month

#allofus
our wellbeing at work

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Speak Up Month is an opportunity to raise awareness of how much we value speaking up in our organisation. The theme of this year's Speak Up Month is 'Speak Up, Listen Up, Follow Up'. To make speaking up business as usual it is essential that when people speak up, they are listened to, and that learning and improvement happens as a result.

We will be holding face to face and virtual sessions to celebrate Speak Up Month. Details of all the events can be found on the intranet.

You can contribute by attending one of the sessions or, if you haven't done so already, by completing your Freedom to Speak Up mandatory training on ESR.

Freedom to speak up guardians


Debs Teale


Adrian Deakin


Estelle Myers


Paul Brown

If you have a concern about something happening in the Trust please come to us for a confidential discussion

Contact a guardian on email guardian@swyt.nhs.uk or telephone 07795 367197

Thank you to everyone who has come forward so far to raise their concerns. Over 80 connections have played a vital role in helping to make our culture a better one, one where civility is at its heart

Freedom to Speak Up

With **all of us** in mind.

Take home messages

NHS
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NHS Foundation Trust

For us in healthcare workplace restrictions haven't changed. Keep us with the measures that have kept us safe so far.

Safety comes first, always. Make sure you know what to do if you are asked to isolate.

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

Protect yourself and your loved ones by having your flu vaccine and the COVID booster (if you are eligible).

Make sure you are up to date with your mandatory training.

Find out about the support that is available from our guardians and champions.

Take part in the NHS Staff Survey when you get your invite.

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

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

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 8.1

Title:	**Board Assurance Framework (BAF) Quarter 2 – 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 July 2021, a comprehensive review of controls, assurances and target dates for actions took place. Discussion at the Extended Management Team (EMT) meeting in October considered any change in circumstances which may impact the movement on strategic risk ratings.

	Considerable discussion took place around the gradings of risks in light of the ongoing nature of the pandemic and the operating environment including wider NHS change, demand for services and pressure on staff. 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 the following recommended changes: • **Risk 2.1 – Lack of suitable and robust information systems backed by strong analysis leading to lack of high-quality management and clinical information** - a discussion took place as to whether the Trust has the right level of management information and analysis given additional requirements for it including how we recover equitably from the pandemic. It was agreed that this risk should be moved from Yellow to Amber as the Trust requires further insight into inequalities including deprivation data and have better information available regarding access to services including comprehensive wait times. Significant work is ongoing in this area, but external demands have increased. Recruitment is in progress to appoint a senior team member which is expected to have a positive impact on the grading of this risk in the coming months. • **Risk 2.2 – Failure to create a learning environment leading to lack of innovation and to repeat incidents** - It was agreed that a considerable amount of learning and innovation has taken place within the Trust during the last eighteen months and continues to do so. Concerns regarding the repeated choking incidents and outbreaks of Covid-19 on wards have led to this risk being moved from green to yellow. • **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 -** In line with OPEL 3 reporting, silver command has commissioned a piece of work to look at how the burden can be reduced on operational services in order to support safe and effective service delivery throughout increased demand and reduced capacity over the winter period. Should the outcome of this work demonstrate that significant gaps in capacity to meet demand remain, we will move the risk from Amber to Red or if in the interim period we move from OPEL 3 -4 we will also move the risk to Red. • **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** - EMT considered whether this risk could be moved to green given the current strong financial position but given the level of financial uncertainty in the future it was agreed to maintain a grading of yellow until there is greater certainty of future funding arrangements. • **Risk 3.3** – **Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives** - A focus on available resources and capacity

	continues, particularly in light of leadership changes in the Trust. Extra capacity has been brought in to support some of the key programmes for change and it is recommended the grading remains yellow. • **Risk 4.1** – **Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience** - the amber rating continues to be driven by the availability of clinical workforce and current vacancy levels. • **Risk 4.3** – **Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19** - it is recognised we provide a strong health & wellbeing offer for staff. However, taking into consideration the enduring effect of the pandemic, staff shortages and higher sickness levels, particularly in inpatient units, this risk has increased, which is reflected in the move from yellow to amber. Mitigations continue to be progressed to minimise the level of risk and there is increasing focus on additional actions that need to be taken. The view of EMT is that the recommended changes to the ratings of individual strategic risks are representative of the current operating environment and pressures within our services. 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

South West Yorkshire Partnership NHS Foundation Trust

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

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

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

Strategic Objectives

Approved by Trust Board and reviewed regularly

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

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

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

Strategic risks linked to strategic objectives

Controls in respect of risks and strategic objectives

Assurances in respect of the controls and strategic objectives

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

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

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

Exec Management Team

Individual director/BDU assurance arrangements

Trust Board Committees

TRUST BOARD

Closure of gaps
- Time bound responsibilities identified plus lead

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

Board Assurance Framework (BAF) 2020/21 – 2021/22

Overview of current assurance level:

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

Strategic objective	Strategic risk	Page ref	Assurance levels					
			2020/21		2021/22			
			Q3	Q4	Q1	Q2	Q3	Q4
Improve health	1.1 Changes to commissioning arrangements, an increasing role for each place and variations in local priorities could lead to service inequalities across the footprint.	8	A	A	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	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	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	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	A		
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.	23	G	G	G	Y		
	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	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	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	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	G		
	3.3 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.	35	Y	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	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	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	A		

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 and Involvement Committee, FIP = Finance, Investment & Performance Committee, MHA = Mental Health Act Committee, WRC = Workforce & Remuneration Committee

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

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

RAG ratings:

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

Strategic objective 1: Improve health	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21			2021/22		
Links to ORR (risk ID numbers): 275, 773, 812, 1077,1511, 1531	As noted below.	EMT, CGCS, MHA, Trust Board	Q3	Q4		Q1	Q2	Q3	Q4
			Y A	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, triangulated with other feedback and insight, in particular Healthwatch. • The Trust insight report now feeds the Executive Management Team meeting and Equality, Inclusion and Involvement Committee

Rationale for current assurance level (strategic objective 1: improve health)
• Strong and robust partnership working with local partners, through emerging integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield. • Partnering provider collaborative developments 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, Inclusion, and Involvement 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. • The Trust is involved in the 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 has been developed in Kirklees. The Trust is also a member of the mental health partnership in Barnsley and developing a provider collaborative with Barnsley primary care and Barnsley healthcare federation to strengthen the joined up community offer • Stakeholder engagement plans in place. • Integrated Performance Report (IPR) summary metrics IPR Month 5: out of area beds – red, children and young people accommodated on an adult inpatient ward – 2 service users for a total of 41 days, seven day follow up – green, physical health – not reported, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – red, 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. • The Trust is playing a key role in developing the West Yorkshire ICS creative health hub. • Compliance with the public sector equality duty. • A standard approach is in place to support involvement plans which include previous insight that has been 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. The Trust is currently conducting a review of mandatory training in respect of equality and diversity. • All services have a baseline Equality Impact Assessment (EIA) in place. • Deliver and report on compliance with Equality Delivery System (EDS2) annually.

Strategic objective 2: Improve care	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 852, 1078, 1080, 1132, 1159, 1319, 1424, 1523, 1527, 1530, 1567	As noted below.	EMT, CGCS, WRC, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
			Y	Y	Y	Y A		
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.**	**A**
2.2	**Failure to create a learning environment leading to lack of innovation and to repeat incidents.**	**Y**
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 commitment to the Trust values is evidenced through the excellence awards and regularly reviewed as part of the Trust appraisal and supervision process. (Excellence awards will now be reinstated in Q4 having been paused during the Covid-19 pandemic)
• In the main, positive Friends and Family Test feedback from service users. A recent decline in results is being investigated and will , triangulated this with other feedback and insight, in particular Healthwatch.
• Quarterly staff surveys commencing in January 2022
• 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.
• The Trust has been capturing learning from innovation, a process that has been accelerated through Covid-19 and learning is now in place.
• Repeated incidents of outbreaks of Covid-19 on inpatient wards and repeated choking incidents have led to enhanced scrutiny of Covid-19 infection data being presented in the IPR and the recruitment of a band 7 Speech and Language Therapist to review choking incidents.
• 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. A stock take of the Trusts QI approach and journey to date is underway.
• 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 5 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
• Additional capacity has been secured to support the development of insight using the new inequalities and data dashboard to inform the inequalities plan
• 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.
• Partnership arrangements at different stages of development in each of the places in which we provide services.

Strategic objective 3: Improve resources	Lead Director(s)	Monitoring and assurance	Overall assurance level					
			2020/21		2021/22			
Links to ORR (risk ID numbers): 275, 522, 695, 1076, 1077, 1114,1214, 1217, 1319, 1335, 1511, 1567	As noted below.	EMT, AC, WRC, Trust Board	Q3	Q4	Q1	Q2	Q3	Q4
			Y	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 2021/22continued Interim financial arrangements have been confirmed for H2 21/22, • National funding arrangements continue to mitigate this risk for H2 2021/22. • A cumulative surplus of £2.3m has been recorded for H1 And the Trust is planning to report a surplus for H2 • . 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. • Current cash balance remains strong at c£60m and cash management processes are not a concern. • Positive well-led results following Care Quality Commission (CQC) review. • Capital investment prioritisation process. Remains affordable from internal resources. • Updated priority programmes for 2020-22 are aligned to strategic objectives. • Partnership arrangements are established within each place. • Lead provider collaboratives for forensics, CAMHS and eating disorders in West Yorkshire. Have gone live from 1st October 2021 • 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	A		

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.**	A

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Staff flu and Covid-19 vaccinations cycle for Winter 2021has commenced. • Vacancies in key areas – forensics and LD, including use of medical locums. • Staff turnover rates have increased and is comparable with other trusts in Yorkshire. • Staff sickness now includes Non-Covid and Covid absence combined, and we are above target. We have similar levels to other comparable organisations in Yorkshire. • Staff survey has been launched for 2021 • In the main, positive Friends and Family Test feedback from service users. 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. • Quarterly staff surveys commencing in January 2022 • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. The trio model is currently being reviewed. • 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 current pandemic, including testing, vaccinations, health, and wellbeing offer and BAME taskforce and WRES OD lead. • A range of staff networks in place including BAME, LGBT+, disabilities and working carers. • Full-time lead Freedom to Speak up Guardian is in post and a recent internal audit report has been completed with an action plan in place. • Open and just culture being developed across the Trust. • Virtual international recruitment portal signed off by EMT and we are expecting approximately 25 new nurses commencing employment by the end of 2021. • Chair recruitment process to be completed in October 2021 and review of Board succession planning • Launch of the Great Place to Work immediate managers programme from November 2021 • HPMA award for Partnership Working with Staff Side

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	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

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DS	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C08	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets paused during 2020/21, to return for 2021/22. Discussions are underway and suggest there are no CQUINS for the remainder of 21/22 (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/CEO/DPD	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, and Involvement 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)	CEO	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

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Impact on services because 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 September 2021 and to be reviewed again in January 2022.	To be reviewed by January 2022	DO / DS
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 April 2022 to align with ICS statutory bodies go live	To be reviewed by April 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 now operating in shadow form review date to April 2022 when go live. still in development. Reviewed June 2021 for further review in September 2021.	April 2022	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. Regional and national conversations are taking place around modelling and implementation to be reviewed again in January 2022	To be reviewed by January 2022	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

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)**
A06	Audit of compliance with policies and procedures in line with approved plan co-ordinated through quality improvement and assurance 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, 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) (P)	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
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are 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 for 2021/22 have started 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. 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 H1 2021/22 and again in readiness for H2 2021/22. The Trust submitted a financial plan for a break-even position for the first six months of 2021/22 and is currently in the process of submitting a H2 plan. Work will commence shortly to agree longer term plans for the Trust.in 2022/23 (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	DFR	1.1, 3.1, 3.2

Assurance (strategic risk 1.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
		governing body approval for Calderdale imminently (P) (I) (E)		
A16	Update reports on WY and SY ICS progress.	Routine report into EMT and Board. (P) (I)	DS	1.1
A17	Reports from Barnsley, Calderdale, Kirklees, and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	DS / DPD	1.1, 1.2
A19	Proactively involved as a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated to Trust Board (P) (I, E)	DPD / DS	1.1
A20	Reports to EI&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 include formalising governance of partnership groups and assessment against a maturity matrix resulting in place-based development plans and new partnership agreements to ensure readiness to operate as place-based partnerships linked to formal the ICS structures from April 2022.	April 2022	DS / DPD
Active member of place based / ICS integrated care governance arrangements in all areas. 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. Trust Board has agreed an extension to the secondment duration of the Trust Chief Executive to the ICS until the end of October 2021 after which the outcome of the CEO recruitment process will be known enabling the Trust to progress with recruitment of a new CEO. Reviewed in June 2021 and September 2021.further review required in November 2021.	To be reviewed by 30 November 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. Once the H2 planning process is concluded in November, focus can move to planning for 2022/23. Although guidance re 22/23 is not expected until December 2021, we already planning ahead to address these gaps.	To be reviewed by January 2022	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	BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C14	Project Boards for change programmes and work streams established, with appropriate membership skills and competencies, project initiation documents (PIDs), project plans, project governance, risk registers for key projects in place. (I)	DS	1.1, 1.2
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality, Inclusion, and Involvement 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)	CEO	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
C140	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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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 quality improvement and assurance 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 changes 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
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are 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 for 2021/22 have started 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. 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 H1 2021/22 and again in readiness for H2 2021/22. The Trust submitted a financial	DFR	1.1, 1.2, 3.1, 3.2, 3.3

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
		plan for a break-even position for the first six months of 2021/22 and is currently in the process of submitting a H2 plan. Work will commence shortly to agree longer term plans for the Trust.in 2022/23 (E)		
A17	Reports from Barnsley, Calderdale, Kirklees, and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	DFR	1.1, 1.2
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard. (P) (N) (I)	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Clinical Risk Panel 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) Discussions are underway and suggest there are no CQUINS for the remainder of 21/22 (I, E)	DO	1.2, 3.1, 3.3
A26	New workforce and OD strategy completed in line with national people plan in April 2021	Signed off by Trust Board in April 2021. 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	December 2021	DS/DOF

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
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. H2 planning process is due to be completed in November 2021.		
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. Trust Board has agreed an extension to the secondment duration of the Trust Chief Executive to the ICS until the end of October 2021 after which the outcome of the ICS CEO recruitment process will be known enabling the Trust to progress with recruitment of a new CEO. Reviewed in June 2021 to review further September 2021. Move into November 2021	To be reviewed by 30 November 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/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
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, and Involvement Committee. (I)	DS	1.3, 1.4
C31	JNA data reflected in all service EIAs. (I)	DS	1.3, 1.4

Controls (strategic risk 1.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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)	CEO	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
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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group established. This is chaired by Director of Operation and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P,E, I)	DO	1.3, 2.1

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 will continue to play our part in the development of mental health and wellbeing alliances and working in partnership top reduce health inequalities as part of formalised partnership arrangements in line with guidance.	To be reviewed by 30 April 2022	DS/DPD
Trust wide Equality Impact Assessment (EIA) –is now in place, we also have a dashboard to support planning and have secured capacity to enable us to carry out analysis of the equality dashboard. Reviewed and updated in October 2021. 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. The delayed transition of the Trust intranet onto Sharepoint has led to delay in this work and completion is now anticipated to January 2022.	January 2022	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 quality improvement and assurance 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, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A20	Reports to Equality, Inclusion and Involvement 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. (P) (N) (I)	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. The tool is now in place and is in the early stages of use and further testing is ongoing to establish its effectiveness in future planning. January 2022	To be reviewed by 31 January 2022	DO/DS

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
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. The Trust wide insight report is in place and the approach is being further developed. The patient experience toolkit is in place, but we need to support the embedding and approach of this. Reviewed in October 2021.	To be reviewed by January 2022	DPD

Strategic risk 1.4 Services are not accessible to nor effective for all communities, especially those who are most disadvantaged, leading to unjustified gaps in health outcomes or life expectancy.

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. 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	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 Discussions are underway and suggest there are no CQUINS for the remainder of 21/22 (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

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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, and Involvement 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 and Involvement Committee and task force in place. (I)	DS	1.4
C38	Trust website rated good on Accessible Information Standard. (I)	DS	1.4
C39	Translation and interpretation service in place. (I)	DS	1.4
C40	Photo symbol package available to staff. (I)	DS	1.4
C41	Patient experience and engagement toolkit in place. (I)	DS	1.4
C125	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff, and stakeholders / partners. Annual action plans developed, and ongoing processes established. (P, N) (I, E)	DHR, DS	1.1, 1.3, 1.4, 2.3
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, DO	1.1, 1.2, 1.4, 3.2
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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. The tool is now in place and is in the early stages of use and further testing is ongoing to establish its effectiveness in future planning. Reviewed in June 2021 and September 2021.	To be reviewed by 31 January 2022	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. The Trust wide insight report is in place and the approach is being further developed. The patient experience toolkit is in place, but we need to support the embedding and approach of this. Reviewed in October 2021. .	To be reviewed by January 2022	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
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard. (P, N), (I)	DNQ	1.1, 1.2, 1.3, 1.4
A24	Investment Appraisal report – covers bids and tenders' activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board. (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A33	Customer service reports to Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy implementation plan reports into CG&CS Committee.	Routine reports into CG&CS via IPR and annual report scheduled in 2021/22 work plan. Quality strategy currently under review, with a planned publication of September 2022 (P) (I)	DNQ	1.4, 2.3
A35	Equality dashboard presented to Equality, Inclusion, and Involvement 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. The Trust wide insight report is in place and the approach is being further developed. The patient experience toolkit is in place, but we need to support the embedding and approach of this. Reviewed in October 2021.	To be reviewed by January 2022	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. The tool is now in	January 2022	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
place and is in the early stages of use and further testing is ongoing to establish its effectiveness in future planning. Reviewed in June and September 2021 to be reviewed further January 2022.		

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

Controls (strategic risk 2.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C42	Access to the model hospital to enable effective national benchmarking and support decision making. (I)	DFR	2.1
C43	Development of data warehouse and business intelligence tool supporting improved decision making. (I)	DFR	2.1
C44	Digital strategy in place with quarterly report to Executive Management Team (EMT) and half yearly report to Trust Board. (I)	DFR	2.1
C45	Risk assessment and action plan for data quality assurance in place. (I)	DFR	2.1
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C47	Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	DNQ / MD	2.1, 2.3, 4.1
C48	Improving Clinical Information & Information Governance Group (ICIG) reviews clinical information systems and data quality. (I)	DNQ / DFR	2.1
C49	Internal process to impact assess / review potential new systems from a technical and information governance (IG) standpoint. (I)	DFR	2.1
C50	Change control process in place for operational / service level requests / changes, for system-wide changes and developments. (I)	DFR	2.1
C51	National benchmarking data is reviewed and analysed and taken to OMG, EMT and Finance, Investment & Performance Committee. (I)	DFR	2.1
C132	Trust health intelligence and insight group. Meets monthly – feeds into recovery planning group. (I)	DPD	2.1
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All
C143	Trustwide Benchmarking Group established. This is chaired by Director of Operation and reports will be regularly provided to FIP to ensure the Trust can assess its current service provision in the context of the wider system. (P,E, I)	DO	1.3, 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 and September 2021. To be further reviewed in November 2021*	December 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 and September 2021 Business Intelligence Group established as part of reset and restoration of services. One year band 7	January 2022	DPD

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
waiting list project manager and band 5 data quality officer recruited to start October 2021. Waiting list project brief to be completed by November 2021.		

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
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 Clinical Safety Design Group, EMT and Trust Board.	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board. (P) (I)	DNQ	2.1
A39	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly risk register reports to Board. Triangulation of risk, performance, and governance present to each Audit Committee. (P) (I)	DFR	2.1
A40	Data quality focus at OMG and ICIG.	Regular agenda items and reporting of at ICIG and OMG. (P, N) (I)	DNQ	2.1
A41	Benchmarking reviews and deep dives conducted at Board Committees.	Reports provided regularly. (P) (I)	DNQ / DFR	2.1
A42	BDU and OMG performance management processes.	OMG notes taken into EMT, summary of finance and performance reviews into EMT monthly. (I) (P)	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 developed overarching operational data quality improvement plan which will be monitored by ICIG and OMG. This remains an issue, but the action plan has been completed and the data quality action plan is on track.	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 and September 2021. This work is progressing but not at a point of complete confidence for all measures.	January 2022	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	BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C46	Datix incident reporting system supports review of all incidents for learning and action. (I)	DNQ	2.1, 2.2, 4.1
C52	Customer services reporting includes learning from complaints and concerns. (I)	DNQ	2.2, 4.1
C53	Patient Safety Strategy developed to reduce harm through listening and learning. (I)	DNQ	2.2, 4.1
C54	Quality Improvement network established to provide Trust wide learning platform. (I)	DNQ	2.2, 4.1
C55	Quality Strategy achieving balance between assurance and improvement. (I)	DNQ	2.2
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C57	Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services. (I)	DO	2.2, 4.1
C58	Learning lessons reports, BDUs, post incident reviews. (I)	DNQ	2.2
C59	Risk Management Strategy in place facilitating a culture of horizon scanning, risk mitigation and learning lessons supported through appropriate training. (I)	DFR	2.2
C60	Weekly serious incident summaries to Executive Management Team (EMT) supported by quarterly and annual reports to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. (I)	DNQ	2.2
C61	I-hub platform in place with over 2,000 members providing digital opportunities to share, innovate, collaborate, and improve. (I)	DS	2.2
C62	Peer lead worker role in place and training toolkit developed. (I)	DS	2.2
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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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, with particular reference to clear evidence of the positive impact of lessons learned Reviewed in October 2021 and review again in January 2022.	January 2022	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

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
In the last 18 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 established to aid staff safety. Mandatory training continues to be reviewed with recent action taken in relation to a dip in fire safety training numbers through OMG and EMT. A digital suite is being developed in the Learning Wellbeing Centre to deliver an improved digital training offer. Prospective completion date December 2021.	To be reviewed by 30 December 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
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
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 Risk Panel 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 and September 2021. Further review to take place in December 2021.	January 2022	DFR
Although opportunistic work has taken place on the inpatient strategy improvement plan, this is on hold given the work required to manage the Covid-19 response. Inpatient wards are now a priority programme. Reviewed in June 2021 and September 2021. Further review in January 2022.	Review by January 2022	DO
A Trustwide approach to shared decision making and co-production is being developed to support the delivery of personalised care and innovation	April 2022	DS/DNQ

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	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

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
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 strategic groups 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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All
C142	Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care. (E)(P)	DNQ	2.3

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)**
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

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)**
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
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), and regular visits through our quality monitoring structure. Reports on these visits are 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 for 2021/22 have started with a report going to CG&CS Committee in February 2022. (P, N) (E)	DNQ	1.1, 1.2, 2.3
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
A49	CQC self-assessment process.	Reviewed by EMT as part of preparation for CQC inspection process. (I)	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 2021 and September 2021.	December 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	To be reviewed by December 2021	DO

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
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 and in September 2021.		
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. The tool is now in place and is in the early stages of use and further testing is ongoing to establish its effectiveness in future planning. Reviewed in June 2021 and September 2021.	To be reviewed by 31 January 2022	DS

Strategic risk 2.4

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

Controls (strategic risk 2.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C70	Anti-virus, encryption, and security systems in place for IT devices, servers, and networks. (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)	CEO	2.4
C75	Trust smoking policies. (I)	DO	2.4
C76	Use of sprinklers and other fire suppressant systems within our estate. (I)	CEO	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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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. There is a roll out system based on risk assessments for existing estate. All new buildings have sprinkler systems. Reviewed June 2021 and September 2021.	To be reviewed by January 2022	CEO

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
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 October 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 and advisory piece in 2021 (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. Report published in September and submitted to EMT and Audit Committee.	January 2022	DFR
Cyber audits and penetration testing have highlighted some areas for improvements. Formal action plan in place to address issues highlighted. Reviewed in June and September, to further review in January 2022.	January 2022	DFR

Strategic risk 3.1 **Changes to funding arrangements, increases in costs and failure to deliver efficiency and productivity improvements result in an unsustainable organisation and inability to provide services effectively.**

Controls (strategic risk 3.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C79	Finance managers aligned to Business Delivery Units (BDUs) acting as integral part of local management teams. (I)	DFR	3.1
C80	Standardised process in place for producing business cases supporting full benefits realisation. (I)	DFR	3.1
C81	Standing Orders, Standing Financial Instructions, Scheme of Delegation and Trust Constitution in place and publicised re staff responsibilities. (I)	DFR	3.1
C82	Annual financial planning process, cost improvement programmes (CIP) and Quality Impact Assessment (QIA) process. (I)	DFR, DNQ	3.1
C83	Financial control and financial reporting processes. (I)	DFR	3.1
C84	Regular financial reviews at Executive Management Team (EMT). (I)	DFR	3.1
C85	Service line reporting / service line management approach. (I)	DFR	3.1
C86	Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	DO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DS	3.1, 3.2
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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) (Linked to ORR risks 1077, 1214).	December 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. CIP challenge for H2 expected to continue to be met non-recurrently via level of vacancies and workforce shortages.*	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 September 2021 and to be reviewed again in January 2022.	To be reviewed by January 2022	DO
Recurrent impact of Covid-19 on underlying cost structure and financial sustainability plan not fully clear. Review when H2 guidance is received.	December 2021	DFR

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A10	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework.	Contracting risks, bids & tenders update standing item on delivery EMT agenda. 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
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. 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 H1 2021/22 and again in readiness for H2 2021/22. The Trust submitted a financial plan for a break-even position for the first six months of 2021/22 and is currently in the process of submitting a H2 plan. Work will commence shortly to agree longer term plans for the Trust.in 2022/23 (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)	DFR	1.2, 1.4, 3.1, 3.2, 3.3

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
		Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I)		
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) Discussions are underway and suggest there are no CQUINS for the remainder of 21/22 (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
A59	Temporary financial arrangements in place for 2021/22.	Financial plan for first half of 21/22 approved by Trust Board in May and H2 plan expected to be received in November 2021 (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. Reviewed June 2021 and September 2021. Further review in January 2022	January 2022	DO
Increasing expenditure on staffing in inpatient wards with spend higher than income. Ongoing raising of this issue during contract negotiations. Reviewed in August 2021 and to be reviewed further on receipt of H2 planning guidance.	December 2021	DFR
Financial plan for H2 2021/22 not yet developed. Timescale for completion November 2021.	December 2021	DFR
A cumulative surplus of £2.3m has been recorded for H1. Reviewed in June 2021 and September 2021 *Ongoing - Financial sustainability work is focusing on recurrent improvement opportunities.*	December 2021	DFR
Financial arrangements for 2021/22 and recurrent cost base given the impact of Covid-19 are not yet fully known.	December 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	Annual review of the strategic stakeholder engagement plan and action plans. (I, E)	DS	3.2
C91	Strategic Business and Risk Report including PESTEL / SWOT and threat of new entrants / substitution, partner / buyer power. (I)	DS	3.2
C92	Quality Impact Assessment (QIA) process in place. (I)	DNQ	3.2
C93	Partnership agreements in place or being developed in the systems in which we provide services. (I, E)	DS / DPD	3.2
C126	Commissioning intentions are factored into operating plans as part of the planning process. (P, I)	DFR, DO	1.1, 1.2, 1.4, 3.2
C133	Annual strategic business and risk analysis to Trust Board ensuring identification of opportunities and threats. Strategic business and risk analysis reviewed by Trust Board. (P) (I)	DS	3.1, 3.2
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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) Reviewed in June and September 2021.	December 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
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. 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 H1 2021/22 and again in readiness for H2 2021/22. The Trust submitted a financial plan for a break-even position for the first six months of 2021/22 and is currently in the process of submitting a H2 plan. Work will commence shortly to agree longer term plans for the Trust.in 2022/23 (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
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

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)**
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. 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. Trust Board has agreed an extension to the secondment duration of the Trust Chief Executive to the ICS until the end of October 2021 after which the outcome of the CEO recruitment process will be known enabling the Trust to progress with recruitment of a new CEO. Reviewed in June 2021 and September 2021.	To be reviewed by November 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. Trust Board has agreed an extension to the secondment duration of the Trust Chief Executive to the ICS until the end of October 2021 after which the outcome of the CEO recruitment process will be known enabling the Trust to progress with recruitment of a new CEO. Reviewed in June 2021 and September 2021.	To be reviewed by November 2021	DS/DHR

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

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets paused during 2020/21, to return for 2021/22. Discussions are underway and suggest there are no CQUINS for the remainder of 21/22 (I, E)	DO	1.1, 1.4, 3.3
C86	Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	DO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C94	Agreed workforce plans in place which identify staffing resources required to meet current and revised service offers. Also describe how we meet statutory requirements re training, equality, and diversity. (P, N), (I)	DHR	3.3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.3

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DS	3.3
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DS	3.3
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR	3.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2020-22 priorities. (P), (I)	DS	3.3
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DS	3.3
C134	Workforce strategic groups 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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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

Assurance (strategic risk 3.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re: quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
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. Trust engaged in development of Integrated	DFR	1.1, 1.2, 3.1, 3.2, 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)**
		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 H1 2021/22 and again in readiness for H2 2021/22. The Trust submitted a financial plan for a break-even position for the first six months of 2021/22 and is currently in the process of submitting a H2 plan. Work will commence shortly to agree longer term plans for the Trust.in 2022/23 (E)		
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) Discussions are underway and suggest there are no CQUINS for the remainder of 21/22 (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
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. Trust Board has agreed an extension to the secondment duration of the Trust Chief Executive to the ICS until the end of October 2021 after which the outcome of the CEO recruitment process will be known enabling the Trust to progress with recruitment of a new CEO. Reviewed in June 2021 and September 2021.	To be reviewed by 30 November 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. We have secured additional resources and look to ensure sustainable capacity by April 2022. 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 April 2022	DS

Strategic risk 4.1

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

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

Controls (strategic risk 4.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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 due to the current financial and operational planning processes as determined by the centre.	To be reviewed by January 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
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

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)**
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 are being consistently reviewed 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 will receive an updated report on recruitment & retention including exit interviews in November 2021 with a view to identifying themes and trends to develop appropriate action planning.	April 2022	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 and utilised as above. Establishment of new roles group to look at development of new clinical roles.	To be reviewed April 2022	DHR

Strategic risk 4.2

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

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	DHR	4.1, 4.2

Controls (strategic risk 4.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Great place to work programme re-established in April 2021. Great place to work leadership programme has now established to commence from November 2021.Pilot programme now completed with roll out across the organisation now being planned.	To be reviewed by January 2022	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
A75	HR Covid-19 report.	Report received by WRC. (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.	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
C141	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 take place between Chief Executive and Directors. (P) (I)	CEO	All

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

Assurance (strategic risk 4.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
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

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)**
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. The position remains under review with further stocktake in August. Great place to work programme is due in November 2021	To be reviewed by January 2022	DHR

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 8.2

Title:	**Corporate / Organisational Risk Register Quarter 2 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 is being presented as a separate paper for approval at this month's Board meeting. The full organisational risk register is reviewed on a regular basis by EMT and individual risks are reviewed by the responsible director with the corporate governance team.

As part of this review of the ORR and following feedback from internal audit, any risks that were identified as ongoing have been given dates for completion.

It is important to acknowledge at each subsequent review these completion dates will be discussed alongside changes to controls, actions and risk scores and will be closed or extended as appropriate.

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

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

Risk ID	Description	Rationale
1624	Service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts upon the quality of service we can offer to someone who may have a mental health need in our local community.	This risk has been reviewed at OMG and escalated to EMT, where it was agreed that this risk should be placed on the organisational risk register with a score of 9.

At the recent Workforce and Remuneration Committee nine risks were considered for closure/merger and were presented to EMT for approval.

Of the nine risks presented it was agreed that the following risks could be **merged into risks 1615 and 1612:**

	Risk ID	Description	Rationale
	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.	Following discussion at the Workforce and Remuneration Committee and EMT, these risks have been merged under risk ID 1615 under the following description: 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.
	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.	
	1154	Risk of the loss of staff due to their health and wellbeing being adversely affected 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.	
	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.	
	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.	
	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.	
	1613	Insufficient numbers of staff received the Covid-19 vaccination leading to an increased risk of infection across the Trust workforce, service users, patients and carers.	This risk has been closed and consolidated with 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.

EMT requested that the following risks remain on the ORR at this time due to their more specific nature and the level of work still required to fully mitigate them:

	Risk ID	Description	Rationale
	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.	Action is still needed to fully meet the requirements for the indicators for EDS2, WDES and WRES.
	1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	The impact on BAME workforce is still not fully understood and the Equality Involvement Forum have requested a review.

The review of Covid-19 specific risks will continue during the remainder of quarter 3, via relevant operational management groups and Board committees. The outcome of this will be dependent on the status of the pandemic at the time.

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

Risk ID	Description	Updated position and rationale
1080	Risk that the Trust's IT infrastructure and information systems could be	• Phishing campaign being planned for and to be conducted during Q3

	the target of cyber-crime leading to theft of personal data.	• Cyber security enhancements are under investigation also a separate paper is being readied to support the case for this significant investment (capital and recurrent revenue). (Q3 2021/22)
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.	• Additional temporary staffing resources approved to respond to increased acuity, activity and environmental considerations

The following changes have been made to the ORR since the last Board report in July 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.	• Involved with partners in the co-development of integrated care partnerships in each place as Trust priority programmes of work. (April 2022)
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.	• Go live decision approved by Trust Board • Updated funding offer provided by NHS England • Trust Board task and finish group to develop governance oversight arrangements for Trust Lead Provider functions. • Quarterly contract meetings with sub-contracted partners to ensure oversight of any financial, quality and clinical risks. • Attendance at monthly Quality Review Meetings with NHSEI to ensure oversight of quality issues, and progress against action plans.
905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	• Update- Trust vaccination programme completed May 2021 with national offer still available for those not vaccinated. Booster vaccine programme delivered

			through a partnership model from October 21 and under regular review. • Recent escalation in concerns relating to staffing availability has resulted in additional actions to • accelerate the workforce working groups to ensure actions to address flexible options / recruitment and retention / incentivisation are in place. • Support the patient flow team to use out of area beds as appropriate in order to support the management of acuity on inpatient area • Task the acute leadership team to review the options for the flexible use of the total bed base • Work with partners across ICS to consider how inpatient services can be promoted as an area of expertise and staff can be recognised and rewarded appropriately.
	1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	• Resource has been agreed in Kirklees to address historical waits in ADHD / ASD and new demand. Work has commenced with private providers, with the aim of reaching a steady state in relation to referrals and waits by March 2023. Focus has also been placed on supporting the children who are waiting and the CAMHS team are reviewing clock stop measures across networks to understand how meaningful contacts are recorded in relation to waits.
	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. This has been delayed due to Covid-19. (To be reviewed December 2021). • The reporting of 'hidden waits' to be reviewed March 2022. • Monitoring of demand against expected demand

			has commenced and this will be used to inform service action plans to address waits. (Review December 2021)
	1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	• No further update made • Focused attention placed on fire safety training
	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. (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. This is being actioned within several workstreams. The Clinical Environmental Safety Group oversees ligature risk, our commitment to the recently appointed patient safety specialist roles and the Patient Safety Incident Review Framework seeks to maximise learning from serious incidents and deaths. Clinical risk assessment / application of the FIRM risk assessment is being overseen from both a quantitative and qualitative perspective within BDU Governance Groups, overseen by the Clinical Governance Group. The RRPI team continue to support learning with front line colleagues, and continue to benchmark our practice against other providers. COVID-19 response remains held within the Incident Command structure
	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.	• Urgent work has been completed to restore the use of the damaged seclusion rooms. However, the risk remains the same pending the results of the review to be reported to the operational management group October 2021

	522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	• H2 funding agreed for the NHS and local allocations currently being confirmed
	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.	• Information Commissioner's Office external monitoring of progress by external evidence / desk based reviews
	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.	• 2021/22 H2 planning process following issued H2 guidance. November 2021) • Trust is fully engaged in development of integrated care systems, place-based partnerships and provider collaboratives
	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. (DFR) (October 2021)
	1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	• Assess H2 2021/22 financial arrangements and planning guidance when received. (DFR) (October 2021)
	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.	• Learning from the ICS experience in purchasing additional PICU capacity is informing current discussions across partners regarding the purchase of further beds to relieve pressure. (Review October 2021) • Out of area placements are currently being used to manage high levels of acuity and staffing challenges and to support the safe and effective delivery of care. The actions to maintain patient flow and minimise the impact on care remain in place. Review November 2021
	1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	• Assess H2 2021/22 financial arrangements and planning guidance when received. (DFR) (October 2021) • Negotiation for use of mental health recovery monies (October 2021)

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.	• Work is taking place to develop a report of children who are waiting for a bed and where they are. December 2021)
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.	• The Trust will have to negotiate a fair share of the capital allocation with the ICS. (Q4) • Separate opportunities to bid for national hospital funds and other digital funding are currently available. (Ongoing) • Longer term capital plan being developed
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.	• Appointment of Associate Medical Director for Workforce (AMD)
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.	• Equity guardians are being launched this month (October 2021)
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. (DHR) (December 2021) • Link into and support place-based recruitment. (DHR) • On Boarding project relaunched. (DHR) (December 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.	• Continuing Professional Development plan agreed with Health Education England for nurses and allied health professionals.

<u>Risks within Risk Appetite</u>

695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	• Reset and recovery group in place
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.	Control updated: • Active involvement in place-based communications and engagement groups • Approach to collating and reporting insight from stakeholder's
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	• Development and implementation of interim executive leadership arrangements (July 2021) HR and OD.
1649	The current inconsistency in SALT provision could compromise the quality of care available in response to choking incident.	• Process and structure for risk assessment, an associated care plan and best practice guide for staff is being updated. **Update**: Capacity and best interest guidance is being developed (in conjunction with legal services) to support/inform the care planning process for service users with known swallowing and choking risks
1650	Inpatients areas with gardens that have access to single storey buildings present an increased risk of absconding and/or falling resulting in physical injury.	Controls updated. Actions updated with the following: • Where necessary to maintain safety, a blanket restriction will be applied in order to manage an immediate risk. This will be for the shortest time possible and within the guidance. • Each area has carried out a risk assessment to understand the potential climb risks. • Where appropriate supervised access is maintained. • Ward security checks are in place in each area and safety systems and alarms are part of this.
1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	• The current Quality Strategy is being reviewed and updated, in partnership between the integrated change team

		and the nursing, quality & professions directorate, with the co-produced review undertaken by an external quality improvement specialist, and an expected publication date of September 2022'. • This is completed as interim arrangements are all in place
1432	Risk of problems with succession planning / talent management.	• Development of BAME talent pool • Supporting BAME Fellowship Programme

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

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.	• Inpatient vaccination programme is nearing completion. Ongoing second vaccination programme. (October 2021)
1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.	• Further review to take place in November 2021
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.	• Exception reporting is via Silver Command
1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	• Restoration and recovery programme - there is a need for enhanced clinical leadership which is under review
1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.	• Timely implementation of the Covid-19 vaccination programme has occurred following national guidance. • Action plan related to the Physical Health Optimisation Strategy is regularly reviewed by the Physical Health Lead and with updates. (March 2022)
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. (Risk

		score to be reviewed once the data is received.)
1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**	• Expected date of completion changed to September 2022 awaiting national guidance on the Covid-19 public enquiry
1567	Inability to meet the competing demand of responding to current waves of the pandemic, the regulatory reporting and restoration drives.	• IPR review and triangulation providing early warning of emergent pressures and risks to delivery. • Regular review of capacity and priorities by the executive management team
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	• Link to the BAME staff equality network to increase uptake amongst BAME colleagues (August 2021) (complete) moved to control measure
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.	• Outbreak processes and procedures in place and regularly reviewed and learning implemented at pace monitored through Silver • Vaccine Booster programme commenced

<u>Covid-19 related risks within Risk Appetite</u>

1527	Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care.	• This risk was reviewed in September 2021, however, given issues with the national system it will be reviewed again by November 2021 to establish whether if the national system is effective and adequate to support the Trust needs.

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 decreased from 412 to 351 since the previous quarter, reflecting the consolidation of some workforce and Covid-19 specific risks.

A number of additional potential risks are being explored for future inclusion in the ORR. These cover the impact of the compulsory Covid-19 vaccination requirement for staff working in care homes and the impact this could have on NHS services. In addition, further

	consideration will be given to the potential compulsory requirement for all NHS frontline staff to be fully vaccinated against Covid-19. It is also recognised that there is a strategic risk in the Board Assurance Framework (BAF) relating to health inequalities. Consideration is being given to whether there needs to be a health inequalities risk added on the ORR. **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 of risks 1153, 1158, 1154, 1525, 1533, 1611 and 1613.**
Private session:	Not applicable.

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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

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

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

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

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

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

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

Trust Board 26 October 2021

New 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
1624	Service pressures mean that we are not always able to consistently accept a referral to all three of our 136 suites. This impacts upon the quality of service we can offer to someone who may have a mental health need in our local community.	Work is underway led by service line trio to review 136 access and pathways across Calderdale, Barnsley, Kirklees and Wakefield with a view to optimising resources and facilitating admissions to local areas wherever possible. Review October 2021 IHBTT have taken over the 136 suite in Barnsley as a temporary measure to alleviate current staffing issues	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	Outcome of review across all services to be completed by 30 November 2021. Temporary measures to alleviate to be monitored.	DO	31 March 2022	OMG and EMT	3 Yellow / moderate (4-6)	CGCS		December 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. • NHS Digital Care Cert advisories reviewed on a regular basis & where applicable applied to Trust infrastructure. Any critical alerts are actioned in line with NHS Digital guidance. • Key messages and communications issued to staff regarding potential cyber security risks. • Microsoft software licensing strategic roadmap in place to ensure all software is supported. • Cyber security has been incorporated into mandatory Information Governance training. The Trust achieved the compliance requirement. • Annual table-top cyber exercise scheduled with last exercise completed in January 2021. Next one scheduled for January 2022. • Windows defender advanced threat protection in place. • Strengthened password requirements in place. • IT infrastructure modernisation programme. • Data Security & Protection Toolkit compliance maintained. • Successful adoption of NHS Digital secure boundary service.	5 Catastrophic	3 Possible	15 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	• Ongoing capital programme to upgrade IT infrastructure 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 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. (Q3 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) (Q3 2021/22)	DFR	December 2022	IM&T Managers Meeting (Monthly) EMT Monthly (bi-Monthly) Audit Committee (Quarterly) IT Services Department service management meetings (Trust / Daisy) (Monthly)	5 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 2 & 3 The COVID-19 situation is presenting highly challenging circumstances which means the potential threat of cyber-attack remains potent and possibly heightened. The measures that the Trust has established remain in place and all associated activities are continuing. Whilst there is a need to ensure rapid access to digital solutions and technologies which requires a less comprehensive testing approach in the short-term, security considerations remain at the forefront so as to ensure services remain safe. Overall, from the January 2021	December 2021

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

Risk level <15 - risks outside the risk appetite

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	• Agreed joint arrangements for management and monitoring delivery of integrated teams. • Weekly risk scan by Director of Nursing & Quality and Medical Director. • BDU / commissioner forums – monitoring of performance. • Monthly review through performance monitoring governance structure via EMT of key indicators and regular review at OMG of key indicators, which would indicate if issues arose regarding delivery, such as delayed transfers of	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Involved with partners in the co-development of integrated care partnerships in each place as Trust priority programmes of work. (April 2022) (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)	DS	June 2022	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated	6 Yellow /Moder ate (4-6)	CG&CS FIP	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1, 2 & 3	Decembe 2021

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
		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.					• 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) • A target date of June 2022 has been set, however, given external influences outside our control this needs to be kept under constant review.			performanc e report) Annual review of contracts and annual plan at EMT and Trust Board				
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, and all 5 Providers 'sign off' of Partnership Agreement (incorporating 'Risk Share' arrangements) and Business case enabled 'go live' on 1 October 2021. • Individual work streams developing clinical pathway models, accounting to the Partnership Board. • Trust Board review and approval of final Business Case (which included an updated and improved financial offer from NHSE) ~~prior to~~ enabled 'go live' to be achieved on 1 October 2021. • NHS England assessment process. • Financial due diligence of NHSE financial offer and current spend ~~prior~~ to enabled 'go live' on 1 October 2021. • Internal audit report on collaborative governance and associated action plan. • Shadowing of NHSE systems and processes undertaken prior to 'go live'. • Learning from other Provider Collaboratives that have already gone live. • Memorandum of Understanding (MoU) in place with NHSE to support transition arrangements for Commissioning for a minimum of 3 months.	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Share learning from other lead providers and early implementers across the country. (DPD) • Engagement with other lead provider collaboratives across Yorkshire & Humber. (DPD) • Further financial due diligence has been undertaken following receipt of a revised NHSE financial offer. (DFR) (September 2021), and incorporated into final Business Case approved by Trust Board in September 2021. • Clinical oversight of repatriation plans for the collaborative of patients currently placed out of West Yorkshire. (DPD) • Development of appropriate financial risk and gain share with other providers in the collaborative. (DPD) Option agreed with partners, and incorporated into 'signed off' Partnership Agreement. • Development of quality assurance processes and monitoring across the Collaborative. (DPD) • Development of opportunities for financial efficiencies. (DPD) (November 2021) • Development of governance structures including commissioning (DPD) (September 2021) • Trust Board task and finish group to develop governance oversight arrangements for Trust Lead Provider functions. (DPD) • Quarterly contract meetings with sub-contracted partners to ensure oversight of any financial, quality and clinical risks • Attendance at monthly Quality Review Meetings with NHSEI to ensure oversight of quality issues, and progress against action plans • Post go live risk assessment to be carried out by 30 November 2021 and any risks identified and logged.	DPD	Novemb er 2021	EMT (monthly)	4 Yellow / moder ate (4-6)	FIP	The date of go live for the collaborative has been achieved.. Post Go live risk assessment to be carried out by 30 November 2021.	Decembe 2021
905	Risk that wards are not adequately staffed and there is	• Safer staffing project manager in place with appropriate medium and longer term	4 Major	3 Possib le	12	Minimal / low – Cauti-	• Additional funding requests with commissioners will be maintained throughout contract negotiations for 2021/22. (DO / DFR)	DO / DNQ	Septem ber 2022	EMT (monthly)	6	CG&CS	Risk appetite: Clinical risk target 1 – 6	Decembe 2021

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
	insufficient access to temporary staffing which may impact upon quality of care.	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. • 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) • Silver command now meeting twice a week and receiving reports which are then escalated to gold command as required.			Amber / high (8-12)	ous / moder-ate (1 – 6)	• 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). Update- Trust vaccination programme completed May 2021 with national offer still available for those not vaccinated. Booster vaccine programme delivered through a partnership model from October 21 and under regular review. • Monitoring the impact on staffing of emerging vaccination legislation and booster vaccinations. • Safecare tool roll out has paused due to staffing capacity. This will be reviewed in 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. • Recent escalation in concerns relating to staffing availability has resulted in additional actions to - accelerate the workforce working groups to ensure actions to address flexible options / recruitment and retention / incentivisation are in place. - Support the patient flow team to use out of area beds as appropriate in order to support the management of acuity on inpatient areas - Task the acute leadership team to review the options for the flexible use of the total bed base - Work with partners across ICS to consider how inpatient services can be promoted as an area of expertise and staff can be recognised and rewarded appropriately. (Review December 2021)				Yellow / moder ate (4-6)		Links to BAF, SO 2 & 3	

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							Silver command has commissioned a piece of work to model capacity and demand during winter 2021/22							
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. • Learning from the business continuity plans is captured and shared across CAMHS to support working differently in	4 Major	2 Unlikely	8 Amber / High risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Recruitment to vacant positions takes place in a timely way and showing successes in maintaining capacity. This includes the consideration of new roles to improve opportunities to recruit. (DO) • Calderdale CCG has led on development of a new diagnostic assessment pathway and investment in a waiting list initiative. (DO) • 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 historical waits in ADHD / ASD and new demand Work has commenced with private providers, with the aim of reaching a steady state in relation to referrals and waits by March 2023. • Changes to delivery system have been made to try to manage recent increase in demand on crisis and eating disorder pathway to help to mitigate impact of additional pressure on waiting time for core CAMHS. Recognising that waiting times are increasing, focus has also been placed on supporting the children who are waiting. This will be reviewed via the CAMHS improvement group (DO, December 2021) • The CAMHS team are reviewing clock stop measures across networks to understand how meaningful contacts are recorded in relation to waits. (DO, December 2021) • A target date of April 2022 has been however, this needs to be kept under constant review.	DO	April 2022	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.	

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		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 – Cauti-ous / moder-ate (1 – 6)	• Waiting list initiatives agreed with 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 December 2021) • The reporting of 'hidden waits' where the wait is secondary to the formally reported waiting information is available within the operational performance report but embedding this into routine monitoring has been delayed due to Covid-19. This is further complicated by the impact from waits relating to covid measures. To be reviewed by March 2022 (DO) • 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. This is reported through the reset and recovery work. • Monitoring of demand against expected demand has commenced and this will be used to inform service action plans to address waits. (Review December 2021) • A target date of April 2022 has been set however, this needs to be kept under constant review.	DO	April 2022	Performanc e reporting to OMG and EMT monthly. Assurance report to CG&CS Committee (CAMHS). Individual district performanc e reports reviewed by BDU.	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 Waiting list reporting has commenced in some areas but not all services in view	Decembe 2021
1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	• Fire Safety Advisor produces monthly / quarterly Fire Report and Operational Fire / Unwanted Fire Activation for review / action by EFM Senior Managers. • Quarterly review undertaken by Estates TAG. • Weekly risk scan are completed by the Trust's Fire Safety Advisor and any issues or concerns raised directly with the Head of Estates and Facilities and Head of Estates Operations with the Director of HR, OD and Estates been briefed and action undertaken accordingly.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Smoking group established to review the smoking policy including the trial period for the use of e-cigarettes. (MD). (deferred due to the impact of Covid-19) An update ws submitted 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 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.	CEO	March 2022	EFM (weekly and monthly) Estates TAG (quarterly) OMG (monthly)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 Note - A failure to effectively manage compliance with the Trust Fire/Smoking policies will	Decembe 2021

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		• Trust smoking policies with the use of e-cigarettes agreed for a trial period. • Compliance with the following regulations: ○ The allocation and definition of responsibilities and standards for the provision, installation, testing and planned maintenance of fire safety equipment, devices, alarm and extinguishing systems; ○ The identification of standards for the control of combustible, flammable or explosive materials; ○ The allocation of responsibilities for the implementation of fire emergency plans including evacuation procedures, first-aid firefighting, contacting the emergency services, emergency co-ordination and staff training; ○ The allocation of responsibilities and duties of staff for monitoring and auditing all fire safety management systems and procedures; ○ The development and delivery of suitable staff training in fire safety awareness; ○ Fire safety training compliance measured monthly at OMG with time constrained action plans required for non-compliant areas. ○ The development and implementation of emergency procedures to ensure early recovery from unforeseen incident involving fire in order to maximise safety, minimise problems and enable the core business structure to continue. • Use of sprinklers across all Trust buildings reviewed as part of the capital programme. • 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. • Health and Safety annual report submitted as planned to Trust Board in June 2021.					- 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) • Annual fire risk assessments to be completed by 31st March 2022 • A target date of March 2022 has been applied at which point this risk should be fully reassessed based on incidents, fore training compliance and annual fire risk assessment completion.						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.	
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 – Cauti-ous /	• 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	April 2022	Performance & monitoring via EMT,	6 Yellow /	CG&CS	Risk appetite: Clinical risk target 1 – 6	December 2021

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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. This was further reviewed in August 2021. • The Clinical Environmental Safety Group oversees ligature risk, our commitment to the recently appointed Patient Safety Specialist Roles and the Patient Safety Incident Review Framework seeks to maximise learning from serious incidents and deaths. • Clinical risk assessment / application of the FIRM risk assessment is being overseen from both a quantitative and qualitative perspective within BDU Governance Groups, overseen by the Clinical Governance Group. • The RRPI team continue to support learning with front line colleagues, and continue to benchmark our practice against other providers. COVID-19 response remains held within the Incident Command Structure • 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 in October 2021. (DNQ) • Complaints policy and metrics reviewed. Revised proposal agreed and under implementation.			OMG & TB reports e.g. quarterly Patient Safety report & incident report as well as monthly reporting in the IPR	moder ate (4-6)			

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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											
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 – Cauti-ous / moder-ate (1 – 6)	• The next phase of the seclusion review work will include a review of all suites against the standards with an estate plan to address any gaps in October 2021. OMG received a progress update in June 2021. (DO / DHR) (October 2021) • Urgent work has been completed to restore the use of the damaged seclusion rooms. However, the risk score remains the same pending the results of the review to be reported to the operational management group in October 2021 A target date of March 2022 has been set however, this needs to be kept under constant review.	DO	March 2022	EMT monthly OMG as required	4 Yellow / moder ate (1 – 6)	CG&CS		Novembe 2021

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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 planning process following issued H2 guidance. (DFR) (November 2021) • Continue discussions for use of mental health recovery funding (DFR) (October 2021)	DFR	Novemb er 2021	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	Decembe 2021
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	March 2022	Progress monitored through EMT, OMG and ICIG	4 Yellow / moder ate (4-6)	AC CGCS	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Decembe 2021

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
		• 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) (October 2021) accepted with an update on progress to be submitted to the October Meeting. • ICO external monitoring of progress by external evidence / desk based reviews							
1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	• Systematic and integrated monitoring of contract performance, changes in specification and commissioning intentions to identify and quantify contract risks. • Regular reporting of contract risks to EMT and Trust Board. • Play full role in ICSs in both West and South Yorkshire. • Equality, Involvement, Communication and Membership strategy. • Updated Trust strategy in place. • Approved commercial strategy. • Non-Executive Director led Finance, Investment & Performance Committee. • Prospectus and Board stakeholder engagement plan. • Annual contracting process. • Significant change programmes identified as priorities for the Trust that have high cost, high risks and / or high complexity. • Updates to Trust Board through business tendering opportunities.	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1	• 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) • 2021/22 H2 planning process following issued H2 guidance. (DFR) (November 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	March 2022	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 1 & 3	Decembe 2021

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
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	• Board and EMT oversight of progress made against transformation schemes. • Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP. • Active engagement on place based plans. • Enhanced management of CIP programme. • Updated integrated change management processes. • Non-Executive Director led Finance, Investment & Performance Committee. • Confirmed block income in place for H1 2021/22 and will continue into H2. • Mental health investment standard. • System-wide funding provided on a fair shares basis. • Use of national and internal benchmarking information to support productivity improvements.	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Implementation of longer term financial sustainability plan. (DFR) • Increased use of service line management information by directorates. (DFR) • Increase in joint bids and projects to develop strategic partnerships which will facilitate the transition to new models of care and sustainable services. (DS) • Assess H2 2021/22 financial arrangements and planning guidance when received. (DFR) (November 2021)	DFR	March 2022	EMT (monthly) Trust Board (quarterly)	4 Yellow /Moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Decembe 2021
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)* • Assess H2 2021/22 financial arrangements and planning guidance when received. (DFR) (November 2021)	DFR	March 2022	EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Decembe 2021
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital	• Bed management process. • Critical to Quality map to identify priority change areas. • Joint action plan with commissioners. • Internal programme board.	3 Moder ate	3 Possib le	9 Amber / high	Minimal / low – Cauti- ous / moder-	• 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)	DO	April 2022	OMG	4 Yellow /Moder	CG&CS	Risk appetite: Clinical risk target 1 – 6 Reviewed in light of the	Decembe 2021

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
	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.	• 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.			(8 – 12)	ate (1 – 6)	• 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) • Learning from the ICS experience in purchasing additional PICU capacity is informing current discussions across partners regarding the purchase of further beds to relieve pressure. (Review October 2021) • Out of area placements are currently being used to manage high levels of acuity and staffing challenges and to support the safe and effective delivery of care. The actions to maintain patient flow and minimise the impact on care remain in place. Review November 2021 (DO) • A target date of April 2022 has been set however, this needs to be kept under constant review.				ate (4-6)		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.	
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	• Bed management process. • Joint action plan with commissioners. • Internal bed management programme board. • Weekly oversight at EMT and OMG. • In-depth financial reviews at OMG, EMT and Trust Board. • Temporary contract arrangements in place for the first half of 2021/22.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Ongoing review with commissioners to prioritise areas of expenditure. (DFR) • Implementation of actions identified through independent review of our bed management processes. Remains a priority throughout the Covid-19 outbreak. (DO) • Review recommendations made by Niche regarding PICU bed management across West Yorkshire. (DO) • Assess H2 2021/22 financial arrangements and planning guidance when received. (DFR) (November 2021) • Negotiation for use of mental health recovery monies (DFR) (October 2021)	DO / DFR	March 2022	OMG monthly EMT monthly Trust Board monthly	4 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk 1 – 6 The Trust has remained involved with ICS proposals to purchase additional beds and contributed to the final recommendati on.	Decembe 2021
1368	Risk that given demand and capacity issues across West	• Bed management processes are in place as part of the new care model for Tier 4.	4 Major	3 Possib le	12	Minimal / low – Cauti-	• Leeds and York Partnership FT have established the care collaborative board to verse the development of	DO	April 2022	EMT (monthly)	4	CG&CS	Risk appetite: Clinical risk target 1 – 6	Decembe 2021

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
	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.	These include exhausting out of area provision. • All community options are explored. • Where no age appropriate bed or community option is available then a bed on an adult ward is considered as the least worst option to maintain safety. • Protocol in place for admission of children and younger people on to adult wards. • The most appropriate beds identified for temporary use. • CAMHS in-reach arrange to the ward to support care planning. • Safeguarding policies and procedures. • Safer staffing escalation processes. • Regular report to board to ensure that position does not become accepted practice. • Safeguarding team scrutiny of all under 18 admissions. • Letter sent to NHS England from Director of Nursing & Quality and Medical Director expressing concerns. • Meetings led by NHSE took place. The system is better informed of the challenges with agreement to working together to best meet the needs of children and young people. • All age liaison teams are now embedded in each place. • System-wide meetings take place to review the demand and take action to address delays in discharges of young people to release inpatient capacity.			Amber / High (8-12)	ous / moder-ate (1 – 6)	the new inpatient facility and to lead work across the system to reduce demand on inpatient care. (DO) • Development of new CAMHS inpatient facility in Leeds for West Yorkshire. (DO) (2022) • Recent increase in demand / pressure noted – potentially linked to closed T4 beds due to Covid-19 and this has been escalated to commissioners and to LYPFT for consideration through the collaboration work. (DO) (May 2021) • There is now a regional focus on the increased demand and reduced T4 inpatient capacity with data on capacity being shared by NHSEI regularly. (MD / DnN) (December 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 October 2021) • Commissioners have agreed to additional resources to support young people when they are in the secure estate waiting for a bed. These are in place where staff can be sourced (review October 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 October 2021) • Work is taking place to develop a report of children who are waiting for a bed and where they are. (DO, December 2021) September 2021 - The children who were in the secure estate have been placed. A risk summit has been arranged. Pressure on beds remains high generally across community CAMHS and will be linked to the increase in crisis and EDS referrals.			CG&CS (regular) Trust Board (each meeting through integrated performanc e report)	Yellow /Moder ate (4-6)		The Trust ensures children and young people are only admitted to an adult bed as least worst option and ensure full safeguarding is in place when the need arises. This is in line with our “safety first” approach. April 2021 – the likelihood has been increased as demand for out of area beds appears to have increased potentially as a result of closed beds due to Covid-19.	
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 Moder ate	4 Likely	12 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Updated estates strategy. (DHR) • Effective communication of Trust capital priorities to West and South Yorkshire ICS partners. • NHSI are working on a three-year settlement for capital and the Trust will have to negotiate a fair share of the capital allocation with the ICS. (Q4) • Separate opportunities to bid for national hospital funds and other digital funding are currently available. (Ongoing)	DFR	March 2022	EMT (monthly)	4 Yellow / moder ate (1 – 6)	FIP	2021/22 capital allocation to be confirmed by the ICS early April 2021.	Decembe 2021

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
1151	Risk of being unable to recruit and retain 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. • 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) • An international recruitment portal has been signed off by EMT (June 2021) • Established of work group to look at development of new clinical roles. (DNQ) (Sept 2021) •	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Proposal for On Boarding Systemto include recruitment/career Microsite. (DHR) (delayed due to Covid-19) • (this is a control section now • 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) (DNQ) • Appointment of Associated Medical Director for Workforce (AMD) • Ongoing (Annual work programme to be reviewed in March each year.	DHR	April 2022	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performanc e report)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3	Decembe 2021
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, WDES and EDS2 action plan. • Targeted career promotion in Schools. • Focus development programmes.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Introduction of internal review panel on disciplinary and grievance cases related to discrimination on the grounds of race. (DHR) (December) 2021 • Launch of Equity Guardians – (October 2021) • A target date of April 2022 has been set however, this needs to be kept under constant review.	DHR	April 2022	EMT (quarterly) EIIC Committee (quarterly)	6 Yellow / moder ate (4-6)	EIC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	January 2

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
	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. • 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. • Workforce Strategy 2021-2024 supporting SWYPFT as a Great Place to Work • Established BAME talent pool. • Establishment of a Working Carers Staff network • Civility and Respect Guardians appointed • Review of how representative our decision-making groups are. (DHR) (Sept 2021)											
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.	<u>Safety</u> • 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. <u>Recruitment</u> • 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.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	<u>Safety</u> • Implementation of SafeCare linked to e.rostering system. (DNQ)) (Sept 2021) • Development of collaborative bank across West Yorkshire MH/LD Trusts. (DHR) (March 2022) <u>Recruitment</u> • 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) (December 2021) <u>New workforce supply</u> • Development of exit questionnaires to identify and understand why staff leaving the Trust (November 2021) • A target date of April 2022 has been set however, this needs to be kept under constant review.	DHR	April 2022	EMT (monthly)	6 Yellow / moder ate (1 – 6)	WRC		Decembe 2021

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
		• Workforce plans incorporated into new business cases. • Workforce strategy implementation of action plan. • Retention plan developed. • Workforce plans linked to annual business plans. • Working in partnership across West Yorkshire on international recruitment. • On-line job fairs programme. <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) • New internal group established to look further at the development of new roles. (DHR) (September 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.	3 Moder ate	3 Possib le	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	<u>Feeling safe</u> • moved to control measure. Tackling hate crime against staff. (DHR) (November 2021) • We signed up to the West Yorkshire anti-racism campaign <u>Supportive teams</u> • Review of leadership and management pathway. (DHR) (December 2021) <u>Positive wellbeing</u> • Enhance Occupational Health Service linked to Long COVID. (DHR) (November 2021) • Physical health plans. (DHR) (November 2021) • Appointment of staff dietician. (DHR) November 2021) <u>Personal & professional development</u> • Review of training provision. (DHR) (November 2021) • CPD plan agreed with HEE for nurses and AHPs <u>Everyone's voice counts</u> • New Freedom to Speak Up Strategy and Action Plan. (DHR) (November 2021)	DHR	April 2022.	EMT (monthly)	6 Yellow / moder ate (1 – 6)	WRC		Decembe 2021

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
		• Individual wellbeing reviews. • Psychological support helpline. • BDU wellbeing groups and champions. • Annual staff wellbeing survey and action plan. • Staff vaccination programmes. Personal & professional development • Systematic learning needs analysis linked to workforce plans. • Continuous professional development fund. • Study leave policy. • Establishment of BAME talent pool. • WRES and WDES action plan and KPIs. • Appointment of WRES OD Lead. • Talent and succession plans. 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) • Roll out of equity guardians across the Trust. (DHR) (September 2021) •					• Programme of Insight events for 2021/22. (DHR) (November 2021) • Sustainability Strategy. (DHR) (December 2021) • Annual work programme to be reviewed in March each							

Organisational level risks within the risk appetite

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	• OMG, 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 Systems/ • 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.	3 Moderate	2 Unlikely	6 Yellow/ moderat (4-6)	Minimal / low – Cauti-ous / 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) • 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) • Recovery and strategic recovery group in place	DS	April 2022	EMT (monthly) Transforma tion board (monthly) OMG (weekly) Trust Board (quarterly)	6 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 3 Links to BAF, SO1 & 2	Decemb 2021
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.	3 Moderate	2 Unlikely	6 Yellow /moder ate (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) • 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	DS	April 2022	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	March 2022

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
		• 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. • Active involvement in place based communications and engagement groups • Approach to collating and reporting insight from stakeholders place					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) • 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. • Regular 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 /moderate (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 check Associate of Director of HR and OD	DS	April 2022	Bi-monthly focus by EMT on transformation. Trust Board reports as appropriate. Business cases approved by Calderdale, Kirklees and Wakefield commissioners.	6 Yellow /Moderate (4-6)	CG&CS	Risk appetite - Commercial risk target: 8- 12 Nominated committee - CG&CS Links to BAF, SO 1 & 2	January 2022
1649	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 Moderate	3 Possible	9 Amber / high (8-12)	Open / 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 practice • guide for staff is being updated Update: Capacity and best interest guidance is being developed (in conjunction with legal services) to support/inform the	DON MD	April 2022	EMT (monthly)	6 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 actions remain appropriate subject to monthly review.	Decemb 2021

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
							• care planning process for service users with known swallowing and choking risks • Blue light alert on choking risk issued 5th July 2021 • E- learning programme under development • Referral to protected mealtimes arrangements initiated							
1650	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 have anticlimb measures in each garden worked through with estates • Induction / update for staff includes access to garden areas • FIRM risk assessments identify clinical risks and safety plans • Safe and supportive observation of patients at risk policy is used to manage individual risks.	4 Moderate	3 Likely	12 Amber / high (8-12)	Open / High (8 - 12)	• Where necessary to maintain safety a blanket restriction will be applied in order to manage an immediate risk. This will be for the shortest time possible and within the guidance. • Each area has carried out a risk assessment to understand the potential climb risks. • Where appropriate supervised access is maintained. • Ward security checks are in place in each area and safety systems and alarms are part of this.		April 2022	EMT (monthly)	6 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 actions remain appropriate subject to monthly review.	Decemb 2021
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. • Annual planning process. • Leadership framework to build capability and to include change competencies. • Quality strategy approved and implementation plan established.	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) • 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 2023) • Additional capacity secured for identified programmes (March 2022) • Additional capacity aligned to the Trust to support Alliance and partnership work in Wakefield, Kirklees and Barnsley • Priorities reviewed at each phase of Covid-19 response and recovery phases including management, capacity and resource required aligned to support priorities. (DS) • The current Quality Strategy is being reviewed and updated, in partnership between ICT and NQ&P, with the co-produced review undertaken by an external QI specialist, and an expected publication date of September 2022'. • Development and implementation of interim executive leadership arrangements are complete as interim executive arrangements are all in place	DS	April 2022	Regular reports to transformation board, OMG and EMT Quality Strategy update to CG&CSC	9 Amber / high (8-12)	AC	Nominated Committee - AC Risk appetite: Strategic risk 8 – 12 Links to BAF, SO3	January

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
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) • Established Shadow Board Programme • Comprehensive management and leadership programmes • Key element of Trust Workforce Strategy. (DHR) (August 2021)	3 Moderate	2 Unlikely	6 Yellow /moderate (4-6)	Open / High (8 - 12)	• Development of BAME talent pool • Supporting BAME Fellowship Programme	DHR	April 2022	EMT monthly Trust Board quarterly	Yellow / Moderate (4-6)	WRC	Risk appetite: Commercial risk 8 – 12 Nominated committee - WRC	January

COVID-19 RISKS

Risk level 15+

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1530	Risk that Covid-19 leads to a significant increase in demand for our services (as anxiety and mental health issues increases in our populations) that cannot be met.	• Planning process. • Working as a key partner in each of the Integrated Care Systems, recovery and reset planning and learning from Covid-19 workstreams. • Members of the place-based partnerships and integrated care boards MH alliance in Wakefield, IPCG in Barnsley and ICHLB in Kirklees. • 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.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Learning from Covid-19 is being captured as it becomes available. This continues to support working in a different way in the future. (DO) • Work with partners in each place to understand emerging impact of Covid-19, need and demand. (DS / DPD) • Prioritisation of service planning based on what is known of impact. (DO) • 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.	DO	April 2022	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS	Risk score reviewed and remains the same. The risk is being reviewed on an regular basis to ensure that actions remain appropriate subject to monthly review.	Decemb 2021

							(DS) position remains under review with further stocktake in August • Additional temporary staffing resources approved to respond to increased acuity, activity and environmental considerations							

Risk level <15 - risks outside the risk appetite

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	• Policies and procedures revised to take account of Covid-19. • Publication of guidance on the intranet. • Regular communication to all staff. • Application of social distancing guidance. • Provision of appropriate personal protective equipment in line with national guidance. • Bronze, silver and gold command incident processes established. • Self-isolation guidance. • Process for testing all staff established: symptomatic, asymptomatic and antibody. • Covid-19 pathway including cohorting protocol developed and implemented. • Enhanced IPC team offer to services as part of Covid-19 response. • Agreed pathway with acute providers to access clinically appropriate support for Covid-19. • Additional training and support plan for staff to respond to needs of suspected and positive Covid-19 patients. • Development of step-up and step-down guidance in partnership with acute trust colleagues. • Face masks available across the Trust for staff in line with government guidance. • 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	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (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) (October 2021) • The scoring of this risk is subject to continual review against the status of the pandemic.	DNQ	April 2022	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Decemb 2021

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
		• 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 – Cauti-ous / moder-ate (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 November 2021 in line with national and local demand	DO	April 2022	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS	Risk score reviewed. Likelihood reduced, current pressures exist but not as a result of focus on Covid-19.	Decemb 2021
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.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Routine review of IPC guidance and horizon scanning. (DNQ) • Exception reporting is via Silver Command	DNQ	April 2022	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Decemb 2021

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
		• PPE supply and demand monitored through IPR.												
1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	• Business continuity plans. • Performance management processes including monthly reporting on quality metrics to the Trust Board via IPR • Risk panel review process. • There is clear escalation structure through bronze / silver / gold meetings in place. Silver reviews all changes in care models. • Use of local clinical expertise in development of models. • Log of all changes made during the outbreak. • QIA process for clinical pathway changes. • EIA rapid decision-making framework • Summary log of legal risks reviewed by MHAC. • An interim CEAG has been established to provide urgent ethical advice to clinical teams and provides a governance framework reporting into CG&CS Committee. • New guidance for staff on decision making regarding face to face or virtual visits has been issued. • The Equality, Involvement, Communication and Membership strategy is now approved and embeds the people plan and phase 3 requirements. Supporting action plans from the strategy have been approved by E&I Committee.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• An enhanced patient safety risk stratification tool is being developed. • Survey of patient experience who have had involvement with MHA. (MD) • 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) • National guidance on integrating learning from Covid-19 pandemic to be reviewed on receipt. (DS) • Restoration and recovery programme – need for enhanced clinical leadership under review. (DNQ / DO / MD)	MD / DNQ	April 2022	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Decemb 2021
1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.	• 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.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Timely implementation of the Covid-19 vaccination programme has occurred following national guidance . (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)	DNQ	April 2022	EMT (monthly)	4 Yellow / moderate (4-6)	EIC		

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		• 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. ○ Equality Impact Assessment (EIA) quick decision tool and action log. ○ Trust wide Covid-19 EIA and process to embed at service level in place. ○ Improvements being made in data quality and data collection in line with national guidance.					• Quality improvement initiatives to continually improve recording and insight. (DNQ) (ongoing review through OMG / ICIG) • Action plan related to the Physical Health Optimisation Strategy is regularly reviewed by the Physical Health Lead and with updates. (MD) (review March 2022 • Easy read versions of new information being developed. • Staff training plan to be initiated on use of translation and interpretation services. • PPE guidance managing communication with those who use non-verbal communication. carers assessments reviewed in context of Covid-19 support. • Additional guidance from community based learning disability teams to families and carers. • Learning disability VIP cards reviewed.							
1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	• New ways of working introduced to enhance clinical contact. • Routine caseload risk scan by responsible clinician and local trio. • Complaint and concern monitoring. • 24 hour helpline available for service users and general public. • Revised guidance issued to clinicians to support appropriate clinical review. • CAMHS “we are still here” campaign. • Enhanced activity data reporting into IPR highlighting themes and trends. • ICS system wide working to improve awareness of secondary services being open for routine referral. • Equality, Involvement, Communication and Membership Strategy approved by Trust Board.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cautious / moderate (1 – 6)	• Risk to be considered as part of recovery and restoration programme. (DO) • Review of new benchmarking data. (DO) • Review impact of vaccination programme upon demand through data group as part of restoration and recovery programme. (DS) • Review recent increase of referral data to understand to what extent this risk has been mitigated. (Risk score to be reviewed once the data is received.) (DO)	DNQ / MD	April 2022	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Decemb 2021
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.	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.	DFR	Septem ber 2022	EMT (monthly)	6 Yellow / moderate (4-6)	AC	Covid-19 Act has been extended to 30 September 2021 Awaiting public enquiry	January

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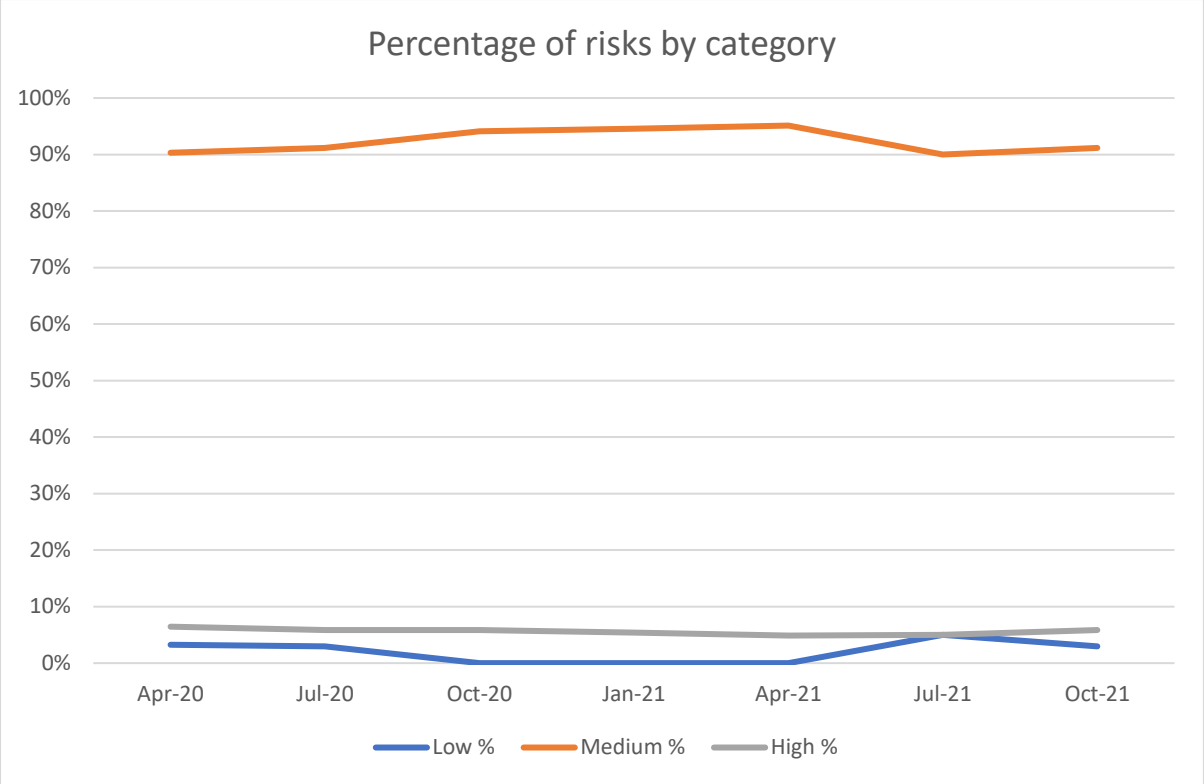
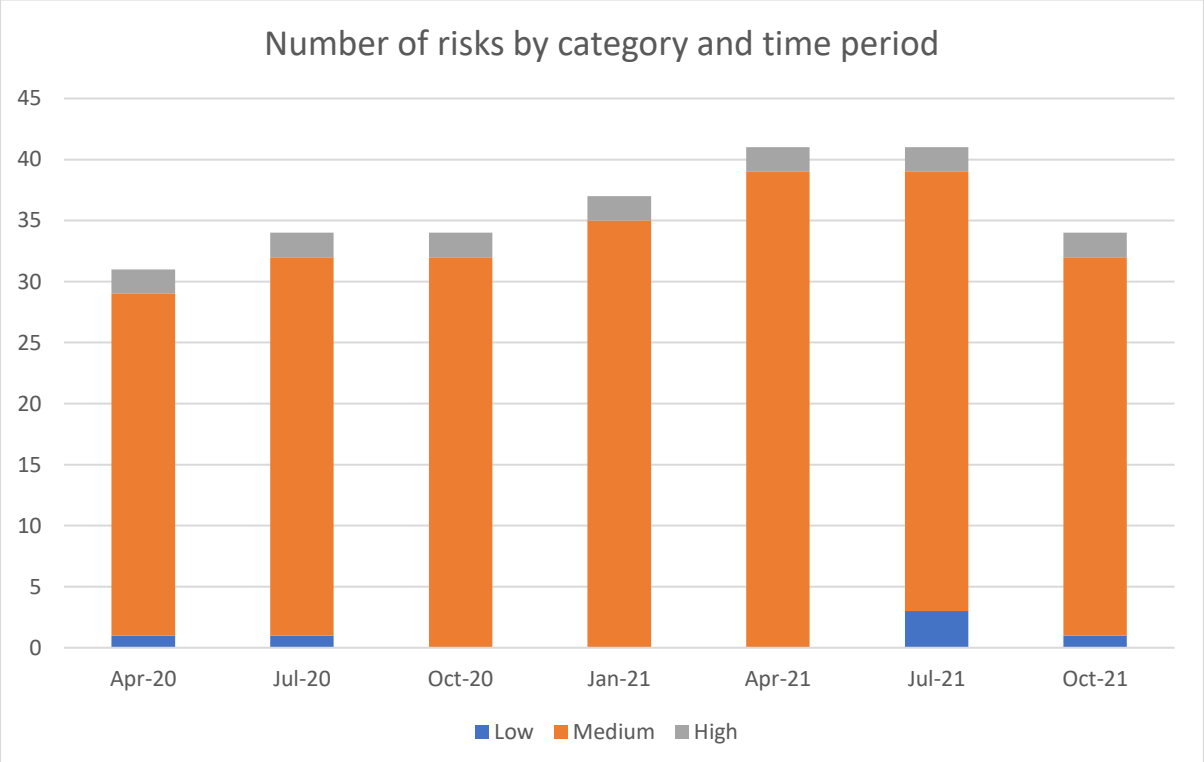
		• Committee structure. • Trust understanding of Equality law – training / EIA process and governance. • Adoption of accessible information standard to support information and communication. • NHS Constitution embedded in Trust strategies, policies and procedures. • Information and communication in accessible 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.					• 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)) • Regular consideration of staff wellbeing offers. (DHR)						guidance expected by December 2021	
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 Moder ate	3 Possibl e	9 Amber / high (8 – 12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Escalation arrangements established. • Routine contact with key regulators to brief on current status and impact. • Recovery and restoration work subject to routine review through performance EMT. (monthly review) • IPR review and triangulation providing early warning of emergent pressures and risks to delivery. (monthly review)	CEO	April 2022	EMT Trust Board	4 Yellow / moder ate (1 – 6	FIP		Decemb 2021
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 5 days a week. • Support arrangements for shielded staff introduced. • Health and wellbeing support centre as part of the Workforce Support Hub. • HR advice line operating 5 days a week. • Self help guide for manager on their own and teams wellbeing and resilience. • Managers and team leaders coaching to support wellbeing and resilience. • Healthy teams self-help guidance. • Team coaching to support wellbeing and resilience. • Staff counselling availability. • Link to the national health and wellbeing offer. • Staff and BAME staff review meeting.	3 Moder ate	3 Possibl e	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Follow up on undertaking second vaccine to be completed by August 2021 (move to controls) • Trust wide Weekly Covid 19 Communications brief with key messages for all staff Booster programme commenced with engagement plan	DHR	April 2022	Command structure of Gold, Silver, Bronze (daily) Trust Board through IPR (monthly) Safer staffing reports (monthly) WRC (as appropriate)	8 Amber / high (8-12)	EIC	It has been agreed to ensure that workforce information is provided to the Trust Board and that the WRC will meet on an exception basis as directed by the Board. Further reductions may require revision on the Business Continuity Plans.	Decemb 2021

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
		• 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) • Link to the BAME staff equality network to increase uptake amongst BAME colleagues (August 2021)											
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 • Updating risk assessment including the impact of the vaccine. (DHR) (September 2021)	3 Moder ate	2	6 Amber / high (8 – 12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Targeted communication and engagement with staff network groups. (DNQ) • Outbreak processes and procedures in place and regularly reviewed and learning implemented at pace monitored through Silver • Vaccine Booster programme commenced	DHR	April 2022	EMT (monthly)	2 Green / low (1 – 6)	CG&C S OR EIC		Decembe 2021

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 was reviewed in September 2021, however, given issues with the national system it will be reviewed again by November 2021 to establish whether if the national system is effective and adequate to support the Trust needs.	DNQ	April 2022	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS	Risk score currently being re-considered given the new national testing regime in place	Decemb 2021


Percentage of risks by category
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Low %
Medium %
High %


Number of risks by category and time period
45
40
35
30
25
20
15
10
5
0
Apr-20
Jul-20
Oct-20
Jan-21
Apr-21
Jul-21
Oct-21
Low
Medium
High

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 8.3

Title:	**Review of the Risk Appetite Statement**
Paper prepared by:	Interim Director of Finance and Resources
Purpose:	To review the risk appetite statement which outlines the level of risk Trust Board is prepared to tolerate.
Mission/values:	Supports the Trust in delivering safe, effective and efficient services which underpins the Trust's mission of helping people reach their potential and live well in their community. Supporting delivery of a key value around improvement and the aim to be outstanding as a Trust.
Any background papers/ previously considered by:	Risk Management Strategy (including Risk Appetite Statement) approved by Trust Board in April 2019 (for review in April 2022). Corporate/Organisational Risk Register received quarterly by Trust Board. Risk Appetite discussion with Non-Executive Directors on 14th September 2021, feedback incorporated into updated draft which was presented to the Executive Management Team 7 October 2021. Recirculated to Trust Board members for final comment on the 14th October 2021.
Executive summary:	**Background** The Trust aims to provide high quality, safe services which help people reach their potential and live well in their community. Trust Board acknowledges that the services provided by the Trust cannot be without risk and it ensures that, as far as is possible, this risk is minimised. The Trust does not seek to take unnecessary risks and determines its approach and its appetite for risk to suit the circumstances at the time. Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy. The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. Under the Risk Management Strategy, the Trust should review its risk appetite at least annually. **Review** The Trust first introduced its Risk Appetite Statement in 2016. This was followed by a planned review and recommended amendments in April 2018.

	The next planned review of the risk appetite statement was discussed at the Strategic Board in May 2020, however due to the impact of the Covid-19 pandemic it was agreed to defer the formal review until October 2021. This review has now taken place and the attached paper provides an updated Risk Appetite Statement for approval which continues to be aligned to the *'Good Governance Institute risk appetite for NHS Organisations'* matrix, updated May 2020. In summary the recommended material changes following consultation are: • Amendment of the heading "Commercial" to "Business" to better reflect the risk to the Trust and amendment to the description as follows: o Reputational risk, negative impact on perceptions of service users, staff, commissioners and the public. o Workforce risk, inability to attract and retain appropriately qualified staff to deliver Trust plans. o Environmental risk, not having appropriate estate and facilities to deliver high quality, modern safe services o Missed opportunities, the Trust fails to identify opportunities for growth impacting on business sustainability and development. • The inclusion of the following statement "When considering risk appetite and areas of risk the Trust will take into consideration any potential impact on inequalities, maintaining a low threshold in this regard". • None of the risk appetite thresholds have changed as result of this this review. **Risk appetite** The Risk Appetite Statement sets out Trust Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds and supports delivery of the Trust's Risk Management Strategy. Where risks cannot be managed within the risk appetite of the Trust, they are subject to scrutiny by the relevant sub-committee as identified within the committee Terms of Reference.
Recommendation:	**Trust Board is asked to REVIEW and APPROVE the update to the Trust's Risk Appetite Statement.**
Private session:	Not applicable.

10.3 Appendix 3 – Risk appetite statement

Risk Appetite, definition, and purpose
Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives. It goes to the heart of how an organisation does business and how it wishes to be perceived by its key stakeholders. The amount of risk an organisation is willing to accept will depend on the business it is in, its systems and policies and the internal and external environment it is facing.

A risk appetite enables Trust Board to formally communicate to the organisation the level and type of risks it is willing to accept to achieve the Trust's mission, strategic objectives and organisational priorities. It will assist decision-makers in understanding the degree of risk to which they are permitted to expose the Trust whilst encouraging enterprise and innovation. The Public Accounts Committee (PAC) supports well managed risk-taking recognising that innovation and opportunities to improve public services often requires risk taking providing the organisation has the ability, skills, knowledge, and training to manage those risks well. The statement of risk appetite is by its nature dynamic and its drafting will be an iterative process that reflects the challenging environment facing the Trust and the wider NHS. The Trust will review its risk appetite at least annually as part of the review of its Risk Management Strategy.

Process
It is recognised that the Trust may have limited influence on external factors that can impact on the Trust's ability to manage a risk down to the risk target. The risk target is just that: a target the Trust is trying to manage down to; however, on occasions the Trust may have to revise that target to the least worst option. The Executive Management Team, through its monthly review of the organisational and directorates risk registers, will consider if there is a likelihood of a risk not being managed down to the right level. A risk exception report will go to the relevant sub-committee or forum of Trust Board (as set out in their Terms of Reference) setting out the actions being taken and the consequences of managing the risk to a higher risk appetite level. Through EMT, a scan across Directorate registers of both risks scoring below 15 and above 15 (before mitigation) will allow any themes / hot spots to be identified, mitigating actions agreed and referral to the appropriate sub-committee / forum of the Board as applicable.

Trust Board will review its activities at the quarterly Business and Risk meeting, ensuring any risks, emerging risks, changes in activities or key risk indicators are reviewed in accordance with the risk appetite of Trust Board. This may involve taking considered risks into account where the long-term benefits outweigh any short-term losses. The impact of these risks will be reflected through the Board Assurance Framework.

The Trust's Risk Management Strategy sets out the Trust's risk scoring approach, which is based on the likelihood of an event happening multiplied by the consequence of the action. When considering risk appetite and areas of risk the Trust will take into consideration any potential impact on inequalities, maintaining a low threshold in this regard.

Risk appetite target scores
We have reviewed and defined our risk appetite in line with the *'Good Governance Institute risk appetite for NHS Organisations'* update published in May 2020 matrix aligned to the Trust's own risk assessment matrix as shown in the table below.

Note: The target score is that after the risk has been mitigated through relevant action plans.

Good Governance Institute matrix	Risk appetite Level	Risk target score (range)
None: Avoidance of risk and uncertainty is a key organisational objective	**None**	**Nil**
Minimal: (ALARP: As low as reasonably possible) Preference for ultra-safe delivery options with low inherent risk and only for limited reward potential	**Low**	**1-3**
Cautious: Preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward.	**Moderate**	**4-6**
Open: Willing to consider all potential delivery options and choose, whilst also providing an acceptable level of reward (and VFM)	**High**	**8-12**
Seek: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)	**Extreme**	**15-20**
Mature: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.	**Extreme**	**25**

Application

Within our Risk Management Strategy, we have defined the following four broad areas of risk which have been used to frame the Trust's risk appetite statement. *Note: The risk appetite and risk targets noted are indicative and for discussion at Trust Board.*

Clinical risks: Risks arising as a result of clinical practice or those risks created or exacerbated by the environment, such as cleanliness or ligature risks.	**Risk appetite Minimal/low-Cautious/moderate**	**Risk target 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.		

Business risks: 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.	**Risk appetite Open/high**	**Risk target 8-12**
• Reputational risk, negative impact on perceptions of service users, staff, commissioners and the public. • Workforce risk, inability to attract and retain appropriately qualified staff to deliver Trust plans. • Environmental risk, not having appropriate Estate and Facilities to deliver high quality, modern safe services • Missed opportunities, the Trust fails to identify opportunities for growth impacting on business sustainability and development.		

Compliance risks: Failure to comply with its licence, CQC registration standards, or failure to meet statutory duties, such as compliance with health and safety legislation.	**Risk appetite Minimal/low-Cautious/moderate**	**Risk target 1-6**
• 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 risks: Risks which might affect the sustainability of the Trust or its ability to achieve its plans, such as loss of income.	**Risk appetite Minimal/low-Cautious/moderate**	**Risk target 1-6**
• 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.		

Strategic risks: 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 Open/High**	**Risk target 8-12**
• 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.		

Reviewed and approved by Trust Board:

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item

Title:	**Sustainability Annual Report and Action Plan**
Paper prepared by:	Associate Director of Estates & Facilities
Purpose:	This paper updates the Board on the progress in year on the sustainability agenda including progress on the Green Plan which has previously been approved by the Trust Board
Mission/values:	Sustainability is a mechanism for the Trust to take a coordinated, strategic and action-orientated approach to being a good corporate citizen with strong social values.
Any background papers/ previously considered by:	Green Plan 2021 and environmental reporting within the Annual Report. Annual report on sustainability provided to Trust Board
Executive summary:	This paper is designed to provide the Board with an update on the progress the Trust has made in year regarding sustainability, focusing on carbon reduction Originally it was planned that the Trust would develop and agree a Sustainable Development Management Plan for 2020-2025 in line with national requirements. This remains a key goal and this year progress has been made on the Green Plan part of that agenda with the following key achievements:- • The adoption of a Board approved Green Plan which will provide focus as the Trust moves to its target of net carbon zero along with the rest of the NHS • The purchasing of green electricity which can be tracked to its generating source • The continued rollout of LED lighting • Investment in high efficiency boilers to heat our premises and hot water • An increase in solar generated electricity on Trust sites • The beginning of our rollout of EV (electric vehicle) charging points • The first electric vehicle in our Trust fleet Year on year our carbon footprint reduced again, although the impact of Covid-19 on travel in particular may not be repeated to the same extent in 2021/22. An increase in gas consumption is being investigated.

	The Trust remains fully committed to the development of its sustainability agenda into the wider areas of • cultural change • new ways of working • social responsibility • behavioural change • placing the Trust where it can be most effective in the wider sustainability of the areas where we operate It is recognised that this is a comprehensive change management programme and further support will be required to take this forward within the Trust. **Risk Appetite** The adoption of a sustainability strategy is in line with the risk strategy adopted by the Trust and its ambition in regard to the sustainability agenda.
Recommendation:	**The Trust Board is asked to NOTE and COMMENT on the content of the update.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD

26 October 2021

SUSTAINABILITY ANNUAL REPORT and ACTION PLAN

INTRODUCTION

As an NHS organisation which spends public funds, the Trust has an obligation to work in a way that has a positive effect on the communities we serve. Sustainability includes spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the best use of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources; demonstrating that we consider social and environmental impacts, and ensuring that the legal requirements in the Public Services (Social Value) Act (2012) are met. We recognise that sustainable development is a critical factor in being able to deliver outstanding physical, mental and social care in a modern healthcare system, both now and in the future. We are therefore dedicated to ensuring we create and embed sustainability and resource efficiency throughout our operations and to ensuring our operations and our estate are as efficient, sustainable and resilient as they possibly can be.

To deliver this vision we need to achieve the threefold sustainability objectives of:

- reducing our environmental impact
- reducing costs
- increasing social value

These are not stand-alone objectives and by balancing the 3 objectives the Trust can have a positive benefit on the environment, our local communities and ourfinances.

We continue to focus on the impact we have on the environment through our activities and notable achievements in year are as follows:

- the adoption of a Board approved Green Plan which will provide focus as the Trust moves to its target of net carbon zero along with the rest of the NHS
- the purchasing of green electricity which can be tracked to its generating source
- the continued rollout of LED lighting
- investment in high efficiency boilers to heat our premises and hot water
- an increase on solar generated electricity on Trust sites
- the beginning of our rollout of EV (electric vehicle) charging points
- the first electric vehicle in our Trust fleet

CURRENT PERFORMANCE

The Trust has substantially reduced its carbon footprint over the years and continues to do so as can be seen below.

Trust Carbon Footprint 2020-21

The Trust's carbon footprint represents the amount of carbon dioxide released into the atmosphere which is a direct result of the activities involved in providing our services. It is the reporting standard for organisations, households, and individuals in calculating their contribution to climate change. In 2020/21 the Trust continued its journey towards achieving net zero carbon emissions by recording the 6th consecutive reduction in its carbon footprint (Fig. 1).

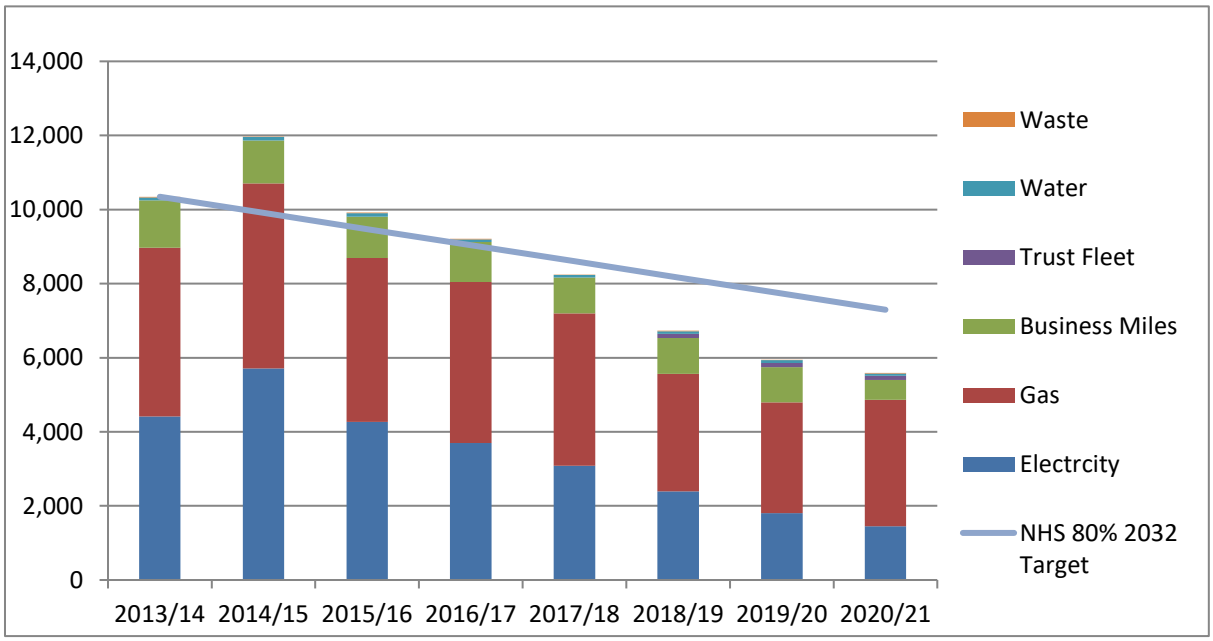


Figure 1. SWYFT Carbon Footprint tonnes CO_2e

The NHS has set a target to for all trusts to be net zero by 2040 and to have reduced its emissions from its baseline by 80% between 2028 and 2032. The Trust has a baseline of 2013 when it combined with the former Barnsley PCT and, since then it has reduced emissions by 46%.

