South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 26 January 2021 at 9.00
Microsoft Teams meeting

AGENDA

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

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
	9.40	8.2 Corporate / Organisational risk register (ORR)	Director of Finance & Resources	**Paper**	20	To receive
	10.00	8.3 Infection, Prevention and Control Board Assurance Framework	Director of Nursing & Quality	**Paper**	10	To receive
	10.10	8.4 Ockenden Review	Director of Nursing & Quality	**Paper**	5	To receive
9.	**10.15**	**Business developments & collaborative partnership working**				
	10.15	9.1 South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS)	Director of HR, OD & Estates / Director of Strategy	**Paper**	10	To receive
	10.25	9.2 West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) • Including BAME review action plan	Director of Strategy / Director of Provider Development	**Paper**	10	To receive
	10.35	9.3 Receipt of Partnership Board minutes	Chair	**Paper**	5	To receive
	10.40	*Break*			*10*	
10.	**10.50**	**Performance reports**				
	10.50	10.1 Update on EPRR arrangements in place for the management of Covid-19, winter planning and EU Exit.	Director of HR, OD and Estates / Director of Strategy	**Paper**	5	To receive
	10.55	10.2 Integrated performance report (IPR) month 9 2020/21	Director of Nursing & Quality / Director of Finance & Resources	**Paper**	45	To receive

Item	Approx. Time	Agenda item	Presented by		Time allotted (mins)	Action
11.	**11.40**	**Strategies and Policies**				
	11.40	11.1 Scheme of Delegation	Director of Finance & Resources	**Paper**	5	To approve
12.	**11.45**	**Assurance and receipt of minutes from Trust Board committees** - Audit Committee 5 January 2021 - Finance, Investment & Performance Committee 25 January 2021 - West Yorkshire Mental Health Learning Disability and Autism Collaborative Committees in Common 21 January 2021 - Workforce and Remuneration Committee 19 January 2021 - Equality and Inclusion Committee 8 December 2020	Chairs of committees	**Paper**	10	To receive
13.	**11.55**	**Trust Board work programme**	Chair	**Paper**	5	To note
14.	**12.00**	**Date of next meeting** 30 March 2021	Chair	**Verbal item**	0	To note
15.	**12.00**	**Questions from the public** *(received in advance in writing)*	Chair	**Verbal item**	10	To receive
	12.10	*Close*				

South West Yorkshire Partnership NHS Foundation Trust

Minutes of the Trust Board meeting held on 1 December 2020
Microsoft Teams Meeting

Present:	Angela Monaghan (AM)	Chair
	Charlotte Dyson (CD)	Deputy Chair / Senior Independent Director
	Mike Ford (MF)	Non-Executive Director
	Chris Jones (CJ)	Non-Executive Director
	Erfana Mahmood (EM)	Non-Executive Director
	Kate Quail (KQ)	Non-Executive Director
	Sam Young (SYo)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
	Tim Breedon (TB)	Director of Nursing and Quality / Deputy Chief Executive
	Mark Brooks (MB)	Director of Finance and Resources (absent between 10:15 and 11:00)
	Alan Davis (AGD)	Director of Human Resources, Organisational Development and Estates
	Dr.Subha Thiyagesh (ST)	Medical Director
Apologies:	Members None	
	Attendees None	
In attendance:	Carol Harris (CH)	Director of Operations
	Andy Lister (AL)	Head of Corporate Governance (Company Secretary) (author)
	Sean Rayner (SR)	Director of Provider Development
	Salma Yasmeen (SY)	Director of Strategy
Observers:	Bill Barkworth	Public governor – Barnsley (Deputy Lead Governor)
	Dylan Degman	Public governor - Wakefield
	Bob Clayden	Public governor – Wakefield
	John Laville	Public governor – Kirklees (Lead Governor)
	Tom Sheard	Public governor – Barnsley
	Debs Teale	Staff governor – Nursing Support
	Tony Wilkinson	Public governor - Calderdale
	Raymond Rowles	Member of the public

TB/20/90 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/20/91 Declarations of interests (agenda item 2)

The chair asked to note that her spouse was no longer a strategic director of Bradford Metropolitan Borough Council, as of today, and asked for the register of interests to be amended to reflect this change. No further declarations were made.

It was RESOLVED to NOTE the change to the chair's declaration of interests.

TB/20/91 Minutes from previous Trust Board meeting held 27 October 2020 (agenda item 3)

Mike Ford asked if there was anything that could be done to acknowledge Elaine who had presented last month's board story. AM asked for this to be noted and agreed to action this.

Action: Angela Monaghan

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 27 October 2020 as a true and accurate record.