Over 87% of the Trust's carbon footprint is generated from our use of gas and electricity within our estate with staff travel (business miles) being the next largest contributor with 10% (Fig. 2).

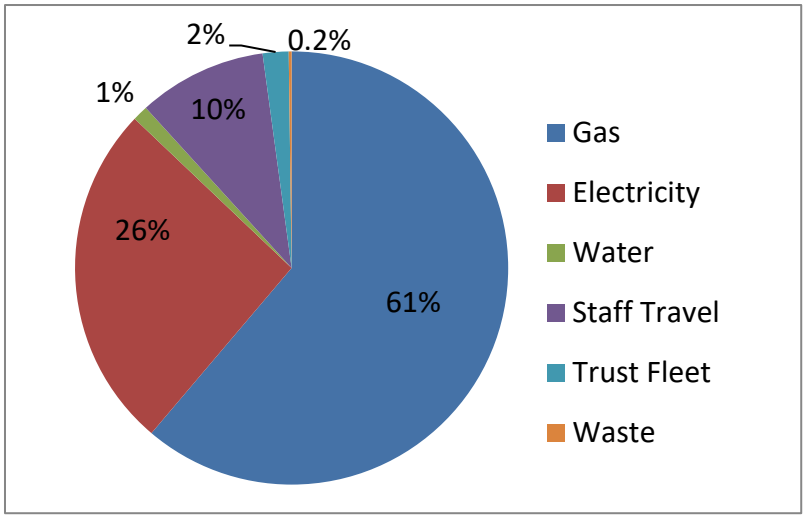


Figure 2. SWYFT Carbon Footprint 2020/21 tonnes CO_2e as %

In order to operate, the Trust needs to consume energy and many of our clinicians need to travel to undertake their work. The challenge going forward is to do this responsibly, more efficiently and by eliminating waste. Figures 3 to 5 separate the 3 main contributors to the Trust's carbon footprint and shows their individual trend since the baseline in terms of emissions but also actual consumption.

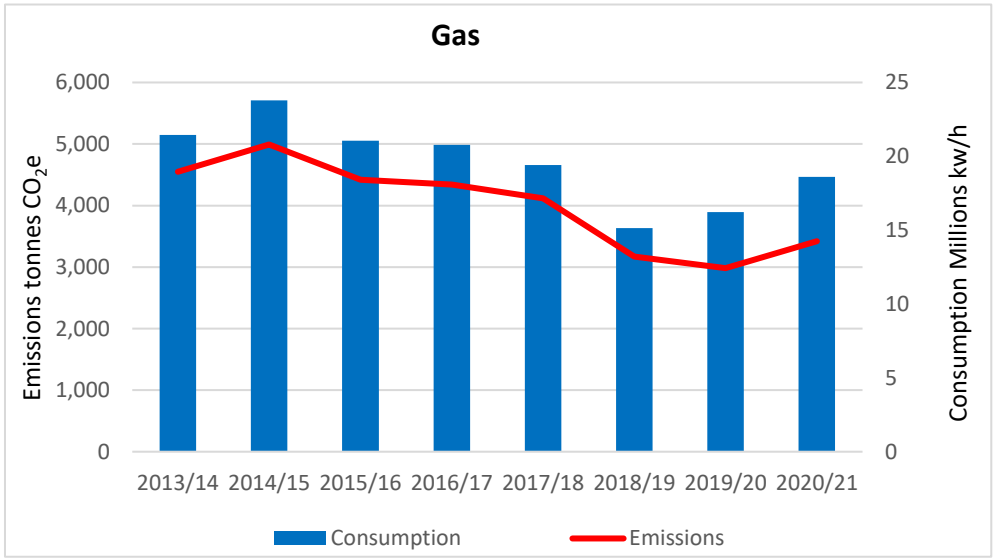


Figure 3. Gas Consumption & Emission Trend

Gas is the largest contributor to the Trust's carbon footprint, accounting for 61% in 2020/21 (Fig.2). This has increased significantly since 2013/14 when gas and electricity contributed a similar amount (44% & 43% respectively). This is largely a result of the increasing level of renewable electricity within the grid lowering emissions (as seen in Fig. 4), whilst gas production has seen some efficiencies in terms of emissions it is at a much-reduced scale.

The trend for both consumption and emissions for gas is of concern as we are seeing an increase despite reductions since the 2013 baseline of 13% and 25% respectively. The largest increase in consumption has occurred at Fieldhead Hospital with a 20% rise from 2019/20 to 2020/21. However, we have also identified upon analysis omissions in the annual ERIC returns where we have not been provided with accurate information from our suppliers and/or partner organisations where we occupy their accommodation to deliver services. If these omissions are adjusted for, we would see an increase in consumption (and emissions) and less dramatic fluctuations but, it would be unlikely to show a decrease. Going forward we will investigate the reasons behind the Fieldhead increase and seek timely and accurate information from partners and suppliers.

Since April 2021, all directly procured electricity has come from renewable sources and, more particularly, is generated from Yorkshire windfarms. This switch will help the Trust further reduce its emissions from electricity as illustrated in figure 4. Since the baseline, emissions related to electricity have reduced by 67% whilst consumption is 28% lower.

Initiatives to make efficiencies in the Trust's electrical consumption is much easier than that for gas. The Trust has introduced LED lighting in a large number of buildings, combined with sensor controls which turn off lights when the room is not in use. Further, each generation of electrical equipment is more efficient than the previous be that PCs, laptops or multi-functional devices.

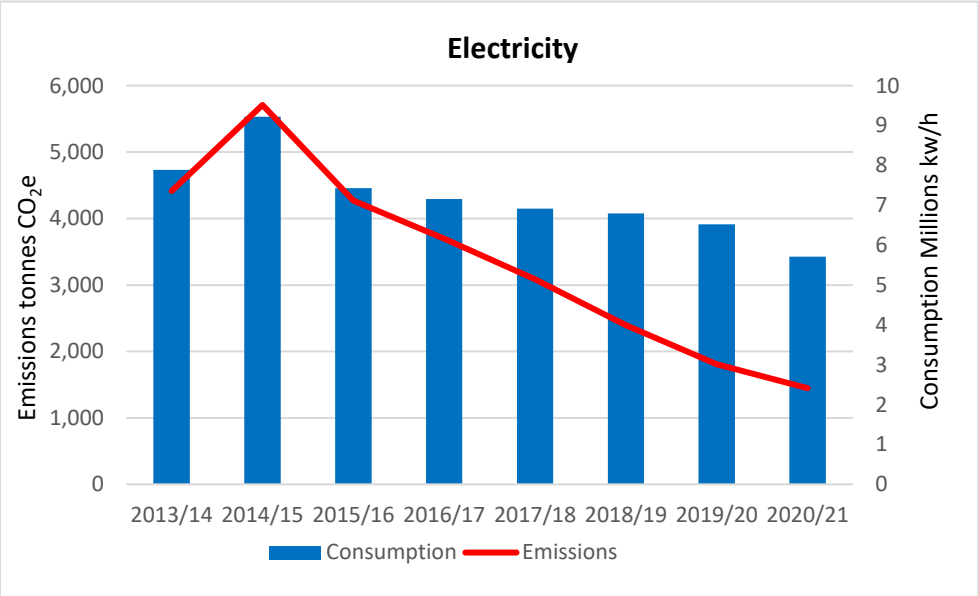


Figure 4. Electricity Consumption & Emission Trend

It needs to be acknowledged that the 2020/21 data is for a period when staff workstyles and activity were significantly different to the previous year's, due to Covid. A year on year decrease of 12% from 2019/20 is perhaps surprising, however none of the Trust's buildings closed during this period and business carried on.

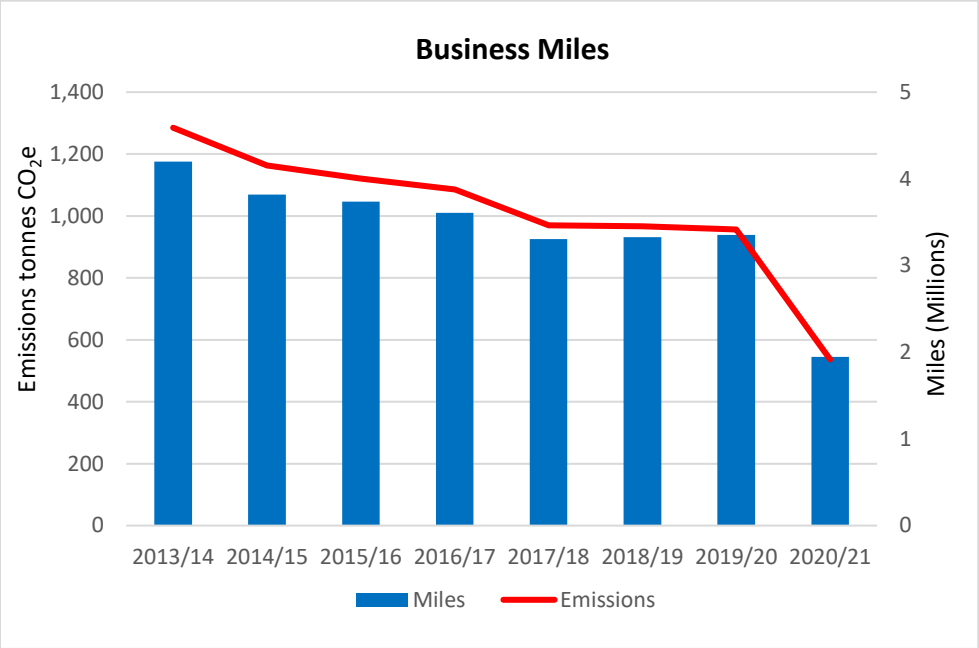


Figure 5. Business Miles & Emission Trend

Business miles reduced by 42% between 2019/20 and 2020/21 with a 44% reduction in emissions during the same period. This reversed a trend of 1% year on year increase since 2017/18 however undoubtedly the scale of reduction is Covid related. Whilst future years may see an increase on the current figures there should not be a return to previous levels as staff continue with different workstyles and the use of technology.

NEXT STEPS

The Trust has recognised that in order to meet its ambitions in the field of sustainability, the advice of specialists will be needed to support the development of a comprehensive sustainability strategy. This was achieved with the Green Plan and now a clear plan for the journey to carbon reduction is in place, which is being managed through a newly established green group which will make recommendations into the Estates Trust Action Group (TAG). It should be recognised that decarbonising the gas heating infrastructure is the greatest challenge we have yet to meet as a Trust and indeed as a wider goal for society.

Following on from this successful engagement we need to seek help in becoming sustainable in the wider sense of the definition outlined earlier and we are in the early stages of seeing what support we need to achieve:

- cultural change
- new ways of working
- social responsibility
- behavioural change

- placing the Trust where it can be most effective in the wider sustainability of the areas where we operate

The key to the overarching sustainability strategy will be to have wide engagement in its development, be co-produced and have collective ownership of the goals that we set.

To achieve this, we will need to lead with cultural change to move from sustainability being about purely reducing environmental impact to the wider definition of sustainability. This will be managed in future as a change programme across the organisation.

RECOMMENDATION

Trust Board is recommended to:

1. Note and comment on the content of this report

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 8.5

Title:	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) 2021**
Paper prepared by:	Interim Director of Human Resources and Organisational Development
Purpose:	WRES and WDES summary reports and action plans require Trust Board sign off prior to submission and publication.
Mission/values:	The Trust serves a diverse population across a large geographical area and it is important we strive for a workforce that reflects the local population. A diverse workforce is vital to enable all parts of the communities served by the Trust to reach their potential. Equality and Diversity and Inclusion is core to the Trust's values and is an important part of its service and is central to the Workforce Strategy and objectives.
Any background papers/ previously considered by:	The WRES workforce 4-point action plan and WDES action plan were considered and agreed at the Workforce Remuneration Committee on 21 September 2021 and at the Equality, Inclusion and Involvement Committee on 30 September 2021.
Executive summary:	The Trust recognises the importance in delivering culturally sensitive services that meet the needs of the communities we serve and a diverse workforce is critical to achieving this aim. Also supporting reducing health inequalities. The WRES, which is a requirement for NHS Trusts and has been included in the NHS standard contracts since 2015, has now been joined by the WDES and together they will provide a framework which will support the embedding of workforce equality. The WDES enables NHS organisations to compare experiences of disabled/non-disabled staff. Like the WRES, it is mandated in the NHS standard contract. The main purpose of the WRES and the WDES is to help local and national NHS organisations to review their workforce data against the metrics. This review should then enable organisations to produce action plans to close any gaps and improve the experience between White and Black and Ethnic minority (BAME) staff and disabled and non-disabled staff as valued members of the workforce, particularly in light of the current pandemic. **WRES 2021** Whilst the results of the Trust's staff survey suggest overall BAME staff are more positive overall in terms of their workplace experience there are significant areas of concern:

	• Bullying and Harassment of BAME staff, particularly from Service Users and Carers. • Likely to experience discrimination. • Appointment from being shortlisted of BAME applicants compared to white applicants. • Career development of BAME staff. The key actions and focus for 2021/2022 building on last year's actions in terms of WRES are: • Review and redesign of the Trust's Recruitment and Selection process: to ensure that any barriers which prevent a diverse workforce are removed. • Embedding and developing a framework to support the Equity Guardians: to reduce bullying and harassment from service users and carers. • Continue to develop the BAME Talent Pool as part of the Trust's Talent and Succession Strategy: to actively support career development of BAME staff. • Roll-out of the Great Place to Work Leadership Programme for Line Managers. **WDES 2021** The Trust's staff survey suggests that staff with a disability are less positive about their experience in the workplace than non-disabled staff with particular areas of concern: • Career Progression. • Bullying and Harassment in the workplace. • Support in the workplace to manage their disability. A comprehensive action plan for 2021/2022 has been developed to support improvements fully detailed in the WDES action plan 2021/2022. This includes: • Supporting and developing the Disability Staff network. • Review of recruitment practices with a focus on inclusive adverts, training for appointing managers. • Launch of new Disability and Reasonable adjustments Policy. • Support networks and promotion of Civility and Respect Champions. • Reciprocal mentoring programme. • Joint HR and Staff Side Bullying and Harassment Taskforce to reduce incidences and improve support.

	WRES: • WRES Summary Final Report 2021 (Appendix 1) • WRES Action Plan & Update 2021(Appendix 2) • WRES Data (Appendix 3) **WDES**: • WDES Summary Report (Appendix 4) • WDES Action Plan (Appendix 5) **Risk appetite:** This is consistent with the Trust's risk register and reflects the current risk appetite.
Recommendation:	**The Board is asked to APPROVE the WRES and WDES summary reports and action plans.**
Private session:	No applicable

Workforce Race Equality Standard
REPORTING TEMPLATE
Template for completion

Name of provider organisation	**Date of report; month/year**	
South West Yorkshire Partnership NHS Foundation Trust	Month: August	Year: 2021
Name and title of Board Lead for the Workforce Race Equality Standard		
Lyndsay Jensen, Interim Director of human resources and organisational development		
Name and contact details of lead manager compiling this report		
Claire Hartland, HR business manager, claire.hartland@swyt.nhs.uk 07881 008185		
Names of commissioners this report has been sent to		
Wakefield CCG, Barnsley CCG, North Kirklees CCG, Greater Huddersfield CCG, Calderdale CCG., NHS North of England SCT		
Names and contact details of co-ordinating commissioner this report has been sent to		
Amanda Capper | Head of Contracts | NHS Barnsley Clinical Commissioning Group | Amanda.capper@nhs.net Michael Bennett | Senior Contract Manager | NHS Calderdale & NHS Greater Huddersfield CCG | michael.bennett2@greaterhuddersfieldccg.nhs.uk Claire Riding | Head of Mental Health | NHS England, North of England Specialised Commissioning Team (Yorkshire & Humber Hub) | claire.riding@nhs.net		
Unique URL link on which this report will be found at: Workforce equality information | South West Yorkshire Partnership NHS Foundation Trust		
This report has been signed off by Alan Davis, Director of human resources, organisational development and estates on behalf of the Board on 25.8.21		

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data
No issues

b. Any matters relating to reliability of comparisons with previous years
No issues

2. Total numbers of staff

a. Employed within this organisation at the date of the report
There were 4597 staff employed by South West Yorkshire Partnership NHS FT as at 31st March 2021

b. Proportion of BME staff employed within this organisation at the date of the report
10.8% BME staff in the workforce as at 31st March 2021

3. Self reporting

a. The proportion of total staff who have self-reported their ethnicity
100% of staff have self-reported their ethnicity

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
The Trust uses ESR employee self-service which staff have been encouraged to use to self-report and check their own data. The reporting level is now at 100%. Data quality improved due to the Covid risk assessment, as 8 staff came forward to declare their ethnicity.

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity
Self-reporting is currently at 100% but we plan to ask staff to check their personal data stored on ESR on an annual basis

4. Workforce data

a. What period does the organisation's workforce data refer to?
Years ending 2020/21 compared to 2019/20

5. Workforce Race Equality Indicators

Please note that only high level summary points should be provided in the text boxes below – the detail should be contained in accompanying WRES action plans

	Indicator	**Data for reporting year**	**Data for previous year**	**Summary points**
	For each of these four workforce indicators, the Standard compares the metrics for White & BME staff.			
1	Percentage of staff in each for the AfC bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Percentage of staff in each of the AfC bands 1-9- or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	Please see Appendix 1	Please see Appendix 1	The number of BAME staff in the workforce has increased by headcount of 72, this equates to 1.6%. The total percentage BAME staff in workforce now 10.8%. (Total workforce 4597 at 31.3.21)
2.	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts	1.16	1.55	The data shows that BME applicants are less likely to be appointed from shortlisting than white applicants.
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	0.79	0.59	The average figure required by the Indicator shows that BME staff are less likely to enter a formal disciplinary process than White staff.
4	Relative likelihood of White staff accessing non-mandatory training and CPD as compared to BME staff	0.77	0.56	The data show that BME staff are more likely to access non-mandatory training and CPD than White staff. The data includes medical staff.

	Indicator	Data for reporting year		Data for previous year		Summary points
	For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff					
5.	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	26.20	White	27.60	The 2020 staff survey was sent to all staff in the Trust. The response rate was good (1864 responded) at 43%, however, this is 2% lower than the previous year 2020 staff survey indicates that the BME staff who responded indicated they were more likely to experience harassment and bullying from service users and carers than white staff. This position has improved since last year.
		BME	39.90	BME	42.40	
6.	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	17.60	White	19.90	2020 staff survey indicates that the BME staff who responded indicated they were more likely to experience harassment and bullying from staff than white staff. This position has worsened since last year and we are below average compared to similar organisations
		BME	26.10	BME	23.70	
7	KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	White	89.20	White	86.10	2020 staff survey indicates that the BME staff who responded indicated they were more negative regarding believing the Trust provides equal opportunities for career progression or promotion than white staff. This position has improved slightly since last year and we are better than average compared to similar organisations.
		BME	75.50	BME	75.30	
8	Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following?	White	5.20	White	5.70	2020 staff survey indicates that the BME staff who responded indicated they were more likely to experience discrimination at work from their Manager/team leader or

	b) Manager/team leader or other colleagues	BME	10.50	BME	10.30	other colleagues than white staff. This position has worsened slightly since last year, however, we remain significantly better than average compared to similar organisations
	Board representation indicator. For this indicator, compare the difference for white and BME staff					
9	Percentage difference between the organisations Board membership and its overall workforce disaggregated by: Voting membership of Board Executive membership of Board	 + 5.9% + 14.2%		 + 7.1% +15.4%		The Trust has 2 BME Voting Board members. 2021, 2 x BME, 10 x white. 2020, 2 x BME, 10 x white. Reporting year White workforce 89.1% BAME workforce 10.8% Previous year White workforce 90.4% BAME workforce 9.6%

Note 1: All provider organisations to whom the NHS Standard Contract applies are required to conduct staff surveys though those surveys for organisations that are not NHS Trusts may not follow the format of the NHS Staff Survey.

Note 2: Please refer to the Technical Guidance for clarification on the precise means of each indicator.

Report on the WRES indicators, continued

6. Are there any other factors or data which should be taken into consideration in assessing progress? Please bear in mind any such information, action taken and planned may be subject to scrutiny by the Co-ordinating Commissioner or by regulators when inspecting against the “well led domain”

The Trust also publishes a detailed Equality Workforce Monitoring Annual Report on our website, link at No 7 below. Progress regarding the Equality agenda is monitored by the Trust Board at the Equality and Inclusion Committee

The Trust provides secure services across Yorkshire and Humber which has a different population make up compared to that of its local services.

7. If the organisation has a more detailed Plan agreed by its Board for addressing these and related issues you are asked to attach it or provide a link to it. Such a plan would normally elaborate on the steps summarised in section 5 above setting out the next steps with milestones for expected progress against the metrics. It may also identify the links with other work streams agreed at Board level such as EDS2

The Trust has developed a WRES workforce 4 point action plan, please see link below:
Workforce equality information | South West Yorkshire Partnership NHS Foundation Trust

WRES workforce 4 point action plan 2021

Key Action – Recruitment	
WRES Indicators ***1)To increase the % of BME staff in each of the AfC bands 1-9 and VSM (inc Executive Board members) to reflect the % in the local population*** ***2) To ensure that the relative likelihood of BME staff being appointed from shortlisting across all posts is the same as that of white staff***	
Agreed Action	**Update**
<u>Increase applications from BAME population</u> • Continuing with the 'New Horizons' project, working with schools and colleges in North & South Kirklees. Project includes engaging with the local BME community on the areas of mental health awareness, employability skills and promoting the Trust and wider NHS as an employer of choice	The Trust remains committed to the programme, however, plans for this year have been suspended due to the pandemic.
• Updated recruitment information continues to include use of social media showing a diverse workforce	The Trust is planning a series of collaborative virtual recruitment fairs and is working with Comms on developing a portfolio with a variety of diverse images.
• Continue and enhance the work with Universities to increase the number of students from BME communities on health related degree courses	The Trust is working with the local universities, Health Education England and as part of the West Yorkshire Mental Health, Learning Disability and Autism Workforce Collaborative in increasing access to health careers from local communities.
• Re-introduce Positive Action Training (PAT) scheme	The work is in planning stages, in partnership with colleagues from BAME network, and has been delayed due to the pandemic
<u>Ensuring our recruitment processes are fair and transparent</u> • Centralised exit interviews for all staff have been approved and the process is now in operation. The feedback will be collated and reviewed by the EMT and Workforce and Remuneration Committee	The Trust has introduced an anonymous survey monkey format for exit interviews with refocussed questions, this is available each week for staff via a link on the Headlines for easy access. It can be emailed to leavers and completed retrospectively.

• Review recruitment process. Look at including BAME representative on all key appointments include 8a and above. Review if there are key areas where there is under representation, e.g. corporate services bands 5 to 7 and key clinical jobs	The recruitment review working group has mapped out our recruitment process and is now looking at developing an action plan highlighting where we can improve our inclusive practice with the relevant stakeholders. The Trust already ensures BAME representation on senior level recruitment panels with a view to moving to including 8a recruitment by the end of Q4.
Key Action – Representative leadership at all levels	
WRES Indicators ***4) To ensure that the relative likelihood of BME staff accessing non-mandatory training and CPD is the same as that of white staff*** ***7) To increase the numbers of BME staff believing the Trust provides equal opportunities for career progression or promotion*** ***9) To have a Trust Board whose BME voting membership reflects its overall BME workforce***	
Agreed Action	**Update**
• Review of all key decision making groups within the Trust to ensure they are representative of the BAME workforce, eg Silver command, OMG etc	Data has been collected and has been reviewed. EMT is reflective and Silver command was adjusted to ensure representation.
• Include representative workforce focus in annual workforce planning discussions with BDU's and services	E&D continues to be a focus in the annual workforce planning meetings with BDU's
• The Trust will actively promote and support BME staff onto the NHS Leadership Academy 'Stepping Up' and 'Ready Now' programmes. (These offers are incorporated in the Trust's Leaders and Managers development pathway)	A review and refresh of our Leadership & Management Development strategy has been completed. 'Stepping Up' and 'Ready Now' programmes are embedded into our Leader & Manager Pathway. Access for staff will continue when NHS Leadership Academy programmes resume these programmes, post-pandemic. Working with services, we are targeting team development by supporting teams to develop their collaboration skills and encouraging them to take ownership of managing themselves. We continue to offer an 'Engaged leader & manager programme' to service team managers in our localities to

• The Trust will continue to deliver the 'Moving Forward' programme in partnership with Bradford District Care, Leeds &York Partnership and Mid Yorkshire NHS Trusts	create local peer coaching and action learning sets. Further local programmes are planned for In-patient services in 2021/22 We have further developed our joint programmes as part of the West Yorkshire Mental Health Alliance. This includes 'Moving Forward', which is now led by us here at SWYPFT and delivered in partnership with Bradford District Care Trust (BDCT), Leeds & York Partnership Foundation Trust (LYPFT), Mid-Yorkshire Hospitals FT and Wakefield CCG. The latest programme commenced in May 2021. The Trust has now incorporated the Edward Jenner programme NHS Leadership Academy e-learning on-line modules into our 'Introduction to Leading & Managing' and 'Moving Forward' programmes. It is also offered to staff completing our inaugural MLDP and Talent programmes. A 'Moving Forward Plus' pilot programme is currently underway as a part of our inaugural Talent programme.
• Crucial conversations training/coaching to be offered to Trust participants on the Moving Forward Programme	The Trusts 'Crucial Conversations' programme includes priority places for colleagues from under-represented groups. The programme has been redesigned into digital format to reflect the current situation and will resume in face-to-face format when circumstances allow
• Continue with Reciprocal Mentoring scheme for BME staff	As a Trust, we piloted a Reciprocal Mentoring programme in 2019/20, subsequently incorporated into our refreshed L&M Pathway with two further cohorts commencing in May 2021, access to which has also been extended to staff with protected characteristics.
• Continue to deliver aspiring directors (Shadow Board) programme and executive coaching/ mentoring for senior leaders/managers	Our next Shadow Board programme has commenced in August 2021 and will complete in January 2022 and is targeted at staff from under-represented communities and/or with protected characteristics.

• Medical leaders development programmes	We further developed the leadership programmes for medical & clinical leaders in 2020/21 including further Masterclasses, access to 'Introduction to Leading & Managing' and launched a 'Medical Leadership Development Programme' in January 2021 for new medical consultants
• Introduction to Leading & Managing (I2LM) programme offer to include staff from under-represented groups	The Trust continues to further develop a Trust-wide offer to all leaders and managers, reflected in a Leader & Manager Pathway. It spans 'Gateway to Leading & Managing' for first-line managers & supervisors, across 'Leading & Managing Service Teams' for operational managers, to 'Leading & Managing in Healthcare Systems' for senior managers and systems leaders. This is for both new and experienced staff and is underpinned by our Values into Behaviours.
• Coaching and Mentoring framework to include offer to staff from under-represented groups	The Trust has continued to develop its Coaching & Mentoring (C&MF) Framework. This includes the provision of coaching via 'Crucial Conversations', 360-feedback, peer coaching and executive coaching programmes to which we have added medical mentoring. As a part of our C&MF, we are developing a register of coaches and mentors. Within our WYMH Alliance joint programmes, we have become part of the Leeds City Wide Coaching Network to provide access to coaches/mentors, give our coaches and mentors opportunities to develop and gain supervision. Within our C&MF, 1:1 coaching, coaching and mentoring is also available with Coaching for Inclusion currently being developed/added. Our programme of Executive Coaching continues to be provided to Deputies and Trios, including access to the NHS Healthcare Leadership 360-degree feedback tool also provided as part of our levy funded apprenticeship offer.

• Introduction of Building Leadership for Inclusion	We completed phase 3 of our 'Building Leadership For Inclusion' (BLFI) programme, supported by the NHS Leadership Academy, resulting in the development of a pool of champions for our "Lets talk about…" conversations. This includes developing a 'Framework-for-a-Conversation' Our BLFI programme includes extending Reciprocal Mentoring for our BAME staff into a second cohort, now extended to include staff with protected characteristics. We have also begun a targeted inclusion programme for our Board Members via the NHS Leadership Academy 'Inclusive Leadership Development for Boards & Organisations (ILDBO)' programme. In addition, we have commenced a targeted inclusion programme for our senior management team with our HR and OD Directorate
• Introduction of BAME Talent Pool	Our BLFI programme has seen us establish an inaugural Talent Programme targeted at our BAME colleagues The WRES OD lead and Head of Leadership and Management Development are working together on the creation of a 'talent pool' and pilot programme for BAME staff.

Key Action – Bullying and Harassment (including Race Forward)

WRES Indicators
3) To ensure that the relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation is the same as that of white staff
5) To reduce the numbers of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
6) To reduce the numbers of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months
8) To reduce the numbers of BME staff who have personally experienced discrimination at work from manager/ team leader or other colleagues in the last 12 months

Agreed Action	Update
• Re-launch the Race Forward network with a zero tolerance approach regarding harassment and bullying from service users, carers and visitors	EMT have recommitted to the programme. Daryll Thompson, Director of Nursing, Quality and Professions, is board lead. Looking for protected time for the chair (yet to be identified)
• The Trust is planning to hold 'engage and listen' events for BAME staff during the next 12 months.	Workforce H&WB lead and WRES OD lead are in post. The WRES OD Lead and Lead Freedom to Speak Up Guardian have been hosting insight events to gather views of staff on bullying and harassment issues

	The H&WB lead regularly holds check ins for racially minoritized staff. Charlene has been carrying out engagement with frontline staff. The WRES OD lead has been engaging with staff in frontline services (Cherill has been focussing on adult service, OPS, and Forensics with more planned with community). Cherill undertaking a focussed piece of work in adult services in Dewsbury as well as some specific OD work in Forensic services regarding racial abuse from service users.
• Preventing Harassment and Bullying Framework to include communications programme on racially motivated B&H.	The team of bullying and harassment advisors has been expanded and the role amended to be a Civility and Respect Champion. The champions colleagues from our staff networks including the BAME network. The champions will support early resolution of workplace issues. WRES OD lead and Lead for FTSUG held a series of B&H listening events regarding B&H and key themes were fed back into the B&H task group. A joint HR and Staff Side working group has been established to review the Trust policy and to develop an approach based on early resolution of concerns.
• Great Place to Work to focus on healthy teams including supporting BAME staff and promoting diversity.	The 'Great Place to Work (GP2W)' senior leader's forum and programme was paused during the lockdown. It is now being redesigned with a focus upon supporting operational managers and system leaders in leading/managing post-pandemic and will be relaunched in September 2021. Key elements will be allyship and feeling safe at work in line with our Great Place to Work pledges and a focus on equality, diversity and inclusion

• Review of Disciplinary procedure will include an EIA which will consider the impact on BAME staff	A new Resolution Process has been agreed with staff side and introduced in addition to the existing process. The full procedure now includes a decision tree in line with the ' A Model Employer' strategy. Cultural and environmental issues will be considered by a panel, including a cultural advisor, in determining which process is followed (disciplinary investigation or resolution process) taking into consideration mitigation. This will be reviewed in 6 months.
• Appointment of Equity Guardians to support staff throughout the Trust who are experiencing racial bullying and harassment from service users and carers	The Trust had appointed 2 Equity Guardians in 2020, with an additional 3 being recruited recently, the official EG launch will be taking place in October to coincide with Black History Month. The Trust has joined the newly established WY&H anti-racism movement.
Key Action – BAME Health and Wellbeing	
No WRES Indicators	
Agreed Action	**Update**
• BAME risk assessments to be undertaken for all staff including Bank staff	All staff risk assessments undertaken and follow up appointments in progress
• Appointment of a BAME H&WB practitioner	The BAME HWB Practitioner has been appointed and has been providing support to BAME colleagues based on insight gained through staff engagement sessions. (Charlene can add if needed)
• Staff wellbeing survey now includes questions for WRES audit. The most recent survey was carried out July 2020.	The 2020 wellbeing results for colleagues from a BAME background were better than the overall Trust average.

Appendix 1

WRES data for summary report 2021

	2019/2020				2020/2021			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Band 1	3	0	1	0	3	0	1	0
Band 2	201	11	315	35	195	9	338	49
Band 3	368	22	497	54	376	21	507	65
Band 4	173	5	145	17	165	7	153	15
Band 5	112	5	555	68	115	4	536	90
Band 6	53	3	801	58	55	2	844	73
Band 7	47	3	349	25	44	4	389	33
Band 8a	39	1	141	7	35	2	157	7
Band 8b	19	0	49	2	17	0	52	2
Band 8c	5	0	20	1	5	0	21	1
Band 8d	9	0	7	1	8	0	10	0
Band 9	0	0	1	0	1	0	1	0
Medical & Dental Consultants			33	48			36	67
Medical & Dental Non-consultant career grade			18	35			15	32
Medical & Dental Trainee grades			8	19			5	9
VSM*	6	2			6	2		
Non-Executive Board	6	1			6	1		
Grand Total	**1041**	**53**	**2940**	**370**	**1031**	**52**	**3065**	**443**
Not Stated**	**14**				**6**			
Total Staff Number	**4418**				**4597**			

*** "Very Senior Managers (VSM)" *are defined as exclusively including:***

• Chief executives

• *Executive directors, with the exception of those who are eligible to be on the consultant contract by virtue of their qualification and the requirements of the post*

• *Other senior managers with board level responsibility who report directly to the chief executive*

**** This has improved due to the Covid risk assessment, as staff came forward to declare their ethnicity.**

	2019/2020				2020/2021			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	White	BME	White	BME	White	BME	White	BME
Band 1	0.07%	0.00%	0.02%	0.00%	0.07%	0.00%	0.02%	0.00%
Band 2	4.55%	0.25%	7.13%	0.79%	4.24%	0.20%	7.35%	1.07%
Band 3	8.33%	0.50%	11.25%	1.22%	8.18%	0.46%	11.03%	1.41%
Band 4	3.92%	0.11%	3.28%	0.38%	3.59%	0.15%	3.33%	0.33%
Band 5	2.54%	0.11%	12.56%	1.54%	2.50%	0.09%	11.66%	1.96%
Band 6	1.20%	0.07%	18.13%	1.31%	1.20%	0.04%	18.36%	1.59%
Band 7	1.06%	0.07%	7.90%	0.57%	0.96%	0.09%	8.46%	0.72%
Band 8a	0.88%	0.02%	3.19%	0.16%	0.76%	0.04%	3.42%	0.15%
Band 8b	0.43%	0.00%	1.11%	0.05%	0.37%	0.00%	1.13%	0.04%
Band 8c	0.11%	0.00%	0.45%	0.02%	0.11%	0.00%	0.46%	0.02%
Band 8d	0.20%	0.00%	0.16%	0.02%	0.17%	0.00%	0.22%	0.00%
Band 9	0.00%	0.00%	0.02%	0.00%	0.02%	0.00%	0.02%	0.00%
Medical & Dental Consultants			0.75%	1.09%			0.78%	1.46%
Medical & Dental Non-consultant career grade			0.41%	0.79%			0.33%	0.70%
Medical & Dental Trainee grades			0.18%	0.43%			0.11%	0.20%
VSM	0.14%	0.05%			0.13%	0.04%		
Non-Executive Board	0.14%	0.02%			0.13%	0.02%		
Grand Total	**23.56%**	**1.20%**	**66.55%**	**8.37%**	**22.43%**	**1.13%**	**66.67%**	**9.64%**
Not Stated	**0.32%**				**0.13%**			
Annual Total	**100%**				**100%**			

South West Yorkshire Partnership NHS Foundation Trust

SWYPFT WDES Annual Summary Report 2021

The WDES is the Workforce Disability Equality Standard that enables NHS organisations to compare experiences of disabled/non-disabled staff. It is mandated in the NHS standard contract and is made up of ten evidence based metrics. NHS organisations are required to publish the data and develop action plans. It will enable organisations to undertake year on year comparisons, highlight areas of improvement and areas where further work is needed to improve the experiences of disabled staff. The trust is required to complete and submit updated WDES data to NHS England and NHS Improvement by 31st August 2021. For ease of reading the data is duplicated below and summarised where appropriate.

The information contained in this report is based on ESR data as at 31st March 2021 and the 2018, 2019 and 2020 staff survey results.

Metric 1 – Workforce representation based on staff in post 31.03.21							
Non Clinical Staff	**Total Disabled**	**% Disabled**	**Total Non Disabled**	**% Non Disabled**	**Total Unknown**	**% Unknown**	**Total Overall**
Cluster 1 (bands 1-4)	52	6.7%	678	87.4%	46	5.9%	776
Cluster 2 (bands 5-7)	13	5.8%	205	91.5%	6	2.7%	224
Cluster 3 (bands 8a-8b)	6	11.1%	47	87%	1	1.9%	54
Cluster 4 (bands 8c-9 & VSM)	0	0%	25	96.2%	1	3.8%	26
Clinical Staff	**Total Disabled**	**% Disabled**	**Total Non Disabled**	**% Non Disabled**	**Total Unknown**	**% Unknown**	**Total Overall**
Cluster 1 (bands 1-4)	102	9%	915	81%	112	9.9%	1129

Cluster 2 (bands 5-7)	182	9.3%	1731	88%	53	2.7%	1966
Cluster 3 (bands 8a-8b)	21	9.5%	188	85.5%	11	5%	220
Cluster 4 (bands 8c-9 & VSM)	1	2.8%	34	94.4%	1	2.8%	36
Cluster 5 (medical and dental consultants)	5	4.9%	94	91.3%	4	3.9%	103
Cluster 6 (medical and dental, non-consultants career grade)	2	4.2%	45	93.8%	1	2.1%	48
Cluster 7 (medical and dental, trainee grades)	0	0%	14	100%	0	0%	0

Overall, 6.6% of the non-clinical and 9.1% of the clinical workforce (excluding medical and dental staff) have declared a disability through the NHS Electronic Staff Record.

For medical and dental staff, 0% of trainee grades, 4.2% of non-consultant career grade and 4.9% of consultants have declared a disability.

For the total workforce, 8.4% of staff have declared a disability.

There has been a significant reduction in the percentage of staff with an undeclared/unknown status i.e. 5.1% compared to 19% in the previous year.

Metric 2 – Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts based on recruitment data year to 31.03.21			
	Disabled		**Non disabled**
Number of shortlisted applicants	315 (394 previous year)		3999 (5340 previous year)
Number appointed from shortlisting	45 (62 previous year)		845 (580 previous year)
Relative likelihood of shortlisting/appointed	0.14 (0.16 previous year)		0.21 (0.11 previous year)
Relative likelihood of disabled staff being appointed from shortlisting compared to non disabled*		1.48 (0.69 previous year)	

*A figure below 1:00 indicates that disabled staff are more likely than non-disabled staff to be appointed from shortlisting.

Based on the recruitment data for the year to 31 March 2021, disabled staff are less likely to be appointed from shortlisting compared to non-disabled staff. This is a significant change from the previous year.

Metric 3 – Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. N.B Metric based on data from a two year rolling average (2019/20 and 2020/21) – number entering the formal capability process divided by 2.				
	Disabled		**Non disabled**	**Unknown**
Number of staff in workforce	284		3976	236
Number of staff entering the formal capability process	0.5		1	0
Likelihood of staff entering the formal capability process	0.00		0.00	0.00
Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff*		5.18		

*A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

The above figure appears to suggest that disabled staff are more likely than non-disabled staff to enter the formal capability process. However, as the total number of staff entering the formal capability process over the reporting period is very low (3 in total and only 1 with a declared disability) it is not possible to draw any firm conclusions from the data.

WDES 2018, 2019 & 2020 Staff Survey Data															
	2020						2019			2018				2020 Benchmarking Group average*	
Metric/Indicator	% Dis-abled	N=	% Non-disabled	N=	Trust	N=	%Dis-abled	%Non-disabled	Trust	%Dis-abled	%Non-disabled	Trust	Change from prev. year	% Dis-abled	% Non-disabled
4a) % experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	36.7	466	24.0	1370			36.6	26.8		39.0	25.6		No significant difference	31.8	24.7
4a) % experiencing harassment, bullying or abuse from managers in the last 12 months	12.9	464	8.1	1363			16.2	8.3		15.4	7.6		improved	15.2	8.5
4a) % experiencing harassment, bullying or abuse from colleagues in the last 12 months	19.5	461	11.3	1348			21.1	12.2		23.5	12.1		improved	21.3	13.0
4b) % reporting harassment, bullying or abuse	59.1	203	61.2	399			53.5	55.5		51.4	57.7		improved	58.8	60.8
5) % believing that the Trust provides equal opportunities for career progression or promotion	84.5	303	89.2	942			76.7	87.4		80.9	87.6		improved	81.6	88.5

6) % experiencing pressure from manager to attend work when unwell	**23.9**	**305**	**16.8**	**548**			**25.2**	**15.6**		**29.8**	**17.0**		**improved**	**24.1**	**16.6**
7) % staff satisfaction with extent work is valued by organisation	**43.3**	**466**	**53.1**	**1372**			**37.1**	**50.6**		**36.7**	**47.6**		**improved**	**44.6**	**55.2**
8) % of disabled staff saying that adequate adjustments have been made	**80.9**	**293**	**n/a**	**n/a**			**71.6**	**n/a**		**75.3**	**n/a**		**improved**	**81.4**	**n/a**
9a) staff engagement score	**6.7**	**468**	**7.2**	**1377**	**7.1**	**1864**	**6.6**	**7.1**	**7.0**	**6.4**	**6.9**	**6.8**	**improved**	**6.8**	**7.3**

*Combined mental health/learning disability and community benchmark group median.

A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This is not significantly different to the previous year.

A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from managers in the last 12 months however, this has improved since the previous year and is the lowest percentage of the last 3 years.

A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from colleagues in the last 12 months however, this has improved compared to the previous year and is the lowest percentage of the last 3 years.

There is lower reporting of harassment, bullying or abuse from disabled staff compared to non-disabled however, this has improved since the previous year and is the highest percentage of the last 3 years.

A lower proportion of disabled staff compared to non-disabled staff believe that the trust provides equal opportunities for career progression or promotion however, this has improved since the previous year.

Disabled staff report being more likely, compared to non-disabled staff to experience pressure to attend work despite not feeling well enough to perform their duties however, this has improved since the previous year.

Disabled staff report less satisfaction that their work is valued by the organisation compared to non-disabled staff however, this has improved since the previous year.

80.9% of disabled staff report that the trust had made adequate adjustments to enable them to carry out their work. This has improved since the previous year when 71.6% reported that adequate adjustments had been made.

Disabled staff report a lower NHS staff survey engagement score than non-disabled staff however, this has improved since the previous year.

Metric 9b – Has your trust taken action to facilitate the voices of disabled staff in your organisation to be heard?

Yes. The trust continues to support the development of a staff disability network and has engaged with a stakeholder group (including disabled members and staff side) to develop a draft staff disability policy which is anticipated to be finalised and launched this year. Members of the staff disability network have also participated in an engagement and listening event with the Trust Board where they were encouraged to share their lived experiences of being a disabled member of SWYPFT staff. The staff network chair (or deputy) attends the quarterly Equality, Inclusion and Involvement committee to provide updates and discuss matters regarding the staff network.

Metric 10 – Board representation based on ESR data as at 31.03.21			
	Disabled	**Non disabled**	**Unknown/null**
Total Board members - % by disability	0%	100%	0%
Voting Board members - % by disability	0%	100%	0%
Non Voting Board members - % by disability	0%	100%	0%
Executive Board members - % by disability	0%	100%	0%

Non Executive Board members - % by disability	0%	86%	14%
Overall workforce - % by disability	8.36%	86.51%	5.13%
Difference (Total Board – overall workforce)	-8.36%	13.49%	-5.13%
Difference (Voting membership – overall workforce)	-8.36%	13.49%	-5.13 %
Difference (Executive membership – overall workforce)	-8.36%	13.49%	-5.13%

There are no board members reporting a disability.

NHS trusts are required to publish the WDES data and associated action plan by 31st October 2021, following Trust Board ratification. An action plan has been produced following discussions with the staff disability network steering group and is attached as a separate document.

WDES Actions Undertaken in 2020/21

A summary of the actions taken in 2020/21 are detailed below:

- Targeted action was taken to encourage employees whose disability status is recorded as null/not known to update their status on ESR. This has resulted in a significant reduction in the percentage of staff with an undeclared/unknown status. A further campaign is being planned to encourage staff and service users to disclose their protected characteristics.
- The trust remains committed to Project Search in partnership with Mid Yorkshire Hospitals NHS Trust. The project is a pre-employment programme which helps young people with learning disabilities gain the skills they need to obtain meaningful paid employment. Due to Covid-19 restrictions an internship has not been possible, however, the commitment remains and we intend to offer an internship when appropriate.

- The Trust has continued with a guaranteed interview scheme and we continue to include a positive statement in our recruitment information on NHS Jobs advertisements which states “We know there’s a wealth of talent among people who have a disability as well as those who have experience of mental of physical health problems. So, if you need any support with your application just give us a call on 01226 644088”. A working group has been established to review and develop inclusive recruitment practices.
- An engagement and listening event has been held with the Trust Board which encouraged disabled staff to discuss and share their own lived experience.
- Building on the previous work undertaken to tackle bullying and harassment issues we are establishing and developing civility and respect champions across services and teams to support local action plans and improve team cultures. A champion has been recruited from the disability staff network.
- We have further engaged with stakeholders regarding the production of a staff disability and reasonable adjustments policy. A revised draft policy has been produced and will be consulted upon with a view to it being launched this year.
- The trust supports the ongoing development of a staff disability network. A new steering group has been established and work is ongoing to embed the network and increase its membership.
- The trust has continued to support and develop the peer support worker role.
- The Trust has allocated £100,000 within the 20/21 Capital Plan for work related to improving accessibility and areas identified within 6 Facet Surveys. Examples of current work include; creating new accessible parking bays to serve the Learning Disabilities base at Mapplewell centre; refurbishing an accessible WC at Wombwell health centre, Installing automatic doors across the estate; improvements to signage across Fieldhead and Kendray hospital sites. Other schemes will be identified through the year in conjunction with the Disability Staff Network.
- Wellbeing conversations form part of the annual appraisal process which provides a vehicle for disability related discussions to take place.

WDES action plan 2021/22

WDES Indicator	Action	Responsibility	Timescale
1. Percentage of staff in AfC bands or medical and dental subgroups and very senior managers compared to the percentage of staff in the overall workforce.	• Increase the confidence of staff to disclose their disability status by working in partnership with the disability staff network through regular and sustained communications and engagement plan using staff stories and experience. • Engage with disabled staff to understand any barriers to career progression and through insight gained develop actions to address these • Trust Wide Group established to review and develop flexible workforce models to support different ways of working	E&I team/Comms Staff Network	March 2022
2. Relative likelihood of non-disabled staff compared to disabled staff being appointed from shortlisting across all posts based on recruitment data year to 31.03.21	• Improve our external job sites to encourage more disabled people to apply for posts. • To ensure that the review of current recruitment practices includes a focus on disability and addresses any barriers. • Review of EDI training & development of new • training offer for appointing managers including the new Disability at Work Policy	HR E&I team/L&D/Recruitment	March 2022 December 21
3. Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Data is inconclusive due to very small numbers entering the formal capability process, therefore no specific action developed at this time.	n/a	n/a

4. Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public. ii. managers iii. other colleagues	• Joint Task and finish group established to improve staff experience and reduce the numbers of formal bullying and harassment cases through a developing early resolution approach. • Promotion of the support available to staff through civility and respect champions. • Engagement and learning event/s to understand why more staff with a disability experience this more frequently than those with no disability and use this insight to develop an improvement plan	HR/Staff Side/ FTSU/ WRES lead Staff Network Staff Network/ HR	March 2022 March 2022 April 2022
5. Percentage of disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression and promotion.	• To ensure that the review of current recruitment practices includes a focus on disability and addresses any barriers. • Promote access to the Reciprocal Mentoring Programme within the next cohort from 2022/23 Q1 • Promote access to the Talent Programme within the next cohort from 2022/23 Q1.	HR L&D L&D	December 2021 2022 in line with cohort dates 2022 in line with cohort dates
6. Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	• Launch staff disability & reasonable adjustments policy/supportive disability and wellness planning agreement. • Review of sickness absence policy to change the focus to supporting wellbeing.	HR/staff network/staff side HR	December 2021 March 2022

7. Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	• Ongoing promotion of the staff disability & reasonable adjustments policy • Ongoing development and promotion of the staff network following the re-establishment of an active steering group • Continue to engage with the staff network to identify learning and associated actions from lived experience.	HR/staff network HR/staff network HR/staff network	Ongoing following launch Ongoing Ongoing
8.Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their work.	• Launch staff disability & reasonable adjustments policy/supportive disability and wellness planning agreement • Continue to identify schemes to improve accessibility and environment as part of the trust capital plan in conjunction with the staff network. • Develop a programme to improve disability awareness for all managers	HR/staff network/staff side Estates/staff network HR. Staff Network/ L&D	December 2021 Ongoing March 2022
9a&b. Staff engagement score and action to facilitate the voices of disabled staff	• Identify and utilise opportunities to engage with disabled staff via the disability staff network • Work in partnership with the network to develop ongoing work/action plans to support the experience of disabled staff. • Promote relevant awareness dates e.g. International Day of the Disabled	HR/staff network HR/staff network Staff network	Quarterly Quarterly Annually

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 8.6

Title:	Equality and Diversity Annual Report 2020/2021
Paper prepared by:	Presented by: Director of Strategy and Change
Purpose:	The purpose of the report is to provide Trust Board with a draft 'Equality and Diversity Annual Report 2020-2021' for comment and approval. The annual report is usually published in September each year as a requirement of our Public Sector Equality Duty. This year the report is delayed due to the pandemic and will be published in November.
Mission/values:	Equality and diversity acts as the golden thread in everything we do, it ensures our approaches and services are inclusive and equitable so we can continue to **put the person first, and in the centre**, **improve and aim to be outstanding** The annual report describes the Trusts progress on equality and diversity, through an integrated approach driven by the Equality, Involvement, Communication and Membership Strategy. This strategic approach will ensure **people reach their potential to live well in their communities** and ensure we remain relevant to the communities we serve. Underpinned by partnership working and involvement we will continue to provide high quality cultural, spiritual, and inclusive services and ensure that **families and carers matter**. The annual report is published each year to demonstrate a **respectful, honest, open, and transparent** account of our progress. And our forward view will ensure we are **relevant today and ready for tomorrow.**
Any background papers/ previously considered by:	The Trust has an integrated Equality, Involvement, Communication and Membership Strategy agreed by the Trust Board in December 2020. The strategy is supported by clear action plans that were co-produced with staff, members, governors, volunteers and wider stakeholders. Whilst our approach to equality and diversity is integrated, there is still a legal requirement to report individually on the Trust annual progress for equality and diversity. Because of the general duties under the Public Sector Equality Duty, which remained in place throughout the pandemic. The importance of paying due regard was particularly important to ensure the Trust maintained the general duties set out below, these are to: • Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act • Advance equality of opportunity between people who share a protected characteristic and those who do not

	• Foster good relations between people who share a protected characteristic and those who do not The annual report provides assurance of our progress and demonstrates our commitment to our duties. The report has already been shard with the Equality Inclusion and Involvement (EI&I) Committee on 30 September. The written report was well received as the first draft version that sets out progress against the strategy that was published 10 months ago. Feedback provided by the committee to strengthen key areas has now been incorporated into this version. The Chair of the EIIC and another NED member have worked with the team to finalise this version and provided additional feedback to enhance future reports that will capture impact and outcomes against the strategy and plans in line with the Trust approach to capturing impact and outcomes matures.
Executive summary:	In the reporting period 2020-2021 our Trust alongside all health and social care services has undergone rapid changes to respond to the global public health emergency presented by the coronavirus pandemic (COVID-19). The pandemic has further exposed the gross inequalities in our society. The 'Equality and Diversity Annual Report' sets out the activity undertaken during the year in support of our equality strategy and reflects the Trusts increased focus on equality, diversity and inclusion. The annual report also provides an overview of some of the key priorities and plans for the next year that will be further refined, prioritised and co-produced as part of the annual planning process. It was also noted that the EDS2 process is not yet complete, due to Covid delaying the process for goals 1 and 2, and the committee requested further clarity on the grading for goals 3 and 4 and whether it was accurate to describe the Trust as 'achieving'. It was agreed to defer approval of the NHS Equality Delivery System 2 (EDS2) report until December, and to set up a small group to review the overall EDS2 report and grading system and process historically adopted.
Recommendation:	**Trust Board are asked to RECEIVE and APPROVE the report, subject to a small group from the Equality Inclusion, and Involvement Committee finalising and agreeing the EDS2 scores.**
Private session:	Not applicable.

Equality and Diversity annual report 2020/2021

1. Introduction

Our mission here at South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) is to help everyone to fulfil their potential and live well in their community. This is supported by a clear set of values that put people at the heart of everything we do.

In the reporting period 2020-2021 our Trust alongside all health and social care services has undergone rapid changes to respond to the global public health emergency presented by the coronavirus pandemic (COVID-19). The pandemic has further exposed the gross inequalities in our society.

These inequalities in health and barriers to accessing services alongside systemic and institutionalised racism and discrimination have been a key focus this year. Whilst it has been an incredibly difficult time, the pandemic has given us the opportunity to work differently, often without barriers, to do the best we can as a Trust and as a partner in our places and wider healthcare systems.

Whilst we know there is still much more that we need to do, this year the Trust has made significant progress in delivering on our equality and public sector equality duty and work is progressing at pace to ensure we continue to build on our progress in the forthcoming year and beyond.

2. About the Trust

We are South West Yorkshire Partnership NHS Foundation Trust, a specialist NHS Foundation Trust that provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees, and Wakefield. We also provide some secure (forensic) services to the whole of Yorkshire and the Humber. All our services are focused on principles of recovery and co-production, working with the strengths of each person and those of their carers and wider community.

The Trust also provides services that promote health-producing communities and prevention through supported self-care, recovery focused approaches, peer support and community involvement, volunteering to supported employment. The Trust's recovery colleges, linked charities Creative Minds, Spirit in Mind, Mental Health Museum, and significant volunteering services, as well as Altogether Better (a national organisation that is hosted by the Trust) further contribute to this. Set out below are our vision, mission, and values.

Our vision:

To provide outstanding physical, mental, and social care in a modern health and care system.

Our mission:

We help people reach their potential and live well in their community.

Our values:

We are a value-based organization, this means our values are followed by all our staff and underpin everything we do:

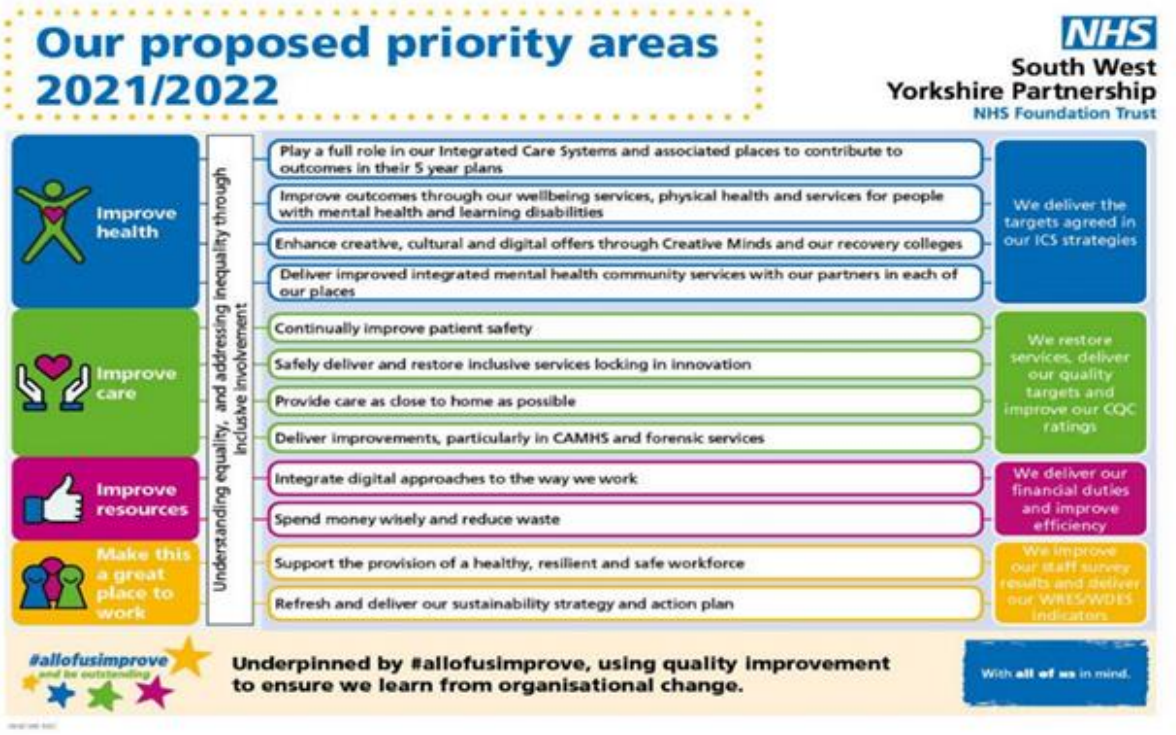
- We put the person first, and in the centre

- We know that families and carers matter
- We are respectful, honest, open, and transparent
- We improve and aim to be outstanding
- We are relevant today and ready for tomorrow

Our strategic objectives are:

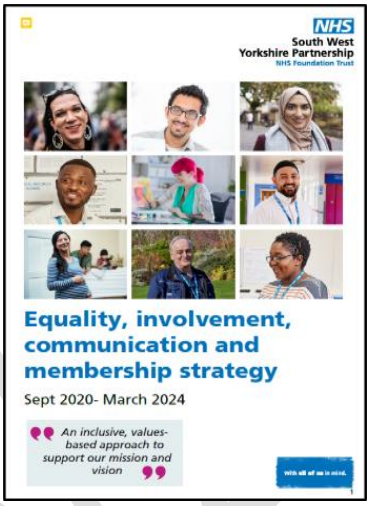
- ✓ Improve health
- ✓ Improve care
- ✓ Improving our use of resources
- ✓ Make this a great place to work

Our priorities for 2021/2022 are driven by understanding equality, and addressing inequality through inclusive involvement. This is the consistent theme that runs through everything that we do driven by our Equality, Involvement, Communication and Membership Strategy.



3. Our strategic approach to equality and diversity

During the period 2020-2021 the Trust has created a single strategy with equality as the key driver. The integrated approach replaced three existing strategies and aligned them into one current strategy. The previous strategies were a Communication, Engagement and Involvement Strategy, an Equality and Inclusion Strategy, and a Membership Strategy.



The integrated 'Equality, Involvement, Communication and Membership Strategy' has been developed over the reporting period. Using the views of over 720 people including our diverse community (see full report here), the new strategy is insight driven and offers a joined-up approach to delivering equality, involvement, communication, and membership.

The strategy is supported by accompanying annual action plans to ensure that the Trust has an integrated approach to improve the health and wellbeing of everyone. Our approach has always been to live our values and *'put the person first and in the centre,'* ensuring the involvement of those who use our services is representative, that care is person centred and that our services are driven by robust insight and data.

4. Progress during the period 2020-2021

As a Trust we are proud of the progress we have made. Despite the pandemic and increased pressure on both staff and services the Trust has continued to build on the previous years' achievements. Some of the highlights from this year are set out below:

We know we have got it right when	Our progress
We can demonstrate an improvement in outcomes and experience for people who use our services.	✓ The Trust has co-designed and launched a **carer's passport** which is now being rolled out across our Trust. The passport will ensure that carers get the support they need. ✓ We continue to support people's **religious and spiritual needs** by providing a multi-faith room in our inpatient settings. ✓ **Co-action study to identify cultural competency** in both forensic services and CAMHS and a chance to replicate the approach in other services. ✓ We have reviewed ourselves against **the Accessible Information Standard** to ensure that people who have a disability, impairment or sensory loops receive information in a way they can access and understand, and that any communication support they need is identified and provided. Continuing to work in partnership with Language Empire, our interpreting, translation, and transcribing provider. ✓ As part of **Active Calderdale**, we have employed a change and innovation facilitator to work alongside our community teams to get physical activity

	embedded into care plans. This post is a new role and the postholder has developed a collaborative plan for this work. ✓ We work closely with our **advocacy partner organisations** to gain insight about the experience of those who access our services. The acute care forums in Barnsley and Wakefield have representatives from the advocacy services in attendance. ✓ We have reviewed our communications request form to include the 10 most common **translation requests** and request this at the design stage to guide people to producing accessible versions. ✓ **Digital inclusion** work is progressing, including the launch of 'CHATpad', which is available for service users on all wards to support contact with loved ones, advocacy and capturing views. ✓ Continued compliance of mandatory **equality training,** at 95% throughout the pandemic. This included a specific focus on transgender awareness through training, and an annual celebration event arranged by BAME staff network to support understanding of systemic racism. ✓ Dedicated piece of work to develop a **data set to inform access, waiting times** starting with people from a BAME background
We can demonstrate meaningful engagement with communities to understand population needs, strengths and experiences.	✓ The **development of a co-created and integrated strategy** for 'Equality, Involvement, Communication and Membership' and accompanying annual action plans. ✓ Ensuring that our Trustwide **digital strategy has a strong focus on our communities** and protected groups to address digital exclusion and promote digital inclusion. ✓ Working as a **partner in the wider integrated care systems (ICS) to develop and drive campaigns** such as 'looking out for your neighbour', 'suicide prevention and awareness' and 'root out racism'. This includes being part of a hate crime podcast and other promotional materials and films featuring Trust staff. ✓ Our '**Choose well for mental' health guide** was co-designed with staff, service users, carers and families and is available on our website to download. This includes easy read and Urdu versions ✓ The Trust **value led recruitment approach** recruits public panels resulting in a diverse range of service users, carers and volunteers who are now able to attend recruitment of senior roles (band 7 and above). This means that there is BAME representation on all senior appointments which will be extended to all key appointments. ✓ **Recovery colleges** in each of our places (Barnsley, Calderdale, Kirklees, and Wakefield) have invested in dedicated websites. The websites went live in July 2020, during the pandemic, to ensure people can continue to access courses as a part of a digital offer. ✓ **An investment in the Third Sector** to map and support relationships with communities in each of our places to ensure we reach diverse groups ✓ The development of a **quarterly insight report,** including equality themes to capture feedback from communities, governors, and partners such as Healthwatch.

	✓ The **Calderdale Creativity and Cultural programme** has been developed over several years, following the approval of the living a larger life creativity arts and culture strategy, supported by the Calderdale Health and Wellbeing Board.
The Trust has a representative workforce that demonstrates we are reflective of our population and exemplars in employing people with lived experience.	✓ **Dedicated equality and inclusion task force and BAME staff workforce taskforce** to support our work to address health inequalities through the pandemic, including leading on dedicated BAME workforce support. This involves a BAME staff wellbeing practitioner, accelerated risk assessments, dedicated intranet resources and a BAME workforce WRES (workforce race equality standard) lead. ✓ The Trust has further developed a **coaching and mentoring framework**. This includes the provision of coaching via 'Crucial Conversations', 360-feedback, peer coaching and executive coaching programmes to which we have added medical mentoring and reciprocal mentoring for our BAME staff. ✓ A new **staff network for carers**, partner network for carer organisations and the launch of a carers passport which resulted in the appointment of a dedicated carers lead for the Trust ✓ A dedicated programme of work to **roll out peer support workers** and ensure lived experience is part of our approach has resulted in the development of a dedicated training programme and increase in internal posts. ✓ The Trust remains committed to **Project Search** in partnership with Mid Yorkshire Hospitals NHS Trust. The project is a pre-employment programme which helps young people with learning disabilities gain the skills they need to obtain meaningful paid employment. Due to Covid-19 restrictions an internship has not been possible, however, the commitment remains, and we intend to offer an internship when appropriate.
All services will have an equality impact assessment (EIA) with annual review and delivery of actions monitored through governance arrangements.	✓ A focus on **using and improving equality impact assessments (EIA) to drive our work,** including a dedicated COVID-19 EIA to ensure impacts during the pandemic were collated and impacts mitigated against. ✓ A **quick decision EIA** and process to ensure decisions made during the pandemic considered impact as part of urgent planning. ✓ **Ongoing monitoring of EIA compliance.**
All change programmes will be co-produced where appropriate and include equality considerations informed by EIA.	✓ A **recovery and reset toolkit for staff** which includes a clear steer on ensuring equality, diversity and insight is central to decision making. ✓ A **clear process for change programmes** using a checklist and dedicated inbox to assess EIA and approach for involvement at the beginning of a programme of work.
We will improve data capture and accuracy of recording in respect of protected characteristics, monitoring of service access by ethnicity in relation to the local population.	✓ Targeted work to encourage staff whose **disability data** is recorded as null/not known to update their status on the Electronic Staff Record (ESR), resulting in a significant reduction in the percentage of staff with an undeclared/unknown status. ✓ **Improvements in collecting and reporting on equality data** during the pandemic and for use in service settings, including a live dashboard for vaccine roll out and take up. ✓ Progress of a **campaign to increase data collection.**

Services will evidence equality considerations in support of Equality Delivery System (EDS2) to demonstrate how driving equality improvements can strengthen accountability to service users and the public	✓ **Part completion of EDS2** 3&4 (with 1&2 due in December 2021) includes our Workforce Race Equality System (WRES) and Workforce Disability Equality System (WDES) data and survey results.
We will monitor any complaints and reported incident about access to services where discrimination was a factor.	✓ **Monitoring systems** in place using Datix recording to identify and flag incidents. ✓ **Process in place** to ensure incidents are recorded and reported and individuals supported.
An increase in positive stakeholder perceptions via Friends and Family Test and feedback via customer services and dedicated surveys.	✓ **Capturing consistent equality data** when gathering views and patient experience, in line with census data. ✓ A Trust wide survey toolkit to support the **collection of patient experience and feedback** allowing for a central collection of data and equality monitoring ensuring insight is reflective and equality themes highlighted.
Our staff wellbeing survey results see improvements in feedback regarding equality of opportunity in training, support and career progression.	✓ A **'Moving Forward Plus'** pilot programme is currently underway as a part of our inaugural talent programme. ✓ Our next **shadow board programme** is planned for August to December 2021 and is targeted at staff from under-represented communities and/or with protected characteristics. ✓ We further developed the **leadership programmes for medical and clinical leaders** in 2020/21 including further masterclasses, access to 'Introduction to Leading & Managing', and launched a 'Medical Leadership Development Programme' in January 2021 for new medical consultants. ✓ A review and refresh of our **Leadership and Management Development strategy** has been completed. 'Stepping Up' and 'Ready Now' programmes are embedded into our Leader and Manager (L&M) Pathway. Access for staff will continue when NHS Leadership Academy programmes resume these programmes, post-pandemic. ✓ As a Trust, we piloted a **Reciprocal Mentoring programme** in 2019/20, subsequently incorporated into our refreshed L&M Pathway with two further cohorts commencing in May 2021, access to which has also been extended to all staff with protected characteristics.
NHS staff survey feedback will report increased staff satisfaction with equality of opportunity.	✓ The Trust has also established a clinical network, called **Race Forward**, to reduce bullying and harassment from service users and carers on staff from BAME backgrounds. ✓ **Workplace health and wellbeing** has been a key priority for 2020/21. Actions included a dedicated health and wellbeing practitioner for BAME staff members and intranet support during the pandemic. ✓ Building on the previous work undertaken to tackle bullying and harassment issues we are establishing and developing **civility and respect champions across services and teams** to support local action

	plans and improve team cultures. A champion has been recruited from the disability staff network.

5. A focus on addressing inequalities in health

Thousands of people use our services across South and West Yorkshire each year, and we make over a million contacts with them. Each is an opportunity to work together on their mental, physical, and social needs. We know that there are differential impacts on different groups in our population and this will have an impact on health and wellbeing outcomes.

If you have experience of a mental health problem or have a learning disability your years of life will be reduced. Black, Asian, and Minority Ethnic (BAME) staff and service users are also more likely to experience poor health. People from Gypsy, Roma and Traveller communities face large barriers to accessing services. People with a physical or sensory disability experience impacts relating to communication, information, and the built environment. Those living in our more deprived areas have a lower average life expectancy and there is evidence that LGBT+ people have disproportionately worse health outcomes. This year we have focussed on addressing the 8 health inequalities highlighted in 'Urgent actions to address 8 inequalities in NHS provision and outcomes'.

5.1 Action1: Protect the most vulnerable from COVID19

Our response:

- Trustwide COVID-19 EIA and research toolkit.
- Quick decision EIA to support response to COVID-19.
- Equality, involvement, communication, and membership strategy and supporting Involvement and Equality action plans which set out our approach, co-designed principles, and specific actions to address inequalities across the Trust.
- Insight composite report to inform recovery using insight from Healthwatch and place-based engagement – key themes identified, and insight fed into recovery.
- Trustwide patient engagement and experience toolkit with mandatory equality monitoring to capture feedback.
- Process now in place for working with communities. A spreadsheet has been set up to capture insight from the process and to map target audience and reach by protected group.
- Co-action study in service settings with individual action plans to ensure service improvement.
- Community reporter programme including specific funding for a BAME lead to support community engagement in North Kirklees.

5.2 Action 2: Restore NHS services inclusively

Our response:

- Recovery toolkit with a requirement to update EIAs and a 'checklist' to ensure patient experience and involvement are part of a planned recovery approach if changes to services, redesign or developments are part of recovery.

- Joint Strategic Needs Assessment (JSNA) used to support EIAs, which are in place for every service, including an action plan to mitigate impacts, address inequalities and ensure culturally sensitive and appropriate care.
- Patient experience and Friends and Family equality monitoring and reporting.
- Monthly Integrated Performance Report (IPR) to our Trust Board, which includes equality and deprivation data and reporting.
- Performance dashboard for all services which can be used to identify activity for all protected groups in every service setting.

5.3 Action 3: Develop digitally enabled care pathways

Our response:

- Digital strategy informed by insight and intelligence.
- Insight captured on digital care and learning used to support recovery of services.
- Co-designed choose well for mental health including national and local digital offers.
- Virtual visitor in all service areas to support communication with friends, family and loved ones.
- Digital inclusion programme to address and mitigate impacts of digital exclusion.
- Recovery college website and digital offer.
- Creative Minds digital offer.
- Digital access in service settings.
- Digital applications identified and approved by the online platform ORCHA.

5.4 Action 4: Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes

Our response:

- Yorkshire Smoke Free initiatives.
- Work in Barnsley and Kirklees through the preventative work of IAPT.
- Health and wellbeing services.
- South Yorkshire's smoking cessation QUIT programme.
- Creative approaches and recovery colleges in each of our places.

5.5 Action 5: Particularly support those who suffer mental ill health

Our response:

- Inpatient and community mental health benchmarking.
- 'SystmOne' data collection and equality monitoring review.
- Electronic Staff Record data collection review.
- Performance dashboard created to support data for each service and broken down by all protected groups in line with census data.
- Vaccination programme roll out, informed by EIA and a data dashboard broken down by diversity, age, gender, and role to ensure communications and approaches were insight led.
- Choose well for mental health campaign and supporting materials.

5.6 Action 6: Strengthen leadership and accountability

Our response:

- Equality, Inclusion and Involvement (EII) Committee and sub committee with named lead.
- BAME workforce task force.

- Appointment of a WRES Organisational Development (OD) Lead.
- Inclusive Leadership Development for Boards Opportunity (ILDBO) OD & development programme commenced.
- Reciprocal mentoring programme applications open for 2021.
- Appraisals and career conversations.
- Identify leadership opportunities, reflected in our leader and manager pathway and Building Leadership for Inclusion (BLI) programmes.
- Support BAME fellowship programme across the West Yorkshire ICS.

5.7 Action 7: Ensure datasets are complete and timely

Our response:

- The Trust has developed an experience and engagement tool which includes a mandatory equality monitoring form so data can be disaggregated and interrogated by diversity and ethnicity.
- All services have an EIA in place, completion and updates are monitored and reported to the EII Committee to provide assurance.
- The Trust has created a Trust wide COVID-19 EIA and an evidence and research toolkit to support staff to update and completed existing EIAs.
- Campaign to improve equality monitoring aimed at staff and people who use services in development to be launched in Summer 2021.

5.8 Action 8: Collaborate locally in planning and delivering action to address health inequalities

Our response:

- Health Intelligence and Insight Group in place - sharing the learning from Barnsley, Calderdale, Kirklees, and Wakefield partners.
- Arts for health in partnership with Calderdale.
- Active health initiatives across the Trust.
- Partner in place based whole system approaches to improving outcomes for people with a learning disability in Calderdale and Wakefield.
- Inequalities priorities to focus on co-morbidities for people with mental health issues in Barnsley.
- Creative Minds in partnership with voluntary and community sector and partners.
- Recovery college and courses co-designed with communities.
- Further use of translations in all information, easy read and translation and interpreter services to be analysed and actions taken to improve access.
- Voluntary and community sector support and grant fund for Barnsley, Calderdale, Kirklees, and Wakefield has been rolled out to support capacity building; identification of partnerships and ensure greater voice and influence.

As a Trust we are active partner in the West Yorkshire Health and Care Partnership and South Yorkshire and Bassetlaw ICS with a commitment as a partner to accelerate progress in tackling inequalities across the region. Whilst we know we know we have more to do to meet the diverse needs of our communities we are working hard to address inequalities that put people at greater risk of ill health, mental ill health, or distress.

6. About our population (infographic to add)

We serve 1.22m people who live across South and West Yorkshire in the local authorities of Barnsley (239,300 people), Calderdale (209,800), Kirklees (440,000) and Wakefield (332,000). However, we also have services and staff in North Leeds, Sheffield, Doncaster, and Rotherham.

Most of the care we provide is delivered in local communities. This means we work in all the villages, towns, and cities, from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east and to Hoyland and the Dearne Valley to the south of Barnsley – and all points in between. Our population lives in a mix of rural and urban areas. In all communities the 2011 census tells us:

- There is on average across all areas a 1% difference in the population reported as male and female, with female reporting higher.
- Across all ages Calderdale has the highest 0-15 population at 19.6%, and Barnsley has a higher working age population 30-44 at 26% and older population 60+ at 23.8%.
- Christianity and Islam respectively are both the highest reported religion and belief.
- We know that white British people make up 87% of our region's local authority population, more than the England average of 81%.
- Of the other main minority groups Black or Black British people comprised 1%, less than the England average of 3%
- Asian or Asian British people comprised 8%, the same as the England average. The local authorities with the largest proportions of Asian people are Kirklees (16%) and Calderdale (8%).
- We know that those who report having a disability that impacts them a lot is higher than the census 2011 national average of just over 4% in the communities the Trust covers. This ranges from 8% to over 13%.

We know this profile is likely to change significantly over the next 20 years with BAME groups accounting for almost 80% of the UK's population growth (Policy Exchange, 2014).

7. About our workforce (infographic to add)

The Trust currently employs **4,597** (data March 2021) staff in both clinical and non-clinical support services. Our staff work hard to make a difference to the lives of service users, families, and carers. Services delivered include mental health, learning disability, forensic, wellbeing services, some physical health and an extensive range of community services.

The Board and Governors believe they, and the workforce, should be reflective of communities we serve. Over the last year diversity has been retained across the Board with a good balance of gender, age, and ethnicity. Governors use a targeted approach to support recruitment from local communities.

Our workforce data is set out below:

- The Trust split of 77.9% female to 22.1% male staff is reflected approximately across most areas, except for medical staff (36% / 64%). As in previous years, female staff continue to make up over three quarters of Trust staff.
- As in previous years, the highest number of Trust staff fall in the age bands 40-49 and 50-59, with over 55% of the total staff being between 40 and 59. Just over 42% of medical staff are between 40 and 49. Support services have the highest percentage of staff in the 60-69 age bands with 14% (102) being 60 or over.
- The data shows that 6.1% of our staff consider themselves to have a disability, the same figure as last year. The total number of staff is 266, this is an increase of 11 since last year.
- The Trusts staff profile has a larger white British representation than the local demographic of the people that it serves collectively. Trustwide, 90% of the total staff in post are white British which is similar to previous years and equates to an over-representation of 1.3% (last year 1.1%).
- Mixed race staff are underrepresented by 0.2%, Chinese staff are over-represented by 0.2%, Black staff are over-represented by 1.6% and South Asian staff are under-represented by 3.2%.
- The number of staff who have not stated their religious belief (unknown) has decreased slightly from 2018 (23%) to just below 21% currently. Staff reported as 48% Christianity, 3% Islam, 12% other and 17% Atheism.

All our staff receive mandatory equality and diversity training and over the past year the Trust has managed to retain compliance of 95% across all staff groups. In addition to mandatory training, staff receive specific training, and in the period 2021/2022 staff received training on:

- Transgender awareness
- Carers
- Peer support working
- Cultural awareness and in relation to the BAME staff network

There are four Trust staff networks. Each network is set up to engage and involve staff, ensure they have a representative voice, and that they can influence the approach for our workforce. Networks can influence our direction of travel, consider equality and address inequalities through discussion, participation, and leadership. The staff networks we have in place are listed below.

- BAME staff network
- Carers staff network
- Disability staff network
- LGBT+ staff network

8. Monitoring our workforce

The Trust requirement for recording and monitoring the diversity of our workforce is further enforced by the requirement to implement a standard for race and measure the experience of staff with a disability.

Implementing the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) are requirements for NHS commissioners and NHS healthcare providers including independent organisations, through the NHS standard contract.

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) that will enable NHS organisations to compare the experiences of Disabled and non-disabled staff. NHS organisations use the metrics data and local data to develop a local action plan and enable them to demonstrate progress against the indicators of disability equality.

8.1 Workforce Race Equality Standard (WRES)

The 2019 Workforce Race Equality Standard (WRES) is delivered through the workforce strategy. This is because *'evidence suggests that improving racial inequality in the workplace not only improves staff experience and organisational innovation but improves safety and outcomes for service users.'* The standard has the following key roles:

- To enable organisations to compare their performance with others in their region
- Aim of encouraging improvement by learning and sharing good practice
- To provide a national picture of WRES in practice, to colleagues, organisations, and the public on developments in the workforce race equality agenda
- Nine indicators of staff experience and opportunity are reported nationally, and figures are analysed to understand improvements

This year 2020/21 the WRES data has told us that we are now 100% compliant with the collection of equality data. In addition the data shows:

- The number of BAME staff in the workforce has increased by headcount of 72, this equates to 1.6%. The total percentage of BAME staff in the workforce is now 10.8%. (total workforce headcount is 4,597 at 31 March 2021).
- BAME applicants are less likely to be appointed from shortlisting than white applicants.
- BAME staff are less likely to enter a formal disciplinary process than white staff.
- BAME staff are more likely to access non-mandatory training and continuous professional development (CPD) than white staff. The data includes medical staff.
- The 2020 staff survey indicates that the BAME staff who responded indicated they were more likely to experience harassment and bullying from service users and carers than white staff. This position has improved since last year.
- The 2020 staff survey indicates that the BAME staff who responded indicated they were more likely to experience harassment and bullying from staff than white staff. This position has worsened since last year and we are below average compared to similar organisations.
- The 2020 staff survey indicates that the BAME staff who responded indicated they were more negative regarding believing the Trust provides equal opportunities for career progression or promotion than white staff. This position has improved slightly since last year and we are better than average compared to similar organisations.
- The 2020 staff survey indicates that the BAME staff who responded indicated they were more likely to experience discrimination at work from their Manager/team leader or other colleagues than white staff. This position has worsened slightly since last year; however, we remain significantly better than average compared to similar organisations.

You can see the full WRES data report and action plan for 2021/2022 on the Trust website.

8.2 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is made up of ten specific measures to help compare the experiences of disabled and non-disabled staff. Mandated through the NHS standard contract its aim is to support positive change for existing employees and enable a more inclusive environment. The specific measures are:

- The recruitment and retention of disabled staff and improving line management action
- Improving disability declaration rates
- The role of senior leaders in supporting workplace disability
- Developing WDES action plans

This year 2020/21 the WRES data has told us that overall, 6.6% of the non-clinical and 9.1% of the clinical workforce (excluding medical and dental staff) have declared a disability through the NHS Electronic Staff Record. In addition the data shows:

- For medical and dental staff, 0% of trainee grades, 4.2% of non-consultant career grade and 4.9% of consultants have declared a disability.
- For the total workforce, 8.4% of staff have declared a disability.
- There has been a significant reduction in the percentage of staff with an undeclared/unknown status i.e., 5.1% compared to 19% in the previous year.
- A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from patients, relatives, or the public in the last 12 months. This is not significantly different to the previous year.
- A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from managers in the last 12 months. However, this has improved since the previous year and is the lowest percentage of the last 3 years.
- A higher proportion of disabled staff compared to non-disabled staff state they have experienced harassment, bullying or abuse from colleagues in the last 12 months. However, this has improved compared to the previous year and is the lowest percentage of the last 3 years.
- There is lower reporting of harassment, bullying or abuse from disabled staff compared to non-disabled. However, this has improved since the previous year and is the highest percentage of the last 3 years.
- A lower proportion of disabled staff compared to non-disabled staff believe that the Trust provides equal opportunities for career progression or promotion. However, this has improved since the previous year.
- Disabled staff report being more likely, compared to non-disabled staff to experience pressure to attend work despite not feeling well enough to perform their duties. However, this has improved since the previous year.
- Disabled staff report less satisfaction that their work is valued by the organisation compared to non-disabled staff. However, this has improved since the previous year.
- 80.9% of disabled staff report that the Trust had made adequate adjustments to enable them to carry out their work. This has improved since the previous year when 71.6% reported that adequate adjustments had been made.

- Disabled staff report a lower NHS Staff Survey engagement score than non-disabled staff. However, this has improved since the previous year.

You can see the full WDES data report and action plan for 2021/2022 on the Trust website.

8.3 Sexual Orientation Monitoring Information Standard

Research shows that LGBT+ people experience greater health inequalities compared to heterosexual people. This includes a higher risk of poor mental health or missing out on routine health screening. This standard provides the categories for recording sexual orientation but does not mandate data collection. The Trust is increasing data collection to ensure we have a minimum standard of representative sampling across services.

If a healthcare service collects information on patient sexual orientation, they will be able to target specific health promotion and services to LGBT+ patients. Sexual orientation monitoring questions need to be part of the data we gather to ensure we meet the needs of this group.

9. About our members (infographic to be added)

Members are made up of local people and staff. Being a member of the Trust means local people and staff have a greater say in how services are provided in the areas the Trust serves and how the Trust is run. Members have an opportunity to get involved and to shape the services we provide and as a foundation trust we are accountable to our members. The Trust currently has 8,971 public and 4,259 staff members

Our aim is to develop membership which is reflective of the populations we serve. The diversity of our public members is set out below. Not all members disclosed equality data during recruitment and in particular there are gaps for recording religion and belief and sexual orientation. All percentages relate to the total number of members who declared equality data which is 8920 (this means 100% equals 8920). The equality data of public members is as follows:

- Members are split across the localities as follows: 16% Barnsley, 15% Calderdale, 37% Kirklees, 26% Wakefield, 6% other parts of South and West Yorkshire.
- The members split is 65% female to 35% male.
- The highest number of members fall in the age bands 46- 65 with over 33% of the total, followed by 26-35 with 24%, 66-80 follows with 16% then 36-45 with 13%. Young people under 25 represent 4% and 80+ at 4.5%. 5.5% did not disclose an age.
- The data shows that 0.6% consider themselves to have a disability, with most stating mental health as the main disability and a few stating a long-term condition or illness.
- Members are predominantly white British with 83% representation, other white at 0.8% and Irish 0.6%.
- African is 0.7%, Caribbean 0.6% and other 0.1%.
- Asian is 0.4%, Indian 4.4%, Pakistani 4.8%, Chinese 0.1% and Bangladeshi 0.2% with mixed and multiple ethnic groups 0.6%.

- Members who have not stated their religious belief is 98% (unknown) with recorded religions being 0.9% Christianity. Other religions such as Islam, Buddhist, Hindu, and other are 0.05% or less.
- Sexual orientation was 98% not recorded, leaving heterosexual 1.5%, bisexual and lesbian 0.03% and gay 0.06%
- 11% of our members declared they are carers

At present we do not collect equality data on our governors, which is a gap we have identified, so we don't know to what extent our governors are representative of our members and/or the communities we serve. We plan to looking at how we address this action going forward.

All members are equal, but the Trust recognises that some members may wish to be more actively involved in the life of our Trust than others. We know that an effective membership can only be achieved if we embrace an inclusive approach, encourage diverse representation, demonstrate effective involvement, and ensure accessible information and communication. We will strive to create a culture of active involvement for as many members as possible through active engagement of the membership.

The Trust's Constitution sets out the role and duties of members. Information on membership is publicly available on the members section of the website. Membership to the Trust is free, with few specific requirements apart from a lower age limit of 11 and no upper age limit, which need to be addressed as we look to recruitment in the future.

10. Equality Delivery System (EDS2)

The Equality Delivery System (EDS2) was designed by the Department of Health, and reviewed by NHS England, to help the NHS measure equality performance. It helps organisations evaluate practices and procedures and understand how driving equality improvements can strengthen accountability to service users and the public. EDS2 helps the Trust to ensure it addresses the Public Sector Equality Duty and includes 18 outcomes grouped into four goals. There are two goals about services:

- Better health outcomes for all
- Improved patient access and experience

There are two goals about NHS staff:

- Empowered, engaged, and included staff
- Inclusive leadership.

The Trust's strategic aims for equality are linked to these goals. The Trust Board approach is to assess the Trust performance via assessment of the four outcomes from the 18 covered by EDS2, reflecting the incremental nature of the journey to improved performance. Priorities are agreed by the commissioners and ratified by the Trust's Equality, Inclusion and Involvement Committee, with EDS2 goals incorporated in director objectives.

The Trust is graded using the national criteria below. Each goal is graded separately following engagement with staff and the public, after the subject or service has been

decided. The overall Trust grade is discussed with the Equality, Inclusion and Involvement Committee after the collation of the evidence from the engagement has taken place. The grades and explanation are in the table below:

Table 1: EDS2 Grading Key

Excelling	**We are doing very well** People from all protected groups fare as well as people overall
Achieving	**We are doing well** People from most protected groups fare as well as people overall
Developing	**We are doing ok** People from some protected groups fare as well as well as people overall
Undeveloped	**We are doing badly** People from all protected groups fare poorly compared with people overall or not enough evidence to make an assessment

In 2020-2021 due to the COVID-19 pandemic the assessment of goals 1 and 2 has been postponed until Autumn 2021. This falls outside the reporting of the annual report. By delaying the start date of assessment, the Trust can ensure that the involvement of key stakeholders is inclusive and not just reliant on digital engagement. In addition, EDS2 grading took place during the peak period of vaccination roll out which was presenting significant challenges to communities and healthcare systems.

The agreed topic to be tested for the period 2020-2021 was agreed as 'Reset and Recovery'. This will be reported on in 2022 with the grading and overall grading updated. The grading for 2020/2021 at the time of the report is as follows. Go to the Trust website for more information.

Goal 1: Grading not complete
Goal 2: Grading not complete
Goal 3: Achieving
Goal 4: Achieving

Overall Trust Grade: To be confirmed: awaiting grading of Goal 1 and 2

11. Our legal and statutory obligations

The Trust is committed to being responsive and supporting the needs of the diverse population it serves, reflected in the Trust's values. Equality and diversity is not an 'add on', it is central to all we do as a provider of services, as an employer, and as part of the public sector. People who use the Trust's services are all different and diverse in their requirements and needs. Equality is about creating a fairer organisation in which everyone can fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense and treating everyone with fairness and understanding, not necessarily treating everyone the same.

To ensure we comply with our statutory responsibilities under the Equality Act 2010, especially the Public Sector Equality Duty (PSED) and the Health and Social Care Act 2014, we must

consider equality and involvement at each stage of service delivery including as part of any decision-making process.

11.1 The Equality Act 2010

The Equality Act 2010 unifies and extends previous equality legislation. Nine characteristics are protected by the Act; gender, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. In addition, the Trust includes carers as an additional priority.

Section 149 of the Equality Act 2010 states that all public authorities must have due regard to the need to a) eliminate discrimination, harassment and victimisation, b) advance 'Equality of Opportunity', and c) foster good relations.

All public authorities have this additional duty so partners will need to be assured that "due regard" has been paid through the delivery of all communication and involvement activity.

11.2 The Public Sector Equality Duty

The Public Sector Equality Duty states that public authorities must consider how they ensure people have equal access to services. The Trust must:

- Remove or minimise discrimination in different groups
- Take steps to meet the needs of people from different groups by using creative approaches and the principles of co-production
- Encourage people from different groups to have a say and influence the way services are planned and delivered
- Make sure people from different groups can participate by removing unnecessary barriers
- Tackle prejudice and promote understanding.

This means the Trust must consider the needs of all individuals in its day-to-day work, for example in shaping policies or how services are delivered. The Trust must ensure that everyone, no matter what their background or personal circumstances is treated with dignity and respect. The Trust's strategy provides a framework to ensure that this consideration takes place.

11.3 NHS Constitution

The NHS Constitution came into force in January 2010 following the Health Act 2009. The constitution places a statutory duty on NHS bodies and explains several patient rights which a legal entitlement is protected by law. One of these rights is that t**he NHS provides a comprehensive service, available to all**:

I*t is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy, and maternity or marital or civil partnership status. The service is designed to improve, prevent, diagnose, and treat both physical and mental health problems with equal regard. It has a duty to everyone that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where*

improvements in health and life expectancy are not keeping pace with the rest of the population.

12. Governance

The Equality, Inclusion and Involvement (EI&I) Committee oversees the agenda to improve access, experience, and outcomes for people from all backgrounds and communities. This includes people who use, work and volunteer for our Trust services and those who work in partnership with the Trust with the strategic aim of improving health, care, resources and making our Trust a great place to work.

The Committee was established to act on behalf of the Board and to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. More recently the committee has changed its title to include involvement to ensure it aligns with our integrated approach.

The Committee oversees the implementation of the Equality, Involvement, Communication and Membership Strategy which was approved by Trust Board in December 2020 and has delegated responsibility for signing off annual action plans.

In addition to the Committee, the Trust response to the pandemic in the past year resulted in the establishment of an Equality and Inclusion Task Force to address and understand wider health inequalities; and a specific task force to address the inequalities that were highlighted during the pandemic for people from a BAME background in the form of a BAME Workforce Task Force. Whilst the BAME task force was time limited, the Equality and Inclusion Task Force has more recently been established as a sub-group of the EII Committee demonstrating our commitment to aligning Trust resources so we can deliver on this agenda.

13. Forward view

The next steps for 2021/22 will be to deliver on the actions set out in the Equality action plan which include:

- Improve baseline equality data and data collection using a campaign and training.
- Improve the resources to support the development and completion of EIAs.
- Demonstrate compliance with our Public Sector Equality Duty (PSED) using EDS2 and action plans in EIAs.
- Review our mandatory and focussed training to support equality, diversity, and inclusion.
- Continue to deliver and report on the WRES and WDES including action planning and improvements.
- Continue to deliver and report on EDS2 and create a public facing website page to share our progress.
- Ensure services remain accessible and inclusive with a focus on ensuring information and communication is timely and appropriate to the target audience.
- Develop tools to ensure we can use data and insight to reduce health inequalities
- Build relationships in each of our places and communities and sustain our work with Healthwatch, the third sector and faith groups and partners.

- Continue to roll out the carer's passport, support for carers and identification of carers.
- Continue to roll out initiatives which will result in a diverse workforce and in particular leadership.
- Continue to support and develop staff networks as a voice and influence network
- Reduce disparity in disciplinary and complaints processes through advocacy and support.
- Eradicate discrimination and prevent bullying across all protected groups and roll out visible campaigns across the Trust in partnership with our ICS and places.
- Increase the diversity of volunteers with a focus this year on people from a BAME background, those with a learning disability, people living with ASD and Autism, LGBT+ people, young people and carers.
- Increase number of peer support workers by identifying vacancy opportunities and accelerating the peer support worker offer in all Trust services.
- Capture insight from all Trust wide data sources and use the information we already hold to inform our decisions.
- Continue to roll out the Trust wide use of the checklist to ensure there is a consistent approach to involving people.
- Use service line and staff equality data to identify the target audience to ensure involvement methods and approaches meet the needs of those audiences.
- Introduce a training package for staff and governors to support the involvement approach and ensure the reach into our communities reflects the population.
- Identify and invest in existing asset-based approaches and identify new opportunities to grow the opportunities for voice in our communities, particularly those who are under-represented.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 August 2021
Agenda item 9 – Assurance from Trust Board Committees

Audit Committee

Date	12 October 2021
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	

Alert:

- 360 Internal Audit presented their report on Freedom to Speak Up which resulted in Limited Assurance.
- Their findings related to gaps in reporting, compliance with steps in the policy not being evidenced and improvements needed in staff awareness
- The Interim Director of HR attended and provided an update on the implementation of actions to address these recommendations

Advise:

- The Audit Committee reviewed and approved the revised Trust Constitution for ratification by the Board.
- Alongside the Constitution, the Committee reviewed and approved the revised Standing Financial Instructions.
- NOTE – both of the above will be reviewed next year to take account of the development of ICS governance arrangements.
- The Committee approved an updated Procurement Strategy subject to some final amendments and the development of a short form summary version
- Nicola Wright introduced herself as Deloittes new partner for our external audit.

Assure:

- The Committee received another positive update on the controls in place with regard to cyber security.
- A paper on the development of the Trust's Data Quality Improvement Plan was presented and reviewed.

Risks discussed:

- N/A – covered above

New risks identified:

- N/A – covered above

Approved Minutes of previous meeting/s for receiving	Minutes of the meeting on 13 July 2021

Equality, Inclusion and Involvement Committee

Date	30 September 2021
Presented by	Angela Monaghan (Chair of Committee)
Key items to raise at Trust Board	

Alert:

- Discussed the draft annual report and proposed some changes. It was agreed a small working group would agree the final version before submission to the Board **for approval**.
- Agreed the Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) annual reports for 2021 be submitted to the Board **for approval**.

Advise:

- Received a written report from our staff equality networks, which is a new development. It was agreed to review if they have the right support.
- Approved the easy read version of the Equality, Involvement, Communication and Membership (EICM) strategy. This will be made available on our website, alongside the full version, a short film and a still image, to ensure our strategy is accessible to our diverse audience.
- Received the EICM strategy implementation plan highlight report, which had an overall RAG status of amber. One red item – committee agreed to defer the completion date for agreement of a policy on reimbursement of expenses for involvement. This was to allow co-design with third sector partners. The policy will now be drafted in early 2022 and agreed in March 2022.
- Agreed to defer approval of the NHS Equality Delivery System 2 (EDS2) report until December, due to Covid delaying the process for goals 1 and 2. A review group will be set up to review the overall EDS2 report and grading system.

Assure:

- Quarterly insight report received, which pulls together insight received from a wide range of sources, including Healthwatch and governors, and identifies themes. It was recognised this is still in development but was welcomed as a valuable new tool.
- The Committee held a strategy session, which considered our approach to addressing inequalities. Discussed:
    - Do we have the right emphasis and focus prioritised in our action plans?
    - Is there anything additional we should consider?
    - Is there anything missing?
    - What more do we need to do to crate the right conditions to develop an inclusive culture and Trust?

Risks discussed:

- Had a broad discussion of the current risks assigned to EIIC. Agreed there was a need to refresh the risks, actions and controls and consider if there is a missing risk in relation to addressing health inequalities.

New risks identified:

- Consider if there is a missing risk in relation to addressing health inequalities.

Approved Minutes of previous meeting/s for receiving	Minutes of the meetings on 15 June 2021

Finance, Investment & Performance Committee

Date	25 October 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 on 23 August 2021

West Yorkshire Mental Health Services Collaborative Committees in Common

Date	21 October 2021
Presented by	Angela Monaghan (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	Nil

Extraordinary Members' Council

Date	19 October 2021
Presented by	
Key items to raise at Trust Board	• The appointment of the new Chair
Approved Minutes of previous meeting/s for receiving	Single agenda item meeting only. August minutes to be approved at November's meeting.

Note: assurance from the Charitable Funds Committee is provided to the Corporate Trustee for charitable funds.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Audit Committee held on 13 July 2021 (Virtual meeting, via Microsoft Teams)

Present:	Mike Ford	Non-Executive Director (Chair of the Committee)
	Sam Young	Non-Executive Director
In attendance:	Rob Adamson (RA)	Deputy Director of Finance
	Mark Brooks (MB)	Director of Finance and Resources (Lead Director)
	Shaun Fleming (SF)	Local Counter Fraud Specialist, Audit Yorkshire
	Caroline Jamieson (CJa)	Senior Manager, Deloitte
	Leanne Hawkes (LH)	Deputy Director, 360 Assurance
	Andy Lister (AL)	Head of Corporate Governance
	Lianne Richards (LR)	Client Manager, 360 Assurance
	Tony Cooper (TC)	Head of Procurement
	Julie Williams (JW)	Assistant Director of Corporate Governance, Performance and Risk
	Nicola Heaton (NH)	Management Accountant
Apologies	Chris Jones (CJ)	Non-Executive Director

AC/21/59 Welcome, introduction, and apologies (agenda item 1)

The Chair of the Committee, Mike Ford (MF), welcomed everyone to the meeting. Apologies were noted as above.

It was noted that the meeting was quorate.

AC/21/60 Declaration of interests (agenda item 2)

There were no further declarations over and above those made in the annual return to Trust Board in March 2021 or subsequently.

AC/21/61 Minutes from the meeting held on 13 April 2021 and 18 June 2021 (agenda item 3)

It was RESOLVED to APPROVE the minutes from the Audit Committee meetings held on 13 April 2021 and 18 June 2021

AC/21/62 Matters arising from the meeting held on 13 April 2021 (agenda item 4)

The following matters were discussed from the action log:

AC/21/32 – Assurance

This action related to items where the Committee required assurance but weren't part of the internal audit plan. MB reported this hasn't been completed yet and was to remain open.

AC/21/34 – Procurement Report

The Procurement Report has had some additions and MF and Tony Cooper (TC) will liaise outside of the meeting.

Action: Mike Ford and Tony Cooper

MF explained that he would speak with Mark Brooks (MB) to identify how James Sabin (JS) could be involved in some of the discussions between now and the next committee.

Action: Mike Ford and Mark Brooks

AC/21/35 - Andy Lister (AL) has spoken to Tim Breedon regarding the enquiry of the triangulation of the Risk Report from the last meeting and can confirm CPA Care Plans are being reported through the Clinical Governance Clinical Safety Committee and are on the agenda for the next meeting.

AC/21/63 Consideration of items from the Organisational Risk Register allocated to the Audit Committee (agenda item 5)

MB explained that the IT department are ensuring that the Cyber risk actions are being maintained. An action has been added to the Risk Register that states the Trust will look to high levels of investment and resource that could enable us to reduce the likelihood of a potential cyber-attack. We would not recommend a change in the risk score but have updated our actions and controls where appropriate.

Sam Young (SY) described how the risk is defined as 'targeted' and believes the wording should be 'compromised' instead because the trust will always be 'targeted'. MB agreed this would be changed.

Action: Mark Brooks

Information Governance (IG) risk, MB reported a reduction in the number of incidents reported, however, the risk score has not gone down. MB raised a question as to whether the actions documented are making a substantial difference to the risk score or are simply maintaining current position. MB asked if there are further actions required to reduce the likelihood of an IG breach of occurring. No recommendations for change were made at this time.

Potential future legal risk, MB reported this risk was flagged as a result of horizon scanning for the potential impact of changes to governance procedures made during the pandemic. This risk remains unchanged. We have not seen any significate increase in legal claims, though it is important that the risk remains on the register at this time. Current controls and actions are to remain in place.

MF asked for any updates from EMT of 8 July 2021 and AL confirmed that updates were ongoing.

It was RESOLVED to NOTE and RECEIVE update to items from the organisational risk register allocated to the committee.

AC/21/64 Triangulation of risk performance and governance report (agenda item 6)

AL explained that this has gone through the normal process and compares the BAF and Risk Register from 27 April 2021 against the IPR from 29 June 2021. There is an increase of 6 risks on the ORR, 16 of which are specific to the COVID pandemic and are currently under review.

In relation to the IPR, of 47 risks on the ORR, 46 are broadly linked to the performance measures and narrative in the IPR, which is an increase of 3 since the last quarter. Of the 47 risks reported, 41 are cross-referenced from the ORR to the BAF, which is an increase of 2.

MF questioned how the summary describes that some information is missing, due to Covid-19 and questioned the information that is missing. MB explained that it is the 'SWOT and PESTLE' process that is undertaken annually. Trust board will update this during the next phase of planning.

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the operation of risk processes within the Trust.

AC/21/65 Reference costs – approval of methodology (agenda item 7)

Rob Adamson (RA) described how, in line with best practice, each year a paper is brought to Audit Committee which outlines the proposed approach to national cost collection, where costs are examined and then compared nationally to discover whether above or below average.

The paper confirms that the Trust is following this guidance and applicable standards. To note, this is the second year the Trust has included items at patient level and we have an action plan to ensure we keep moving this forward. This will then be signed off by the Director of Finance.

MF asked if this exercise is useful? MB explained that in addition to this being mandatory, it can also be used as a base of information and benchmarking, also this is used as part of the national pricing and work is taking place to improve consistency.

MF confirmed that the Committee is required to confirm that the process is appropriate, and MF and SY agreed that the process was appropriate and accept the recommendations given

It was RESOLVED to CONFIRM that the costing plan and supporting information provided are sufficient to provide assurance on the plan to complete the mandated costing submissions for 2020/21, and CONFIRM that the Director of Finance will CERTIFY the submission has been prepared in accordance with the standard.

AC/21/66 Draft Charitable Funds annual report and accounts (agenda item 8)

MB explained the report was being brought to Audit Committee for completeness and for any comments prior to it being reviewed by the external auditors. The report will be taken to the Charitable Funds Committee (CFC) for review.

MF reported he had reviewed the report in CFC and Angela Monaghan had made a number of comments that had been received and are in train.

MF confirmed the Audit Committee is happy to receive the report based the discussions and actions that had been identified in CFC.

It was RESOLVED to RECEIVE the draft Charitable Funds annual report and accounts.

AC/21/67 Declarations of interest for staff (agenda item 9)

AL reported as agreed at EMT in February 2019, decision making staff were required to declare any interest and therefore, as at 1 April 2021, there were 379 recorded decision making staff required to declare any potential interests.

Since April 2021, 318 members of staff have provided declarations of interest (a total of 84%) and those outstanding are either in the process of making their declarations or are being followed up (for their return). This is an improvement on last year.

It was noted that the process is in place and meets the requirements of NHSE/I requirements. An updated register will be presented to Committee in January 2022.

Action: Andy Lister

It was RESOLVED to NOTE the processes in place in relation to staff declarations of interest and be ASSURED that the Trust is meeting the requirements of the NHS England guidance and there are no current declared staff conflicts that present a risk to the Trust.

AC/21/68 Review of proposed changes to Trust's Constitution including Standing Orders (agenda item 10)

AL gave an update explaining changes that we made in January 2020 and the impact of Covid-19. He proposed to review the constitution including outstanding proposals from the last review and will start the process in August 2021, with a view to taking the final version of the Constitution to Members' Bouncil on 16 November 2021. MB explained that it is expected that there will be an annual update for the next couple of years.

It is noted that this will be coming back to Audit Committee in October 2021.

Action:Andy Lister

It was RESOLVED to NOTE the proposed process and timeline to update the Constitution and Standing Financial Instructions.

AC/21/69 Update on Interim governance arrangements (agenda item 11)

AL reported this paper went to Trust Board in June 2021. The main item to note is that the Command structure is being stood down and in the main items going through the Command structure will now be going through OMG or EMT. It was agreed at June's Board meeting that Board Committees will now look at agendas and work plans and review them going forward, in light of restrictions being lifted in July 2021.

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

AC/21/70 Arrangements to cover Director of Finance (agenda item 12)

It was noted that James Sabin would be in post as Interim Director of Finance before next committee.

It was RESOLVED to NOTE the cover arrangements in place for the director of finance & resources whilst he acts up as interim chief executive

AC/21/71 SBS/Oracle post implementation review (agenda item 13)

RA explained that the SBS system had been well implemented, with some areas of improvement required, which are in the recommendations. The recommendations are already being in train, therefore this is a good, positive report that supported the work taking place.

MF asked whether it would be good to undertake a stakeholder survey again after the work has been completed and RA agreed that it would. It is understood that the Trust is already part of an SBS user group which has already been found to be useful.

MF asked what are the benefits of being part of this group and Rob Adamson (RA) agreed to speak with MF outside of the meeting to update him on this.

Action: Mike Ford and Rob Adamson

Chris Jones (CJ) in his absence had submitted a question: when might we expect an update on the System One optimisation?

Julie Williams (JW) explained the optimisation project had achieved its objectives prior to lockdown and any improvement to SystmOne is led by the systems team.

It was RESOLVED to NOTE the hard work of staff involved in the implementation of the Oracle finance and procurement system and to SUPPORT the recommendations identified in the main body of the paper which aim to address any outstanding issues and make better use of the system.

AC/21/72 Ernst and Young report on costing audit (agenda item 14)

RA gave a summary of the report, which is a positive report and received a 'substantial' assurance rating overall. The Trust processes and practices have been identified as examples of 'good practice'. There some low and medium recommendations and therefore the Trust is developing an action plan to take these forward. These recommendations will be built into the next round of processes, there is also a large focus on engagement. RA agreed to share the full report with the Committee.

Action: Rob Adamson

MF asked where was the recommendation that addresses CP6, the assurance of cost data is? RA explained there will be a strategy dealing with this and that this has wider than implications beyond the Finance strategy.

It was RESOLVED to NOTE the paper and independent review into the Trust's compliance with healthcare costing standards and AGREED that the cost strategy will go back to the Audit Committee, rather than FIP.

AC/21/73 Data Quality improvement proposal (agenda item 15)

JW introduced the paper explaining that this was requested following the Audit report in March 2021 by an internal auditors on specific data quality issues.
This was requested to update on current data quality practices and to provide the data quality improvement plan to the Committee.
It was explained that the improvement of data input, with changes to the SystmOne user experience, will contribute to improved data quality and completeness.

JW to provide an update report to Audit Committee in October 2021.

Action: Julie Williams

It was RESOLVED to RECEIVE the report as part of the evidence of assurance on the ongoing operation of data quality processes within the Trust.

AC/21/74 Procurement update report (agenda item 16)

Tony Cooper (TC) gave an overview of the report. It was explained that this report covers all aspects of procurement including the level of spend.
MF explained that he understands the figures in isolation and will liaise with TC outside of the Committee to discuss this.

Action: Mike Ford and Tony Cooper

Procurement strategy

TC reported this is an update on the strategy with an emphasis on sustainable procurement. From April 2022 NHSE and NHSI have mandated that all contracts have a sustainability criteria of at least 10% included.
Two years ago, the Trust received procurement standard level 1 and this will now change in April 2022. This will include a Crown commercial services collaboration with the NHS.
There is also a national initiative, such as a procurement target operating model which looks at national procurement from various aspects. The West Yorkshire and Harrogate ICS will be prominent and is referenced within the document.

MF asked how this strategy is shared across the whole organisation? MB explained that other strategies have been publicised on the intranet and formed part of staff briefings and suggests that this is handled the same.

It was agreed to bring this strategy back in October 2021 in order to provide more time to go through it, even though it is understood that it is expiring.

Action: Tony Cooper

It was RESOLVED to NOTE the Procurement update report and Procurement Strategy.

AC/21/75 Treasury management update (agenda item 17)

RA reported the report is attached for information. Minimal interest is being received and there are no plans to explore investing as it's not appropriate at this time.

It was RESOLVED to NOTE the Treasury Management update report.

AC/21/76 Internal audit progress report (agenda item 18)

Lianne Richards (LR) gave an overview of the internal audit progress report.
It was found that the areas outlined in the report were typical of usual findings. It was noted that Appendix E was now closed.
Thanks was given for the work undertaken on this audit.

It was RESOLVED to NOTE the Internal audit progress report.

AC/21/77 Counter fraud progress report (agenda item 19)

Annual report 20/21
Shaun Fleming (SF) presented the report and explained the fraud prevention masterclasses will be on-line sessions that will be available to all staff and clients. Fraud alerts and intelligence sharing will continue to be disseminated.
There is one outstanding investigation that is due to close next month and SF will have a complete update on this at the next audit committee.
There is also a potential issue with regard to the Mental Health Act Assessment and therefore an investigation has commenced and SF will report to the next audit committee.
A post pandemic assurance exercise released by the counter-fraud authority will look at procurement issues over the COVID period which will be taken up by the Procurement department over the next couple of weeks.

Appendix A - counter fraud functional standard return and
Risk assessment 21/22
SF explained that this is a summary of fraud incidents reported in 2021. This summary shows a new standard, as previously discussed, and the Trust has resulted in achieving 'amber'. SF explained why amber was expected. The plan approved in April 2021 is based on the new standards and has all the workstreams in place.
MF asked if there were any expenses fraud and SF confirmed there were none reported.

It was RESOLVED to NOTE the Counter Fraud Progress report.

AC/21/78 External audit update (agenda item 20)

CJa gave a verbal confirmation that they have signed the accounts and that the Value for Money work required by 20 September 2021 is in progress.

It was agreed that MB shall agree this offline, unless something needs attention, and then circulating to members for review.

Action: CJa to liaise with MB

It was RESOLVED to NOTE the External audit update.

AC/21/79 Losses and special payments (agenda item 21)

RA explained that seven payments have been made since the last report to Audit committee. The single largest payment was due to a loss of jewellery and the Trust has now reached an agreement

with the individual. A further 3 claims had been made, also due to the loss of property, but no trend has been identified.

It was RESOLVED to NOTE the losses and special payments report.

AC/21/80 Any other business (agenda item 22)

MF gave thanks to Sam, for her contribution to the committee, as this was her last Audit Committee meeting. MB also thanked Sam and highlighted her fresh perspective.

AC/21/81 Items to report to Trust Board (agenda item 23)

MF will send a note to MB and AL after the meeting to update these items.

AC/21/82 Work Programme (agenda item 24)

AL explained there was nothing extra to be discussed here.

AC/21/83 Date of next meeting (agenda item 25)

The next meeting of the Committee will be held on Tuesday 12 October at 2.00pm via Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Equality, Inclusion and Involvement Committee held on 15 June 2021 Via Microsoft Teams

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair of Committee)
	Rob Webster (RW)	Chief Executive
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Salma Yasmeen (SY)	Director of Strategy
	Erfana Mahmood (EM)	Non-Executive Director
	Mike Ford (MF)	Non-Executive Director
	Chris Jones (CJ)	Non-Executive Director
Apologies	Alan Davis (AD)	Director of Human Resources, Organisational Development and Estates
In attendance	Aboobaker Bhana (ABB)	Equality and Engagement Manager
	Rachel Irwin (RI)	PA to Director of Strategy (author)
	Dawn Pearson (DP)	Marketing, Communications, Engagement and Inclusion Lead
	Elaine Shelton (ES)	Disability network Chair & Staff Side Chair/Covid Lead
	Cherill Watterston (CW)	WRES OD Lead/Specialist Physiotherapist
	Donna Somers (DS)	LGBT+ staff network Chair/Ward Manager
	Paul Brown (PB)	HR Business Partner
	Melissa Harvey (MH)	General Manager
	Gillian Cowell (GC)	Carers staff network Chair/Carer Support Worker
	Lauren Summers (LS)	Vice Chair staff side/Assistant Branch Secretary Unison
	Lindsey Metcalfe (LM)	Business Intelligence Lead
	Lindsay Jensen (LJ)	Deputy Director of Human Resources, Organisational Development and Estates
	Asima Bibi (AB)	Community Mental Health Nurse
	Melanie Wood (MW)	Head of Performance
	Chiara DeBiase (CDeB)	Insight Programme Placement
Apologies	Dr Subha Thiyagesh (SThi)	Medical Director
Attendees:	Zahida Mallard (ZM)	Equality and Engagement Manager

Due to AM's technology issues, Tim Breedon (TB) chaired the meeting during some sections.

Section 1 – Standing Opening Items

EIC/21/26 Welcome, introductions and apologies (agenda item 1)

The Chair, Angela Monaghan (AM), welcomed everyone to the meeting, particularly those who had not attended an EI&I Committee meeting previously. AM introduced Chiara DeBiase (CDeB), the new placement on the Insight Programme, who was present as an observer. Apologies were noted and that a recording was taking place for note purposes.

EIC/21/27 Declarations of Interest (agenda item 2)

The Committee noted that there were no further declarations over and above those previously declared by existing Directors.

EIC/21/28 Minutes of previous meeting held on 2 March 2021 (agenda item 3)
The minutes of the previous meeting were agreed as a correct record.

It was RESOLVED to APPROVE the minutes of the meeting held on 2 March 2021.

EIC/21/29 Matters arising from previous meeting and action log (agenda item 4)
The actions from the meeting held on 2 March 2021 were noted and the action log was updated as appropriate.

EIC/21/04 – Commitment to Carers - on agenda **(agenda item 16)**.

EIC/21/06 - Context report – national, regional and local - Reform of the Mental Health Act – consultation underway - action closed.

EIC/21/09 - Feedback from Staff Equality Networks – Meeting held with all the networks on Staff Network Day. Really successful event and hopefully it can be repeated in the future. AM thanked all those who engaged in this – action complete.

EIC/21/10 - Feedback from BDU Forums - Forensics/Specialist feedback from the Forum and how to make best use of the information received. TB had had a brief conversation with Sean Rayner about how to bring the BDU forum feedback into the insight report. Agreed to keep on the action log and note to discuss at next agenda setting meeting, together with the Wakefield Mental Health Alliance work.

EIC/21/13 - Covid-19 Vaccination - WDES/WRES Survey - Noted that the volunteers were included in the vaccination programme – action to be closed.

EIC/21/13 - Equity guardians and how they are recruited and supported to carry out their roles. AD to address this outside of the meeting due to time pressures. Lindsay Jensen (LJ) unsure if Alan had actioned but equity guardians will be covered in update in meeting – action to be closed.

EIC/21/14 - Performance Dashboard development update – LM to share the link to the dashboard with the Committee – action complete. TB confirmed that both Melanie Wood (MW) and Lindsey Metcalfe (LM) would be joining the meeting.

LM to advise if there is a non-binary option on gender – to pick up later in the meeting.

TB informed that the sub-committee will consider broader areas of the dashboard and bring suggestions to the Committee – on agenda.

EIC/21/15 - Equality, Involvement, Communication and Membership Strategy Implementation Plan report – Action Plan update – on agenda.

EIC/21/20 - Committee Annual Report - Work Programme - TB to consider if the programme will need to alter in light of “involvement.” AM felt we needed to ensure we are sufficiently covering involvement in our insight report given the broadened brief of the Committee. To be included at next agenda setting meeting.

EIC/21/24 - Work Programme - Agreed to look at a strategy session and business meeting at the next Committee. Item on agenda.

Actions from 8 December 2020

EIC/20/71 - Equality Standard updates (WRES, WDES) – update will be provided during the meeting.

EIC/20/74 - Update Report on Commitment to Carers - Commitment to Carers to be included in the local induction programme. ABB and GC to assist with messaging - complete.

EIC/20/77 - Feedback from BDU Forum - Barnsley and Wakefield - compare and contrast will be brought back to a future Committee. This had a time scale of March 2021 – have some insight from the forums.

AM asked whether anyone was present from the BAME network as there was an issue with the distribution list, which did not include Manreesh or Noma, current Chair and Vice Chair of BAME network, so they did not get notification or papers for the meeting. Asima Bibi (AB) and Cherill Watterston (CW) were present. AM apologised for this oversight and said that this distribution list would be reviewed and updated to make sure it reflects the current Steering Group Chairs and Vice Chairs for all the staff network members.

Action: Salma Yasmeen

EIC/21/30 Review of Committee related risks and any exception reports as required (agenda item 5)

TB confirmed for those who had not attended a previous meeting that all the items on the corporate risk register were assigned to various Committees. This Committee holds 3 risks, described in the update paper. Anything is noted which has changed since the last meeting. These are reviewed by EMT and ratified through Board. The job of the Committee is to comment on those risks and any additional mitigation/action/controls felt necessary.

Risk ID1157 – Diversity and representation within the workforce. Has been updated – the target date for review was June 2021. Review concluded and changes made. Alan Davis (AD) had not shared with LJ so unable to provide an update at the meeting but LJ advised that she would find out and share the outcomes on how representative our decision-making groups are. **Action: Lindsay Jensen**

Mike Ford (MF) mentioned diverse representation at meetings which formed part of the last Private Board development session and whether this was part of the review. Rob Webster (RW) felt it was very important that our decision making was representative and that the more we could demonstrate different voices in the room, the better – need to build into our thinking at all times.

Erfana Mahmood (EM) also felt it was important not to lose the output work from the development sessions in the Board meetings and whether this could be pulled together and filtered back to EI&I. TB also agreed that this learning shouldn't be lost. It was agreed to pick up the learning from the inclusive leadership development work being done for Board and other parts of the organisation and use that to provide insight to feed into the strategy session. **Action: Lindsay Jensen**

Risk ID1531 - Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19. Has been extensively reviewed before and have added additional information in terms of our response – will be considered at risk meeting on 16 June by Exec Trio – no further update for Committee.

Chris Jones (CJ) asked how we are measuring impact on the most vulnerable groups. TB advised that information is picked up from the insight report, from the EI&I Task Group which looks at the outcomes of some of the control measures in place, the physical health group which provides updates on the vaccination programme, access to services and from the PPE group to ensure we have appropriate access in terms of required modifications needed for PPE for people in certain groups.

Risk ID1536 - BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus – no further update.

EM mentioned the self-help guide for managers on resilience and wellbeing and felt this might not be the right approach given people have been isolated for well over a year. LJ confirmed that a lot of work had taken place around wellbeing i.e. managers continuing with regular risk assessments/wellbeing conversations with staff, promotion of occupational health services, ability to access wellbeing hub supported by West Yorkshire & Harrogate which went online from 1st April which provides access to psychological services, plus availability of helplines and access to local health and wellbeing advisors. AM asked whether the take up in health and wellbeing offers and also the protected characteristics were monitored and segregated. LJ will pick up with Helen Whitlam (head of occupational health) as this is something not currently done. Lauren Summers (LS) felt there was a problem with other protected characteristics, not just BAME, which also needed more support and representation and that it was important not to forget these i.e. disabled and LGBT+ staff. Felt we needed to look at these equally. AM confirmed that this is something we are trying to reflect in the action plans.

The Committee DISCUSSED and commented on the current Trust-wide corporate/organisational level risks relevant to this Committee and were ASSURED that the current risk levels, although above the Trust risk appetite, given the current environment, are appropriate.

EIC/21/31 Context report – National, ICS and Trust level (agenda item 6)

Dawn Pearson (DP) shared her slide set and apologised for sending late. DP advised that anything we are asked to do as part of the agenda (recommendations/actions) are lined up with our action plan. Links will be created within the report for easy access to documents. Real emphasis on addressing health inequalities, focusing on a number of recommendations which have come out from the West Yorkshire and Harrogate Health and Care Partnership (ICS) and NHS long term plan, together with aligning with the NHS advancing mental health equality strategy. Good articles contained within the report, particularly calling out and acting on racism and racist practice and Speaking Up and Listening Well, encouraging open conversations. RW mentioned that organisations are being asked to sign up to the anti-racism movement and hoped through this Committee and also Board that we could sign up to this, which EM also supported.

The Committee RECOMMENDED signing up to the anti-racism work which is being led from West Yorkshire and Harrogate ICS and in which we are partners. AM will write on behalf of the Committee.

Action: Angela Monaghan

Section 2 – Feedback from service users, staff networks, BDU equality forums and development programmes

EIC/21/32 Insight Report from Equality, Involvement and Inclusion Task Group (agenda item 7)

AM thanked the sub-committee for pulling this first report together – DP confirmed that it was a work in progress and probably required refinement. New format for pulling together anything which is happening quarterly. Includes lots of insight captured anecdotally or from what we hear which we can acknowledge sight of, that we have taken on board and from which we can pull out the themes to consider, to make a more robust report in future. Healthwatch very supportive of this and have been given a dedicated inbox to provide feedback. Will use the website as a "You told us, we listened" type exercise so that communities feel that they have been heard.

CJ felt it was a great start but needed to know how we would build on this to get a good picture of what is going on, how we would make sense of one-off comments and also how to ensure if we are signposting service users that we quality assure those organisations we are passing them on to and they get a good experience. TB confirmed that at present there was no formal quality assurance of other organisations unless already involved in a current partnership arrangement.

In terms of future reporting, it was agreed the Committee would be happy to receive a summary/overview of the key themes and headlines from each area, with more detail included in an exception report linked to the risks. With regard to the themes recommended to be included in the 'You told us' website publication, DP and TB to discuss, to agree that the right themes have been identified.

Action: Dawn Pearson/Tim Breedon

The Committee RECEIVED the report, noting the comments made and the actions agreed in relation to future reports and key themes.

EIC/21/33 Inclusive Leadership and Development Update (agenda item 8)

LJ advised that the Board Development Leadership Programme had been running from December to May which had been successful. Review meeting planned for 21 July with NHS Leadership Programme Director and Andrew Cribbis. Looking to draw up another Reciprocal Mentoring Programme – currently out for interest/applications - and a Shadow Board Programme to be targeted at staff from protected characteristics groups, plus re-starting the Moving Forward Programme again from this month in collaboration with our partners, Bradford District Care Trust.

CW confirmed that a BAME talent pool had been established, looking at how we develop our staff to become leaders and also that a development programme was running. SY enquired if we had identified jobs people can move into as part of that transition programme, as previously staff have felt frustrated by the lack of development opportunities, and what were we going to do differently to build our diverse talent. LJ agreed that it had not been followed through in the past but via the Fellowship Programmes we could start to move this forward. RW felt it was important to provide people with opportunities to flourish and to link to Fellowship Programmes and create a culture where line managers see this as the way we work at the Trust. LJ to capture and build into work on recruitment and retention.

Action: Lindsay Jensen

MF reflected on LS's comments earlier about all different groups and whether we applied the same focus and principles as we do to BAME. LS felt not. AM would like a brief written update for the next meeting in the inclusive leadership and development section about which protected characteristics are covered.

Action: Lindsay Jensen

Need to recognise intersectionality as well as ethnicity and ensure we address the needs of all protected characteristics across the Trust. It may well be there is an action plan addressing all protected characteristics. AM thanked LS for her challenge. RW reminded committee members that it was the Board's decision to focus on BAME communities as well as ensuring a strong focus on all other protected characteristics – this to be picked up as part of the strategy session.

The Committee NOTED the verbal update and the actions agreed.

Section 3 – Strategy and Policy

EIC/21/34 Film and easy-read version of the Equality, Involvement, Communication and Membership Strategy

DP shared the film which required sign off at the meeting. Final version to have subtitles. DP thanked all who had contributed to the narrative. All gave very positive feedback on what was a real partnership effort. MF suggested including the involving people email address at the end of the film and DP felt there should also be a mobile number.

DP asked for comments on the easy-read version, which was hot off the press. SY felt the easy-read version still needed a fair bit of work and that both herself and DP had noticed that it didn't reference all the protected characteristics. SY had wanted to get the easy-read to Committee to see but would like comments back over the next 2 weeks with a view to bringing back to the next Committee meeting.

MF felt the easy-read was very long, a little repetitive and would be better to mirror the style of the film. CJ asked if it had been tested on people for whom it is intended. DP advised that it had been shared internally by Aboo Bhanabaker (ABB) and a group had been identified to review the document in a couple of weeks. AM asked for all comments on the document to be sent to DP by end of June.

Action: All

The Committee AGREED the film, with a couple of amendments as noted above, and NOTED the comments made in relation to the easy-read version of the strategy.

Section 4 – Performance Reports

EIC/21/35 Covid-19 related Equality & Inclusion Report (agenda item 10)

LJ reported to Committee on the vaccination programme which ended in May. Very successful and still ongoing for any staff who haven't yet had the vaccine.

At the time of this report, the Trust has had a 87.6% uptake (72.9% non-white) so still a difference between uptake in white and non-white colleagues. We have a breakdown of ethnic minority groups, the lowest take-up being amongst staff with a Pakistani and black Caribbean heritage.

We are continuing to provide an 'evergreen offer' on vaccination and signpost to National Vaccination Programme. CJ asked about the key risks and the fact we had flagged that not all the side effects of the vaccine were known, which may deter some people from having the vaccine. TB said we needed to look at the amber risk rating and review the impact upon uptake. CJ also asked whether we were collecting/analysing data from service users and inpatients vaccination. TB confirmed that we were but had not brought the data to this meeting. Further information required on why showing as amber risk. TB to discuss with LJ outside of meeting.

Action: Tim Breedon & Lindsay Jensen

RW advised that the level of risk was very small in terms of some of the side effects i.e. blood clots, and needs to be reflected in likelihood scores. Also need to continuously ask the question about how it looks against protected characteristics. RW thanked all the people involved in building confidence around the vaccine ie. CW, Exec Trio and SY, and reiterated that we would continue with our evergreen offer so no-one is left behind.

MF asked what the risk was to the Trust, our service users and those who have chosen not to be vaccinated if the numbers stayed as they were. RW advised that the biggest risk was not having the right number of staff to provide the quality of care which was a risk to the organisation rather than a risk to individuals, the people they work with and the people they care for – these can be mitigated through proper use of PPE.

The Committee RECEIVED the report and NOTED that it would like to see some segregation of service user vaccination data and look into the amber risk around side effects.

EIC/21/36 Staff Survey Results (agenda item 11)
Deferred as WRC did not discuss on 18 May 2021. Work programme to be amended.

Action: Salma Yasmeen

EIC/21/37 Performance Dashboard – Development Update (agenda item 12)
A presentation had been circulated on the urgent actions to address the 8 inequalities in NHS provision and outcomes, which has been developed over the past few months. One of the things to consider is which areas we should target in terms of the information available.

MW advised that LM would demonstrate the work which has been undertaken with the business intelligence team showing some data around people accessing our services and how that compares with our local population data.

LF shared her screen and demonstrated how it worked, highlighting any areas where referrals and admissions have been over-represented or under-represented against population data during 18/19, 19/20 and 20/21 for ethnicity, age band (18-25 or older) and gender. This is work in progress and feedback was welcomed on where this could be used and who could benefit from using it.

AM thanked everyone for the development work done, noting the potential for this tool to be used for a range of things within the Trust, including dashboard reporting to Committee and EIAs. EM agreed and mentioned that the Mental Health Act Committee is looking at access for all protected characteristics so would be useful if information could be shared and fed back to SThi.

EM thought there were a lot of referrals from Bradford but the reason was that BD postcodes cover both Kirklees and Calderdale. CJ felt it required some form of performance review/process to ensure managers used the data and was happy to offer to test the model.

Need to determine how we are going to use the tool in terms of reporting against our plans and strategy but also across the rest of the Trust and what actions to take, and this could be discussed at the strategy session. SY welcomed CJ's point and his help to co-design. It would present a challenge to develop a process for it all so might well be that data is taken from one or two areas as a trial before launching into a more comprehensive process. RW suggested we use this information to support the roll out of some of the work we are doing around the community health team transformation.

Action: Salma Yasmeen

The Committee RECEIVED the update report and NOTED the actions agreed for future development.

EIC/21/38 Equality, involvement, communication and membership strategy implementation plan report – action plan update (agenda item 13)

DP advised that as part of the signing off of the action plans in March, we were asked to bring back an exception and highlight report. First draft of this type of report presented to the meeting – does not yet include KPIs as we need to make sure we do some work to define them first (planned for end of the month).

DP felt the report was in a logical format but this can be amended as necessary - any actions/exceptions are highlighted where we may be slipping and reasons for this. Also included is the equality impact assessment and training compliance, plus 6 examples of things going on with regard to inequality and involvement and a recommendation section at the end. AM liked the format and way in which the information was presented.

MF felt it may be better to have a simple headline summary of totals and their status ie. total number of actions, number complete, number on target and number at risk. DP will flag any concerns. Lot of work where reviews were put on hold but the teams are working through the backlog due to Covid and we are trying to train a larger number of people to work through them and strengthen the way in which we agree and sign them off. The Committee would like to have further information to keep track of the actions we are taking to get our EIAs back on track and noted that it was a work in progress. AM thanked DP for her work on this.

The Committee RECEIVED and commented on the report and APPROVED the recommendations.

EIC/21/39 Equality Standard Updates (WRES, WDES) (agenda item 14)

LJ advised that Covid had got in the way of some action plans but some have moved forward.

Recruitment – have been leading on international recruitment on behalf of partners across our region but slow start due to the Covid situation in India. We now have a partner to work with who have international nurses ready for us to start looking at and recruit. Hopeful this will happen in the next few months and will see some international nurses coming into the organisation. Have someone seconded into role to support the pastoral care of those nurses. Will get some messages/communication out about this.

Some funding is available for virtual recruitment fairs and we are looking at how these will work. We are hoping to do 3 or 4 per year, working with partners and looking at hard to fill areas.

Have been waiting for national information around what the WRES indicators will be this year so are not able to share what it looks like with the Committee at the moment, but have had the information through for the workforce disability equality scheme (WDES).

CW picked up on the equity guardian action point from the log around how we are recruiting them. The role profile has been designed collaboratively with clinical staff and went out recently through internal communications. Have had some interest already. CW, Ashley Hambling and Catherine Musagedi will be interviewing – will decide based on values and fit for the job as to who will be appointed. No cap on how many will be appointed. With regard

to training, will be putting a package together with Manreesh Bains and Jon Millard – aim is to have clinical support network with the staff and also how we manage service users, looking at care pathways and care planning.

With regard to Race Forward, CW, Manreesh Bains and Richard Holder have looked at previous terms of reference and are refreshing these to make sure they are relevant.

Paul Brown (PB) had provided an update on where we were with regard to last year's action plan. Now need to look at new action plan for this year based on the data - collection period is July and August, with final submission in October. No indication that indicators will change so will be able to compare year on year. This work will be picked up alongside the newly-formed staff disability network and we will work on actions for 21/22.

PB had redrafted proposed Disability & Reasonable Adjustments Policy with Elaine Shelton (ES), after circulating amongst key stakeholders, which is more supportive and person-centred. AM asked if this was going to come to this Committee for approval. PB noted it doesn't need to but he is happy to send to Committee for comment. MF agreed to receive this personally from PB.

Action: Paul Brown

AM asked about Project Search which has been delayed. PB not sure when this will be active again so will make enquiries and feed back.

Action: Paul Brown

ES raised a question in the MST chat around recruitment. She noted there is lots around international recruitment of nurses but wanted to know what was happening with disability recruitment and development. LJ noted we are looking at recruitment in total, and widening access to it, and it is not just around people from a BAME background. Supporting people with reasonable adjustments will help, together with some of the other work around promoting the organisation and linking in with place-based opportunities to go out and engage with schools and colleges.

The Committee NOTED the report.

EIC/21/40 Internal Audit Reports (agenda item 15)

Nothing to report.

EIC/21/41 Commitment to Carers Report (agenda item 16)

Gillian Cowell (GC) provided a verbal update. Continually working with all partner organisations across the system with regard to the staff carers' passport. Working closely with HR and also with wider staff carers' networks across the UK to support making care a 10th protected characteristic whilst sharing good practice.

ABB confirmed that a number of carer champions had been identified (15 in total across a range of services) plus promoting the unpaid carers' passport – want this to be offered at the point of contact with services and teams.

Congratulations were offered to Gill on her new appointment within the Trust.

Last week had been carers' week with lots of events and speakers/partners involved. It had been very well received, as was the poem by one of the carers in Calderdale which highlighted what carers are all about.

AM thanked GC and ABB and noted a full written annual report on our commitment to carers will be provided at the meeting in December.

RW made connection between GC's work and the workforce strategy – need to make sure all learning is fed into what we have been doing in the Covid recovery phase. GC and LJ to have a conversation about how we introduce flexibilities into the workforce plan to ensure work with carers gets supported.

Action: Gillian Cowell and Lindsay Jensen

Section 5 – Annual Items

EIC/21/42 Annual Items (agenda item 17)

No annual items.

Section 6 – Governance

EIC/21/45 Governance (agenda item 18)

AM noted that the Board had approved the change of name so the Committee was officially now the Equality, Inclusion and Involvement Committee.

Section 7 – Standard Closing Items

EIC/21/46 Return to review of risks in light of Committee discussion (agenda item 19)

There were no further comments on the risks assigned the Committee.

EIC/21/47 Items to bring to the attention of Trust Board or other Committees (agenda item 20)

For Board:

- Risks have been reviewed and commented on.
- Outputs from the inclusive leadership development work will be considered in the strategy discussion.
- Agreed to sign up to the anti-racism work at West Yorkshire & Harrogate Health and Care Partnership.
- Now have new insight report which is still in development but collates insight received from each quarter.
- Significant developments on performance dashboard. Welcomed the work of the business intelligence team noting they will continue to develop this – to consider priority areas in the strategy session.
- Welcomed the new highlight report summarising exceptions and progress against action plans.
- Strategy has now been captured in a short video which was approved and draft easy read document produced for further work.
- Committee sub-group to be refreshed and ensure coordination of all strands of the action plans - opportunity to revise both committee and sub-committee membership in light of changes.
- Significant work underway on carers, including carers' development worker appointed, carers' champions and carers' passport.

EIC/21/48 Work Programme (agenda item 21)

It was noted that the staff survey report had not been discussed at the Workforce and Remuneration Committee on 18 May so to move this item to the next meeting in September.

Committee strategy sessions – previously discussed these taking place twice per year (March and December). Action plans are due back in September so might be good to reflect at that time. To discuss at next agenda setting meeting.

Action: Salma Yasmeen/Angela Monaghan

AM thanked everyone for their input and hard work in preparing the papers.

EIC/21/49 Date of next meeting (agenda item 22)

The next meeting will be 21 September 2021.

South West Yorkshire Partnership NHS Foundation Trust

Finance, Investment & Performance Committee (FIP) – Monday 23 August 2021
Virtual meeting, via Microsoft Teams

Members	**Present**	**Apologies**	
Mark Brooks (MB) Chris Jones (CJ) (Chair) Kate Quail (KQ)	Carol Harris (CH) James Sabin (JS) Nat McMillan (NM) Robert Adamson (RA) Nick Phillips (NP) Darryl Thompson (DT) Amanda Miller (AM) Emma Robinson (ER)		

Item no.	Item/area	Progress and actions/decisions	Lead	Action
1	Introductions and apologies	Chris Jones (CJ) welcomed everyone to the meeting.	CJ	
2.	Declarations of interest	James Sabin (JS) declared an interest in the Forensic Lead Provider agenda item noting that it involves his substantive employer	CJ	
3.	Minutes from previous meeting	The minutes from the FIP meeting held on 26 July agreed.	CJ	
4.	Review of progress against agreed actions and matters arising	A number of actions are due for completion: Action 70 – sharing of governance structure - Complete Action 61 – circulation of learning disability benchmarking report questions - Complete Action 72 GC to re-circulate Benchmark report out to all attendees from CH Complete	CJ	**GC**
5.	Review committee related risks and any exception reports as required	JS referred to the paper which describes the risks relevant to the committee and actions taken. The next full risk report is going to the Board on 26 October 2021. There is no risk with a score of 15 plus that need to be escalated to Trust Board aligned to this committee's remit. The Committee continues to monitor 9 risks in total. e 3 key risks reviewed at the meeting are risk 1511 which is the West Yorkshire adult secure lead provider collaborative risk. The key issue at the moment is the agreement of a base line funding offer with NHS England which is ongoing. The main update to risk 522, which is the financial	JS	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		viability risk, is the impact of the mental health recovery funding stream review which is ongoing. There is currently a higher use of out of area bed placements given higher referral numbers and increasing complexity and acuity. CJ raised risk 1585 in terms of capital funding and ICS capital spending processes. **The committee reviewed and discussed the paper.**		
6	Financial Performance	6.1.2021/2022-month 4 financial performance RA discussed the report with the committee and ran through the slides. In July the Trust recorded a surplus of £377k in month which takes the year to date surplus to £2.1m. Forecasting for the last 2 months of this period to is to broadly break-even which will result in a £2.3m surplus forecast for the first 6 months of the year. Key headlines relate to vacancies & recruitment, and non-recurrent IT spend. Covid response expenditure has been included for the last 18 months and is currently showing reduced additional spend related to Covid. With the current outbreak on Stanley ward, some additional out of area spend bed expenditure is being incurred. Income is below plan due to timing of receipt of the mental health investment standard. Pay spend is broadly flat month on month, although agency costs have increased in the last couple of months, with spend of £834k in July which is the highest monthly agency spend in the last 4 years. Out of area bed costs reduced in June/July, although they are expected to increase in the next few months. From a cash perspective £2.1m due from NHS England in August is now likely to be received in September. NM asked for clarity on the agency spend cost reported as higher but on the WTE has reduced to 95. RA confirmed this was an error on the report and he will update the report. CJ wanted to know the implications on staffing as there are circa 100 fewer WTE than we had at the start of the year and asked what the operational implications are for the organisation, as this seems very stressful for staff. CH agreed it is challenging for staff and planned HR strategy meetings have been brought forward to look at flexible working, recruitment and retention. CJ referred to the £1m adverse variance on income this month. If this was a trend it would be difficult to achieve the forecast surplus of £2.3m at the end of month 6, it's a big variance in a month. RA explained the income variance is offset by pay related to that income. RA agreed to look into this and clarify. MB returned to the meeting.	RA	**RA**

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		6.2 H1 forecast 21/22 RA shared papers with the committee and pointed out that the main headline was the £2.3m H1 forecast previously agreed through the Committee and approved at Trust Board. Predominantly more spend is projected for months 5 & 6 including staffing and out of area bed costs which are shown in the breakdowns provided. CJ noted it is positive there are more opportunities than risk on the forecast spreadsheet, and asked if it is there will be a higher surplus than forecast. RA said the position for half 1 is close to £2.3m and continuing with the planning exercise for half 2. MB added that the approach that has been taken in the West Yorkshire ICS, we are the only Trust at this point that has changed its forecast and declaring a surplus for H1 at present. **The committee discussed and commented on the report.**		
7.	Forensics lead provider update	MB gave an update and reported that there had not been much change since the last report other than one significant proposal which will be discussed later. He went on to add an updated financial offer for the West Yorkshire adult secure lead provider collaborative has not yet been received. The regional commissioner is awaiting confirmation from national commissioning of its allocation. Work is being carried out in order to go live operationally on 1 October 2021 and financially/contractually when the finances have been confirmed. All collaborative member governing bodies will need to confirm they are in agreement with the proposed arrangements. A lot of work has been carried out with developing the commissioning and governance arrangements. A paper is being taken to the Board with what the proposed structure is. Recruitment of a joint clinical lead between CAMHS and forensic services has commenced, and Leeds York Partnership is actively recruiting for a Head of Commissioning for the collaborative. Sheffield Health Social Care NHS Foundation Trust (SHSC) have reached a decision at Board level that they do not feel it is appropriate now to move forward to becoming the collaborative Lead Provider across South Yorkshire. One option is for the Trust to be the lead provider across South Yorkshire as well as West Yorkshire. Preliminary discussions have taken place and it has been agreed to do conduct exploratory work with no commitment at this stage, NHS England are supportive of this approach. This means that South Yorkshire will not go live on 1 October. This should not affect the West Yorkshire go-live. CJ questioned what would happen if we went live but then didn't get the financial funding wanted. MB responded by stating that whilst there is a lot of pressure to go live he doesn't envisage that any Board will approve go live without firm financial foundations in place. CJ asked for clarity around the governance arrangements and what the Board's responsibility for the collaborative will be. MB recognised it is complicated and the fact that there are two different Lead Providers across West Yorkshire for the different services and collaboratives makes it slightly more complex. Leeds York Partnership will be hosting the	MB	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		commissioning function, but they are not the lead provider for forensics. There will need to be some structure to make sure that we manage the collaborative effectively. Exact responsibilities need clarity. CJ accepted the report with work still to be done. He went on to discuss South Yorkshire and agrees this is a good idea to explore and to look at the due diligence. The West Yorkshire business case is based on repatriation and wondered how many of South Yorkshire people have been repatriated. MB referred to the due diligence and agreed there is a lot of work to be done to determine if this approach is viable and feasible. A milestone plan is being established to ascertain when we can have a view on this option., He asked JS for his thoughts given his background with SHSC. JS commented that there is less opportunity in South Yorkshire to bring people back from out of area and there is a significant financial gap unless funding is increased. **The committee discussed and commented on the report.**		
8.	Bretton Centre Update	Mark Brooks (MB) explained that this was not the final business case. The draft proposal has gone through EMT and that there is still further work to be done. A scheme of this size requires Board approval, and it will be helpful to get initial feedback from Committee members to inform any further work in preparation for Trust Board. Nick Phillips (NP) explained that this is referred to as the Bretton Scheme. The main driver is to bring the two wards, Thornhill and Sandal, up to the same standard, which takes into account any national guidance. In addition to the need for en-suite facilities there are other issues to address including day space and meeting new improved seclusion standards. These have been recognised as requirements for forensic services by the CQC and Royal College of Psychiatry. There is a significant financial cost in total of circa £10m. This cost is higher than originally envisaged when initial budgets were compiled and will have an impact on total ICS capital spend in both this year and even more so in 2021/22. There are significant non-recurrent revenue costs mainly around decanting leading to substantial additional staffing costs of £725k Bed numbers will be maintained throughout the project but the decanting will lead to double staffing requirements. With reference to the procurement process consideration is being given to utilising a framework agreement, looking at 3 different possible procurement methods. The majority of the capital spend will be incurred in the next financial year (probably about £8-£9mm which puts a strain on the system). Our total capital budget for this year is £9.6m, much higher than what we have spent in each of the last two years. It is important to consider affordability. Nat McMillan (NM) asked about the additional financial cost and the views of the ICS. MB responded and explained that he has informed the ICS of the situation and that this will need to go through an internal and system planning process. It has become evident that capital costs are increasing as a result of a number of factors including the pandemic and Brexit. NM raised the issue of risk operationally and an understanding of the potential impact of decanting. Carol Harris (CH) agreed there is a risk of using Gaskell ward but we will use the cohort procedure and isolate a ward if there is an outbreak. MB stated	NP	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		that one risk regarding using the decant ward is to staff it, as it is challenging to recruit staff into forensics. MB raised the issue of alignment with the adult securely collaborative work and the ability to repatriate service users from out of area which is a fundamental part of the business case and he has asked for assurance that this is still achievable. CJ was concerned about the increase in capital cost requirements. MB explained the scope of work has undoubtedly changed and that he has also expressed his concerns over the fact the costs differ significantly from the original estimate. MB left the meeting. Nick Phillips (NP) explained that the cost of the project had been underestimated at the beginning and upon realising this the current market was used to get a more realistic amount. CJ said that from a committee's perspective having to reassure the Board, there must be more certainty, accepting it can never be 100% certain on a project of this scale. NP asked if the committee required further information. CJ commented that he would like to see the breakdown of the difference between the originally assumed and current assumed costs to understand the different changes. Also, there is very little in the business case about our carbon footprint and the Board/Trust interest on more things green. NP agreed to put a section into the business case on sustainability. CJ raised the issue of quality make sure the quality is right and the right tool for managing costs. Kate Quail (KQ) mentioned sustainability and procurement, asking what has been learned from previous builds. Noise is an example and having an autism friendly environment should be included in the business case. KQ asked who is looking at the operational risk when the user won't decant? NP stated there was an operational group and their remit cover operational practicalities and risk. KQ mentioned the operational risk about design and if there was an issue with cleaning staff. Carol Harris (CH) explained the plan has been developed with the operation leaders at the outset and will also engage with service users and staff once the scheme is agreed. CJ asked if enough feedback had been given regarding the project. NP confirmed he had received enough feedback and thanked the committee for the invite. NP left the meeting. **The committee reviewed and discussed the paper.**		**NP**
9.	Service Review (EIP)	An overview of Early Intervention in Psychosis (EIP) services in the Trust was presented by Amanda Miller (AM) and Emma Robinson (ER). The presentation highlighted early intervention in Psychosis, there are 5 EIP teams Trust wide Barnsley, Calderdale, North Kirklees, South Kirklees, Wakefield. Established 2007/8. A discussion took place covering ARMS (At Risk Mental State) getting patients back into primary care. Investment, KPI Performance, Referrals to EIP services, NCAP Audit	AM/ER	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
		(National Clinical Audit of Psychosis). Overall, the service is preforming well in terms of access across the 5 areas and performance in terms of national surveys is very good. **The committee reviewed and discussed the presentation and thanked the presenters for their presentation**		
10.	Horizon scanning	JS explained it was a brief report this month with limited updates, 3 key points were noted: Financial settlement for half 2 - the guidance is due out in September and planning will run through into October. Funding is likely to be lower than half 1 and initial scenarios are being developed to model this. Guidance is also expected regarding the funding for the pay award. Continuation of the ICS financial framework, the forming of the governance structures and the roles across the ICS places, where provide collaboratives fit and individual providers within the new regime from 1 April. Regarding the new national hospital programme trusts have been asked to put in expressions of interest by early September which will be narrowed down to 9 bids. The Trust is considering putting something forward regarding, the Dales and Priestley. KQ asked about control totals and what was known about them, will they return and what will they look like. JS stated very little was known now except there is likely to be an increased efficiency requirement. **The committee reviewed and discussed the paper.**	JS	
11.	High Performance report benchmarking	CH stated the paper was just to note the High-Performance report that is produced by the National Benchmarking Agency, which show where trusts are performing over the national average. It has been also been received by EMT and reviewed by the internal benchmarking group. CJ asked what the timescale t is covered by the report. **CH took an action to confirm the time period covered**. CJ asked how the information is used to improve service provision. CH responded that the report is used to corroborate issues already identified and to identify if there are any points made we did not expect. We can also share benchmarking information with other trusts. We can also look at whether the report re-iterates information and therefore provide assurance. It acts as a prompt for further discussions. NM asked how this information gets shared with staff? CH explained it is provided to BDU meetings. There is a benchmarking group of staff from across all services and benchmarking services and representatives which the information is reviewed at and circulated from. **The committee discussed and reviewed the paper.**	CH	

Item no.	Item/area	Progress and actions/decisions	Lead	Action
12.	Annual Work Plan	JS will review the plan and make some amendments with CJ outside of the meeting. MB noted an action from the Trust Board to look at the use of SPC charts in the IPR which should be included on the next agenda. **The committee reviewed the paper and discussed.**	JS	**CJ**
13	Items to be brought to the attention of Trust Board/Committees	CJ reported suggested the following is reported to Trust Board: Continued assurance regarding performance Assurance the H1 financial forecast will be delivered Good assurance around the performance EIP service noting the opportunities to improve further in Wakefield Assurance from the high-performance report that shows the Trust is performing well across a wide range of services Alerts around workforce with data showing c100 fewer whole-time equivalents since March and higher agency for several months is clearly a sign of pressure. South Yorkshire & Bassetlaw Lead Provider opportunity. Bretton Centre capital scheme Awaiting updated financial offer for the West Yorkshire lead provider collaborative	CJ	
14	The next meeting date of the Committee	The Committee noted the next FIPC meeting will take place via MS Teams on Wednesday 22 September 2021, 1:00 – 3:00.		

NHS
South West Yorkshire Partnership
NHS Foundation Trust

WORKFORCE AND REMUNERATION COMMITTEE
Terms of Reference

All Trust Board Committees are responsible for the scrutiny, monitoring and provision of assurance to Trust Board on key issues set out in their terms of reference and/or allocated to them by the Board. Agendas are set to enable Trust Board to receive assurance that scrutiny and monitoring processes are in place to allow the Trust's strategic objectives to be met and to address and mitigate risk.

The Workforce and Remuneration Committee (formerly known as Remuneration and Terms of Service Committee) was established in June 2002. The Terms of Reference of the Committee are reviewed annually and, if appropriate, amended to reflect any changes to the Committee's remit and role and revised membership. The Committee is a non-executive committee of the Board and has no executive powers other than those specifically delegated in these terms of reference and, as appropriate, by Trust Board. Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

Purpose

The Workforce and Remuneration Committee has delegated authority for developing and determining appropriate pay and reward packages for the Chief Executive and Executive Directors and a local pay framework for senior managers as appropriate that actively contribute to the achievement of the Trust's aims and objectives. The Committee also has delegated authority to approve any termination payments for the Chief Executive and Executive Directors. Additionally, the Committee is responsible for ratifying Clinical Excellence Awards for Consultant Medical Staff.

The Committee also supports and monitors the strategic development of human resources and workforce development and considers issues and risks relating to the broader workforce strategy. On behalf of Trust Board, it reviews in detail key workforce performance issues, and takes ownership of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, and giving assurance to the Board around the management of such risks.

The Committee will support the development of an organisational culture where staff feel free, safe and able to raise concerns at work without fear of suffering a detriment. This includes supporting the lead Freedom to Speak Up Guardian to actively encourage and promote the Trust's commitment to the principles of Freedom to Speak Up which ensures the safety and welfare of Staff, Service Users, Carers and Visitors.

Membership

Membership of the Committee is comprised of the Chair of the Trust, two Non-Executive Directors and the Chief Executive.

Membership as at 1 October 2021
Chair – Non-Executive Director – Mandy Griffin;
Non-Executive Director - Angela Monaghan (Chair of the Trust);
Non-Executive Director – Natalie McMillan;
Interim Chief Executive (non-voting Committee member) – Mark Brooks.

Attendance

The Chief Executive is a non-voting member of the Committee and will take no part in or be present for any items relating to his/her own personal remuneration or conditions of service. The Director of Human Resources and Organisational Development is also in attendance at meetings as lead Director and provides advice and support to the Committee. Administrative support is provided by the Personal Assistant to the Director of Human Resources and Organisational Development.

Quorum

The quorum will be two Non-Executive Director members. Members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Committee will agree another Non-Executive Director to take the chair. In the absence of the Chief Executive, the Chair of the Committee will decide whether it is appropriate for the Deputy Chief Executive to attend as a non-voting member.

Frequency of meetings

The Committee will meet no less than four times per year.

It is the responsibility of the Lead Director to ensure items are identified for the Committee's agenda in line with the Committee's terms of reference, its work programme agreed at the beginning of each year and the current risks facing the organisation and to agree these with the Chair of the Committee.

Authority

The Committee is authorised by Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Sub-committees

To fulfil its duties and to ensure the Trust complies with its statutory responsibilities and duties, the Committee will receive reports from identified sub-committees including but not limited to:

- Clinical Excellence Awards Panel.

Duties

1. To develop and determine appropriate pay and reward packages for the Chief Executive, Executive Directors and other designated senior managers and other locally determined pay arrangements that actively contribute to the achievement of the Trust's aims and objectives, are affordable and are in line with the Trust's financial strategy. Specifically to:
    a) determine the remuneration and terms of service for the Chief Executive;
    b) determine the remuneration arrangements for Executive Directors and to agree individual salary levels for Executive Directors;
    c) to determine any annual uplift, for example, cost of living, for the Chief Executive and Executive Directors;
    d) to ratify remuneration arrangements for senior management posts;
    e) to approve any annual uplifts in pay structures and any performance-related pay arrangements for senior posts;

f) to approve any termination payments to the Chief Executive and Executive Directors and ensure these are properly calculated and reasonable with regard to probity and value for money;
g) to receive a report from the Chief Executive of any proposed termination payments to be made to senior managers.

2. Under delegated authority from Trust Board as deemed appropriate for each circumstance, to agree and oversee the process for the appointment of the Chief Executive and Executive Directors of the Trust.
3. To approve recommendations of the Clinical Excellence Awards Panel for Clinical Excellence Awards to Consultant Medical Staff.
4. To support the strategic development of human resources and workforce development and consider issues and risks relating to the broader workforce strategy.
5. On behalf of Trust Board, to monitor progress of the Workforce Strategy and review in detail key workforce performance issues.
6. To have oversight of workforce-related strategic risks, providing additional scrutiny of any such risks which are outside the Trust's Risk Appetite, giving assurance to the Board around the management of such risks.
7. To consider future national developments which could impact on the Trust's strategic workforce objectives.
8. To have oversight of the Trust's approach to Freedom to Speak Up including receiving at least 2 reports every year, one of which should be the annual report, from the lead Freedom to Speak Up Guardian.
9. On behalf of the Trust Board, to monitor progress of the Freedom to Speak Up Strategy and action plan and review in detail relevant performance indicators.

Monitoring

The Committee will monitor its performance both in terms of providing assurance to Trust Board and in terms of ensuring it meets the remit as set out in its terms of reference through agreement of an annual work plan, inclusion in the work plan of any items delegated to the Committee by Trust Board and through the Assurance Framework, monitoring implementation of the annual work plan, assessment of the Committee's performance through an annual self-assessment, and an evaluation of the Committee's performance through an annual report to Trust Board.

The Committee will assess, measure and evaluate its impact, both quantitatively and qualitatively, and include the outcome of this in its annual report to the Audit Committee and to Trust Board.

Reporting to Trust Board

Trust Board will receive the minutes of Committee at the next Trust Board meeting following the Committee meeting. Confidential personnel matters will go to the private session of Trust Board, if appropriate, and the decisions of the Committee in relation to specific salary matters are reported to the Non-Executive Directors of the Trust only. The Committee will also report to the Board annually on its work (see above).

All Trust Board Committees have a responsibility to ensure they foster and maintain relationships and links between Committees and Trust Board. Each Committee also has a responsibility to ensure action identified and agreed is placed within the organisation either through the Executive Management Team or other internal groups, such as Trust-wide Action Groups (TAGs).

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 10.2

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:	<u>SYB ICS Update</u> 1. Coronavirus (COVID-19) Position Covid case rates remain high across South Yorkshire & Bassetlaw (SYB) at between 400 – 600 per 100,000. Case rates in children and young people are the highest and there are signs of low-level increases in other age groups. Work is underway to offer Covid vaccine boosters across SYB communities in line with national guidance. 2. Community Diagnostic Centres £3million of capital funding has been confirmed to develop two new community diagnostic centres in SYB. Two initial sites have been identified for the first year of funding - The Glass Works in Barnsley and Montagu Hospital in Mexborough. 3. QUIT Update SYB's QUIT programme, funded by Yorkshire Cancer Research, has successfully recruited more than 200 'QUIT Champions' to help reduce smoking-related illnesses across the region. Tobacco Treatment Advisers (TTAs) will provide the majority of specialist support and are being supported by the new QUIT Champions

	who help provide first-hand experience of having quit successfully - and how they did it. 4. ICS Development The design work to prepare for the creation of statutory body integrated care systems by April 2022 continues. The Chair designate is already agreed and in place, and the recruitment process for the ICS CEO is entering its final stage. Within the national guidance, it is clear that CCGs are legally responsible for proposing the Integrated Care Board (ICB) constitution with the expectation the designate ICS leaders will take ownership of this process once in place. There are various deadlines approaching for engaging on component parts such as ICB membership. SYB is looking to expand on the number of NEDs on the ICB so they operate with more than the minimum recommended. The need to focus on relationships, partnership working and culture is clearly evident and recognised within the ICS. Work is taking place in each sector and place to develop strong provider collaboratives. A key consideration is the level of delegation that will take place from ICBs to place and provider collaboratives. 5. Digital Transformation Strategy A digital transformation strategy for SYB has been developed. It is built on 5 missions which are: • Digital services for our public • Enabling the SYB workforce • Integrated digital care & health • Data & intelligence • Excellent infrastructure 6. Mental Health, Learning Disability & Autism Alliance A meeting took place for all provider chairs and chief executives in October to further progress the development of the provider alliance. In addition to the Trust, the members of this alliance are Rotherham, Doncaster & South Humber (RDASH), Sheffield Health & Social Care (SHSC), Nottinghamshire Healthcare and Sheffield Children's. A proposed vision, mission and purpose have been defined and previously been shared with the Trust Board. These are supplemented by a number of guiding principles. These are attached to this paper along with the provider alliance objectives. Also included is a draft proposed governance structure. The Alliance Board will develop in a phased approach as the scope and functions of the alliance increase

	including joint strategic decision making for areas delegated to the SYB MHLDA Alliance. The CAMHS tier 4 and eating disorder lead provider collaboratives went live on 1 October. The Trust is reviewing the due diligence already completed on the adult secure leader provider collaborative and will make a recommendation to Trust Board in November regarding how this should progress. A shared commissioning hub has been established for the SYB provider collaboratives. Work has commenced with mental health providers and Yorkshire Ambulance Service to implement the Long Term Plan ambition for ambulance service transformation to support people with mental health needs. It has been agreed that a pilot will be implemented to test out the dedicated response vehicle for mental health related calls, data is being collated to support the determination of where and how this pilot should operate in South Yorkshire. Lead in time for the vehicles along with availability of appropriate workforce are key risks to the delivery of the project. Operational Pressures in S136 capacity - a first meeting to consider the operational challenges has taken place, reviewing the South Yorkshire protocol and variation in service offers. Children & Young People (CYP) access to crisis pathways is being reviewed across SYB with a shared intent to work towards a joint model. The pathway model is being developed in partnership with Yorkshire and Humber Clinical Network. S136 provision for CYP is still an area of need across the ICS. Work continues in partnership with places to ensure solutions are in place having agreed that a regional response is a flawed response. The alliance is working jointly with the CYP Transformation Programme to review how to meet the mental health needs of all children with health needs. There have been a number of concerns within South Yorkshire and Bassetlaw ICS regarding mental health provision across the locality, particularly the challenges to meet the increasing needs of complex mental health and learning disability provision. SYB mental health organisations are reporting sustained pressure and small fluctuations in demand can cause significant issues within the locality. If mental health trusts do not have capacity and patients are experiencing a period of crisis, this can result in the nearest place of safety being an emergency department within an acute trust. This then places significant pressure on already challenged emergency departments and the acute bed base in local hospitals. There are sustained pressures across CAMHS services, both across SYB and nationally, with a recognised national shortage of specialist Tier 4

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

Perinatal mental health services across SYB will be reviewed in Q3 working with colleagues in NHS England/Improvement team and partners in SYB.

7.Workforce – S-WIM Recommendations

In July 2021, KPMG were nationally commissioned to deliver an external review of SYB Workforce function called System Workforce Improvement Model (S-WIM). This process has been delivered across ten ICS areas and defines best practice for ICS Workforce Hub Function and the organisations in nine workforce related themes, aligned to national people function guidance.

The themes are:
1. The whole system as the best place to work
2. Developing leadership culture
3. Releasing time to care
4. Preparing for new models of care
5. Preparing for the impact of Technology
6. Optimising new workforce roles
7. Supporting the VCSE and carers
8. Growing and training our future workforce
9. Workforce management capability and capacity

The objectives of the review were to:
• Identify and share good practice
• Flag areas for development based on global good practice
• Assess the systems ability to deliver

Thirty five interviews and 7 workshops attended by 128 stakeholders were held – more than any other ICS.
The maturity level of each theme is assigned in a scale of four categories as per below where emerging is the least mature and thriving is the most:

a.Emerging
b.Developing
c.Maturing
d.Thriving

SYB has been rated as maturing, the highest rating of any ICS review to date. There are five recommendations for further development to support alignment with ICS developments of a People Function.

8. Barnsley Integrated Care Partnership and Developments

We have continued to work with Primary Care Partners through the Barnsley Health Care Federation (BHF) to progress the evolution of the

	partnership to a more formalised provider collaborative through an Alliance agreement. Community teams have continued to work with Primary Care partners to support the vaccination programmes and deliver joined up support in neighbourhoods and for care home residents. The community transformation programme continues to be developed in partnership with input and oversight through the place based Mental Health Partnership Board. This involves providing early mental health support through primary care networks and the increasing use of peer support workers through our Recovery Colleges. A new mental health and wellbeing strategy that places a greater emphasis on prevention and wellbeing has been co-produced by partners and was led by the CCG mental health commissioner has been through the Health and Wellbeing Board for discussion. We have contributed to key elements of the strategy that is aligned to the Trust's strategic direction. The Barnsley Integrated Care Partnership has continued to respond to the changes set out in the NHS White Paper and developed a place agreement that is currently being taken through all partner governing boards. The agreement was discussed by Trust Board in September in private and is on the agenda for approval at this meeting. 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.

MH Alliance Purpose (Mission, Vision) and Principles

Proposed Purpose:

- Vehicle for planning and leading the strategic direction of the Alliance (including transformation of Long Term Plan)
- Provide a mechanism for joint action and joint decision-making
- Provider mechanism ways for collectively working through difficult issues and resolved to ensure the achievement of better health and care outcomes for the population of SYB
- Oversight of the Alliance programme/priorities
- Plans a unified approach to how the Alliance and related MHLDA services are represented at the ICS Board

Proposed Mission:

"Improving People's Mental Health and Wellbeing"

Proposed Vision:

"A partnership driven by the commitment to improve the outcomes and experience of care for the population and service users, families and carers of mental health, learning disabilities and autism services in South Yorkshire and Bassetlaw."

Proposed Guiding Principles:

We will collectively use our resources and expertise to improve experience and outcomes for all

We will co-produce with people

We will always demonstrate mutual respect, trust, open transparent communication, and will act with integrity

We will share responsibility, accountability, risk and reward

We will be clinically driven and ensure services are locally owned

We will reduce health inequalities and deliver inclusive care and support

We will collectively support and develop our people

MH Provider Alliance Objectives

Provide **a strong, unified and representative voice** to champion and advance health and care outcomes for MHLDA and all ages within the SYB local (ICP) and system (ICS)

Collaborate with members to **deliver improved patient care**, enhancing resilience and sharing best practice

Ensure that all member Trusts are **driven** to make decisions which lead to **tangible benefit for the service users,** families and carers

Secure investment to deliver improved and innovative services for the population of SYB

Develop a **clinical strategy** to collectively **improve the experience of care** and tangible impact of MHLDA services in SYB

Promote the Alliance and facilitate **stakeholder engagement** at Partner, Place and System level

Securing delivery of LTP ambition for MHLDA and investment decisions on behalf of the ICS

Develop and update the **governance & assurance framework** to enable the Alliance to deliver and mature

Apply a **data driven approach to decision making** and to identify high value and **need based opportunities and priorities**

Deploy resources and make decisions to **reduce health inequalities, and unwarranted variation**

Build a **sustainable workforce** by advancing opportunities to share and strengthen capabilities and capacity

Commit to **promoting inclusivity** and creating services **which improve access and quality of care** to all members of our community

Take **a population health management approach** to target and **improve patient outcomes**

Provide Governance framework for Specialised Commissioning **Provider Collaboratives**

System level commissioning

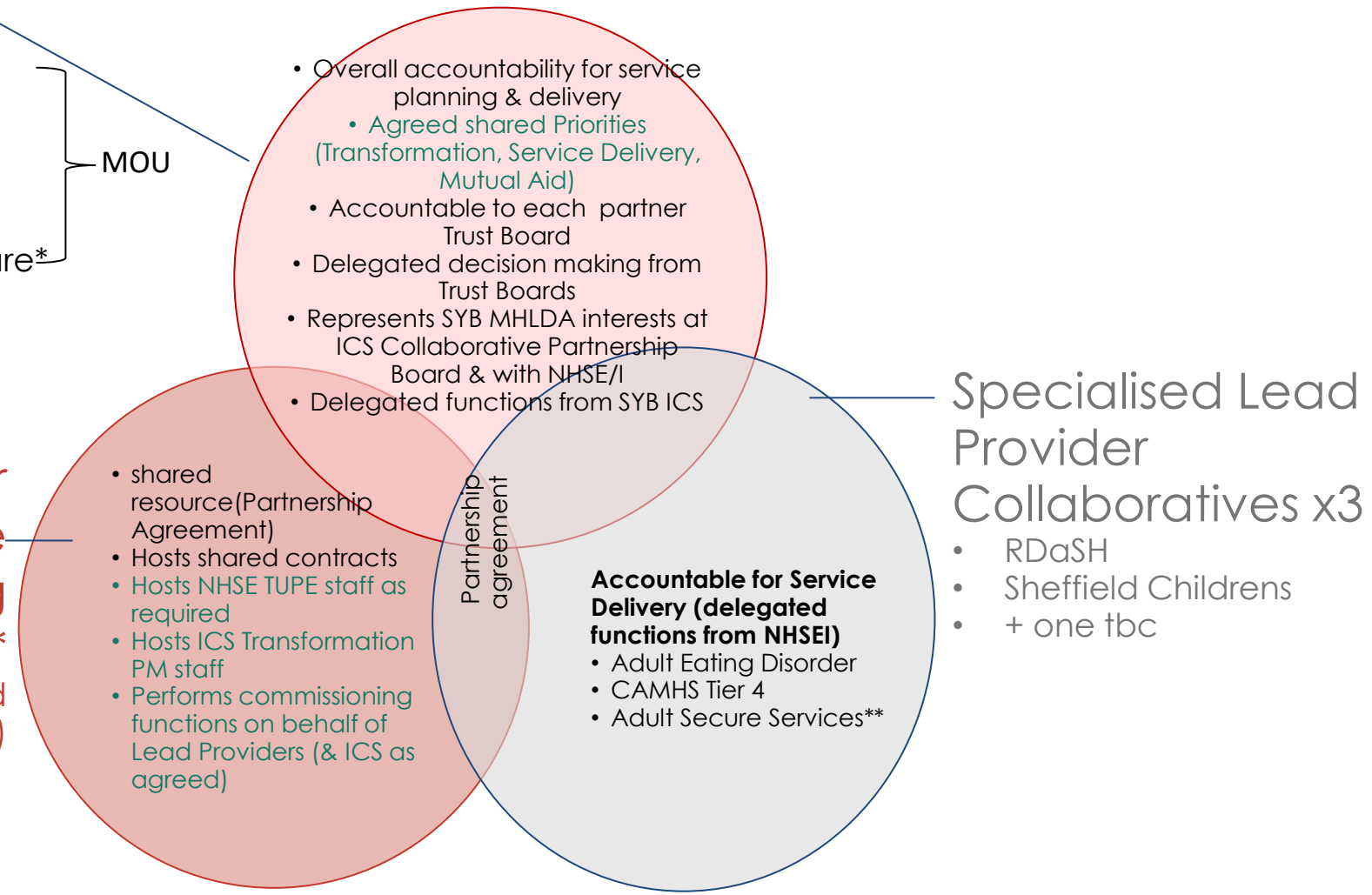
Develop and embed the **infrastructure to mobilise** the Alliance in order to **develop an Implementation Plan**

Mental Health Provider Alliance and Lead Provider Specialised Collaborative Approach

SY MHLDA Provider Alliance

- SWYFT
- RDASH
- SHSC
- Sheffield Childrens
- Nottinghamshire Healthcare*

MOU



Provider Collaborative Commissioning Support Hub**

(Hosted by Sheffield Childrens NHS FT)

Specialised Lead Provider Collaboratives x3

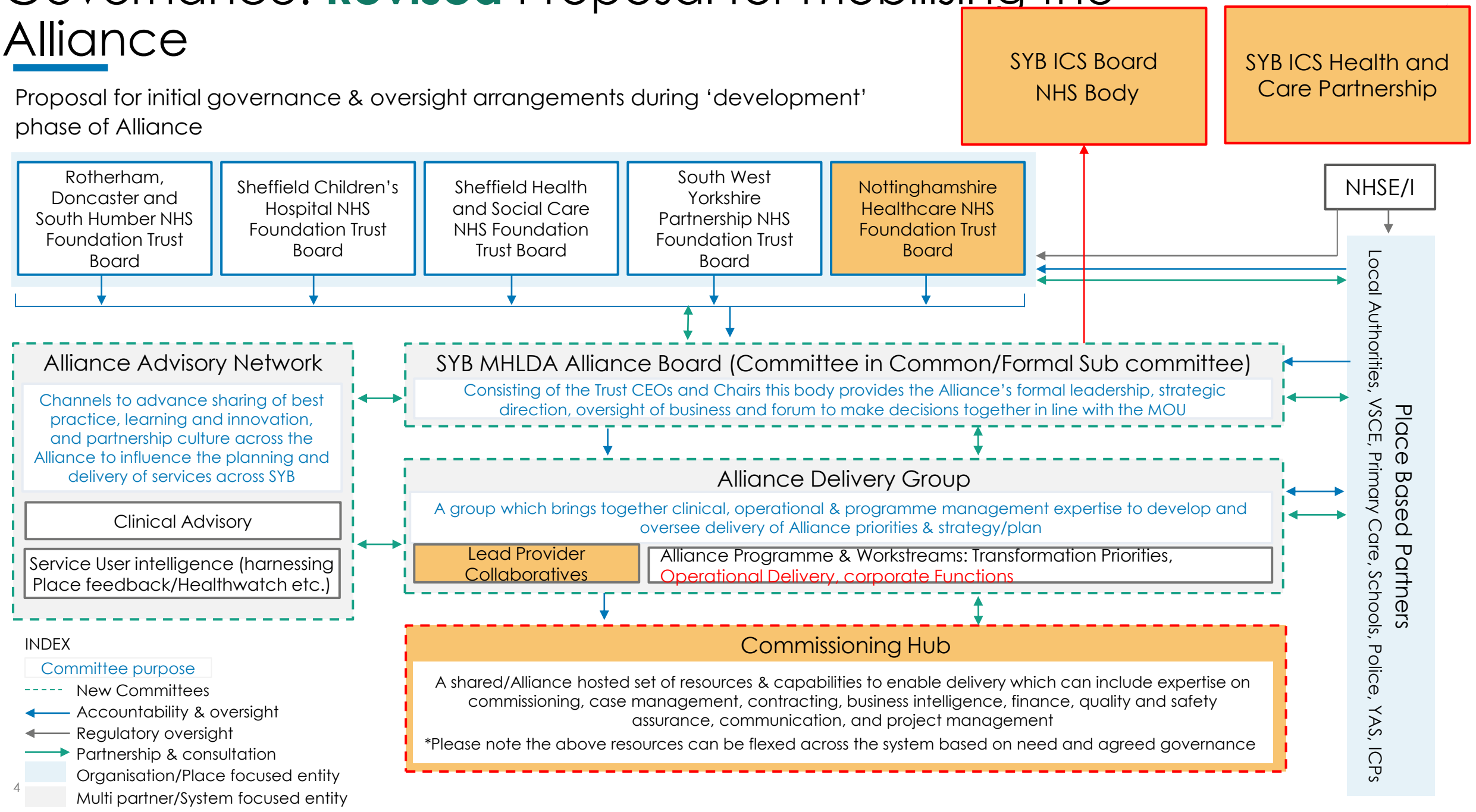
- RDaSH
- Sheffield Childrens
- + one tbc

* Understand implication of membership due to boundary changes for SY ICS

** Commissioning support Hub current established to deliver functions on behalf of Lead Providers; possible this could be expanded out to include additional resource and capacity as determined and agreed with ICS, for example, commissioning (CCG), Transformation Programme PMO

Governance: **Revised** Proposal for mobilising the Alliance

Proposal for initial governance & oversight arrangements during 'development' phase of Alliance



NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 October 2021

Agenda item 10.2

Title:	**Barnsley Integrated Care Place Partnership Agreement**
Paper prepared by:	Director of Strategy
Purpose:	The purpose of this paper is: **1.** **To provide an update** on the proposed arrangements for the development of the Barnsley Integrated Care Partnership (ICP), including a collaborative agreement for the ICP (referred to as the "**Place Agreement**"). **2.** Provide Board **with an opportunity to consider and discuss the proposed approach and provide support for the Place Agreement.**
Mission/values/objectives:	The development of joined-up care through place-based plans are central to the **Trust's strategy**. As such, it is supportive of our mission, particularly to **help people to live well in their communities.** The development of operational and strategic partnerships **can support the achievement of the Trust's strategic objectives** – to improve health and wellbeing through an enhanced focus on prevention and early intervention; improve quality and experience through more integrated ways of working and improve the use of resources across the whole system. **The way in which the Trust approaches strategic developments and service change 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:	Regular updates received at Trust Board with respect to the development of Integrated Care and key developments in Barnsley, including the draft agreement. The draft agreement was supported by the Barnsley Integrated Care Partnership Group (ICPG) on 29 July 2021 with a recommendation to Partner Boards for consideration and approval. Trust Board considered the agreement in Private Board in September.
Executive summary:	**Background/Context** The Trust has been working with partners in Barnsley over the last few years to strengthen collaboration and partnership arrangements that

include the Integrated Care Partnership Group (ICPG) and Integrated Care Delivery Group (ICDG). These partnership arrangements are further evolving to respond to the changes set out in the DHSC White Paper – *Integrating Care* – and as outlined in the Health and Care Bill, which has now had its second reading in Parliament. The final draft of the Place Agreement was developed by Hill Dickinson LLP, with input from Partner representatives forming a 'Design Team' which reports into the Barnsley ICPG.

It is clear from the Health and Care Bill that a formal place-based partnership will need to be in place in Barnsley from April 2022 and that the Partners will need to undertake a programme of work in 2021/22 to prepare for the transition. The development of the ICP will be undertaken in parallel with, and linked to, the further development of the SYB ICS. The ICS is expected to become a statutory entity in its own right in April 2022, with the CCG being dissolved and its functions transferred to the ICS.

Place Agreement

The **Place Agreement** is intended to facilitate further progress towards an ICP model for Barnsley, in line with the national policy direction. The Place Agreement has been co-produced and work on it has been led on behalf of the Integrated Care Partnership Group (ICPG) by its sub-committee, the Place Design Team. ICPG approved the Place Agreement with a recommendation for Partner boards to support and formally approve on the 29 July 2021, subject to a clarification amendment re-emphasising our commitment as a place to equality and diversity. This draft agreement was also considered by Trust Board in private in September 2021.

The proposal is that current members and partners of ICPG will be formal partners in the Place Agreement, including NHS Barnsley CCG, Barnsley Metropolitan Borough Council, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust, Barnsley Healthcare Federation, Barnsley Hospice and Barnsley Community and Voluntary Services (referred to in the Place Agreement as the Partners). Barnsley Healthwatch will continue to play a key role in the ICP through continued attendance at BICPG and Barnsley ICP Delivery Group (ICDG) meetings.

Key features of the Place Agreement

The Place Agreement is a collaborative agreement similar to other such agreements already in place in a number of other systems. Key examples include Bradford District & Craven, Collaborative Newcastle and St Helens Cares.

The Place Agreement sets out the following key elements:

	• Vision and core objectives of the Partners for the development and delivery of the ICP; • Key collaborative principles that the Partners will comply with in working together to achieve the common vision and objectives (in line with the Health and Care Compact); • The governance structures underpinning the ICP; • The priority programmes and key enabling programmes which the Partners agree to deliver together (The Barnsley Health and Care Plan); • The ICP development plan (in outline – and which will be refined considerably once full guidance has been released to support the implementation of the Health and Care Bill) as referred to above; and • Other standard provisions for agreements of this nature, including dealing with conflicts of interest, confidentiality and a dispute resolution process. Each Partner who signs up to the Place Agreement agrees to collaborate with the other Partners to deliver the vision, objectives and priorities and to act in accordance with the agreed collaborative principles. **The Place Agreement provides a framework for the Partners to make aligned decisions respecting existing statutory duties and functions of the Partners.** As a framework, the Place Agreement is designed to be flexible and to evolve over time; this is particularly important because of the upcoming period of transition in 2021/22 to formalise the place-based partnership for Barnsley. ***It is important to note that the Place Agreement will <u>not</u>:*** • Override the existing statutory requirements/duties or governance arrangements of the Partner organisations including the Trust. • Change or replace any existing service contracts that we hold as a Trust. • Pool any funds; or • Transfer any staff. The current thinking of the Design Team is that the Place Agreement should have a duration of 2 years from 1 June 2021, with a review taking place by Q4 2021/22 and at intervals as agreed thereafter (to reflect the transition period in 2021/22) so that it can be updated as agreed between the Partners. Subject to approval of the Partners, the Place Agreement will not be legally binding in its entirety, with limited clauses such as confidentiality being legally binding. From a governance perspective, the Place Agreement will document the existing governance groups (the ICPG and the ICPDG) and their terms of reference, with the ICPG continuing to report to individual Partner boards (through Partner representatives) and providing updates to the Health and Wellbeing Board.

	The future governance arrangements are to be developed and will need to take into account guidance issued by NHS England & Improvement, the Health and Care Bill (currently in Committee Stage in Parliament) and the approach developed by the ICS with Partners. It is anticipated however that the Health and Wellbeing Board would continue to play a central role in the ICP approach and the shift to a population health management model for Barnsley. **Risk Appetite** Supporting the development of strategic partnerships and place-based plans that facilitate integrated joined-up planning and delivery of care and ensure sustainability of existing services are within the Trust's risk appetite. The risks and mitigations will need to be regularly reviewed and managed as the integrated partnerships and services develop to ensure that the impact upon services, clinical and financial flows are managed.
Recommendation:	**The Trust Board is asked to APPROVE the Place Agreement as a key steppingstone towards the establishment of a Place Based Partnership as part of South Yorkshire ICS from 1 April 2022.**
Private session:	Not applicable.

Barnsley Integrated Care Partnership:
Place Agreement - Overview

Introduction

This presentation provides an **overview** of the Barnsley Integrated Care Partnership place agreement,

The Partners have, for a **number of years, been working collaboratively** across Barnsley to integrate services and provide care closer to home for local people. The Partners established the Integrated Care Partnership Group (ICPG) in 2019 through which to collaborate, reporting into Partner organisations,

It is clear from emerging policy direction that a **formal place-based partnership** will need to be in place in Barnsley from April 2022 and that the Partners will need to undertake a programme of work in 2021/22 to prepare for the transition to an Integrated Care Systems (ICS),

The **Place Agreement** is intended to facilitate further progress towards an Integrated Care Partnership (ICP) model for Barnsley,

Partners have nominated representatives to form a **'Design Team',** reporting into the ICPG, whom have led on the development of the Place Agreement, with input from Hill Dickinson.

At the July 21 ICPG, partners endorsed the place agreement for **formal sign off through sovereign Partner Boards.**

Key features (1)

The Place Agreement is a collaborative agreement across partners that sets out the:

- **Vision and core objectives** of the Partners for the development and delivery of the ICP;
- Key collaborative **principles** that the Partners will comply with in working together to achieve the common vision and objectives (in line with the SYB ICS Health and Care Compact);
- **Governance** structures underpinning the ICP;
- Priority programmes and key enabling programmes which the Partners agree to deliver together; namely the **Health and Care Plan and ICP Development Plan**; and
- Other standard provisions for agreements of this nature, including dealing with conflicts of interest, confidentiality and a dispute resolution process.

Key features (2)

Each Partner who signs up to the Place Agreement **agrees to collaborate** with the other Partners to deliver the vision, objectives and priorities and to act in accordance with the agreed collaborative principles.

The Place Agreement provides a **framework** for the Partners to make aligned decisions respecting existing statutory duties and functions of the Partners.

As a framework, the Place Agreement is designed to be **flexible and to evolve** over time; this is particularly important because of the upcoming period of transition in 2021/22 to formalise the place-based partnership for Barnsley.

Key features (3)

It is important to note that the Place Agreement for July 2021 **will <u>not</u>:**

- Override the existing statutory requirements / duties or governance arrangements of the Partner organisations;
- Change or replace any existing service contracts;
- Pool any funds; or
- Transfer any staff.

The Agreement shall take effect on the Commencement Date and will continue in full force and effect and will expire on 31 March 2023 (the “Initial Term”), partners will review progress made against the ICP Development Plan and the terms of the agreement by September 2021 and at regular intervals thereafter.

Subject to approval of the Partners, the Place Agreement will not be legally binding in its entirety, with limited clauses such as confidentiality being legally binding.

Key features (4)

From a **governance perspective**, the Place Agreement will document the existing governance groups (the ICPG and the ICPDG) and their terms of reference, with the ICPG continuing to report to individual Partner boards (through Partner representatives) and providing updates to the Health and Wellbeing Board.

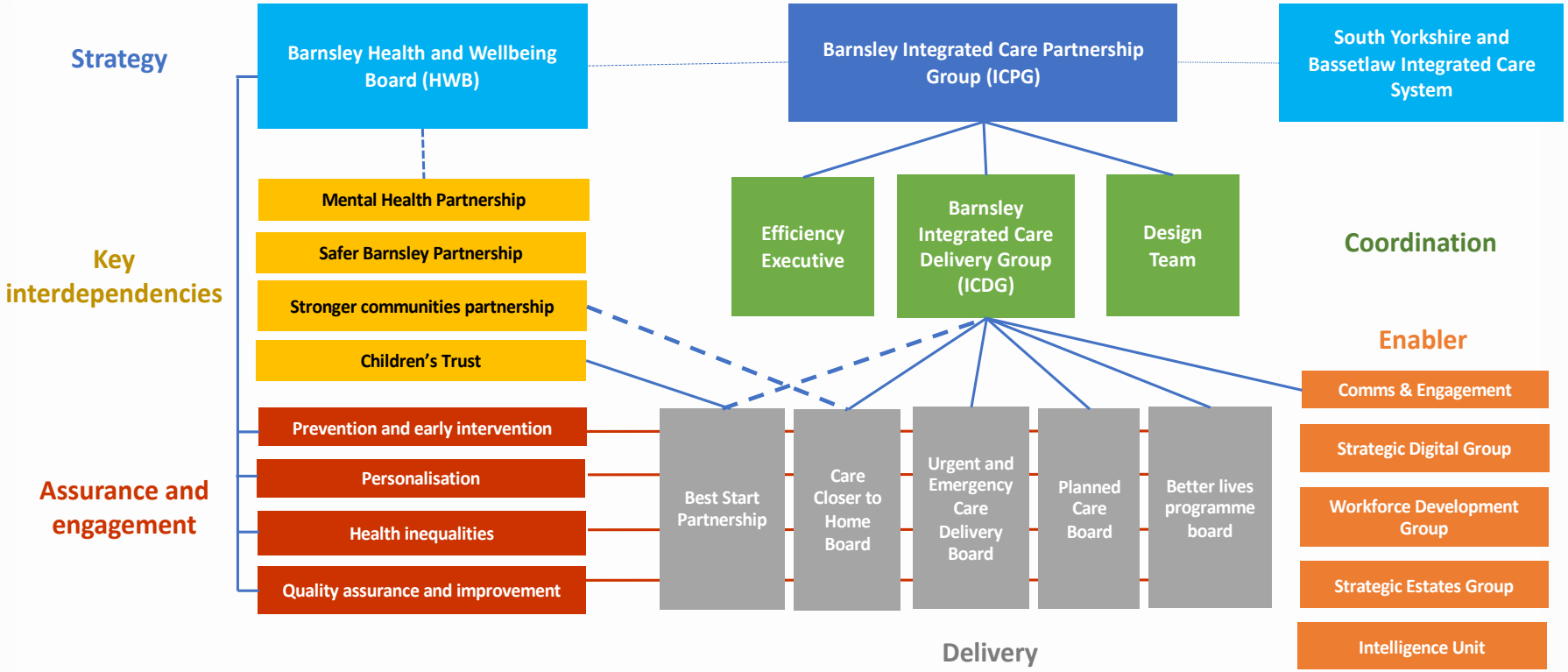
The future governance arrangements are to be developed and will **need to take into account emerging guidance** issued by NHS England & Improvement, the Health & Care Bill and the approach developed by the ICS with Partners.

Partner organisations

The Place Agreement, is entered into by the following partner organisations:

- NHS Barnsley CCG,
- Barnsley Metropolitan Borough Council,
- Barnsley Hospital NHS Foundation Trust,
- South West Yorkshire Partnership NHS Foundation Trust,
- Barnsley Healthcare Federation,
- Barnsley Hospice and Barnsley Community and Voluntary Services
- Barnsley Healthwatch

Integrated Governance



Timetable and Next Steps

A draft Place Agreement was brough to the June ICPG for final comments and pending these the document was agreed in principle,

A final draft Place Agreement was brought to July ICPG for final approval, to then be taken through the governance of the Partner Sovereign boards for formal approval during August/September.

It is proposed that the Place Agreement would be effective from October 2021.

Partners will be kept informed of developments in relation to the ICS and the ICP generally, including the implications for Barnsley of any guidance published centrally on place-based partnerships and the Health & Care Bill itself, in due course.

BARNSLEY PLACE AGREEMENT

DATE **2021**

1. NHS BARNSLEY CLINICAL COMMISSIONING GROUP

2. BARNSLEY METROPOLITAN BOROUGH COUNCIL

3. BARNSLEY HOSPITAL NHS FOUNDATION TRUST

4. SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

5. BARNSLEY HEALTHCARE FEDERATION

6. BARNSLEY HOSPICE

7. BARNSLEY COMMUNITY AND VOLUNTARY SERVICES

BARNSLEY PLACE AGREEMENT

No	Date	Version Number	Author
1	09.03.21	1	Hill Dickinson
2	29.03.21	2	Hill Dickinson – following Design Team meetings 11.03.21 / 23.03.21
3	12.04.21	3	Hill Dickinson – minor updates to drafting plus incorporating comments from Wendy Lowder and Andrew Osborn
4	26.04.21	4	Hill Dickinson – updated diagram and governance Clause 12
5	17.05.21	5	Hill Dickinson – update to Clause 7
6	19.05.21	6	Hill Dickinson – update to incorporate provider collaboration wording and minor amendments from Design Team meeting 19.05.21
7	10.06.21	7	BNHFT mark up
8	18.06.21	8	Hill Dickinson – following BHNFT mark up
9	16.07.21	9	Hill Dickinson – insertion of footnote at 10.4; refs to Health and Care Plan and removal of Priority Programmes, and remit of ICDG included in line with TORs.
10	31.08.21	10	Addition of principle (section 7.3.15) to reflect feedback from July ICPG around Equality & Diversity.

BARNSLEY PLACE AGREEMENT

Contents

Overarching Note – Barnsley Place Agreement

This Agreement provides an overarching framework for the continued development of an integrated care partnership for Barnsley. The arrangements set out are intended to build on the existing integrated governance structures between the health and care partners in Barnsley, including the Integrated Care Partnership Group and the Integrated Care Delivery Group, and further strengthen relationships between the Partners for the benefit of the Barnsley population.

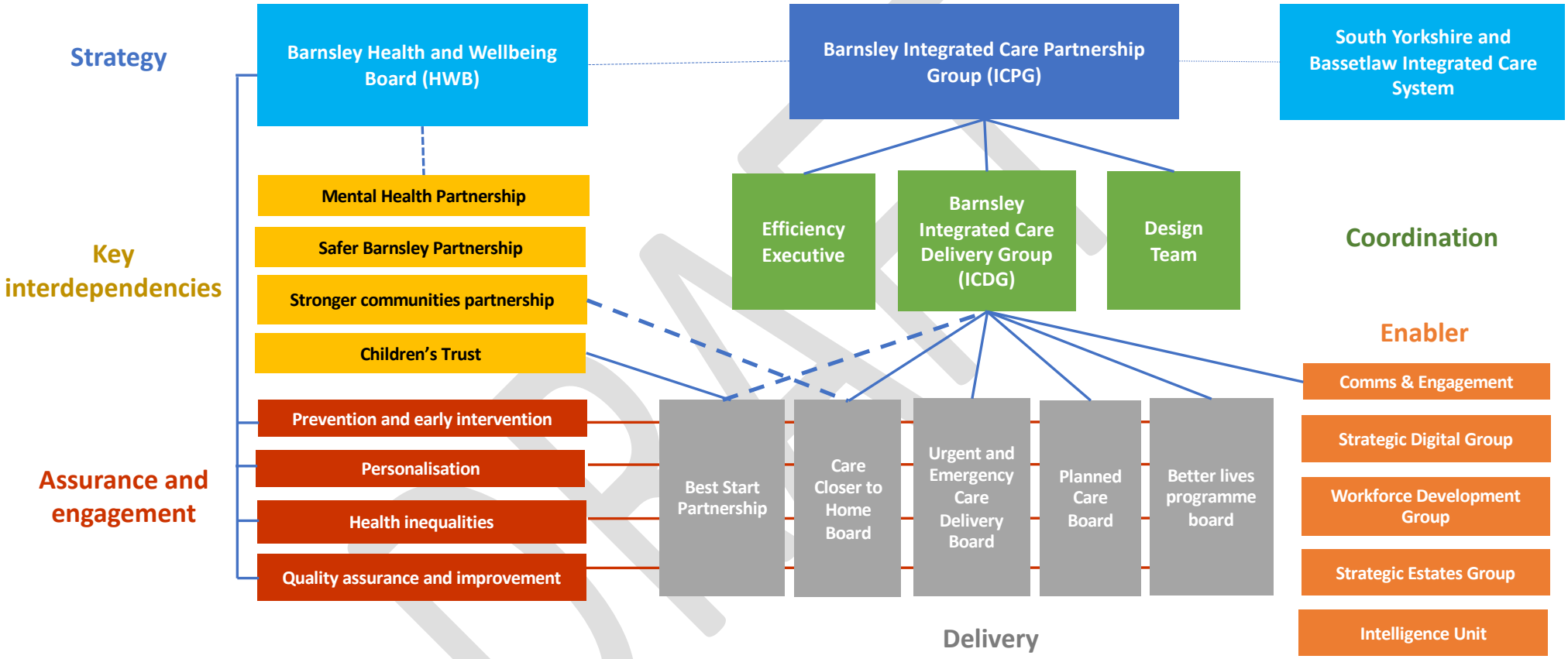
Figure 1 below includes a diagram illustrating the governance arrangements for Barnsley Integrated Care Partnership ("ICP") as at the Commencement Date.