TB/20/92 Matters arising from previous Trust Board meeting held 27 October 2020 (agenda item 4)

The following items from the action log were reviewed:

TB/20/83a – Mark Brooks (MB) reported that this action needed to be split. A discussion followed which agreed one action related to the committees in common relationships that are emerging in terms of the mental health alliance in South Yorkshire and Bassetlaw (SYB). The second action is to review our relationship in the emerging provider collaboratives in SYB and assess if we should seek a formal involvement in these arrangements. Separate actions to be created.

Action: Andy Lister

TB/20/83b MB asked for some clarity regarding this action. Rob Webster (RW) reported this action relates to the Executive Management Team (EMT) looking at our digital strategy and seeing if it fits with the West Yorkshire and Harrogate Integrated Care System digital strategy, and the Digital Charter agreed at regional level. Action wording to be amended.

Action: Andy Lister

TB/20/66b - Tim Breedon (TB) confirmed that the key themes around learning disabilities are scheduled to be discussed at the next Equality and Inclusion Committee on 8 December 2020. To close.

TB/20/68 Salma Yasmeen (SY) confirmed the Equality, Involvement, Communication and Membership strategy is on today's board agenda and work has commenced in terms of engagement to establish priorities and actions for the next 12 months. To close.

TB/20/69d Alan Davis (AGD) reported that the next four actions are linked to the equalities' agenda. The Equality and Inclusion Committee (EIC) is meeting on 8 December. The Workforce Race Equality Standards (WRES) is well established but there is further work to

be done on the Workforce Disability Equality Standards (WDES) and how it links back to the Board. AGD would be able to provide a further update at the next meeting. To close and be monitored by the EIC.

Action: EIC

TB/20/69d – AGD reported the WRES organisational development lead has been appointed. Cherill Watterston starts on 14 December and part of her action plan is to roll out the equity guardians in the framework around racial harassment of staff, service users and carers. This also covers some of the broader aspects of harassment. To close.

TB/20/69d - Project search. AGD stated we are continuing to work with the Mid Yorkshire Trust and mirror and adapt their programme. A further update would be provided at the EIC. Keep open.

TB/20/69g - The inclusive leadership board development programme is due to start in December with a discussion taking place at the strategic board. To close.

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

TB/20/93 Service User/Staff Member/Carer Story (agenda item 5)

AM introduced Janet Owens and Joanne Daveron who had joined the Board to share a patient and family story about the community teams in Barnsley working together, to support end-of-life care.

Carol Harris (CH) added how important end-of-life care is, stating the team make people's lives as comfortable and enjoyable as possible in difficult times.

Janet is the end of life care lead in Barnsley and Joanne is a clinical nurse specialist in specialist palliative care, who works alongside Macmillan. They reported today's story is illustrative of the work the team carries out on a day-to-day basis. The story reflects the whole team approach, including the end of life care team, the Macmillan team, the crisis response team, community teams and Barnsley integrated community equipment services (BICES). It illustrates how the team pulls together in the best interests of the patient and does so with care and compassion.

The patient the story refers to someone admitted to hospital where he was diagnosed with cancer and began to decline rapidly. He was given the choice, with his family, and decided he wanted his end-of-life care to be at home (the incident pre-dates Covid-19). Equipment was quickly put in place at his home address.

Joanne then visited the gentleman and realised he was very close to the end of his life. Joanne is an independent nurse prescriber and was able to prescribe medications to relieve any symptoms that may appear. The supportive care at home team provided "night sits" to enable his wife to sleep.

The gentleman's swallowing was a concern and the speech and language therapy team promptly responded, identifying issues with the gentleman's mattress which was swiftly resolved by the BICES team.

All teams worked hard together, which enabled him to pass away peacefully at home. The gentleman's wife expressed to Joanne how impressed and thankful she was for the service and how everyone had worked together.

In response to questions about the value of being a nurse prescriber, Janet reported they have an “aspiring course” within the team so that someone appointed as a band six nurse will aspire to be a band seven, and as part of that complete the prescribing course.

Janet stated Covid-19 has had an immense impact on their work, especially within care homes. There has been a significant rise in people who did not want to go to hospital, and the number of patients choosing to pass away at home has increased.

The psychological impact on the team has been hard but Improving Access to Psychological Therapy (IAPT) has supported the team and there is now a psychologist working with the team to conduct a monthly reflection.

Janet stated local partnerships have been important in maintaining morale, including the local hospital and consultants from the hospice who have been very supportive.

AM and RW thanked Janet and Joanne for the story and noted the positive comments received from the family. They also noted the impact of additional support for staff wellbeing was being felt and was having a positive impact.

It was RESOLVED to NOTE the Staff Member Story.