This Agreement is designed to work alongside existing NHS Standard Contracts (commonly the Services Contract) and arrangements for the delivery of non-NHS care, support and community services via the Council to the extent such services are within the scope of the Agreement. The Agreement is only intended to be legally binding for specific elements, which are identified, such as confidentiality and intellectual property.

The Partners intend to work together under the governance framework set out in this Agreement to embed and further develop the ICP approach to ultimately include requirements in relation to population health outcomes, risk/gain share, and financial and contract management and regulatory requirements, as may be agreed between the Partners. The Partners acknowledge that 2021/22 will be a transitional year during which they will work together through this Agreement to implement a development plan (the ICP Development Plan – set out in Schedule 2) to create a thriving ICP for Barnsley which enables provider collaboration where this aligns with the ICP vision and objectives, and the Barnsley Health and Care Plan. The Partners intend to work towards documenting such arrangements as may be agreed in a formal legally binding agreement for April 2022, in line with the policy direction in respect of the development of Integrated Care Systems and place-based partnership set out in the White Paper, *"Integration and Innovation: working together to improve health and social care for all"* (February 2021).

The Partners will review progress made against the ICP Development Plan and the terms of this Agreement no later than September 2021 and at such intervals as the Partners may agree thereafter. The Partners may agree to either vary the Agreement to reflect developments or enter into a new agreement for April 2022.

FIGURE 1 – BARNSLEY INTEGRATED CARE PARTNERSHIP



BARNSLEY PLACE AGREEMENT

DATE: **2021**

This Place Agreement (the **Agreement**) is made between:

1. **NHS BARNSLEY CLINICAL COMMISSIONING GROUP** of 49, 51 Gawber Road, Barnsley, S75 2PY ("**CCG**");

2. **BARNSLEY METROPOLITAN BOROUGH COUNCIL** of 1 Westgate, Western Street, Barnsley, S70 2DR ("**Council**");

3. **BARNSLEY HOSPITAL NHS FOUNDATION TRUST** of Gawber Road, Barnsley, S75 2EP ("**BHNFT**");

4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Ouchthorpe Lane, Wakefield, WF1 3SP ("**SWYPFT**");

5. **BARNSLEY HEALTHCARE FEDERATION COMMUNITY INTEREST COMPANY** (Registered Company No: 09651047) of Oaks Park Primary Care Centre, Thornton Road, Barnsley, S70 3NE ("**BHF**");

6. **BARNSLEY HOSPICE** (Registered Charity No: 700586) of Church Street, Barnsley, S75 2RL ("**BH**"); and

7. **BARNSLEY COMMUNITY AND VOLUNTARY SERVICES** of Pontefract Road, Barnsley S71 5PN ("**CVS**");

together referred to in this Agreement as the "**Partners**".

The CCG and the Council (in its role as commissioner of social care and public health services) are together referred to in this Agreement as the "**Commissioners**".

BHFT, SWYPFT, BHF, BH, CVS and the Council (in its role as provider of social care services, whether directly or through contracting arrangements with third party providers) are together referred to in this Agreement as the "**Providers**".

BACKGROUND

(A) The NHS Five Year Forward View set out a clear goal that "*the NHS will take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, between health and social care*". The NHS Long Term Plan, published in January 2019, provided a vision of health and care joined up locally around population needs.

(B) The white paper published by the Department of Health and Social Care in February

2021[1] (the "White Paper") builds on the NHS Long Term Plan vision and sets out the key components of an integrated care system ("ICS"). One of these components is "*strong and effective place-based partnerships*" in local places between the NHS, local government and key local partners, interfacing with a statutory ICS for South Yorkshire & Bassetlaw and provider collaboratives established both at Place and on a broader sector-based footprint.

(C) In addition, as at the Commencement Date, the Covid-19 pandemic is continuing, and the Partners acknowledge that they will need to continue to support each other and work in partnership through this Agreement to address the significant health and care challenges, including health inequalities, facing the people of Barnsley.

(D) The Partners have been working collaboratively across Barnsley to integrate services and provide care closer to home for local people for some time. This Agreement sets out the vision, objectives and shared principles of the Partners in supporting the further development of place-based health and care provision for the people of Barnsley using a population health management approach, building on the progress achieved by the Partners to date.

(E) The Partners will focus on delivery of the Barnsley Health and Care Plan to work towards specific outcomes over the term. Changes or additions to the Health and Care Plan may be identified by the Partners during the term of this Agreement as required to further the collaborative work of the Partners for the benefit of the population of Barnsley. The ICP governance framework will enable the Providers to collaborate in order to identify opportunities for service improvement or redesign in relation to the Health and Care Plan where such opportunities align with the Barnsley ICP vision and objectives.

(F) In light of the White Paper, the Partners recognise that from the Commencement Date until April 2022 they will need to undertake a programme of work through the governance arrangements set out in this Agreement to further develop their place arrangements to become a thriving ICP ready to manage Barnsley resources together for the benefit of the Barnsley population. This programme of work is set out, in initial outline terms, in the ICP Development Plan in Schedule 2 to this Agreement.

(G) The Commissioners are the statutory bodies responsible for planning, organising and buying social care, NHS-funded healthcare, support and community services for people who live in Barnsley.

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[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation: working together to improve health and social care for all (publishing.service.gov.uk)

(H) The Providers (including the Council in its provider role) are together providers of social care, public health and education services, NHS funded healthcare services including primary care services, community and support services to the population of Barnsley.

(I) The Partners acknowledge that the delivery and development of the ICP will rely on both Commissioners and Providers working collaboratively rather than separately to plan financially sustainable methods of delivering integrated, population-focused services in furtherance of the Health and Care Plan and the ICP Development Plan.

(J) The Partners acknowledge that the Council has a dual role within the Barnsley health and care system as both a commissioner of social care and public health services but also as a provider of social care services either through direct delivery or through contracts with third party providers. In its role as commissioner of social care services the Council shall work in conjunction with the CCG and in its role as a provider of social care services the Council shall work in conjunction with the Providers. The Council recognises the need to and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified and managed.

(K) This Agreement is intended to work alongside:

a) the Services Contracts; and

b) the Section 75 Agreement between the CCG and the Council.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular;

1.2.3 a reference to a “Provider” or a “Commissioner” or any Partner includes its personal representatives, successors or permitted assigns;

1.2.4 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory

provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted; and

1.2.5 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. STATUS AND PURPOSE OF THIS AGREEMENT

2.1 The Partners have agreed to work together on behalf of the people of Barnsley to further develop the ICP through which to identify and respond to the health and care needs of the Barnsley population, and deliver integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the people of Barnsley.

2.2 This Agreement sets out the key terms that the Partners have agreed, including:

2.2.1 the vision of the Partners, and key objectives for the development and delivery of integrated services in Barnsley and the Health and Care Plan;

2.2.2 the key principles that the Partners will comply with in working together through the ICP;

2.2.3 the governance structures underpinning the ICP; and

2.2.4 the initial Development Plan for the ICP for 2021/22, which the Partners will work together to implement through this Agreement.

2.3 Notwithstanding the good faith consideration that each Partner has afforded the terms set out in this Agreement, the Partners agree that, save as provided in Clause 2.4 below, this Agreement shall not be legally binding. The Partners each enter into this Agreement intending to honour all of their respective obligations.

2.4 This Clause 2.4, Clauses 10 (*Transparency*), 18 (*Liability*), 20 (*Confidentiality and FOIA*), 21 (*Intellectual Property*), 22.4 (*Counterparts*) and 22.5 (*Governing Law and Jurisdiction*) shall come into force from the date of this Agreement and shall give rise to legally binding commitments between the Partners.

2.5 Each of the Providers has one or more individual Services Contracts (or where appropriate combined Services Contracts) with the CCG or the Council. This Agreement will work alongside these Services Contracts and the Section 75 Agreement as appropriate.

2.6 Each of the Commissioners and the Providers agree to work together in a collaborative and integrated way on a Best for Barnsley basis and the Services Contracts set out how

the Providers provide Services to the Population. This Agreement is not intended to conflict with or take precedence over the terms of the Services Contracts or the Section 75 Agreement unless expressly agreed by the Partners.

3. APPROVALS

Each Partner acknowledges and confirms that as at the date of this Agreement, it has obtained all necessary authorisations to enter into this Agreement and that its own organisational leadership body has approved the terms of this Agreement.

4. DURATION AND REVIEW

4.1 This Agreement shall take effect on the Commencement Date and will continue in full force and effect and will expire on 31 March 2023 (the "**Initial Term**"), unless and until terminated in accordance with the terms of this Agreement.

4.2 At the expiry of the Initial Term this Agreement shall expire automatically without notice unless, no later than 3 months before the end of the Initial Term, the Partners agree in writing that the term of the Agreement shall be extended for a further term to be agreed between the Partners (the "**Extended Term**").

4.3 The Partners will review progress made against the ICP Development Plan and the terms of this Agreement by September 2021 and at such intervals thereafter as the Partners may agree. The Partners may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 19 (*Variations*).

SECTION A: VISION, OBJECTIVES AND PRINCIPLES

5. THE VISION

5.1 The Partners have agreed to work towards a common vision for the ICP as follows:

> *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*

6. THE OBJECTIVES

6.1 The Partners have agreed to work together and to perform their duties under this Agreement in order to achieve the following Objectives:

6.1.1 Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication;

6.1.2 Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing;

6.1.3 Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance;

6.1.4 Embed integrated care that delivers the best value for the Barnsley pound;

6.1.5 Develop population health management approaches to improve health and wellbeing and reduce health inequalities;

6.1.6 Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2021/22 and beyond; and

6.1.7 Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.

6.2 The Partners acknowledge that they will have to make decisions together in order for the ICP arrangements to work effectively. The Partners agree that they will work together and make decisions on a Best for Barnsley basis in order to achieve the Objectives, save for the Reserved Matters listed at Clause 9.

7. THE PRINCIPLES

7.1 These Principles underpin the delivery of the Partners' obligations under this Agreement and set out key factors for a successful relationship between the Partners for the delivery of the ICP.

7.2 The Partners agree that the successful delivery of the ICP operating model will depend on their ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of community assets and services across the Partners.

7.3 The Partners will work together in good faith and, unless the provisions in this Agreement state otherwise, the Partners will:

7.3.1 Aim for better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the taxpayer alongside the reduction of health inequalities (the "quadruple aim");

7.3.2 Play our part in social and economic development and environmental sustainability of Barnsley and the wider South Yorkshire and Bassetlaw region;

7.3.3 Commit to making decisions at the right level and with the relevant partners at the ICP level to deliver the ICP vision and the Shared Purpose and benefit the population of Barnsley and the wider South Yorkshire and Bassetlaw region. Decisions should not adversely affect the outcomes or equity for populations within Barnsley or the ICS;

7.3.4 Ensure that the children's, young people and families' agenda is a key element of the ICP's work;

7.3.5 Support each other and work collaboratively to take decisions at the most local level as close as possible to the communities that we affect whether that be system, place or neighbourhood (subsidiarity);

7.3.6 Develop collaborative system leadership encompassing health, social care and wider system partners to deliver the ICP vision and the Shared Purpose, and a culture and values to support transformation. All members are respected and valued. They understand their own contribution and support the contributions of other members to the ICP vision and the Shared Purpose;

7.3.7 Strengthen clinical and professional leadership including general practitioners as expert generalists with the patient;

7.3.8 Enable the leadership role of citizens, communities and voluntary sector;

7.3.9 Strengthen the links between neighbourhoods, Place and the ICS and demonstrate inclusivity and shared ownership;

7.3.10 Make time and other resources available to develop the ICP and deepen working relationships between the Partners at all levels;

7.3.11 Be transparent with each other and the people of Barnsley and the wider South Yorkshire and Bassetlaw area around decisions and appointments;

7.3.12 Use the best available data to inform priorities and decision-making;

7.3.13 Look for simplicity and effectiveness in any ICP structures and governance and follow the rule of form following function;

7.3.14 Act with honesty and integrity and trust that each other will do the same. This includes each Partner being open about the interests of their organisation and any disagreement they have with a proposal or analysis. The Partners will assume that each acts with good intentions;

7.3.15 Value individuals, celebrate equality & diversity and be inclusive in all that we do;

7.3.16 Work to understand the perspective and impacts of their decisions on other parts of the health and social care system;

7.3.17 Adopt an asset based approach that is citizen-led, relationship orientated, asset based, place-based and inclusion focussed;

7.3.18 Provide a proactive and person-centred approach that empowers patients and addresses people's needs;

7.3.19 Improve quality and efficiency of services through sharing records, data and information including integrated information management and technology;

7.3.20 Support the delivery of more enhanced and specialised services in the community where appropriate;

7.3.21 Neighbourhood focus for delivery of services whilst ensuring services are wrapped around patients and aligned to GP practices;

7.3.22 Focus on self-care to promote independence and reduce pressures on the health and care system;

7.3.23 Focus on prevention including the wider determinants of health and understanding the perspective and impacts of our decision on other parts of the health and social care system

7.3.24 Maximise the agreed outcomes within the resources available to deliver best possible value for the Barnsley pound,

7.3.25 Promote and strive to adhere to the Nolan Principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership) including:

7.3.26 Being accountable to each other for the performance of respective roles and responsibilities for the ICP and the ICS, in particular where there is an interface with other Partners;

7.3.27 Communicating openly about major concerns, issues or opportunities relating to this Agreement and adopt transparency as a core value, including through open book reporting and accounting, subject always to appropriate treatment of Commercially Sensitive Information if applicable;

7.3.28 Having conversations about supporting the wider health and care system, not just furthering our own organisation's interests;

7.3.29 Undertaking more aligned decision-making across the Partners and trying to commission and deliver services in an integrated way wherever reasonably possible;

7.3.30 Using insights from data to inform decision making;

7.3.31 Engaging positively with other partners in other geographies in pursuit of the aim described at 7.3.1 and effective planning and delivery;

7.3.32 Ensuring that problems are resolved where possible rather than being moved around the system; and

7.3.33 Acting promptly. Recognising the importance of integrated working and the ICP and responding to requests for support from other Partners,

and these are the "**Principles**".

8. PROBLEM RESOLUTION AND ESCALATION

8.1 The Partners agree to adopt a systematic approach to problem resolution which recognises the Objectives and the Principles set out in Clauses 6 and 7 above and which:

8.1.1 seeks solutions without apportioning blame;

8.1.2 is based on mutually beneficial outcomes;

8.1.3 treats the Partners as equal parties in the dispute resolution process; and

8.1.4 contains a mutual acceptance that adversarial attitudes waste time and money.

8.2 If a problem, issue, concern or complaint comes to the attention of a Partner in relation to the Objectives, Principles or any matter in this Agreement and is appropriate for resolution between the Commissioners and the Providers such Partner shall notify the other Partners and the Partners each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion within 20 Operational Days of such matter being notified.

8.3 Any Dispute arising between the Partners which is not resolved under Clause 8.2 above will be resolved in accordance with Schedule 4 (*Dispute Resolution Procedure*).

8.4 If any Partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this Agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this Agreement) the receiving Partner will liaise with the Integrated Care Partnership Group as to the contents of any response before a response is issued.

SECTION B: OPERATION OF AND ROLES IN THE SYSTEM

9. RESERVED MATTERS

9.1 The Partners acknowledge that each of the Commissioners is required to comply with certain statutory duties as statutory commissioners. Consequently, the Commissioners each reserve the matters set out in Clause 9.2 for their respective determination as they see fit in accordance with Clause 9.3.

9.2 Each of the Commissioners shall be free to determine the following Reserved Matters:

9.2.1 making any decision or action where necessary to ensure compliance with their respective statutory duties, including the powers and responsibilities conferred on each of the Commissioners respectively by Law, its constitution or the Section 75 Agreement; or

9.2.2 any matter upon which they may be required to submit to public consultation or in relation to which they may be required to respond to or liaise with a local Healthwatch organisation.

9.3 The Partners agree that:

9.3.1 the Reserved Matters are limited to the express terms of Clause 9.2 above; and

9.3.2 the Integrated Care Partnership Group may not make a final recommendation on any of the matters set out in Clause 9.2 above, which are reserved for determination by either Commissioner respectively.

9.4 Where determining a Reserved Matter, subject to any need for urgency because to act otherwise would result in the relevant Commissioner breaching their statutory obligations, the relevant Commissioner will first consult with the Integrated Care Partnership Group in respect of their proposed determination of a Reserved Matter in line with the Objectives and the Principles.

9.5 Nothing in this Agreement obliges any Commissioner or Provider to act contrary to its respective statutory or regulatory obligations.

10. TRANSPARENCY

10.1 Subject to Clause 10.4, the Partners will provide to each other all information that is reasonably required in order to deliver the Health and Care Plan and implement the ICP Development Plan in line with the Objectives.

10.2 The Partners have responsibilities to comply with Law (including Competition Law). The Partners will make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with Competition Law and, accordingly, the Integrated Care Partnership Group and the Integrated Care Delivery Group will each ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

10.2.1 it is essential;

10.2.2 it is not exchanged more widely than necessary;

10.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of this Agreement; and

10.2.4 it may not be used other than to achieve the Objectives in accordance with the Principles.

10.3 The Commissioners will make sure that the Integrated Care Delivery Group establishes appropriate information barriers between and within the Providers so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Providers who need to see it to achieve the Objectives and for no other purpose whatsoever so that the Partners do not breach Competition Law.

10.4 It is accepted by the Partners that the involvement of the Providers in the governance arrangements for the ICP is likely to give rise to situations where information will be generated and made available to the Providers which could give the Providers an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Provider with a commercial advantage over a separate Provider). Any Provider will have the opportunity to demonstrate to the reasonable satisfaction of the CCG and/or the Council (where acting as a commissioner) in relation to any competitive procurements that the information it has acquired as a result of its participation in the ICP, other than as a result of a breach of this Agreement, does not preclude the CCG and the Council (where acting as a commissioner) from running a fair competitive procurement in accordance with their legal obligations. A Provider shall not be obliged to provide any

information which in its reasonable opinion would provide any other Partner with an unfair advantage in any competition or would distort competition.[2]

10.5 Notwithstanding Clause 10.4 above, the Commissioners may take such measures as they consider necessary in relation to such competitive procurements in order to comply with their obligations under Law which may include excluding any potential bidder from the competitive procurement in accordance with the Law governing that competitive procurement.

11. OBLIGATIONS AND ROLES OF THE PARTIES

Commissioners' obligations and role

11.1 Each Commissioner will:

11.1.1 help to maintain and further develop an environment that encourages collaboration between the Providers;

11.1.2 provide clarity on the resources available for Barnsley from their organisations clearly articulating health, care and support outcomes for the Providers, performance standards, scope of services and technical requirements;

11.1.3 support the Providers in developing links to other relevant services;

11.1.4 comply with their statutory duties;

11.1.5 seek to commission the services within the Health and Care Plan in an integrated, effective and streamlined way to meet the Objectives and in accordance with the Principles; and

11.1.6 work collaboratively with the Providers to develop the ICP approach for the Health and Care Plan and implement the ICP Development Plan.

Providers' obligations and role

11.2 Each Provider will:

11.2.1 act collaboratively and in good faith with each other in accordance with the Law and Good Practice to achieve the Objectives, having at all times regard to the best interests of the Population;

[2] This clause was discussed by the Partners at the ICPG meeting on 24th June 2021, and agreed following consideration of advice from Hill Dickinson.

11.2.2 co-operate fully and liaise appropriately with each other Provider in order to ensure a co-ordinated approach to promoting the quality of patient care and so as to achieve continuity in the provision of services within the Health and Care Plan that avoids inconvenience to, or risk to the health and safety of, Service Users, employees of the Providers or members of the public;

11.2.3 work collaboratively with any or all of the other Providers to identify and develop opportunities for service improvement/ redesign in line with the Objectives, including where such opportunities are identified by the Partners through the ICPG; and

11.2.4 through high performance and collaboration, unlock and generate enhanced innovation and better outcomes and value for the Population in line with the Objectives.

Commissioners' and Providers' obligations and role

11.3 Each of the Partners acknowledges and confirms that:

11.3.1 it remains responsible for performing its obligations in accordance with the Services Contracts to which it is party;

11.3.2 it will be separately and solely liable to the relevant counterparty or counterparties under its own Services Contracts;

11.3.3 it remains responsible for its own compliance with all relevant regulatory requirements and remains accountable to its board/cabinet and all applicable regulatory bodies; and

11.3.4 it will work collaboratively with the other Partners to develop the ICP approach for the Health and Care Plan and implement the ICP Development Plan.

SECTION C: GOVERNANCE ARRANGEMENTS

12. BARNSLEY INTEGRATED CARE PARTNERSHIP GOVERNANCE

12.1 In addition to the Partners' own Boards / Cabinet / Governing Body, which shall remain accountable for the exercise of each of the Partners' respective functions, the governance structure for the ICP arrangements will comprise:

12.1.1 the Barnsley Integrated Care Partnership Group (ICPG); and

12.1.2 the Barnsley Integrated Care Delivery Group (ICDG).

12.2 The diagram in Schedule 3 (*Governance*) sets out the governance structure and the links between the various groups in more detail.

Barnsley Integrated Care Partnership Group (ICPG)

12.3 The ICPG reports to Partner organisation boards and is the group responsible for:

12.3.1 overseeing the ICP arrangements under this Agreement;

12.3.2 reporting to Partner organisations on progress against the Objectives; and

12.3.3 liaising where appropriate with:

(a) national stakeholders (including NHS England and NHS Improvement); and

(b) South Yorkshire & Bassetlaw ICS,

to communicate the views of the ICP on matters relating to integrated care in Barnsley.

12.4 The ICPG will act in accordance with its terms of reference set out in Schedule 3 Part 1 and will:

12.4.1 provide visible leadership, direction and commitment to the Vision and Objectives for developing integrated care in Barnsley and ensuring effective governance, communication and delivery of the Objectives;

12.4.2 work together to achieve the Objectives through providing strategic and operational oversight, developing new models of joined up services including through referring specific opportunities for service improvement /redesign to collaboratives of some or all of the Providers (dependent on the opportunity);

12.4.3 providing shared responses to the South Yorkshire & Bassetlaw ICS on strategic developments including through nomination of ICP representatives to attend governance groups at ICS level as required;

12.4.4 produce shared communications;

12.4.5 develop shared strategies to enable the achievement of the Vision and Objectives;

12.4.6 develop a shared understanding of collective finances across the Partners with the ultimate aim of shared management of financial risk, and consider investment decisions across the ICP;

12.4.7 oversee and inform the work of the ICDG; and

12.4.8 have regard to the strategy developed by the Barnsley Health and Wellbeing Board; and

12.4.9 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.4.

12.5 Where the ICPG refers opportunities to a collaborative group of some or all of the Providers pursuant to Clause 12.4.2, the Providers involved may collaborate through existing governance groups (e.g. the ICDG), or set up specific task and finish groups, in either case aligning with the work of the ICDG and reporting into the ICPG. The scope and detail of delivery by the Providers of any such opportunities will be agreed by the relevant Partners through the ICPG and appended to this Agreement.

Barnsley Integrated Care Delivery Group

12.6 The ICDG is the group responsible for the oversight and delivery of the Health and Care Plan and the ICP Development Plan. The ICDG will report to the ICPG, acting in accordance with its Terms of Reference set out in Schedule 3 (*Governance*) Part 2 and will:

12.6.1 oversee and deliver the Health and Care Plan and the ICP Development Plan and report regularly to the ICPG and Partner organisation boards on progress;

12.6.2 ensure all risk is assessed and assure that mitigating actions are in place;

12.6.3 manage and utilise resources across the ICP to optimise service delivery;

12.6.4 work within the overall scope of the ICP, recognising that changes will be agreed during the course of its development and introduction. Where relevant make recommendations to the ICPG for changes to the Health and Care Plan and/or ICP Development Plan;

12.6.5 support programme boards to deliver their objectives and milestones as set out in the Health and Care Plan; and

12.6.6 discharge the functions set out in its terms of reference, to the extent that they are not set out in this Clause 12.6.

12.7 The Partners will communicate with each other clearly, directly and in a timely manner to ensure that the Partners (and their representatives) present at the ICPG and the ICDG are able to represent their nominating organisations to enable effective and timely recommendations to be made in relation to the Health and Care Plan and the ICP Development Plan.

12.8 Each Partner must ensure that its appointed members of the ICPG and the ICDG (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for Barnsley basis and in accordance with Clause 5 (*Objectives*) and Clause 7 (*Principles*).

12.9 The Partners agree that, in line with the ICP Development Plan, the governance arrangements set out in this Clause 12 will be further refined over the Initial Term. A key principle agreed by the Partners is that the chair of the place-based partnership board (whether the ICPG or otherwise) for Barnsley in place by April 2022 will rotate between the Partner organisations.

13. CONFLICTS OF INTEREST

13.1 Subject to compliance with Law (including without limitation Competition Law) and contractual obligations of confidentiality the Partners agree to share all information relevant to the achievement of the Objectives in an honest, open and timely manner.

13.2 The Partners will:

13.2.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the operation of the ICPG or the ICDG immediately upon becoming aware of the conflict of interest whether that conflict concerns the Partner or any person employed or retained by them for or in connection with the performance of this Agreement;

13.2.2 not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Partners) before they participate in any decision in respect of that matter; and

13.2.3 use best endeavours to ensure that their representatives on the ICPG and the ICDG also comply with the requirements of this Clause 13 when acting in connection with this Agreement.

SECTION D: FINANCIAL PLANNING

14. PAYMENTS

14.1 The Providers will continue to be paid in accordance with the mechanism set out in their respective Services Contracts.

14.2 The Partners have not agreed as at the Commencement Date to share risk or reward.

14.3 The Partners will work together during the Initial Term to consider the further development of system financial principles in accordance with the principles contained within the terms of reference of the Efficiency Executive (as set out in Part 3 of Schedule 3), including potential risk/reward sharing mechanisms.

SECTION E: FUTURE DEVELOPMENT OF THE ICP

15. ICP DEVELOPMENT PLAN

15.1 The Partners have agreed to work together to further develop, and implement, the ICP Development Plan using the South Yorkshire and Bassetlaw ICS ICP Development Matrix to enable maximum delegation to a weight-bearing Barnsley ICP able to receive and make decisions about Barnsley's resource allocation, the initial draft of which is set out in Schedule 2 (*ICP Development Plan*). The areas for development set out in the ICP Development Plan have been identified by the Partners as priorities for 2021/22 in order to ensure that the ICP is ready to transition to the new model of health and care planning and delivery in Barnsley by April 2022. The Partners will keep the ICP Development Plan under review through the governance structures set out in this Agreement and may agree to amend the ICP Development Plan as required during the Initial Term, in line with policy direction and legislative developments.

SECTION F: GENERAL PROVISIONS

16. EXCLUSION AND TERMINATION

16.1 A Partner may be excluded from this Agreement on notice from the other Partners (acting in consensus) in the event of:

16.1.1 the termination of their Services Contract; or

16.1.2 an event of Insolvency affecting them.

16.2 A Partner may withdraw from this Agreement by giving not less than 6 months' written notice to each of the other Partners' representatives.

16.3 A Partner may be excluded from this Agreement on written notice from all of the remaining Partners in the event of a material or a persistent breach of the terms of this Agreement by the relevant Partner which has not been rectified within 30 days of notification issued by the remaining Partners (acting in consensus) or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Partner.

16.4 The ICPG may resolve to terminate this Agreement in whole where:

16.4.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure; or

16.4.2 where the Partners agree for this Agreement to be replaced by a formal legally binding agreement between them.

16.5 Where a Partner is excluded from this Agreement, or withdraws from it, the excluded or withdrawing (as relevant) Partner shall procure that all data and other material belonging to any other Partner shall be delivered back to the relevant Partner or deleted or destroyed (as instructed by the relevant Partner) as soon as reasonably practicable.

17. INTRODUCING NEW PROVIDERS

Additional parties may become parties to this Agreement on such terms as the Partners shall jointly agree in writing, acting at all times on a Best for Barnsley basis. Any new Partner will be required to agree in writing to the terms of this Agreement before admission.

18. LIABILITY

The Partners' respective responsibilities and liabilities in the event that things go wrong with the Services will be allocated under their respective Services Contracts and not this Agreement.

19. VARIATIONS

Any amendment to this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Partners.

20. CONFIDENTIALITY AND FOIA

20.1 Each Partner shall keep confidential all Confidential Information that it receives from the other Partners except to extent such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner to this Agreement.

20.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

20.3 The Partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 20 (*Confidentiality and FOIA*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

20.4 Nothing in this Clause 20 (*Confidentiality and FOIA*) will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law of any applicable jurisdiction.

20.5 The Partners acknowledge that some of them are subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that any Partner which is subject to FOIA is able to comply with their statutory obligations.

21. INTELLECTUAL PROPERTY

21.1 In order to develop and deliver the arrangements under this Agreement in accordance with the Principles each Partner grants each of the other Partners a fully paid up, non-exclusive licence to use its existing Intellectual Property insofar as is reasonably required for the sole purpose of the fulfilment of that Partner's obligations under this Agreement.

21.2 If any Partner creates any new Intellectual Property through the development and delivery of the arrangements under this Agreement, the Partner which creates the new Intellectual Property will grant to the other Partners a fully paid up, non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Partner's obligations and the development and delivery of the arrangements under this Agreement.

22. GENERAL

22.1 Any notice or other communication given to a Partner under or in connection with this Agreement shall be in writing, addressed to that Partner at its principal place of business or such other address as that Partner may have specified to the other Partner in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

22.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 22.1 above; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

22.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Partners, constitute any Partner the agent of another Partner, nor authorise any Partner to make or enter into any commitments for or on behalf of any other Partner except as expressly provided in this Agreement.

22.4 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Partner has executed at least one counterpart.

22.5 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and where applicable, the Partners irrevocably submit to the exclusive jurisdiction of the courts of England and Wales.

22.6 A person who is not a Partner to this Agreement shall not have any rights under or in connection with it.

This Agreement has been entered into on the date stated at the beginning of it.

Signed by [insert] .....

for and on behalf of **NHS BARNSLEY CLINICAL COMMISSIONING GROUP** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY METROPOLITAN BOROUGH COUNCIL** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY HOSPITAL NHS FOUNDATION TRUST** [ ]

Signed by [insert] .....

for and on behalf of **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** [ ]

Signed by [insert]

for and on behalf of **BARNSLEY HEALTHCARE FEDERATION** .....

[ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY HOSPICE** [ ]

Signed by [insert] .....

for and on behalf of **BARNSLEY COMMUNITY AND VOLUNTARY SERVICES** [ ]

Healthwatch Barnsley *is the independent consumer champion created to gather and represent the views of the public in Barnsley. As it does not exist as a separate legal entity, it is not a Party to this Agreement and cannot be bound by the terms of this Agreement, but signs this Agreement below to confirm its support for the ICP, its vision, objectives and principles, and agrees to participate in the ICP governance structure.*

Signed by [insert] .....

for and on behalf of **HEALTHWATCH BARNSLEY** [ ]

SCHEDULE 1

Definitions and Interpretation

1. The following words and phrases have the following meanings:

Agreement	this agreement incorporating the Schedules.
Best for Barnsley	best for the achievement of the Objectives and the Outcomes for the Barnsley population on the basis of the Principles.
Commencement Date	the date entered on page one (1) of this Agreement.
Commercially Sensitive Information	Confidential Information which is of a commercially sensitive nature relating to a Partner, its intellectual property rights or its business or which a Partner has indicated would cause that Partner significant commercial disadvantage or material financial loss.
Competition Law	the Competition Act 1998 and the Enterprise Act 2002, as amended by the Enterprise and Regulatory Reform Act 2013 and as applied to the healthcare sector by Monitor in accordance with the Health and Social Care Act 2012.
Competition Sensitive Information	Confidential information which is owned, produced and marked as Competition Sensitive Information by one of the Partners and which that Partner properly considers is of such a nature that it cannot be exchanged with the other Partners without a breach or potential breach of Competition Law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Partner, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions.
Confidential Information	the provisions of this Agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including

	Commercially Sensitive Information and Competition Sensitive Information.
Dispute	any dispute arising between two or more of the Partners in connection with this Agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in Schedule 4 for the resolution of disputes which are not capable of resolution under Clause 8 (*Problem Resolution and Escalation*).
Efficiency Executive	the Efficiency Executive, the terms of reference for which are set out in Part 3 of Schedule 3 (Governance).
Extended Term	has the meaning set out in Clause 4.2.
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
Good Practice	Good Clinical Practice and/or Good Health and/or Social Care Practice (each as defined in the Services Contracts), as appropriate.
Health and Care Plan	the Barnsley Health and Care Plan, available at: https://www.barnsleyccg.nhs.uk/barnsley-integrated-health-and-care-plan
ICDG	the Integrated Care Partnership Delivery Group, the terms of reference for which are set out in Part 2 of Schedule 3 (*Governance*).
ICP	Integrated Care Partnership.
ICPG	the Barnsley Integrated Care Partnership Group, the terms of reference for which are set out in Part 1 of Schedule 3 (Governance).
ICP Development Plan	the initial ICP Development Plan set out in Schedule 2 (*ICP Development Plan*).
ICS	Integrated Care System.
Initial Term	the period from and including the Commencement Date until 31 March 2023.
Insolvency	(as may be applicable to each Partner) a Partner taking any step or action in connection with its entering administration, provisional

	liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for the ICP set out in Clause 6.1.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Population	the population of Barnsley covered by each of the Commissioners.
Principles	the principles for the ICP set out in Clause 7.
Reserved Matter	has the meaning set out in Clause 9.2.
Section 75 Agreement	the agreement entered into by the Commissioners under section 75 of the National Health Service Act 2006 to commission the services listed in the Schedules to that agreement.
Service Users	people within the Barnsley population served by the Commissioners and who are in receipt of the Services.

Services	the services provided, or to be provided, by each Provider to Service Users pursuant to its respective Services Contract.
Services Contract	a contract entered into by one of the CCG or the Council and a Provider for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires.
Shared Purpose	the shared purpose of the South Yorkshire & Bassetlaw ICS to deliver the quadruple aim (better health, care, value and reduced inequalities) in order to: improve population health outcomes; and reduce health inequalities for the population of South Yorkshire & Bassetlaw.

SCHEDULE 2

ICP Development Plan 2021/22

1. The Partners will work together, through the governance structures set out in this Agreement to develop the ICP during the Initial Term in line with the specific areas of focus set out in the outline ICP Development Plan set out below:

Development area	Proposed focus / Must Do's
Governance	Development of the current Barnsley integrated governance arrangements to include: • Develop proposals for a weight-bearing partnership structure (function then form) that can receive a delegated budget from the ICS and make collective decisions about resource allocation from the future ICS and other sources • Define and agree a place provider collaborative(s) with defined scope of services/pathway, resources and governance arrangements • Develop detailed place operating model for agreed weight bearing structure to include Governance, Infrastructure/Functions, Resources/Skills, Systems and Processes. • Develop ICP implementation rollout plan to transition to new weight bearing structure • Determine place based leadership team in accordance with agreed weight bearing model, with roles/responsibilities clearly articulated • Establish a clinal and professional forum/senate that is incorporated into the revised place based governance structure
Workforce / HR	• Develop an integrated organisational development programme • Investment by Partners in the development of the relationships between Partners that underpin working at Place, at all levels of seniority. Including investment of staff time and possibly also external resource to support organisational development. • Plans to improve flexibility of movement between organisations and development of joint appointments • Workforce resources that can be utilised by Place (e.g. former CCG staff now at the ICS and or staff employed by Partners)

Development area	Proposed focus / Must Do's
	have been identified and consideration given to the practicalities of line management/ secondments etc. • Skills mapping exercise and developing a plan to ensure that workforce needs are aligned to population health needs.
Shared functions across the ICP	Identifying functions which could be more integrated, shared and managed by the ICP across place (e.g. BI, safeguarding, quality)
Financial framework	• Consider how the financial flow and allocation mechanism will work within the ICP and to operate in shadow form a place P&L from September 21. (in accordance with ICS design framework and subsequent guidance). • Clear financial principles have been developed and will need to be tested against the initial priority areas where possible and link into the governance and delegation work described above.
Contracting	• Develop a clear contracting model from the ICP to provider parties. Link this to the development of the finance, governance and delegation processes at ICP and discussions with the ICS in terms of the proposed model of delegation. • Identify the elements which will be picked up at ICS level and work through how the ICP based arrangements should operate from April 2022.
Quality	Consider the quality principles for the ICP and bring the process for consideration of quality into line with finance for a linked process when making/taking decisions.
Population Health & BI	• Further development and embedding of the integrated dashboard, that supports the delivery of the Barnsley health and care plan. • Developing capacity to have a joint approach to data infrastructure, sharing and governance to enable: the forecasting of the population risk profile for the Place footprint • Develop approach to ensure there is a clear understanding across Place / Provider Collaborative of the population health needs and this is driving the delivery of strategy / plans and approach
Public and patient engagement	• Development of an integrated engagement strategy/framework • Engagement built in to emerging governance structures. • Engagement carried out regarding the new ways of working and used to inform service development

SCHEDULE 3

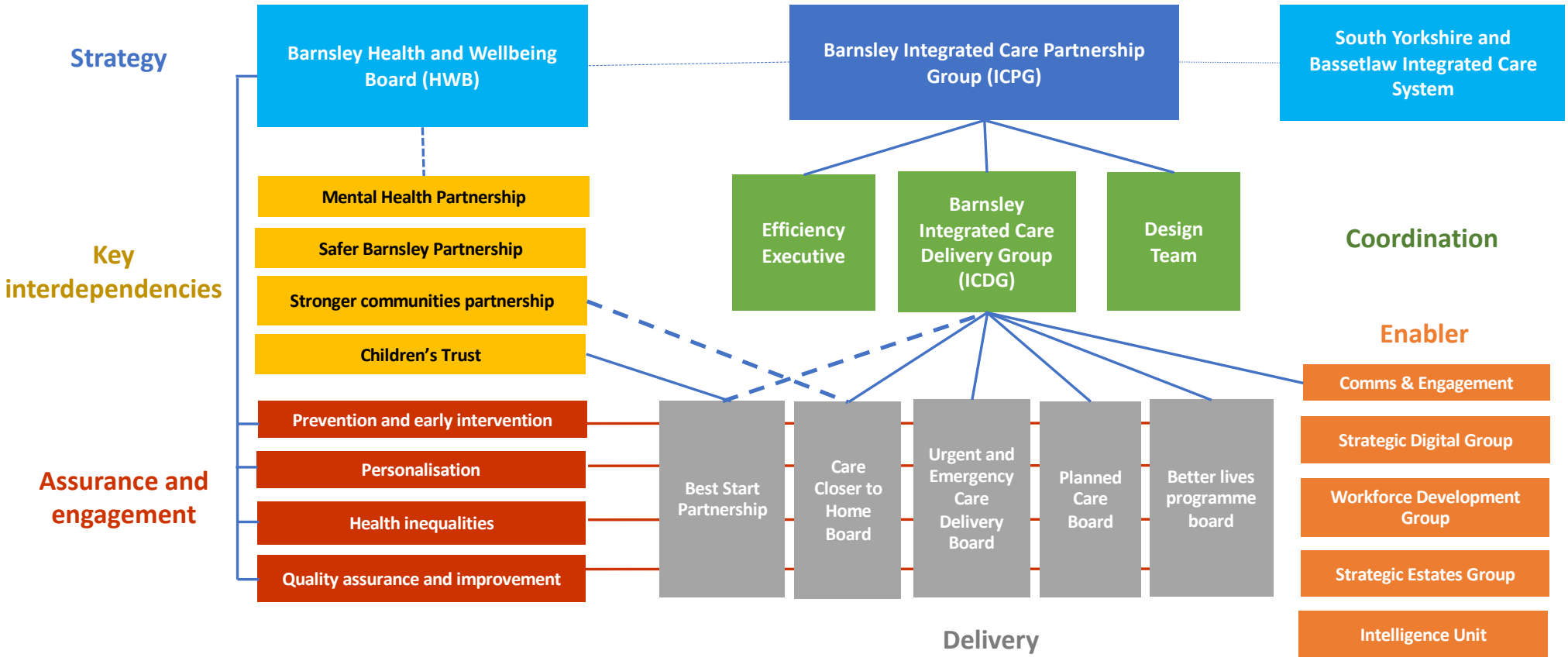
Governance

This Schedule 3 sets out the governance arrangements for the ICP under this Agreement.

The diagram below summarises the governance structure which the Partners have agreed to establish and operate from the Commencement Date, to provide oversight of the development and implementation of the ICP approach and the arrangements under this Agreement.

This Schedule also contains the terms of reference for the ICPG and the ICDG.

Overview of the Barnsley ICP governance model



Part 1 – Barnsley Integrated Care Partnership Group - Terms of Reference

Part 2 – Barnsley Integrated Care Delivery Group – Terms of Reference

Part 3 – Barnsley Efficiency Executive – Terms of Reference

SCHEDULE 4

Dispute Resolution Procedure

1. Avoiding and Solving Disputes

1.1 The Partners commit to working cooperatively to identify and resolve issues to the Partners' mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this Agreement. Accordingly the Partners will look to collaborate and resolve differences under Clause 8 (*Problem Resolution and Escalation)* of this Agreement prior to commencing this procedure.

1.2 The Partners believe that by focusing on their agreed Objectives and Principles they are reinforcing their commitment to avoiding disputes and conflicts arising out of or in connection with the ICP arrangements set out in this Agreement.

1.3 The Partners shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement or the operation of the ICP (each a '**Dispute**') when it arises.

1.4 In the first instance the relevant Partners' representatives shall meet with the aim of resolving the Dispute to the mutual satisfaction of the relevant Partners. If the Dispute cannot be resolved by the relevant Partners' representatives within 10 Operational Days of the Dispute being referred to them, the Dispute shall be referred to senior officers of the relevant Partners, such senior officers not to have had direct day-to-day involvement in the matter and having the authority to settle the Dispute. The senior officers shall deal proactively with any Dispute on a Best for Barnsley basis in accordance with this Agreement so as to seek to reach a unanimous decision.

1.5 The Partners agree that the senior officers may, on a Best for Barnsley basis, determine whatever action it believes is necessary including the following:

1.5.1 If the senior officers cannot resolve a Dispute, they may agree by consensus to select an independent facilitator to assist with resolving the Dispute; and

1.5.2 The independent facilitator shall:

(i) be provided with any information he or she requests about the Dispute;

(ii) assist the senior officers to work towards a consensus decision in respect of the Dispute;

(iii) regulate his or her own procedure;

(iv) determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed or such longer period as may be agreed between the Partners in Dispute; and

(v) have its costs and disbursements met by the Partners in Dispute equally.

1.5.3 If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 4 and only after such further consideration again fails to resolve the Dispute, the Partners may agree to:

(i) terminate this Agreement in accordance with Clause 16.1.1; or

(ii) agree that the Dispute need not be resolved.

Barnsley Integrated Care Delivery Group

Terms of Reference

Barnsley Integrated Care Delivery Group

1.	Introduction	
	1.1	Barnsley Metropolitan Borough Council (BMBC), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Healthcare Federation (BHF) and Barnsley Clinical Commissioning Group (BCCG) have, as partners, agreed to develop an integrated system of health and social care in Barnsley working with other partners including Barnsley CVS, Healthwatch Barnsley and Barnsley Hospice. This integrated system is referred to in these terms of reference, and in the Place Agreement that the above partners have signed up to, as an "Integrated Care Partnership" or "ICP". The Integrated Care Delivery Group (ICDG) will oversee and deliver the Priority Programmes as agreed by the Partners, in accordance with vision and objectives set out below and in the Place Agreement, and report to the Integrated Care Partnership Group (ICPG) on progress.
	1.2	Together we will develop a model for integrated services that joins up care around the mental, physical and social needs of people. In doing so, we will help deliver the Barnsley health and care plan and ICP development plan.
	1.3	The Partners have agreed to work towards a common Vision for the Integrated Care Partnership (ICP) as follows: *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*
	1.4	The Partners have agreed to work together in accordance with the Place Agreement in order to achieve the following Objectives: • Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication; • Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing; • Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance; • Embed integrated care that delivers the best value for the Barnsley pound; • Develop population health management approaches to improve health and wellbeing and reduce health inequalities; • Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2021/22 and beyond; and

		• Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.	
2.	**Purpose**		
	2.1	The purpose of the ICDG is to oversee and deliver the ICP priority programmes as agreed within Barnsley health and care plan and also overseeing delivery of the ICP development plan. Ensuring there is operational ownership of the agreed programme of work, agreeing where changes to the workplan need to made and reporting progress and risks to delivery to ICPG.	
3.	**Responsibilities**		
	3.1	Overseeing and delivering the ICP health and care plan and the ICP Development Plan.	
	3.2	Regular reporting to Partner organisation boards on progress against the ICP health and care plan and the ICP Development Plan.	
	3.3	Regular reporting to the ICPG on progress against the ICP health and care plan and the ICP Development Plan.	
	3.4	Operating in accordance with the principles as set out within the Barnsley Place Agreement.	
	3.5	Ensuring all risk is assessed and assuring that mitigating actions are in place.	
	3.6	Managing and utilising resources across the ICP to optimise service delivery.	
	3.7	Working within the overall scope of the ICP, recognising that changes will be agreed during the course of its development and introduction. Where relevant make recommendations to the ICPG for changes to the plan.	
	3.8	Supporting the Transformation and Enabling Programme boards to deliver their objectives and milestones as set out within the Barnsley health and care plan.	
	3.9	Considering and agree issues raised by the programme boards within the remit of the ICDG.	
	3.10	Overseeing and co-ordinating dependencies which exist across the ICP health and care plan.	
4.	**Membership**		
	4.1	The membership of the ICDG will be:	
		4.1.1	Partner organisation rotation - Chair of the ICDG
		4.1.2	BHNFT - Deputy CEO and Chief Delivery Officer
		4.1.4	BMBC - Director of Public Health,
		4.1.5	BMBC – Executive Director of Adults & Communities
		4.1.6	BMBC – Director of Children's Services
		4.1.8	BHF - CEO
		4.1.10	SWYPFT - Director of Strategy
		4.1.11	Healthwatch – CEO
		4.1.12	Barnsley Hospice - CEO
		4.1.13	Barnsley Community & Voluntary Services – CEO
		4.1.14	Barnsley Clinical Commissioning Group - Director of Strategic Commissioning & Partnerships, NHS Barnsley CCG
		4.1.15	Barnsley Clinical Commissioning Group - Chief Operating Officer

	4.2	Membership will be reviewed and adjusted by agreement of the members as necessary to ensure the ICP meets its responsibilities. Every effort will be made to seek consensus.
	4.3	With effect from 1 April 2022, the role of Chair of the ICDG will be rotated to another member of the ICDG as agreed by the members in accordance with paragraph 5.1 below. This will be undertaken on an annual basis at the beginning of every financial year.
	4.4	The chair of ICDG cannot come from the same organisation as the chair of ICPG.
5.	**Decision making and Quorum:**	
	5.1	The ICDG will operate as a forum for discussion with the aim of reaching consensus among the Partners. The ICDG is neither a separate legal entity, nor a joint committee of the Partners, and is therefore unable to take decisions separately to its Partner members or bind any one of them; nor can one Partner organisation 'overrule' another on any matter.
	5.2	Each Partner organisation will delegate to its representative on the ICDG such authority as is agreed to be necessary in order for the ICDG to function effectively in discharging the responsibilities set out in these terms of reference.
	5.3	Each Partner organisation will ensure that their representatives understand the status of the ICDG and the limits of the authority delegated to them.
	5.4	The Board will be quorate when at least half of the membership is present.
	5.5	Deputies may be nominated to attend, although there should be a clear and consistent intention to attend by each appointed member.
	5.6	Any organisation failing to send a representative for two consecutive meetings will be asked to confirm their commitment.
	5.7	If ICDG is unable to reach consensus and make a decision it will refer to ICPG for resolution.
6.	**Reporting Arrangements**	
	6.1	Formal minutes will be completed from the meeting. This is a private meeting between member organisations. However in the interests of good governance and promoting transparency the minutes relevant to a wider public audience can be taken in the public section of the member organisation' sovereign Boards.
	6.2	The members of the ICDG are responsible for providing feedback on a regular basis to their member organisations' Boards/ relevant decision making bodies.
	6.3	ICDG will report on its activities monthly to ICPG.
7.	**Administration**	
	7.1	The ICDG will be administered by the Partner organisation of the current Chair.
8.	**Frequency**	
	8.1	The ICDG will meet on a monthly basis at minimum.
9.	**Code of Conduct**	
	9.1	The ICDG shall conduct its business in accordance with national guidance, and relevant codes of practice including the Nolan Principles.

	9.2	All members are required to notify the Chair of any actual, potential or perceived conflict of interest in advance of the meeting to enable appropriate management arrangements to be put in place.
10.	**Review**	
	10.1	The ICDG will review on a regular basis its own performance, membership and terms of reference. These terms of reference and any resulting changes to the terms of reference or membership will be approved by the member organisations' Boards/relevant decision making bodies.

Barnsley Integrated Care Partnership Group

Terms of Reference

Barnsley Integrated Care Partnership Group

1.	**Introduction**	
	1.1	Barnsley Metropolitan Borough Council (BMBC), Barnsley Hospital NHS Foundation Trust (BHNFT), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Barnsley Healthcare Federation (BHF) and Barnsley Clinical Commissioning Group (BCCG) have, as partners, agreed to explore and develop an integrated system of health and social care in Barnsley working with other partners including Barnsley CVS, Healthwatch Barnsley and Barnsley Hospice.
	1.2	Together we will develop a model for integrated services that joins up care around the mental, physical and social needs of people. In doing so, we will help deliver the Barnsley health and care plan and ICP development plan.
	1.3	Partners have agreed to work towards a common vision for the Integrated Care Partnership (ICP) as follows: *People of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, regardless of who they are and wherever they live.*
	1.4	The Partners have agreed to work together and to perform their duties under a place agreement in order to achieve the following objectives: • Develop an integrated joined up health and care system where the people of Barnsley experience continuity of care – each Partner delivering their part without duplication; • Individuals, families and communities are empowered to take control wherever possible of their own health and wellbeing; • Shift the focus on treating patients with health problems to supporting the community to remain healthy in the first instance; • Embed integrated care that delivers the best value for the Barnsley pound; • Develop population health management approaches to improve health and wellbeing and reduce health inequalities; • Work towards becoming a thriving ICP in accordance with the ICP Development Plan for 2021/22 and beyond; and • Play a pivotal role in delivering our shared vision for Barnsley: a place of possibilities, set out in Barnsley 2030. A healthy, learning, growing and sustainable Barnsley.
2.	**Purpose**	
	2.1	Provide visible leadership, direction and commitment to the Vision and Objectives for developing integrated care in Barnsley and ensuring effective governance, communication and delivery of the Objectives.

	2.2	Work together to achieve the Vision and Objectives of the partnership through:
		• providing strategic and operational oversight
		• developing new models of joined up services in communities that:
		  ○ set out a new relationship with residents in neighbourhoods
		  ○ are person centred, with a focus on supported self-care, prevention and asset based
		  ○ ensure that services developed in neighbourhoods and new primary care networks are complementary in both services and governance.
		  ○ take a 'one public sector – one borough - one team' approach
		• providing shared responses to the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) strategic developments on primary care networks and other associated integration requirements, including the horizontal provider collaboratives
		• producing shared communications
		• developing shared information governance and record keeping
		• developing a shared workforce strategy
		• developing a shared understanding of collective finances with the aim of a shared management of financial risk
		• considering investment decisions across the partnership
		• having regard to the strategy developed by the Barnsley Health and Wellbeing Board
		Ultimately this will ensure that we work together to drive efficiencies and better outcomes for the residents of Barnsley, in line with the Barnsley Plan.

	2.3	Provide mutual assurance to the constituent bodies through regular reports to the Boards of the constituent bodies.
	2.4	Oversee and inform the work of the ICDG providing support and strategic decision making either directly, within their scope of delegated authority, or by making recommendations to sovereign organisation Boards/relevant decision making bodies.
	2.5	Review and if appropriate, adapt the Programmes objectives, milestones and governance in light of internal or external strategic changes.
3.	**Responsibilities**	
	3.1	Operate within the authority delegated to it by the constituent governing bodies/Boards
	3.2	Provide mutual assurance to the constituent bodies through regular reports to the Boards of the constituent bodies/boards
	3.3	Reflect the underlying principles as set out within the Barnsley place agreement.

	3.4	To review progress and guide the Programme (health and care plan and ICP development plan) towards the overall agreed objectives and benefits.	
	3.5	Ensure all risk is assessed and assure that mitigating actions are in place.	
	3.6	Make best use of the Barnsley £ putting Barnsley people first ahead of the needs of individual partner organisations. In doing so, to collectively manage risk through effective arrangements between partner organisations that meet regulatory requirements and develop a collective voice in managing our position with the SYBICS.	
	3.7	Work within the overall scope of the Programme, recognising that changes will be agreed during the course of its development and introduction.	
	3.8	Support the ICDG to deliver the Programme objectives in line with the agreed Integrated Care Operating Principles.	
	3.9	Strategic decision making for issues raised by the ICDG within the scope of delegated authority.	
	3.10	The ICPG will help to develop clinical models and partnership priorities in line with mature partnership arrangements. For the avoidance of doubt, the ICPG will not have the final decision on clinical/operational models or the commissioning intentions of the CCG, as the CCG is not legally allowed to delegate its commissioning decisions.	
4.	**Membership**		
	4.1	The membership of the ICP will be:	
		4.1.1	Partner organisation rotation - Chair
		4.1.2	BHNFT – Chief Executive
		4.1.3	BHNFT – Chair
		4.1.4	BMBC – Leader of the Council (or delegated councillor)
		4.1.5	BMBC Chief Executive (or delegated Director)
		4.1.6	BHF – Chief Executive
		4.1.7	BHF – Chair
		4.1.8	SWYPFT – Chair
		4.1.9	SWYPFT – Chief Executive Officer
		4.1.10	Barnsley Hospice- Chief Executive
		4.1.11	Barnsley Voluntary Services- Chief Executive
		4.1.12	Barnsley Clinical Commissioning Group- Chair
		4.1.13	Barnsley Clinical Commissioning Group- Accountable Officer
		4.1.14	Barnsley PCN -Chair or Chief Executive
	4.2	In attendance of the ICP will be:	
		4.2.1	Healthwatch – Chair
		4.2.2	Integrated Care Delivery Group executive members
	4.3	Membership will be reviewed and adjusted as necessary to ensure the ICP meets its responsibilities. All members (as set out in 4.1) are voting members.	
	4.4	With effect from 1 April 2022, the role of Chair of the ICPG will be rotated to another member of the ICPG as agreed by the members in accordance with paragraph 5.1 below. This will be undertaken on an annual basis at the beginning of every financial year.	
	4.5	The same organisation cannot hold the chair position in both the ICPG and the ICDG at the same time.	
5.	**Voting and Quorum:**		

	5.1	The Board will operate through the development of a consensus and within its delegated authority.
	5.2	The Board will be quorate when at least half of the membership is present.
	5.3	Deputies may be nominated to attend, although there should be a clear and consistent intention to attend by each appointed member.
	5.4	Any organisation failing to send a representative for two consecutive meetings will be asked to confirm their commitment.
6.	**Reporting Arrangements**	
	6.1	Formal minutes will be completed from the meeting. This is a private meeting between member organisations. However in the interests of good governance and promoting transparency the minutes relevant to a wider public audience can be taken in the public section of the member organisation' sovereign Boards.
	6.2	The constituent members of the ICPG are responsible for providing feedback on a regular basis to their member organisations' Boards/ relevant decision making bodies.
7.	**Administration**	
	7.1	The ICPG will be administered by the organisation of the chair.
8.	**Frequency**	
	8.1	The ICPG will meet on a monthly basis.
9.	**Code of Conduct**	
	9.1	The ICPG shall conduct its business in accordance with national guidance, and relevant codes of practice including the Nolan Principles.
10.	**Review**	
	10.1	The ICPG should review on a regular basis its own performance, membership and terms of reference. These ToR and any resulting changes to the terms of reference or membership should be approved by the member organisations' Boards/relevant decision making bodies.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 10.3

Title:	**West Yorkshire 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 Health and Care Partnership (WY 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 September Trust Board.
Executive summary:	The Trust's strategy outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire Health and Care Partnership (WY HCP). The Trust has continued to work as a member of the partnership. **WY 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 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. **Developing the Partnership's People Plan** The Partnership is developing a People Plan which builds on the NHS People Plan. The plan will be reflective of the 'one workforce' across

	the Partnership. It will include health, social care, voluntary, community and social enterprise, unpaid carers and the education sector. **Connected on Inclusion - 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). The Partnership held a week long learning and celebration event that commenced on 4 October 2021 - Connected on Inclusion - that brought together people from across the partnership, region and nationally. The week concluded with a celebration and awards ceremony. A number of the Trust staff were both shortlisted and recognised for their contribution and work on the equality agenda. **Mental Health, Learning Disabilities and Autism Collaborative** An overview of key work streams and developments being progressed collaboratively are included in the paper. This includes a **separate briefing paper** on the West Yorkshire NHS-led Provider Collaboratives. **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, developing 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 Health and Care Partnership and place-based developments in Calderdale, Wakefield and Kirklees.**
Private session:	Not applicable.

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West Yorkshire Health and Care Partnership and Local Integrated Care Partnerships - Update
Trust Board 26 October 2021

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire Health and Care Partnership (WY 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, operational priorities and winter planning

The number of people testing positive for COVID in England remains high with 192,258 people testing positive in the seven days up to the 28 September. This is equivalent to a rate of 340 per 100,000 people. Whilst rates remain high, they are fluctuating and we have seen case numbers rise and fall over the last six weeks. The number of people testing positive has increased over the most recent weeks; this increase has largely been driven by a rise in cases in people aged 11-16. The trends at a national level are mirrored in the regions. The rate in Yorkshire and Humber is higher than the national rate at 427 per 100,000 people. Rates remain highest in 11–16-year-olds, but we have also seen rate rises in 40–49-year-olds in the last week. Case rates in the over 50s are relatively stable.

Rates in West Yorkshire remain high and are rising in all five local authority areas. Rates are close to or above 400 per 100,000 population. Rates remain highest in the younger age groups and the rising number of cases is largely being driven by increasing cases in the 12-15 age group and to a lesser extent in the under 12s. The decline in case rates in the over 65 population observed in recent weeks has stalled and rates remain high.

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. WY has continued to deliver a co-ordinated vaccination programme across the region and the focus on recovery and winter 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. Partners across each of the places continue working together to develop plans to respond to system pressures and increased need as well as developing winter plans. The WY Strategic Health Co-ordination Group has been re-established and the WYAAT gold command and escalation framework has been reinstated.

3. Planning Oversight

Planning/system oversight NHS England and NHS Improvement published its planning guidance on Thursday 30 September. This is to the end of March 2022.

The priorities are:

- Managing through a challenging autumn and winter
- Ensure dedicated capacity to enable elective recovery
- Manage ICS transition

- Reaffirming commitment to delivering the ambitions of the Long Term Plan and Mental Health investment
- The unknown of the next six months

The ICS will be working with place teams and leads over the next few weeks to support the development of plans that will be submitted in November. **(There is a separate agenda item that will cover Trust planning in more detail).**

4. WY 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. Now that the national guidance has been published, the draft constitution and other governance documents will be shared with the partnership as they are developed. The partnership is well placed to transition to 'shadow' operation in November 2021, in preparation for new statutory arrangements from April 2022. The recruitment process for the Chair is now complete and Cathy Elliot has been appointed as Chair for the ICS. Recruitment to the CEO role for the ICS is well underway in line with national timescales. Other senior roles will be appointed to once the CEO and Chair take up their respective roles. **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 recently published guidance and the CEO and Chair are part of the ICS oversight groups.**

5. Integrated Care Board constitution – development and stakeholder involvement

The proposed Health and Care Bill requires CCGs to propose the ICB constitution and carry out involvement on it. NHS England guidance was that the process should be led by the designate ICS Chair and Chief Executive, with system partners engaged throughout. This supports the 'whole Partnership' approach, building on the work of the Partnership Governance Working Group, which includes partners from across our places and sectors. The involvement process will be 'designed once' and delivered five times across the local places, involving all relevant and interested stakeholders via the local communication and engagement leads. Final agreement of the constitution will be through the Partnership Board and the shadow ICB Board. The Joint Committee recommended that each CCG agrees that the Partnership will co-ordinate the development of the draft integrated care board (ICB) constitution and stakeholder involvement on the constitution.

6. Developing Place Based Partnerships (PBP)

West Yorkshire has led on building a development approach for places as part of the North East and Yorkshire Region ICS Development Programme. The place-based development work is a key workstream of the Future Design and Transition Group (FD&TG), in terms of programme leadership. To support the work, an ICP Reference Group was created which meets fortnightly to oversee progress and to ensure it links to the other FD&TG programmes of work. The group is represented by sectors, place-based colleagues and provider collaboratives and has been a useful sounding board to ensure that the framework is both grounded, whilst also facilitating ambition. The three sections in the PBP framework are:

- Vision and ambition: what the PBP is there for and what does it hope to achieve (this covers areas such as the vision, placed based plans and community/neighbourhood/citizen informed)
- System leadership and behaviours: what does it take to be an effective PBP (this covers areas such as common narrative, culture, trust and leadership)
- Design and delivery: what systems, processes, structures need to be in place to deliver the ambition (covering areas such as CCG transition, governance, finance and risk).

The system leadership and behaviours section is supported by a leadership and behaviours framework commissioned from McMillan Associates and funded by the NEY region as part of the place development work. The framework has been developed by McMillan Associates, engaging with each of the five place partnerships. The PBP development framework has continued to iterate over the last nine months to respond to national guidance, place feedback and subject matter experts. This and the leadership and behaviours framework have been signed off by the ICP Reference Group and are now being utilised across the places. It's important to note that the framework is one element of the place-based development work and is also supported by peer review and the ICP peer support group. **The Trust as a partner in places Calderdale, Kirklees and Wakefield have been contributing to the place based assessments using the framework and development plans that set out how the partnerships will evolve on their journey to maturity. Updates have been regularly provided to Trust Board as part of the WY ICS update.**

7. Developing the Partnership's People Plan

The Partnership is developing a People Plan which builds on the NHS People Plan. The plan will be reflective of the 'one workforce' across the Partnership. It will include health, social care, voluntary, community and social enterprise, unpaid carers and the education sector.

The ongoing and sustained response to the pandemic has put enormous pressure on the workforce across the health and care sector which has impacted on the wellbeing of the workforce and the ability to recruit and retain the workforce we need now and in the future. The Partnership People Plan aims to set out how we will address the short to medium term challenges resulting from the pandemic, whilst setting out the strategic ambitions for the future. The five core purposes of the plan are:

- Looking after our people
- Belonging in the health and care partnership
- New ways of working to deliver care
- Grow for the future
- System leadership

Forum members discussed recruitment, retention, development and support for existing and new clinicians. New care models were also discussed, alongside our work with universities on the workforce observatory. It's important that everyone feels connected to the plan and can see themselves within it. Career pathways and wider understanding on opportunities to enter the health and care sector will be highlighted in the plan. **The Trust is a key partner in helping shape and develop the plan and our Director of HR and OD is linked in to the partnership arrangements.**

8. Connected on Inclusion week - 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). The Partnership brought together local, regional and international speakers for a week-long celebration that started on Monday 4 October. The week showcased the work taking place across the area to connect on inclusion, whilst celebrating diversity within its workforce, learning from others and highlighting the positive difference made when all come together. The week concluded with a celebration and awards **ceremony where a number of our Trust staff were recognised for their significant contribution to the agenda**. There were a series of reflections from leaders that attended the October System Leadership Executive meeting on the system ambition, progress made as well as what more we can all do to improve care for people, for example commissioning culturally competent care and the wider determinants of health. The Partnership reverse mentoring scheme has also been launched. **The Trust is a key partner in the programmes and will continue to progress this work through the priorities set out in the annual equality and involvement action plans.**

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

The Trust Board was appraised at the September 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 September meeting include:

West Yorkshire Adult Secure Lead Provider Collaborative:
The Collaborative 'go live' position was confirmed with NHS England as 1 October 2021, and this was achieved. A **separate briefing report** is contained with this agenda item.

Further progress has been made in terms of progressing recruitment to posts at Leeds and York Partnership NHS Trust (LYPFT) to implement the commissioning capacity requirements for the West Yorkshire Collaboratives.

WY Mental Health, Learning Disabilities and Autism (MHLDA) Programme:
The October meeting of the WY MHLDA programme board covered a wide-ranging agenda. There were presentations and papers on the progress of work programmes including: The WY ICS Plan for Children & Young Peoples' mental health; Presentation on diversity in the workforce; Community Mental Health Transformation update; Functions mapping progress report.

In addition, two organisational development sessions involving executive representatives from the four NHS Trusts in the MHLDA Collaborative have taken place in recent weeks and have focused on how we work together in the future and the scope of what the main areas for collaboration are.

10. Local Integrated Care Partnerships - Key developments

We continue to work with partners to develop and deliver joined-up Covid-19 response including winter plans and recovery approach in each of the places that we provide services. We have also continued to work with partners to develop our place approach and response to the white paper and related national guidance.

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 reported to the emerging place based Integrated Care Partnership Board that is made up of health and care leaders including VCS partners. A draft MoU is being developed and a system development plan that will be shared with Board for discussion in private Board at this meeting.

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 September Trust Board meeting on the work of the ICP, including a separate paper summarising Wakefield's further progress in relation to the white paper *Integration and Innovation: working together to improve health and social care for all.* The Wakefield Integrated Care Partnership Board met on 28 September 2021. The main areas of

focus at the meeting included: Development of services to support people with Long Covid; Transformation reports relating to Urgent Care redesign and arrangements to support hospital discharge; Reports on the development of the ICP – Place development plans, governance, organisational development.

The detailed workstreams on the next phase of the development of the ICP continue. Multi-agency command arrangements continue to remain in place in light of the increase in service pressures in the district and winter planning arrangements are being finalised.

Kirklees
The Kirklees Integrated Health and Care Leadership Board continues to meet monthly. The most recent meeting took place on 30 September 2021. The meeting focused on: Development of the ICP, including governance arrangements and draft Terms of Reference; Learning and evaluation – shaping the future of public services in Kirklees; overview of Kirklees place performance.

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 continue to remain in place.

Recommendations

- **Trust Board is asked to receive and note the update on the development of Integrated Care Systems and collaborations:**
    - **West Yorkshire Health and Care Partnership**
    - **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees**

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

Appendix - Links to relevant partnership meetings and papers

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board – 26 October 2021

West Yorkshire NHS-Led Provider Collaboratives – Update Briefing

NHS-Led Provider Collaboratives are a new way of planning and providing mental health, learning disability and autism services that have previously been commissioned by the Specialised Commissioning team at NHS England and NHS Improvement.

An NHS-Led Provider Collaborative is a group of providers of specialised mental health, learning disability and autism services who have agreed to work together to improve the care pathway for their local population. They will do this by taking responsibility for the budget and pathway for their given population. The Collaborative is led by an NHS Provider (the Lead Provider) who remains accountable to NHS England and NHS Improvement for the commissioning of high-quality, specialised services.

To begin with, NHS-Led Provider Collaboratives will deliver:

- Children and Young People Mental Health inpatient services
- Adult Low and Medium Secure Services
- Adult Eating Disorder Services

The introduction of NHS-led Provider Collaboratives creates a shift in the approach to commissioning specialised mental health, learning disability and autism services. Our collective focus is to understand and meet the health needs of our local populations, improving outcomes, experience and the delivery of transformation in pathways of care. Our ambition is to ensure that people with specialised mental health, learning disability and autism needs experience high quality, specialist care, as close to home as appropriately possible, which is connected with local teams and support networks.

In West Yorkshire, we have three Provider Collaboratives (PCs); Adult Eating Disorders, Children and Young People Mental Health inpatient services, and Adult Secure.

The West Yorkshire Adult Eating Disorder PC, named CONNECT by service users, is led by Leeds and York Partnership NHS Foundation Trust and went live as a Provider Collaborative on 1st October 2020.

At the Trust Board on 28th September 2021 the Adult Secure Business and Clinical Case, and the Partnership Agreement, were discussed and approved. These were also approved by Boards of all partner organisations at their September 2021 meetings. Following these governance approvals, the Adult Secure Provider Collaborative (PC) went live on 1st October 2021. Led by the Trust, the PC is a partnership between South West Yorkshire Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust, Cygnet Health Care, In Mind Healthcare Group for the provision of low and medium adult secure services. It covers the areas of Leeds, Calderdale, Kirklees, Wakefield and Bradford.

Key ambitions of the collaborative are:

- Service Users should be cared for in the least restrictive environment possible with individuals being supported as close to home and carers as possible.
- The needs of the West Yorkshire population should be met within West Yorkshire.
- Development of enhanced community provision to allow individuals to move from low and medium secure estate into the community.

Work has progressed to establish an independent Commissioning Hub, hosted by LYPFT on behalf of the three West Yorkshire PCs. A number of key posts within this Hub are currently being recruited. Case managers who were previously working for NHSE, TUPE transferred on 1st October 2021 to LYPFT as host of the Commissioning Hub, to cover the three PCs.

Provider Collaboratives will need to ensure commissioning oversight of the collaborative from 1 October 2021, therefore interim commissioning arrangements have been agreed with NHSE/I, including a minimum of three months transitional support. A Memorandum of Understanding has been agreed with NHSE/I, which sets out the scope of the transitional support.

The West Yorkshire Children and Young People Mental Health inpatient services PC also went live on 1st October 2021, following a similar governance approvals process to that described above for the Adult Secure PC. Led by Leeds and York Partnership NHS Foundation Trust, the PC is a partnership between Leeds and York Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust, and covers the areas of Leeds, Calderdale, Kirklees, Wakefield and Bradford. The collaborative builds on work we have achieved as a New Care Model site for Tier 4 CAMHS.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021

Agenda item 10.4 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	Next meeting scheduled for 3 Feb 2022
Member	Interim 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	14 October 2021
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	• Health Inequalities stock-take - Progress update - Calderdale Black Asian and Minority Ethnic (BAME) action plan • Supporting People with learning disabilities to live a larger life in Calderdale; Employment and meaningful activities • Health and Care Bill - Integrated Care Strategy implementation/ Integrated Care Partnership Development • Homelessness & Rough Sleeping Strategy - Focus on progress and plans for the Winter • An Age-Friendly Borough • Covid -19 - Update by exception • Forward Plan for the December meeting
Minutes	Papers and draft minutes are available at: https://www.calderdale.gov.uk/council/councillors/councilmeetings/results.jsp?committee=190&start=15%2F10%2F2020&p_SQ_ID=5102139&phrase=N&type=agenda&offset=0&id=211221434

Kirklees Health and Wellbeing Board

Date	30 September 2021 Next meeting scheduled for 2 December 2021
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Showcasing Innovation: Kirklees Better Outcomes Partnership • Shaping the partnership response to Tobacco Control in Kirklees • The Health and Care Bill: Preparations in West Yorkshire and Kirklees for the proposed changes
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 18 November 2021
Member	Chief Executive / Director of Provider Development
Items discussed	
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	**Message sent on behalf of Helen Stevens-Jones** Following the co-design of the South Yorkshire and Bassetlaw Integrated Care System Health and Care Compact and Health and Care Partnership (H&CP) Terms of Reference for the transition year 2021/22, led by the ICS Development Steering Group, the Collaborative Partnership Board will be succeeded by the H&CP later this year.
Member	Director of Human Resources, Organisational Development and Estates / Director of Strategy
Items discussed	N/A
Minutes	Approved Minutes of previous meetings are available at: https://sybics.co.uk/about/meetings-and-minutes

West Yorkshire & Harrogate Health & Care Partnership Board

Date	7 December 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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 11.1

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resources and Director of Quality & Nursing
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for September 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 September is in line with developments agreed by the Trust Board, including a section on monitoring progress against our strategic objectives. **Quality** • The majority of quality reporting metrics continue to be maintained during the pandemic. • The number of restraint incidents was 166 in September, an increase of 30 since August. • No avoidable pressure ulcers were reported in the month. • There were 12 information governance breaches reported in September, an increase from 8 in August. • There was 1 duty of candour breach in September. • The number of inpatient falls increased to 69 in September (compared to 43 in August). • Out of area bed usage increased in September to 311 days. **NHSI Indicators** • Performance against national reported targets remains largely positive. • Percentage of service users waiting less than 18 weeks remains above the target threshold at 99.7%. • There were no young people under the age of 18 were on an adult ward in September, an improvement from 2 in August. • The percentage of individuals completing IAPT treatment who have moved to recovery is within target (54.5% compared to 50% target), an improvement since August.

Locality

- Increased referrals and levels of acuity are being experienced across many service lines.
- Staffing levels remain under constant review.
- Four wards, an increase of one since August, fell below the 90% overall fill rate threshold in September. Significant efforts are underway to address our current staffing pressures.
- In Barnsley, the Covid-19 vaccination programme for 12–15-year-olds has commenced in schools.
- Adult ASD/ADHD services have seen a significant increase in referrals for assessment.
- The West Yorkshire Adult Secure Provider Collaborative has gone live, with support from NHSE/I agreed for the transition stage whilst the commissioning hub for the West Yorkshire Provider Collaborative is established.
- Forensic OPEL Level has been upgraded to 3 due to staffing pressures.
- OPEL Level for the Assessment and Treatment Unit has been increased to Level 3, due to staffing pressures.
- Mental health acute wards continue to see high levels of acuity, with further challenges in managing isolated and cohorted patients.
- Barnsley 136 suite and triage functions out of hours are now provided as an extension of the intensive home base treatment team function.
- CAMHS referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield with % treated within 18 weeks beginning to deteriorate.

Communications, Engagement and Involvement

- Coronavirus updates continue weekly to all staff and governors.
- The Trust were highly commended in the NHS Communicate Awards for use of data and insight in our communications approach to Covid-19 staff vaccinations.
- Staff wellbeing initiatives continue to be promoted.
- Promotion is in place linked to Stoptober, support to Yorkshire Smokefree, and preparation for the Trust QUIT launch.
- Calderdale IAPT website has been launched.
- Staff engagement has taken place for the equality campaign, and content is in the process of being developed.

Priority Programmes

- The Adult Secure Provider Collaborative final business case and partnership agreement was approved at September Trust Board, and by partner Boards, and the collaborative went live on 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.
- Implementation of CAMHS neuro-developmental waiting list initiatives in ongoing in Kirklees

	• The Trust is a key partner in the West Yorkshire Adversity Trauma and Resilience Programme and is working towards being a trauma-informed Trust. **Finance** • A £0.1m surplus was recorded in the month, taking the cumulative position to a surplus of £2.3m. • Pay costs increased in September to 19.1m from £17.3m in August which included the impact of the Agenda for Change pay award and pay arears. • Agency staffing costs were £0.8m in September. This is an increase from August, and is expected to continue to support maintaining safer staffing requirements. • Out of area bed costs were 301k in September. Increased usage is in part linked to conscious decision to reduce pressure on inpatient wards. • Capital expenditure of £1.3m has been recorded to date, which is £1.1m less than planned. The forecast remains that the full £9.6m capital programme will be utilised in year. This is being reviewed regularly. • The cash balance remains positive at £63.3m. **Workforce** • Non Covid- 19 sickness is within target at 4.6% in September. • Staff turnover remains higher than target at 14.5%. • As of 20th October, there were 93 staff off work and not working Covid-19 related. • 86.6% of staff are double vaccinated. **Covid-19 response** • 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. • The Trust OPEL level remains at level 3 due to continuing staffing pressures and high acuity. • The Trust flu vaccination programme has commenced. • Silver command structure is currently meeting twice a week, and Gold command weekly. • National guidance continues to be monitored, reviewed, and adopted. • A range of staff wellbeing support offers continue to be available and used.
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

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Integrated Performance Report
Strategic Overview

September 2021

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report (IPR) for September 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 September 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 performance data related to the West Yorkshire and Harrogate and South Yorkshire and Bassetlaw integrated care systems – 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. Our integrated performance strategic overview report is publicly available on the internet.

The Trust's Finance, Investment and Performance Committee is currently reviewing the use of SPC charts and if any further metrics could benefit from their use, and on its work plan in the near future is a review of risks that have not met target for an extended period of time.

The following eight pages highlight the performance against the Trust's strategic objectives.
EMT during the year agreed to include community mental health transformation as an additional priority.

Improving health

Priority programme	Metrics	Threshold	Jul-21	Aug-21	Sep-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 apparent suicides for patients with an open referral to SWYPFT services		5	2	2			Apparent suicide of those under SWYPFT care at the time of death have been analysed and rates are not outside of normal variation. Figures may be subject to change as we become aware of deaths. In the current month, there is no commonality in reporting teams. Suicide not confirmed by coroner at point of reporting.
	2.Smoking Quit rates for patients seen by SWYPFT Stop Smoking services (4 weeks) *	55%	Q2 data available November Q1 - 66%					A weighted average is used given there are different targets in different places.
	3.Proportion of people from BAME communities accessing IAPT		13.7%	14.3%	15.6%			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	**68% screened 58% compliant	**65% screened 58% compliant	**66% screened 55% compliant			For current inpatients (as at 19th Oct) 66% of applicable patients have been screened using the cardio metabolic screening tool and of those 55% have been screened across all 9 domains. For current patients (as at 19th Oct) within Early Intervention services, 59% of applicable patients on caseload have been screened using the cardio metabolic assessment tool. Of those, 43% 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.
	1b. Cardio metabolic assessment & treatment - Community (Early Intervention services)	70% screened 70% compliant	**55% screened 41% compliant	**55% screened 42% compliant	**59% screened 43% compliant			
	2. IAPT - proportion of people completing treatment who move to recovery	50%	44.8%	43.8%	*54.5%*			September data is provisional and will be refreshed in November 2021.
	3. % service users on CPA followed up within 7 days of discharge	95%	139/140 =99.3%	113/114 =99.1%	89/89 =100%			
	4. % of service users on CPA with a 12 month follow up recorded	95%	94.2%	92.5%	95.7%			
	5. % Learning Disability referrals that have had a completed assessment, care package and commenced service delivery within 18 week	90%	*85.7%*	*83.8%*	*76.5%*			Q1 total is 91.5%. Q2 data is provisional at the time of producing this report and will be refreshed in November 2021. Staff shortages are impacting on performance.
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 along with working with Creative Minds partners to develop the approach to better data collection and monitoring. Further update to be provided in next months report.

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 September and progress towards milestones set for the next three months. 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: Development of a Creativity & Health digital app with first stage research and development and proof of concept completed by end of September 21. Three creativity courses produced by end of September 21 and testing and evaluation completed by end of November 2021.		**Creativity and Health:** Work to develop a proof-of-concept creativity app is underway and meetings scheduled with the developer. Testing of initial content has been completed and feedback has been positive. Timescales for testing and evaluating will need to be adjusted. A project manager has been appointed by the National Centre of Creativity and Health (NCCH) to work in partnership to analyse health sector investment in creative projects, to inform sustainability plans and development of West Yorkshire and Harrogate Creativity Hub. **Active Calderdale:** Work to develop in-house motivational interviewing training with physical activity focus is underway with clinicians. However initial timescales to pilot will need to be revised. **ICS and partnership developments:** The Trust is part of two advanced Integrated Care Systems (ICS) and is also part of place-based partnerships and provider collaboratives. The Trust continues to work with partners to deliver the shared priorities in relation to Covid-19 response, vaccination programme, and recovery and reset, in addition to establishing our place response to the Health and Care Bill through the development of shared governance arrangements. The Trust is a key partner in tackling health inequalities and achieving a diverse leadership and workforce programme and has formally signed up to the anti-racism campaign. The Trust will continue to progress this work through the priorities set out in our annual equality and involvement action plans. The Trust is a key partner in the West Yorkshire Adversity, Trauma and Resilience (ATR) Programme and is working towards being a trauma-informed Trust by integrating and developing trauma-informed pathways to care and approaches. The September meeting of the West Yorkshire Mental Health, Learning Disabilities and Autism (MHLDA) Programme Board covered a wide-ranging agenda including workforce strategy and implementation plans, proposals for further discussion on the governance of the Programme Board and the programme of collaborative work going forward. The West Yorkshire Suicide Prevention website was launched on 10th September 2021, and there was an update on the staff mental health wellbeing hub. A Health and Care Compact Agreement has been co-produced by the partners in the South Yorkshire and Bassetlaw (SYB) ICS, that outlines principles and how organisations intend to work with each other. A proposal is being developed to strengthen support to the workforce in suicide prevention and bereavement, both preventative and for those affected by suicide. This will form part of the workforce resilience support offer for staff across SYB. Children and young people's access was a focus of the Mental Health Deep Dive meeting with NHSE/I regional and national colleagues. A range of actions have been identified to support an improvement in access in SYB which is currently lower than the national average. Development of the SYB Mental Health Provider Alliance is being pursued, with support offers from NHSE/I Service Improvement Team.
2. 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 of November 2021.		
3. 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 of August 2021.		
4. Active Calderdale: to hold a partnership event showcasing the work across SWYPFT in integrating physical activity into systems and processes by end of October 2021.		
5. Forensic Lead provider collaborative: The business case and partnership agreement were approved by Trust Board on 28th September 2021, and approved by partner September Boards. The Provider Collaborative went live on 1st October 2021. Transition arrangements have been agreed with NHSE/I whilst the commissioning hub for the West Yorkshire Provider Collaboratives is fully established.		
6. Community mental health transformation: Recruitment into project/programme lead posts has now taken place and all programme leads are now in post. SWYPFT delivery leads network meeting is now established to facilitate shared learning across our place-based programme leads and operational managers.		

Improve Care

Priority programme	Metrics	Threshold	Jul-21	Aug-21	Sep-21	Trend	Year end forecast	Notes
Continually improve patient safety	1. Incidents involving moderate or severe harm or death	Trend monitor	18	21	26			
	2. Number of c-diff avoidable cases	0	0	0	0			
	3. Number of pressure ulcers	Trend monitor	22	21	28			Although there appears to be an increase in September, this remains below the average number of incidents in Q1.Pressure ulcer prevention and waterlow risk assessment training has been delivered in April 2021 in two neighbourhood teams with good improvements but further work required around consistency of reporting and documentation. Further training sessions are planned in November 2021.
	4. Safer staffing fill rates (%)	90%	115.0%	111.2%	109.7%			
	5. Number of children & young people in adult wards	0	3	2	0			Total of 0 days in September
	6. Staff absence due to Covid-19		40	29	42			No of staff still absent from work - Covid-19 positive
	7. Number of nosocomial incidences of Covid-19 in our inpatient units		147	149	173			Cumulative. New outbreaks in September. Reinforcement of procedures and identification of additional measures.
Provide care as close to home as possible	1. Out of area bed placements (days)		117	170	311			Continued pressure and demand with the number of placements minimised. Conscious decision to use so as to alleviate pressure on inpatient wards.
Deliver improvements particularly in CAMHS and forensic services	1. Numbers waiting over 4 weeks for assessment (CAMHS)		194	221	157			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)		146	161	203			Higher referral numbers, including eating disorders
	3. Friends & Family test - CAMHS	80%	83.3%	66.0%	73.7%			114 responses in September
	4. Forensics staff sickness	<=5.4%	6.6%	5.4%	5.5%			
	5. Forensics staff turnover		11.1%	11.6%	12.8%			Registered nurses turnover
	6. Race related incidents against staff in forensics		6	9	6			There were a total of 21 race related incidents against staff reported between July and September 2021, occurring in Forensic BDU.
Safely deliver and restore inclusive services locking in innovation	1a. Waiting lists - Referral to assessment within 2 weeks (external referrals)	75%	89.4%	87.9%	82.7%			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%	93.3%	94.2%	92.7%			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%	92.2%	94.8%	95.9%			This mostly relates to IHBT and liaison services
	2a. Average contacts per day - Core mental health		226	210	226			Pre Covid-19 - 240 (October 2019 which is representative of the following 6 months). Services are reporting increasing acuity and complexity resulting in longer visit times.
	2b. Average contacts per day - intensive home based treatment team		133	125	127			Pre Covid-19 - 154 (October 2019 which is representative of the following 6 months). Services are reporting increasing acuity and complexity resulting in longer visit times.
	2c. Average contacts per day - Learning disability community		156	119	145			Pre Covid-19 - 89 (October 2019 which is representative of the following 6 months). Services are reporting increasing acuity and complexity resulting in longer visit times.
	2d. Average contacts per day - District nursing, end of life and community matrons		622	590	608			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 next month

Glossary

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

Improve care (Carol Harris)

Key Milestones	
1. Recovery and Reset – Operational recovery and reset: Undertake 'as is' stocktake of current contact methods used and set 'proxy' measures for the future 'to be' state by end of September 2021.	
2. Recovery and Reset – Operational recovery and reset: Gather evidence to shape service user involvement by end of November 2021.	
3. Recovery and Reset – Operational recovery and reset/enabling working effectively: Toolkit and best practice guides to support services in recovery and reset inclusively has been codesigned, tested and agreed by end of November 2021	
4. Recovery and Reset – Enabling working effectively: Ways of working codesigned and tested and framework agreed by end of November 2021.	
5. Recovery and Reset – Enabling working effectively: First phase of clinical space review to be completed by end of November 2021.	
6. Care close to home: Gatekeeping analysis has been completed and priority activity has now been agreed. As a result the programme is now formally establishing a strand of coordinated work around crisis house support. Focus on discharge solutions is now also being included in the partnership governance. (September 2021)	
7. Care close to home: Psychiatric Intensive Care Unit standard operating procedure agreed and ready for launch – now September 2021	
8. Care close to home: Plan established and agreed for crisis alternative to admission work (November 2021)	
9. Care close to home: Review of trajectories and activity required to address them given recent and ongoing system pressures (November 2021)	
10. Improve Services for people acutely unwell and improve ward environment: initial governance is being set up with first formal meeting scheduled for October. Workstream milestones will then be agreed.	
11. Older People Inpatient Services Transformation - Start the conversations with and share the consultation plan and collateral with the Overview and Scrutiny Committee – activity ongoing through September – October 2021	
12. 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 Q3), ongoing.	
13. Older People Inpatient Services Transformation - Develop collateral required to deliver formal consultation (start Autumn 2021, exact timing to be confirmed)	
14. CAMHS improvement- Neuro waiting lists (Calderdale and Kirklees:) Princess Royal site ready for enhanced service (now aiming for late November)	

Comments:

Recovery and Reset:

• Significant progress on setting of benchmark proxy measures has been made. Using intelligence and insight, each area has been able to identify the current blend of face to face and non face to face contact methods used in each service (as is position).

• Services have been identified to undertake reset work, test out the support toolkit and develop the Enabling Working Effectively framework for wider use across the organisation.

• Business Intelligence involvement is established to support development of recovery and reset dashboards to support interpretation and tracking of data and help understand impact of Covid-19 and health inequalities.

•There is agreement to undertake an improvement approach and develop an involvement plan to ensure the voice and influence of staff, service users, carers and families shape recovery and reset.

• A room and desk booking system prototype is in development to support hybrid working.

• A testing of space utilisation review has been undertaken with services and a clinical space review is on track to commence mid-October.

Older People Inpatient Services Transformation

Work is now progressing towards the delivery of the outline business case for the proposals, and the formal consultation and conversations continue with key external stakeholders to test support for proposals before moving forward. Internal activity is re-focussing on staffing required to deliver the model and estates.

CAMHS

The focus for the project is moving onto establishing the enhanced service and the project team has developed a plan for activity over the coming months. Work continues on estates and locating the Kirklees service primarily at the Princess Royal site. The aim was to be operational at that site by early November, although this timeframe now appears to be challenging as we are awaiting the refurbishment, and late November / early December appears to be more realistic. Calderdale CAMHS is also planning to use this site to deliver some assessments. Recruitment across the services continues.

Inpatient Improvement

Formal governance for the programme is now being established, whilst some urgent priority activity has also been considered to ease some of the immediate pressures. Improvement activity is also being planned that can support easing immediate pressures, such as support to reduce time clinicians spend in non-clinical facing activity. The first formal programme board is scheduled for October and aims to set the scopes for each strand of delivery in the programme.

Glossary	
PICU	Psychiatric intensive care unit
CCG	Clinical commissioning group
CAMHS	Child and Adolescent Mental Health Services
NHSE	NHS England

Improve resources

Priority programme	Metrics	Threshold	Jul-21	Aug-21	Sep-21	Trend	Year end	Notes
Spend money wisely and reduce waste	1. Surplus/(deficit) vs target	In line with Plan	£377k	£118k	£116k		£2.3m	H1 surplus is favourable to plan.
	2. Underlying surplus/(deficit)							Not currently calculated due to interim financial arrangements
	3. Cash		£61.2m	£63.3m	£63.1m		£64.6m	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'		5.1%	4.2%	4.2%			
	2a. Percentage of video consultations		3.3%	2.1%	2.5%			Slightly lower than national averages.
	2b. Percentage of telephone consultations		35.2%	32.6%	32.2%			Both video and telephone contacts have reduced and face to face contacts have typically increased compared to earlier months as services increase the face to face activity.
	2c. Percentage of face to face consultations		61.5%	65.4%	65.4%			
	3. Prescribing errors (EPMA) (development required)		Reporting to commence November 2021					Reporting to commence next month 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:** High level business case seeking EMT engagement prior to tender has been prepared and will now be submitted to EMT on 21st October with initial timescales for procurement revised accordingly. **Trust email platform accreditation (NHS Digital dependencies):** Remains on track but timescales are dependent upon NHS Digital dependencies. The Trust has completed all pre-requisite activities and is awaiting final approval from NHS Digital from which to further issue Trust communications and start NHS mail decommissioning. **IT Services re-procurement:** Trust authority to proceed approved, development of the detailed specification of requirements progressing to support the procurement exercise and remains on track. **Information Sharing:** Development proposal for onboarding Viper360 portal to Yorkshire and Humber Care Record (YHCR) approved and work underway. Work ongoing to support the establishment of a minimum viable product (MVP) for a Barnsley Shared Care Record – potentially utilising Viper360 together with existing capabilities available within SystmOne and ICE (results reporting) as used by partners across the place. Work ongoing with partners. **Digital Inclusion:** Dr Abida Abbas, Trust Chief Clinical Information Officer (CCIO) is developing a proposal for a digital inclusion survey for service users and to establish mechanisms for collecting service user digital inclusion/preferences at relevant points of contact to be recorded in SystmOne. **Finance:** Confirmation of initial mental health investment standard (MHIS) monies received. We continue to recruit into new positions to deliver the anticipated outcomes. **Financial Sustainability Plan:** Work to refresh the sustainability plan is underway, roadmap on next steps and proposal for governance arrangements and oversight approved by the Operational Management Group.
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.		
3. IT Services re-procurement: approach planning prior to procurement – Q1/Q2.		
4. Cyber Security: Annual Survey/Phishing Survey and evaluation of findings – Q2 and implementation of action plan – Q3		
5. Digital capital programme 21/22: detailed programme planning and mobilisation of planned expenditure. A review of HY1 underway and forecast for HY2.		
6. Information Sharing: Yorkshire & Humber Care Record onboarding (utilising Trust clinical portal) – Q1/Q2.		
7. 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 has been launched across the Trust. • Continued support to Covid-19 response activities - additional routine reporting in place to support the covid-19 response e.g. OPEL reporting, daily sitreps for bed availability and capacity reporting, monthly benchmarking submissions, Elective recovery fund (EROC) submissions, vaccinations, sickness reporting • Dashboard development work taking place for recovery and reset and data quality workstreams.		
8. Digital Inclusion: Technical Feasibility (in collaboration with WY&H ICS).		
9. Finance: Confirmation of mental health investment standard (MHIS) monies and other investments by 30.06.21		
10. Finance: Update of recruitment and implementation against investment. To be updated monthly. Need to agree strategy		
11. Financial plan: Develop a financial plan for H2 2021 / 22 utilising all available funding and spend to save opportunities.		
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	Jul-21	Aug-21	Sep-21	Trend	Year end forecast	Notes
Support the provision of a healthy, resilient & safe workforce	1a. Sickness absence	4.5%	4.5%	4.6%	4.7%			Non Covid-19 sickness has increased in the last three months
	1b. Sickness absence (including Covid-19)		6.4%	6.2%	6.1%			
	2. Staff turnover - YTD	10%	14.1%	14.6%	14.5%			High focus on recruitment, retention and wellbeing. This figure is calculated on the numbers of substantive staff who leave the Trust and excludes internal moves, end of temporary contracts and junior doctors on rotation.
	2a. Staff Turnover - monthly		1.2%	1.5%	1.4%			
	3a. Clinical supervision	>=80%	70.5%					Reduced performance reported this quarter. We recognise that clinical supervision is critical during challenging times yet the staff will cancel supervision in order to prioritise the delivery of care. Vacancies and absences also impact upon the availability of supervisors and the uptake of supervision. Additional operational support has been provided to release the matrons capacity for clinical supervision and leadership and in the community staff are encouraged to consider flexible approaches to clinical supervision, including peer and group supervision. This will remain under review.
	3b. Appraisal	>=95%	Data currently unavailable					Revised deadline for completion agreed with EMT. Reporting to commence from December 2021.
	4. Incidents of violence and aggression against staff	Trend monitor	72	62	52			
	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		0	0	0			A joint task group between human resource and and staff side has been established to review the policy, our approach and to identify appropriate measures.
	7. Absence due to stress & anxiety and MSK		2.6%	2.3%	2.2%			
	8. Relative likelihood of appointment to roles band 5 and above for people from BAME backgrounds		1.18	1.31	1.29			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	Carbon Impact (tonnes CO2e) - business miles		57	58	Due November 2021			Data is now available showing the carbon impact of staff travel / business miles. For August staff travel contributed 58 tonnes of carbon to the atmosphere a year on year increase of 12 tonnes but 12 tonnes lower than 2019.

Glossary

MSK	Musculoskeletal
GPTW	Great place to work

Make this a great place to work (Lindsay Jensen)

Key Milestones	
1. Feeling Safe (Physical and Psychological Safety): Preventing bullying and harassment - Appointment of Civility and Respect Champions Q2 21/22 – training undertaken and role launched in August, ahead of schedule. - Redesigned Bullying and Harassment Policy Q2 21/22 - Panel to review all race related bullying and harassment Q2	
2. Feeling Safe (Physical and Psychological Safety): More staff - Commence ethical International Recruitment for Nursing Q2 21/22 - Virtual recruitment fairs Q3/4	
3. Supportive Teams (Healthy Teams): Effective and Compassionate Leaders - Start rollout of 'GPTW programme' across Trust Q2 21/22 following successful pilot with senior leaders - Start review & refresh of principles of Trust-wide leadership model (Trios) in Q2	
4. Supportive Teams (Healthy Teams): Quality appraisal and supervision - Streamline appraisal process and develop link to an e-supervision Q2	
5. Keeping Fit and Well (Staff Wellbeing): Enhanced Occupational Health Support Enhanced Occupational Health offer linked to recovery and long covid Q1 21/22	
6. 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	
7. Sustainability: - Bi-monthly meetings to identify Trust wide actions commencing October 21/22 - Additional staff resource for Trust Sustainability Plan to be agreed by end of Q3 21/22	

Comments:

Great Place to Work Themes:

Performance indicators for great place to work themes continue to be developed.

Working in partnership to review Bullying and Harassment procedure, with an engagement plan being developed to gain insight from staff.

Progress on reviewing the early resolution process has been hampered owing to Covid-19 pandemic restrictions.

Successful CPD (continuing professional development) bid for nursing and AHP (allied health professional) staff to Health Education England and funding secured– training schedule to be completed and rolled out at the beginning of November.

Window for completion of appraisals has been extended to December with revised guidance owing to pressures resulting from Covid-19 pandemic.

Nursing and professions directorate have established a stand-alone clinical supervision system that will sit outside WorkPAL e-appraisal.

BAME Talent Pool has been established and work continues to develop opportunities, with current members undertaking ILM7 Leadership and Management training, CBT (cognitive behavioural therapy) post-graduate and Shadow Board programmes. Scoping/planning discussions between partners within our West Yorkshire Mental Health (WYMH) Collaborative towards a joint and reciprocal approach/programme now underway.

Shadow Board programme is now recruited to with a cohort of 12 colleagues undertaking the programme between August and March 2021.

Planning discussions between partners within our WYMH Collaborative towards a joint programme in Q1-2022/23 now underway.

International nurse recruitment on track with 37 conditional offers made, estimated to commence working for the Trust in November. Pastoral package and internal OSCE (objective structured clinical examination) training is being implemented.

Workforce strategic groups set up and first meetings held in September

Equality data (WDES (Workforce Disability Equality Standard) and WRES (Workforce Race Equality Standard) collated) with action plans to the WRC (Wakefield recovery college) and EIIC (Equality Inclusion Involvement Committee) in September.

Sustainability:

Sustainability action plan is in development and includes the identification of a range of reportable areas. Meetings to commence October initially involving estates leads and staff side representatives before wider involvement/subgroups as actions plan is developed.

Discussions are ongoing around additional staff resource to be dedicated to sustainability and the green agenda.

Data is now available showing the carbon impact of staff travel/business miles. For August, staff travel contributed 58 tonnes of carbon to the atmosphere a year on year increase of 12 tonnes, but 12 tonnes lower than 2019.

Glossary	
BAME	Black, Asian and Minority Ethic
GPTW	Great place to work

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 reporting metrics continue to be maintained during the pandemic.
- The number of restraint incidents was 166 in September, an increase of 30 since August.
- No avoidable pressure ulcers were reported in the month.
- There were 12 information governance breaches reported in September, an increase from 8 in August.
- There was 1 duty of candour breach in September.
- The number of inpatient falls increased to 69 in September (compared to 43 in August).
- Out of area bed usage increased in September to 311 days.

NHSI Indicators
- Performance against national reported targets remains largely positive.
- Percentage of service users waiting less than 18 weeks remains above the target threshold at 99.7%.
- There were no young people under the age of 18 were on an adult ward in September, an improvement from 2 in August.
- The percentage of individuals completing IAPT treatment who have moved to recovery is within target (54.5% compared to 50% target), an improvement since August.

Locality
- Increased referrals and levels of acuity are being experienced across many service lines.
- Staffing levels remain under constant review.
- Four wards, an increase of one since August, fell below the 90% overall fill rate threshold in September. Significant efforts are underway to address our current staffing pressures.
- In Barnsley, the Covid-19 vaccination programme for 12–15-year-olds has commenced in schools.
- Adult ASD/ADHD services have seen a significant increase in referrals for assessment.
- The West Yorkshire Adult Secure Provider Collaborative has gone live, with support from NHSE/I agreed for the transition stage whilst the commissioning hub for the West Yorkshire Provider Collaborative is established.
- Forensic OPEL Level has been upgraded to 3 due to staffing pressures.
- OPEL Level for the Assessment and Treatment Unit has been increased to Level 3, due to staffing pressures.
- Mental health acute wards continue to see high levels of acuity, with further challenges in managing isolated and cohorted patients.
- Barnsley 136 suite and triage functions out of hours are now provided as an extension of the intensive home base treatment team function.
- CAMHS referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield with % treated within 18 weeks beginning to deteriorate.

Communications, Engagement and Involvement
- Coronavirus updates continue weekly to all staff and governors.
- The Trust were highly commended in the NHS Communicate Awards for use of data and insight in our communications approach to Covid-19 staff vaccinations.
- Staff wellbeing initiatives continue to be promoted.
- Promotion is in place linked to Stoptober, support to Yorkshire Smokefree, and preparation for the Trust QUIT launch.
- Calderdale IAPT website has been launched.
- Staff engagement has taken place for the equality campaign, and content is in the process of being developed.

Priority programmes
- The Adult Secure Provider Collaborative final business case and partnership agreement was approved at September Trust Board, and by partner Boards, and the collaborative went live on 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.
- Implementation of CAMHS neuro-developmental waiting list initiatives in ongoing in Kirklees.
- The Trust is a key partner in the West Yorkshire Adversity Trauma and Resilience Programme and is working towards being a trauma-informed Trust.

Finance
• A £0.1m surplus was recorded in the month, taking the cumulative position to a surplus of £2.3m.
• Pay costs increased in September to 19.1m from £17.3m in August which included the impact of the Agenda for Change pay award and pay arears.
• Agency staffing costs were £0.8m in September. This is an increase from August, and is expected to continue to support maintaining safer staffing requirements.
• Out of area bed costs were 301k in September. Increased usage is in part linked to conscious decision making to reduce pressure on inpatient wards.
• Capital expenditure of £1.3m has been recorded to date, which is £1.1m less than planned. The forecast remains that the full £9.6m capital programme will be utilised in year. This is being reviewed regularly.
• The cash balance remains positive at £63.3m.

Workforce
• Non-Covid-19 sickness is within target at 4.6% in September.
• Staff turnover remains higher than target at 14.5%.
• As of 20th October, there were 93 staff off work and not working due to Covid-19.
• 86.6% of staff are double vaccinated.

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.
• The Trust OPEL level remains at level 3 due to continuing staffing pressures and high acuity.
• The Trust flu vaccination programme has commenced
• Silver command structure is currently meeting twice a week, and Gold command weekly.
• National guidance continues to be monitored, reviewed, and adopted.
• A range of staff wellbeing support offers continue to be available and used.

Covid-19 response

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

Managing the clinical response

PPE position

• Deliveries and stock levels remain good, ensuring sufficient supply to meet staff needs

PPE Levels	Approx days stock as at 15-Jun	Approx days stock as at 13-Jul	Approx days stock as at 09-Aug	Approx days stock as at 09-Sep	Approx days stock as at 07-Oct
Surgical masks	42	22	50	35	24
Respirator masks	101	105	106	98	95
Aprons	20	19	20	31	25
Gowns	87	88	86	86	126
Gloves	20	19	23	23	22
Visors	33	36	29	28	34

Testing

KPI	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	As at 11th August 2021	As at 15th Sept 2021	As at 12th Oct 2021	Notes
No of service users tested (ward)	257	278	297	300	302	302	303	304	306	330	Symptomatic
No of service users tested positive (ward)	94	115	134	137	139	139	140	147	149	173	Cumulative
No of service users recovered	94	115	119	121	123	125	125	125	125	127	

Patient testing & pathway/Outbreak response & management

• In line with the increasing prevalence nationally we have also seen a number of outbreaks on our inpatient wards. We have responded appropriately to these in order to maintain staff and service user safety and minimise further spread. We recognise that contact with loved ones is important to our services users and we have tried to provide information in a timely way and restore visiting as soon as possible. Where learning is available, we ensure this is shared across all areas. Outbreaks are reported and monitored through the command structure.

• Inpatient vaccination offer is being actioned and reviewed through the vaccination Bronze group.

• Hard copies of Covid-19 useful information is being produced for ease of access for inpatient wards.

Covid-19 response

Testing approach
Current position
Patients:
• Swabbing for symptomatic testing through Pillar 1 inpatient and through Pillar 2, if required, for community setting.
• Inpatient asymptomatic Covid-19 testing is undertaken through Pillar 1, taking place on admission, day 3 and day 5 and testing prior to discharge to adult care facility. Patients 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 patients 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 pre and post-operative procedures as required.
• Outbreak and hotspot testing is managed and provided through internal testing route, with adequate capacity from local labs as required.
• Identified SWYPFT staff are undertaking lateral flow testing.

Lateral flow Testing
NHS England and Improvement ended supply of Lateral Flow Testing (LFT) devices to Trusts on 12th July 2021 and advised that all NHS staff should report their results through the national (NPEX) portal rather than through any local reporting.
Except for a small reserve, all the Trust's remaining LFT stock has now been redistributed. We continue to text staff on the LFT database twice weekly (three times for staff on the care home programme). From 2nd August 2021, the link on that text has been to the gov.uk portal. When requested, we continue to add new staff to the LFT database and encourage staff to continue lateral flow testing via the coronavirus briefing and occasional text/email reminders highlighting the importance of lateral flow testing and of submitting their results.
Prior to 2nd August 2021, we were typically reporting between 2500 and 3000 test results per week. Since moving to the national systems reporting figures have fallen significantly although there are early indications that numbers are increasing.

Week commencing 13/9/21	448
Week commencing 20/9/21	534
Week commencing 27/9/21	747

A factor that might be impacting on reporting figures was an issue with the NPEX site, and the ability to pick your employing NHS Trust from a configured list. This issue was reported and a fix was implemented in mid-September. This may account for the increase numbers reported for week commencing 27th September. We have also been advised that this is an 'interim fix' and that a proper fix will be implemented in mid-October. There is no indication that this been rolled out yet (we expect people will be asked to record their employing Trust again when the full fix is implemented) and suggest we continue to monitor weekly lateral flow reports before proposing any action to increase numbers testing and reporting.

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 response to the Covid-19 pandemic.

Supporting the system

ICS stress test and outbreak support

• We continue to work closely with partners in outbreak support responses in each of our four places. The Trust has fully engaged with system command structures 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 into the communication and engagement cells in each of our places to support the Covid management and outbreak response.

Covid-19 first and second vaccinations

• A total of 4,612 staff have been recorded as having received their first vaccination (87.8%) and 4,547 staff have been recorded as having received their second vaccination (86.6%).
• The internally provided Covid-19 vaccination programme has now closed, with staff offered vaccination routes via the national system.
• In addition to providing vaccinations for our staff, we have provided 969 first vaccinations and 894 second vaccinations for partner organisations.

Covid-19 Booster programme

• Continuing representation across place-based discussions and progressing SWYPFT-specific requirements as appropriate through local task and finish groups.
• Booster vaccination clinic offers (John Smiths Stadium, Barnsley Hospital NHS Foundation Trust and Priory Campus) from our local partners are promoted through targeted communications to eligible staff in addition to national booking system.
• To support all frontline staff to have their Covid-19 booster vaccination, Trust letters have been created for staff to take to their vaccination appointment to prove eligibility. Managers can request these letters for staff.
• Progressing inpatient vaccination programme - work has begun to identify who needs vaccines at which phase. Further work is required to identify where they are and when vaccines are needed.
• Forensic inpatient vaccinations are being supported by the primary care nurse, who will administer boosters and continue first and second doses. This cohort of patients are already identified in terms of who and when these will be required
• Discussions commenced around safe space sessions, and whether we should have open conversations about the vaccine generally for boosters, but also those who are vaccine free.
• A total of 640 staff have been recorded as receiving their booster vaccination (12.2%)

Standing up services

Emergency preparedness, resilience and response (EPRR) update including OPEL levels

• Silver command meetings now taking place twice per week.
• Gold command meetings once a week.
• The Trust OPEL level remains at level 3 due to continuing inpatient staffing pressures and acuity levels.
• OPEL discussions taking place to review pressures to clinical services with a view to identify wider supporting mechanisms.
• West Yorkshire and Humber strategic meetings continue with trends regionally being impact to staffing.

Flu Vaccinations

• Flu vaccination programme is now underway, with 2000+ vaccines currently in the Trust, with further deliveries expected in October.
• As at 21st October 2021 43% of frontline staff and 33% of all staff have had a flu vaccination.

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks 5	Improving Health	Responsive	CH	TBC	66.6%	73.9%	73.0%	70.9%	66.7%	62.8%	N/A
Complaints	% of feedback with staff attitude as an issue 12	Improving Health	Caring	AD	< 20%	11% 3/27	6% 2/35	19% 7/37	16% 4/25	20% 5/25	14% 4/28	1
Service User Experience	Friends and Family Test - Mental Health	Improving Health	Caring	TB	85%	81%	78%	81%	82%	82%	79%	1
	Friends and Family Test - Community	Improving Health	Caring	TB	98%	95%	96%	97%	95%	96%	93%	1
Quality	Number of compliments received	Improving Health	Caring	TB	N/A	37	28	22	26	20	16	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) 4	Improving Health	Caring	TB	trend monitor	36	24	31	18	20	30	
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One exceptions 4	Improving Health	Caring	TB	trend monitor	3	1	2	3	1	1	N/A
	Notifiable Safety Incidents (where Duty of Candour applies) - Number of Stage One breaches 4	Improving Health	Caring	TB	0	0	0	0	0	0	1	1
	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	40.9%	41.8%	41.5%	41.6%	41.2%	40.9%	2
	Number of Information Governance breaches 3	Improving Health	Effective	MB	<12	7	8	11	11	8	12	2
	Delayed Transfers of Care 10	Improving Care	Effective	CH	3.5%	1.2%	1.1%	1.3%	1.9%	2.9%	2.3%	1
	Number of records with up to date risk assessment - Inpatient 11	Improving Care	Effective	CH	95%	61.6%	68.3%	56.4%	59.9%	60.3%	*57.6%*	N/A
	Number of records with up to date risk assessment - Community 11	Improving Care	Effective	CH	95%	51.8%	68.9%	67.0%	69.4%	56.4%	*64.6%*	N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	1034	1040	1058	1080	1012	1041	
	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	25	18	25	10	14	16	
	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	6	3	1	1	1	5	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) 9	Improving Care	Safety Domain	TB	trend monitor	6	3	5	7	6	5	
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	118.9%	119.8%	118.5%	115.0%	111.2%	109.7%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	94.6%	94.9%	84.7%	88.5%	85.1%	84.9%	1
	Number of pressure ulcers (attributable) 1	Improving Care	Safety Domain	TB	trend monitor	43	32	38	20	21	28	
	Number of pressure ulcers (Lapse in Care) 2	Improving Care	Safety Domain	TB	0	1	3	1	0	0	0	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less 8	Improving Care	Safety Domain	CH	90%	93.7%	100%	93.8%	88.0%	85.0%	91.0%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	50	39	41	56	43	69	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	157	106	170	161	136	166	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	89.3%	90.3%	84.6%	94.1%	87.1%	81.0%	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

** 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 damage
3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - Notifiable Safety Incidents are where Duty of Candour is applicable. A review has been undertaken of the data and some issues identified with completeness and timeliness. To mitigate this, the data will now be reported a month in arrears. Target only applicable to breaches.
5 - CAMHS referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data quality (DQ) issues are impacting on the reported data from March 19. Some improvement in dq has seen in recent months and this is expected to continue. Excludes ASD waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available).
10 - In the 2017/18 mandate to NHS England, the Department of Health set a target for delayed transfers to be reduced to no more than 3.5 % 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.
12 - 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 September increased from 136 to 166. Further detail can be seen in the managing violence and aggression section of this report.
• Number of falls (inpatients) – Total number of falls was 69 in September, which is an increase compared to last month's data. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation. See falls section below for further detail.
• 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 that resulted in a degree of harm of moderate harm, severe harm or patient safety related death tend to fluctuate over time and data is constantly refreshed within Datix as further information comes to light. This results in changes to the level of harm, severity and categories of incidents amongst other data. We encourage staff to report with an upwards bias initially especially when the outcome is unknown. These are adjusted subsequently. Incident data is regularly analysed to explore any potential higher or lower rates than would be usually expected. Where there are outlying areas, these will be reported on.
• Duty of candour - 1 breach in September. The breach related to a self harm incident that took place on a mental health ward in Barnsley. There was a delay in issuing the apology and issues surrounding the incident have been reviewed to mitigate any further breaches.
• Percentage of service users on CPA offered a copy of their care plan -
  • Work continues to review the practice and data quality issues relating to care plans.
  • Previously this measure related to 1 specific care plan, the overarching CPA plan, since the introduction of the SystmOne clinical record system it relates to multiple care plans (as above).
  • To achieve that the service is compliant in their reporting that a care plan has been shared, all care plans must be ticked to say that the service user has copies of all care plans. However, there are old / inactive care plans on the system that have not been closed. These will be reviewed in line with our review of clinical data quality.
  • There are also data quality issues being explored around how CPA care plan data includes data from teams who would not have people on CPA.
  • Operational interrogation of the data on active care plans is that the practice is better than the performance is showing. However, there remain areas for improvement.
• Number of pressure ulcers (avoidable) - there were no incidences of avoidable pressure ulcers to report during September. 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 has increased. Services have highlighted that sustained increases will negatively impact on the length of wait.
• As the Trust's risk management tool, formulation informed risk management (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 business delivery unit 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 Patient Safety Strategy
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 share information into the Trust.
The current nine NHS England/Improvement priority areas are being progressed locally.
Patient Safety Incident Response Framework - we are currently assessing our position as a Trust against the draft framework.
Patient Safety Education and training - we have presented a paper to the Education Governance Group to advise that patient safety training will soon be available to all staff via e-learning.
NHS England/Improvement continue to develop their programmes to support the NHS patient safety strategy. There has been some amendment to timescales throughout due to the impact of the pandemic.
Further details are available here: https://swyt.sharepoint.com/sites/Intranet/Patientsafetystrategy/Pages/NHS-England-updates.aspx
Other developments
A Learning event is being held on 5 November to bring BDUs and specialists together to share their learning with each other.
A question and answer session on the Duty of Candour changes (notifiable safety incidents) took place in September which was well received. This approach will be expanded upon by the patient safety support team to provide tailored education sessions on a range of patient safety related topics.

Safety First

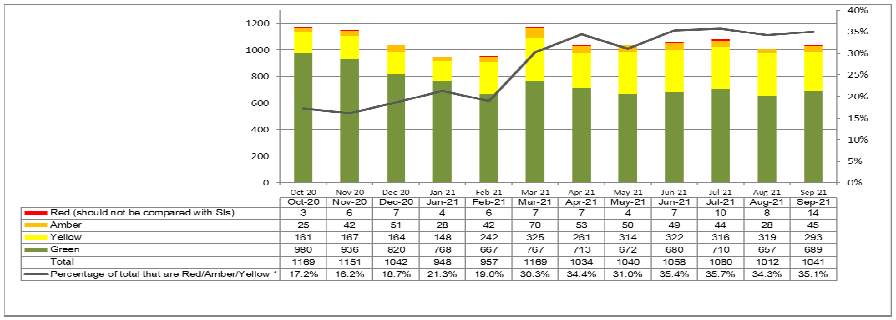
Summary of Incidents October 2020 - September 2021

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

Incident Reporting Update:
Please note - changes were made to Datix on 05/02/2021 to embed the Trust's risk grading matrix. The incident severity options have reduced from five to four with the removal of Green (no harm). We can identify incidents resulting in no harm via a different method on Datix.

Incident reporting levels have been checked and remain within the expected range.

Red incidents includes deaths where the cause of death is unknown. As further information is received and decision made about review processes, red deaths may be regraded to green, eg when confirmed not related to a patient safety incident.
Incidents that occur within the Trust will have different levels of impact and severity of outcome. The Trust grades incidents in two ways. The degree of harm is used by all Trusts to grade the actual level of harm to ensure consistency of recording nationally. When staff report incidents, they will complete the Degree of Harm to rate the actual harm caused by the incident. Where this is not yet known, they will rate this as what they expect the harm level to be. It will be reviewed and updated at a later point. This differs from the incident severity (green, yellow, amber, red), which is how we grade incidents locally in the Trust. Incident severity takes into account actual and potential harm caused and the likelihood of reoccurrence (based on the Trust's risk grading matrix).
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).
96% of incidents reported in September 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 is based on the degree of actual harm.
Further details about severity and degree of harm can be found in the Incident Reporting and Management Policy.
Initial incident reporting is upwardly biased, and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers, and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change, therefore figures may differ in each report. Data in this report is refreshed monthly.
Incident reporting levels have been checked and remain within the expected range, any areas with higher or lower rates than normal are explored further.



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Red (should not be compared with SIs)	3	6	7	4	6	7	7	4	7	10	8	14
Amber	25	42	51	28	42	70	53	50	49	44	28	45
Yellow	181	167	164	148	242	325	281	314	322	316	319	293
Green	980	936	820	768	667	767	713	672	680	710	657	689
Total	1189	1151	1042	948	957	1169	1034	1040	1058	1080	1012	1041
Percentage of total that are Red/Amber/Yellow	17.2%	18.2%	16.7%	21.3%	19.0%	30.3%	34.4%	31.0%	35.4%	35.7%	34.3%	35.1%

Reporting of deaths in line with the Learning from Healthcare Deaths policy has increased the number of red incidents. Deaths are re-graded upon receipt of cause of death/clarification of circumstances. As further information is received and decision made about review processes, red deaths may be regraded to green, e.g. when confirmed not related to a patient safety incident.
All serious incidents are investigated using Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly and annual incident reports, available on the patient safety support team intranet pages.
See http://nww.swyt.nhs.uk/incident-reporting/Pages/Patient-safety-and-incident-reports.aspx
Risk panel meets weekly and scans for themes that require further investigation. Operational Management Group continues to receive a monthly report, the format and content is regularly reviewed.
No never events reported in September 2021

Safety First cont....

Summary of Patient Safety Incidents resulting in moderate or severe harm or death

This section relates to the patient safety incidents that resulted in a degree of harm of moderate harm, severe harm or patient safety related death. Please note this is different to severity as described above.
Initial incident reporting is upwardly biased, and staff are encouraged to report incidents and near misses. Once incidents are reviewed by managers, and further information gathered and outcomes established, incident details such as severity, category and degree of harm can change, therefore figures may differ in each report. This is a constantly changing position within the live Datix system. Incident reporting levels have been checked and remain within the expected range, any areas with higher or lower rates than normal are explored further.

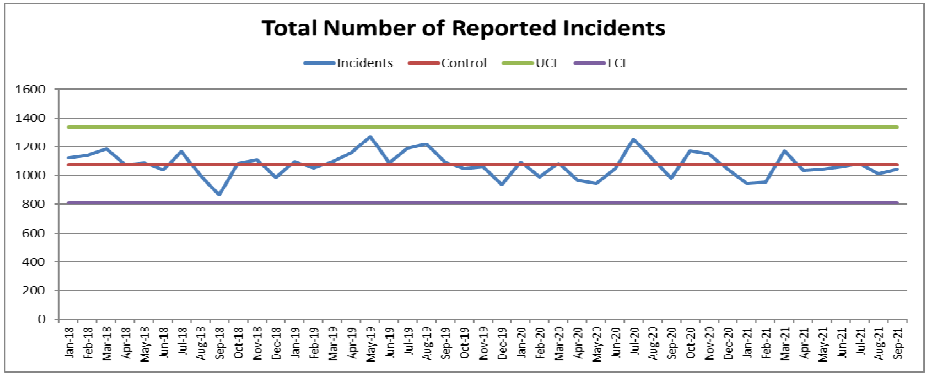
Breakdown of incidents in September 2021:
16 moderate harm incidents:
7 incidents across Barnsley neighbourhood teams - 7 pressure ulcer category 3 incidents
7 self harm (Clark Ward - Barnsley, CMHT - South Kirklees (OPS), Nostell Ward, Wakefield, Early Intervention Service - Barnsley, Intensive Home Based Treatment Team - Wakefield (OPS), Intensive Home Based Treatment Team (IHBTT) - Wakefield)
2 slip, trip or fall patient (Crofton Ward (OPS), Wakefield, Willow Ward - Barnsley)

5 Severe harm incidents:
2 self harm - (Clark Ward - Barnsley, Elmdale Inpatient Services Ward)
1 pressure Ulcer - Category 4 (Barnsley Neighbourhood Nursing Team)
1 slip, trip or fall - patient (Poplars Unit, Wakefield)
1 Assessment, treatment and intervention issues - Ashdale Ward (based at The Dales, Kirklees BDU)

5 patient safety related deaths:
5 patient safety related deaths:
1 death - cause of death unknown/ unexplained/ awaiting confirmation (Intensive Home Based Treatment Team (IHBTT) - Barnsley)
2 apparent suicide - community team care - current episode (ADHD Service, Enhanced Team West - Kendray, Barnsley)
2 apparent suicide - community team care - discharged (Enhanced Team North 2 - Kirklees, Intensive Home Based Treatment Team (Kirklees)

Mortality
The next structured judgement review (SJR) training session for new reviewers is taking place on 26 October 2021.

The next regional mortality meeting is taking place on 14 October 2021. Agenda items include Covid-19 and learning from deaths, the experience of feedback of SJR findings to relatives and learning from SJR with a discussion on local experience of learning from SJR. A letter has been mocked up by the Deputy Medical Director STHFT which the trust plans to send out to those relatives that have asked for access to the SJR. We will review the letter as part of our being open process following a family bereavement where an SJR has been agreed to take place to identify if we need to include something similar this in our process.



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

SBAR SI learning 2020.24290.docx

SBAR Learning Library Summary Safeguarding Children WEB129192.docx

SBAR recognising the need for specialist assessment - addiction to prescribed medications final.docx

SBAR lethal means and online access final.docx

SBAR EPMA discontinuation

Sharing learning from Covid 19 29.06.21 possible transmission

SBAR - specimen collection from urinary catheters

SBAR learning Choking

SBAR learning Covid 19 restraints

Bluelight alerts

Bluelight alert 49 - 7 July 2021 - Risk of choking

Bluelight alert 48 - 9 June 2021 - Use of en-suite toilet seat as ligature

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

Patient Safety Alerts

Patient safety alerts received - September 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 Trios 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
	No Patient Safety Alerts received in September 2021				

Safer Staffing Inpatients

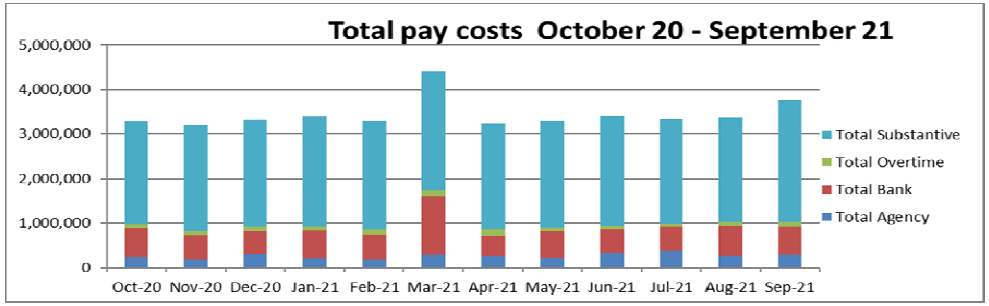
September has continued a sustained period of significant challenges for staffing in all areas. There are various reasons for this including an increase in sickness, the continued vacancy factor as well as a sustained increase in acuity and Covid-related issues. The Trust's task and finish groups looking at staffing issues including recruitment and retention, workforce planning and flexible staffing are ongoing. There has been an increase in staffing issues and shortages being reported.
The ongoing situation continues to impact on the pressure on the community services with business continuity plans and escalation plans being utilised more frequently. We have had an increase in band 5 new starters. This brings additional short-term pressures in supporting their transition from student to preceptee. We will be able to report on the staffing uplift towards the end of October although the migration of staff nurses from inpatient areas into community continues which impacts on the staffing complement within inpatients.
International recruitment continues, and we have offered 45 posts and to date no one has withdrawn which the agency has said is unusual and reflective of our comprehensive package. We have held a teams meeting with the candidates who were successful which was very well received by Trust staff who attended and the candidates themselves. We hosted our first virtual recruitment fair at the end of September and have had a presence at other online recruitment events. We continue to explore the collaborative bank to increase our resources and we have increased the recruitment campaign onto bank.
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.
Four wards, an increase of one on August, fell below the 90% overall fill rate threshold, which were Enfield Down (has supported other areas), Stroke Rehab, Appleton and Priestley. Barnsley BDU continue to experience increased pressures through vacancies, sickness and staff being off clinical areas for various reasons. Of the 31 inpatient areas, 18 (57.6%), a decrease of three wards on the previous month, achieved 100% or more. Indeed, of those 18 wards, 10 (consistent with the previous month) achieved greater than 120% fill rate. The main reason for this is cited as acuity, observation, and external escorts.
Although safe and effective staffing remains a priority in all our teams, and there has been a systems wide increase of requests for additional staffing on all inpatient areas, the focus for the flexible staffing resources has been within the Dales mental health unit in Halifax, The Oakwell mental health Unit within Kendray Hospital in Barnsley and Newton Lodge within the forensic BDU. There have been supportive measures put in place in these areas including block booking staff to provide consistency and continuity, placing bespoke recruitment adverts, and ensuring that additional resources are placed at their disposal. However, with the added pressures of track and trace, as well as other reasons cited above, they remain a priority for support.

Safer Staffing Inpatients cont....

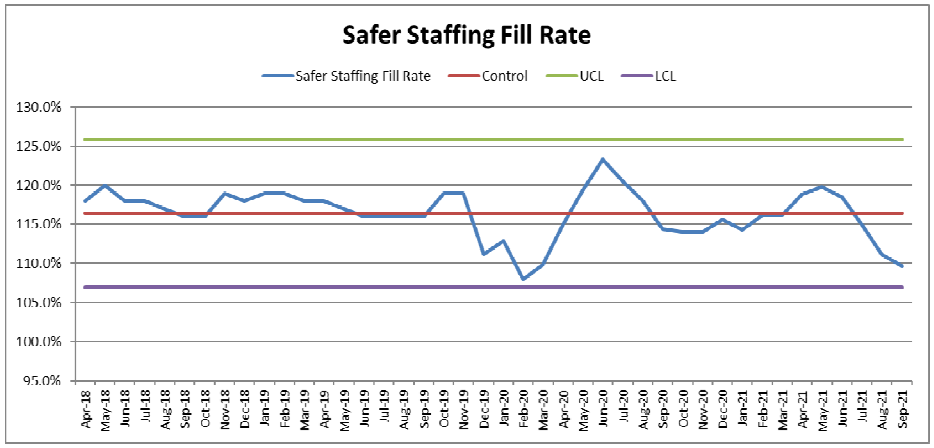
Registered Nurses Days
Overall registered fill rates have increased by 0.1% to 78.1% in September compared with the previous month.
Registered Nurses Nights
Overall registered fill rates have decreased by 0.5% in September to 91.6% compared with the previous month.
Overall Registered Rate: 84.85% (reduced by 0,2% on the previous month)
Overall Fill Rate: 109.7% (reduced by 1.5% on the previous month)

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.

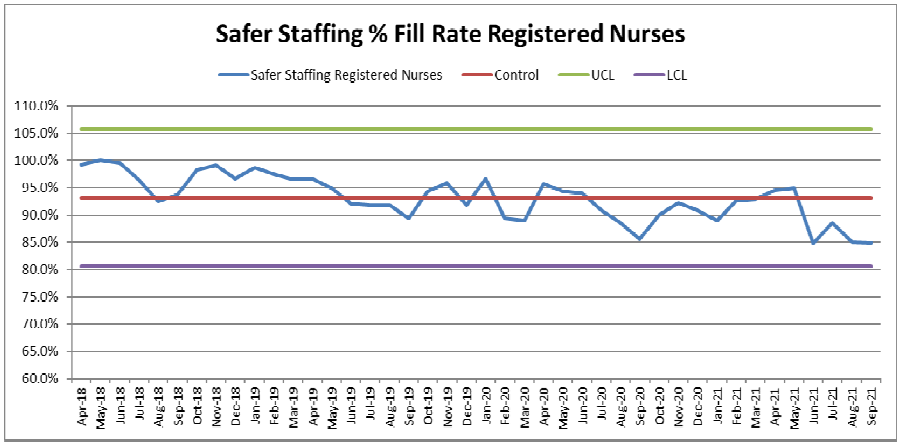
Unfilled Shifts				Filled Shifts
Categories	No. Of Shifts	Total Hours	Unfill Percentage	
Registered	520 (-24)	5,688.00	42.81% (+1.79%)	774 (-63)
Unregistered	665 (+67)	7,387.50	17.40% (+2.06%)	3,203 (-157)
Grand Total	1185 (+43)	13,055.50	23.44% (+0.81%)	



We are continuing to target areas where vacancies are within our recruitment campaigns. Block booking and prioritisation within bank booking varies on a daily/weekly basis dependent on acuity and clinical need.
These figures also allow us to monitor an increase on the flexible staffing resource and look at what appropriate resources are required from the Trust bank flexible staffing resource.
There was an overall increase, £411k, on spend on inpatient staffing (see table below) for the month of September 2021. There was also an increase on substantive spend of £415k. This included an decrease in bank spend of £26k as well as an increase in agency and overtime spend of £12k and £10k respectively.



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.

The charts demonstrate the reduction in our safer staffing fill rates and evidence a concerning reduction in the percentage of shifts that should be filled with registered nurses. Board should note that the safer staffing levels are measured against the agreed staffing levels and are not sensitive enough to include demand increases as acuity presents. Therefore although the charts still show over 100% this is not assurance that staffing levels were maintained in line with demand. Safety of staff and service users remains our priority and staff are deployed across services to maintain safety. Work on inpatient safer staffing is taking place across the integrated care system as a priority.

Information Governance

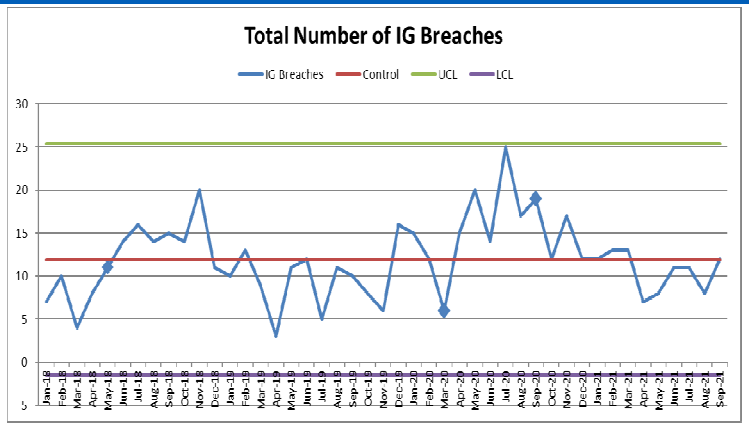
12 personal data breaches were reported during September, which is higher than recent months, but lower than experienced last year.

All but one involved information being disclosed in error, which continues to be the highest report category. Six incidents were due to letters being sent to the wrong address and four involved information containing another person's data being shared.

Information governance campaign materials continue to be shared via Trust communications, The Headlines, and further work will be undertaken to share best practice from teams who have made improvements after reporting high numbers of breaches during the last financial year.

The Trust reported an incident involving inappropriate access to patient data to the Information Commissioner's Office (ICO) and has been advised that further investigations are required. No new complaints about the Trust were made to the ICO.

SPC Chart
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported IG breaches are within the expected range. The data point in May 2018 has been highlighted to indicate the introduction of GDPR.
The data point in March 2020 highlights the start of the Covid-19 pandemic, which resulted in changes to some working practices.
The data point in September 2020 has been highlighted given the start of the refreshed awareness and communication plan.

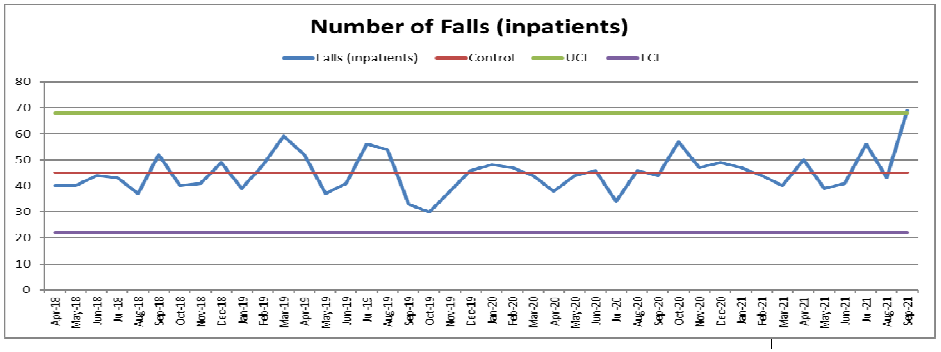


Commissioning for Quality and Innovation (CQUIN)

Schemes for 19/20 were suspended during the Covid-19 pandemic period. There are no CQUIN schemes for 2021/22. NHS England are currently consulting on a proposed set of mental health indicators for 2022/23. The consultation closes at the end of October and further information is expected to be shared after that.

Falls

Total number of falls was 69 in September, which is an increase compared to 43 falls in August.
All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

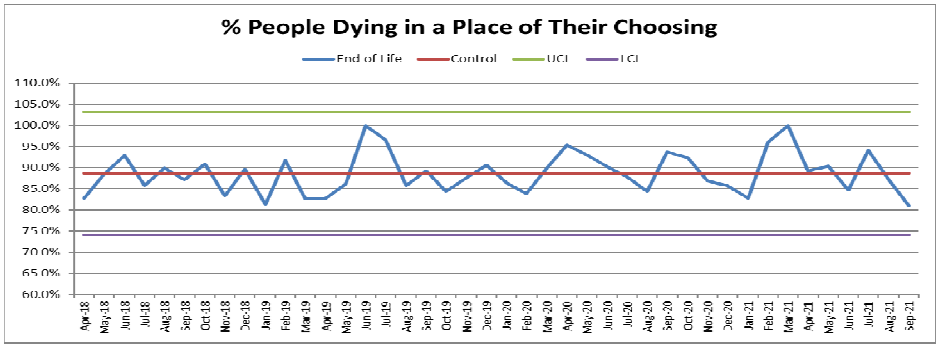


All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

There has been an increase in falls in September with 69 incidents reported. Increases relate to Wakefield and Kirklees wards in particular and are linked to acuity of the patient group. All falls are reviewed to identify measures required to prevent reoccurrence, and more serious falls are subject to investigation.

End of Life

Total percentage of people dying in a place of their choosing was 81.0% in September which is a decrease compared to 87.1% in August



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.

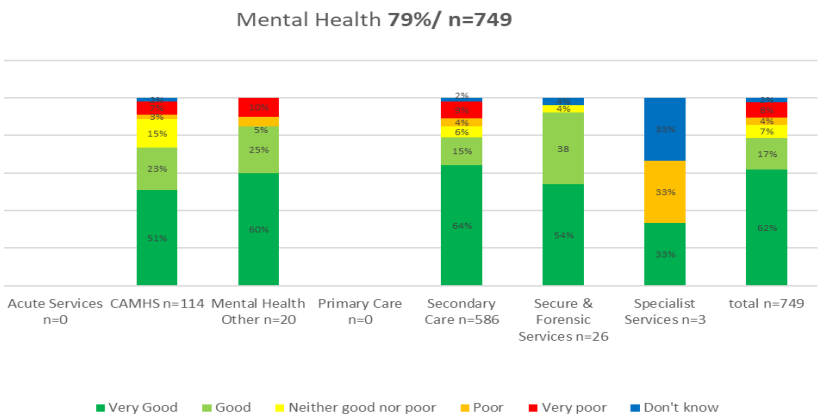
There has been a decrease in the percentage of people dying in a place of their choosing in September. This relates to 17 out of 21 people.

Patient Experience

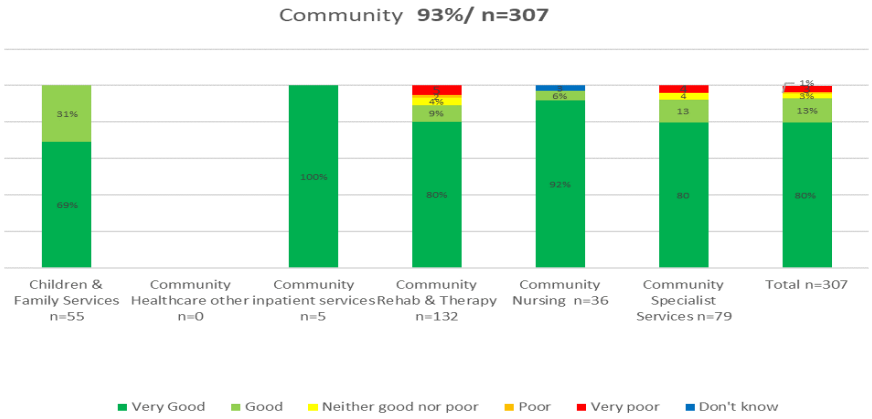
Friends and family test shows

- 93% would recommend community services.
- 79% would recommend mental health services

Mental Health Services



Community Services



•83% (1058) of respondents felt that their experience of services had been very good or good across Trust services.
•93% (n=307) of respondents felt that their experience had been very good or good across community services.
•79% (n=751) of respondents felt that their experience had been very good or good across mental health services.
•The text messaging service provided 69% (732/1058) of responses for September. We are piloting the text message service in three services in Barnsley Community at the end of September and has provided 41% of their responses for September (127/307).
•A review of the negative feedback highlighted the following:
•We received 103 negative feedback (poor or very poor)
Breakdown by BDU:
· Barnsley Com – 12
· Barnsley MH – 22
· Calderdale & Kirklees – 36
· Forensics 0
· Specialist Services – 15
•CAMHS – 11
•Learning Disability – 3
•ADHD – 1
· Wakefield – 18
•99 of the 118 negative feedback was received by text message
•85 of the 99 negative feedback received by text had provided no comments.
•9 of the 14 negative comments provided useful comments. There themes were:
•Communication (4)
•Patient Care (4)
•Waiting Times (2)
•There were no other themes or trends identified for those response of either 'neither good nor poor' and 'don't know'

	Top three positive themes	Top three negative themes
Barnsley community service	1. Staff (107) 2. Communication (21) 3. Access and Waiting Times (20)	1. Staff (6) 2. Clinical Treatment (5) 3. Admission & Discharge (2)
Mental Health Service	1. Staff (100) 2. Patient Care (24) 3. Communication (19)	1. Staff (17) 2. Communication (7) 3. Access and Waiting Times (3)
Trust wide	1. Staff (207) 2. Communication (40) 3. Patient Care (39)	1. Staff (23) 2. Communication (9) 3. Clinical Treatment (7)

- Feedback indicates that there is a decline in satisfaction across the Trust. Reviewing the comments received there is no clear indication as to why service user satisfaction is low. To understand the data further:
  - •Trust data is being benchmarked alongside other Trusts to establish if this is theme across other mental health Trusts.
  - •Data is also be triangulated with other departments across the Trust to identify any areas of concern.
  - •Services are receiving automated monthly reporting for them to review and take the appropriate action, which is to be demonstrated through 'You said, we did' posters in waiting areas.
  - •We continue to identify the appropriate service to pilot a url code being used within text messages to improve the qualitative data received via text message.
  - •We continue to work with services to identify the best method of collection for them.

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. Safeguarding care certificate training aligned to standard and intercollegiate document has also been undertaken. West Yorkshire Quality Mark for domestic abuse training delivered to a clinical team in response to SI recommendations. Parental mental illness and the impact on children was delivered to the 0-19 service (health visitors and school nurses) in Locala and was well received.
safeguarding advisor is attending social work practice educator training with York university.
Safeguarding adult and children training packages were developed for Barnsley Hospice and the local MPs, and they were delivered by the safeguarding team and positive feedback given.
All members of the team have attended training sessions to ensure that their practice, the training material, and advice provided is up to date and relevant. The Safeguarding team have attended and contributed to: Safer Sleep Young babies & Infant's Masterclass at WSCP and Working group and risk escalation conference.
The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections. All external information gathering requests have been responded to in a timely manner.
Safeguarding children's nurse advisor was successful at interview and will take up the post of named nurse safeguarding children on October 18th, Safeguarding nurse advisor post advertised on NHS jobs and shortlisting has been completed.
There was a safeguarding link practitioners meeting in September, there was a speaker from "Talk Thru" formerly Huddersfield Pregnancy Crisis Centre, they offers a non-judgmental, confidential counselling service for women and men facing unplanned pregnancy and baby loss (lost a baby up to 2 years of age). Their trained practitioners provide counselling support to those who have lost a baby due to miscarriage, death or stillbirth, termination (including termination for foetal abnormalities) or through adoption, this was well received.
The safeguarding team attended the "bridging the gap" learning event for transitional Safeguarding and the Calderdale safeguarding children partnership development day.
Safeguarding team completion of safeguarding annual report and developed a PowerPoint presentation for the assurance day, this was well received.

Infection Prevention Control (IPC)

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

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

Mandatory training figures are healthy:
Hand Hygiene-Trust wide Total –91.5%
Infection Prevention and Control- Trust wide Total –89.6%

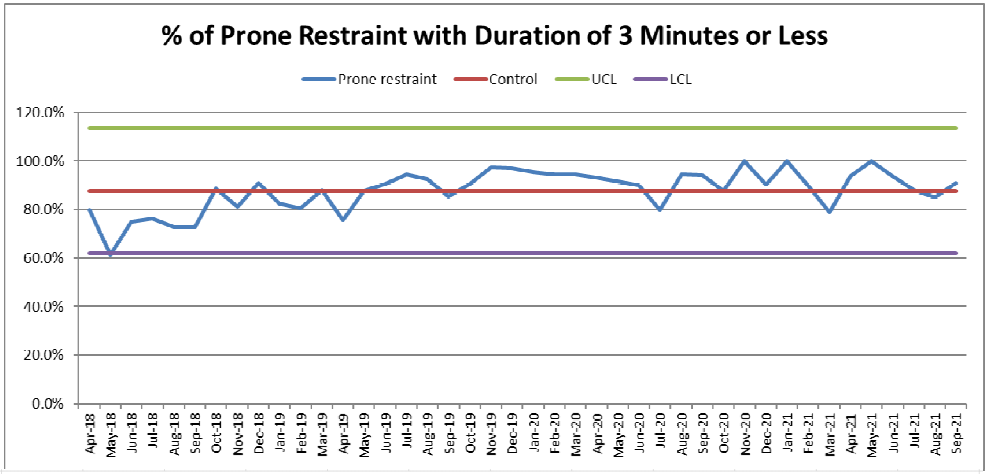
Policies and procedures are up to date.

Complaints

There were 28 new formal complaints in September 2021. Of these 3 have a timescales start date, 1 is no contact/consent and 24 are awaiting consent/questions.
14% of new formal complaints (n=4) have staff attitude as a primary subject.
16 compliments were received
Customer services closed 9 new formal complaints in September 2021. Of the 9 formal complaints, only 3 achieved the 40 working day target (33%). If we look at the revised timescales for responding due to complexity 2 would have achieved their target of 40 days. 5 would have been on a 25 day target and none would have achieved this.
Count of written complaints/count of whole time equivalent - 4.73 WTE (including a band 6 and 7)

Reducing Restrictive Physical Intervention (RRPI)

There were 166 reported incidents of reducing restrictive physical interventions used in September 2021 this is an increase of 30 (22%) incidents since August 2021 which stood at 136 incidents.
Of the different restraint positions used in the 166 incidents, standing position was used most often 77 (42.7%) followed by prone 33 times 19.8% then supine including safety pod 26 15.6%
Prone was reported 33 times (19.8% of total restraints), this is an increase of 20 (153%) from last month.
All the reported prone restraints that started in prone and remained in prone were directly linked to seclusion, medication, extreme aggression or a combination of these.
Wakefield recorded 20 prone restraints; Calderdale 6, Forensics 4, Kirklees 3 prone restraints that remained in prone during 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 September the percentage of prone restraints lasting under 3 minutes was 91%, an increase of 6%
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 increased to 56 which is an increase of 7 (14.2%). The psychiatric intensive care unit (PICU) at Wakefield and the assessment and treatment unit (ATU) at Fieldhead have experienced a high number of incidents and seclusion due to a range of complex and challenging needs expressed by service users.
The RRPI team continue to provide face to face training in line with current infection prevention and control guidance. Although Covid restrictions have impacted on our delivery, we have maintained a compliance of over 80% in all courses (figures sourced from the mandatory training opereational management group report).
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.



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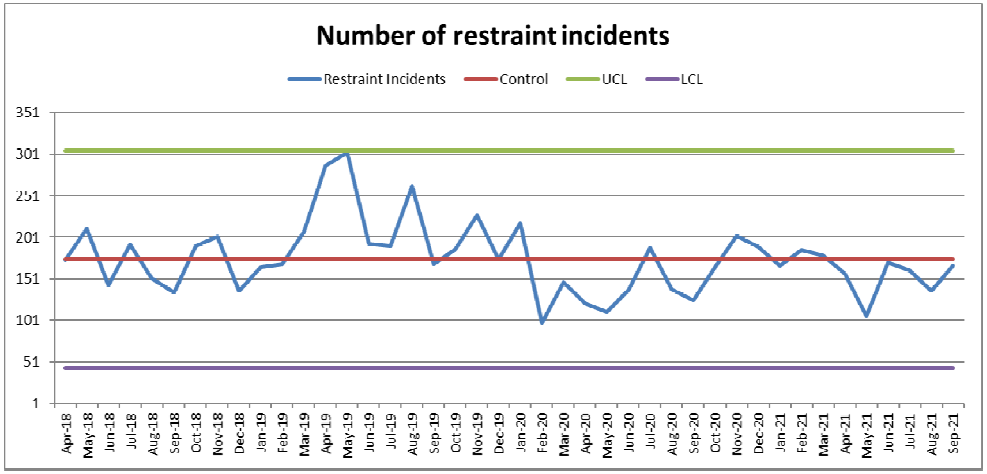


All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

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, 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 – further technical guidance relating to the metrics was published on 24th September 2021, the Trust is undertaking a review of this and will provide further update next month.

NHS Improvement - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Data quality rating [8]	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	99.2%	99.9%	100%	99.7%	100%	100%	100%	99.7%	99.7%	99.7%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	56.8%	97.8%	100%	100.0%	98.7%	100%	100%	94.1%	100.0%	100.0%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	98.7%	99.4%	99.7%	99.4%	100%	100%	99.1%	100%	98.9%	99.1%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	301/302 =99.7%	277/281 =98.6%	278/284 =97.9%	341/343 =99.4%	93/96 =96.8%	82/83 =98.8%	103/105 =98.1%	139/140 =99.3%	113/114 =99.1%	89/89 =100%		
% service users followed up within 72 hours of discharge from inpatient care	Improving Care	Safe	CH	80%	83.6%	83.5%	85.7%	83.0%	83.3%	86.3%	87.3%	81.9%	84.1%	83.2%		
Data Quality Maturity Index 4	Improving Health	Responsive	CH	95%	98.8%	98.7%	99.0%	*98.9%*	99.1%	99.1%	98.7%	98.2%	*99.2%*	*99.2%*		
Out of area bed days 5	Improving Care	Responsive	CH		316	251	496	457	122	204	170	117	170	311		
IAPT - proportion of people completing treatment who move to recovery 1	Improving Health	Responsive	CH	50%	56.3%	53.4%	55.2%	*47.5%*	57.0%	55.6%	53.2%	44.8%	43.8%	*54.5%*		
IAPT - Treatment within 6 Weeks of referral 1	Improving Health	Responsive	CH	75%	96.5%	98.8%	98.7%	*97.9%*	99.1%	98.6%	98.5%	98.1%	98.4%	*97.2%*		
IAPT - Treatment within 18 weeks of referral 1	Improving Health	Responsive	CH	95%	99.9%	99.9%	99.9%	*99.9%*	100%	100%	99.8%	100%	100%	*99.8%*		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	94.4%	91.5%	90.5%	88.5%	87.0%	89.7%	96.8%	89.2%	78.6%	94.9%		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	91.7%	92.1%	87.7%	*87.5%*	88.1%	87.6%	87.6%	87.3%	87.7%	*88.0%*	⚠	
% clients in employment 6	Improving Health	Responsive	CH	*10%*	12.5%	12.5%	10.3%	*10.5%*	10.4%	10.3%	10.2%	10.5%	10.5%	*10.5%*	⚠	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Data quality rating [8]	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	10	23	87	82	25	22	40	41	41	0		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	2	6	9	5	3	3	3	3	2	0		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	210	189	217	192		217			192			
Proportion of people detained under the MHA who are BAME 2	Improving Care	Safe	CH	*Trend Monitor*	18.1%	19.0%	19.8%	23.4%		19.8%			23.4%			

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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%	99.5%	99.4%	98.9%	*98.2%*	98.9%	99.6%	98.4%	97.2%	98.4%	*99.2%*		
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%	99.9%	98.1%	100.0%	*99.9%*		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	98.0%	98.1%	98.2%	*98.6%*	98.3%	98.3%	98.2%	99.9%	98.6%	*98.6%*		

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

Headlines:

- The Trust continues to perform well against most NHS Improvement metrics
- The percentage of service users waiting less than 18 weeks remains above the target threshold at 99.7%
- The percentage of service users seen for a diagnostic appointment within 6 weeks has increased up to 100% and is now above target.
- During September 2021, there were no service users aged under 18 years placed in an adult inpatient ward. This is the first time this has been achieved this year. 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- There are some data completeness issues that may be impacting on the reported position of this indicator.
- Data quality maturity index - the Trust has been consistently achieving this target.
- IAPT proportion of people completing treatment who move to recovery has increased above the 50% target at 54.5% for September.

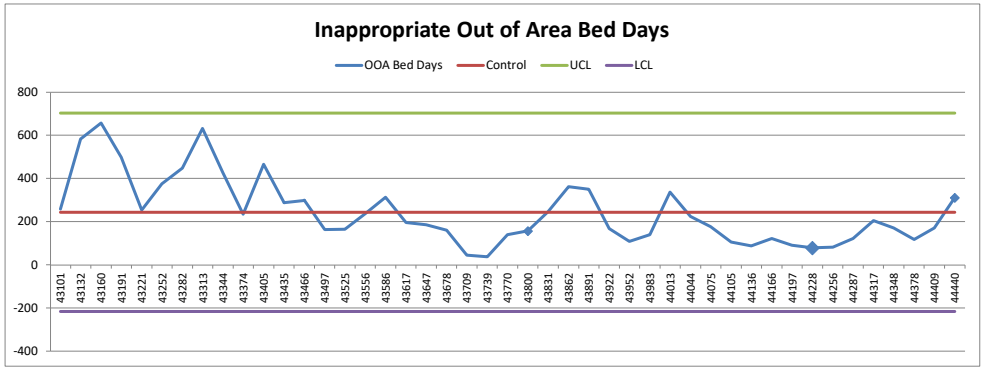
Data quality:

An additional column has been added to the above table to identify where there are any known data quality issues that may be impacting on the reported performance. This is identified by a warning triangle and where this occurs, further detail is included.

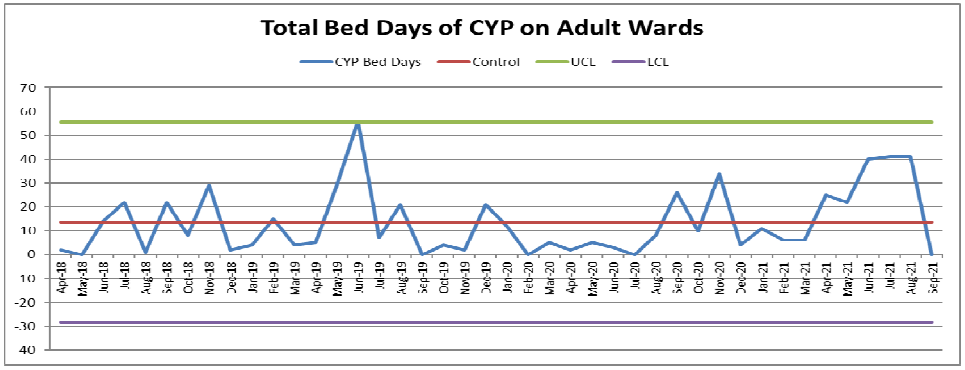
For the month of September the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for September shows 17.8% of records have an unknown or missing employment and/or accommodation status, this in line with August which showed 17.7% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work takes place within business delivery units to review this data and improve completeness.

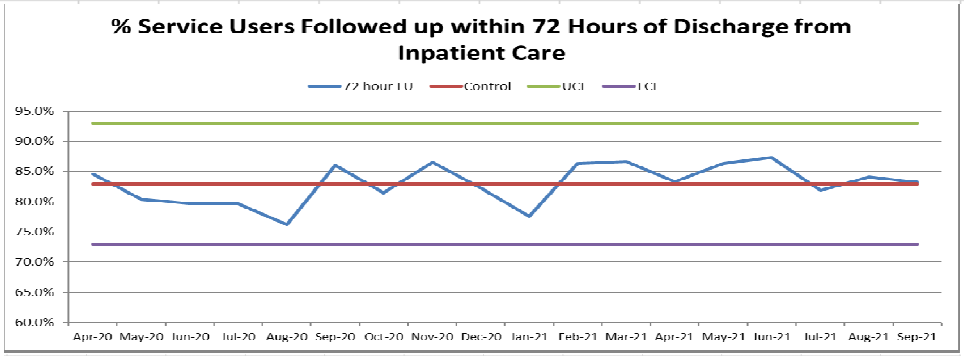
SPC Charts



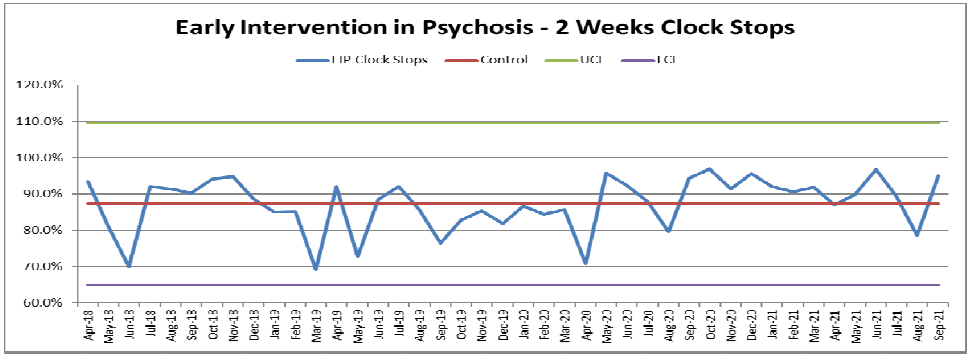
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data points in December 2019 and February 2021 have been highlighted for this reason. The data point in September 21 has been highlighted to note the decision to increase out of area bed usage to ease pressure on the inpatient wards.



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



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.

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 two ICS footprints, West Yorkshire and 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 and 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 November.

South Yorkshire & Bassetlaw Partnership

The South Yorkshire and Bassetlaw integrated care system produces a range of performance information each month. This includes a delivery report which includes information pertaining to restoration of elective services, urgent and emergency care, hospital and out of hospital, and primary care activity. For mental health service, performance data regarding CAMHS access, out of area bed placements and IAPT is shown. All IAPT standards are currently being met and the dementia diagnosis rate is above standard. However children and young people waiting time targets are not being achieved,

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:

Barnsley community Mental Health

Strengths

• Strong mental health partnerships are in place in the local system. A strategy has been drafted (agreed by the Health and Wellbeing Board) for consultation.
• Improving access to psychological therapies (IAPT) waiting list initiative has commenced, with focus on evidence based group interventions.
• 136 suite and triage functions out of hours are now provided as an extension of the intensive home base treatment (IHBT) team function.

Areas of focus

• Maintaining 136 suite function
• Increased referrals and acuity have been seen– with associated increase in caseloads across core, enhanced and intensive home based treatment (IHBT). The community service is currently reporting OPEL 3 and business continuity measures are in place.
• Proactive review of core caseload and signposting to alternative support is in place. Appropriate communication in place with GP referrers and other stakeholders to offer reassurance of alternative and more appropriate support.
• Focus on staff wellbeing/resilience has been maintained
• Developing plans to strengthen crisis services, with emphasis on reducing A&E attendances

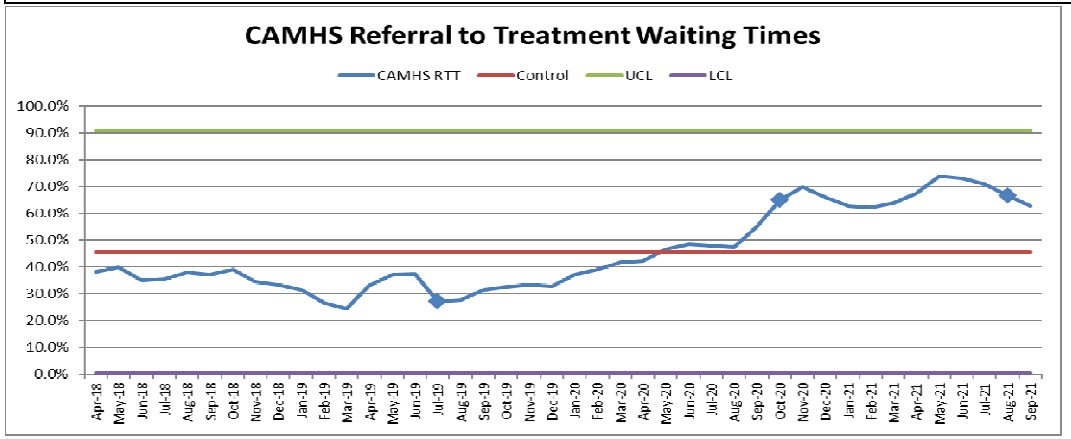
CAMHS

Strengths

• Business continuity plans have to date been effective, although increases in acuity and demand are presenting challenges on these.
• Waiting numbers/times from referral to treatment are being maintained in Barnsley.

Areas of focus

• Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have continued to increase. We are moving to implementation of agreed waiting list initiatives
• Referral numbers are placing pressure on waiting times in Calderdale/Kirklees and Wakefield. The percentage of children treated within 18 weeks increasingly challenging. The medium term trajectory is unclear as we don't yet understand the impact of schools being fully open for example. The position remains under review and we will work in partnership with commissioners on future plans.
• Crisis referrals, particularly in relation to eating disorders, are high. Although no children were admitted to adult beds in September, Tier 4 bed access remains problematic, leading to inappropriate stays for children and young people in acute or Trust mental health beds.
• There are staffing capacity issues across the eating disorder pathway, and significant capacity shortfall in Barnsley. This places pressure on the other care pathways as resources are deployed to ensure we safely manage children at risk.
• There is a focus on maintaining staffing levels in Wetherby Young Offenders Institution (YOI) and Adel Beck and responding to demands presented by placement of girls at Wetherby YOI
• Focus on staff wellbeing/resilience has been maintained



The data point in July 2019 has been highlighted as the neurodevelopmental teams have been excluded from this point onwards.
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in August 2021 has been highlighted for this reason.

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

Barnsley general community services

Key Issues
• The Covid-19 vaccination programme for 12–15-year-olds has commenced in schools. Partnership working is working well. To note, the same pool of vaccinators are being used across various vaccination programmes.
• The Musculo- Skeletal Service (MSK) waiting times have increased at all stages of the pathway, due to increased demand, and some staffing shortages in both the administration and clinical workforce.
• The Neuro Rehab Unit (NRU) has experienced significant pressures due to a Covid outbreak which has seen the unit closed to admissions.
• All neighbourhood teams are seeing increased referrals and increased acuity of patients. System pressures are also impacting across service areas.
• The Local Authority (Barnsley Metropolitan Borough Council) had a SEND (Special Educational Needs and/or Disabilities) inspection in September with the Trust's general community children's services having focussed sessions. with the inspectors over 3 days. We are awaiting the outcome of the inspection.

Strengths
• Health and wellbeing services and children's services continue to perform well, with positive feedback received from commissioners.
• The Children's Speech and Language Therapy Service were shortlisted as a finalist for the Public Sector Children's Team Award at the Children and Young People Now Awards 2021.
• Yorkshire Smoke Free presented at Healthcare Excellence Through Technology (HETT) a best practice case study (smoking cessation with digital health).
• The Musculo-skeletal (MSK) service exercise instructor has started in post implementing a wider range of groups to support current client demographics and reduce waits in other parts of the system.

Challenges
• There is an increasing waiting list for access to tissue viability clinic assessments due to the increasing number of lymphoedema-related care interventions being referred to the service from primary care.
• Temporary posts within the musculoskeletal service have been difficult to recruit to, reducing ability to develop skill mix and improve patient flow.
• Neuro rehab unit staffing challenges remain to ensure safe staffing levels are maintained.

Areas of Focus
• Urban House Health Integration team nurse prescriber role and support for the Lead Nurse.
• Delivery of the Covid-19 vaccination programme for 12–15-year-olds.
• Workforce and skill mix review of the neighbourhood teams.
• Health and wellbeing of staff.

Forensic business delivery unit and Learning Disability services:

Forensic BDU
Key Issues
• OPEL Level upgraded to 3 due to staffing pressures created by Covid absences, non- Covid absences, and vacancies.
• The Adult Secure Provider Collaborative has gone live, with support from NHS England agreed for the transition stage whilst the commissioning hub for the West Yorkshire Provider Collaborative is established.
• Absence levels (Covid and non-Covid absence) are just over 12%.
• Recruitment of registered nurses remains a key focus. The Forensic service continues to be supported with a bespoke recruitment and retention plan and is looking forward to welcoming the new international recruits. .
• 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.
• All targets being met re national timescales. Nationally the pressure appears to be around male low secure beds and female beds (both medium and low secure).
• All mandatory training which is below expected targets is the focus of attention across the service and recovery trajectories are in place.
• Supervision levels are 73% in medium secure, 84% in low secure and 79% in Newhaven. Despite ongoing work the service has not met the target, and this reflects the pressure the service is under in relation to acuity, absence and vacancies. Work continues to ensure supervision is improved.
• Appraisals are a current area of focus
• Staff well-being remains a focus, with the service utilising recent NHS survey results to modify plans.
• Financial resources to effectively run this service are being developed with the CCG.

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 continued:

Learning Disability Services
• OPEL Level remains at Level 2 for community and Level 3 for the Assessment and Treatment Unit (Horizon)
• Supervision levels have fallen and are 64% currently Supervision is critical at times when acuity and pressure is high, and steps are ongoing to ensure supervision levels are improved.
• Medical cover across all learning disability services is critical. Short term plans are in place, and service managers are liaising closely with the Medical Director.
Organisational development support has been agreed to support the learning disability teams working towards improvements in relation to a Great Place to Work.

Community Learning Disability Teams
• Sickness absence remains higher than usual and the service is working with HR to understand this further.
• Some challenges experienced regarding available, safe space to see people face to face which the service is working with estates to address.
• Medical staffing longer term remains a challenge though short-term plans for cover are in place.
• Vacancies in psychiatry and psychology posts across all our community teams are proving difficult to fill, and we are seeing the impact through increased caseloads and increased waiting times for some pathways (e.g. autism diagnosis)
• There is increased pressure on speech and language therapy provision both from within learning disability services and the wider Trust. This is compounded by recent staff turnover and difficulties in recruitment of specialist staff.
• Face-to-Face activity is increasing across all our community teams (currently around 65%) and we are aiming to increase this further to around 85% by end of Q4 although the availability of suitable environments could impact on this.

Inpatients (ATU)
• Occupancy and clinical acuity remain high.
• Need for high levels of observation and support currently is requiring high staffing levels (approx. 2:1 staffing) which is proving difficult to source.
• Recently, finding registered nurses to cover shifts has proven challenging and impacted on wellbeing of nursing workforce, which in turn compounds the issue.
• Use of bank/agency has increased due to current absence rates.
• Sickness levels on the unit remain high and recruitment to vacancies is ongoing but slow as in line with the national pressure on registered nurse capacity. Additional temporary occupational therapists and therapy assistant posts are being recruited to help with immediate pressures. Learning will be used from this to advise the future workforce model.
• Medical staffing balance between the Trust and Bradford District Care, who is the lead provider. is being reviewed by medical directors.
• Wellbeing, supervision and appraisals are a key focus of attention.

ASD/ ADHD service
• The Royal College of Psychiatry invited review will start in November 2021.
• The service is operating fully but has seen a short- term spike in sickness.
• Supervision is currently 58% with the highlighted pressures a contributing factor.
• There has been a 23% surge in referrals for assessment, the service has received admin support to process all referrals in a timely manner.
• The service has a list of new business opportunities/ developments to explore further.
• Performance metrics remain good.
• Appraisals will be a focus of attention over the next month..

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

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Trustwide Acute Inpatients:

• Acute wards continue to see high levels of acuity and service user distress, with further challenges in managing isolated and cohorted patients. Senior leadership from matrons and general managers remains in place across 7 days.
• The difficulties have been recently compounded by staff absences and difficulties sourcing bank and agency staff, leading to staffing shortages across the wards, plus further Covid outbreaks.
• An action plan is in place to address improvement required across the service in relation to concordance with fire safety training. This is detailed and specific to each ward led by the matrons and general manager, and actively reviewed in service line meetings and BDU governance meetings. The current position shows significant improvement in performance across all but two wards.
• Intensive work to maintain a safe and effective inpatient service throughout very challenging times continues. Maintaining safety and well-being of current staff and service users, reducing ward sizes and improving recruitment and retention are key areas for action. The work involves:
・ a task and finish approach reporting through the command structure
・ the use of out of area placements on a planned basis to release pressure, with the support of commissioners
・ using the staffing establishment differently if required
・ building identified challenges and priorities into the workforce strategy and planning work.

Community

• Work continues in front line services to adopt collaborative approaches to care planning, build community resilience, and to offer care at home. This includes providing robust gate-keeping assessments, trauma informed care approaches and effective intensive home treatment.
• . 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. Work is underway to better understand and report our balance of face to face and virtual interventions as part of our total offer.
• We are optimising our use of space across Trust sites so that group work and more face to face therapies can be delivered, and are currently reviewing space utilisation in each building to optimise clinical capacity.
• Demand into the Single Point of Access (SPA) continues to increase either in line with or above predicted demand, leading to significant pressure in the service and necessitating the use of additional staff and sessions for assessment slots. SPA is prioritising risk screening of 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 to support people who are at risk.
• We continue to work in collaboration with our places to implement the community mental health transformation. A concern is that the new roles within primary care networks will draw experienced staff from our resources but not release a commensurate level of demand.
• The wellbeing and support of staff is at the forefront of the BDUs aims, including ensuring clinical supervision takes place each month. Quality and governance leads in each place are working with teams to enable this in terms of quality access and prioritisation.

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

• Coronavirus updates continue to be sent out weekly to all staff and governors.
• Coronavirus sections on the intranet and website are maintained and updated.
• Sharing of staff and service user good news stories, internally, externally and through social media channels continues.
• Coronavirus vaccination, booster, third doses and 12-15 year olds (Barnsley) communications are maintained.
• The Trust was highly commended in the NHS Communicate Awards for use of data and insight in our communications approach to COVID-19 staff vaccinations.
• Staff wellbeing initiatives continue to be promoted.
• Design and print of materials continues for services and corporate functions.
• Awareness days and weeks continue to be supported on social media and in internal communication channels.
• We have ensured nhs.net removal and Trust email accreditation communication.
• Support has been provided to the Bretton Centre improvement programme (including intranet and web content and letters to local residents)
• Our equality campaign is in development – staff engagement carried out, and content developed
• Flu campaign supported
• Ongoing promotion of civility and respect/equity guardians and freedom to speak up work has continued
• The NHS staff survey is being promoted
• A menopause matters communication plan has been developed and support provided for Menopause Awareness Month.
• Support the virtual recruitment fair
• Support has been provided to EyUp Charity e.g. Annual Report and case studies, Creative Minds e.g. Moving Mental Health Forward promotion and development of new comms toolkit, Spirit in Mind e.g. promotion of events and to the Mental Health Museum
• Launch of Calderdale IAPT website.
• Promotion of Barnsley IAPT in various publications, including Barnsley Football Club has taken place
• Promotion is in place linked to Stoptober, support to Yorkshire Smokefree, and preparation for the Trust QUIT launch (to be confirmed)
• Website and intranet development work, including new equality and inclusion content is supported.
• Media enquiries have been co-ordinated and responses issued, alongside a proactive news piece on Barnsley Recovery College with BBC Radio Sheffield.
• Ongoing promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICS initiatives and campaigns continues

Overall Financial Performance 2021/22

Executive Summary / Key Performance Indicators

Performance Indicator		Year to Date	Forecast 2021/22	Narrative
1	Surplus / Deficit	£2.3m	£2.3m (H1 21/22)	In September a surplus of £0.1m has been reported which is favourable to plan. The year to date position is a surplus of £2.3m which is in line with the previous H1 forecast. The H2 planning guidance has been published and the H2 plan and submission is being finalised.
2	Agency Spend	£4.2m		Agency expenditure in September was £0.8m and continues to be a higher run rate than last year. This is expected to continue for the remainder of the year to support staffing requirements.
3	Cash	£63.1m	£68.9m	Cash in the bank continues to be positive and is forecast to remain so. This continues to be closely monitored to ensure that the cash position is appropriately maximised.
5	Capital	£1.3m	£9.6m	Year to date spend is £1.3m which is £1.1m less than planned. The forecast remains that the full £9.6m capital programme will be utilised in year although this continues to assessed taking account of issues from covid-19, Brexit and supplier availability and pricing.
6	Better Payment Practice Code	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 97% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 12 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

	Objective	CQC Domain	Owner	Threshold	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	4.0%	4.0%	3.9%	4.0%	4.3%	4.3%	4.5%	4.6%	4.6%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	4.0%	4.0%	3.9%	4.0%	4.3%	4.3%	4.5%	4.6%	4.7%
Staff Turnover (registered nurses)	Improving Resources	Well Led	AD	10%	10.0%	10.0%	10.3%	15.6%	14.7%	13.1%	14.1%	14.6%	14.5%
Gross Vacancies	Improving Resources	Well Led	AD	-	Reporting Commenced April 2021			10.8%	5.5%	7.9%	7.3%	6.6%	7.7%
Net Vacancies	Improving Resources	Well Led	AD	-				2.9%	0.6%	3.2%	4.0%	2.2%	3.1%
Aggression Management	Improving Care	Well Led	AD	>=80%	84.1%	84.1%	82.3%	80.7%	79.95%	85.1%	85.4%	84.7%	83.9%
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80%	85.2%	84.5%	81.7%	78.8%	77.7%	76.27%	75.91%	74.60%	71.87%
Clinical Risk	Improving Care	Well Led	AD	>=80%	93.3%	93.1%	93.5%	94.6%	94.9%	94.7%	94.6%	93.9%	92.9%
Display Screen Equipment	Improving Care	Well Led	AD	>=80%	Reporting to Commence in November 2021								
Equality and Diversity	Improving Health	Well Led	AD	>=80%	95.5%	95.6%	95.5%	95.6%	95.5%	95.2%	95.0%	94.7%	94.7%
Fire Safety	Improving Care	Well Led	AD	>=80%	86.9%	87.6%	86.2%	85.9%	84.3%	84.6%	83.3%	83.2%	84.9%
Food Safety	Improving Care	Well Led	AD	>=80%	74.8%	75.9%	75.3%	76.3%	77.2%	79.60%	80.0%	81.3%	81.9%
Freedom to Speak Up (FTSU)	Improving Care	Well Led	AD	>=80%	Reporting Commenced in August 2021							42.2%	42.2%
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	95.0%	94.7%	94.3%	94.0%	94.2%	92.7%	91.8%	90.7%	89.9%
Information Governance	Improving Care	Well Led	AD	>=95%	97.5%	97.8%	97.9%	96.6%	95.7%	94.67%	93.18%	92.20%	91.79%
Moving and Handling	Improving Resources	Well Led	AD	>=80%	95.0%	95.1%	94.9%	95.1%	95.7%	96.3%	96.7%	96.8%	96.6%
National Early Warning Score 2 (NEWS2)	Improving Care	Well Led	AD	>=80%	Reporting Commenced in September 2021								49.8%
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80%	94.6%	93.9%	91.0%	90.8%	88.9%	87.7%	87.6%	87.4%	87.7%
Mental Health Act	Improving Care	Well Led	AD	>=80%	91.3%	90.5%	85.0%	85.1%	82.0%	80.7%	81.9%	81.7%	82.4%
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%		81.3%			76.4%			70.5%	
Prevent	Improving Care	Well Led	AD	>=80%	95.6%	95.6%	95.6%	95.6%	95.3%	95.4%	95.4%	95.4%	95.0%
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	94.0%	94.2%	94.0%	94.7%	94.7%	94.7%	93.8%	93.6%	92.4%
Safeguarding Children	Improving Care	Well Led	AD	>=80%	93.1%	93.6%	93.5%	93.3%	93.4%	93.1%	92.5%	92.2%	91.0%
Bank Cost	Improving Resources	Well Led	AD	-	£946k	£682k	£1,120k	£803k	£911k	£795k	£822k	£1001k	£1053k
Agency Cost	Improving Resources	Effective	AD	-	£587k	£562k	£760k	£583k	£560k	£794k	£834k	£705k	£754k
Overtime Costs	Improving Resources	Effective	AD	-	Data unavailable at the time of producing this report								
Additional Hours Costs	Improving Resources	Effective	AD	-									
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-									
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-									
Business Miles	Improving Resources	Effective	AD	-									
Health & Safety													
Number of RIDDOR incidents(reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	7			4			4		

Covid-19

KPI Additional Metrics to Highlight Response to and Impact of Covid-19	Target	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	As at 20th August 2021	As at 22nd Sep 2021	As at 20th Oct 2021	Trend	Notes
No of staff off sick - Covid-19 not working 7		**159**	**91**	**89**	**33**	**15**	**32**	**95**	**106**	**81**	**93**		
Shielding		48	42	50	1	0	0	1	1	1	0		
Symptomatic		64	29	19	16	2	8	33	57	43	45		
House hold symptoms		19	4	10	5	3	6	28	7	18	15		
OH Advised Isolation		0	1	1	1	0	0	4	1	0	0		
Test & Trace Isolation		0	0	0	0	0	0	0	0	0	0		
Other Covid-19 related		28	15	9	10	10	18	29	40	1	33		
No of staff working from home - Covid-19 related 8		**84**	**78**	**88**	**16**	**8**	**21**	**66**	**27**	**42**	**62**		
Shielding		49	54	74	8	0	0	1	2	2	0		
Symptomatic		9	4	3	2	2	3	15	8	18	15		
House hold symptoms		6	10	4	1	3	8	28	10	16	26		
OH Advised Isolation	N/A	4	2	2	1	1	0	0	0	0	0		
Test & Trace Isolation		0	0	0	0	0	0	0	0	0	0		
Other Covid-19 related		16	8	5	4	2	10	22	7	2	21		
No of staff tested positive for Covid-19 10		545	598	610	610	610	610	610	807	929	1040		Cumulative
No of staff returned to work (including those who were working from home)		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%	3125/3258 =95.9%	3254/3296 =98.7%	3363/3522 =95.5%		
No of staff returned to work (not working only) 13		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%	2051/2166 =94.7%	2168/2264 = 95.7%	2253/2369 = 95.1%		
No of staff still absent from work who were Covid-19 positive 12		43	22	13	13	0	0	0	40	29	42		
Additional number of staff enabled to work from home		1175	1306	1369	1281	1271	1223	1350	1359	1394	1369		Cumulative
Calls to occupational health healthline		2274	2451	2565	2655	2713	2798	2911	3007	3105	3181		Cumulative

Staffing Issues

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

- Regular messages to staff about personal protective equipment (PPE) requirements to keep them and service users safe
- Regular updating of vulnerable and BAME staff risk assessments when circumstances change
- Regular and ongoing recruitment into the bank to increase capacity
- 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 a BAME health and wellbeing taskforce has been established 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 and recently the Trust menopause support group has re-commenced.
- 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 and have access to psychological support through the West Yorkshire & Harrogate integrated care system.
- We continue to promote and use lateral flow tests for many of our staff.
- Calls to the occupational healthline have continued to increase.

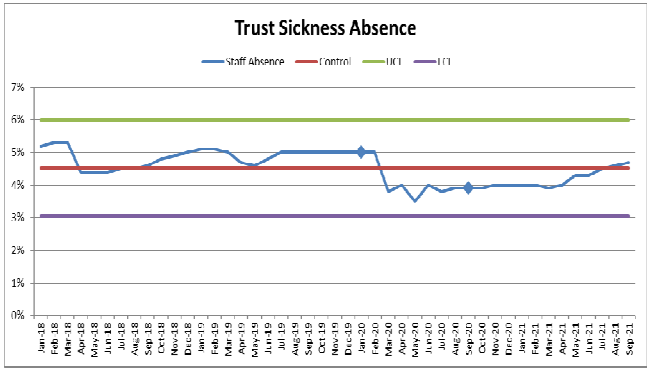
Freedom to Speak Up (FTSU)

In September FTSU mandatory training was introduced for all staff and is part of our strategy to increase awareness and build confidence across our staff to feel able to raise concerns, identify improvements and to improve more generally staff experience and staff engagement. 42% of staff have already completed this newly introduced training.

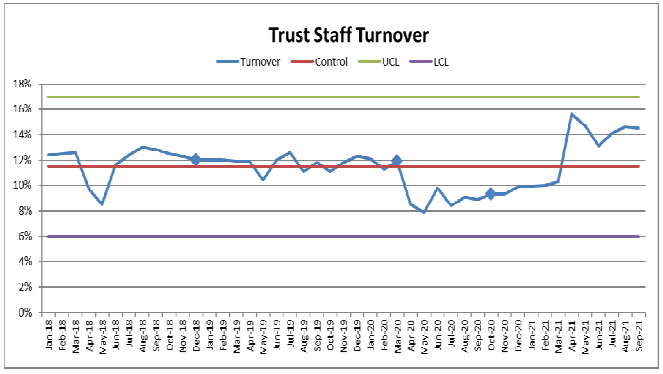
Workforce Issues

- As at 20th October, 93 staff off work Covid-19 related, not working which compares to 81 one month earlier. A further 62 were working from home.
- Staff turnover decreased to 14.5% in September a detailed workforce planning report was considered by the workforce and renumeration committee on 21 st September which gave a deep dive into the turnover figures.
- Non-Covid sickness absence increased slightly to 4.7% in September. The summary section also reports the Covid and non-Covid absence as one figure.

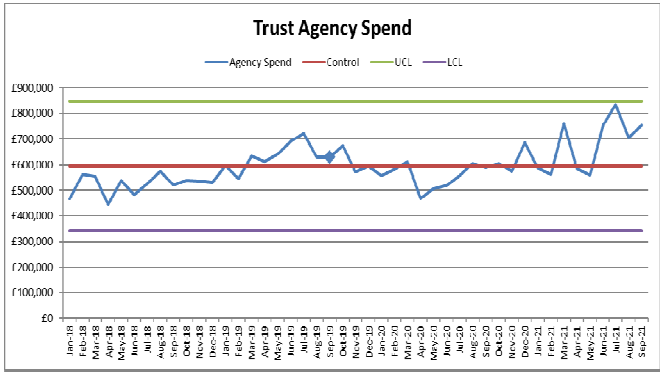
SPC Charts



SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data points in January 2020 and September 2020 have been highlighted for this reason.



SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in October 2020 has been higlighted for this reason. Turnover has been lower since the onset of the Covid-19 pandemic.

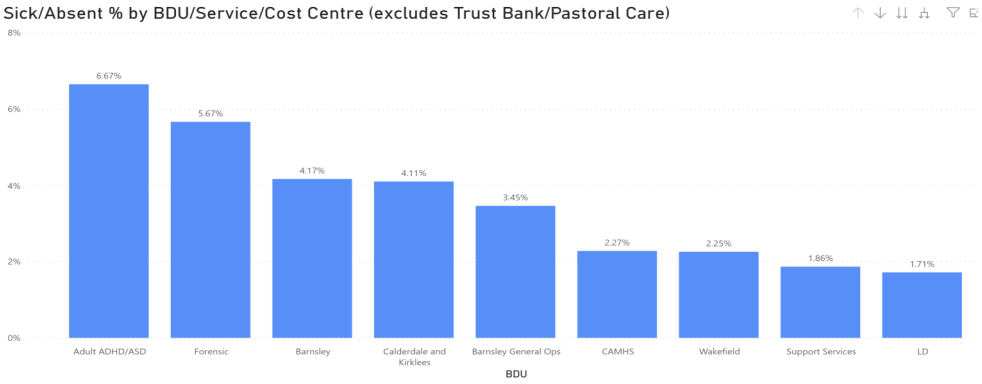


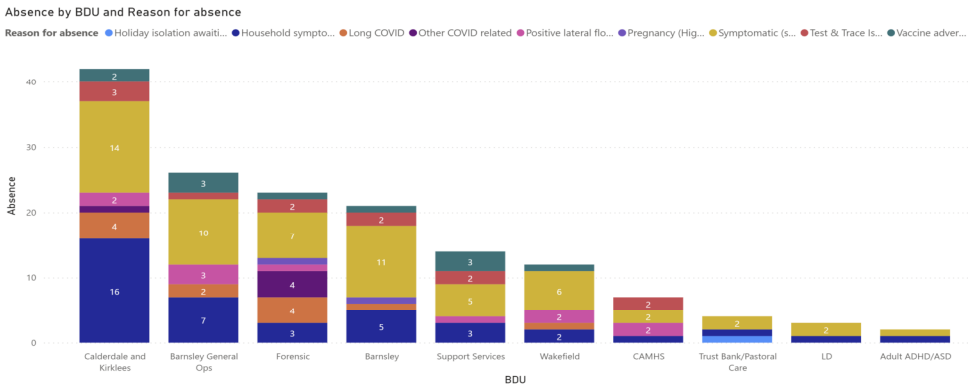
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in September 2019 has been highlighted for this reason.

Sickness reporting

As at 20th October, the Trust has 154 staff absent or working from home due to Covid-19. This makes up 2.97% of the workforce. Of those absent, 38.96% are symptomatic and 25.97% have household symptoms. The business delivery unit (BDU) with the biggest impact is Adult ADHD/ASD with 6.7% 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 7.8 days in September.





Publication Summary

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

Community services statistics: June 2021

NHS sickness absence rates: May 2021, provisional statistics

NHS workforce statistics: June 2021 (including selected provisional statistics for July)

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 6
(2021 / 22)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0	Executive Summary / Key Performance Indicators

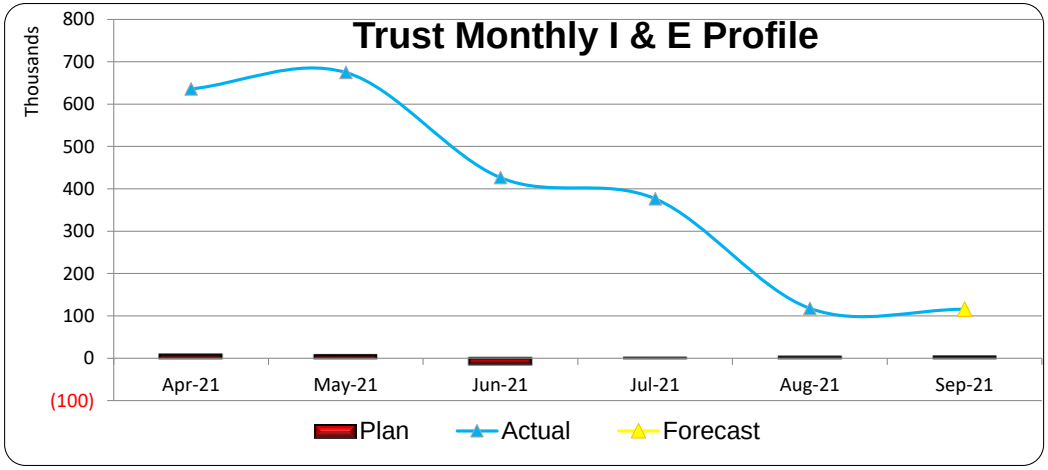
Performance Indicator		Year to Date	Forecast 2021 / 22	Narrative
1	Surplus / (Deficit)	£2.3m	£2.3m (H1 21/22)	In September a surplus of £0.1m has been reported which is favourable to plan. The year to date position is a surplus of £2.3m which is in line with the previous H1 forecast. The H2 planning guidance has been published and the H2 plan and submission is being finalised.
2	Agency Spend	£4.2m		Agency expenditure in September was £0.8m and continues to be a higher run rate than last year. This is expected to continue for the remainder of the year to support staffing requirements.
3	Cash	£63.1m	£68.9m	Cash in the bank continues to be positive and is forecast to remain so. This continues to be closely monitored to ensure that the cash position is appropriately maximised.
4	Capital	£1.3m	£9.6m	Year to date spend is £1.3m which is £1.1m less than planned. The forecast remains that the full £9.6m capital programme will be utilised in year although this continues to assessed taking account of issues from covid-19, Brexit and supplier availability and pricing.
5	Better Payment Practice Code	97%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 97% of invoices have been paid within 30 days for the year to date. On average non NHS invoices have been paid in 12 days from receipt.

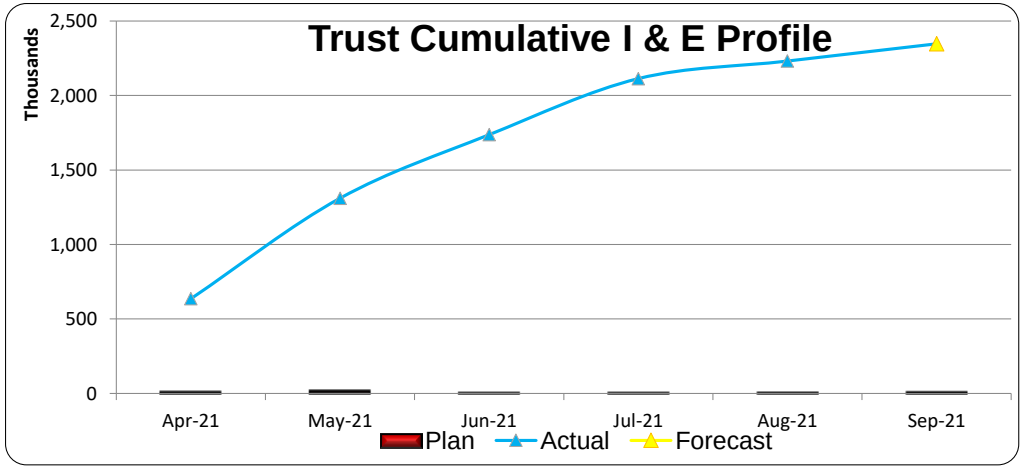
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

2.0 Income & Expenditure Position 2021 / 2022

Budget Staff	Actual worked	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Draft Budget	Year to Date Actual	Year to Date Variance	Budget M1 - M6	Forecast M1 - M6	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				24,321	22,784	(1,538)	Clinical Revenue	130,174	125,641	(4,533)	130,174	125,641	(4,533)
				24,321	**22,784**	**(1,538)**	**Total Clinical Revenue**	**130,174**	**125,641**	**(4,533)**	**130,174**	**125,641**	**(4,533)**
				1,030	1,248	218	Other Operating Revenue	6,424	7,595	1,171	6,424	7,595	1,171
				25,352	**24,032**	**(1,320)**	**Total Revenue**	**136,598**	**133,236**	**(3,362)**	**136,598**	**133,236**	**(3,362)**
4,825	4,444	(381)	7.9%	(20,795)	(19,187)	1,608	Pay Costs	(109,069)	(103,023)	6,046	(109,069)	(103,023)	6,046
				(3,805)	(3,949)	(144)	Non Pay Costs	(23,038)	(23,254)	(216)	(23,038)	(23,254)	(216)
4,825	**4,444**	**(381)**	**7.9%**	**(24,600)**	**(23,136)**	**1,464**	**Total Operating Expenses**	**(132,107)**	**(126,277)**	**5,830**	**(132,107)**	**(126,277)**	**5,830**
4,825	**4,444**	**(381)**	**7.9%**	**752**	**896**	**144**	**EBITDA**	**4,491**	**6,959**	**2,468**	**4,491**	**6,959**	**2,468**
				(537)	(568)	(31)	Depreciation	(3,220)	(3,340)	(120)	(3,220)	(3,340)	(120)
				(212)	(212)	(0)	PDC Paid	(1,271)	(1,272)	(1)	(1,271)	(1,272)	(1)
				0	0	0	Interest Received	0	0	0	0	0	0
4,825	**4,444**	**(381)**	**7.9%**	**3**	**116**	**112**	**Surplus / (Deficit)**	**0**	**2,347**	**2,347**	**0**	**2,347**	**2,347**
				0	0	0	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
4,825	**4,444**	**(381)**	**7.9%**	**3**	**116**	**112**	**Surplus / (Deficit)**	**0**	**3,484**	**3,484**	**0**	**3,484**	**3,484**

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. The plan for H2 is being finalised and will be submitted in line with national deadlines.





Income & Expenditure Position 2021 / 22

For the period April to September 2021 a surplus of £2.3m has been reported. This is in line with previous forecast positions.