TB/20/94 Chair’s remarks (agenda item 6)

AM reported, for the public record, that the following items would be discussed in the private board meeting:

- A verbal update on serious incident investigations
- Commercially confidential business developments in both integrated care systems
- the recently published NHSE/I consultation paper about next steps for integrated care systems.
- Trust board succession planning
- Maintaining high professional standards

It was RESOLVED to NOTE the Chair’s remarks.

TB/20/95 Chief Executive’s remarks (agenda item 7)

RW took his report as read. He presented the following additional updates:

- The Brief was attached in the papers with the monthly report update
- National Covid-19 restrictions have started to show an impact, reducing prevalence in South and West Yorkshire.
- Barnsley Hospital Teaching NHS Foundation Trust has lowered its Operational Performance Escalation Level (OPEL) from 4, Trust staff have assisted the hospital in a number of ways including working on their wards during this time.
- Parliament is debating lockdown today and the move to tougher tiers than previously. Previous tiers did not always reduce prevalence.
- Both West and South Yorkshire will likely be placed in tier 3, the highest level of tiering, if the decision is to remove the national lockdown.
- The staff vaccination programme for Covid-19 will start next week in Leeds. The Pfizer vaccine has been approved for use.
- The military and local councils will be involved in mass testing of the public.

- Mass scale public testing has recently taken place in Liverpool and there is a suggestion this has helped reduced prevalence in Merseyside.
- All tier 3 areas are expected to get some form of mass testing.
- We are getting ready to support asymptomatic staff testing in both South and West Yorkshire.
- Our front-line staff will be testing themselves with their home testing kits twice a week from Thursday (lateral flow testing). We believe this will identify staff who will need to self-isolate.
- Clinically extremely vulnerable status of individuals has been updated to include people with stage 5 chronic kidney disease and adults with downs syndrome.
- Staff identified as clinically extremely vulnerable, as per guidance, are currently working from home. Approximately 100 additional staff have now not been physically at work but are working from home.
- We remain at Opel level 3, this was confirmed at gold command.
- We continue to focus on inequalities and assess all our emergency decision making against the equality impact assessment tool.
- Following a conversation at the NHSE/I Board meeting last Thursday, a substantial range of suggestions about how Integrated Care Systems (ICS's) will develop in the future was published.
- The majority of these options are in line with those already in place in West and South Yorkshire.
- They indicate two options for the future of clinical commissioning groups (CCGs) in legislation. One is that a CCG is coterminous with an ICS and that the CCG can form a statutory partnership with local government which gives ICS's a statutory footing.
- The other, is that CCGs cease to exist. Over the next six weeks there is a feedback process. Both ICSs will have discussion about these options, as will we as a Trust in both this afternoon's private board and December's strategic board.
- The briefing is very clearly a view of system working, provider collaboratives and place-based working. We are already doing these things. We would want more focus on co production and involvement of local people in future plans nationally.
- The new financial arrangements for this year are in place. £50m is being made available to the mental health system to support discharge from acute mental health beds.
- Staff well-being continues to be a top priority.
- RW informed the Board of a staff death as a result of Covid-19. Kalli Mantala-Bozos was a psychological therapist in Calderdale. The Trust is working with her family in relation to communications and how we commemorate her service.
- Kalli will be very much missed by her team and the service. She was a mum, a partner and worked in our bereavement group and is described as dedicated and supportive. Her husband, the reverend Stavros Bozos, has given permission to talk about her today. RW quoted from the reverend:

    - *"Thank you for all the good words you have put together for Kalli, we are so sad as a family to have lost her, but judging by the inundation of messages like yours we have a very positive conviction that her soul is rested into Abraham's bosom, getting prepared for the eternity of a constantly augmenting and improving communion with our Trinitarian god. Many thanks for your tremendously important work within this Covid madness."*

- Our response to this as an organisation will be one that is a fitting tribute to Kalli and her service. It will be a reminder to everyone that this virus should not be taken lightly.
- Our teams have been affected by the pandemic for months, we are asking them to:

- conduct the biggest flu vaccination in history

- implement the biggest and fastest vaccination programme for Covid-19
- implement the biggest testing programme
- work with digital technology they haven't used before, with a group of people in communities who are distressed.

- As a board our emphasis on staff wellbeing has to be maintained because without them we don't have services.
- As we heard from Joanne and Janet our staff perform small miracles of kindness and compassion every day.

Board members expressed their condolences to Kalli's family, friends and colleagues.

CD asked about partnership working in Barnsley and staff wellbeing noting pressure in Barnsley community services.

RW reported there is prioritisation of caseloads on a constant basis which makes sure those that need care, receive it. Mutual aid calls are rare, but we consider the impact on our patients, services and staff. This is managed through bronze command for operational impact, and silver command for the tactical issues around the place-based arrangements.