For April to September 2021 the Trust has an operational plan to deliver a breakeven position. It is 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 payment from each commissioner. These are based upon national funding principles and includes 2020 / 21 and 2021 / 22 Mental Health Investment Standard (MHIS) and system recovery (SR) funding.

Mobilisation of these services, including recruitment where appropriate, is being undertaken. Any variation in spend is being monitored to ensure that all funding can be utilised to support mental health services and overall system recovery.

Other income streams, such as those from local authorities, continue as normal with standard contracting arrangements in place.

Pay

The national Agenda for Change pay award has been paid, including arrears back to April 2021, in month. This is £2m and is currently fully funded by commissioner income. This will be updated in month 7 as funding will flow from the various commissioners.

Discounting this value to create a normalised run rate would mean that pay expenditure in September was less than August. This would be expected with the one off payments accounted for in August relating to safer staffing levels.

Utilisation of temporary workforce options, including bank, agency and overtime payments has continued. Bank and agency accounted for 9.4% of overall pay expenditure although this is impacted by the in month pay award. The headlines 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.

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Total
Heading	**Description**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Staffing - backfill	Additional staff costs to support Trust workforce response. Includes acting up and backfill arrangements	22	51	37	38	145	46	**339**
Staffing - vaccination	Additional staff costs to support vaccination programme (including overtime)	33	62	19	11	26	19	**170**
Staffing - Isolation	Isolation, shielding and backfill for covid absence	56	15	31	32	41	31	**206**
Staffing - premium	Additional exceptional payments agreed to ensure safe staffing levels over key periods	0	0	0	0	158	0	**158**
Total – Pay		**110**	**128**	**87**	**81**	**370**	**96**	**872**
Lateral Flow Testing	Distribution of kits to staff	7	2	12	8	2	7	**38**
Laundry & Scrubs	Purchase of scrubs for staff and associated laundry costs	2	1	1	0	1	0	**5**
IT	Purchase of equipment and agile working enabling costs (VPN)	0	35	3	0	0	0	**38**
OOA Placements	Out of area bed placements required to covid issues	0	6	12	0	77	213	**308**
Staffing - security	External security costs to support vaccination	0	0	8	0	0	0	**8**
Furniture	Replacement furniture to support infection prevention and control	0	0	0	0	0	138	**138**
Misc / other	Other general non pay not captured in the headings above	0	15	8	6	17	25	**71**
Total – Non Pay		**8**	**59**	**44**	**14**	**97**	**383**	**605**
Total costs		**119**	**187**	**131**	**95**	**467**	**479**	**1,477**

2.1 Income Information

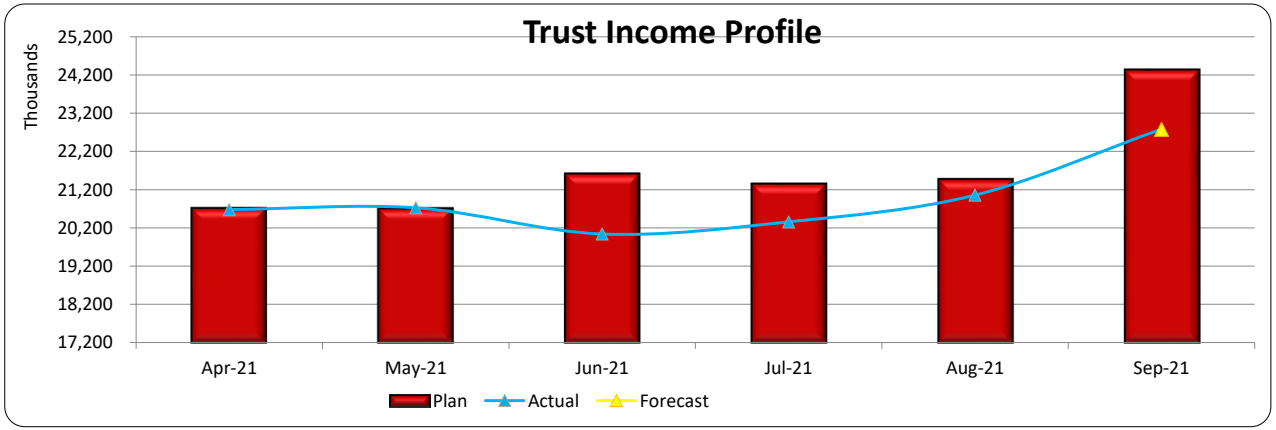
Within the Trust Income and Expenditure position clinical revenue is separately identified. This is income received through contracts to provide clinical services. This does not include other income which the Trust receives such as contributions to training, staff recharges and catering income.

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, and other 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 from those organisations.

Guidance for H2 has now been received and fundamentally the same arrangements as the past 18 months will continue. It is expected that formal contracts will recommence April 2022.

Income source	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	15,120	15,237	17,206							**92,828**	**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	2,493	2,550	2,512							**14,973**	**28,281**
Local Authority	404	490	402	385	458	429							**2,567**	**5,025**
Partnerships	657	636	654	547	939	803							**4,237**	**7,514**
Top Up / ERF	0	0	169	85	21	7							**282**	**5,458**
Other	41	50	46	(9)	116	90							**333**	**4,815**
Total	**20,679**	**20,725**	**20,039**	**20,358**	**21,057**	**22,784**	**0**	**0**	**0**	**0**	**0**	**0**	**125,641**	**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**	



As previously noted national guidance states that the month 6 position should assume income, funded via the lead commissioner, equal to the costs incurred. This will revert to funding through each of the individual commissioners in month 7. As this will include an efficiency assumption there will be a gap to be managed within the financial position.

H2 guidance confirms that the current block payment arrangements will continue for the remainder of the year with a current planning assumptions that contracts will restart in April 2022.

2.2 Pay Information

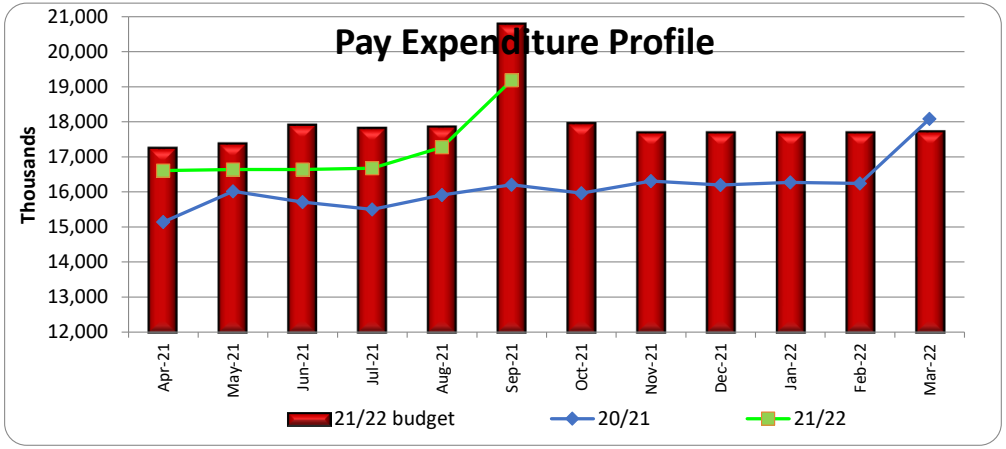
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for 80% of our budgeted total expenditure. Trust priorities include a focus on the health and wellbeing 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.

Staff type	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	15,019	15,567	17,381							**93,450**
Bank & Locum	803	911	795	822	1,001	1,053							**5,383**
Agency	583	560	754	834	705	754							**4,190**
Total	**16,610**	**16,641**	**16,637**	**16,675**	**17,273**	**19,187**	**0**	**0**	**0**	**0**	**0**	**0**	**103,023**
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%	4.9%	5.8%	5.5%							5.2%
Agency as %	3.5%	3.4%	4.5%	5.0%	4.1%	3.9%							4.1%

WTE Worked	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Average
Substantive	4,104	4,078	4,051	4,068	4,074	4,089							**4,077**
Bank & Locum	255	263	218	224	283	231							**246**
Agency	107	115	128	155	138	123							**128**
Total	**4,465**	**4,456**	**4,398**	**4,447**	**4,494**	**4,444**	**0**	**0**	**0**	**0**	**0**	**0**	**4,451**
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**



The September position includes payment of the Agenda for Change pay award. This has been backdated to April 2021. Due to it's nature it does not generate an additional WTE and therefore there is a disconnect in month between the two pay elements.

Budgets have been increased in line with funded establishments. Due to the level of vacancies this has increased the year to date underspend.

Internal working groups have been established to support the workforce and staffing agenda. These include recruitment and retention, health and wellbeing and the financial implications.

2.2 Pay Information

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	Substantive	Bank / Locum	Agency	Total	Variance
	£k	£k	£k	£k	£k	£k
Medical	13,304	11,942	377	1,598	13,917	613
Nursing Registered	42,261	30,926	1,748	554	33,228	(9,033)
Nursing Unregistered	13,160	10,738	2,712	1,511	14,961	1,801
Other	29,792	25,102	213	507	25,823	(3,970)
Corporate Admin	8,616	8,033	136	18	8,187	(429)
BDU Admin	7,110	6,710	197	1	6,907	(202)
Vacancy Factor	(5,175)				0	5,175
Total	**109,069**	**93,450**	**5,383**	**4,190**	**103,023**	**(6,046)**

WTE In month Budget v Actual - by staff group

Staff Group	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	WTE	WTE	WTE	WTE	WTE	WTE
Medical	229	197	0	16	214	(15)
Nursing Registered	1,486	1,220	61	15	1,296	(189)
Nursing Unregistered	884	713	148	78	940	56
Other	1,387	1,200	7	13	1,220	(167)
Corporate Admin	353	343	4	1	349	(4)
BDU Admin	486	415	11	0	426	(61)
Total	**4,825**	**4,089**	**231**	**123**	**4,444**	**(381)**

By staff group the key elements to highlight are:

The largest area of underspend continues to be registered nursing. In month there has been a slight reduction across all the categories with reductions in substantive, bank and agency. Work continues with recruitment to support the additional investment received. This includes an overseas recruitment programme with the initial cohort (c. 14 indviduals but plans to increase to 40) due to arrive shortly. These will largely be supporting inpatient areas initially.

The second largest category is the other category includes a wide range of staff not covered in the other headings. This is reflective of the wide range of staff that support the services which we provide. Large WTE group examples include psychologists, PAMs, ancillary staff and housekeepers and occupational therapists.

The financial plan includes a value relating to expected staff vacancies and posts not back filled. This value, shown separately 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. Vacancies, higher than this assumed level, contribute to the overall pay underspend position.

Year to date Budget v Actual - by service

	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	£k	£k	£k	£k	£k	£k
MH Community	47,123	39,807	1,093	1,970	42,869	(4,253)
Inpatient	24,129	20,183	3,519	1,914	25,615	1,486
BDU Support	6,566	3,910	245	9	4,165	(2,402)
Community	15,033	12,668	216	71	12,955	(2,078)
Corporate	21,392	16,882	311	226	17,419	(3,973)
Vacancy Factor	(5,175)				0	5,175
Total	**109,069**	**93,450**	**5,383**	**4,190**	**103,023**	**(6,046)**

In month Budget v Actual - by service

	Budget	Substantive	Bank / Locum	Agency	Total	Variance
	WTE	WTE	WTE	WTE	WTE	WTE
MH Community	1,881	1,601	33	24	1,659	(222)
Inpatient	1,133	953	168	86	1,208	74
BDU Support	357	214	7	0	222	(135)
Community	757	649	11	3	663	(93)
Corporate	697	671	11	10	693	(4)
					0	
Total	**4,825**	**4,089**	**231**	**123**	**4,444**	**(381)**

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.

This information continues to inform the Trust workforce and recruitment strategy and the overall financial planning process.

2.2 Agency Expenditure Focus

Agency spend is £754k in September.

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.

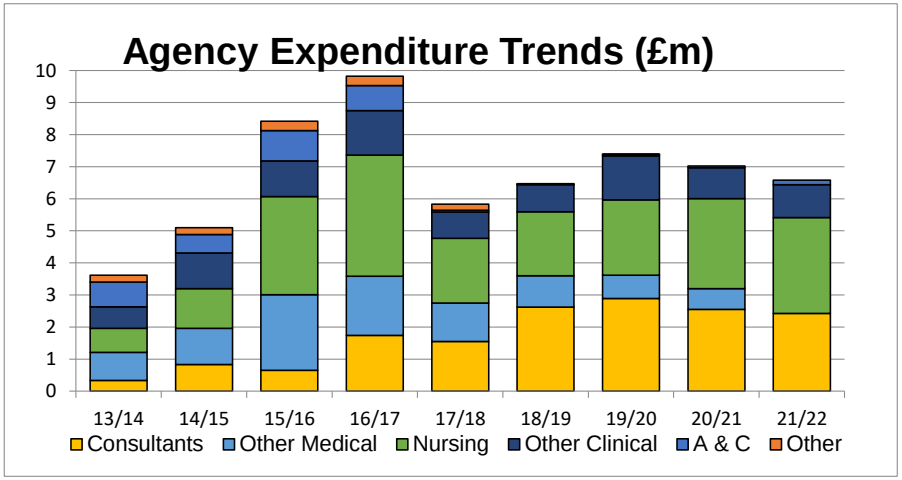
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

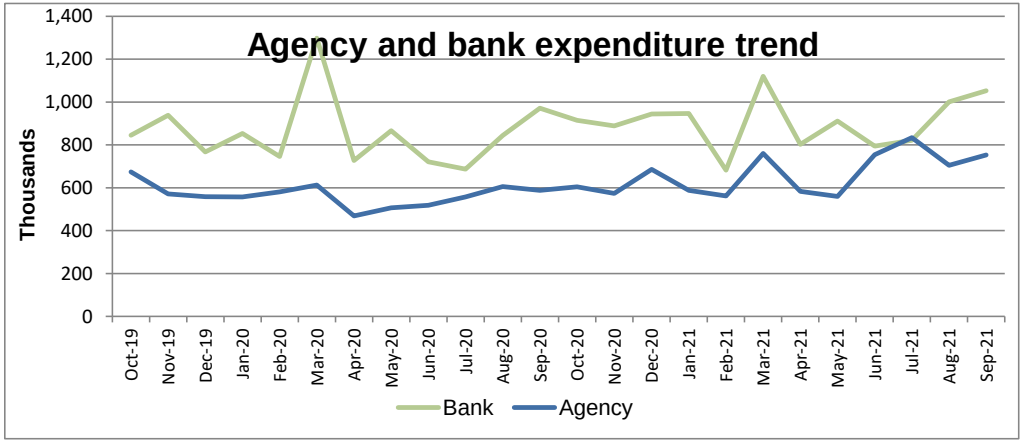
NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.

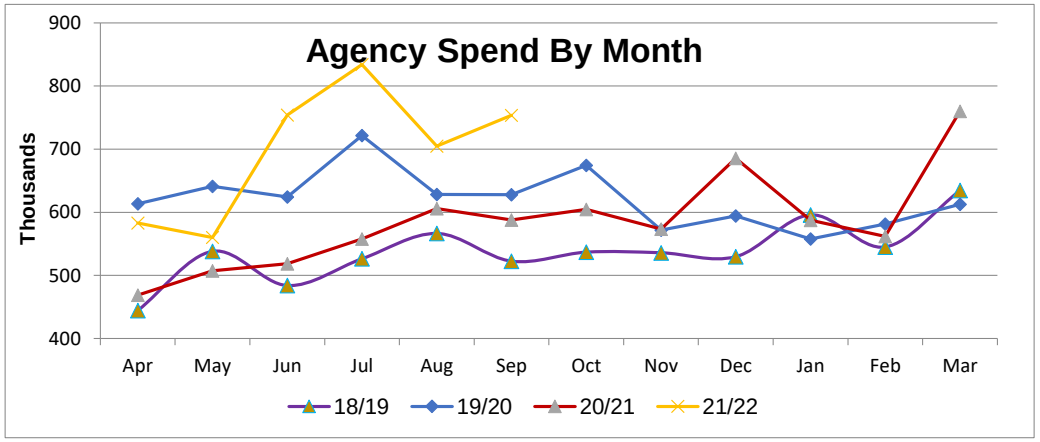
Due to covid 19 there is currently no agency cap for 2021/22 (although a value of £7.7m has been indicated), however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised 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.

Although not as high as the peak spend in July 2021, the £754k in September is £49k more than last month. This increase is within the unregistered nurse heading.

Triangulation continues to compare agency spend with substantive staff and bank staff payments.





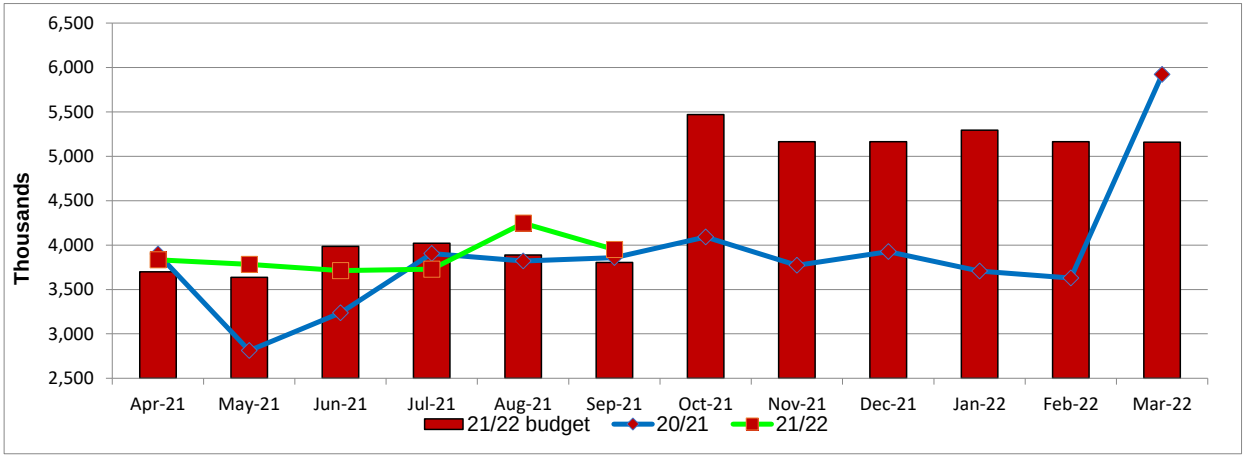


2.3 Non Pay Expenditure

Whilst pay expenditure represents approximately 80% of all Trust expenditure, non pay expenditure also presents a number of key financial challenges. This analysis focuses on non pay expenditure within the BDUs and corporate services, and excludes capital charges (depreciation and PDC) which are shown separately in the Trust Income and Expenditure position.

Non pay spend	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	3,729	4,246	3,949							**23,254**
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**

	Budget Year to date	Actual Year to date	Variance
Non Pay Category	**£k**	**£k**	**£k**
Drugs	1,858	1,675	(183)
Establishment	3,788	4,313	525
Lease & Property Rental	3,829	3,953	124
Premises (inc. rates)	2,933	3,024	90
Purchase of Healthcare	3,343	3,314	(29)
Travel & vehicles	2,119	1,981	(138)
Supplies & Services	3,618	2,966	(652)
Training & Education	348	400	52
Clinical Negligence & Insurance	436	644	208
Other non pay	767	985	218
Total	**23,038**	**23,254**	**216**
Total Excl OOA and Drugs	**17,838**	**18,265**	**428**



Key Messages

There has been a small reduction in non pay expenditure when compared to last month which is being driven by the headings which have been underspending throughout the year such as drugs, travel and supplies.

The purchase of healthcare is considered seperately on page 12 and although this remains a pressure is broadly in line with plan overall.

Supplies and services, such as consumable products and food provisions, continue to be less than planned. Elements of this are also timing related with additional spend forecast later in the year. Some of these also offsets the overspends in establishment costs.

2.3 Out of Area Beds Expenditure Focus

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 provide 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 Year to date	Actual Year to date	Variance
Heading	**£k**	**£k**	**£k**
Locked Rehab	1,141	1,345	204
Out of Area			
Acute	626	65	(561)
PICU	380	65	(315)
Other Services	1,196	1,839	643
Total	**3,343**	**3,314**	**(29)**

Out of Area Expenditure Trend (£)

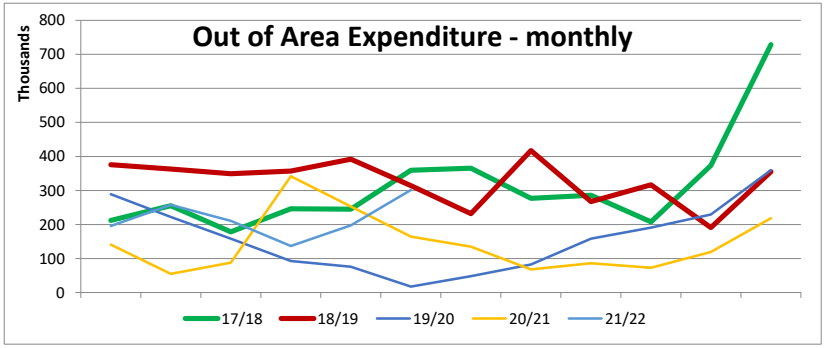
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	76	17	48	82	158	191	230	359	**1,924**
20/21	141	55	88	342	253	164	135	68	86	73	119	218	**1,741**
21/22	195	257	211	137	198	301							**1,299**

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	313	316	223	261	409							**1,743**

Bed Day Information 2021 / 2022 (by category)

PICU	203	236	233	176	188	311							**1,347**
Acute	18	77	83	47	73	98							**396**
Total	221	313	316	223	261	409	0	0	0	0	0	0	**1,743**



Despite all of the operational pressures being faced, including the impact that covid-19 has on both staffing and bed availability, out of area placements continue to be minimised as far as possible. Specific placements due to covid-19 issues continue to be charged against that allocation but are included in the above information.

Due to the conscious decisions made for specific placements there has been an increase of 132 bed days in September which makes this the highest individual month in year. This is a direct response to the ongoing impact of covid-19 and providing the safest possible location for each individual.

Additional Mental Health Investment Standard (MHIS) funding has been identified to support patient flow and the impact will be seen in future months.

3.0 Statement of Financial Position (SOFP) 2021 / 22

Balance Sheet / Statement of Financial Position (SOFP)	2020 / 2021 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	103,508	101,452	Pg 14
Current Assets			
Inventories & Work in Progress	173	173	
NHS Trade Receivables (Debtors)	1,173	183	1
Non NHS Trade Receivables (Debtors)	1,817	2,879	1
Prepayments	2,867	3,572	2
Accrued Income	3,090	5,450	3
Cash and Cash Equivalents	56,659	63,128	Pg 16
Total Current Assets	**65,781**	**75,385**	
Current Liabilities			
Trade Payables (Creditors)	(1,182)	(974)	4
Capital Payables (Creditors)	(585)	(633)	
Tax, NI, Pension Payables, PDC	(5,920)	(8,104)	
Accruals	(24,112)	(24,462)	5
Deferred Income	(3,981)	(5,161)	6
Total Current Liabilities	**(35,779)**	**(39,335)**	
Net Current Assets/Liabilities	**30,001**	**36,050**	
Total Assets less Current Liabilities	**133,510**	**137,502**	
Provisions for Liabilities	(7,348)	(7,511)	
Total Net Assets/(Liabilities)	**126,162**	**129,991**	
Taxpayers' Equity			
Public Dividend Capital	45,384	45,384	
Revaluation Reserve	10,596	10,596	
Other Reserves	5,220	5,220	
Income & Expenditure Reserve	65,307	68,791	7
Total Taxpayers' Equity	**126,507**	**129,991**	

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, 90% of this value is less than 30 days overdue. This includes £1m to BMBC which is not yet due.

2. Prepayments remain high, this includes software licences (£1.1m), rent (£0.3m) and the cost associated with lease cars for the Trust (£0.9m).

3. Accrued income remains high primarily due to additional income forecast from NHS England in March 2021 (£2.1m) relating to annual leave payments. We are awaiting confirmation when this will be paid. £1.9m is new in September relating to funding for the agreed pay rise.

4. Creditors, invoices outstanding for the Trust to pay, continues to be closely reviewed alongside Better Payment Practice Code (page 17) performance. 99% of aged creditors are less than 30 days old.

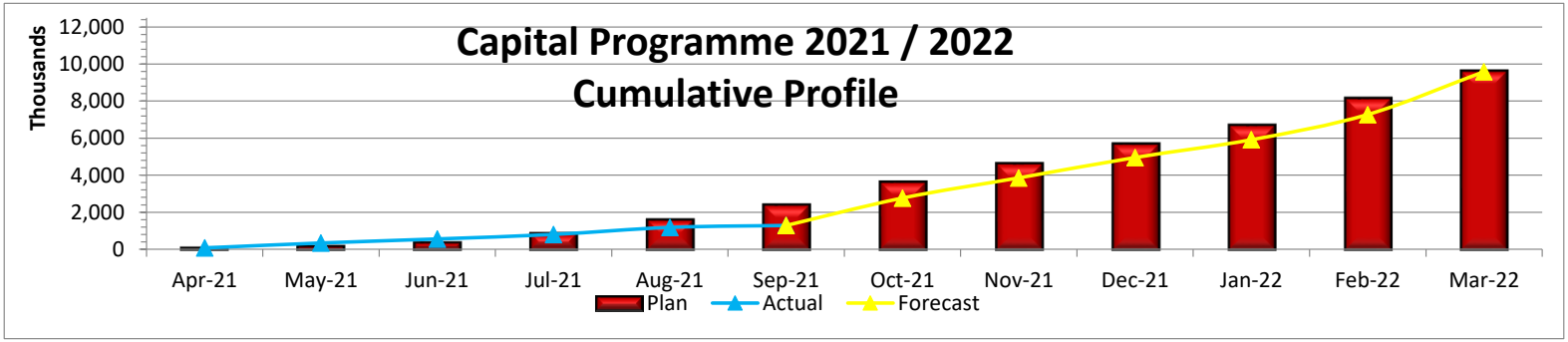
5. Accruals continue to be at a higher level than historically. Work continues to chase invoices to reduce this value.

6. Deferred income remains high and includes £0.9m from Health Education England and £1.9m from CCG's relating to H2 costs.

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

3.1 Capital Programme 2021 / 2022

Capital schemes	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Funding Source
Major Capital Schemes							
En Suite	2,000	100	45	(55)	1,000	(1,000)	Internal
OPS transformation	578	0	0	0	300	(278)	Internal
Maintenance (Minor) Capital							
Routine Maintenance	3,194	974	561	(413)	3,174	(20)	Internal
Fire Safety	160	30	0	(30)	195	35	Internal
Plant & Machinery	455	291	17	(274)	345	(110)	Internal
Equipment	100	40	34	(6)	100	0	Internal
Fixtures & Fittings	45	0	0	0	45	0	Internal
Other	643	412	526	114	1,888	1,245	Internal
IM & T							
Clinical Systems	275	32	1	(31)	275	(0)	Internal
Hardware	200	50	24	(26)	200	0	Internal
Cybersecurity, Infrastructure	200	75	46	(29)	327	127	Internal
Software	600	100	29	(71)	600	0	Internal
Other	1,140	319	0	(319)	1,140	0	Internal
VAT Refunds						0	
TOTALS	**9,590**	**2,423**	**1,283**	**(1,140)**	**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.

The plan assumed minimal spend at the start of the year with preparatory work and business cases to be finalised as required.

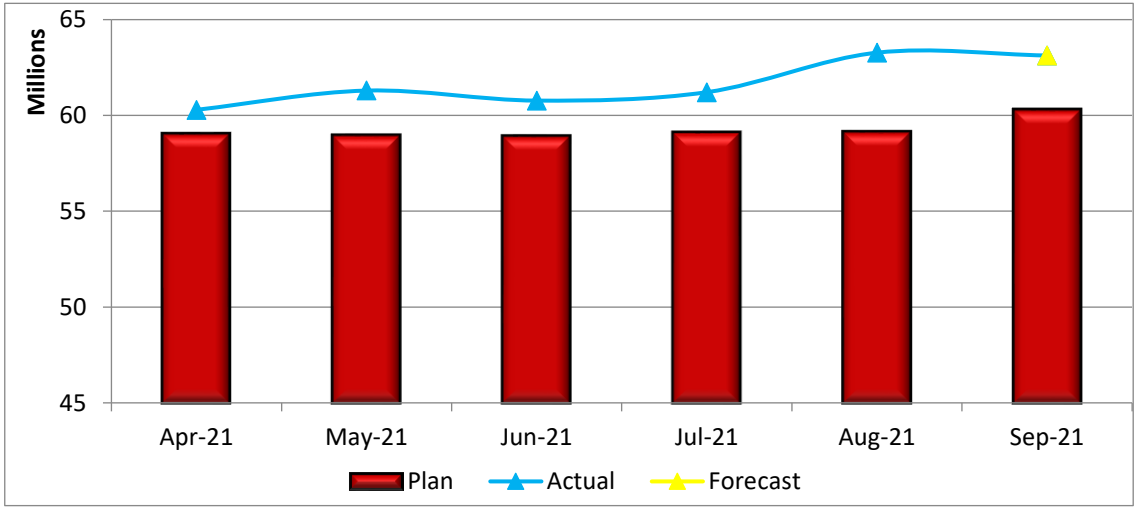
Spend is £1.1m less than originally planned. Detailed readiness and planning activities are on going although there are some delays due to resource / capacity and external influences.

External suppliers have highlighted issues with supply of good and services (staffing, shipping) and also a change in cost base.

As such there is potential underspends in year. The Trust will continue to obtain the best value for money taking account of the market conditions.

Following the approval of the Bretton Centre En Suite scheme, preparatory work continues as a partner for the scheme is procured.

3.2 Cash Flow & Cash Flow Forecast 2021 / 2022

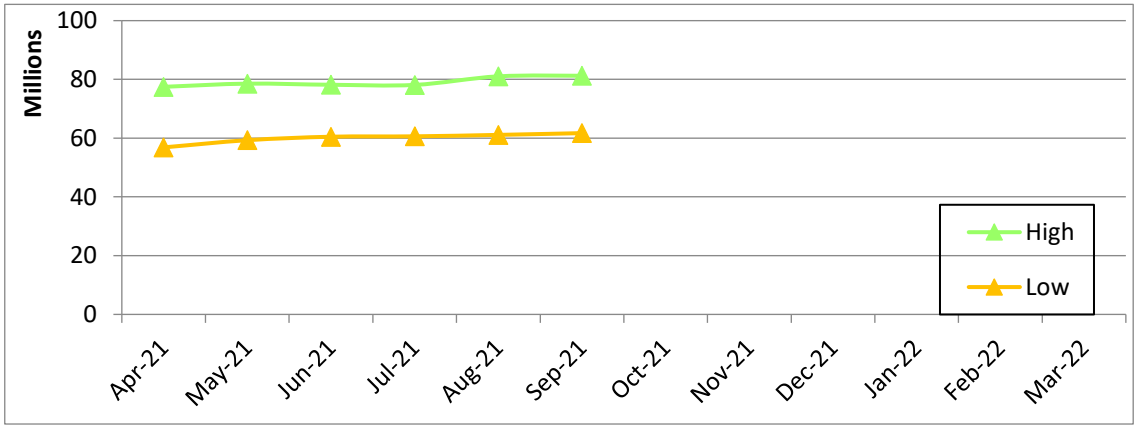


	Plan £k	Actual £k	Variance £k
Opening Balance	56,659	56,659	
Closing Balance	60,310	63,128	2,818

Cash remains positive. This helps to enable continued investment in the Trust capital programme.

Cash has remained higher than planned over the course of the year. We anticpate cash to reduce over the second half of the year as more investment and capital expenditure is planned.

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



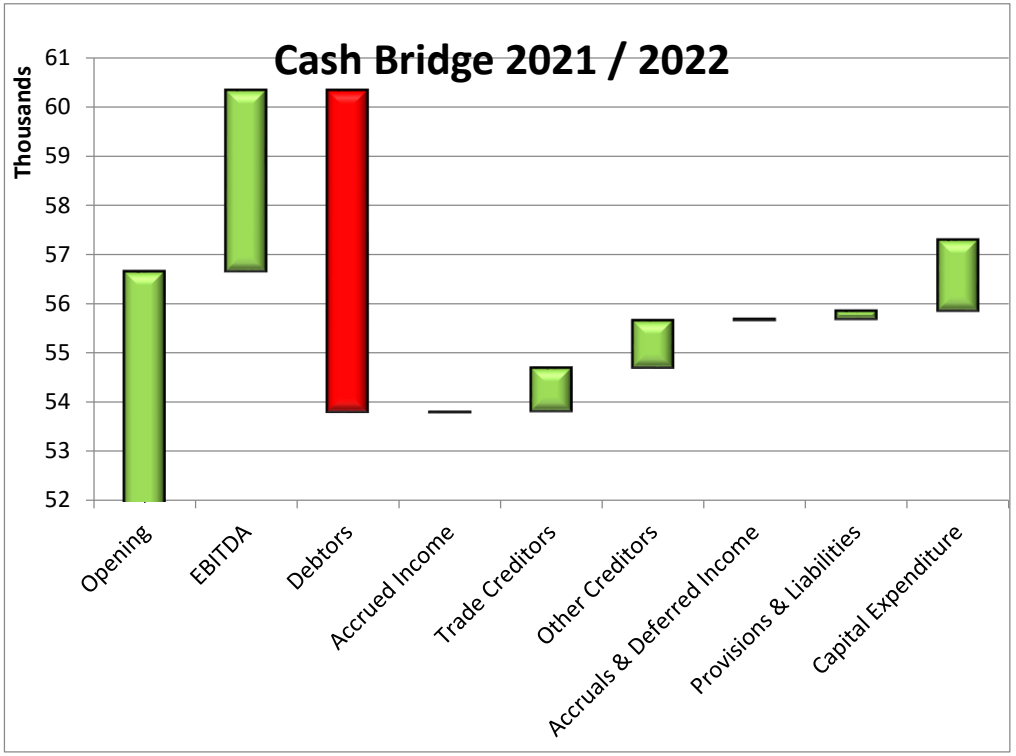
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £81.2m
The lowest balance is: £61.7m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Note
Opening Balances	**56,659**	**56,659**	
Surplus / Deficit (Exc. non-cash items & revaluation)	3,271	6,959	
Movement in working capital:			
Inventories & Work in Progress	0	0	
Receivables (Debtors)	3,400	(3,136)	
Accrued Income / Prepayments	0	0	
Trade Payables (Creditors)	971	1,854	
Other Payables (Creditors)	0	969	
Accruals & Deferred income	(27)		
Provisions & Liabilities	0	164	
Movement in LT Receivables:			
Capital expenditure & capital creditors	(2,683)	(1,235)	
Cash receipts from asset sales	0	1,482	
PDC Dividends paid	(1,271)	(588)	
PDC Dividends received			
Interest (paid)/ received	0	0	
Closing Balances	**60,321**	**63,128**	



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.

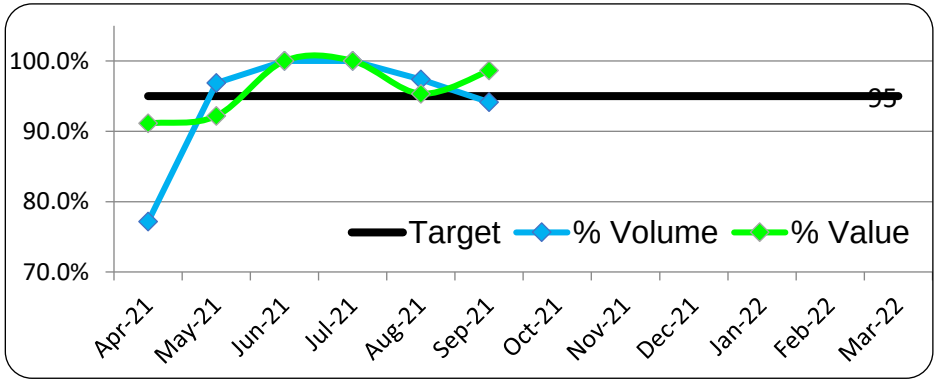
4.0 Better Payment Practice Code

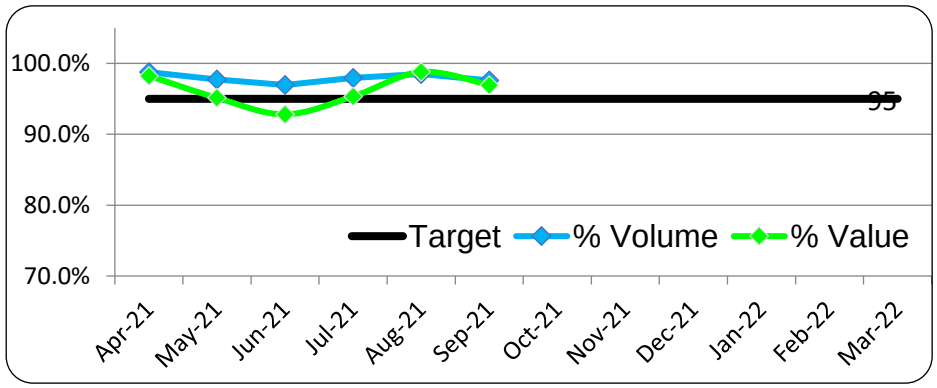
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

Performance in September has seen overall 98% of volume and 97% 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	94%	99%
Cumulative Year to Date	94%	98%

Non NHS	Number %	Value %
In Month	98%	97%
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 (including VAT where applicable).

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
19-Sep-21	Staff Recharge	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600017911	192,194
06-Sep-21	Drugs	Trustwide	Bradford Hospitals NHS Trust	319481	125,627
03-Sep-21	Rent	Kirklees	Bradbury Investments Ltd	1598	118,518
08-Sep-21	IT Services	Trustwide	Daisy Corporate Services	3I477256	90,250
22-Sep-21	Drugs	Trustwide	Lloyds Pharmacy Ltd	102696	74,237
08-Sep-21	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	995976	45,208
01-Sep-21	Rent	Trustwide	Mid Yorkshire Hospitals NHS Trust	1600017782	37,977
24-Sep-21	Drugs	Trustwide	NHS Business Services Authority	1000070276	34,918
08-Sep-21	Staff Recharge	Trustwide	Leeds & York Partnership NHS Foundation Trust	995971	33,404
22-Sep-21	Mobile Phones	Trustwide	Vodafone Ltd	98806447	31,794
01-Sep-21	Rent	Barnsley	Chapelfield Medical Centre	282	31,599
21-Sep-21	Staff Recharge	Calderdale	Calderdale Metropolitan Borough Council	IN2014890X	30,220
18-Sep-21	Staff Recharge	Barnsley	Barnsley Hospital NHS Foundation Trust	6024692	28,726
03-Sep-21	Rent	Kirklees	Bradbury Investments Ltd	1599	27,758
01-Sep-21	Rent	Barnsley	SJM Developments Ltd	LINV42401	27,000
09-Sep-21	Rent	Barnsley	SJM Developments Ltd	LINV40452	27,000
02-Sep-21	IT Hardware	Trustwide	Dell Corporation Ltd	7402740955	27,000

4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect

* Non-Recurrent - an action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year.

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* CDEL - Capital Departmental Expenditure Limit. This refers to the amount of capital set by Her Majesty's Treasury each year which the whole of the NHS must remain within for capital expenditure.

* ICS - Integrated Care System.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.2%	4.3%	4.2%	4.2%	4.0%	4.0%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.2%	4.3%	4.2%	4.3%	3.5%	4.1%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	78.8%	79.4%	88.2%	87.4%	83.3%	83.0%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	82.5%	82.5%	79.5%	76.0%	70.9%	70.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.7%	96.1%	94.3%	94.6%	91.3%	91.4%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	97.3%	96.9%	96.6%	95.3%	96.0%	96.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.4%	82.7%	83.6%	82.1%	86.2%	86.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	75.9%	77.7%	79.3%	76.6%	77.3%	77.6%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				53.4%	51.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.7%	95.6%	93.9%	91.9%	90.9%	91.1%
Information Governance	Resources	Well Led	AD	>=95%	96.9%	96.0%	95.2%	93.4%	93.3%	94.0%
Moving and Handling	Resources	Well Led	AD	>=80%	90.0%	91.6%	93.0%	93.5%	94.4%	94.0%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					51.7%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.8%	90.2%	87.0%	85.7%	87.1%	86.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	90.7%	86.8%	78.9%	80.8%	81.0%	80.9%
Prevent	Improving Care	Well Led	AD	>=80%	95.6%	96.0%	96.0%	95.8%	96.2%	96.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.5%	94.4%	94.3%	92.3%	91.4%	91.5%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.1%	93.9%	93.4%	92.6%	93.2%	93.1%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.2%	5.7%	4.8%	5.1%	5.2%	5.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	4.2%	5.1%	4.7%	4.8%	5.1%	5.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.7%	80.1%	85.5%	86.0%	86.5%	86.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.8%	78.0%	79.5%	81.1%	76.2%	76.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.3%	96.8%	96.4%	97.0%	96.3%	95.8%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	98.1%	97.3%	97.2%	97.4%	96.1%	96.6%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.9%	87.2%	85.5%	83.5%	83.4%	82.9%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.9%	79.4%	85.2%	90.1%	91.6%	91.6%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				43.1%	41.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	95.5%	95.3%	94.2%	94.7%	91.4%	91.2%
Information Governance	Resources	Well Led	AD	>=95%	97.5%	96.8%	95.6%	94.4%	91.3%	91.6%
Moving and Handling	Resources	Well Led	AD	>=80%	94.7%	95.0%	95.8%	96.9%	96.8%	96.5%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					60.6%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.3%	83.6%	84.6%	85.0%	85.4%	84.8%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.2%	79.6%	80.7%	81.5%	83.0%	82.3%
Prevent	Improving Care	Well Led	AD	>=80%	96.1%	95.8%	94.8%	95.4%	94.7%	94.6%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.0%	94.9%	94.7%	94.9%	92.2%	92.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.5%	94.7%	93.9%	93.0%	89.3%	88.6%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Forensic Services										
Month	Objective	CQC Domain	Owner	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	4.4%	4.2%	4.6%	5.1%	5.4%	5.5%
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	4.4%	4.3%	5.2%	6.6%	6.9%	5.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	79.9%	80.6%	80.5%	81.7%	80.0%	80.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.8%	73.2%	73.0%	74.1%	72.4%	71.6%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.4%	93.4%	93.8%	94.1%	94.5%	92.9%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	94.1%	94.9%	95.5%	95.4%	93.8%	94.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.4%	85.8%	84.5%	85.0%	84.4%	84.1%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	64.8%	65.4%	69.1%	69.3%	69.9%	70.7%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				42.1%	40.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.8%	93.3%	92.4%	92.8%	91.3%	90.7%
Information Governance	Resources	Well Led	AD	>=95%	95.1%	93.3%	93.0%	92.0%	90.6%	90.7%
Moving and Handling	Resources	Well Led	AD	>=80%	97.4%	97.9%	98.0%	98.3%	97.8%	97.8%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					41.1%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	87.5%	87.1%	87.3%	88.5%	89.0%	88.7%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	80.1%	79.7%	81.2%	83.4%	85.1%	84.4%
Prevent	Improving Care	Well Led	AD	>=80%	92.3%	92.4%	93.4%	93.7%	91.3%	90.9%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.9%	94.2%	94.2%	93.4%	92.0%	91.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.2%	91.2%	91.4%	90.9%	88.9%	88.0%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

CAMHS										
Month	Objective	CQC Domain	Owner	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.6%	2.8%	2.7%	2.8%	2.9%	2.8%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.6%	2.7%	2.6%	3.1%	3.0%	2.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	74.8%	72.2%	81.6%	82.1%	82.6%	81.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	71.3%	71.4%	67.7%	69.3%	70.5%	69.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.5%	95.0%	95.0%	92.0%	87.4%	87.2%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	95.5%	96.5%	96.8%	96.6%	95.0%	95.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.2%	79.8%	83.1%	81.6%	83.3%	84.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	20.0%	20.0%	33.3%	33.3%	25.0%	25.0%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				38.7%	37.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	93.6%	93.9%	93.6%	91.6%	91.8%	91.8%
Information Governance	Resources	Well Led	AD	>=95%	95.5%	94.9%	91.7%	91.6%	88.1%	89.0%
Moving and Handling	Resources	Well Led	AD	>=80%	98.4%	98.7%	98.7%	98.1%	98.7%	99.1%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					N/A
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	83.7%	84.0%	81.4%	81.2%	82.8%	81.6%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	81.2%	81.0%	79.1%	79.3%	81.0%	81.2%
Prevent	Improving Care	Well Led	AD	>=80%	93.5%	94.1%	94.8%	93.9%	93.5%	94.5%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	91.7%	92.6%	94.2%	94.4%	93.9%	94.0%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	93.0%	94.2%	95.5%	94.4%	92.7%	92.4%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	2.6%	3.0%	3.0%	3.1%	3.3%	3.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	2.6%	2.8%	3.1%	3.6%	3.4%	4.0%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	89.9%	86.5%	94.2%	92.0%	90.1%	90.1%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	93.1%	83.3%	83.3%	75.9%	72.4%	72.4%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	100%	100%	100%	100%	100%	100%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	89.3%	89.9%	88.2%	89.3%	89.5%	89.5%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.9%	84.2%	85.3%	83.8%	87.7%	87.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	99.3%	98.5%	98.5%	97.0%	95.5%	95.5%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				34.4%	34.4%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	90.3%	91.1%	89.4%	87.2%	85.0%	85.0%
Information Governance	Resources	Well Led	AD	>=95%	96.1%	96.0%	95.2%	93.0%	93.4%	93.4%
Moving and Handling	Resources	Well Led	AD	>=80%	99.2%	99.3%	98.9%	99.5%	99.6%	99.6%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					N/A
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	98.2%	98.2%	97.7%	97.2%	98.2%	98.2%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	68.2%	78.3%	72.7%	76.2%	85.0%	85.0%
Prevent	Improving Care	Well Led	AD	>=80%	98.7%	97.2%	97.2%	97.5%	98.2%	98.2%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.4%	97.5%	97.1%	96.3%	95.4%	95.4%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	96.9%	97.6%	97.0%	96.6%	96.4%	96.4%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	3.4%	4.1%	3.6%	3.5%	3.6%	3.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	3.4%	3.7%	3.8%	3.3%	3.7%	3.7%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.8%	84.1%	86.8%	86.7%	86.1%	86.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.5%	75.6%	69.9%	69.8%	66.1%	67.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	94.0%	93.6%	93.6%	93.1%	93.1%	94.0%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	96.9%	96.4%	96.2%	95.9%	76.6%	95.9%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.7%	85.6%	88.2%	86.6%	84.2%	83.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	84.3%	84.2%	85.4%	86.6%	87.1%	85.9%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				42.0%	39.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	93.6%	94.4%	91.9%	92.5%	90.2%	89.7%
Information Governance	Resources	Well Led	AD	>=95%	98.0%	95.9%	95.2%	94.3%	92.3%	92.6%
Moving and Handling	Resources	Well Led	AD	>=80%	93.9%	93.6%	95.7%	95.6%	94.6%	94.4%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					52.9%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	89.8%	89.5%	84.4%	84.5%	82.6%	81.9%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.0%	86.1%	80.6%	81.0%	82.3%	80.6%
Prevent	Improving Care	Well Led	AD	>=80%	95.9%	95.4%	95.9%	95.6%	95.3%	95.1%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.6%	95.1%	95.9%	94.8%	93.5%	93.3%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.4%	91.1%	90.1%	89.7%	89.2%	89.0%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Inpatient Service										
Month	**Objective**	**CQC Domain**	**Owner**	**Threshold**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	6.4%	7.5%	7.0%	7.6%	7.7%	7.7%
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	6.4%	7.0%	7.4%	8.6%	8.2%	7.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.3%	79.2%	84.0%	85.0%	77.5%	79.4%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	78.2%	77.1%	77.3%	77.8%	72.6%	72.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	90.4%	89.7%	92.1%	91.7%	92.1%	89.5%
Display Screen Equipment	Resources	Well Led	AD	>=80%	Reporting to commence in November 2021					
Equality and Diversity	Resources	Well Led	AD	>=80%	97.8%	97.8%	97.0%	95.9%	94.9%	93.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.5%	82.0%	82.4%	81.0%	88.3%	87.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.3%	79.0%	79.3%	79.4%	84.6%	86.3%
Freedom to Speak Up (FTSU)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in August 2021				41.2%	39.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.0%	94.9%	92.5%	90.9%	90.7%	90.1%
Information Governance	Resources	Well Led	AD	>=95%	96.7%	95.8%	94.6%	92.3%	86.7%	85.7%
Moving and Handling	Resources	Well Led	AD	>=80%	98.3%	98.6%	97.6%	97.5%	98.0%	97.2%
National Early Warning Score 2 (NEWS2)	Health & Wellbeing	Well Led	AD	>=80%	Reporting commenced in September 2021					50.4%
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	88.3%	87.1%	87.1%	88.2%	87.8%	86.1%
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.4%	83.5%	83.3%	84.3%	85.1%	83.6%
Prevent	Improving Care	Well Led	AD	>=80%	95.3%	94.7%	94.6%	94.2%	94.9%	94.1%
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.0%	91.8%	91.0%	90.3%	90.3%	88.9%
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	87.4%	86.0%	87.3%	86.8%	87.0%	85.9%
Bank Cost	Resources	Well Led	AD		Data unavailable at the time of producing this report					
Agency Cost	Resources	Effective	AD							
Overtime Costs	Resources	Effective	AD							
Additional Hours Costs	Resources	Effective	AD							
Sickness Cost (Monthly)	Resources	Effective	AD							
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD							
Business Miles	Resources	Effective	AD							

Glossary

ACP	Advanced clinical practitioner
ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View
HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IBCF	Improved Better Care Fund
ICD10	International Statistical Classification of Diseases and Related Health Problems
ICO	Information Commissioner's Office
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
JAPS	Joint academic psychiatric seminar
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
MARAC	Multi Agency Risk Assessment Conference
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus Aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NK	North Kirklees
NMoC	New Models of Care
OOA	Out of Area
OPS	Older People's Services
ORCHA	Preparatory website (Organisation for the review of care and health applications) for health related applications
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
SRO	Senior Responsible Officer
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YHAHSN	Yorkshire and Humber Academic Health Science
YTD	Year to Date

KEY for dashboard Year End Forecast Position / RAG Ratings	
1	On-target to deliver actions within agreed timeframes.
2	Off trajectory but ability/confident can deliver actions within agreed time frames.
3	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
4	Actions/targets will not be delivered
	Action Complete

NB: The year end forecast position for the dashboards was reviewed in October 2019 and revised to align with the NHSI rating system.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26th October 2021
Agenda item 11.2

Title:	**H2 2021/22 Operational & Financial Planning Update**
Paper prepared by:	**Interim Director of Finance and Resources**
Purpose:	To provide the Trust Board with an headline update of the operational and financial planning process for H2 now the formal guidance has been issued. This touches on the early draft of the updated operational plan and the early financial plan position for H2. The bulk of the detail within the operational and financial plan remains within the Private Board section of the agenda, until such time this is finalised and agreed. The final operational and financial plan is scheduled to come back to the next Public Trust Board meeting once finalised and agreed.
Mission/values:	Use of resources. This links to our priority around improving resources. We achieve our financial plan and targets.
Any background papers/ previously considered by:	Previous operating and financial plan covering H1. Regular finance reports to the Trust Board. Financial Sustainability Plan. Linked to priority programmes and reset and recovery workstreams. Detailed review at the Finance, Investment and Performance Committee

Executive summary:	• The six areas set out in NHSE/I's priorities and operational planning for 2021/22 published in March 2021, remain the priorities for the second half of the financial year (H2):
	  ○ Supporting the health and wellbeing of staff and taking action on recruitment and retention.
	  ○ Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with Covid-19
	  ○ Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand for mental health services.
	  ○ Expanding primary care capacity to improve access, local health outcomes and address health inequalities.
	  ○ Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital of ED patients and reduce length of stay.
	  ○ Working collaboratively across systems to deliver on these priorities,
	• In addition, there will continue to be a focus on the five priority areas for talking health inequalities and delivering sustained progress against the ambition of the NHS long term plan.
	• From a finance perspective, the NHS will receive an extra £5.4bn to cover covid 19 costs in H2. This includes £1.5bn for elective recovery, of which £500m is capital.
	• We have had to feed into an early ICS submission by the 14th October, following discussion and support at EMT on the 13th October. This is

	acknowledging that this is prior to governance and formal sign off at FIPC and Trust Board. The final submission is the 16th November. NHS Mental health implementation plan 2019/20 - 2023/24 remains the foundation for the mental health response to Covid-19**.** Systems should continue to make use of the additional £500m funding made available at the start of 2021/22 and continue to deliver on the MHIS. The system should continue to focus on • Accelerate the recovery of face to face care in community mental health services • Reduce out of area placements, long length of stay and long waits in ED for mental health patients. • Continue to increase access to NHS funded children's and young people services • Advancing inequalities, including delivering the target for physical health checks • Delivering actions to enable whole pathway commissioning for provider collaboratives from April 22. • Ensuring digital capabilities are in place across services to drive interoperability and improvements in patient safety, supporting digitally enabled pathway redesign, and using digital services to improve access and personalisation of care is also encouraged. Financial Arrangements • The financial regime for H2 is continuing on in a similar block payment theme to H1 but adjusted for additional known pressures such as pay awards. • There is hard close at H1 so all providers will be able to carry forward their positions into H2 like any normal financial year. • The efficiency requirement is 0.82% for the 6 month period H2, with further reductions in covid and system top ups. • The Trusts initial plan for H2 project a surplus. No value is quoted at present, until such time that this is finalised. This is in addition to the H1 surplus of £2.3m. • At present, conversations are progressing both internally and externally across the wider ICS that means the position could be subject to further change. • Within the H2 positions, a substantial element of risks and mitigations have been factored in. The extent to which MHIS investment needs to be mobilised is significant and a sense of realism has been applied to recruitment timelines and non-recurrent spending plans. Looking ahead to 2022/23 Wider planning needs to cover how projected increases in demand will be met, addressing of inequalities and meeting all the commitments in the long term plan. • NHSE/I are looking at negotiating a 3 year settlement with Treasury re 22/23 – 24/25. This will help longer term planning across the ICS and support the delivery of capital investment within the CDEL control totals.

	• There has been no clarity about the longer-term planning and timetable for 22/23. This is unlikely to get much traction pre December as the outlined planning process for H2 runs until November 21.
Recommendation:	**It is recommended that the Trust Board DISCUSS and COMMENT on this report acknowledging more detail will be discussed in the Private Board and under item 5.2.**
Private session:	N/A

NHS
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Trust Board 26th October 2021
Agenda item 12.1

Title:	**Digital Strategy 2021-24 – Strategy Progress Report**
Paper prepared by:	Interim Director of Finance and Resources
Purpose:	To provide the Trust Board with an update on progress mid-year against the 2021/22 digital strategy milestones.
Mission/values:	"Integrate digital approaches to the way we work" is one of the priority programmes supporting delivery of our strategic objectives in pursuit of our mission. The 2021-24 Digital Strategy supports our values of being open, honest & transparent, and to be always improving
Any background papers/ previously considered by:	Digital Strategy 2021–24 presented to and approved by Board in March 2021.
Executive summary:	The purpose of this report is to inform the Board of the progress and developments made during the first part of 2021/22 in respect of the Digital Strategy milestones as of 30 September 2021. This report has been structured and reformatted in line with the revised 2021-24 Digital Strategy. To support the delivery of the digital strategy and achievement of these key objectives, which are for the benefit of the person, people, and communities at the centre, we have set out to achieve the following outcomes: - • Championing digital inclusion, digital equality, and thus ensuring that no-one is left behind. • Keeping our staff, service users and carers information safe. • Digital being integral throughout the organisational culture. • Adopting and learning from digital best-practices. • Developing a digital capable workforce that embraces flexible and adaptable work-life balance. • Designing services that are fit for today and ready for tomorrow whilst being in a state of readiness for the future. • Reduce duplication and waste in processes to optimise care delivery, ways of working and improve service user, carer, and staff experience. The 2021-24 digital strategy is fully in tune with our mission, vison, strategic objectives, and ambitions. To support the implementation of the 2021-24 digital strategy, the report summarises the progress made against the planned activities and digital priority programme milestones during the first half of the 2021/22 financial year. Below is a summary of the main notable achievements in this reporting period by domain.

Digital infrastructure

- The IT Team completed the annual review of the Trust's Microsoft licencing requirements to cover 2021/22 in June 2021, ahead of the renewal deadline.
- Accreditation of the Trust's Microsoft Office365 (@swyt.nhs.uk) email platform is nearing completion, with all pre-requisite activities now completed and awaiting confirmation of accreditation status achievement by NHS Digital.
- A paper was presented to EMT in June 2021 with approval granted to proceed with re-procurement activities regarding the future provision of the Trust's IT Services as the existing contract with Daisy expires on 31 October 2022. Invitations to tender are set to be issued in Q3 2021/22.
- A detailed programme of works preparing and mobilisation of planned 2021/22 capital expenditure focusing on the Trust's IT and network infrastructure remains on track, providing a reliable and good service ensuring network accessibility, resilience against unplanned outages and effective support for remote working.
- Cyber security: The annual phishing email exercise to gauge staff awareness, susceptibility, and understanding was conducted during July 2021 to determine if vigilance is improving. The subsequent findings highlighting the need for further guidance and communications to raise staff awareness, with an action plan being developed to further raise staff awareness.
- A project is underway to replace the Trust's current VPN and authentication service provided by Virgin Media which expires on 3 March 2022 and it is planned that this project will conclude at the end of December 2021.

Digital care records

- The deployment of SystmOne within the Breathe Service which transitioned from Barnsley Hospital NHS Foundation Trust to SWYPFT was completed on 1 July 2021 as planned.
- The Systems team are working in collaboration with Mental Health Services to explore options to support the development of electronic referral capabilities (for services to receive referrals electronically from primary care) from within SystmOne. The deployment of SystmOne for Forensic SPA and Barnsley Quit Services were completed during September 2021 as planned. The implementation of task management within SystmOne has commenced initially within CAMHS services following delay due to the pandemic.
- To further enhance the digital systems training offer, the Systems team are continuing to develop bespoke and tailored eLearning

	training packages. The Systems team are also evaluating options to support future smartcard requirements, considering both physical and virtual smartcard solutions, as well as reviewing new eObservations functionality available within SystmOne. • The Trust has successfully implemented Electronic Prescriptions and Medicines Administration (EPMA) in the following inpatient service areas: Ward 18, Ward19, Enfield Down, Lyndhurst and Poplars, and has been positively received by staff. The implementation of EPMA functionality in SystmOne is continuing across other remaining inpatient service ward areas, with this work being led by the Pharmacy Dept. **Digital information sharing** • The Trust are currently working with its integration solutions partner, Restart Consulting and with the Yorkshire & Humber Care Record (YHCR) team with regards to connecting the Trust's clinical portal solution "PORTIA" to the YHCR. This initial connectivity will provide the Trust with the ability to consume currently available YHCR datasets and it is planned for this initial development within SWYPFT to be completed by the end of September 2021. • The Trust are engaged with NHS Digital and NHSX to explore to the potential of adopting the eReferral Service (ERS, formerly Choose & Book) within Mental Health Services, and it is anticipated that this work will progress during Q3/Q4 2021/22. • Access to ICE: There are current operational challenges in gaining access to our acute partners instances of the ICE system for requesting/receiving order communications. Discussions with partners are ongoing and the Trust are evaluating the viable options to improve and address the operational challenges being experienced. • The Trust is continuing to deliver its Information Governance service effectively during these challenging times, applying appropriate governance and assurance mechanisms to fast-track decision-making to allow processes to be adapted, adhering to new and amended guidance. The next deadline for mandated annual information governance training is June 2022, a key component for maintaining Data Security & Protection Toolkit compliance. **Digital intelligence** • Work is continuing in line with the service re-design activities to support new ways of working in Barnsley Community Services, ensuring suitable reporting outputs are available, with additional work undertaken to support the Breathe service. • Team dashboards have been developed and rolled out across services. A recovery dashboard is currently in development with metrics identified to support the Trust's recovery and restoration

	workstream. Finally, a data quality dashboard is being developed to allow monitoring of progress against the Trust's data quality action plan during 2021/22. • Health inequalities reporting has been established with this tool being demonstrated at BDU governance meetings. • Development work completed to support the proposed CQUIN metrics for 2021/22, with some schemes on hold and expected to take effect from Q1 2022/23. • Additional reporting established to support new services such as Quit Barnsley, Kirklees CAMHS Mental Health Support teams, planning and development work required to support the Forensic Provider collaborative. • Preparations for H2 and 2022/23 are awaiting further national guidance. • A review of activity in preparation for operational planning requirements is underway. • Additional routine reporting has been established to support the pandemic response. • Development work is progressing and monitoring of the Trusts forecasting and demand tool and providing support to the restoration and recovery group. **Digitally enabled workforce** • Whilst significant progress has been made with regards to the migration of the Trust's Microsoft SharePoint 2010 sites to the Microsoft SharePoint365 environment, some SharePoint technical issues encountered resulted in delayed go-live due to the complexity of this work. Originally it was planned to go live by the end of March 2021 ahead of the 17 April 2021 deadline. However, these ongoing issues have delayed the go live further. Go live was successfully achieved on 24 August 2021. • The findings from the previously conducted time-limited pilot project have informed the development of a business case for a Trust-wide digital dictation solution. It is planned that the business case will be presented to EMT during October 2021 and once approved, a formal procurement exercise will be initiated. It is anticipated that the procurement will be completed in December 2021, with implementation and deployment of the preferred solution commencing from January 2022. • Initial work is underway by the IT Team to evaluate digital conferencing technologies that are adaptable and scalable for use across the organisation. It is planned to test out these capabilities via OMG in the first instance, which will help to inform a Trust-wide approach during Q3 2021/22. • Collaborative work is underway between Learning & Development, Estates & Facilities, and IM&T to review and improve the Trust's

digital training service offer and delivery capabilities. Guidance and support materials have been made available for educators, trainers, and facilitators in delivering sessions virtually. Learning & Development have reviewed all existing training materials that were previously delivered in classrooms and have converted those appropriate to delivery using Microsoft Teams and other digital solutions.

Digitally enabling service users & carers

- A proposal is being finalised to seek approval for the introduction of a digital personal health record solution (service user/patient portal) within the Trust that enables service users and carers, where appropriate, to gain access to elements of their electronic care record held by the Trust, via a secure digital platform.
- The Trust needs to consider its needs for video consultation solutions based on current usage and future requirements, to determine an appropriate and strategic way forward. MS Teams is funded via the Trust's licence agreement with Microsoft, whereas AccuRX is centrally funded through to 31 March 2022. There is an expectation that central funding for AccuRX will not continue beyond 31 March 2022.
- Whilst the Trust is actively engaging in wider system digital inclusion discussions at ICS and place level, there are several internal opportunities being explored, such as trialling the provision of a small number of tablets to service users via the EYUP Charity, exploring avenues to potentially donate redundant IT equipment being decommissioned by the Trust for re-usage within our communities and a development of a question set that aims to collect service user digital preferences at relevant points of contact, which are to be recorded within SystmOne.
- Work is ongoing with the Carers Lead Network to link in some carers to help review the existing promotional material to design a public facing leaflet about CHATpad (formerly virtual visitor) to promote across community and for the public to learn how/where to access it to use whilst their loved one is in our care. It is also planned to produce a Trust-wide survey for reset and recovery insight which will focus on digital, estates and working effectively.

Within Appendix A of this report are the detailed activities for all digital initiatives that are currently being implemented and progressed in support of the agreed 2020/21 Digital Strategy key domain milestones.

Financial Investment

To meet the priorities outlined in this report, a capital allocation of £2.415m has been made available during 2021/22 for digital developments and the report provides a summary of the year-to-date

	position against the capital allocation and associated expenditure against the digital schemes as of 30 September 2021. **Risk appetite** The provision of digitally enabled services is vital in enabling Trust staff to deliver safe care. As such the overall risk appetite is to be considered low with a target score of 1-6. Notable risks worth highlighting currently are: - • Cyber Security: The continued risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data. • Capacity & capability to deliver on all 2021/22 digital priorities: There is a dependency on limited available capacity with suitable project skills and experience within corporate support services to deliver against all 2021/22 digital priorities. • Ever-increasing demand and reliance upon digital technologies and solutions: Ability to continue to meet expectations brought about by significantly heightened digital needs and dependencies will require careful balancing of resources and management of expectations. As this report hopefully demonstrates, good general progress is being made against 2021/22 priorities, especially considering the focus that the pandemic and recovery continues to present. The reported position has been rated as GREEN overall.
Recommendation:	**Trust Board is asked to NOTE the achievements made to date in respect of the 2021/22 milestones.** The Board and other stakeholders will be kept informed of all current and future Digital Strategy developments on a regular basis.
Private session:	Not applicable.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Digital Strategy 2021-24

Strategy Progress Report

Assistant Director of IT Services & Systems Development

September 2021

With **all of us** in mind.

www.southwestyorkshire.nhs.uk

Table of Contents

Purpose of report

The purpose of this report is to inform the Board of the progress and developments made during the first half of 2021/22 in respect of the Trust's 2021-24 digital strategy and how the digital agenda continues to support the Trust's response to the coronavirus pandemic and recovery.

Introduction

This report focuses on the progress made during the first half of 2021/22 regarding the digital priority areas which support delivery against the aims and objectives of the 2021-24 digital strategy.

As this is the initial report focusing on the 2021-24 digital strategy priorities, there are several new and emerging themes, as well as ongoing programmes of work carried forward from the preceding digital strategy. All initiatives have been incorporated into the milestone delivery plan supporting the implementation of the digital strategy.

The 2021-24 digital strategy is fully in tune with our mission, vison, strategic objectives, and ambitions. To support the implementation and of the 2021-24 digital strategy, the six digital domains have been mapped against the Trust's priorities as shown in the matrix below.

Digital Domains	Improve health	Improve care	Improve resources	Make this a great place to work
Digital Infrastructure			❖	❖
Digital Care Records		❖	❖	❖
Digital Information Sharing		❖	❖	❖
Digital Intelligence	❖	❖	❖	❖
Digitally Enabled Workforce		❖	❖	❖
Digitally Enabling Services Users & Carers	❖	❖		

Summary of progress against the 2021-22 digital schemes (September 2021 position)

This report summarises the progress made against the planned activities and digital priority programme milestones during the first half of the 2021/22 financial year. Below is a summary of the main notable achievements in this reporting period by domain.

Digital Infrastructure	Supports the following Trust Priorities			
			Improve resources	Make this a great place to work
Ensuring that the Trust has a strategically aligned, resilient and robust digital infrastructure (network/end user computing hardware and software) that guarantees end user accessibility, with enhanced business continuity, disaster recovery measures and safeguards against potential cyber security threats, aiding organisational assurance. This domain provides the foundations from which all other digital domains are built upon.				

Key achievements and notable updates

Microsoft licencing review: The IT Team conducted the annual review of the Trust's Microsoft licencing requirements to cover 2021/22 in June 2021, ahead of the 1 July 2021 renewal deadline. This supports making best use of resources, ensuring cost avoidance, and maintaining effective risk management.

Email accreditation: Accreditation of the Trust's Microsoft Office365 (@swyt.nhs.uk) email platform is nearing completion, with all pre-requisite activities now completed and awaiting confirmation of accreditation status achievement by NHS Digital. This initiative also supports making best use of resources.

IT Services re-procurement: A paper was presented to EMT in June 2021 seeking approval to proceed with re-procurement activities regarding the future provision of the Trust's IT Services as the existing contract with Daisy expires on 31 October 2022. The development of the detailed specification of requirements for future IT Services provision will be completed during September 2021, which incorporated a brief staff survey which gave the opportunity to provide feedback to inform the specification. Invitations to tender are set to be issued in Q3 2021/22.

Infrastructure modernisation: Detailed programme planning, and mobilisation of planned 2021/22 capital expenditure focusing on the Trust's IT and network infrastructure remains on track, concentrating on server and network hardware replacements and cyber security enhancements predominantly, providing a reliable and good service ensuring network accessibility, resilience against unplanned outages and effective support for remote working.

Cyber security: The annual phishing email exercise to gauge staff awareness, susceptibility, and understanding was conducted during July 2021 to determine if vigilance is improving. This was due to be scheduled during 2020/21 but delayed due to the pandemic. The subsequent findings highlighting the need for further guidance and communications to raise staff awareness. An action plan is being developed to further raise awareness to ensure staff know what they should (and should not) do if they receive potentially malicious email correspondences, benefitting staff both in the workplace and in their personal lives.

VPN solution replacement: A project is underway to replace the Trust's current VPN and authentication service provided by Virgin Media which expires on 3 March 2022, with the Cisco AnyConnect VPN solution making use of authentication software that forms part of the Trust's Microsoft licensing agreement. It is planned that this project will conclude at the end of December 2021.

Digital Care Records	Supports the following Trust Priorities			
		Improve care	Improve resources	Make this a great place to work
Digital care record information systems are the cornerstone of the Trust's digital capabilities which support clinical and operational front-line services in providing high quality care and service provision. Digital care records provide the basis from which to support business intelligence and data analytics, interoperability in the exchange of information and electronic messaging capabilities. This domain focuses on the creation of a comprehensive digital care record and the eradication of paper records where possible.				

Key achievements and notable updates

Physical health services SystmOne developments: The deployment of SystmOne within the Breathe Service which transitioned from Barnsley Hospital NHS Foundation Trust to SWYPFT was completed on 1 July 2021 as planned. This service forms part of the wider re-design of SystmOne as part of the integrated Neighbourhood Team Service.

Mental health services SystmOne developments: The Systems team are working in collaboration with Mental Health Services to explore options to support the development of electronic referral capabilities (for services to receive referrals electronically from primary care) from within SystmOne. The deployment of SystmOne for Forensic SPA and Barnsley Quit Services were completed during September 2021 as planned. The implementation of task management within SystmOne has commenced initially within CAMHS services following delay due to the pandemic.

Trust-wide SystmOne developments: To further enhance the digital systems training offer, the Systems team are continuing to develop bespoke and tailored eLearning training packages. The Systems team are also evaluating options to support future smartcard requirements, considering both physical and virtual smartcard solutions, as well as reviewing new eObservations functionality available within SystmOne.

Electronic prescriptions & medicines administration (EPMA): The Trust has successfully implemented EPMA in the following inpatient service areas: Ward 18, Ward19, Enfield Down, Lyndhurst and Poplars, and has been positively received by staff. The implementation of EPMA functionality in SystmOne is continuing across other remaining inpatient service ward areas, with this work being led by the Pharmacy Dept.

Digital Information Sharing	Supports the following Trust Priorities			
		Improve care	Improve resources	Make this a great place to work
There are numerous information systems both within the Trust and wider within our partner organisations across the geographic footprint that we serve, many of which function in isolation and where staff from different organisations cannot access, where there is a clear need to support direct care. This leads to staff having to adopt time-consuming activities to overcome these obstacles and has the potential to lead to clinical risk and patient safety concerns. This domain will focus on improving the ability to share and access information digitally, where is it clinically appropriate to do so and where there is a legitimate need.				

Key achievements and notable updates

Yorkshire & Humber Care Record (YHCR) onboarding: The Trust are currently working with its integration solutions partner, Restart Consulting and with the YHCR team with regards to connecting the Trust's clinical portal solution "PORTIA" to the YHCR. This initial connectivity will provide the Trust with the ability to consume currently available YHCR datasets and it is planned for this initial development within SWYPFT to be completed by the end of September 2021. The richness of the YHCR datasets will increase as more partner organisations onboard to the YHCR.

Electronic referrals: The Trust are engaged with NHS Digital and NHSX to explore to the potential of adopting the eReferral Service (ERS, formerly Choose & Book) within Mental Health Services, where it is considered applicable and appropriate. It is anticipated that this work will progress during Q3/Q4 2021/22.

Patient reminder system review: A review of the two existing systems in use which send service user's a text (SMS) message reminding of their forthcoming appointments is underway and a paper being produced recommending a way forward for the Trust to move towards a single Trust-wide platform to meet this need, during Q3/Q4 2021/22.

Access to ICE: There are current operational challenges in gaining access to our acute partners instances of the ICE system for requesting/receiving order communications. Discussions with partners are ongoing and the Trust are evaluating the viable options to improve and address the operational challenges being experienced.

Information Governance: The Trust is continuing to deliver its Information Governance service during these challenging times, applying appropriate governance and assurance mechanisms to fast-track decision-making to allow processes to be adapted and adherence to new and amended guidance, and reviewing the effectiveness of previous decisions, via the Improving Clinical Information Group (ICIG). The next deadline for mandated annual information governance training is June 2022, a key component for maintaining Data Security & Protection Toolkit compliance.

Digital Intelligence	Supports the following Trust Priorities
	   
The use of business intelligence tools helps to deliver information in a more standardised and user-friendly way e.g. via dashboards. Such developments increase the use of forecasting, benchmarking, and statistical techniques to deliver information rather than data, whilst also supporting the delivery of care, improving data quality and accuracy. This domain arms the Trust with the capabilities from which to inform future service planning based on the ever-changing needs of the populations we serve, enabling continuous service improvements ensuring that we remain relevant for today and tomorrow.	

Key achievements and notable updates

Barnsley Neighbourhood Teams Service reporting: Work is continuing in line with the service re-design activities to support new ways of working in Barnsley Community Services, ensuring suitable reporting outputs are available, with additional work undertaken to support the Breathe service.

Dashboard developments: Team dashboards have been developed and rolled out across services. Further analysis to be undertaken on the Trust's benchmarking and Model Hospital data during Q3/Q4 2021/22. A recovery dashboard is currently in development with metrics identified to support the Trust's recovery and restoration workstream. Finally, a data quality dashboard is being developed to allow monitoring of progress against the Trust's data quality action plan during 2021/22.

Health inequalities: Health inequalities reporting has been established with this tool being demonstrated at BDU governance meetings.

CQUIN developments: Development work completed to support the proposed CQUIN metrics for 2021/22, with some schemes on hold and expected to take effect from Q1 2022/23.

Business as Usual (BAU) reporting: Additional reporting established to support new services such as Quit Barnsley, Kirklees CAMHS Mental Health Support teams, planning and development work required to support the Forensic Provider collaborative.

National guidance implementation: Preparations for H2 and 2022/23 are awaiting further national guidance.

Annual planning requirements: A review of activity in preparation for operational planning requirements is underway.

COVID-19 response: Additional routine reporting has been established to support the pandemic response.

Health Intelligence: Development work is progressing and monitoring of the Trusts forecasting and demand tool and providing support to the restoration and recovery group.

Digitally Enabled Workforce	Supports the following Trust Priorities			
		Improve care	Improve resources	Make this a great place to work
Equipping Trust staff with the requisite digital skills is critical in the full utilisation of digital technologies, systems, and information. By improving such capabilities, all staff are provided with the appropriate digital skills to use current and future digital solutions in line with the changing demands of the organisation and the services we provide. This domain focusses on the Trust's workforce becoming digitally excellent, to be fully conversant, competent, capable, and confident in their use of digital solutions.				

Key achievements and notable updates

Microsoft SharePoint migration: Whilst significant progress has been made with regards to the migration of the Trust's Microsoft SharePoint 2010 sites to the Microsoft SharePoint365 environment, some SharePoint technical issues encountered resulted in delayed go-live due to the complexity of this work. Originally it was planned to go live by the end of March 2021 ahead of the 17 April 2021 deadline. However, these ongoing issues have delayed the go live further. Go live was successfully achieved on 24 August 2021. Some remaining residual activities are in progress ahead of closure during October 2021.

Trust-wide Digital Dictation solution: The findings from the previously conducted time-limited pilot project have informed the development of a business case for a Trust-wide digital dictation solution. It is planned that the business case will be presented to EMT during October 2021 and once approved, a formal procurement exercise will be initiated. It is anticipated that the procurement will be completed in December 2021, with implementation and deployment of the preferred solution commencing from January 2022.

Digital conferencing capabilities: Initial work is underway by the IT Team to evaluate digital conferencing technologies that are adaptable and scalable for use across the organisation. It is planned to test out these capabilities via OMG in the first instance, which will help to inform a Trust-wide approach during Q3 2021/22.

Digital Education, Training & Development: Collaborative work is underway between Learning & Development, Estates & Facilities, and IM&T to review and improve the Trust's digital training service offer and delivery capabilities. Guidance and support materials have been made available for educators, trainers, and facilitators in delivering sessions virtually. Learning & Development have reviewed all existing training materials that were previously delivered in classrooms and have converted those appropriate to delivery using Microsoft Teams and other digital solutions.

Digitally Enabling Services Users & Carers	Supports the following Trust Priorities			
	Improve health	Improve care		
To provide our service users and carers with access to services and care that has digital embedded within the service offer that is more in keeping with how they prefer to engage with other services digitally in everyday life. This domain will also be concerned with championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve.				

Key achievements and notable updates

Digital personal health record: A proposal is being finalised to seek approval for the introduction of a digital personal health record solution (service user/patient portal) within the Trust that enables service users and carers, where appropriate, to gain access to elements of their electronic care record held by the Trust, via a secure digital platform.

Video consultation review: The Trust needs to consider its needs for video consultation solutions based on current usage and future requirements, to determine an appropriate and strategic way forward. MS Teams is funded via the Trust's licence agreement with Microsoft, whereas AccuRX is centrally funded through to 31 March 2022. There is an expectation that central funding for AccuRX will not continue beyond 31 March 2022.

Digital inclusion: Whilst the Trust is actively engaging in wider system digital inclusion discussions at ICS and place level, there are several internal opportunities being explored, such as trialling the provision of a small number of tablets to service users via the EYUP Charity, exploring avenues to potentially donate redundant IT equipment being decommissioned by the Trust for re-usage within our communities and a development of a question set that aims to collect service user digital preferences at relevant points of contact, which are to be recorded within SystmOne.

CHATpad (Virtual Visitor): These devices have now been returned to wards with new promotional materials to display and a file with guidance inside for staff use. Work is ongoing with the Carers Lead Network to link in some carers to help review the existing promotional material to design a public facing leaflet about CHATpad to promote across community and for the public to learn how/where to access it to use whilst their loved one is in our care. It is also planned to produce a Trust-wide survey for reset and recovery insight which will focus on digital, estates and working effectively.

Key risks

The provision of digitally enabled services remains vital in enabling Trust staff to deliver safe care. Whilst the progress set out in this report continues to reduce the likelihood of risk associated with digital system failure, the highlighted key risks summarised below require sustained focus and advancement of remedial controls and measures. As such the overall risk appetite is to be considered low with a target score of 1-6.

Risk	Summary	Actions, controls, and measures
Cyber Security (ORR 1080)	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Continuation of persistent infrastructure modernisation spanning disaster recovery, network resilience and applicable/systems availability. This work incorporates cyber security enhancements that establish further controls, measures and safeguards that reduce the risk and likelihood associated with the threat of cyber-attacks.
Microsoft SharePoint migration	There remains a risk that the Trust's dependency on the existing Microsoft SharePoint environments may severely impact Trust business due to the current platform going out of support in April 2021. This is being actively monitored with remediation plans established to address this situation.	Whilst subject to delays, the migration to the SharePoint365 environment has now been completed as of 24 August 2021. This has remediated the impact to Trust business and further residual work ongoing will now enable decommissioning of the legacy SharePoint 2010 platform.
Capacity & capability to deliver on all 2021/22 digital priorities	Dependency on limited available capacity with suitable project resources within corporate support services to delivery against all 2021/22 digital priorities.	Exploration of options to expand scarce project resources available to the Trust, such as graduate schemes, apprenticeships, and internal development opportunities.
Ever-increasing demand and reliance upon digital technologies and solutions	Ability to continue to meet expectations brought about by significantly heightened digital needs and dependencies will require careful balancing of resources and management of expectations.	Careful management of expectations through robust communications and engagement planning, together with horizon scanning to exploit opportunities to source and secure external funding to support digital organizational aspirations.

Overall RAG rating

The information included in this update report clearly articulates the breadth and scale of the 2021/22 digital initiatives and the work conducted/completed to date. A considerable amount of time has been afforded in the planning of activities which has taken account of the annual planning cycles. This means timescales for delivery of the initiatives in this document remain realistic and achievable, subject to allocated/available resources and wider system pressures. Any associated risks are managed with mitigating actions put in place where necessary. As this report hopefully demonstrates, good general progress is being made against 2021/22 priorities, especially considering the sustained focus that the pandemic and recovery continues to present, which is a great achievement when balanced with responding to additional ad-hoc urgent and unplanned work. The reported position has been rated as **GREEN** overall.

The Board is asked to note this progress to date and will continue to be updated twice a year in respect of progress against the 2021-24 Digital Strategy, with the next update to be provided in April 2022.

Digital Strategy 2021-24 Dashboard (September 2021 Position)

SEPTEMBER 2021 POSITION	RAG Status	Progress Indicator	Key supporting comments by exception
DIGITAL INFRASTRUCTURE			
Microsoft Licence Trust Wide Agreement Review	C	✓	Completed in June 2021 as planned
Email Platform Accreditation	A	↗	Awaiting confirmation of accreditation award from NHS Digital
NHSMail Account Decommissioning	P	→	Dependency upon email platform accreditation being completed
IT Services Contract Re-procurement	G	↗	
Infrastructure Modernisation	G	↗	
Cyber Security & Threat Monitoring	G	↗	
Microsoft Office365 Development Roadmap	G	↗	
Telephony Services Review & Contract Re-procurement	P	→	
Wide Area Network (WAN) Data Connections Review & Contract Re-procurement	P	→	
DIGITAL CARE RECORDS			
Clinical Records System (CRS)	G	↗	
Electronic Prescribing & Medicines Administration (EPMA) Deployment	G	↗	
Mental Health Annual Physical Health Check & ECG devices	P	↗	Subject to NHSE/I approval and funding award from which to progress this opportunity
DIGITAL INFORMATION SHARING			
Yorkshire & Humber Care Record Onboarding	G	↗	
Electronic Referrals	G	↗	
Patient Reminder Systems Review	G	↗	
Access to ICE	G	↗	Additional focused work in response to clinical/operational issues being encountered
Information Goverance	G	↗	Includes Data Security & Protection Toolkit standards & compliance
National Data Opt-Out	P	→	
DIGITAL INTELLIGENCE			
Business Intelligence	G	↗	
Performance Management & Reporting	G	↗	
DIGITALLY ENABLED WORKFORCE			
Microsoft SharePoint Migration	R	↗	Technical issues resulted in delayed go-live which was achieved on 24/8/2021
Microsoft SharePoint365 Developments	G	↗	
Digital Dictation	A	↗	It is planned that the business case will be presented to EMT during October 2021.
Digital Conferencing	G	↗	
Digital Education, Training & Development	G	↗	
DIGITALLY ENABLING SERVICE USERS & CARERS			
Digital Personal Held Care Record (Service User/ Patient Portal) Development	G	↗	
Video Consultation/Conferencing Solution Review	G	↗	
Digital Inclusion	G	↗	
CHATpad (Virtual Visitor)	G	↗	
Collecting and Reporting Health Outcomes	P	↗	

Dashboard Key

C	Completed	G	On track	A	Off track but in control	R	Off track major issues impacting overall viability	P	Planned for the future
↗	Improving position	→	No progress	↘	Deteriorating position	✓	Completed activities		

Financial Investment

To meet the priorities outlined in this report, a capital allocation of £2.415m has been made available during 2021/22 for digital developments. The table below provides a summary of the year-to-date position against the capital allocation and associated expenditure against the digital schemes as of 30 September 2021.

Scheme		21/22 (£k)			Comments
		Allocation	Expenditure	Variance	
Digital Infrastructure	Server replacements and enhancements	150	76	74	
	Network hardware replacements and enhancements	200	36	164	
	Cyber Security	250	0	250	
	Microsoft Office 365	100	5	95	
Digital Care Records	SystmOne enhancements	50	0	50	
	EPMA	75	0	75	
Digital Information Sharing	Y&H Care Record	100	0	100	
	Place-based digital information sharing	200	0	200	
Digital Intelligence	Business Intelligence enhancements	50	19	31	
Digitally Enabled Workforce	SharePoint365 developments	100	30	70	
	Digital Training	100	0	100	
	Digital Dictation	450	0	450	
	Robotic Process Automation opportunities	75	0	75	
Digitally Enabling Service Users & Carers	Patient held record	150	0	150	
	Website enhancements	15	0	15	
	Artificial Intelligence & Assistive/Self Care technology opportunities	150	0	150	
IM&T Contingency	IM&T Contingency	200	0	200	
Overall Capital Total		**2,415**	**166**	**2,249**	

Appendix A – Digital Initiative Profiles

Digital Infrastructure

Title	**Microsoft Licence Trust Wide Agreement Review**					*Status*	*Progress Indicator*
Lead	C Crocker	*Start Date*	01/04/2021	*End Date*	30/06/2021	C	✓
Purpose	To review and re-provision the Trust's requirements for future Microsoft products based on usage, exploring the most appropriate and cost-effective strategic way forward for continued access to Microsoft products as used by the Trust. Whilst Microsoft licence costs have increased in real terms during 2020, the new NHS-wide agreement for Microsoft Office365 (N365) has reduced the Trust's direct annual costs associated with Microsoft licence arrangements.						
Achieved Outcomes	• Ensures that the Trust is appropriately licenced for Microsoft products based on the needs of the organisation.						

Key Milestones		*Completion Dates*	
Activity	*Summary*	*Target*	*Actual*
Microsoft licencing review	To conduct a review of the Trust's licencing requirements to cover 2021/22. The renewal date is 1 July 2021.	Jun 2021	Jun 2021

Key Risks	*Likelihood*	*Impact*	*Risk Score*	*Actions & Controls*

Title	**Email Platform Accreditation**					*Status*	*Progress Indicator*
Lead	R Tyas	*Start Date*	01/01/2021	*End Date*	31/08/2021	A	↗
Purpose	To oversee accreditation and compliance with NHS Digital's advanced security protocols meaning that emails can then be sent and received containing sensitive/confidential information using the Trust's Microsoft Office365 email platform.						
Expected Outcomes	• Once accreditation has been confirmed, allows staff to use their Trust's Microsoft Office365 email accounts to send and receive emails containing sensitive and confidential information. The sending of sensitive and confidential information via this means to external 3rd parties requires the organisation in question to confirm that their email platform complies with the requirement of DCB 1596 Secure Email Standards and Transport Layer Security (TLS) encryption. • Removes the need for Trust staff to use multiple email platforms for Trust business purposes. Please note that there will be a requirement for a small number of Trust staff to retain their NHSMail email accounts for specific external correspondence purposes. • Commence the decommissioning of existing NHSMail (NHS.Net) email accounts in use across the Trust.						

Key Milestones		*Completion Dates*	
Activity	*Summary*	*Target*	*Actual*
Email Penetration Test	Undertake an NHS Digital commissioned penetration test and complete any actions necessary to satisfy the accreditation process.	Aug 2021	Aug 2021
Email platform compliancy	The Trust's Microsoft Office365 email environment complies with the NHS Digital standards. Confirmation of accreditation achievement awaited from NHS Digital.	Sep 2021	

Key Risks	*Likelihood*	*Impact*	*Risk Score*	*Actions & Controls*

Dependency upon external NHS Digital accreditation processes & timescales	3	2	**6**	• Ensure Trust responsibilities are completed in a timely manner. • Ensure continuous dialogue with NHS Digital regarding progress and timelines.

Title	**NHSMail Account Decommissioning**					***Status***	***Progress Indicator***
Lead	R Tyas	***Start Date***	01/10/2021	***End Date***	31/03/2022	**P**	➔
Purpose	To oversee the decommissioning of existing Trust staff's NHSmail (NHS.Net) email accounts following accreditation of the Trust's Microsoft Office 365 email environment.						
Expected Outcomes	• Accreditation of the Trust's Microsoft Office365 email platform enables the Trust to commence the decommissioning of existing NHSMail (NHS.Net) email accounts in use across the Trust.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Staff Communications	Development of a communications plan and guidance materials for staff co-ordinated by a time-limited working group.	TBD	
NHSMail Account Decommissioning	The new Microsoft Office365 email platform has been built to comply with the NHS Digital standards, therefore once NHS Digital accreditation has been achieved, the need for operating a mixed economy of email accounts (@swyt.nhs.uk for corporate business and NHS mail @nhs.net for personally identifiable information transmission) will no longer be required.	TBD	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***
Staff do not adhere with communications and guidance related to NHSmail account decommissioning	3	4	12	• Ensure communications plan is timely, effective and provides clear & concise messages and guidance to staff during the period of transition and decommissioning.
Activities have some dependency upon NHS Digital processes & timescales to complete this work	3	2	**6**	• Ensure Trust responsibilities are completed in a timely manner. • Ensure continuous dialogue with NHS Digital regarding progress and timelines.

Title	**IT Services Contract Re-procurement**					***Status***	***Progress Indicator***
Lead	Paul Foster	***Start Date***	01/04/2021	***End Date***	31/12/2022	**G**	➚
Purpose	To oversee the future provision of IT Services and the need to undertake a re-procurement exercise during 2021/22 to afford the necessary time to complete potential service transition activities ahead of the expiry of the existing contract with the incumbent IT Service provider, Daisy Corporate Services Trading Limited ("Daisy"), which ends on 31 October 2022.						
Expected Outcomes	• Ensure continuity of IT Service provision to support the business requirements and operational needs of the Trust.						

	• To ensure as seamless and smooth transition of IT Services provision during a period of significant change and upheaval. • Ensure that the Trust has a robust and fit for purpose contract for the provision of IT Services which meets the needs of the organisation now and in the future. • Ensure compliance with robust procurement/commercial requirements, whilst demonstrating best value.

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Proposal seeking approval to proceed to tender	Paper to be presented to EMT to gain approval to proceed with re-procurement activities.	Jun 2021	Jun 2021
Development of the detailed specification of requirements	Development of the detailed service specification and associated tender documents to form the Invitation to Tender (ITT).	Oct 2021	
Formal procurement	Invitation to Tender issuance, prospective supplier engagement & clarification questions (including due diligence).	Dec 2021	
Procurement evaluation	Tender responses, clarification & evaluation (Evaluation paper to EMT/Trust Board).	Jan 2022	
Preferred supplier contract negotiations & contract award	Preferred supplier confirmed and contract negotiations (including further due diligence).	Mar 2022	
IT Service Transition	IT Service Transition to enable live service re-provision from 1 November 2022 (covering IT Service Transition project mobilisation, new IT Service provider service on-boarding and incumbent IT Service provider exit management). Depending on the outcome, it may be prudent to adopt a phased approach to transition of services as suspect some elements of the service may remain with the incumbent supplier for a defined period beyond go-live in other areas, where beneficial to the Trust and to mitigate any potential risks to services.	Dec 2022	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Title	**Infrastructure Modernisation**					***Status***	***Progress Indicator***
Lead	Chris Crocker	***Start Date***	01/04/2021	***End Date***	31/03/2022	G	↗
Purpose	Continuous programme of replacement, modernisation, and enhancement of the Trust's IT infrastructure. The purpose being to ensure the Trust has a strategic, robust, and secure IT environment which is maintained, providing the necessary assurances of business resilience and disaster recovery capabilities to support the digital footprint now and in the future.						
Expected Outcomes	• Improved resilience by removing single points of failure and introducing development potential, thus providing the Trust with the ability to easily switch from one data centre to another in the event of a disaster (e.g., from Fieldhead to Kendray). • A more readily scalable infrastructure that can flex to meet changing demands. • No requirement for major short-term investment in event of a disaster. • Introduction of enhanced software monitoring, which would in turn enable better management of Microsoft licences (potentially reducing costs). • Proven disaster recovery position with confirmed recovery points and associated timelines.						

	• Enhanced cyber security position would bring about improved resilience and greatly reduce the risk from cyber-attack, malicious or otherwise.

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Digital Infrastructure Capital Programme	Detailed programme planning, and mobilisation of planned 2021/22 capital expenditure focusing on: - ▪ Server and network hardware enhancements and replacements. ▪ Cyber security infrastructure enhancements. ▪ Microsoft Office365 environment enhancements. ▪ Review of local area network (LAN) and wide area network (WAN) connectivity requirements to support recovery planning.	Mar 2022	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Cyber Security & Threat Monitoring					Status	Progress Indicator
Lead	C Crocker	Start Date	01/04/2021	End Date	31/03/2022	G	↗
Purpose	Given that the threat of a cyber-attack remains constant, the Trust continues to take such threats extremely seriously and has established several steps to safeguard against the likelihood, impact, and considers cyber security in all aspects of the digital agenda.						
Expected Outcomes	• Continued vigilance and awareness of the threat of cyber-attack. • Pro-active monitoring of hardware/software solutions to counter the potential of cyber threats. • Adoption of industry standard best practices, as appropriate. • Improve the defences against a cyber-attack.						

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Cyber security survey	An annual Phishing survey to further gauge staff awareness, understanding and determine if vigilance is improving. This was due to be scheduled during 2020/21 but was delayed due to the volume of communications relating to the pandemic. This has been rescheduled and was undertaken during Q2 2021/22, with findings highlighting the need for further guidance and communications to raise staff awareness.	Sep 2021	Aug 2021
Cyber security survey findings action plan	To develop and deliver a programme of guidance and communications to set out how to identify a phishing email, and what staff should (and should not) do if they receive them.	Dec 2021	
Cyber Essentials Plus accreditation compliance	Annual review of the Trust's cyber security measures and controls to ensure continued accreditation compliance.	Dec 2021	
Cyber tabletop exercise	Annual cyber security tabletop exercise to be scheduled early 2022 in line with the cyber programme.	Jan 2022	
Penetration testing	The Trust undertakes an independent annual infrastructure, server, and client penetration (PEN) test to ensure and provide further assurances that the services being provided are being proactively managed.	Feb 2022	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Microsoft Office365 Development Roadmap					Status	Progress Indicator
Lead	C Crocker	Start Date	01/04/2021	End Date	31/03/2022	G	↗
Purpose	To ensure that the Trust make optimal use of existing and future Microsoft products available via the Trust's enterprise-wide agreement with Microsoft.						
Achieved Outcomes	• Ensuring that the Trust makes best use of the available Microsoft products and functionality, in the most appropriate and cost-effective strategic way forward to support the wider digital agenda.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
VPN Replacement	A project to replace the Trust's current VPN and authentication service provided by Virgin Media which expires on 03/03/2022, with the AnyConnect VPN solution included as part of the Trust's Microsoft licensing agreement.	Dec 2021	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Telephony Services Review & Contract Re-procurement					Status	Progress Indicator
Lead	M Maughan	Start Date	01/04/2021	End Date	31/06/2022	P	➔
Purpose	To ensure that the Trust has a resilient and robust desk telephony platform which is flexible and scalable in line with current and future business requirements.						
Expected Outcomes	• Ensures the Trust has a stable and resilient corporate telephony platform which is cost effective and makes best use of available resources.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Desk Telephony Services	To undertake a procurement exercise for the future provision of desk telephony services ahead of the expiry of the existing contract with Virgin Media Business.	TBD	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Wide Area Network (WAN) Data Connections Review & Contract Re-procurement					Status	Progress Indicator
Lead	R Tyas	Start Date	01/04/2021	End Date	31/06/2022	P	➔
Purpose	To ensure that the Trust has resilient and robust wide area network data connections that are suitably sized bandwidth which is flexible and scalable in line with current and future business requirements.						
Expected Outcomes	• Ensures the Trust has a stable and resilient corporate wide area network connections which is cost effective and makes best use of available resources.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual

WAN Data Connectivity	To undertake a procurement exercise for the future provision of WAN data connectivity services ahead of the expiry of the existing contract with Virgin Media Business.	Nov 2021	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Digital Care Records

Title	Clinical Records System (CRS)					Status	Progress Indicator
Lead	S Pidgeon L Maden	Start Date	01/04/2021	End Date	31/03/2022	G	↗
Purpose	SystmOne is the Trust's main electronic clinical record system spanning both mental health and physical health services. This programme of work ensures that the Trust continues to utilise SystmOne to its full potential, improving how services work both now and in the future, presenting opportunities and challenges faced by an ageing population with changing health needs, linked long-term conditions and those triggered by lifestyle choices. Supported through constantly adapting and enhancing integrated care pathways.						
Expected Outcomes	• SystmOne is used more consistently and effectively. • Processes and workflows that help staff and improve outcomes for our service users. • Supports the development of new integrated models of care. • Contribute to the drive towards digitisation of the NHS. • Ensures continuity of care with key clinical documentation re-designed to meet service needs and providing easier access to clinical information. • To ensure that all services are fully optimised in their usage of SystmOne.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Trust wide developments	▪ Evaluation of smartcard options spanning both physical and virtual smartcards solutions. ▪ Evaluation of new eObservations functionality available within SystmOne. ▪ Continued development of bespoke and tailored eLearning training packages.	Mar 2022	
Mental Health Service developments	▪ SystmOne record sharing review in line with COVID-19 legislation. ▪ Task management implementation with focus initially within CAMHS services. ▪ Deployment of SystmOne for Barnsley Quit Services (completed September 2021). ▪ Deployment of SystmOne for Forensic SPA Services (completed September 2021).	Mar 2022	
Physical Health Service developments	▪ Continued deployment of services within the integrated Neighbourhood Team Service. ▪ Deployment of SystmOne for Breathe Services (completed July 2021).	Mar 2022	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Electronic Prescribing & Medicines Administration (EPMA) Deployment					Status	Progress Indicator
Lead	K Dewhirst	**Start Date**	01/04/2021	**End Date**	31/03/2023	G	↗
Purpose	Electronic Prescribing and Administration of Medications (EPMA) is a key development which is designed to improve patient safety, efficiency in service delivery, quality of data and deliver financial benefits for the organisation. Essentially, it converts the traditional paper prescription and administration card into an electronic record accessible by an authorised user from any device with the requisite software. This approach is being taken by many trusts.						
Expected Outcomes	• Technologies developed and piloted will drive investment into the regions directly influencing the solutions that are available to clinicians and patients we serve. • Reduce risks associated with medicines administration. • This provides the opportunity for shared learning and development, for SWYPFT to provide systems leadership and work with partners to influence national changes required within the digital solution. • Improves the Trust's overall digital maturity.						

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
ePrescribing/EPMA Deployment into Inpatient Wards	▪ The Trust has successfully implemented EPMA in the following inpatient ward areas, W18, W19, Enfield Down, Lyndhurst and Poplars. ▪ Continued deployment of EPMA functionality within SystmOne across the Trust's Inpatient wards.	Mar 2022	
ePrescribing/EPMA Community Services Deployment	▪ Continued deployment of EPMA functionality within SystmOne across the Trust's Community Services.	Mar 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Recruitment & retention of staff within the EPMA project are resulting in capacity challenges impacting the ability to maintain the good progress made to date.	3	3	**9**	• Ensure options to recruit appropriate staff in as timelier manner as possible, whilst exploring and establishing additional resilience/continuity measures to enable the project to maintain progress.

Title	Mental Health Annual Physical Health Check & ECG devices					Status	Progress Indicator
Lead		**Start Date**		**End Date**		P	↗
Purpose	Through the NHS Long Term Plan, NHSE/I has committed to transforming provision of community mental health care for adults and older adults with severe mental illness (SMI) by delivering new and integrated models for primary and community mental health care. These models will include joint working and partnerships across primary, secondary care, local authorities, and voluntary and community services. This includes better integration of physical and mental health care and ensuring a total of 390,000 people with SMI will receive an annual physical health check (APHC) and follow-up care by 2023/24. Through this opportunity, the Trust submitted a bid for funding to support this initiative. We have a specific focus on supporting vulnerable people with SMI, (including BAME populations, older people, pregnant women, those with pre-existing long-term health conditions, and those with missed reviews),						

	recognising this could include homeless population. Physical health checks are vital and as a specialty it is a recognised area for improvement.
Expected Outcomes	• To improve our patient's life expectancy is a lot shorter due to multiple factors lifestyle and medications. • To ensure and demonstrate improvements and compliance with NICE/other physical health check guides. • To establish a robust outreach infrastructure which can be utilised and scaled up wider across the health & care system. • It would improve morbidity and mortality in our population with improved satisfaction. • By capturing this data remotely, face to face appointments can focus on other health requirements of the patient, considering the measurements saved onto the system. • Patients have responsibility and accountability for ensuring these measurements are recoded before their review • Data recorded can be updated on to their comprehensive care plan. This encourages partnership working with the patients registered GP and the MH team.

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Refine & finalise the bid previously submitted	The Trust are engaged with NHSE/I and the preferred annual physical health check device solution provider to refine and finalise the bid in terms of financial support and considerations.	Oct 2021	
Mobilise the project to implement and deploy this capability (subject to NHSE/I approval & funding award)	▪ Recruit/secure the necessary project resources to facilitate and support this project. ▪ Order the requisite APHC devices directly from the preferred supplier and obtain requisite ECG devices from NHSE/I.	Nov/Dec 2021	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***
Project resource capacity & capability to deliver this digital opportunity	3	3	**9**	• Ensure options to recruit/secure appropriate staff in as timelier manner as possible, whilst exploring and establishing additional resilience/continuity measures to enable the project to maintain progress. Including exploring option of securing additional digital graduates.
Operational service capacity & capability resourcing issues impacting the ability to progress this digital initiative	3	3	**9**	• Ensure project timelines consider and take account of the pressures currently faced by operational services.

Digital Information Sharing

Title	**Yorkshire & Humber Care Record Onboarding (Clinical Portal Development/(PORTIA)**					***Status***	***Progress Indicator***
Lead	S Pidgeon	***Start Date***	01/04/2021	***End Date***	31/03/2022	**G**	↗

Purpose	Enables the Trust to bring together information from different clinical information systems into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need.
Expected Outcomes	• Enhances integrated holistic patient record view. • Sourcing data from Trust internal systems and externally with partners leveraged via the YHCR. • Supports informed clinical decision making and patient care delivery through access to information in a timelier manner.

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Yorkshire & Humber Care Record onboarding	The Trust are currently engaged in connecting with the Yorkshire & Humber Care Record (YHCR) via the Trust's existing clinical portal solution (Viper360). This initiative aims to provide a channel for the Trust from which to start consuming available YHCR datasets, from the end of September 2021 onwards. The richness of the YHCR datasets will increase as more partner organisations onboard to the YHCR.	Mar 2022	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Title	**Electronic Referrals**					***Status***	***Progress Indicator***
Lead	S Pidgeon L Maden	***Start Date***	01/04/2021	***End Date***	31/03/2022	**G**	↗
Purpose	Enables the Trust to reduce the reliance and flow of paper both internally and externally with our partners in respect of delivering patient care.						
Expected Outcomes	• Supports the continued drive towards digitisation of the NHS and reducing our paper footprint. • Potential to improve more timely access to appropriate care. • Ability to receive referral correspondence electronically rather than traditional printing/posting channels.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
eReferral Services in Mental Health	The Trust has been engaged with NHS Digital and NHSX with regards to the potential of eReferral Service (ERS) adopted within Mental Health Services, where applicable and appropriate. The Trust are also exploring other avenues that enable the transmission of electronic referrals between primary care, other partners, and the Trust.	Mar 2022	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Title	**Patient Reminder Systems Review**					***Status***	***Progress Indicator***
Lead	S Pidgeon M Garnham	***Start Date***	01/04/2021	***End Date***	31/10/2021	**G**	↗
Purpose	The Trust currently has two patient appointment reminder systems in operation which aim to reduce "did not attend" (DNA) levels across Trust services. This is a legacy arrangement due to different						

	clinical information systems and practices in place previously. This review will look to explore the options and opportunity to rationalise down to a single platform within the Trust.
Expected Outcomes	• Reduce DNAs by increasing re-use of appointment slots ('fast-track' patients in need of urgent appointment) and in turn reduce costs and waiting times. • Improve efficiency of services. • Improve quality of services. • Improve patient experience. • Make best use of Trust resources.

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Evaluation of the existing patient appointment reminder systems in use	Produce an evaluation paper which assesses the existing systems in use and consider the options based on advantages/disadvantages of rationalising to a single Trust-wide platform to meet this need.	Oct 2021	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Title	**Access to ICE**					***Status***	***Progress Indicator***
Lead	S Pidgeon	***Start Date***	01/04/2021	***End Date***	30/11/2021	**G**	↗
Purpose	To improve accessibility and arrangements for accessing ICE to request and receive order communications and results reporting information with our acute partners (Mid-Yorkshire NHS Foundation Trust, Calderdale & Huddersfield NHS Foundation Trust and Barnsley Hospital NHS Foundation Trust.						
Expected Outcomes	• Improved ability to access and make requests e.g., blood test via the ICE systems(s) in place with our acute partners. • Improve timeliness of access to results information electronically. • Ability to update the results directly into the SystmOne record.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Exploration of the options to improve access to ICE for Trust staff	Explore the viable options and produce a paper evaluating the advantages/disadvantages, associated costs, and indicative timelines for each option. Some options may be interim measures until more strategic avenues come to fruition.	Oct/Nov 2021	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***
Challenges across the wider system impacting the ability to improve access to ICE for requesting/receiving order communications.	4	3	**12**	• Explore options and produce paper for Trust consideration. • Liaise and collaborate with local acute partners and system suppliers to explore having access to their ICE systems and to work through clinical, operational, and technical challenges for mutual benefits. • Arrange appropriate training for staff to use the proposed new functionality.

Title	**Information Governance**					*Status*	*Progress Indicator*
Lead	R Smith	***Start Date***	01/04/2021	***End Date***	31/03/2022	**G**	↗
Purpose	To ensure that the Trust achieves compliance with its information governance responsibilities and statutory obligations.						
Expected Outcomes	• Mandatory IG training target is achieved. • The Data Protection & Security toolkit target of meeting all mandatory standards is maintained. • Ongoing compliance with GDPR is assured and processes established which are reviewed regularly.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Information Commissioner's Office (ICO)	<u>New/amended legislation & guidance in response to the COVID-19 pandemic</u> The ICO revised its regulatory approach in July 2021, setting out their understanding that public bodies are operating during uncertain and challenging times whilst acknowledging that privacy protections and transparency of decision-making continue to play an important role; regulatory work will focus on the issues likely to cause the greatest public harm. **Please note: There is currently no end date as the ICO's regulatory approach document is regularly reviewed and updated in line with national and public requirements.**	Ongoing	
The Health Service (Control of Patient Information) Regulations 2002	<u>New/amended legislation & guidance in response to the COVID-19 pandemic</u> On 23 March 2020 the Secretary of State for Health & Social Care served a statutory requirement notice on health care providers, GPs, local authorities, and arm's length bodies of the Department of Health & Social Care to disseminate confidential, patient information to organisations permitted to process such information where it is to be processed solely to manage and mitigate the spread and impact of the current COVID-19 outbreak. Necessary processing for the specified purpose shall be taken to be lawfully done despite any duty of confidence owed in respect of this but has been extended twice. **Please note: This notice was due to expire on 30 September 2021 but an extension to 31 March 2022 was announced on 25 August 2021.**	Mar 2022	
Information Governance support	The Trust is continuing to deliver an Information Governance service during the COVID-19 outbreak, applying appropriate governance and assurance mechanisms to fast-track decision-making to allow processes to be adapted and adherence to new and amended guidance, and reviewing the effectiveness of previous decisions, via the Improving Clinical Information Group (ICIG).	Mar 2022	
Information Governance training	Ensure that the mandated annual information governance training update is maintained. In July 2021, NHS Digital confirmed that the deadline would continue to be the end of	Jun 2022	

	June. Classroom training continues to be suspended due to the COVID-19 restrictions but self-assessment using approved workbooks that are marked by the IG Manager is available for staff who do not have access to computers.		

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	National Data Opt-Out					Status	Progress Indicator
Lead	R Smith	Start Date		End Date		P	➔
Purpose	The national data opt-out is a new service which allows individuals to choose if they do not want their confidential patient information to be used for purposes beyond their individual care and treatment, for research and planning. Service users or people acting for them by proxy have control over setting or changing their own opt-out choices, which they can change at any time.						
Expected Outcomes	• Preparedness for the national data opt-out is assured and processes established to ensure compliance within prescribed timescales.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
National Data Opt-Out	In recognition that the health and social care system is going to face significant pressures in the coming months due to the COVID-19 outbreak, and that staff will need to work in different ways, NHS Digital has made the decision to further extend the compliance deadline for the national data opt-out to 31 March 2022, at which point the position will be reviewed.	Mar 2022	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Digital Intelligence

Title	Business Intelligence					Status	Progress Indicator
Lead	L Metcalfe	Start Date	01/04/2021	End Date	31/03/2022	G	↗
Purpose	The development of a business intelligence/data warehouse that facilitates the provision of an information hub and dashboards to improve access to business performance information that informs service improvements and delivery.						
Expected Outcomes	• Continue to improve and make available the use of real time information to support operational services and transformation agendas.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Health Inequalities	Health inequalities reporting has been established. The tool is being demonstrated at BDU governance meetings.	Jun 2021	Jul 2021
Neighbourhood Teams Developments (NTS)	Development work to support new ways of working in Barnsley Community Services (NTS) and ensure suitable reporting outputs available. Additional work is being undertaken following successful bid for Breathe service contract.	TBC	

	Please note: Timeframes are to be linked to project timescales as some slippage has occurred due to impact of COVID-19.		
Team Dashboards	Team dashboards developed and rolled out across services. Work is ongoing to consider variation internally and potential opportunities for improvement – linked to the Trust benchmarking group work plan. Further analysis to be undertaken on the Trusts benchmarking and Model Hospital data.	Mar 2022	
Recovery Dashboard	A recovery dashboard is in development. Metrics identified to support the Trusts recovery and restoration workstream.	Dec 2021	
Data Quality Dashboard	Data quality dashboard is being developed to allow monitoring of progress against the Trusts data quality action plan.	Mar 2022	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Title	**Performance Management & Reporting**					***Status***	***Progress Indicator***
Lead	M Wood	***Start Date***	01/04/2021	***End Date***	31/03/2022	G	↗
Purpose	The development of the Trust's performance management and reporting capabilities to improve service line reports, key performance indicators and business performance information provisioning.						
Expected Outcomes	• Continue to improve performance information to support operational services and transformation agendas.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
CQUIN Developments	Development work completed to support the proposed CQUIN metrics for 2021/22 – some schemes on hold and expected to take effect from Q1 2022/23. Further work may be required subject to any changes to the schemes.	Sep 2021	Sep 2021
Business As Usual (BAU) Reporting	BAU reporting was re-established from Aug 2020 (July 2020 data). Additional reporting established to support new services such as Quit Barnsley, Kirklees CAMHS Mental Health Support teams, planning and development work required to support the Forensic Provider collaborative.	Ongoing (linked to contract start dates)	
National Guidance Implementation	Preparation and planning for H2 – awaiting further national guidance. Preparation and planning for 2022/23 also awaiting national guidance.	TBD	
Operational Planning Requirements	Review of activity in preparation for operational planning requirements.	TBD	
COVID-19 response	Additional routine reporting is in place to support the COVID-19 response e.g. OPEL reporting, daily sitreps for bed availability and capacity reporting, monthly benchmarking submissions, Elective recovery fund (EROC) submissions, vaccinations, sickness reporting.	Ongoing	
Health Intelligence	Development work is ongoing and monitoring of the Trusts forecasting and demand tool and providing support to the restoration and recovery group.	Ongoing	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Digitally Enabled Workforce

Title	**Microsoft SharePoint Migration**					***Status***	***Progress Indicator***
Lead	A Meloy G Richardson B Haworth	***Start Date***	01/03/2020	***End Date***	~~31/03/2021~~ ~~31/07/2021~~ 24/08/2021	**R**	↗
Purpose	The Trust has a major dependency on Microsoft SharePoint and the current version (Microsoft SharePoint 2010) that is in use across the organisation goes out of extended support (end of life) in April 2021. Plans and activities have been established to support the migration to a Microsoft SharePoint365 cloud hosted environment to ensure continuity. The Trust is reliant upon SharePoint for the following service areas: • Intranet (Communications, Marketing & Engagement) • Payroll forms and processes (HR) • Business Intelligence dashboards and performance reporting (P&I) • Criteria led discharge dashboard and processes (Integrated Change Team) • Membership database (Corporate Governance)						
Expected Outcomes	• To improve access to corporate systems and information in a timely and responsive manner. • To ensure that the Trust corporate intranet is developed, maintained and services/information is accessible across the workforce. • Supports information asset management, integrity, and confidentiality to comply with GPDR requirements. • Establish a robust and strategic approach for ongoing maintenance & support and continuous development of the SharePoint environment, subject to Trust governance and approvals.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
SharePoint Readiness Assessment	A scope of works commissioned a third-party SharePoint specialist to conduct a readiness check on the current SharePoint environments ahead of the potential move to SharePoint365 was completed.	Jun 2020	Jun 2020
Development of Implementation Plans	Outline implementation plans were developed by the respective corporate services asset owners to determine the migration plans via the SharePoint working group.	Jul 2020	Jul 2020
Procurement of Specialist SharePoint Consultancy Services	A procurement exercise was undertaken to contract for SharePoint specialist services to support the Trust in migrating the SharePoint environments to cloud hosted SharePoint365. The invitation to tender did not yield any responses despite acknowledged interest. A professional services arm of Hayes Consulting (James Harvard) was engaged via a procurement framework to undertake this work. In addition, the Trust appointed a dedicated project manager to oversee the migration and work closely with the Trust's respective SharePoint asset owner leads and James Harvard resources.	Dec 2020	Dec 2020
SharePoint Office 2010 Migration to SharePoint365	Whilst significant progress has been made with regards to the migration activities, some technical issues have been encountered that have delayed go-live due to the complexity of the environment. Originally it was planned to go live by the end of March 2021 ahead of the 17 April 2021 deadline. However, these ongoing issues have delayed the go live further. Go live was successfully achieved on 24 August 2021.	~~Mar 2021~~ Jul 2021	Aug 2021

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Microsoft support for SharePoint 2010 ended on 17/4/2021 so any requirement to upgrade this platform could have rendered the environment unusable.				• Additional specialist resources have been secured and a remediation (get to green) plan was developed to urgently re-baseline outstanding activities for go live. • The 'internal to the Trust 'SharePoint 2010 environment has been subject to close monitoring to ensure continuity of services. • Subsequent decommissioning of the SharePoint 2010 platform will commence imminently.

Title	Microsoft SharePoint365 Developments					Status	Progress Indicator
Lead	G Richardson B Haworth	Start Date	01/09/2021	End Date	31/03/2022	G	↗
Purpose	Following on from the migration to the Microsoft SharePoint365 environment, this provides the Trust with a robust and strategic platform from which to further develop the SharePoint sites within the Trust.						
Expected Outcomes	• To continue to improve access to corporate systems and information in a timely and responsive manner. • Ensuring that the Trust corporate intranet is continually developed, maintained and services/information is accessible across the workforce. • Continues to support information asset management, integrity, and confidentiality to comply with GPDR requirements. • Establish a robust and strategic approach for ongoing maintenance & support and continuous development (strategic roadmap) of the SharePoint environment, subject to Trust governance and approvals.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Creation of a SharePoint development priority list for 2021/22	To compile a list of potential developments to be prioritised by the SharePoint Development Group and key priorities planned to for the remainder of 2021/22 in line with the digital capital plan.	Sep 2021	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Digital Dictation					Status	Progress Indicator
Lead	V Whyte	Start Date	01/02/2021	End Date	31/03/2023	A	↗
Purpose	Procurement and deployment of a strategic Trust-wide digital dictation solution informed by the previous time limited pilot that concluded at the end of March 2021.						
Expected Outcomes	• To develop a Trust wide solution for digital dictation that offers standardisation. • Supports the paperless agenda. • Improves service effectiveness and efficiencies.						

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Pilot to inform business case development	Completion of a digital dictation pilot within Wakefield BDU medical secretarial team using Lexicom's digital dictation solution. The findings from the pilot were positive and serve to inform the development of a business case for a Trust-wide solution.	Mar 2021	Mar 2021
Business Case Development	Development and approval of business case and specification for procurement of single supplier.	~~Jun 2021~~ Oct 2021	
Procurement of Specialist SharePoint Consultancy Services	Completion of a formal procurement exercise for a Trust-wide digital dictation solution/service and identification of preferred supplier.	Dec 2021	
Deployment of Trust-wide Digital Dictation Solution	Implementation and deployment of the Trust-wide Digital Dictation Solution.	Mar 2023	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls
Ability to identify internal/external capacity and to recruit & secure the required project resources to provide the necessary capacity to support this key initiative.	3	3	**9**	• Ensure options to recruit appropriate staff in as timelier manner as possible to enable this key initiative to make progress within the stated timelines.

Title	Digital Conferencing					Status	Progress Indicator
Lead		**Start Date**	01/04/2021	**End Date**	31/3/2022	G	↗
Purpose	We need to take stock and plan for new and innovative ways of working (hybrid working) now and in the future, supported through exploring digital technologies and solutions that meet approaches to conducting meetings with a blend of physical and virtual attendees. This needs to be both adaptable and scalable and be able to be tailored to specific needs at all levels.						
Expected Outcomes	• Improve meeting attendance, experiences of all regardless of attendance medium. • Improve efficiency and effectiveness. • Improve quality of services. • Make best use of Trust resources.						

Key Milestones		Completion Dates	
Activity	**Summary**	**Target**	**Actual**
Evaluation of digital conferencing technologies	Evaluate digital conferencing technologies that are adaptable and scalable across the organisation, testing out capabilities via OMG in the first instance, to inform a Trust-wide approach.	Nov 2021	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Digital Education, Training & Development					Status	Progress Indicator
Lead		**Start Date**	01/04/2021	**End Date**	31/3/2022	G	↗
Purpose	Our workforce is our greatest asset and to be truly digitally excellent, our staff need to be fully conversant, competent, capable, and confident in their use of digital solutions which promote high quality care provision. Exhibiting good digital knowledge, skills and capabilities is not about developing						

	technical proficiency but in recognising that when coupled with an assured outlook, it is how digital solutions can be applied during effective care delivery which improves care and creates positive health outcomes. To enable this, when planning for and introducing new and innovative ways of working, this needs to be supported by effective learning, education and training which is tailored to the individual and available through different channels.
Expected Outcomes	• Supports in making this a great place to work, also improving staff retention. • Improve access, timeliness and availability of training and development opportunities in support of identified needs. • Appropriately skilled workforce in terms of requisite specialist skills, knowledge, experience, and capabilities. • Better use of Trust resources.

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Educator and trainer capability using digital resources	Guidance and support materials have been made available for educators, trainers, and facilitators in delivering sessions virtually.	Jun 2021	Jun 2021
Conversion of classroom delivery	Learning & Development have reviewed all existing training materials that were previously delivered in classrooms and have converted those appropriate to delivery using Microsoft Teams and other digital solutions. New education and training programmes developed on an emergent basis are assessed against risk and best impact measures to inform using digital solutions over classroom-based training methods. The Education and Training Governance Group provides assurance for all training delivery and oversees changes in Mandatory Training provision.	Aug 2021	Aug 2021
Further development of Digital Training Services incorporating a review of the Trust estate to facilitate digital training delivery	Work is ongoing in collaboration between Learning & Development, Estates & Facilities, and IM&T with regards to reviewing and improving digital training delivery capabilities across the Trust. This work will take learning from our recent experiences and across our networks, to improve the digital training offer, where applicable and appropriate. Developing plans for converting a selection of training rooms into digital training suites to reduce the need for large groups in one place, support the Trust's sustainability agenda, and reduce associated costs for travel, etc.	Dec 2021	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***
Network stability with increased training delivery with large groups accessing programmes from a blended hybrid working model (home or agile bases).	2	3	**6**	• Assessment and evaluation of digital technologies and solutions that support digital training delivery will take account of this specifically for the Trust's network. There may remain some staff when working from home or outside of the Trust's premises as these fall outside the control/remit of the Trust.

Digitally Enabling Service Users & Carers

Title	Digital Personal Held Care Record (Service User/ Patient Portal) Development					Status	Progress Indicator
Lead	P Foster	Start Date	01/04/2021	End Date	31/03/2022	G	↗
Purpose	Development of a SWYPFT capability that provides service users and carers with access to their own digital care record via a portal solution. Potentially providing opportunities to self-manage and engage more readily in the delivery of their care and that delivers alternative means from which to engage with care professionals offering greater flexibility.						
Expected Outcomes	• Improve communication between service users, carers, and care professionals. • Providing service users (and, where appropriate their carers) with online access to relevant parts of the clinical record. • Support self-management using online self-management tools. • Supports recovery through signposting to support and recovery resources. • Improve service user and carer awareness of and engagement with Trust related initiatives, events, research opportunities and Recovery College courses. • Improve the consistency and quality of service user related data collection through direct online input by individuals themselves, saving staff significant time.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Business Case Development	A proposal is being readied to seek approval for the introduction of a Digital Personal Health Record solution within the Trust (Essentially this is a service user/patient portal) and forms part of the Trust's digital strategic roadmap and is a key milestone within the NHS Long Term Plan.	Oct 2021	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

Title	Video Consultation/Conferencing Solution Review					Status	Progress Indicator
Lead	S Pidgeon	Start Date	01/08/2021	End Date	31/03/2022	G	↗
Purpose	Video consultations are electronic means of establishing consultative communications between clinician-to-clinician either at a provider-to-provider level or in collaboration with patients/service users/carers via video conferencing appropriate solutions.						
Expected Outcomes	• Improves the patient experience. • Improves access to services, engaging information users and further supporting the digitisation agendas in line with wider ICS digital aspirations.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Evaluation of video consultation solutions in use	The Trust needs to consider its needs for video consultation solutions based on current usage and future requirements, to determine an appropriate and strategic way forward. MS Teams is funded via the Trust's licence agreement with Microsoft, whereas AccuRX is centrally funded through to 31 March 2022.	Nov 2021	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

There is an expectation that central funding for AccuRX will not continue beyond 31 March 2022	3	3	**9**	• The Trust to review is requirements for video consultation solutions based on current and anticipated future usage. • Collaborate across ICS regions and partners to explore most financially cost-effective options if central funding does not continue.

Title	**Digital Inclusion**					***Status***	***Progress Indicator***
Lead	P Foster S Barton	***Start Date***	01/04/2021	***End Date***	31/03/2022	**G**	↗
Purpose	Championing digital inclusion and in addressing digital inequalities in terms of access and capability for our service users, carers, their families, and the wider communities that we serve. Digital inclusion is a key area of focus across both ICSs and in all our places at a digital level.						
Expected Outcomes	• Service users and carers are more informed about their care, the options available and what they can expect from accessing services digitally. • Needs, wishes and aspirations of our service users are comprehensively considered, and they feel listened to and are actively in control of the care they receive. • Service users and carers can use digital technology available to them to access services and information in ways that are preferable.						

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
'Gifting/loaning' of tablet devices	Integrated Change Team are exploring options to trial the provision of a small number of tablets to service users via the EYUP Charity, supported through Recovery College.	Dec 2021	
Exploration of redundant Trust IT equipment for re-use within our communities	The IT Team have been undertaking technical feasibility work in collaboration with WY&H ICS Digital Team. Exploring avenues to potentially donate redundant IT equipment being decommissioned by the Trust for re-usage within our communities.	Dec 2021	
Collection of service user digital preferences within SystmOne	A proposal has been developed to establish a series of questions focussed on digital inclusion, to collect service user digital preferences at relevant points of contact to be recorded in SystmOne.	Dec 2021	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***

Title	**CHATpad (Virtual Visitor)**					***Status***	***Progress Indicator***
Lead	Alexis Richie	***Start Date***	01/04/2021	***End Date***	31/03/2022	**G**	↗
Purpose	To help prevent the spread of COVID-19, visiting across SWYPFT inpatient areas has been restricted. To ensure the people in our care do not become socially isolated, continue to have contact with their families, have up to date information and are still able to stay in contact with services, a virtual visitor project was launched to support well-being with a solution being implemented across the Trust. Virtual visitor devices have now been rebranded as CHATpad. The devices can now be used for virtual visits, completion of surveys and feedback, plus give service users access to advocacy support digitally whilst in our care.						

Expected Outcomes	• Serves to combat service user isolation and enhance contact with family; combats service user isolation and enables contact with services and initiatives to support wellbeing. • Supports staff to continuously innovate, improve and transform. • Improves quality of services. • Improves patient experience.

Key Milestones		***Completion Dates***	
Activity	***Summary***	***Target***	***Actual***
Deployment of CHATpad devices to wards.	Most of the devices have now been returned to wards with new promotional materials to display and a file with guidance inside for staff use. This has been communicated in Headlines for staff awareness. There is a CHATpad folder for each ward containing useful information and guidance, and this information will be available on the intranet in the future. Slippage of timescales was due to a software issue needing to be reconfigured by Healthcare Communications (solution supplier). New tokens were issued and software reinstalled.	~~Jul 2021~~ Sep 2021	
Development of a public facing leaflet for them to learn about CHATpad	Work is ongoing with the Carers Lead Network to link in some carers to help review the existing promotional material to design a public facing leaflet about CHATpad to promote across community and for the public to learn how/where to access it to use whilst their loved one is in our care.	Sep 2021	
Discovery Interviews (DI) pilot	The Equality & Involvement Team are to run a pilot with Forensics service users via the CHATpad to produce a discovery interview. Discovery interviews are a framework for allowing someone to tell you their story, via written prompts (lines of enquiry) to create a focus, for example this might be: ▪ Experience of admission ▪ Experience of day-to-day activities on the ward? ▪ Share views and thoughts on care and treatment ▪ Experience of the Ward both positive and areas requiring improvement? ▪ Hopes for the future	Nov 2021	
Reset and Recovery survey	Produce a Trust-wide survey for reset and recovery insight which will focus on digital, estates and working effectively. This will be hosted via Healthcare Communications and be available on the CHATpad. Staff from the Equality and Involvement team will assist completion in person, plus assistance by ward staff and possibly volunteers will be required as support. This is still in the design phase currently.	Nov 2021	

Key Risks	***Likelihood***	***Impact***	***Risk Score***	***Actions & Controls***
Healthcare comms software issue on some devices (10 out of 35)	3	2	**6**	• We are working with the provider to resolve the issue on the outstanding devices, and these will be returned as soon as possible to the wards.

Title	Collecting and Reporting Health Outcomes					Status	Progress Indicator
Lead	M Garnham	Start Date	01/04/2021	End Date	31/03/2022	P	↗
Purpose	The Trust is exploring digital solutions to collection and reporting of outcomes. Some services such as IAPT, CAMHS and early intervention are required to routinely collect outcome measures. There is no consistent approach to outcome measure collection presently within the Trust. Clinical outcomes can be measured by data such as hospital re-admission rates, or by the 5 domains set out in The NHS outcomes framework indicators: ▪ Preventing people from dying prematurely. ▪ Enhancing quality of life for people with long-term conditions. ▪ Helping people to recover from episodes of ill health or following injury. ▪ Ensuring that people have a positive experience of care. ▪ Treating and caring for people in a safe environment and protecting them from avoidable harm.						
Expected Outcomes	• Improved efficiency by ensuring the delivery of the appropriate questionnaire, at the right time, to the right patient. • Improved timeliness offering real time insight into patient wellbeing and quality of life, providing quicker decision making and ability to tailor treatment. • Automatic analysis, scoring and reporting in real time at clinical, service, and organisational level. • Better understanding of clinical need and effectiveness of services.						

Key Milestones		Completion Dates	
Activity	Summary	Target	Actual
Development of a solution to enable collecting and reporting health outcomes	A potential pilot was curtailed by the COVID-19 pandemic and commencing this work remains subject to the recovery planning and ongoing social distancing requirements.	TBD	

Key Risks	Likelihood	Impact	Risk Score	Actions & Controls

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 October 2021
Agenda item 13.1

Title:	**Proposal to update Constitution, Standing Financial Instructions and Scheme of Delegation**
Paper prepared by:	Assistant director of corporate governance, performance and risk
Purpose:	To provide an updated version of the Constitution, following review by and consultation with Governors, Non-Executive Directors, the Executive Management team and Audit Committee (12.10.21) To provide an updated version of the Standing Financial Instructions and work place for the Scheme of Delegation following review and approval by the Audit Committee on the 12th October 2021.
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 amendment to the constitution was approved by the Members' Council on the 17th August 2021. This amendment dealt solely with the amendment to Annex 1 (1.5) (the public constituencies), 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.*** • To further amend Annex 1 to state ***"Non-Executive Directors recruited from the above public constituency, MUST be able to demonstrate a commitment to, and significant knowledge of, the communities the Trust serves".*** Following consultation, the amended Constitution, was presented to the Audit Committee on the 12th October 2021 and subsequently approved for presentation to the Trust Board on the 26h October 2021. Attached are the suggested further amendments to the Constitution presented as "tracked changes". The Standing Financial Instructions (SFIs), together with the Trust's Standing Orders and Scheme of Delegation, provide a business and financial framework and set the rules that everyone

	within the Trust is required to work within. These were presented separately to the Audit Committee on the above date. The SFI's were approved for presentation to the Trust Board on the 26h October 2021 and it was agreed that work on the Scheme of Delegation will be completed in January 2022. The Constitution and SFI's are now presented to the Trust Board for approval.
Executive summary:	The attached version of the Constitution contains tracked changes for the suggested further amendments to the Constitution • inclusion of code of conduct for Governors as Annex 6 • inclusion of Director Declarations and register of fit & proper persons interests and independence criteria as Annex 8 Standing Financial Instructions (SFIs) have been reviewed and minor technical adjustments were approved by the Audit Committee (12/10/21). • Periodic 2 year review • Review against current understanding of the lead provider collaboratives and specifically the centralised commissioning hub approach • SFIs remain fundamentally the same. Changes mainly for names and updates for Charitable Funds committee actual processes. • A more detailed and significant review of the SFIs and the Scheme of Delegation will be undertaken early in 2022/23 to ensure they reflect national changes in NHS provider financial structures from 1 April 2022. The Corporate Governance team have reviewed the Constitution, SFIs and Scheme of Delegation against the NHS constitution and can confirm that subject to and taking account of the changes above, meet the requirements therein. It is recommended: • The SFIs and Scheme of Delegation are reviewed in early 2022/23 to ensure they are fit for purpose • The Trust Constitution is fully reviewed by October 2022 to take account of any further changes required.
Recommendation:	**Trust Board is asked to DISCUSS the attached changes and APPROVE the updates to the Trust Constitution and Standing Financial Instructions for 2021/22**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

CONSTITUTION OF

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Version 10~~9~~ (approved by Trust Board on 26th October 2021~~27th July 2021~~ and Members Council on 16th November 2021~~17th August January 2021~~ (effective ~~17th August 2021~~)16th November 2021)

With all of us in mind.

Constitution of South West Yorkshire Partnership NHS Foundation Trust

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1. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

Headings are for ease of reference only and are not to affect interpretation.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

"the Accounting Officer"	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act;
"appointed Governors"	means those Governors appointed by the appointing organisations;
"appointing organisations"	means those organisations named in this constitution who are entitled to appoint Governors;
"constitution"	means this constitution and all annexes to it;
"Director"	means a member of the Trust Board;
"elected Governors"	means those Governors elected by the Public constituencies and the classes of the Staff Constituency;
"Financial year"	means: (a) the period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
"Local Authority Governor"	means a Governor appointed by one or more local authorities whose area includes the whole or part of an area specified as a public constituency of the Foundation Trust;
"Members' Council"	means the Council of Governors'

"Monitor"	means the body corporate known as Monitor (or successor organisation), as provided by Section 61 of the 2012 Act;
"partner"	means, in relation to another person, a member of the same household living together as a family unit;
"Partnership Governor"	means a Governor appointed by a partnership organisation;
"Public Governor"	means a Governor elected by the members of one of the Public Constituencies;
"Secretary"	means the Secretary of the Foundation Trust or any other person appointed to perform the duties of the Secretary, including a joint, assistant or deputy secretary;
"Staff Governor"	means a Governor elected by the members of one of the classes of the Staff Constituency;
"terms of Authorisation"	means the terms of authorisation issued by Monitor under Section 35 of the 2006 Act;
"the 2006 Act"	means the National Health Service Act 2006;
"the 2012 Act"	means the Health and Social Care Act 2012;
"the Foundation Trust"	means the South West Yorkshire Partnership NHS Foundation Trust;
"Trust Board"	means the Board of Directors, as set out in 23.1;
"voluntary organisation"	means a body, other than a public or local authority, the activities of which are not carried on for profit.

2. Name

The name of the foundation trust is South West Yorkshire Partnership NHS Foundation Trust ("the Foundation Trust").

3. Principal purpose

3.1 The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England.

3.2 The Foundation Trust does not fulfil its principle purpose unless, in each financial year, its total income from the provision of goods and

services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Foundation Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness

3.3.2 the promotion and protection of public health.

3.4 The Foundation Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principle purpose.

4. Powers

4.1 The powers of the Foundation Trust are set out in the 2006 Act.

4.2 All the powers of the Foundation Trust shall be exercised by the Trust Board on behalf of the Foundation Trust.

4.3 Any of these powers may be delegated to a committee of directors or to an executive director.

5. Membership and constituencies

The Foundation Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1 a public constituency

5.2 a staff constituency

Further provisions as to members' meetings are set out in Annex 11~~9~~.

6. Application for membership

An individual who is eligible to become a member of the Foundation Trust may do so on application to the Foundation Trust.

7. Public Constituency

7.1 An individual who lives in an area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Foundation Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The minimum number of members in each Public Constituency is specified in Annex 1.

8. Staff Constituency

8.1 An individual who is employed by the Foundation Trust under a contract of employment with the Foundation Trust may become or continue as a member of the Foundation Trust provided:

8.1.1 He / she is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months

8.1.2 He / she has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Foundation Trust, otherwise than under a contract of employment with the Foundation Trust may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt this does not include individuals who assist or provide services to the Foundation Trust on a voluntary basis.

8.3 Those individuals who are eligible for membership of the Foundation Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into seven descriptions of individuals who are eligible for membership of the Staff Constituency, each description of individuals being specified within Annex 2 and being referred to as a class within the Staff Constituency.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2.

8.6 In line with General Data Protection Regulations (GDPR), staff membership is no longer automatic. Staff will be asked if they would like to be a member on appointment.

9. Restriction on membership

9.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

9.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

9.3 An individual must be at least 11 years old to become a member of the Trust.

9.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Foundation Trust are set out in Annex11 ~~9~~.

10. Annual Members' Meeting

10.1 The Foundation Trust shall hold an annual meeting of its members (Annual Members' Meeting). The Annual Members' Meeting shall be open to members of the public.

10.2 Further provisions about the Annual Members' Meeting are set out in Annex 11~~9~~.

11. Members' Council – composition

11.1 The Foundation Trust is to have a Council of Governors, referred to as the Members' Council, which shall comprise both elected and appointed Governors.

11.2 The composition of the Members' Council is specified in Annex 3.

11.3 The members of the Members' Council, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

12. Members' Council – election of Governors

12.1 Elections for elected members of the Members' Council shall be conducted in accordance with the Model Election Rules using the single transferable vote method of voting.

12.2 The Model Election Rules, as published from time to time by the Department of Health, form part of this constitution. The Model Election Rules current at the date of the Trust's authorisation are attached at Annex 4.

12.3 A subsequent variation of the Model Election Rules by the Department of Health shall not constitute a variation of the terms of this constitution for the purposes of paragraph 46 of the constitution. For the avoidance of doubt, the Foundation Trust cannot amend the Model Election Rules.

12.4 An election, if contested, shall be by secret ballot.

13. Members' Council - tenure

13.1 An elected Governor shall normally hold office for a period of three calendar years.

13.2 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

13.3 An elected Governor shall be eligible for re-election at the end of his term.

13.4 An elected Governor may not hold office for more than nine years in total, and shall not be eligible for re-election if he has already held office for more than six consecutive years.

13.5 Further provisions as to tenure for appointed Governors are set out at Annex 5.

14. Members' Council – disqualification and removal

14.1 The following may not become or continue as a member of the Members' Council:

14.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged

14.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it

14.1.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

14.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

14.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Members' Council are set out in Annex 5.

15. Members' Council – Lead Governor / Deputy Lead Governor

15.1 The Trust will ensure a process is in place to appoint a Lead Governor / Deputy Lead Governor for the Members' Council (in accordance with the provisions set out in Annex 5).

16. Members' Council – duties of Governors

16.1 The general duties of the Members' Council are:

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board

16.1.2 to represent the interests of the members of the Foundation Trust as a whole and the interests of the public.

16.2 The Foundation Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Members' Council – meetings of Governors

17.1 The Chair of the Foundation Trust (i.e. the Chair of the Trust Board, appointed in accordance with the provisions of paragraph 26) or, in his / her absence the Deputy Chair (appointed in accordance with the provisions of paragraph 27 below) shall preside at meetings of the Members' Council. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Lead Governor (or Deputy Lead Governor in their absence) will preside over that part of the meeting.

17.2 Meetings of the Members' Council shall be open to members of the public unless the Members' Council decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. Members of the public may be excluded from a meeting if they are interfering with or preventing the proper conduct of the meeting or for other special reasons.

17.3 For the purposes of obtaining information about the Foundation Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Foundation Trust's or Directors' performance), the Members' Council may require one or more of the Directors to attend a meeting.

18. Members' Council – standing orders

The standing orders for the practice and procedure of the Members' Council, as may be varied from time to time, are attached at Annex 9~~7~~.

19. Members' Council – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of a Foundation Trust may refer a question as to whether the Foundation Trust has failed or is failing:

19.1.1 to act in accordance with its Constitution

19.1.2 to act in accordance with the provision made by or under Chapter 5 of the 2006 Act.

19.2 A governor may refer a question to the Panel only if more than half of the members of the Members' Council voting approve the referral.

20. Members' Council – conflicts of interest of Governors

20.1 A Governor shall disclose to the Members' Council any material interests (as defined below) held by a Governor, their spouse or partner, which shall be recorded in the register of interests of the Members' Council.

20.2 Subject to the exceptions below a material interest is:

20.2.1 directorships, including non-executive directorships, held in private companies or PLCs (with the exception of those of dormant companies)

20.2.2 any interest or position in any firm, company, business or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Foundation Trust

20.2.3 any interest in an organisation providing health and social care services to the National Health Service

20.2.4 a position of authority in a charity or voluntary organisation in the field of health and social care

20.2.5 any connection with any organisation, entity or company considering entering into a financial arrangement with the Foundation Trust including but not limited to lenders or banks.

20.3 The exceptions which shall not be treated as interests or material interests for the purposes of these provisions are as follows:

20.3.1 shares not exceeding 1% of the total shares in issue or £5,000 in value held in any company whose shares are listed on any public exchange

20.3.2 an employment contract with the Foundation Trust held by a Staff Governor

20.3.3 an employment contract with a local authority held by a Local Authority Governor

20.3.4 an employment contract with a university held by a University Governor

20.3.5 an employment contract with or other position of authority within a partnership organisation held by a Partnership Governor.

20.4 Any Governor who has an interest in a matter to be considered by the Members' Council (whether because the matter involves a firm, company, business or organisation in which the Governor or his spouse or partner has a material interest or otherwise) shall declare such interest to the Members' Council and:

20.4.1 shall withdraw from the meeting and play no part in the relevant discussion or decision

20.4.2 shall not vote on the issue (and if by inadvertence they do remain and vote) their vote shall not be counted).

20.5 Details of any such interest shall be recorded in the register of interests of the Members' Council.

20.6 Any Governor who fails to disclose any interest or material interest required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

21. Members' Council – travel expenses

The Foundation Trust may pay travelling and other expenses to members of the Members' Council at rates determined by the Foundation Trust.

22. Members' Council – further provisions

Further provisions with respect to the Members' Council are set out in Annex 5.

23. Trust Board – composition

23.1 The Foundation Trust is to have a Board of Directors, referred to as the Trust Board, which shall comprise both executive and non-executive directors.

23.2 The Trust Board is to comprise:

23.2.1 a non-executive Chair

23.2.2 up to six other non-executive directors

23.2.3 up to six executive directors.

23.2.4 There will be at least one more non-executive director than executive directors, including the Chair of the Trust.

23.3 One of the executive directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the executive directors shall be the finance director.

23.6 One of the executive directors is to be a registered medical practitioner.

23.7 One of the executive directors is to be a registered nurse.

24. Trust Board – general duty

The general duty of the Trust Board and of each Director individually is to act with a view to promoting the success of the Foundation Trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public.

25. Trust Board – qualification for appointment as a non-executive director

A person may be appointed as a non-executive director only if

25.1 he / she is a member of a Public Constituency

25.2 where any of the Foundation Trust's hospitals includes a medical or dental school provided by a university, he / she exercises functions for the purposes of that university, and

25.3 he / she is not disqualified by virtue of paragraph 29 below or Annex 7~~6~~.

26. Trust Board – appointment and removal of Chair and other non-executive directors

26.1 The Members' Council at a general meeting of the Members' Council shall appoint or remove the chair of the Foundation Trust and the other non-executive directors.

26.2 Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the Members' Council.

26.3 Further provisions as to the appointment and removal of the Chair and other non-executive directors are set out at Annex 7~~6~~.

27. Trust Board – appointment of Deputy Chair

The Members' Council at a general meeting of the Members' Council shall appoint one of the non-executive directors as a Deputy Chair. If the Chair is unable to discharge his / her office as Chair of the Foundation Trust the Deputy Chair of the Trust Board shall be acting Chair of the Foundation Trust.

28. Trust Board – appointment and removal of the Chief Executive and other executive directors

28.1 The non-executive directors shall appoint or remove the Chief Executive.

28.2 The appointment of the Chief Executive shall require the approval of the Members' Council.

28.3 A committee consisting of the Chair, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

29. Trust Board – disqualification

The following may not become or continue as a member of the Trust Board:

29.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.3 a person who within the preceding five years has been convicted in the British Isles of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust Board are set out at Annex 7~~6~~.

30. Trust Board – meetings

30.1 Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Members of the public may be excluded from a meeting if they are interfering with or preventing the proper conduct of the meeting or for other special reasons.

30.3 Before holding a meeting, the Trust Board must send a copy of the agenda of the meeting to the Members' Council. As soon as practicable after holding a meeting, the Trust Board must send a copy of the minutes of the meeting to the Members' Council.

31. Trust Board – standing orders

The standing orders for the practice and procedure of the Trust Board, as may be varied from time to time, are attached at Annex 10~~8~~.

32. Trust Board – conflicts of interest of directors

32.1 The duties that a Director of the Foundation Trust has by virtue of being a Director include, in particular:

32.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Foundation Trust

32.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in this capacity.

32.2 The duty referred to in paragraph 32.1.1 is not infringed if:

32.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest

32.2.2 the matter has been authorised in accordance with the Constitution.

32.3 The duty referred to in paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In paragraph 32.1.2, “the third party” means a person other than:

32.4.1 the Foundation Trust

32.4.2 a person acting on its behalf.

32.5 If a Director of the Foundation Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Foundation Trust, the Director must declare the nature and extent of that interest to the other Directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate or incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Foundation Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest:

32.9.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest

32.9.2 if, or to the extent that, the Directors are already aware of it

32.9.3 if, or to the extent that, it concerns terms of the Director’s appointment that have been or are to be considered:

32.9.3.1 by a meeting of the Board of Directors

32.9.3.2 by a committee of the Directors appointed for the purpose under the Constitution.

32.10 Any Director who has an interest in a matter to be considered by the Board of Directors that is required to be declared in accordance with paragraph 32 of this Constitution shall declare such interest to the Board of Directors and:

32.10.1 shall withdraw from the meeting and play no part in the relevant discussion or decision

32.10.2 shall not vote on the issue (and if by inadvertence they do remain and vote) their vote shall not be counted).

32.11 Details of any such interest shall be recorded in the register of interests of the Directors.

32.12 Any Director who fails to disclose any interest required to be disclosed under these provisions may be removed from office in accordance with the process for removing such a Director, as set out in this constitution.

33. Trust Board – remuneration and terms of office

33.1 The Members' Council at a general meeting of the Members' Council shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors.

33.2 The Foundation Trust shall establish a committee of non-executive directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other executive directors.

34. Registers

The Foundation Trust shall have:

34.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.2 a register of members of the Members' Council

34.3 a register of interests of Governors

34.4 a register of directors

34.5 a register of interests of the directors.

35. Admission to and removal from the registers

35.1 The Secretary shall remove from the register of members the name of any member who ceases to be entitled to be a member under the provisions of this constitution.

35.2 The Secretary is to send to Monitor a list of persons who were first elected or appointed as Governors and Directors.

36. Registers – inspection and copies

36.1 The Foundation Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

36.2 The Foundation Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Foundation Trust, if the member so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

36.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

37. Documents available for public inspection

37.1 The Foundation Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current constitution

37.1.2 a copy of the latest annual accounts and of any report of the auditor on them

37.1.3 a copy of the latest annual report.

37.2 The Foundation Trust shall also make the following documents relating to special administration of the Foundation Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final

report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act

37.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act

37.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act

37.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to the re-submitted final report) of the 2006 Act

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act

37.2.8 a copy of any final report published under section 65I (administrator's final report) of the 2006 Act

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act

37.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a member of the Foundation Trust, the Foundation Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Foundation Trust shall have an auditor.

38.2 The Members' Council shall appoint or remove the auditor at a general meeting of the Members' Council.

38.3 Further provisions as to the auditor are set out at Annex 120.

39. Audit committee

The Foundation Trust shall establish a committee of non-executive directors as an audit committee to perform such monitoring, reviewing and other functions as are appropriate.

40. Accounts

40.1 The Foundation Trust must keep proper accounts and proper records in relation to the accounts.

40.2 Monitor may, with the approval of the Secretary of State, give directions to the Foundation Trust as to the content and form of its accounts.

40.3 The accounts are to be audited by the Foundation Trust's auditor.

40.4 The Foundation Trust shall prepare in respect of each Financial Year annual accounts in such form as Monitor may, with the approval of the Secretary of State, direct.

40.5 The functions of the Foundation Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.6 Further provisions as to accounts are set out at Annex 12~~0~~.

41. Annual report, forward plans and non-NHS work

41.1 The Foundation Trust shall prepare an Annual Report and send it to Monitor. Further provisions as to Annual Reports are set out at Annex 12~~0~~.

41.2 The Foundation Trust shall give information as to its forward planning in respect of each Financial Year to Monitor.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the directors.

41.4 In preparing the document, the directors shall have regard to the views of the Members' Council.

41.5 Each forward plan must include information about:

41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Foundation Trust proposes to carry on

41.5.2 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Foundation Trust carries on an activity of a kind mentioned in paragraph 41.5.1, the Members' Council must:

41.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Foundation Trust of its principal purpose or the performance of its other functions

41.6.2 notify the Directors of the Foundation Trust of its determination.

41.7 A Foundation Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Members' Council of the Foundation Trust voting approve its implementation.

42. Presentation of the annual accounts and reports to the governors and members

42.1 The following documents are to be presented to the Members' Council at a general meeting of the Members' Council:

42.1.1 the annual accounts

42.1.2 any report of the auditor on them

42.1.3 the annual report.

42.2 The documents shall also be presented to the members of the Foundation Trust at the Annual Members' Meeting by at least one member of the Trust Board in attendance.

42.3 The Foundation Trust may combine a meeting of the Members' Council convened for the purposes of paragraph 42.1 with the Annual Members' Meeting.

43. Instruments

43.1 The Foundation Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Trust Board.

44. Amendment of the constitution

44.1 No amendment shall be made to this constitution (including its Annexes) unless:

44.1.1 it has been approved by more than half of the Governors present and voting at a meeting of the Members' Council duly called in accordance with this constitution.

44.1.2 it has been approved by more than half of the Directors present and voting at a meeting of the Trust Board duly called in accordance with this constitution; and

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions of that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with Schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Members' Council (or otherwise with respect to the role that the Members' Council has as part of the Foundation Trust):

44.3.1 at least one member of the Members' Council must attend the next Annual Members' Meeting and present the amendment

44.3.2 the Foundation Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4 If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Foundation Trust must take such steps as are necessary as a result.

44.5 Amendments by the Foundation Trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers, etc. and significant transactions

45.1 The Foundation Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Members' Council.

45.2 The Foundation Trust may enter into a significant transaction only if more than half of the members of the Members' Council of the Foundation Trust voting approve entering into the transaction.

45.3 The Constitution does not contain any descriptions of the terms 'significant transaction' for the purpose of section 51A of the 2006 Act (Significant Transactions). The Foundation Trust will refer to guidance issued by Monitor or the Department of Health in determining what constitutes a significant transaction.

ANNEX 1 – THE PUBLIC CONSTITUENCIES

(Paragraphs 7.1 and 7.3)

The Public Constituencies are:

1.1 Barnsley (the area covered by Barnsley Council)

1.2 Calderdale (the area covered by Calderdale Council)

1.3 Kirklees (the area covered by Kirklees Council)

1.4 Wakefield (the area covered by Wakefield Council)

1.5 Rest of Yorkshire, the Humber, Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire (covering all local authorities within these counties).

(*Non-Executive Directors recruited from the above public constituency (1.5), MUST be able to demonstrate a commitment to, and significant knowledge of, the communities the Trust serves.)*

The minimum number of members of the above Public Constituencies is to be 10.

ANNEX 2 – THE STAFF CONSTITUENCY

(Paragraphs 8.4 and 8.5)

The Staff Constituency will consist of the following classes:

1.1 registered medical practitioners and registered pharmacists

1.2 registered nurses

1.3 nursing support

1.4 allied healthcare professionals

1.5 psychological therapies

1.6 social care staff working in integrated teams

1.7 non-clinical support services, including management

The minimum number of members of the above Staff Constituency is to be 4.

ANNEX 3 – COMPOSITION OF MEMBERS' COUNCIL

(Paragraphs 11.2 and 11.3)

1. The aggregate number of Public Governors is to be more than half of the total number of members of the Members' Council.

2. The Members' Council, subject to the 2006 Act, shall seek to ensure that through the composition of the Members' Council:

   2.1 the interests of the community served by the Foundation Trust are appropriately represented

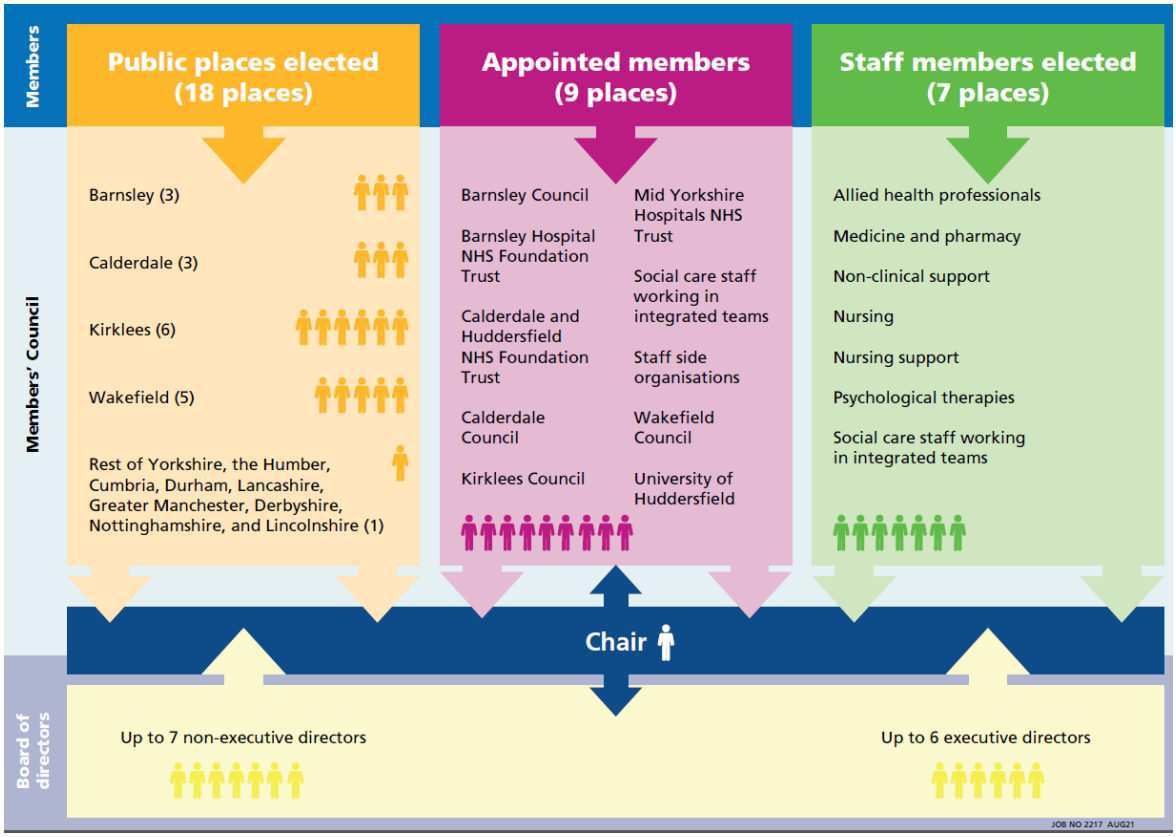
   2.2 the level of representation of the Public Constituency, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Foundation Trust's affairs

   and, to this end, the Members' Council:

   2.3 shall at all times maintain a policy for the composition of the Members' Council which takes account of the involving people strategy

   2.4 shall from time to time and not less than every three years review the policy for the composition of the Members' Council

   2.5 when appropriate shall propose amendments to this constitution.



3. The Members' Council of the Foundation Trust is to comprise:

3.1 Eighteen Public Governors from the Public Constituencies as follows:

3.1.1 Barnsley – three Public Governors

3.1.2 Calderdale – three Public Governors

3.1.3 Kirklees – six Public Governors

3.1.4 Wakefield – five Public Governors

3.1.5 Rest of Yorkshire, the Humber, Cumbria, Durham, Lancashire, Greater Manchester, Derbyshire, Nottinghamshire, and Lincolnshire – one public Governor

3.2 seven Staff Governors from the following classes;

3.2.1 Registered medical practitioners and registered pharmacists – one Staff Governor

3.2.2 Registered nurses – one Staff Governor

3.2.3 Nursing support – one Staff Governor

3.2.4 Allied healthcare professionals – one Staff Governor

3.2.5 Psychological therapies – one Staff Governor

3.2.6 Social care staff working in integrated teams – one Staff Governor

3.2.7 Non-clinical support staff, including management – one Staff Governor

3.3 four Local Authority Governors to be appointed by each of Barnsley Council, Calderdale Council, Kirklees Council and Wakefield Council;

3.4 five Partnership Governors to be appointed by partnership organisations.

4. The partnership organisations which are specified for the purposes of paragraph 9(7) of Schedule 7 to the 2006 Act and may appoint a Partnership Governor are:

4.1 Calderdale and Huddersfield NHS Foundation Trust;

4.2 The Mid Yorkshire Hospitals NHS Trust;

4.3 Barnsley Hospital NHS Foundation Trust

4.4 The University of Huddersfield;

4.5 Joint Committee of Staff Organisations (comprising British Medical Association, Chartered Society of Physiotherapists, Amicus, Royal College of Nursing of the United Kingdom, and UNISON (including BOAT))

ANNEX 4 –THE MODEL ELECTION RULES

(Paragraph 12.2)

Sponsored by the Foundation Trust Network (FTN) and endorsed by the Department of Health and Monitor, August 2014

PART 1: INTERPRETATION

1. Interpretation

PART 2: TIMETABLE FOR ELECTION

2. Timetable
3. Computation of time

PART 3: RETURNING OFFICER

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
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PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

Action to be taken before the poll

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

The poll

27. Eligibility to vote

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:
(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper

envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper “disqualified”,

(b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

applicable) “disqualified”,

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or

communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with “rejected in part”,

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the

poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions

that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to

rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – MEMBERS' COUNCIL

(Paragraphs 13.4, 13.5, 14.3, 15.1 and 22)

Elected Governors

1. A member of the Public Constituency may not vote at an election for a Public Governor unless within twenty-one days before they vote they have made a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

2. The Secretary, having consulted Barnsley Council, Calderdale Council, Kirklees Council and Wakefield Council is to adopt a process for agreeing the appointment of Local Authority Governors with those local authorities.

3. The Partnership Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

Appointment of Lead Governor / Deputy Lead Governor

4. A Lead Governor / Deputy Lead Governor is to be appointed for the Members' Council using the following procedure.

5. Publicly elected Governors will be invited to self-nominate supported by a brief written explanation of why they are putting themselves forward and evidencing how they would be able to fulfil the role.

6. The Nominations Committee will shortlist the self-nominations and invite shortlisted candidates to make a brief presentation and answer questions based on their 'application'.

7. The Nominations Committee will then make a recommendation to the full Members' Council.

Deputising arrangements for the Chair

8. The Deputy Chair of the Trust Board will chair the Members' Council in the absence of the Chair.

9. If the person chairing the meeting has a conflict of interest in relation to the business being discussed, the Lead Governor (or the Deputy Lead Governor in their absence) will preside over that part of the meeting.

Tenure for appointed Governors

10. An appointed Governor:

    10.1 shall normally hold office for a period of three calendar years

10.2 shall be eligible for re-appointment at the end of his term

10.3 may not hold office for longer than nine years in total, and shall not be eligible for re-appointment if he has already held office for more than six consecutive years.

11. An appointed Governor shall cease to hold office if the appointing organisation which appointed him terminates the appointment.

Further provisions as to eligibility to be a Governor

12. A person may not become a Governor of the Foundation Trust, and if already holding such office will immediately cease to do so, if:

12.1 they are a Director of the Foundation Trust or a Governor or director of an NHS body (unless they are appointed by an appointing organisation which is an NHS body)

12.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Foundation Trust

12.3 they are a member of a local authority's Scrutiny Committee covering health matters

12.4 they have been previously removed as a Governor pursuant to paragraph 14 of this Annex 5

12.5 being a member of one of the Public Constituencies, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Foundation Trust, and that they are not prevented from being a member of the Members Council

12.6 they are subject to a sex offender order

12.7 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body

12.8 they are a person whose tenure of office as the Chair or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

13. A person holding office as a Governor shall immediately cease to do so if:

13.1 they resign by notice of one month in writing to the Chair of the Trust

13.2 they fail to attend three consecutive meetings of the Members' Council, unless the other Governors are satisfied that:

13.2.1 the absences were due to reasonable causes

13.2.2 they will be able to start attending meetings of the Members' Council again within such a period as the other Governors consider reasonable;

13.3 they have refused without reasonable cause to undertake any training which the Members' Council requires all Governors to undertake;

13.4 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the code of conduct for Governors; (see Annex 6)

13.5 they are removed from the Members' Council under the following provisions.

14. A Governor may be removed from the Members' Council by a resolution approved by not less than two thirds of the remaining Governors present and voting on the grounds that:

14.1 they have committed a serious breach of the code of conduct

14.2 they have acted in a manner detrimental to the interests of the Foundation Trust

14.3 the Members' Council consider that it is not in the best interests of the Foundation Trust for them to continue as a Governor.

Vacancies amongst Governors

15. Where a vacancy arises on the Members' Council for any reason other than expiry of term of office, the following provisions will apply.

16. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement to hold office for the remainder of the term of office.

17. Where the vacancy arises amongst the elected Governors, the Members' Council shall be at liberty either:

17.1 to call an election within three months to fill the seat for the remainder of that term of office

17.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next annual election, at which time the seat will fall vacant and subject to election for any unexpired period of the term of office

17.3 if the unexpired period of the term of office is less than nine months, to leave the seat vacant until the next elections are held.

ANNEX 6 – CODE OF CONDUCT FOR GOVERNORS
(Annex 5, 13.4 and Annex 10 4.1.1)

1. Introduction

The Code of Conduct seeks to outline the appropriate conduct for Governors of this Trust. It addresses both the requirements of office and of personal behaviour. Ideally, any penalties for non-compliance would not need to be applied; however, it is considered an essential guide for Governors, particularly those who are newly elected.

As a member representative dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role. Governors are required to maintain confidentiality with regard to information gained through their involvement in the Trust.

This Code seeks to expand on and complements the Constitution of the Trust. Copies of the Constitution will be provided to all Governors on election or appointment.

Governors, once elected or appointed, will be required by the Chair of the Trust to sign a declaration to confirm they will comply with this Code of Conduct in all respects and that, in particular, they support the mission, vision, values and goals of the Trust.

2. Qualification for Office

Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Head of Corporate Governance (Company Secretary) should be advised of any changes in circumstances that might or do disqualify the Governor from continuing in office.

All Governors will be expected to understand, agree and promote the Trust's Equal Opportunities Policy in every aspect of their work, a copy of which will be provided on appointment. There are also a number of other policies to which Governors will be expected to adhere. Copies of these will be included in the Governors' information pack.

One of the key objectives of the Members' Council will be to promote local accountability for all communities throughout its work. As such, the development and delivery of initiatives should not prejudice any part of the community on the grounds of age, sex, disability, marital status, sexual orientation or religious belief. The promotion of any personal or political view that undermines this prime objective is grounds for dismissal from the Member's Council.

3. Role and function of the Members' Council

Governors are expected to:

a) Actively support the mission, vision, values and goals of the Trust in developing a successful NHS Foundation Trust.
b) Act in the best interests of the Trust at all times.
c) Communicate with members and act as a bridge between local communities and Trust Board.
d) Contribute to the Members' Council in order for it to fulfil its role and functions as defined in the Constitution.
e) Recognise that the Members' Council exercises collective decision making in the meeting room, which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member.
f) Recognise that the Members' Council has no managerial role within the Trust.
g) Value and treat with respect colleagues on the Members' Council and all members of staff with whom the Governor has contact.
h) Attend meetings of the Members' Council and training events on a regular basis in order to carry out the role of Governor.
i) Conduct themselves in a manner that enables them to act as an ambassador for the Trust.
j) Abide by the policies and procedures of the Trust.

4. Conflicts of Interest

Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment.

Any Governor who has a material interest in a matter as defined in the Constitution, should declare such interest to the Members' Council for it to be recorded in the Register of Interests for the Members' Council, and will not be present, except with the permission of the Members' Council, in any discussion of the matter and shall not vote on the issue.

If in any doubt they should seek advice from the Chair of the Trust. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the Trust and all individuals concerned.

Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

Information on the Declaration of Interests process in contained in the Governors' information pack.

5. Members' Council meetings

Governors have a responsibility to attend meetings of the Members' Council. When this is not possible they should submit an apology to the Chair of Trust in advance of the meeting.

In accordance with the Constitution, absence from the Members' Council meetings without good reason established to the satisfaction of the Chair and/or the Deputy Chair is grounds for disqualification. Absence from three consecutive meetings, unless the Chair and/or Deputy Chair are satisfied that the absences were due to reasonable causes and they will start attending meetings again within a reasonable period of time, will result in the Governor being deemed to have resigned their position.

Governors should attend the whole of the meeting.

6. Personal Conduct

Governors are required to adhere to the highest standard of conduct in the performance of their duties. In respect to their interaction with others, they are required to agree and adhere to the following statements:

- I acknowledge that the Trust is an apolitical organisation.
- If I am a member of any trade union, political party or other organisation, I recognise that, should I be elected or appointed, I will not be representing those organisations (or the views of those organisations) but will be representing the constituency (public or staff) that elected me or organisation who nominated me.
- I will be honest and act with integrity and probity at all times.
- I will respect and treat with dignity and fairness the public, service users and carers, relatives, NHS staff and partners in other agencies.
- I will seek to ensure that my fellow Governors are valued as colleagues and that judgements about colleagues are consistent, fair and unbiased and are properly founded.
- I will not use language or behaviour that others might find offensive.
- I agree to abide by the directions of the Chair of the meeting.
- I will accept responsibility for my actions.
- I will show my commitment to working as a team member by working with my colleagues in the NHS and wider community.
- I will seek to ensure that the membership of the constituency I represent is properly informed and able to influence services.
- I will seek to ensure that no-one is discriminated against because of their religion, belief, race, colour, gender, marital status, disability, sexual orientation, age, social or economic status or national origin.
- I will, at all times, comply with the Standing Orders and Standing Financial Instructions of the Trust.
- I will respect the confidentiality of individual service users and comply with the confidentiality policies of the Trust.
- I will not make, permit or knowingly allow to be made any untrue or misleading statement relating to my own duties or the functions of the Trust.
- I will seek to ensure that the best interests of the public, service users, carers and staff are upheld in decision-making and the decisions are not improperly influenced by gifts or inducements.
- I will support and assist the Accounting Officer of the Trust (the Chief Executive) in his/her responsibility to answer to the Independent Regulator, Commissioners and the public in terms of fully faithfully declaring and explaining the use of

resources and the performance of the total NHS in putting national policy into practice and delivering targets;

- I will uphold the seven principles of public life as defined by the Nolan Committee.

The Members' Council and Trust Board will follow the principles set out by the Committee on Standards in Public Life (the Nolan Committee - now the Wicks Committee). The Members' Council will, therefore, also be expected to adhere to the following principles.

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

Integrity
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

Objectivity
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for awards or benefits, holders of public office should make choices on merit.

Accountability
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

Openness
Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

Honesty
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
Holders of public office should promote and support these principles by leadership and example.

All Governors are required to respect the confidentiality of the information received in the role as Governor and act with integrity and objectivity in the best interests of the Trust, without any expectation of personal benefit. Any disclosure of confidential information could result in dismissal from the Members' Council.

7. Confidentiality

As a member representative dealing with difficult and confidential issues, Governors are required to act with discretion and care in the performance of their role.

Governors are required to maintain confidentiality with regard to information gained through their involvement in the Trust and disclosure of confidential information is likely to result in dismissal from the Members' Council.

8. Training and development

Training and development are essential for Governors to ensure they have the necessary skills and competencies to fulfil their role and there is an obligation on Governors to attend training relevant to their needs.

9. Reimbursement of expenses

Governors will not receive payment for their role; however, they will receive reimbursement of any out of pocket expenses incurred whilst carrying out their duties as a Governor of the Trust. Guidelines are contained in the Governors' information pack. The expenses of Governors will be published in the annual report.

10. Visits to SWYPFT premises

Requests to make formal visits to any Trust service should be made through the Corporate Governance team. This does not apply to personal visits to Trust premises.

11. Non-compliance with the Code of Conduct

Non-compliance with the Code may result in the following action:

a) Where misconduct takes place, the Chair shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.

b) Where such misconduct is alleged, it shall be open to the Members' Council to decide, by simple majority of those in attendance, to lay a formal charge of misconduct.

c) Notifying the Governor in writing of the charge/s, detailing the specific behaviour, which is considered to be detrimental to the Trust, and inviting and considering their response within a defined timescale.

d) Inviting the Governor to address the Members' Council in person if the matter cannot be resolved satisfactorily through correspondence.

e) Deciding, by simple majority of those present and voting, whether to uphold the charge of conduct detrimental to the Trust.

f) Imposing such sanctions as shall be deemed appropriate. Such sanctions will range from the issuing of a written warning as to the Governor's future conduct and consequences, non-payment of expenses to the removal of the Governor from office.

A Governor may be removed from the Members' Council by a resolution approved by not less than two-thirds of the remaining Governors present and voting at a General Meeting of the Council of Members.

This Code of Conduct does not limit or invalidate the right of the Governor or the Trust to act under the Constitution.

ANNEX 7~~6~~ – ADDITIONAL PROVISIONS – TRUST BOARD

(Paragraphs 25.3, 26.3, and 29)

Appointment and Removal of Chair and other Non-Executive directors

1. Non-Executive Directors are to be appointed by the Members' Council using the following procedure.

   1.1 The Members' Council will maintain a policy for the composition of the Non-Executive Directors which takes account of the membership strategy, and which they shall review from time to time and not less than every three years.

   1.2 The Trust Board may work with an external organisation recognised as expert at appointments to identify candidates with appropriate skills and experience required for Non-Executive Directors vacancies.

   1.3 (An) appropriate candidate(s) will be identified by a Nominations Committee through a process of open competition, which takes account of the policy maintained by the Members' Council and the skills and experience required.

   1.4 The Nominations Committee will comprise the Chair of the Foundation Trust (or, when a Chair is being appointed, another non-executive Director), the Chief Executive and at least two Governors selected by the Members' Council. The Nominations Committee will have the power to co-opt external persons to act as independent assessors to the Nominations Committee.

2. The removal of the Chair or another Non-Executive Director shall be in accordance with the following procedures.

   2.1 Any proposal for removal must be proposed by a Governor and seconded by not less than three-quarters of the Members' Council of whom at least two must be elected Governors and two must be appointed Governors.

   2.2 Written reasons for the proposal shall be provided to the Non-Executive Director in question, who shall be given the opportunity to respond to such reasons.

   2.3 In making any decision to remove a Non-Executive Director, the Members' Council shall take into account the annual appraisal carried out by the Chair.

   2.4 If any proposal to remove a Non-Executive Director is not approved at a meeting of the Members' Council, no further proposal can be put forward to remove such Non-Executive Director based upon the same reasons within 12 months of the meeting.

Further provisions as to disqualification of Directors

3. A person may not become or continue as a Director of the Foundation Trust if:

3.1 they are a member of the Members' Council or, except with the permission of the Trust Board, a governor or director of an NHS body

3.2 they are the spouse, partner, parent or child of a member of the Trust Board of the Foundation Trust

3.3 they are a member of a local authority's Scrutiny Committee covering health matters

3.4 they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986

3.5 they are a person whose tenure of office as a Chair or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non attendance at meetings, or for non-disclosure of a pecuniary interest

3.6 they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body

3.7 in the case of a Non-Executive Director they have refused without reasonable cause to fulfil any training requirement established by the Trust Board

3.8 in the case of a Non-Executive Director they are currently employed as a member of staff with the Trust

3.9 in the case of a Non-Executive Director they are not a member of the Trust. If a Non-Executive Director moves out of the Yorkshire & the Humber area during their term, they can continue in their role for the remainder of their existing term so far as it is practical to do so

3.10 they have refused to sign and deliver to the Secretary a statement in the form required by the Trust Board confirming acceptance of the declaration and register of fit and proper persons, interests and independence ~~code of conduct~~ for Directors. (see Annex 8)

Expenses

4. The Foundation Trust may reimburse Executive Directors travelling and other costs and expenses incurred in carrying out their duties at such rates as the remuneration committee of Non-Executive Directors decides. These are to be disclosed in the annual report.

5. The remuneration, allowances and other terms of office of the Non-Executive Directors are determined by the Members' Council as set out in paragraph 33.1 of the constitution.

6. The remuneration and allowances for Directors are to be disclosed in bands in the annual report.

ANNEX 8 - TRUST BOARD DECLARATION AND REGISTER OF FIT AND PROPER PERSONS, INTERESTS AND INDEPENDANCE (Annex 7, 3.10)

1. Introduction and background

In accordance with the Constitution of the Trust, the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) and Monitor's (referred to in this paper as NHS England / Improvement) Code of Governance for Foundation Trusts, and in recognition of the Codes of Conduct and Accountability issued by the Department of Health and the UK Corporate Governance Code produced by the Financial Reporting Council, the Trust is required to maintain a Register of Interests of Directors. The Trust is also required, under the new fundamental standard regulations set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, to ensure its Directors meet fit and proper person requirements, which came into force on 1 October 2014.

2. Policy development

The Trust has had a policy in place in relation to Directors' declarations of interests since its inception in April 2002. This Policy was updated in May 2009 when the Trust was authorised as a Foundation Trust.

In September 2011, the Policy was subsequently revised to incorporate the Bribery Act 2010, which came into force on 1 July 2011 and created criminal offences of being bribed, bribing another and failing to prevent bribery for all organisations, including the NHS. Under the Act, bribery is defined as an inducement or reward offered, promised or provided to gain personal, commercial, regulatory or contractual advantage. If a Director is offered, or any attempt is made to offer, any type of possible inducement or reward covered by the Bribery Act, details should be immediately reported to the Trust's Local Counter Fraud Specialist.

In December 2013, a further revision was made to reflect the changes to the Trust's Constitution as a result of the provisions in the Health and Social Care Act 2012 relating to Directors' interests.

In March 2015, a further revision was made to incorporate 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.

In March 2018, a further revision was made to align the Policy with the Trust's Standards of Conduct in Public Service Policy (conflicts of interest policy) which addresses the requirements of the NHS England guidance and model policy for the NHS organisations on managing staff conflicts of interests.

This Policy applies to all directors and 'equivalents', which, for this Trust, includes both Non-Executive and Executive Directors of the Trust, and other Directors forming the Executive Management Team.

3. Fit and proper person requirement for directors

The fit and proper person requirement for directors states that individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care and, as such, can be held accountable if standards of care do not meet legal requirements. It applies to all directors and 'equivalents', which, for this Trust, includes both Non-Executive and Executive Directors of the Trust, and other Directors forming the Executive Management Team. It is the responsibility of the Chair to ensure that all Directors meet the fitness test and do not meet any of the 'unfit' criteria.

In addition to the usual requirements of good character, health, qualifications, skills and experience, the regulation bars individuals who are prevented from holding the office (for example, under a director's disqualification order) and excludes from office people who:

"have been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider."

The Care Quality Commission (CQC) is the body that will decide whether a person is not fit to be a director on the basis of any previous misconduct or incompetence in a previous role for a service provider. This would be the case even if the individual was working in a more junior capacity at that time, or working outside England.

The regulation requires the Chair to:

- Confirm to the CQC that the fitness of all new directors has been assessed in line with the regulations.
- Declare to the CQC in writing that they are satisfied that they are fit and proper individuals for that role.

A notification is required following a new director-level appointment. The CQC will cross-check notifications about new directors against other information they hold or have access to, to decide whether it wants to look further into the individual's fitness. The CQC will also have regard to any other information they hold or obtain about directors in line with current legislation on when convictions, bankruptcies or similar matters are to be considered 'spent'.

Where a director is associated with serious misconduct or responsibility for failure in a previous role, the CQC will have regard to the seriousness of the failure, how it was managed, and the individual's role within that. There is no time limit for considering such misconduct or responsibility. Where any concerns about an existing director come to the attention of the CQC, it may also ask the Trust to provide the same assurances.

Should the CQC use its enforcement powers to ensure all directors are fit and proper for their role, it will do so by imposing conditions on the provider's registration to ensure the provider takes appropriate action to remove the director.

4. Fit and proper person requirement – Trust duties

To meet the requirements of the fit and proper person test, the Trust must carry out all necessary checks to confirm that persons who are appointed to the role of director in the Trust are:

- Of good character (Schedule 4, Part 2 of the regulations).
  Have the appropriate qualifications, are competent and skilled (including that they show a caring and compassionate nature and appropriate aptitude).
- Have the relevant experience and ability (including an appropriate level of physical and mental health, taking account of any reasonable adjustments).
- Exhibit appropriate personal behaviour and business practices.

In addition, persons appointed to these roles must not have been responsible for, or known, contributed to or facilitated any serious misconduct or mismanagement in carrying on a regulated activity.

The Trust will ensure it has procedures in place to assess an individual against the fit and person requirements for new Director appointments prior to that appointment. The Head of Corporate Governance (Company Secretary) is responsible for ensuring procedures are in place and implemented for Non-Executive Director appointments and the Director of Human Resources and Organisational Development for Executive and 'other' Director appointments.

The CQC does recognise that the Trust may not have access to all relevant information about a person, or that false or misleading information may be supplied to it; however, the CQC does expect the Trust to demonstrate due diligence in carrying out checks and that it has made every reasonable effort to assure itself about an individual by all means available to it.

If the Trust decides to appoint a director, or continues to employ or appoint a Director, who does not meet the 'fit and proper person' test, it will need a strong rationale for doing so, which is defendable by the Chair both to the CQC and to NHS England / Improvement. Currently, the only outcome if the CQC decides an individual is not a 'fit and proper person' is removal.

5. Fit and proper person requirement – individual responsibilities

Although the obligation is on the Trust to ensure it meets the regulation particularly in relation to new appointments, Trust Board agreed in September 2014 that Directors have a responsibility to continue to make a declaration that they meet the fit and proper person requirement as part of the annual declaration of interests process and should their circumstances change.

The criteria for a 'fit and proper person' are as follows.

- The individual is of good character.
- The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed or appointed.
- The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
- The individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
- None of the grounds for unfitness specified in Part 1 of Schedule 4 apply to the individual (see below):

Schedule 4 criteria
Fit and proper

1. The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
2. The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
3. The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
4. The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
5. The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
6. The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

And for good character

7. Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
8. Whether the person has been erased, removed or struck-off a register of professionals maintained by a regulator of health care or social work professionals.

6. Conflicts of interest – duties of Directors

Meeting the fit and proper person requirement as set out above does not remove the responsibility of Directors of the Trust to adhere to the duties of a Director of the Trust, as set out in the Trust's Constitution, which include the following.

1. A duty to avoid any situation where a Director has (or could have) a direct or indirect interest that conflicts (or may possibly conflict) with the interests of the Trust. This duty is not infringed if the situation cannot reasonably be regarded as

likely to give rise to a conflict of interest or the matter has been authorised in accordance with the Constitution.

2. A duty not to accept a benefit from a third party because they are a Director or doing (or not doing) anything in this capacity. This duty is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest. (A "third party" means a person other than the Trust or a person acting on its behalf.)

The Trust's *Standards of Conduct in Public Service Policy* (conflicts of interest policy), which addresses the requirements of the NHS England guidance and model policy for the NHS organisations on managing staff conflicts of interests, applies to Directors of the Trust as 'decision making staff'. The policy describes the requirements for declaring interests including gifts, hospitality, outside employment, shareholdings and other ownership issues, patents, loyalty interest, donations, sponsored events, sponsored research, sponsored posts, and clinical private practice. Further to this, Directors are expected to:

a) Refuse gifts, benefits, hospitality or sponsorship of any kind that might reasonably be seen to compromise their personal judgement or integrity and / or exert influence to obtain preferential consideration. All such gifts should be returned and hospitality refused other than isolated gifts of a trivial nature, such as, calendars, or conventional hospitality, such as working lunches.
b) Declare and register gifts, benefits and sponsorship of any kind within two weeks of it being offered, whether refused or accepted. If an individual is unsure whether the offer constitutes hospitality, gifts or rewards as defined by the Trust's policy, then they should declare.

This applies to both implicit and explicit offers and whether or not linked to the awarding of contracts or a change in working practices.

If a Director of the Trust has a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to Trust Board. If a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any declaration must be made before the Trust enters into the transaction or arrangement.

If the Director is not aware of an interest, or where the Director is not aware of the transaction or arrangement in question, no declaration is required.

A Director need not declare an interest:

a) If it cannot reasonably be regarded as likely to give rise to a conflict of interest.
b) If, or to the extent that, the Directors are already aware of it.
c) If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered either by a meeting of the Board of Directors or by a committee of the Directors appointed for the purpose under the Constitution.

All declarations will be entered into the Trust's Register of Interests maintained by the Head of Corporate Governance (Company Secretary).

7. Declaration of interest – duties of Directors

In a spirit of openness and transparency, Directors are also encouraged to declare all relevant and material interests. These apply to the Director as well as the husband / wife, partner, parent, child or sibling of the Director and can be defined as follows.

a) Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies).
b) Ownership, part-ownership or directorship of private companies, business or consultancies likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust.
c) Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS or which may conflict with the interests of the Trust.
d) A position of authority in a charity or voluntary organisation in the field of health and social care.
e) Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services.
f) Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS Foundation Trust, including but not limited to, lenders or banks.

If Directors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair.

Details of any such interests will be recorded in the register of interests of the Directors as outlined below.

8. Declaration of interest – conduct at meetings

Any Director who fails to disclose any interest required to be disclosed under the Constitution and as set out in this Policy may be removed from office in accordance with the process for removing a Director as set out in the Trust's Constitution.

Any Director who has an interest in a matter to be considered by Trust Board that needs to be declared should declare such interest to Trust Board and:

1. Withdraw from the meeting and play no part in the relevant discussion or decision.
2. Not vote on the issue (and, if by inadvertence, they do remain and vote, their vote shall not be counted).

At the time an interest is declared, it should be recorded in Trust Board meeting minutes. Any changes in interests should be officially declared at the next Trust Board meeting following the change occurring. The Trust should be informed in writing within four weeks of becoming aware of the existence of, or a change to, an interest. The Register of Interests will be amended on receipt within seven working days and the interest notified to the next relevant meeting.

During the course of a Trust Board meeting, if a conflict of interest is established, the Director(s) concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt, this includes voting on such an issue where a conflict is established. If there is a dispute as to whether a conflict of interest does exist, a majority will resolve the issue with the Chair having the casting vote.

9. Register of interests

Details of any interests declared by Directors will be recorded in the Register of Interests of the Directors.

The details of Directors' interests recorded in the Register will be kept up-to-date by means of a monthly review of the Register by the Head of Corporate Governance (Company Secretary) during which any changes of interests declared during the preceding month will be incorporated.

An annual review process will be undertaken by the Head of Corporate Governance (Company Secretary) and the Register of Interests presented to Trust Board on an annual basis (usually in March each year). As part of this process, Trust Board will assess any apparent conflicts and / or any risks an interest might present to the Trust. This annual review is over and above the requirement for Directors to declare interests during the year and is a standing item on each public Trust Board meeting agenda.

Subject to contrary regulations being passed, the Register will be available for inspection by the public free of charge and will be available on the Trust's website. The Head of Corporate Governance (Company Secretary) will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it. Copies or extracts of the Register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the Register, informed by guidance from the Information Commissioner.

10. Determination of independence

Monitor's (NHS England / Improvement) Code of Governance also requires the Board to identify in the Trust's annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances likely to affect, or could appear to affect, the Director's judgement. In addition to the above fit and proper person requirements and declaration of interests, Non-Executive Directors are also asked to declare whether he / she:

a) Has been an employee of the Trust within the last five years.
b) Has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust.
c) Has received or receives additional remuneration from the Trust apart from the Non-Executive Directors' fee, participates in the Trust's performance related pay scheme, or is a member of the Trust's pension scheme.

d) Has close family ties with any of the Trust's advisers, Directors or senior employees.
e) Holds cross-directorships or has significant links with other Directors through involvement in other companies or bodies.
f) Has served on the Trust Board for more than nine years from the date of their first appointment.

Non-Executive Directors have a responsibility to continue to make a declaration of independence as part of the annual declaration of interests process and should their circumstances change.

11. Appendices

- Fit and proper person declaration by the Chair and Directors of the Trust form.
- Declaration of interests by the Chair and Directors of the Trust form.
- Declaration of independence by the Chair and Non-Executive Directors of the Trust form.

ANNEX 9~~7~~ – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE MEMBERS' COUNCIL

(Paragraph 18)

1. Calling Meetings

1.1 The Members' Council is to meet at least four times in each financial year (excluding the Annual Members' Meeting) at such times and places as the Council may determine.

1.2 Meetings of the Members' Council may be called by the Secretary, or by the Chair, or by ten Governors including at least two elected Governors and two appointed Governors who give written notice to the Secretary specifying the business to be carried out.

2. Admission of the Public

2.1 All meetings of the Members' Council are to be General Meetings open to members of the public unless the Members' Council decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Members' Council if they are interfering with or preventing the proper conduct of the meeting.

3. Notice of Meetings

3.1 Save in the case of emergencies or the need to conduct urgent business, the Secretary will give at least seven days' notice of the date and place of every meeting of the Members' Council to all Governors. Notice will also be published on the Trust's website.

3.2 After the receipt of a request to call a meeting the Secretary shall send notice to all Governors, specifying the business to be carried out, as soon as possible after the receipt of such a request. The Secretary shall call a meeting on at least 14 but not more than 28 days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or 10 Governors, whichever is the case, shall call such a meeting.

3.3 The notice of the meeting specifying the business proposed to be transacted at it shall be delivered to every Governor, so as to be available to him / her at least five clear days before the meeting.

3.4 Lack of service of the notice shall not affect the validity of a meeting.

3.5 In the case of a meeting called by the Chair or the Governors in default of the Secretary, the Chair or those Governors shall sign the notice and no business shall be transacted at the meeting other than that specified in the notice.

3.6 In such a case, failure to serve such a notice on more than 20 Governors will

invalidate the meeting.

4. Setting the Agenda

4.1 The Foundation Trust may determine that certain matters shall appear on every agenda for a meeting of the Council and shall be addressed prior to any other business being conducted.

4.2 In accordance with the Constitution every agenda for meetings of the Members' Council will draw to the attention of Governors the declaration they are required to make in clause 9.1 stating that they are qualified to vote as a member of the Trust and that they are not prevented from being a member of the Members' Council. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Members' Council.

4.3 Any Governor wishing to submit an agenda item must notify the Secretary in writing at least ten clear days prior to the meeting at which it is to be considered. Requests made less than ten clear days before a meeting may be included on the agenda at the discretion of the Chair.

5. Chair of the Meeting

5.1 The Chair of the Trust or, in their absence, the Deputy Chair is to preside at meetings of the Members' Council.

5.2 If the Chair has a conflict of interest in relation to the business being discussed, the Deputy Chair will chair that part of the meeting.

5.3 If the person chairing the meeting has a conflict of interest in relation to the business being discussed, the Lead Governor (Deputy Lead Governor in their absence) will preside over that part of the meeting.

5.4 If a vote concerns matters relating to the Chair and / or Non-Executive Directors, neither the Chair of the Trust nor any other Non-Executive Director should preside over the meeting. In this instance the Lead Governor (Deputy Lead Governor in their absence) should preside over that part of the meeting and have the casting vote.

6. Annual Members' Meeting

6.1 The Foundation Trust will publicise and hold an Annual Members' Meeting in accordance with the Constitution.

7. Motions

7.1 Motions may only be submitted by a Governor and must be received by the Secretary in writing at least one week prior to the meeting at which they are to be considered.

7.2 Emergency motions may only be submitted by a Governor and must be received by the Secretary before the commencement of the meeting. Acceptance of such motions for inclusion on the Agenda will be at the discretion of the Chair.

7.3 Any other business should be notified to the Chair at the commencement of the meeting. Acceptance of such items of business for inclusion on the agenda will be at the discretion of the Chair.

7.4 Notice of a motion to rescind a previous Minute must be received by the Secretary at least 21 days before the meeting and must be signed by a majority of members. Such a motion should not be taken until at least 30 minutes after the start of the meeting.

7.5 An amendment that does not directly negate a resolution may be moved by any member. No further amendments may be moved until the first amendment is disposed of. If an amendment is passed it shall become part of the substantive motion and subject to further amendment.

8. Chair's Ruling

8.1 Statements of Governors made at meetings of the Members' Council shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

9. Voting

9.1 An elected Governor may not vote at a meeting of the Members' Council unless, before attending the meeting, they have made a declaration in the form specified by the Members' Council of particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Members' Council. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Members' Council, and every agenda for meetings of the Members' Council will draw this to the attention of elected Governors.

9.2 Subject to the Constitution questions arising at a meeting shall be determined by a majority of the votes of the Governors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

9.3 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

9.4 In accordance with the Constitution the appointment of the Chair and any Non-Executive Director of the Trust is subject to the approval of a majority of the votes of the Governors present.

9.5 In accordance with the Constitution the removal of the Chair and any Non-Executive Director of the Trust is subject to a three-quarters majority of all the members of the Council of Members, voting at the meeting, of which at least two must be elected and two appointed.

9.6 In accordance with the Constitution the appointment of the Chief Executive is subject to the approval of a majority of the members of the Council of Members present and voting at a meeting.

9.7 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

9.8 Subject to the Constitution, and subject to clause 9.5, questions arising at a meeting of the Members' Council shall be decided by a majority of votes.

9.9 No resolution of the Members' Council shall be passed if all the Public Governors present unanimously oppose it.

9.10 All decisions taken in good faith at a meeting of the Members' Council or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

10. Attendance

10.1 Governors who are unable to attend the Members' Council meeting should advise the Secretary in advance of the meeting so that their apologies may be submitted.

10.2 The Members' Council may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute the presence of the person at the meeting.

10.3 The Members' Council may invite the Chief Executive or any other member or members of the Trust Board, or a representative of the Trust's auditors or other advisors to attend a meeting of the Members' Council.

11. Minutes

11.1 The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting. The person presiding at that meeting will sign them.

11.2 No discussion shall take place upon the Minutes except upon their accuracy or where the Chair considers discussion appropriate (for example, consideration of matters arising). Any amendment to the Minutes shall be agreed and recorded at the next meeting.

11.3 Minutes shall be circulated in accordance with the Governors' wishes. Where

providing a record of a public meeting the Minutes shall be made available to the public.

12. Record of Attendance

12.1 The names of the Governors present at the meeting shall be recorded in the minutes.

13. Suspension of Standing Orders

13.1 Except where this would contravene the Constitution or any statutory provision, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Council are present, and that a majority of those present vote in favour of suspension.

13.2 A decision to suspend Standing Orders shall be recorded in the minutes of the Meeting.

13.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Governors.

13.4 No formal business may be transacted while Standing Orders are suspended.

14. Variation and Amendment of Standing Orders

14.1 These Standing Orders may only be amended in accordance with paragraph 44 of this constitution. A motion to change the Standing Orders must be submitted to the Secretary in writing at least 21 days before the meeting.

15. Quorum

15.1 The quorum for the Members' Council will be one-third of the membership of the Council provided that a minimum of half of this one-third are publicly elected Governors.

15.2 Any Governor who has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of the declaration of a conflict of interest shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

15.3 In accordance with the Constitution if at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for seven days and upon reconvening, those present shall constitute a quorum.

16. Committees

16.1 The Members' Council may not delegate any of its powers to a committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Members' Council in carrying out its functions. The Members' Council may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

ANNEX 10~~8~~ – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE TRUST BOARD

(Paragraph 31)

To be read in conjunction with the Standing Financial Instructions, Reservation of Powers to the Board and Scheme of Delegation.

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the National Health Service Act 2006, the Health and Social Care Act 2012 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in these Standing Orders and Standing Financial Instructions and in addition:

"Accounting Officer" refers to the Chief Executive who is responsible and accountable to Parliament for ensuring the proper stewardship of public funds and assets.

"Trust" means the South West Yorkshire Partnership NHS Foundation Trust.

"Trust Board" means the Chair, executive and non-executive directors of the Trust collectively as a body.

“Constitution” means the Constitution of the Trust and all annexes to it.

"Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

“Budget holder” means the director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

"Chair of the Board (or Trust)" is the person appointed by the Members’ Council to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chair of the Trust” shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.

"Chief Executive" means the chief officer of the Trust, who is also the Accounting Officer.

"Commissioning" means the process for determining the need for and for obtaining the supply of healthcare and related services within available resources.
"Committee" means a committee or sub-committee created and appointed by the Trust.

"Committee members" means persons formally appointed by the Board to sit on or to chair specific committees.

"Contracting and procuring" means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Governor" means a person elected or appointed to serve on the Members' Council.

"Deputy Chair" means the non-executive director appointed by the Members' Council to take on the Chair's duties if the Chair is absent for any reason.

"Director of Finance and Resources" means the Chief Financial Officer of the Trust.

"Executive Director" means a director of the Trust who is an employee of the Trust.

"Funds held on trust" shall mean those funds which the Trust holds on date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

"Members' Council" is the body established according to the constitution to represent the interests of stakeholders.

"Monitor" (or successor organisation) is the Regulator appointed under the National Health Service Act 2006.

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

"Non-Executive Director" means a director of the Trust who is not an employee of the Trust.

"Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

"Secretary" means a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the law, Standing Orders, and guidance issued by the Department of Health and Monitor.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

"Trust Board member" means an executive or non-executive director of the Board as the context permits.

2. INTRODUCTION

2.1 Statutory Framework

South West Yorkshire Partnership NHS Foundation Trust is a public benefit corporation established in accordance with the provisions of the National Health Service Act 2006 and was authorised on 1 May 2009. The Standing Orders of the Trust are designed to facilitate effective working of the Trust Board and to reflect the standards for business conduct and probity that are set out in the Monitor Code of Governance.

2.1.1 The Trust provides services to the population of Barnsley, Calderdale, Kirklees and Wakefield and the principal places of business are within the boundaries of these local authority areas. The Trust also operates regional forensic psychiatric services for the population of Yorkshire and the Humber. The headquarters of the Trust is Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.

2.1.2 NHS Foundation Trusts are governed mainly by the National Health Service Act 2006 and the Health and Social Care Act 2012, and are subject to regulation by Monitor.

2.1.3 The functions of the Trust are conferred by this legislation.

2.1.4 As a statutory body, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health.

The Trust is required to adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) setting out the responsibilities of individuals. The Trust is additionally required to draw up a schedule of decisions that are reserved for the Board and to ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The documents setting out the Reservation of Powers to the Board and Scheme of Delegation, and the Standing Financial Instructions have effect as if incorporated into the Standing Orders.

The Trust is also bound by such other statutes and legal provisions which govern the conduct of its affairs. In addition to the statutory requirements, the Secretary of State through the Department of Health issues further directions and guidance. These are normally issued under cover of a circular or letter.

2.2 Dissemination of the Trust Board standing orders

The Chief Executive is responsible for ensuring all existing directors and staff and all new appointees to the Trust Board are notified of and understand their responsibilities within Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

2.3 Changes to Standing Orders

Changes to the Standing Orders are subject to the following conditions.

- A notice of motion under SO 4.4 has been given.
- The amendment has been approved in accordance with paragraph 45 of the constitution.

2.4 Review of standing orders

These standing orders will be reviewed biannually by the Trust Board or when required. This review will include all documents having the effect as if incorporated into Standing Orders.

3. THE TRUST BOARD: COMPOSITION AND THE ROLE AND TERMS OF OFFICE OF DIRECTORS

3.1 Role of Directors

The Board will function as a unitary board. Executive and Non-Executive Directors will be full and equal members of the Board which will act as the corporate decision body. Their role as members of the Trust Board will be to consider the key strategic, risk and governance issues facing the Trust in carrying out its statutory and other functions.

3.2 Chair

The Chair shall be responsible for the operation of the Trust Board and chair all meetings of the Trust Board and the Members' Council when present. The Chair must comply with the terms of appointment and with these Standing Orders.

The Chair shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

The Chair will meet at least four times per year with the Non-Executives without the Executive Directors present.

3.3 Non-Executive Directors

The Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may

however, exercise collective authority when acting as members of or when chairing a committee of the Trust which has delegated powers.

3.4 Executive Directors

Executive Directors shall exercise their authority within the terms of these Standing Orders and Standing Financial Instructions and the Scheme of Delegation.

3.5 Chief Executive

The Chief Executive is the Accounting Officer for the Trust and is responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for NHS Foundation Trust Chief Executives.

3.6 Director of Finance and Resources

The Director of Finance and Resources is responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He / she shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

3.7 Composition of the Trust Board

In accordance with the constitution the composition of the Trust Board shall be:

(1) the Chair of the Trust (appointed by the Members' Council);

(2) up to six non-executive directors (appointed by the Members' Council);

(3) up to six executive directors including:

- the Chief Executive who is the accounting officer;
- the Director of Finance and Resources
- the Director of HR and OD ~~and Estates~~
- a registered medical practitioner
- a registered nurse

There will be at least one more non-executive director than executive directors, including the Chair of the Trust.

3.8 Appointment of Chair and Non-Executive Directors of the Trust

Provisions covering the appointment and removal of the Chair and Non-Executive Directors of the Trust Board are set out in paragraphs 26 of the constitution and Annex 7~~6~~ of the constitution: Additional Provisions. The Chair and Non-Executive Directors will be appointed by the Members' Council for an initial period of three years or as determined by the Nominations Committee. The Chair may be re-appointed for a further three years (up to a maximum of nine years in total) subject to the approval of the members' Council. Appointment of Non-Executive directors may be re-

appointed for a further three years (up to a maximum of nine years in total), subject to approval by the Members' Council following confirmation by the Chair that they have performed effectively and remain committed to the role. Appointments beyond six years will be subject to annual review.

On appointment the Chair must meet the 'independence' criteria set out in the Monitor Code of Governance.

The Members' Council will be responsible for agreeing the remuneration of the Chair and Non-Executive Directors.

The senior independent director will meet annually with the Non-Executive Directors to review the Chair's performance. Any further arrangements for appraisal of the chair will be agreed with the Members' Council.

3.9 Appointment of Chief Executive and Executive Directors

The Chief Executive will be appointed by a Committee of the Trust Board, consisting of the Chair, other Non-Executive Directors, and a representative from the Members' Council. The Committee shall be advised by an independent assessor, who will have no formal role in making an appointment. Appointment of the Chief Executive will be subject to approval by the Members' Council at the first general meeting after appointment.

Executive Directors of the Trust Board will be appointed by a Committee of the Trust Board consisting of Chair, the Chief Executive and other non-executive directors.

3.10 Appointment and Powers of Deputy Chair

The Members' Council will appoint a Non-Executive Director to be the Deputy Chair for period of three years or for the remainder of their term as a member of the Trust Board (if less than three years) or for any other period determined by the Members' Council.

Any member so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair. The Members' Council may thereupon appoint another member as Deputy Chair.

Where the Chair of the Trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

3.11 Appointment of a Senior Independent Director

The Trust Board shall appoint one of the independent non-executive directors to act as the Senior Independent Director. This will be done in consultation with the Members' Council. The Senior Independent Director may be, but need not necessarily be, the Deputy Chair.

The Senior Independent Director will be available to directors and Governors if they have concerns which they cannot resolve with the Chair, Chief Executive or Director of Finance and Resouces.

3.12 Company Secretary

The Trust Board shall appoint a senior member of staff to carry out the functions of a Company Secretary to provide advice on corporate governance issues to the Chair, the Trust Board and the Members' Council and monitor the Trust's compliance with these standing orders, the Constitution, the terms of authorisation, statutory provisions and guidance and directions given by Monitor. The Secretary will ensure good information flows between the Trust Board, its committees and the Members' Council.

3.13 Corporate role of the Board

(1) All business shall be conducted in the name of the Trust.

(2) All funds received in trust shall be held in the name of the Trust as corporate trustee.

3.14 Schedule of Matters reserved to the Board and Scheme of Delegation

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to officers and other bodies are contained in the Scheme of Delegation.

3.15 Lead Roles for Board Members

The Chair will ensure that the designation of lead roles or appointments of Board members as required by commissioners or as set out in any statutory or other relevant guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Member with responsibilities for Infection Control or Child Protection Services etc.).

3.16 Indemnity for Directors

Directors may, at the Trust's expense, seek external advice or appoint an external advisor on any material matter of concern provided the decision to do so is a collective decision by the majority of directors.

A director who acts honestly and in good faith will not have to meet out of his / her personal resources any personal civil liability incurred in the execution of the functions of the Trust Board, save where he has acted recklessly. Any costs arising from a director acting honestly and in good faith will be met by the Trust. The Board of Directors may make any arrangements it considers appropriate for the provision of indemnity insurance to meet any liabilities which are properly the liability of the trust.

4. MEETINGS OF THE TRUST

4.1 Calling meetings

4.1.1 Ordinary meetings of the Board shall be held sufficiently regularly to enable the Board to discharge its duties effectively at such times and places as the Board may determine subject to the conditions set out in Annex ~~6~~7 of the constitution (Additional provisions for the Trust Board).

4.1.2 The Chair of the Trust may call a meeting of the Board at any time.

4.1.3 Meetings of the Trust Board may be called by the Secretary or the Chair or by four directors who give notice to the Secretary specifying the business to be carried out. The Secretary will send notice to all directors as soon as possible after receipt of such a request. The Secretary will call a meeting at least 14 days but not more than 28 days after receipt of such a notice to discuss the specified business. If the Secretary fails to do so, then the Chair or the directors may call such a meeting.

4.2 Notice of Meetings and the Business to be transacted

4.2.1 At least 14 days notice of the date, time and place of meetings will be given except in an emergency.

4.2.2 In the case of a meeting called by directors in default of the Chair calling the meeting, the notice shall be signed by those directors.

4.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency motions allowed under Standing Order 4.5.

4.2.4 A director desiring a matter to be included on an agenda shall make his / her request in writing to the Chair at least 10 clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chair.

4.2.5 Before each public meeting of the Board notice of the time and place of the meeting, and the public part of the agenda, shall be displayed on the Trust's website at least three clear days before the meeting

4.3 Agenda and Supporting Papers

The Agenda will be sent to Trust Board directors at least six clear days before the meeting and supporting papers, whenever possible, will accompany the agenda, unless there are exceptional circumstances and the Chair and Secretary have agreed to one or more papers being circulated later. Failure to serve such a notice on any director shall not affect the validity of a meeting.

4.4 Notice of Motion

4.4.1 Subject to the provision of Standing Orders 4.6 ‘Motions: Procedure at and during a meeting’ and 4.7 ‘Motions to rescind a resolution’, a member of the Board wishing to move a motion shall send a written notice to the Secretary who will ensure that it is brought to the immediate attention of the Chair.

4.4.2 The notice shall be delivered at least 10 clear days before the meeting. The Secretary shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

4.5 Emergency Motions

Subject to the agreement of the Chair, and subject also to the provision of Standing Order 4.6 ‘Motions: Procedure at and during a meeting’, a director of the Board may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

4.6 Motions: Procedure at and during a meeting

4.6.1 **Who may propose?**

A motion may be proposed by the Chair of the meeting or any director present. It must also be seconded by another director.

4.6.2 **Contents of motions**

The Chair may exclude from the debate at their discretion any motion not included in the notice summoning the meeting except motions relating to:

- the receipt of a report
- consideration of any item of business before the Trust Board
- the accuracy of minutes
- that the Board proceed to next business
- that the Board adjourn
- that the question be now put.

4.6.3 **Amendments to motions**

A motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to motions shall be moved relevant to the motion, and shall not have the effect of negating the motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a motion has been amended, the amended motion shall become the substantive motion before the meeting, upon which any further amendment may be moved.

4.6.4 **Rights of reply to motions**

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive / original motion

The director who proposed the substantive motion shall have a right of reply at the close of any debate on the motion.

4.6.5 **Withdrawing a motion**

A motion, or an amendment to a motion, may be withdrawn.

4.6.6 **Motions once under debate**

When a motion is under debate, no motion may be moved other than:

- an amendment to the motion
- the adjournment of the discussion, or the meeting
- that the meeting proceed to the next business
- that the question should be now put
- referral of the matter to a committee of the Trust Board
- that a director be not further heard
- a motion resolving to exclude the public (see Standing Order 4.17).

In those cases where the motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a director of the Board who has not taken part in the debate and who is eligible to vote.

If a motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive motion under debate a right of reply, if not already exercised. The matter should then be put to the vote. No resolution will be passed if it is opposed by all of the Non-Executive Directors or all of the Executive Directors.

4.7 Motion to Rescind a Resolution

4.7.1 Notice of motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the director who gives it and also the signature of three other directors, and before considering any such motion of which notice shall have been given, the Trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

4.7.2 When any such motion has been dealt with by the Trust Board it shall not be competent for any director other than the Chair to propose a motion to the same effect within six months. This Standing Order shall not apply to motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

4.8 Chair of meeting

At any meeting of the Trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair, if present, shall preside.

4.9 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

4.10 Quorum

4.10.1 One third of the whole number of directors, including not less than one executive director (one of whom must be the Chief Executive or another executive director nominated by the Chief Executive) and not less than two non-executive directors (one of whom must be the Chair or deputy Chair of the Trust Board) shall form a quorum.

The Trust Board may agree that its members can participate in its meeting by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

If the Chair or director has been disqualified from participating in the discussion on any matter and / or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.8) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and / or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.11 Voting

4.11.1 The following Directors are entitled to vote as per the composition of the Trust Board:

- a non-executive Chair
- up to six other non-executive directors
- up to six executive directors including:
  - one of the executive directors shall be the Chief Executive.
  - one of the executive directors shall be the finance and resources director.
  - one of the executive directors shall be the director of human resources, organisational development and estates.
  - one of the executive directors is to be a registered medical practitioner.
  - one of the executive directors is to be a registered nurse.
- there will be at least one more non-executive director than executive directors, including the Chair of the Trust.

4.11.2 Except for the provisions made in Standing Orders 4.13 - Suspension of Standing Orders and 4.14 - Variation and Amendment of Standing Orders), every question put to a vote at a meeting shall be determined by a majority of the votes of directors present and voting on the question. In the case of an equal vote, the person presiding (i.e. the Chair of the meeting) shall have the casting vote.

4.11.3 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

4.11.4 If at least one third of the directors present so request, the voting on any question may be recorded so as to show how each director present voted or did not vote (except when conducted by paper ballot).

4.11.5 If a director so requests, their vote shall be recorded by name.

4.11.6 In no circumstances may an absent director vote by proxy. Absence is defined as being absent at the time of the vote.

4.11.7 A manager who has been formally appointed to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy shall be entitled to exercise the voting rights of the Director.

4.11.8 A manager attending the Trust Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. The status of people when attending a meeting will be recorded in the minutes.

4.11.9 Where the office of a director of the Board is shared jointly by more than one person, either or both of those persons may attend or take part in meetings of the Board:

- if both are present at a meeting they should cast one vote if they agree;
- in the case of disagreements no vote should be cast;
- the presence of either or both of those persons should count as the presence of one person for the purposes of Standing Order 4.10 - Quorum.

4.11.10 No resolution of the Trust Board shall be passed if it is opposed by all of the Non-Executive Directors present or by all of the Executive Directors present.

4.12 Disputes

Where directors have issues that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, this should be recorded in the minutes. The Chief Executive, as Accounting Officer, should follow the

procedure set out by Monitor in the Accounting Officer's memorandum for advising the Trust Board and Members' Council and for recording and submitting objections to decisions on matters of propriety or regularity or on the wider responsibilities of the Accounting Officer

4.13 Suspension of Standing Orders

4.13.1 Except where this would contravene any statutory provision or the rules relating to the Quorum (SO 4.10), any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the whole number of the directors of the Board are present (including at least one director who is a Non-Executive Director and one of whom is an Executive Director of the Trust) and that at least two-thirds of those directors present signify their agreement to such suspension. The reason for the suspension shall be recorded in the Trust Board's minutes.

4.13.2 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Chair and directors of the Trust.

4.13.3 No formal business may be transacted while Standing Orders are suspended.

4.13.4 The Audit Committee shall review every decision to suspend Standing Orders.

4.14 Variation and amendment of Standing Orders

No amendment shall be made to these Standing Orders unless:

- notice of motion has been given in accordance with Standing Order 4.4;
- the amendment has been approved in accordance with paragraph 46 of the constitution.

4.15 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded. Where a director arrives late or leaves before the end of the meeting, this will be reflected in the minutes. A record of each director's attendance at meetings of the trust Board and Committees of the Board will be kept and reported to the Members' Council on request.

4.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendments to the minutes will be agreed and recorded prior to being signed as a true record.

Minutes will be circulated in accordance with the wishes of the Chair and, where the minutes provide a record of a public meeting, will be made available to the public as required by the Code of Practice on Openness in the NHS, the Freedom of Information Act and the Monitor Code of Governance.

4.17 Admission of public and the press

4.17.1 **Admission and exclusion on grounds of confidentiality of business to be transacted**

Meetings of the Trust Board shall be open to members of the public. Members of the public may be excluded from a meeting of the Trust Board for special reasons, which shall include, but not be limited to, the following reasons.

- Discussion of matter which contains confidential personally identifiable information relating to a member of staff or a service user or carer.
- Discussion of any matter which contains commercially sensitive information relating to the Trust or a third party.
- In the interests of public order, in accordance with Standing Order 4.17.2 below.

4.17.2 **General disturbances**

The Chair or the person presiding over the meeting shall give such directions as he / she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Trust Board resolving as follows:

- "That, in the interests of public order, the meeting adjourns for (the period to be specified) to enable the Trust Board to complete its business without the presence of the public".

4.17.3 **Business proposed to be transacted when the press and public have been excluded from a meeting**

Matters to be dealt with by the Trust Board following the exclusion of representatives of the press, and other members of the public, as provided in 4.17.1 and 4.17.2 above, shall be confidential to the members of the Board.

Directors and Officers or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

4.17.4 **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings**

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the Trust or Committee thereof. Such permission shall be granted only upon resolution of the Trust.

Use of recording devices may be permitted, in agreement with the Chair, to support disability requirements and if recordings are to be for personal use only and will not be shared in line with Trust policies. If a recording device is to be used, it will be declared at the beginning of a meeting.

4.18 Observers at Trust meetings

The Trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

5. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

5.1 Appointment of Committees

Subject to the constitution, Terms of Authorisation, statutory provision and directions given by Monitor (or successor organisation), the Trust Board may appoint committees of the Trust made up of Directors of the Trust.

The Trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

Committees of the Board may appoint sub-committees consisting wholly or partly of members of the committee, whether or not they include directors, or wholly of persons who are not members of the committee, whether or not they include Directors.

Each committee or sub-committee will have terms of reference and powers approved by the Trust Board, which will have the effect of being incorporated into the Standing Orders.

5.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the Trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the Trust. In which case the term “Chair” applies to the Chair of the committee, and the term “member” is to be read as a reference to a member of the committee. There is no requirement to hold meetings of committees established by the Trust in public.

5.4 Terms of Reference

Each committee will have terms of reference and powers and will be subject to conditions, such as a requirement to report to the Trust Board, which will

be determined by the Trust Board. The terms of reference will have effect as if incorporated into the Standing Orders.

5.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Trust Board.

5.6 Approval of Appointments to Committees

The Trust Board will approve the appointments to each of the committees which it has formally constituted. The Board will define the powers of such appointees and will agree allowances, including reimbursement for loss of earnings, and / or expenses in accordance where appropriate with national guidance.

5.7 Appointments for Statutory functions

Where the Trust Board is required to appoint persons to a committee and / or to undertake statutory functions, and where such appointments are to operate independently of the Board such appointment shall be made in accordance with the regulations and / or directions made by Monitor.

5.8 Committees established by the Trust Board

Without prejudicing the formation of other committees or sub-committees as are considered necessary by the trust, the major committees are:

5.8.1 **Audit Committee**

The Audit Committee provides the Trust Board with an independent and objective view on its systems of control, including the adequacy of the governance arrangements and the systems for financial control and financial reporting. At least one of the Non-Executive directors on the Audit Committee must have relevant financial experience. The purpose of the committee is defined in its terms of reference.

5.8.2 **Clinical Governance and Clinical Safety Committee**

The Clinical Governance and Clinical Safety Committee provides assurance to the Trust Board on matters of service quality and the effectiveness of clinical risk management, practice effectiveness and standards of clinical and professional practice. The purpose of the committee is defined in its terms of reference.

5.8.3 **Equality, ~~and~~ Inclusion, and Involvement Committee**

The Equality and Inclusion Committee's role is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. The purpose of the committee is defined in its terms of reference.

5.8.4 **Finance, Investment and Performance Committee**

The Finance, Investment and Performance Committee's role is to provider oversite and challenge of the Trust's financial performance and financial plans to ensure the Trust and the services it provides remain financially

sustainable. The purpose of the committee is defined in its terms of reference,

5.8.5 **Mental Health Act Committee**

The Mental Health Act Committee is responsible for ensuring the organisation operates within the legal requirements of the Mental Health Act and Mental Capacity Act. The purpose of the committee is defined in its terms of reference.

5.8.6 **Workforce and Remuneration Committee**

The Workforce and Remuneration Committee will be made up at least three Non-Executive Directors, all of whom must meet the independence criteria set out in the Monitor Code of Governance. The purpose of the committee is defined in its terms of reference.

5.8.7 **Other Committees**

The Trust Board may also establish such other committees or sub committees as required to discharge the Trust's responsibilities. The Trust Board will determine those duties that can be delegated to committees or sub-committees.

5.8.7.1 **Nominations Committee**

The Nominations Committee is a committee of the Members' Council and is responsible for overseeing the appointment of Non-Executive Directors. Its membership will include the Chair of the Trust Board, the Chief Executive and at least two members of the Members' Council. The purpose of the committee is defined in its terms of reference.

5.8.7.2 **Charitable Funds Committee**

In line with its role as a corporate trustee for any funds held in trust, either as charitable or non charitable funds, the Trust Board has established a Charitable Funds Committee of the Corporate Trustee to administer those funds in accordance with any statutory or other legal requirements or directions set out by the Charity Commission. The purpose of the committee is defined in its terms of reference.

5.8.7.3 **West Yorkshire Mental Health Services Collaborative (WYMHSC) Committee in Common**

The WYMHSC Committee in Common is responsible for overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for acute and specialist mental health services in West Yorkshire. Membership of the committee includes the Trust Chair and Chief Executive. The purpose of the WYMHSC and the committee is defined in the Memorandum of Understanding, which includes the terms of reference.

Committees are expected to conduct their business in accordance with the 7 principles of public life (Nolan principles): selflessness, integrity, objectivity; accountability; openness; honesty; and leadership.

6. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

6.1 Delegation of Functions to Committees and Officers or other bodies

6.1.1 Subject to paragraph 3 of the constitution, the Board may make arrangements for any of its functions to be carried out on its behalf by a committee, Executive Team or Executive Director, subject to approval by the Trust Board and to restrictions and conditions which will be agreed by the Board.

6.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 3.14) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.

6.3 Delegation to Committees

6.3.1 The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

6.4 Delegation to Executive Directors

6.4.1 Those functions of the Trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee shall be exercised on behalf of the Trust by the Chief Executive. The Chief Executive shall determine which functions he / she will perform personally and shall nominate officers to undertake the remaining functions for which he / she will still retain accountability to the Trust.

6.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying decision making rights and accountability. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

6.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability of the Director of Finance and Resources to the Trust Board to provide information and advise the Board in accordance with statutory duties. Outside these statutory requirements the roles of the Director of Finance and Resources shall be accountable to the Chief Executive for operational matters.

6.5 Schedule of Matters Reserved to the Trust and Scheme of Delegation of powers

6.5.1 The arrangements made by the Board as set out in the "Schedule of Matters Reserved to the Board" and "Scheme of Delegation" of powers shall have effect as if incorporated in these Standing Orders.

6.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action (which may include disciplinary action) or ratification. All members of the Trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6.7 Confidentiality

A member of a committee will not disclose a matter dealt with by or brought before the committee without its permission until the committee has reported to the Board or has otherwise concluded on the matter.

A Director of the Trust or a member of a committee will not disclose any matter reported to the Trust Board or otherwise dealt with by the committee, whether or not it has been reported to the Trust Board, if the Trust Board or the Committee resolve that it should remain confidential.

7. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

7.1 Policy statements: general principles

The Trust Board will from time to time agree and approve Policy statements which will apply to all or specific groups of staff employed by South West Yorkshire Partnership NHS Foundation Trust. The decisions to approve such policies and procedures will be recorded in an appropriate Trust Board minute and will be deemed where appropriate to be an integral part of the Trust's Standing Orders and Standing Financial Instructions.

7.2 Specific Policy statements

Notwithstanding the application of SO 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct in Public Service Policy (including Declarations of Interests) for South West Yorkshire Partnership NHS Foundation Trust staff

- the staff disciplinary and appeals procedures adopted by the Trust.

7.3 Standing Financial Instructions

Standing Financial Instructions adopted by the Trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

7.4 Specific guidance

Notwithstanding the application of SO 7.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other issued by the Secretary of State for Health:

- Caldicott Guardian 1997
- Human Rights Act 1998
- Freedom of Information Act 2000.

8. DUTIES AND OBLIGATIONS OF BOARD MEMBERS/DIRECTORS AND SENIOR MANAGERS UNDER THESE STANDING ORDERS

8.1 Declaration of Interests

Trust Board directors are required to comply with the provisions set out in paragraph 32 of the constitution.

Directors should declare any interests required to be declared by paragraph 32 of the constitution in writing to the Secretary as soon as practicable. Declarations of interest should be made on appointment to the Trust Board or as soon as the Director becomes aware of the interest.

Any changes in interests should be declared at the next Trust Board meeting following the change occurring and recorded in the minutes of that meeting.

Declared interests of Board members' should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

8.2 Register of Interests

The Chief Executive will ensure that a Register of Interests of the Directors is established to record formally declarations of interests of Board members. The Register will include details of any directorships held by any of the Directors and any interests declared pursuant to paragraph 34 of the constitution by any Executive Director or Non-Executive Director of the Trust Board. The Register will be available to the public.

8.3 Standards of Business Conduct

All Trust staff and members of the Trust Board must comply with the Trust's Standards of Business Conduct in Public Service Policy and the national guidance contained in HSG(93)5 on 'Standards of Business Conduct for NHS staff'.

8.3.1 Interest of Officers in Contracts

i) Any officer or employee of the Trust who comes to know that the Trust has entered into or proposes to enter into a contract in which he / she has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or Trust's Company Secretary as soon as practicable. In the case of spouses or persons cohabiting as partners, the interest of one spouse or partner shall, if known to the other, be deemed to be also the interest of the other.

ii) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his / her, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

iii) The Trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

8.3.2 Canvassing of and Recommendations by Directors in Relation to Appointments

i) Canvassing of directors of the Trust or of any Committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

ii) Directors of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

8.3.3 Relatives of Directors or Officers

i) Candidates for any staff appointment under the Trust shall, when making an application, disclose in writing to the Trust whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

ii) The Chair and every director and officer of the Trust shall disclose to the Trust Board any relationship between himself and a candidate of whose candidature that director or officer is aware. It is the duty of the Chief Executive to report to the Trust Board any such disclosure made.

iii) On appointment, directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether

they are related to any other member or holder of any office under the Trust.

iii) Where the relationship to a director of the Trust is disclosed, that director will have no part in the appointment process.

9. RESOLUTION OF DISPUTES WITH THE MEMBERS' COUNCIL

In the event of a dispute between the Trust Board and the Members' Council which cannot be resolved by the Chair, the Chair may at his / her discretion seek to bring in independent facilitation or mediation.

On satisfactory completion of the disputes process, the Board of Directors will implement the agreed changes.

On unsatisfactory completion of the process, the view of the Board of Directors will prevail.

The Members' Council will not be prevented from informing Monitor that the Board of Directors has not responded constructively to the concerns of the Members' Council or reporting a failure of the Trust to meet the terms of its Authorisation.

10. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

10.1 Custody of Seal

The common seal of the Trust shall be kept by the Chief Executive or a nominated Manager by him / her in a secure place.

10.2 Sealing of Documents

The Seal of the Trust will not be fixed to any documents unless the sealing has been authorised by a resolution of the Trust Board or a committee of the Board or where the Trust Board has delegated its powers.

Where it is necessary that a document be sealed, the seal shall be affixed in the presence of the Chair of the Trust or Deputy Chair of the Trust and the Chief Executive (or his / her nominated deputy). Before any building, engineering, property or capital document is sealed, it must be approved and signed by the Director of Finance and Resources or an officer nominated by him and authorised and countersigned by the Chief Executive or an officer nominated by him, who will not be from the originating directorate.

The form of attestation of documents will be 'The Common Seal of South West Yorkshire Partnership NHS Partnership Foundation Trust was hereto affixed in the presence of….'.

10.3 Register of Sealing

An entry of every sealing will be made and numbered consecutively in a register provided for that purpose and will be signed by the person who approved and authorised the document and those who attested the seal. A report of each sealing will be made quarterly to the Trust Board.

10.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the Trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

The Chief Executive or nominated officers will be authorised by resolution of the Trust Board to sign on behalf of the Trust any agreement or other document not required to be executed as a deed, the subject matter of which has been approved by the Trust Board or committee or sub-committee to which the Trust Board has delegated authority.

ANNEX 11~~9~~ – ADDITIONAL PROVISIONS – MEMBERSHIP

(Paragraphs 5~~.2~~, ~~7.4~~ and 10.2)

1. DISQUALIFICATION FROM MEMBERSHIP

1.1 An individual may not become a member of the Foundation Trust if:

1.1.1 they are under 11 years of age; or

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence at any of the Foundation Trust's hospitals or facilities or against any of the Foundation Trust's employees or other persons who exercise functions for the purposes of the Foundation Trust, or against any registered volunteer.

2. TERMINATION OF MEMBERSHIP

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary

2.1.2 they die

2.1.3 they are expelled from membership under this constitution

2.1.4 they cease to be entitled under this constitution to be a member of the Public Constituency or of any of the classes of the Staff Constituency

2.1.5 it appears to the Secretary that they no longer wish to be a member of the Foundation Trust, and after enquiries made in accordance with a process approved by the Members' Council, they fail to demonstrate that they wish to continue to be a member of the Foundation Trust

2.1.6 they behave in a way that is incompatible with the Code of Conduct for members.

2.2 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Foundation Trust.

2.2.2 If a complaint is made, the Members' Council may itself consider the complaint having taken such steps as it

considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this constitution

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Members' Council.

2.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Members' Council, details of the complaint must be sent to the member complained of not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Members' Council will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Members' Council present and voting at a General Meeting.

3. MEMBERS' MEETINGS

3.1 The Foundation Trust shall hold its Annual Members' Meeting within nine months of the end of each financial year.

3.2 All members' meetings, other than Annual Members' Meeting, are called special members' meetings.

3.3 The Annual Members' Meeting is open to the public, all members of the Foundation Trust, Governors and Directors, and representatives of the auditor.

3.4 Special Members' Meetings are open to all members of the Foundation Trust, Governors and Directors, but not to members of the public unless the Trust Board decides otherwise.

3.5 The Trust Board may invite representatives of the media and any experts or advisors whose attendance they consider to be in the best interests of the Foundation Trust to attend a Members' Meeting whether Annual or Special.

3.6 All members' meetings are to be convened by the Secretary by order of the Trust Board.

3.7 The Trust Board may decide where a members' meeting is to be held and may also for the benefit of members:

3.7.1 arrange for the annual members' meeting to be held in different venues each year:

3.7.2 make provisions for a members' meeting to be held at different venues simultaneously or at different times. In making such provision the Trust Board shall also fix an appropriate quorum for each venue, provided that the aggregate of the quorum requirements shall not be less than the quorum set out below.

3.8 At the annual members' meeting:

3.8.1 the Trust Board shall present to the members:

3.8.1.1 the annual accounts

3.8.1.2 any report of the auditor

3.8.1.3 a copy of the annual report

and

3.8.1.4 forward planning information for the next Financial Year

3.8.2 the Members' Council shall present to the members a report on:

3.8.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership

3.8.2.2 the progress of the membership strategy

3.8.2.3 any proposed changes to the policy for the composition of the Members' Council and of the non-executive Directors

3.9 Notice of a members meeting is to be given:

3.9.1 by notice to all members

3.9.2 by notice prominently displayed at the head office and at all of the Foundation Trust's places of business

3.9.3 by notice on the Foundation Trust's website

at least 14 clear days before the date of the meeting. The notice must:

3.9.4 be given to the Members' Council and the Trust Board, and to the auditor

3.9.5 state whether the meeting is an annual or special members' meeting

3.9.6 give the time, date and place of the meeting

3.9.7 indicate the business to be dealt with at the meeting.

3.10 Before a members' meeting can do business there must be a quorum present. A quorum is at least two Governors' present from the Foundation Trust's public constituencies, and one staff Governor, and one appointed Governor.

3.11 The Foundation Trust may make arrangements for members to vote by post, or by using electronic communications.

3.12 It is the responsibility of the Trust Board, the Chair of the meeting and the Secretary to ensure that at any members' meeting:

3.12.1 the issues to be decided are clearly explained

3.12.2 sufficient information is provided to members to enable rational discussion to take place.

3.13 The Chair of the Foundation Trust, or, in their absence, the Deputy Chair of the Trust Board, shall act as chair at all members' meetings of the Foundation Trust. If neither the Chair nor the Deputy Chair of the Trust Board is present, the members of the Members' Council present shall elect one of their number to be Chair and if there is only one Governor present and willing to act they shall be Chair.

3.14 If no quorum is present within half an hour of the time fixed for the start of the meeting, the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Trust Board determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting, the number of members present during the meeting is to be a quorum.

3.15 A resolution put to the vote at a members' meeting shall be decided upon by a show of hands unless a poll is requested by the Chair of the meeting.

3.16 Every member present and every member who has voted by post or using electronic communications is to have one vote. In the case of an equality of votes the Chair of the meeting is to have a second and casting vote.

3.17 The result of any vote will be declared by the Chair and recorded in the minutes.

ANNEX 1210 – FURTHER PROVISIONS

(Paragraphs 38.3, 40.6 and 41.1)

1. COMMITMENTS

1.1 The Foundation Trust shall exercise its functions effectively, efficiently and economically.

Representative membership

1.2 The Foundation Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

1.2.1 the Foundation Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Members' Council, and shall be reviewed by them from time to time, and at least every three years

1.2.2 the Members' Council shall present to each annual members' meeting a report on:

1.2.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership

1.2.2.2 the progress of the membership strategy;

1.2.2.3 any changes to the membership strategy.

Co-operation with NHS bodies and local authorities

1.3 In exercising its functions the Foundation Trust shall co-operate with NHS bodies and local authorities.

Openness

1.4 In conducting its affairs, the Foundation Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting distribution

1.5 The profits or surpluses of the Foundation Trust are not to be distributed either directly or indirectly in any way at all among members of the Foundation Trust.

2. FRAMEWORK

2.1 The affairs of the Foundation Trust are to be conducted by the Board of Directors, the Members' Council and the members in accordance with this constitution and the Foundation Trust's authorisation. The members, the Members' Council and the Trust Board are to have the roles and responsibilities set out in this constitution.

Members

2.2 Members may attend and participate at members' meetings, vote in elections to, and stand for election to, the Members' Council, and take such other part in the affairs of the Foundation Trust as is provided in this constitution.

Members' Council

2.3 The roles and responsibilities of the Members' Council, which are to be carried out in accordance with this constitution and the Foundation Trust's terms of Authorisation, are:

2.3.1 at a General Meeting:

2.3.1.1 to appoint or remove the Chair and the other non-executive Directors

2.3.1.2 to approve an appointment (by the non-executive Directors) of the Chief Executive

2.3.1.3 to decide the remuneration and allowances, and the other terms and conditions of office, of the non-executive Directors

2.3.1.4 to appoint or remove the Foundation Trust's auditor

2.3.1.5 to be presented with the annual accounts, any report of the auditor on them and the annual report

2.3.2 to provide their views to the Trust Board when the Trust Board is preparing the document containing information about the Foundation Trust's forward planning;

2.3.3 to respond as appropriate when consulted by the Trust Board in accordance with this constitution

2.3.4 to undertake such functions as the Trust Board shall from time to time request

2.3.5 to prepare and from time to time review the Foundation Trust's membership strategy and its policy for the

composition of the Members' Council and of the non-executive Directors and when appropriate to make recommendations for the revision of this constitution.

Board of Directors

2.4 The business of the Foundation Trust is to be managed by the Trust Board, who shall exercise all the powers of the Foundation Trust, subject to any contrary provisions of the 2006 Act as given effect by this constitution.

3. SECRETARY

3.1 The Foundation Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary's functions shall include:

3.1.1 acting as Secretary to the Members' Council and the Trust Board, and any committees

3.1.2 summoning and attending all members' meetings, meetings of the Members' Council and the Trust Board, and keeping the minutes of those meetings

3.1.3 keeping the register of members and other registers and books required by this constitution to be kept

3.1.4 having charge of the Foundation Trust's seal

3.1.5 publishing to members in an appropriate form information which they should have about the Foundation Trust's affairs

3.1.6 preparing and sending to Monitor and any other statutory body all returns which are required to be made.

3.2 Minutes of every members' meeting, of every meeting of the Members' Council and of every meeting of the Trust Board are to be kept. Minutes of meetings will be read at the next meeting and signed by the Chair of that meeting. The signed minutes will be conclusive evidence of the events of the meeting.

3.3 The Secretary is to be appointed and removed by the Trust Board, in consultation with the Members' Council.

3.4 The Board of Directors of the applicant NHS Trust shall appoint the first Secretary of the Foundation Trust.

4. FURTHER PROVISIONS AS TO AUDITOR

4.1 A person may only be appointed as the auditor if they (or in the case of a firm each of its members) are a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

4.2 The auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by Monitor and / or the Department of Health on behalf of the Secretary of State on standards, procedures and techniques to be adopted.

5. FURTHER PROVISIONS AS TO ACCOUNTS

5.1 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

5.1.1 the accounts

5.1.2 any records relating to them

5.1.3 any report of the auditor on them.

5.2 In preparing its annual accounts, the Accounting Officer shall cause the Foundation Trust to comply with any directions given by Monitor and / or the Department of Health on behalf of the Secretary of State with the approval of the Treasury as to:

5.2.1 the methods and principles according to which the accounts are to be prepared

5.2.2 the information to be given in the accounts

and shall be responsible for the functions of the Foundation Trust as set out in paragraph 25 of Schedule 7 to the 2006 Act.

5.3 The Accounting Officer shall cause the Foundation Trust to:

5.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament

5.3.2 once it has done so, send copies of those documents to Monitor or the Secretary of State (as required by the 2006 Act, from time to time) within such period as Monitor may direct.

6. FURTHER PROVISIONS AS TO ANNUAL REPORTS

6.1 The annual reports are to give:

6.1.1 information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff

Constituency is representative of those eligible for such membership

6.1.2 any other information Monitor and/or the Department of Health requires.

6.2 The Foundation Trust is to comply with any decision Monitor and/or the Department of Health makes as to:

6.2.1 the form of the reports

6.2.2 when the reports are to be sent to it

6.2.3 the periods to which the reports are to relate.

7. INDEMNITY

Members of the Members' Council and the Trust Board and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Foundation Trust. The Foundation Trust may purchase and maintain insurance against this liability for its own benefit and for the benefit of members of the Members' Council and the Trust Board and the Secretary.

8. DISPUTE RESOLUTION PROCEDURES

8.1 Every unresolved dispute which arises out of this constitution between the Foundation Trust and:

8.1.1 a member

8.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute

8.1.3 any person bringing a claim under this constitution

8.1.4 an office-holder of the Foundation Trust

will be determined by the Chair of the Trust, whose decision will be final and binding except in the case of manifest error. If a dispute is brought by or against the Chair of the Trust, the dispute will be determined by the Trust Board (excluding the Chair) whose decision will be final and binding except in the case of manifest error. In the event that the dispute is referred to the Chair (or the Trust Board if it is by or against the Chair) and the Chair considers that he / she has a perceived or real interest in the outcome of the dispute (or the Trust Board considers it has a perceived or real interest in the outcome of the dispute) and / or that the dispute would be better resolved externally, then the Chair may refer the dispute for resolution under the Rules of the Chartered Institute for Arbitrators.

8.2 Any person bringing a dispute must, if required to do so, deposit with the Foundation Trust a reasonable sum (not exceeding £250) to be determined by the Members' Council and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

9. DISSOLUTION

The Foundation Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

10. HEAD OFFICE

The Foundation Trust's head office is at Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP or such other place as the Trust Board shall decide.

11. NOTICES

11.1 Any notice required by this constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

11.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

South West Yorkshire Partnership NHS Foundation Trust

Standing Financial Instructions (SFI)
October 2021

Introduction

The Trust has Standing Financial Instructions (SFIs) to provide a framework for the proceedings and business of the Trust. This protects both the Trusts interests and protects staff from possible accusations of acting improperly.

These are subject to periodic review and the current exercise is 2 years since the last update (October 2019) and is timely to consider the impact of the recently approved lead provider collaboratives. Due to their intra-organisational nature these are different ways of working to traditional internal only processes. The current impact and role of the local Integrated Care Systems (ICSs) has also been considered and these will be subject to continued review.

Changes

Fundamentally the SFI's remain valid and in line with best practice recommendations and the SFI's in place at other organisations. Basic typographical and formatting amendments have been made but are not individually logged below.

The following changes have been made and all changes are logged in red:

Section / Page / Reference	Original	Revised	Notes
Foreword	These SFI's have been adopted by the Trust Board and are mandatory for all directors and employees of the organisation.	These Standing Financial Instructions (SFIs) have been adopted by the Trust Board and are therefore mandatory for all parties identified above.	
Page 8 2.1.1	Any expression, to which a meaning is given in Health Service Acts or in the Financial Directions made under the Acts or in the 2003 Act or regulations made under it, shall have the same meanings in these instructions.	Any expression, to which a meaning is given in Health Service Acts or in the Financial Directions made under the Acts or in the 2012 Act or regulations made under it, shall have the same meanings in these instructions.	Update to 2012 Health & Social Care Act. Not specifically reference covid additions in 2020

Page 15 5.1.1	The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast available resources.	The Chief Executive will compile and submit to the Board an annual business plan, or more frequently if required, which takes into account financial targets and forecast available resources.	Add increased frequency if needed.
Page 18 5.3.2 f	they provide all information as requested by the Director of Finance to enable him discharge his duties.	they provide all information as requested by the Director of Finance to enable them to discharge their duties.	Remove gender
Page 20 7.4.2	Competitive tenders should be sought at least every 5 years	Competitive tenders should be sought when needed or every 5 years	Add when needed as currently no requirement
Page 25 10.4.2.c	Superannuation	NHS Pension scheme	Updated terminology
Page 26 11.2.3 d	A list of directors/employees (including specimens of their signatures) authorised to certify invoices.	A list of directors/employees authorised to certify invoices.	Removed as signatures electronic and system driven
Page 28 11.2.6 d	all service level agreement which are provided by and for the Trust must be formally authorised by the Director of Finance.	all service level agreement which are provided by and for the Trust must be formally authorised by the Director of Finance or nominated officer in line with the scheme of delegation.	Add nominated officer
Page 30		A list of agreed exemptions will be maintained by the procurement department.	Add
Page 31		A list of agreed exemptions will be maintained by the procurement department.	Add
Page 32 12.11	This includes, but is not limited to, Procure 21 and Section 75 agreements	This includes, but is not limited to, Estates and Section 75 agreements	Procure 21 no longer exists
Page 33 13.1.3	Any application for PDC, a loan or overdraft will only be made by the Director of	Any application for PDC, a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by them.	Remove gender

	Finance or by an employee so delegated by him/her.		
Page 35 16.1.4	For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of ESTATECODE or Procure 21+ or any other legally binding contractual process as appropriate.	For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of ESTATECODE or any other legally binding contractual process as appropriate.	Remove Procure 21 reference
Page 39	The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.	The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.	Remove gender
Page 41 19.1.2	The Director of Finance shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.	The Director of Finance shall satisfy their self that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.	Remove gender
Page 41 19.1.4	Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy him/herself that	Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy their selves that	
Page 41	Patients Property	Service User Property	Update heading
Page 43 21.1.1	The Board may execute its responsibilities through a Committee established for that purpose, although it	The Board may execute its responsibilities through a Committee established for that purpose (The Charitable Funds	

	remains responsible for the proper management and administration of the Charitable Funds.	Committee), although it remains responsible for the proper management and administration of the Charitable Funds.	
Page 43 21.1.5	All other sections of the SFIs shall apply equally to Charitable Funds as to other funds except that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and made in accordance with approval limits set by the Trust Board, or a Committee established for the administration of the Charitable Funds.	All other sections of the SFIs shall apply equally to Charitable Funds as to other funds except that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and made in accordance with approval limits set by the Trust Board, or the Charitable Funds Committee established for the administration of the Charitable Funds.	Define that the committee is specifically the Charitable Funds Committee
Page 44 21.2.1	He shall ensure that a governing instrument exists for every Fund and shall produce procedures covering every aspect of the financial management of the Charitable Fund, for the guidance of directors and employees.	They shall ensure that a governing instrument exists for every Fund and shall produce procedures covering every aspect of the financial management of the Charitable Fund, for the guidance of directors and employees.	Remove gender
Page 44 21.2.2		The Charitable Funds Committee have agreed that funds must have expenditure at least annually otherwise the fund would be reviewed for consolidation into the general fund.	Add
Page 44 21.2.3		New designated Funds can be created where the donation is large or regular and warrants its own fund.	Add
Page 44 21.3.1	The Director of Finance shall, taking legal advice if necessary, arrange for the creation of a new Charitable Fund where funds and / or	The Charitable Funds Committee shall, taking legal advice if necessary, arrange for the creation of a new Charitable Fund where funds and / or other assets,	Replace Director with Charitable Funds Committee.

	other assets, received in accordance with the Trust's policies, cannot be managed adequately as part of an existing Charitable Fund. The Director of Finance shall present the governing document to the Board for adoption for each new Charitable Fund.	received in accordance with the Trust's policies, cannot be managed adequately as part of an existing Charitable Fund. The governing document will be presented to the Charitable Funds Committee and then the Corporate Trustee for adoption for each new Charitable Fund.	
Page 45 21.4.8	In respect of fund raising the Director of Finance shall after taking legal advice deal with the arrangements for fund raising by and on behalf of the Trust and ensure compliance with all statutes and regulations.	The Charity is a member of the Fundraising Regulator and adheres to their guidelines, anyone fundraising on behalf of the Charity has to sign a Fundraising Agreement and is given advice on the legalities of Fundraising to ensure compliance with all statutes and regulations.	Update for current practice
Page 45 21.4.9	The Director of Finance shall be empowered to liaise with other organisations/persons raising funds for this Trust and provide them with adequate discharge. The Director of Finance shall be the only officer empowered to give approval for such fund-raising subject to the overriding direction of the Board.	All fundraising is reported to the Charitable Funds Committee and any specific campaigns would be approved by the Charitable Funds Committee and reported to the Corporate Trustee.	Update for current practice
Page 46 21.5	Taking legal advice, the Director of Finance shall be responsible for alerting the Board to any irregularities regarding the use of the Trust's name and its registration numbers and for the appropriate treatment of all funds raised.	Taking legal advice, the Charitable Funds Committee shall be responsible for alerting the Corporate Trustee to any irregularities regarding the use of the Trust's name and its registration numbers and for the appropriate treatment of all funds raised.	

Page 48 21.14	The Board shall be advised by the Director of Finance on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.	The Corporate Trustee shall be advised by the Charitable Funds Committee on the outcome of the annual audit.	Update for current practice

Lead Provider

The centralised commissioning hub, as linked to the lead provider collaborative, will be employed by Leeds and York Partnership NHS Foundation Trust.

The existing clause at 2.1.3 ensures that these SFI's apply as they will be acting on behalf of the Trust. In doing so they will be treated as an 'employee'. This is also supplemented by clause 3.4.2.

Next Steps

Following this review stage a further review of the Trust scheme of delegation will be completed. This will include a detailed review of the approval hierarchies and limits to ensure that they remain valid and appropriate within the new finance and procurement system. It is intended to bring this update to Audit Committee in January 2022.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Standing Financial Instructions

October 2021

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Foreword

The Code of Accountability requires NHS Foundation Trusts to adopt:

- Standing Financial Instructions (SFIs)
- Standing Orders (SOs)
- Reservation of Powers to the Board and Delegation of Powers

These documents provide a regulatory framework for the proceedings and the business of the Trust.

They fulfil the dual roles of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

All executive and non-executive directors and all members of staff, including staff seconded into the Trust and contractors working for the Trust, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These Standing Financial Instructions (SFIs) have been adopted by the Trust Board and are therefore mandatory for all parties identified above. None compliance will be reported to the Trust Audit Committee and could lead to disciplinary proceedings.

Introduction

1.1 The Financial Framework

1.1.1 These Standing Financial Instructions (SFIs), together with the Trust's Standing Orders and Scheme of Delegation, provide a business and financial framework and set the rules that Directors and officers of the Trust, including employees of third parties contracted to the Trust, shall be expected to work within. Together, they cover all aspects of financial management and control, and set out the responsibilities of individuals, including the levels of responsibility clearly delegated to Executives and other senior officers.

1.1.2 These documents protect the interests of the Trust, explain financial responsibilities and regulate the conduct of the Trust, its Directors, officers and agents in relation to all financial matters, and provide the financial framework to enable staff to be confident they are acting properly.

1.2 Authority and Compliance

1.2.1 These SFIs shall have effect as if incorporated in the Trust Board Standing Orders and, as a result, are part of the Trust's Constitution. As the Trust Board approves SFIs, they may only be overridden with the express authority of Trust Board in accordance with **SO 4.13** (Suspension of Standing Orders) relating to suspension of Standing Orders.

1.2.2 These SFIs document the financial responsibilities and instructions adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and the requirements of the Independent Regulator to achieve probity, accuracy, economy, efficiency, and effectiveness. They should be used in conjunction with the Scheme of Delegation for the Trust, which includes a list of the Decisions Reserved to Trust Board.

1.2.3 These SFIs identify the financial responsibilities that apply to everyone working for the Trust and its constituency organisations, including trading units and any shared services centre. They do not provide any detailed procedural advice. These statements should, therefore, be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.2.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs, then the advice of the Director of Finance **must be sought before acting.** The user of the SFIs should also be familiar and comply with the provisions of the Trust's Standing Orders. Failure to comply with the Trust's Standing Orders or SFIs is a disciplinary matter, which could result in disciplinary action. Non-compliance must be reported to the Director of Finance.

2 Definitions and Terminology

2.1.1 Any expression, to which a meaning is given in Health Service Acts or in the Financial Directions made under the Acts or in the 2012 Act or regulations made under it, shall have the same meanings in these instructions. In particular:

a) **"Board"** means Board of the Trust and is regarded as synonymous with "The Trust";

b) **"Trust"** means South West Yorkshire Partnership NHS Foundation Trust and is to be regarded as synonymous with Trust Board.

c) **"Chair"** is the person appointed by the Members' Council to lead the Trust Board and to ensure that it successfully discharges its overall responsibility to the Trust as a whole;

d) **"Chief Executive"** means the chief officer of the Trust;

e) **'Accountable Officer'** means the NHS Officer responsible and accountable for funds entrusted to the Trust. They shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

f) **"Director of Finance"** means the Chief Financial Officer of the Trust;

g) **"Budget"** means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specified period, any or all of the functions of the Trust;

h) **"Budget Holder"** means the Director or employee with delegated authority to manage the finances (income and expenditure) for a specific area of the organisation;

i) **"Constitution"** means the Constitution of the Trust

j) **"Members' Council"** means the Members' Council of the Trust as constituted by the Constitution;

2.1.2 Wherever the title of Chief Executive, Director of Finance or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

2.1.3 Wherever the term "employee" is used and where the context permits, it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

3 Responsibilities and Delegation

3.1 Responsibilities of the Trust Board

3.1.1 The Board exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within approved allocations / overall income;

c) setting limits on expenditure that may be committed without Board approval

d) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

e) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document;

3.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Reservation of Powers to the Board' document. The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

3.2 Responsibilities of the Chief Executive

3.2.1 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as accounting officer to Parliament for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

3.2.2 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

3.2.3 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

3.3 Responsibilities of the Director of Finance

3.3.1 The Director of Finance is responsible for:

a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of

separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

d) the provision of financial advice to the Trust and its directors and employees;

e) the design, implementation and supervision of systems of internal financial control;

f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

g) leading the Trust Board in the development of the financial strategy of the Trust

3.4 Responsibilities of all Directors and employees

3.4.1 All directors and employees, severally and collectively, are responsible for:

a) the security of the property of the Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources; and

d) conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

3.4.2 Any agent, contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3.4.3 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

4 Audit

4.1 Audit Committee

4.1.1 In accordance with Standing Orders and the Audit Code for Foundation Trusts the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook (2011), which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;

b) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgements including the Trust's Annual Report and Accounts;

c) monitoring compliance with Standing Orders and Standing Financial Instructions;

d) reviewing schedules of losses and compensations and making recommendations to the Board;

e) reviewing the information prepared to support the assurance statements prepared on behalf of the Board and advising the Board accordingly; and

f) receive the annual report of the Local Counter Fraud Specialist (LCFS).

4.1.2 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

4.1.3 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit Committee should raise the matter at a full meeting of the Board. In exceptional circumstances the matter may need to be referred to the Independent Regulator. The Audit Committee should comply with Counter Fraud guidance on the reporting of potential or actual fraudulent actions.

4.1.4 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

4.2 Fraud and corruption

4.2.1 In line with prevailing requirements as to their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Counter Fraud Authority (NHSCFA) Standards for Providers and any relevant guidance or best practice advice issued by the Independent Regulator, or HM Government on fraud and corruption.

4.2.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified within NHSCFA Standards for Providers.

4.2.3 The LCFS shall report to the Trust Director of Finance on matters relating to fraud, bribery and corruption. All work completed by the LCFS will be in line with the NHSCFA Standards for Providers.

4.2.4 The LCFS will provide regular progress reports to the Director of Finance and Audit Committee detailing work undertaken against the Trust's counter fraud plan. In addition the LCFS will work with the Trust to ensure an annual submission is made to NHS Counter Fraud Authority via the return of the Self Review Toolkit (SRT). The SRT will detail work undertaken by the Trust and the LCFS in ensuring compliance against NHSCFA's Standards for Providers. The LCFS will submit an annual report to the Audit Committee which will include the completed SRT. The Director of Finance will be responsible for determining when to report to the police matters of suspected fraud or corruption and will seek advice from the LCFS and where appropriate NHSCFA.

4.2.5 If it is considered appropriate that evidence of offences exists and that a prosecution is desirable, the LCFS will consult with the Director of Finance to obtain the necessary authority and agree the appropriate route for pursuing any action e.g. criminal investigation.

4.2.6 The LCFS will ensure that measures to mitigate identified fraud risks are included in an organisational work plan which ensures that an appropriate level of resource is available to the level of risks identified. Work will be monitored by the Director of Finance and outcomes fed back to the Audit Committee.

4.3 Bribery Act / Corruption

4.3.1 The Trust's Standards of Business Conduct and Bribery Act Policy defines the standards of conduct expected of employees, contractors etc. in the course of the Trust's business. The policies also instruct in what gifts, hospitality and other interests should be declared and how to report suspicions and bribery and other financial irregularities.

4.4 Role of the Director of Finance

4.4.1 The Director of Finance is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

b) ensuring that the internal audit is adequate and meets NHS mandatory audit standards;

c) deciding at what stage to involve the police in cases of misappropriation, and other irregularities;

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

i) a clear statement on the effectiveness of internal control,
ii) major internal control weaknesses discovered,
iii) progress on the implementation of internal audit recommendations,
iv) progress against plan over the previous year,
v) strategic audit plan covering the coming three years,
vi) a detailed plan for the coming year.

4.4.2 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises or employee of the Trust;

c) the production of any cash, stores or other property of the Trust under an employee's control; and

d) explanations concerning any matter under investigation.

4.5 Role of Internal Audit

4.5.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies,

plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) fraud and other offences,
ii) waste, extravagance, inefficient administration,
iii) poor value for money or other causes.

4.5.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

4.5.3 The Chief Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

4.5.4 The Chief Internal Auditor shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Chief Internal Auditor.

4.5.5 The agreement shall be in writing and shall comply with the best practice guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

4.6 Role of External Audit

4.6.1 The external auditor is appointed by the Members' Council and paid for by the Trust. The auditor must fulfil the requirements as set out in the Local Audit and Accountability Act 2014.

4.6.2 The External Auditors are required to work in accordance with the Audit Code for NHS Foundation Trusts.

4.6.3 The Chief Internal Auditor shall work closely with External Audit and conduct joint planning audit coverage in order to minimise duplication of work and to provide the Trust with the best value for money.

4.6.4 The Audit Committee will be responsible for ensuring the External Auditor's work presents value for money.

5 Business Planning, Budgets, Budgetary Control and Monitoring

5.1 Preparation and approval of business plans and budgets

5.1.1 The Chief Executive will compile and submit to the Board an annual business plan, or more frequently if required, which takes into account financial targets and forecast available resources. The annual business plan will contain:

a) a statement of the significant assumptions on which the plan is based; and

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

5.1.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

a) be in accordance with the aims and objectives set out in the annual business plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds; and

e) identify potential risks.

5.1.3 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

5.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

5.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage their budgets effectively.

5.2 Budgetary delegation

5.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing, accepted by the budget holder and be accompanied by a clear definition of:

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise virement or transfer;

e) services to be delivered through the delegated budget; and

f) the provision of regular reports.

5.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement or transfer limits set by the Board. Any requirement to overspend must first be explained and agreed with the Director of Finance and formal approval must then be sought from EMT. The Director of Finance must then communicate any such changes to the Trust Board

5.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement or transfer. Non-recurrent sources of funding should not be used to finance recurring expenditure without Executive Management Team approval.

5.3 Budgetary Control and Reporting

5.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

a) monthly financial reports to the Board in a form approved by the Board containing:

i) income and expenditure to date showing trends and forecast year-end position;

ii) movements in working capital

iii) capital project spend and projected outturn against plan

iv) cash-flow and rolling cash-flow forecast

v) balance sheet

vi) explanations of any material variances from plan;

vii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting of variances from financial and staff budgets

d) monitoring of management action to correct variances; and

e) arrangements for the authorisation of budget virements and transfers.

5.3.2 Each Budget Holder is responsible for ensuring that:

a) any likely overspending or reduction of income which cannot be met by authorised virement is not incurred without the prior consent of the Executive Management

Team (EMT) or if necessary the Board, or the Chief Executive within his delegated limits;

b) any reduction in income in excess of £250,000 which cannot be met by corresponding cost saving should be reported to the Board;

(a) and (b) above may be replaced at the discretion of the Chief Executive with required contribution targets for defined business units;

c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of transfer and virement;

d) no permanent employees are appointed without the approval of the Chief Executive other than those provided for in the budgeted establishment as approved by the Executive Management Team;

e) that the use of contractors, agency staff, locums, or non-contractual payments to employees, such as overtime, is not used to circumvent the budgeted establishment; and;

f) they provide all information as requested by the Director of Finance to enable them to discharge their duties.

5.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a budget which achieves the target surplus.

5.4 Capital Expenditure

5.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 16)

5.5 Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Independent Regulator.

6 Annual Accounts and Report

6.1.1 The Director of Finance, on behalf of the Trust, will:

a) prepare financial returns in accordance with the accounting policies and guidance given by the Independent Regulator and the Treasury, the Trust's accounting policies, and International Financial Reporting Standards (IFRS) and/or generally accepted accounting practice;

b) prepare and submit periodic and annual financial reports in accordance with prevailing guidelines and requirements;

c) submit financial returns for each financial year in accordance with the guidelines and timetable prescribed by the Independent Regulator.

d) Provide regular reports on the financial performance of the trust to the Members' Council

6.1.2 The Trust's audited (by an auditor appointed by the Members' Council) annual accounts and auditor's report must be presented to a general meeting of the Member's Council.

6.1.3 The Trust will publish an annual report, in accordance with the prevailing requirements of the Independent Regulator and present it at a public meeting.

7 Bank and Government Banking Service (GBS) Accounts

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance / directions issued from time to time by the Independent Regulator. The Audit Committee shall approve the banking arrangements on behalf of the Trust Board

7.2 Bank and GBS Accounts

7.2.1 The Director of Finance is responsible for:

a) bank accounts and Government Banking Service (GBS) accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds;

c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

a) the conditions under which each bank and GBS account is to be operated;

b) the limit to be applied to any overdraft;

c) those authorised to sign cheques or other orders drawn on the Trust's accounts.

d) those authorised to approve electronic banking transfers.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated; the limits to be applied to any overdraft and the limitation on single signatory payments and any changes that may be required by resolution of the Board of Directors as may be necessary from time to time. In addition, the Director of Finance shall advise the bankers in writing, of the officer(s) and / or Director(s) authorised to release money from, and draw cheques on, each bank account of the Trust and shall notify promptly the cancellation of any such authorisation.

7.4 Tendering and review of banking arrangements

7.4.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

7.4.2 Competitive tenders should be sought when needed or every 5 years. The results of the tendering exercise should be reported to the Board. This exercise is not necessary for GBS accounts.

8 Income, Fees and Charges and Security of Cash, Cheques and Other Negotiable Instruments

8.1 Income Systems

8.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due. The Director of Finance is also responsible for the prompt banking of all monies received.

8.2 Fees and charges

8.2.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

8.2.2 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate / deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

8.2.3 Any income generated from the activities of staff working in their employment hours, and/or utilising any of the Trust's facilities shall be declared as Trust Exchequer Income and dealt with in line with the Trust's official income systems and controls and any relevant aspects of an employee's terms and conditions of employment.

8.2.4 All income generation activities shall be approved, before they are undertaken, by the appropriate budget holder / manager, and comprehensive and detailed records retained for audit. Such approval shall only be granted where the scheme generates a minimum of break even after taking account of all overheads and after further approval of prices by the Director of Finance. Any exceptions to this will be agreed by the Finance, Investment and Performance Committee. Income generation activities attracting an annual income of £500,000 or above require Board approval.

8.3 Debt Recovery

8.3.1 The Director of Finance is responsible for ensuring appropriate recovery action on all outstanding debts. Income not received should be dealt with in accordance with the losses procedures. Overpayments should be detected (or preferably prevented) and recovery initiated.

8.4 Security of cash, cheques and other negotiable instruments

8.4.1 The Director of Finance is responsible for:

a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

8.4.2 Official money shall not under any circumstances be used for the encashment of neither private cheques nor IOU's.

8.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

9 Contracting for Provision of Services

9.1.1 The Chief Executive is responsible for negotiating contracts for the provision of healthcare services in accordance with the business plan, and for establishing the arrangements for extra-contractual services. In discharging this responsibility, the Chief Executive shall take into account:

a) the standards of service quality expected;

b) costing and pricing of services;

c) payment terms and conditions;

d) amendments to contracts and extra-contractual arrangements

9.1.2 Contracts should be so devised as to ensure a measured balance between risk and opportunity and should be made with the long-term interests of the Trust in mind.

9.1.3 The Director of Finance shall produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of any variable elements of that income. This shall include any partnership arrangements the Trust enters into for the provision of healthcare related services.

10 Terms of Service and Payment to Directors and Employees

10.1 Workforce and Remuneration Committee

10.1.1 In accordance with Standing Orders the Board shall establish a Workforce and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The duties of the Committee are outlined in the Scheme of Delegation and detailed in the terms of reference of the Committee.

10.1.3 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee. Remuneration and terms of services of the Chair and Non-executive Directors will be determined by the Members' Council, based on external advice and / or the remuneration offered to Non-executive Directors in comparable Foundation Trusts.

10.2 Funded establishment

10.2.1 The workforce plans incorporated within the annual budget will form the funded establishment. The funded establishment of any department may not be materially varied without the approval of the Chief Executive who will establish and maintain schemes of transfer and virement, and the use of contractors, agency staff or locums will be counted against the funded establishment. Variations not considered material include minor skills mix changes as a result of recruitment to vacant positions, which will be agreed with the appropriate director.

10.3 Staff appointments

10.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

a) unless authorised to do so by the Chief Executive; and

b) within the limit of their approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

10.4 Processing of payroll

10.4.1 The Executive Director (Director of Human Resources) responsible for payroll is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances;

c) making payment on agreed dates; and

d) agreeing method of payment.

10.4.2 The Executive Director responsible for payroll will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the General Data Protection Regulations (GDPR);

g) methods of payment available to various categories of employee;

h) procedures for payment by cheque, bank credit, or cash to employees;

i) procedures for the recall of cheques and bank credits

j) pay advances and their recovery;

k) recovery of overpayments and the correction of underpayments;

l) maintenance of regular and independent reconciliation of pay control accounts;

m) separation of duties of preparing records and handling cash; and

n) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Executive Director's instructions and in the form prescribed by the Executive Director ;

c) completing documentation changing to employees terms and conditions of service, subject to compliance with the prevailing procedures and verification agreed by the Director of Finance, and the Director of Human Resources; and

d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Executive Director must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Director of Human Resources shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to the Director of Human Resources for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) dealing with variations to, or termination of, contracts of employment.

11 Non Pay Expenditure

11.1 Delegation of authority

The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers. The Trust Audit Committee will be responsible for agreeing the Trust's procurement strategy.

11.1.1 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level. (as outlined within the Trust Scheme of Delegation)

11.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Choice, requisitioning, ordering, receipt and payment for goods and services

11.2.1 The Director of Finance will be responsible for ensuring staff operate within the approved procurement arrangements. The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the requisitioner must follow the prevailing procedures issued by the Director of Finance for the procurement of goods and services.

11.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance and as outlined in 11.2.3.

11.2.3 The Director of Finance will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. Once approved the thresholds will be incorporated into standing orders and any amendment will require approval of Trust Board, the Members' Council and Monitor.

b) prepare and disseminate procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) A list of directors/employees authorised to certify invoices.

ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the

appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

i) A system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

ii) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as stated below).

11.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cashflows must be discounted to NPV) and the intention is not to circumvent cash limits.

b) the appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed; and

d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.5 Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Director of Finance;

c) state the Trust's terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts [other than for a simple purchase permitted within the Scheme of Delegation or delegated budget], leases, tenancy agreements, service level agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with EU and GATT rules on public procurement and comply with the White Paper on Standards, Quality and International Competitiveness (CMND 8621);

c) contracts that commit the organisation to revenue consequences above £500,000 over three or less years are approved by the Trust Board

d) all service level agreement which are provided by and for the Trust must be formally authorised by the Director of Finance or nominated officer in line with the scheme of delegation. The Director of Finance must be notified of any intention to exit a service level agreement in advance of that exit being confirmed.

e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii) conventional hospitality, such as lunches in the course of working visits;

f) no requisition / order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

g) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

h) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”;

i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

k) changes to the list of directors / employees authorised to certify invoices are notified to the Director of Finance;

l) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

m) petty cash records are maintained in a form as determined by the Director of Finance.

11.2.7 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice, utilising the guidance contained within CONCODE and ESTATECODE where appropriate. The technical audit of these contracts shall be the responsibility of the relevant Director.

12 Tendering and Contract Procedures

12.1 Duty to comply with standing orders

12.1.1 The procedure for making all contracts for or on behalf of the Trust will comply with these standing orders except where **SO 4.13 (Suspension of Standing Orders)** is applied.

12.2 Directives Governing Public Procurement

12.2.1 Directives by the Council of the European Union promulgated by the Department of Health prescribing procedures for awarding all forms of contracts shall have the effect as if incorporated into these standing orders.

12.2.2 The Trust will comply as far as possible with relevant guidance issued by the Department of Health and the Independent Regulator (or other relevant regulatory body as appropriate)

12.3 Trust Procurement Framework

12.3.1 The Trust will look to ensure Value For Money by utilising existing Trust Procurement Framework arrangements. Should not this be the case then the Procurement team will explore Quotations (12.4) or Formal competitive tendering (12.5) as appropriate.

12.4 Quotations

12.4.1 Quotations are required where the formal tendering procedures are waived under 12.7 (Waiver of Tenders) and where the intended expenditure is between £10,000 and £25,000.

12.4.2 Where quotations are required they should be obtained from at least three firms or individuals based on specifications or terms of reference prepared by or on behalf of the Board.

12.4.3 Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so, in which case quotations may be obtained by telephone. Written quotations must be sought by post, email or an approved electronic trading system through the Trust Procurement department.

12.4.4 Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation should be obtained should be set out in a permanent record. All quotations should be treated as confidential and should be retained for inspection.

12.4.5 The Chief Executive or his nominated officer should evaluate the quotations and select the one that best meets the trust's requirements. If this is not the lowest, then this fact and the reasons why the lowest quotation was not chosen should be a permanent record.

12.4.6 Non-competitive quotations in writing may be obtained for the following purposes:

a) Supply of goods and services of a special character for which, in the opinion of the Chief executive or nominated officer, it is not possible or desirable to obtain competitive quotations.

b) The goods and services are required urgently.

A list of agreed exemptions will be maintained by the procurement department.

12.5 Formal competitive tendering

12.5.1 The Trust will ensure that competitive tenders are invited for the supply of goods, materials, manufactured articles and services including all forms of management consultancy (other than specialised services sought from or provided by the Department of Health), for the design, construction and maintenance of buildings and engineering works (including construction and maintenance of grounds and gardens) and for disposals. Formal competitive tenders will be invited for all aforementioned procurement or disposals above £25,000 in value.

12.5.2 The Director of Finance will be responsible for the receipt, endorsement and safe custody of all tenders received either by post or via an approved electronic trading system and for maintaining a register showing each set of tender invitations dispatched by post or electronically.

12.5.3 Where only one tender is received, the Chief Executive and Director of Finance will be responsible for assessing whether it represents value for money.

12.6 Where tendering or quotation is not required

12.6.1 The Trust will use the procurement system for all goods and services under £10,000 in value unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

12.6.2 The Chief Executive is responsible for ensuring that best value for money can be demonstrated for all service provided under contract or in-house. The Trust Board may determine from time to time that in-house services should be market tested by competitive tendering.

12.7 Waiver of tenders

12.7.1 Formal tendering procedures may be waived by the Chief Executive or Director of Finance if:

a) The supply is proposed under special arrangements negotiated by the Department of Health in which event the special arrangements must be complied with; or

b) The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for a single tender; or

c) Specialist expertise is required and is available only from one source; or

d) The task is essential to complete the project AND arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or

e) There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

f) The circumstances are covered by provision in the NHS Estate Code.

A list of agreed exemptions will be maintained by the procurement department.

12.7.2 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

12.7.3 Where it is decided that competitive tendering is not applicable and should be waived by virtue of one or more of the above criteria, the fact of the waiver and the reasons should be documented and reported by the Director of Finance to the Audit Committee at the next formal meeting.

12.7.4 Except where the criteria agreed in SFI12.7 (Waiver of Tenders) apply, the Board will ensure that invitations to tender are sent to sufficient number of firms or individuals to provide fair and adequate competition as appropriate and in no case less than three firms / individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

12.7.5 The Board via the Director of Finance will ensure that the companies or individuals invited to tender are among those on the Trust's e Tendering database, procurement system or a recognised public sector framework agreement. The Director of Finance is responsible for ensuring that the approved supplier lists are reviewed and have a documented process which allows for the addition and deletion of companies and organisations from the lists.. Where, in the opinion of the Director of Finance, it is desirable to seek tenders from firms not on the approved list, the reason should be recorded in writing to the Chief Executive.

12.8 Contracts

12.8.1 The Trust may only enter into contracts within its statutory powers and within its Terms of Authorisation.

12.8.2 Where appropriate contracts will be in (or embody) the same terms and conditions of contract as was the basis on which the tender or quotation was obtained. In all contracts made by the Trust, the Board will endeavour to obtain best value for money. The Chief Executive will nominate an officer to oversee each contract on behalf of the trust.

12.9 Healthcare Services Contracts

12.9.1 The Chief Executive shall delegate power to negotiate for the provision of health services with commissioners to nominated officers.

12.10 Partnerships

12.11 Where the trust enters into partnership for the delivery of services or for obtaining goods and services where there is no exchange of monies or where the terms and conditions are negotiated by another body, and the value of the goods or services exceeds £500,000, then the partnership must be approved by the Trust Board, who will set a timescale for its review and renewal. This includes, but is not limited to, Estates and Section 75 agreements. The Chief Executive shall ensure there are adequate systems for the management of such partnerships

12.12 Cancellation of contracts

12.13 Except where specific provision is made for contracts with NHS organisations, all written contracts will include a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if the contractor (or any person acting on his behalf with or without the knowledge of the contractor) has offered, given or agreed any gift, inducement or reward to any person for entering into the contract or any other contract with the Trust or if the contractor or any person acting on his behalf has committed any offence relating to corruption.

12.14 Determination of contracts for failure to deliver goods or materials

12.15 Every written contract for the supply of goods or materials will include a clause to allow the Trust to determine the contract if the contractor fails to deliver the goods or materials (or any portion of them) to purchase other goods to make good the default. The clause will secure that the Trust can recover the cost of making good the default from the contractor.

12.16 Contracts involving funds held on trust

12.17 Contracts involving funds held on trust shall do so individually to a specific named fund. Such contracts involving charitable funds shall comply with the requirements of the Charities Act.

13 External Borrowing

13.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by the Independent Regulator. The Director of Finance is also responsible for reporting periodically to the Board concerning the Public Dividend Capital (PDC) debt and all loans and overdrafts.

13.1.2 Any decision to undertake external borrowing must be made by Trust Board.

13.1.3 Any application for PDC, a loan or overdraft will only be made by the Director of Finance or by an employee so delegated by them.

13.1.4 The Director of Finance must prepare detailed procedural instructions concerning applications for PDC, loans and overdrafts.

13.1.5 All borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance.

13.1.6 All long term borrowing must be consistent with the plans outlined in the current Business Plan.

14 Investments

14.1.1 The Director of Finance shall produce a Treasury Management strategy and policy requiring Audit Committee approval providing a comprehensive framework for the management and investment of cash balances.

14.1.2 The Treasury Management strategy and policy shall have a conservative approach to investments appropriate for a tax-funded public body and shall comply with the prevailing guidance or instructions of the Independent Regulator.

14.1.3 The Director of Finance shall prepare and implement detailed procedural instructions for the implementation of the Treasury Management strategy and policy.

15 Financial Framework

15.1.1 The Director of Finance will ensure that the Trust Board are aware of the prevailing instructions and guidance of the Independent Regulator, and any statutory or regulatory requirements, regarding the financial management and financial duties of the Trust.

16 Capital Investment, Private Finance, Fixed Assets and Security of Assets

16.1 Capital investment

16.1.1 All decisions relating to capital investment above £500,000 will require approval by the Trust Board.

16.1.2 The Chief Executive

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without full consideration of the impact on the Trust's cash and working capital position and Financial Risk Rating.

16.1.3 For every capital expenditure proposal, requiring Trust Board approval, the Chief Executive shall ensure:

a) that a business case (in line with the guidance contained within the Capital Investment Manual) is produced setting out:

i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

ii) appropriate project management and control arrangements; and

b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

16.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of ESTATECODE or any other legally binding contractual process as appropriate.

16.1.5 The Director of Finance shall issue regular reporting of expenditure and commitment against authorised expenditure.

16.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

a) specific authority to commit expenditure;

b) authority to proceed to tender;

c) approval to accept a successful tender.

The Chief Executive will issue a scheme of delegation for capital investment management broadly in line with ESTATECODE guidance, and in accordance with the Trust's Standing Orders.

16.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

16.2 Private finance

16.2.1 Any proposal to use private finance (PFI, LIFT or similar), or to enter into a contract that commits the Trust to long term (15 years or more) arrangements for capital assets with a lifetime value in excess of £500,000, require approval by the Trust Board.

16.2.2 The Director of Finance shall ensure that any such proposal is fully assessed against alternative routes for obtaining that capital asset applying prevailing guidance or instruction from the Independent Regulator or best practice guidance.

16.3 Asset registers

16.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical sample check of assets against the asset register to be conducted once a year.

16.3.2 Each Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified by the Independent Regulator.

16.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

16.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

16.3.5 The Director of Finance shall ensure there is a regular process for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

16.3.6 The value of each asset shall be re-valued in line with accounting policies drawn up by the Director of Finance, reviewed by the audit committee, and which are in accordance with the accounting requirements of the Independent Regulator.

16.3.7 The value of each asset shall be depreciated using methods and rates in accordance with the accounting requirements of the Independent Regulator.

16.4 Security of assets

16.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

16.4.2 This is supported by Trust employed Local Security Management Specialists (LSMS) who, utilising the Trust security management strategy (as aligned to NHS Protects Strategy and Standards) and Safe and Secure Environment Policy to protect NHS staff and patients, security of premises, protection of property and assets and security resilience.

16.4.3 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses, where relevant and beneficial;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

16.4.4 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

16.4.5 Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

16.4.6 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

16.4.7 Where practical, equipment assets should be marked as Trust property.

17 Stores and Receipt of Goods

17.1 Stores

17.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) kept to a minimum;

b) subjected to annual stocktake;

c) valued at the lower of cost and net realisable value.

17.1.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer, the control of fuel oil and coal of a designated Estates Manager, the control of the equipment store to the designated Equipment Store Manager.

17.1.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

17.1.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

17.1.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

17.1.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

17.1.7 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also 19, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.2 Receipt of goods

17.2.1 For goods purchased using the Trust's requisitioning/purchase order system, they will be delivered to the Trusts central receipt point before being delivered by Trust personnel to the end user. These goods will be checked and receipted on the purchase order system by the central receipt point staff in readiness for payment. An internal delivery note will accompany the goods and will be signed as acceptance of receipt of the goods by the end user (person/ward/department requesting the goods). Any discrepancies on the goods delivered must be reported to the receipt and distribution department within five working days, who will then take the most appropriate action.

18 Disposals and Condemnations, Losses and Special Payments

18.1 Disposals and condemnations

18.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

18.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate. All staff have a responsibility to report asset disposals and those determined as obsolete or missing.

18.1.3 Disposal of assets with a Net Book Value in excess of £50,000 require approval of the Board. Any proposed disposal requires a paper detailing options for disposal and expected net realisable value from such options. Any such proposal must include criteria for proceeding with the disposal (such as net receipt, or eradication of an associated liability), such that if the criteria is not achieved then the disposal is not completed.

18.1.4 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and

b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of.

All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

18.1.5 It is the responsibility of all staff to ensure that obsolete / damaged / missing assets are reported to the Director of Finance.

18.2 Losses and special payments

18.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Director of Finance must also prepare a process that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

18.2.2 Any employee discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved.

18.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

a) the Board, and

b) the External Auditor.

18.2.4 The Director of Finance shall take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidation. For any loss, the Director of Finance should consider whether any insurance claim can be made.

18.2.5 The Director of Finance shall maintain a Losses and Special Payments Register in which any write-off action is recorded and presented to the Audit Committee for approval. This includes the write off for bad debts and the report will include volumes, values and reasons for the write off. Authorisation for write off is by the Director of Finance.

19 Information Technology as regards Financial Systems

19.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulations and Caldicott principles;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the production systems are separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

19.1.2 The Director of Finance shall satisfy their self that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

19.1.3 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

19.1.4 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation. Where computer systems have an impact on corporate financial systems the Director of Finance shall satisfy their selves that:

a) systems acquisition, development and maintenance are in line with any relevant prevailing corporate policies such as an Information Technology Strategy;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Directorate of Finance staff have access to such data; and

d) Such computer audit reviews as are considered necessary are being carried out.

19.1.5 Where the Trust provides IT services to other health organisations, the Director responsible for information systems shall ensure that appropriate contracts are drafted and agreed.

20 Service User Property

20.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as “property”) handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival in the possession of patients who lack capacity to take care of it for themselves.

20.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

20.1.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20.1.4 Where statutory or regulatory instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

20.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

20.1.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

20.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

21 NHS Charitable Funds

21.1 Introduction

21.1.1 The discharge of the Trust's corporate trustee responsibilities for Charitable Funds are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes. The Director of Finance shall ensure that each Charitable Fund is managed appropriately with regard to its purpose and to its requirements. The Charitable Funds are administered by the Board acting as corporate trustee. The Board may execute its responsibilities through a Committee established for that purpose (The Charitable Funds Committee), although it remains responsible for the proper management and administration of the Charitable Funds.

21.1.2 Standing Orders (SOs) identify the Trust's responsibilities as a corporate trustee for the management of Charitable Funds it holds and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately, and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on trust and to the Independent Regulator for all funds held on trust.

21.1.3 The reserved powers of the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

21.1.4 As management processes overlap most of the sections of these SFIs will also apply to the management of Charitable Funds. This section however covers those instructions which are specific to the management of Charitable Funds.

21.1.5 All other sections of the SFIs shall apply equally to Charitable Funds as to other funds except that expenditure from Charitable Funds shall be restricted to the purpose(s) of the appropriate fund and made in accordance with approval limits set by the Trust Board, or the Charitable Funds Committee established for the administration of the Charitable Funds.

21.1.6 The over-riding principle is that the integrity of each Charitable Fund must be maintained and Statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21.1.7 The Board hereby nominates the Director of Finance to have primary responsibility to the Board for ensuring that these SFIs are applied taking legal advice as required.

21.2 Existing Charitable Funds

21.2.1 The Director of Finance shall arrange for the administration of all existing Charitable Funds taking legal advice as required. They shall ensure that a governing instrument exists for every Fund and shall produce procedures covering every aspect of the financial management of the Charitable Fund, for the guidance of directors and employees. Such guidelines shall identify the restricted nature of certain Funds including Linked Charities.

21.2.2 The Director of Finance shall periodically review the Funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such Funds within statutory guidelines. The Charitable Funds Committee have agreed that funds must have expenditure at least annually otherwise the fund would be reviewed for consolidation into the general fund.

21.2.3 The Director of Finance may recommend an increase in the number of the Funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds e.g. designation for specific wards or departments. New designated Funds can be created where the donation is large or regular and warrants its own fund.

21.3 New Charitable Funds

21.3.1 The Charitable Funds Committee shall, taking legal advice if necessary, arrange for the creation of a new Charitable Fund where funds and / or other assets, received in accordance with the Trust's policies, cannot be managed adequately as part of an existing Charitable Fund. The governing document will be presented to the Charitable Funds Committee and then the Corporate Trustee for adoption for each new Charitable Fund. Such document shall clearly identify, inter alia, the objects of the new Charitable Fund, the capacity of the Charity to delegate powers to manage and the power to assign the residue of the Fund to another Fund contingent upon certain conditions, e.g. discharge of original objects. This same process applies to Linked Charities.

21.4 Sources of new funds

21.4.1 In respect of donations the Director of Finance shall provide guidelines to officers of the Trust as to how to proceed when offered funds. These to include:-

a) the identification of the donor's intentions;

b) where possible, the avoidance of new Charitable Funds;

c) the avoidance of impossible, undesirable or administratively difficult objects;

d) sources of immediate further advice; and

e) treatment of offers for personal gifts.

21.4.2 The Director of Finance shall provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's Charitable Funds and that the donor's intentions have been noted and accepted.

21.4.3 All gifts accepted shall be received and held in the name of the Trust and administered in accordance with the Trust's policy, subject to the terms of specific trusts. As the Trust can accept gifts only for all or any purposes relating to the Health Service, officers shall, in cases of doubt, consult the Director of Finance before accepting any gifts.

21.4.4 In respect of legacies and bequests the Director of Finance shall provide guidelines to officers of the Trust covering any approach regarding the wording of wills and the receipt of funds/other assets from executors.

21.4.5 Where necessary the Director of Finance will obtain grant of probate or make application for grant of letters of administration where the Trust is the beneficiary.

21.4.6 The Director of Finance will be empowered on behalf of the Trust to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty and shall be directly responsible taking legal advice as necessary for the appropriate treatment of all legacies and bequests.

21.4.7 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the Trust by the Director of Finance who alone shall be empowered to give an executor a good discharge.

21.4.8 The Charity is a member of the Fundraising Regulator and adheres to their guidelines, anyone fundraising on behalf of the Charity has to sign a Fundraising Agreement and is given advice on the legalities of Fundraising to ensure compliance with all statutes and regulations.

21.4.9 All fundraising is reported to the Charitable Funds Committee and any specific campaigns would be approved by the Charitable Funds Committee and reported to the Corporate Trustee.

21.5 Taking legal advice, the Charitable Funds Committee shall be responsible for alerting the Corporate Trustee to any irregularities regarding the use of the Trust's name and its registration numbers and for the appropriate treatment of all funds raised.

21.5.1 In respect of trading income the Director of Finance shall be responsible, taking legal advice as required, along with other designated officers, for any trading undertaken by this Trust as a corporate trustee and for the appropriate treatment of funds from this source.

21.6 Investment management relating to charitable funds

21.6.1 In respect of investment income the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source, in accordance with the approved strategy and policy.

21.6.2 The Director of Finance shall be responsible for all aspects of the management of the investment of funds held on trust. They will, taking legal advice as required, formulate an investment policy for approval by the Charitable Funds Committee and the Corporate Trustee. The policy will be within statutory powers and governing instruments to meet its requirements with regard to income generation and the enhancement of capital value.

21.6.3 The Director of Finance will be responsible for the appointment of advisors, brokers and where appropriate fund managers. Taking legal advice as necessary the Director of Finance shall agree the terms of such appointments and written agreements will be drawn up and signed by the Chief Executive.

21.6.4 The Director of Finance shall be responsible for pooling investment resources and for the preparation of a submission to the Charity Commission for them to make a scheme and for the participation of the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds.

21.6.5 The Director of Finance will ensure that the use of trust assets is appropriately authorised in writing and charges raised within policy guidelines.

21.6.6 The Director of Finance shall review the performance of brokers and fund managers and shall report on investment performance.

21.6.7 All share and stock certificates and property deeds shall be deposited either with the Trust's bankers or in a safe, or a compartment within a safe, to which only the Director of Finance will have access.

21.7 Disposition management relating to Charitable Funds

21.7.1 The Director of Finance shall manage the dispositive discretion of the Trust in respect of Charitable Funds in conjunction with the Corporate Trustee.

21.7.2 Account will be taken of:-

a) the objects of various funds and the designated objectives;

b) the availability of liquid funds within each trust;

c) the powers of delegation available to commit resources;

d) the avoidance of the use of Exchequer funds to discharge trust fund liabilities (except where administratively unavoidable) and to ensure that any indebtedness to the Exchequer shall be discharged by Charitable Funds at the earliest possible time;

e) funds are to be spent rather than preserved, subject to the wishes of the donor and identified needs; and

f) the definitions of "charitable purposes" as agreed by the NHS Executive with the Charity Commission.

21.8 Banking service for Charitable Funds

21.8.1 The Director of Finance shall advise the Charitable Funds Committee and with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. Those bank accounts should permit the separate identification of liquid funds to each trust fund where this is deemed necessary by the Charity Commission.

21.9 Asset management for Charitable Funds

21.9.1 Assets in the ownership of or used by the Trust as corporate trustee shall be maintained along with the general estate and inventory of assets. The Director of Finance shall ensure, taking legal advice as required that:-

a) appropriate records of all assets owned by the Trust as corporate trustee are maintained and that all assets at agreed valuations are brought to account;

b) appropriate measures are taken to protect and/or replace assets. These to include decisions regarding insurance, inventory control and the reporting of losses;

c) donated assets received on trust rather into the ownership of the Secretary of State shall be accounted for appropriately; and

d) all assets acquired from funds held on trust which are intended to be retained within Charitable Funds are appropriately accounted for and that all other assets so acquired are brought to account in the name of the Secretary of State.

21.10 Reporting

21.10.1 The Director of Finance shall ensure that regular reports are made to the Charitable Funds Committee, the Terms of Reference of which are outlined in the Standing Orders and Scheme of Delegation.

21.10.2 The Director of Finance shall prepare annual accounts in the required manner which shall be submitted to the Trust Board within agreed timescales.

21.10.3 Taking legal advice as required, the Director of Finance shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the Independent Regulator and to the Charity Commission for adoption by the Corporate Trustee.

21.11 Accounting and audit of Charitable Funds

21.12 The Director of Finance shall maintain all financial records including an Investments Register to enable the production of reports as above and to the satisfaction of internal and external audit.

21.13 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They will liaise with external audit and provide them with all necessary information. The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

21.14 The Corporate Trustee shall be advised by the Charitable Funds Committee on the outcome of the annual audit.

21.15 Administrative costs

21.16 The Director of Finance shall identify all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, shall charge such costs to the appropriate trust accounts.

21.17 Taxation and excise duty

21.18 The Director of Finance shall ensure that liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

22 Retention of Documents

22.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with Information Governance requirements.

22.1.2 The documents held in archives shall be capable of retrieval by authorised persons.

22.1.3 Documents held under SFI 22 (Retention of Documents) shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

22.1.4 The Chief Executive will ensure all records are stored securely with proper environmental controls and adequately protected against fire and flood.

22.1.5 The local records office should be consulted before records more than sixty years old are destroyed.

22.1.6 The method used for destruction of confidential records should ensure that their confidentiality is fully maintained. Normally destruction should be by incineration or shredding. Where this service is provided by a contractor, it is necessary to ensure that the methods used throughout all stages (including transport to the destruction site) provide satisfactory safeguards against accidental loss or disclosure.

23 Risk Management and Insurance

23.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

23.1.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) arrangements to review the risk management programme.

g) The existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of Internal Financial Control within the Annual Report and Accounts as required by Monitor.

23.1.3 The Chief Executive shall ensure that insurance arrangements exist in accordance with the risk management programme.

23.1.4 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority (NHSLA) or self-insure for some or all of the risks covered by the schemes. If the Board decides not to use the risk pooling schemes (clinical, property and non-clinical third party liability), this decision shall be reviewed annually. For insurable risks not covered by the NHSLA the Board shall decide whether to self-insure or seek third-party insurance.

23.1.5 All the risk-pooling schemes require members to make some contribution to the settlement of claims. The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2021-22

	Business and risk
	Performance and monitoring
	Strategic Board Meeting
✘	Item deferred due to Covid-19

Note that some items may be verbal

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												
Welcome, Introduction and Apologies	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Declarations of Interest	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Minutes from the previous meeting	✘		✘	✘		✘	✘	✘		✘		✘
Action log and matters arising from previous meeting	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘	✘
Service User/Staff Member/Carer Story	✘		✘	✘		✘	✘	✘		✘		✘
Chair's remarks	✘		✘	✘		✘	✘	✘		✘		✘

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
Chief Executive's Report	✘		✘	✘		✘	✘	✘		✘		✘
Questions from the public	✘		✘	✘		✘	✘	✘		✘		✘
Risk and Assurance												
Board Assurance Framework	✘			✘			✘			✘		
Corporate / organisational risk register	✘			✘			✘			✘		
Strategic overview of business and associated risk									✘			
Review of Risk Appetite statement							✘					
Serious Incident investigations update (private session)	✘		✘	✘		✘	✘	✘		✘		✘
Serious Incidents quarterly report (public)			✘			✘		✘				✘
Risk assessment of performance targets, CQUINS and System Oversight Framework and agreement of KPIs	✘						?					
Assurance from Trust Board committees and Members' Council	✘		✘	✘		✘	✘	✘		✘		✘
Guardian of safe working hours annual report	✘											
Workforce Equality Standards						✘	✘					
Medical appraisal / revalidation annual report						✘						
Data Security and Protection toolkit	✘											
Annual report and accounts (including Quality Account for 2022)		✘										
Annual Governance Statement	✘											

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
Equality and diversity annual report							✘					
Serious incidents annual report			✘									
Health and safety annual report			✘									
Patient Experience annual report			✘			✘						
Sustainability annual report						✘	✘					
Premises Assurance Model (annual report)			✘									
Business Developments and Collaborative Working												
Integrated Care System developments	✘		✘	✘		✘	✘	✘		✘		✘
South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	✘		✘	✘		✘	✘	✘		✘		✘
West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP)	✘		✘	✘		✘	✘	✘		✘		✘
Receipt of Partnership Board minutes	✘		✘	✘		✘	✘	✘		✘		✘
Performance reports												
Integrated Performance Report (IPR)	✘		✘	✘		✘	✘	✘		✘		✘
Safer Staffing report	✘						✘	✘				
Strategic Direction												
Board Development		✘			✘				✘		✘	
Covid-19 Reflections		✘			✘				✘		✘	
Horizon Scanning – Focus On		✘			✘				✘		✘	

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
Investment Appraisal Framework (private)							✘					
Strategic Objectives												✘
Trust Board Annual Work Programme											✘ (draft)	✘
Operational Plan (private)										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)
Five-year plan (for review November 2023)												
Governance												
Constitution (including Standing Orders) and Scheme of Delegation *(January 2020) (deferred to June 2021)*						✘	✘					
Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘		✘									
Assessment against NHS Constitution				✘				✘				
Audit Committee annual report including committee annual reports and terms of reference	✘											
Use of Trust Seal			✘			✘		✘				✘
Strategies and Policies												
Digital strategy (including IMT) **update**							✘					
Estates strategy **update**				✘						✘		
Customer Services policy *(May 2021)*			✘									
Estates strategy *(July 2022) (in draft prior to sign off) (private)*												✘
Learning from Healthcare Deaths Policy (January 2022)										✘		
Sustainability strategy *(June 2020)*			✘									
Organisational Development Strategy *(June 2020)*				✘								

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
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))*