CH reported teams were fully engaged with the people of Barnsley. Our teams have worked hard in the community to take pressure off the hospital. More acute illness is present in the community, but staff are working together to help manage our shared population.

CJ asked about system planning for when things became pressured and the impact on the workforce.

RW stated the difference from the first wave is there hasn't been any national scenario modelling provided. In the second wave, forecasting had been condensed into what may happen in the next couple of weeks. Our two ICS areas have five-point plans for dealing with the impact of Covid-19 which start with having a shared view of the forecast position of the virus in the coming weeks.

Our modelling needs developing further but alongside this at the end of last week NHS England released some models for the demand on mental health services.
These need to be reviewed to establish what the consequences may be for us. We need to be flexible and remain flexible, using our business continuity plans and emergency preparedness resilience and response (EPRR) plans. If things get significantly worse, we need to be able to respond.

EM noted in the report a person with a learning disability was six times more likely to die from Covid-19.

RW stated this is higher than the disparities within our black, Asian and minority ethnic (BAME) groups and as such requires a system response. In West Yorkshire and Harrogate, a similar response is being taken as that used to address the inequalities faced by our BAME communities.

Dr.Sara Munro is the lead for the mental health, learning disability and autism programme and has picked this up. Terms of reference have already been developed.

TB reported for people with a learning disability, face-to-face contact is preferential, and this has continued wherever necessary with appropriate risk assessments.

Physical health is also reviewed in the local passports that have been produced to gain swift support from general or acute services, when needed.

People with a learning disability should be a high priority for the pending vaccination.

RW noted all GPs are being asked to contact patients who have a learning disability to make sure they are having their annual health check and flu jab.

AM noted the Trust is having to respond to rapid changes on a regular basis. The staff response over the last few weeks and months has been phenomenal.

Dr Subha Thiyagesh (ST) reported the Trust will be involved in any potential research studies that will go towards further work on prevention.

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

TB/20/96 Performance reports (agenda item 8)

TB/20/96a Integrated performance report month 7 2020/21 (agenda item 8.1)

Covid-19 and Quality

TB noted the following:

- The Infection Prevention and Control (IPC) team continue to support staff and give advice.
- There is a revised testing regime for long term inpatients.
- Supply of Personal Protective Equipment (PPE) remained in a good position.
- Asymptomatic testing is being rolled out for staff to test themselves twice a week. There is a recording system in place. The purpose is to get early alerts, but this may result in increased staff absence.
- The vaccine will be delivered locally and we have a team working on how this will be managed.
- Significant work has been put into the Barnsley system and this has been acknowledged.
- Silver command continue to meet three times a week, gold command twice a week.
- Silver command's terms of reference have altered slightly. They are now focusing on four key issues, flu, Brexit, Covid-19 and testing.
- Complaints continues to be a pressure due to staff capacity. Individual timescales are being agreed with complainants.
- The number of under-18 admissions to adult wards remains concerning but safeguards are in place.
- Out of area bed use continues to be challenging but we are managing well given the current circumstances.
- Staff pressures remain in forensic services, there has been close scrutiny of the safer staffing report in Clinical Governance and Clinical Safety Committee (CGCS).
- Care Programme Approach (CPA) care plans data is being queried. There was an issue managing the transition within SystmOne. The data show a low return rate. Work is taking place to resolve this issue.
- There has been a focus on restraint as detailed in the report, self-harm and suicide rates continue to be closely monitored at clinical risk panel.
- Safeguarding remains critical, we will continue to be engaged in local panels and putting supervision in place.
- The Care Quality Commission (CQC) improvement plan refresh continues, and work is ongoing to align our work with the plans for the new CQC arrangements.

- Metrics show performance is holding up well but there are significant pressures in the system. This is being managed through the command structure, business continuity plans and the tremendous goodwill and determination of staff within the Trust.

Kate Quail (KQ) asked what safeguards and assurance were in place for children being placed on adult wards.

TB reported protocols had been established in liaison with the CQC so that we were providing an appropriate response and the "least-worst" option within the wider system. We maintain links with child and adolescent mental health services (CAMHS) pre, post and during any admission.

All staff have completed child safeguarding training on the ward. We have specific wards where this option can take place, so that staff know how to respond. Specific care plans and specific supervision are required, and environmental changes are put in place.

KQ asked what level of information the Executive Management Team (EMT) get?

TB reported that EMT receives the IPR too and is therefore in receipt of the same information as the Board. Each case of a child being placed on an adult ward is recorded as an incident, goes through the clinical risk panel and is investigated separately. If a more detailed enquiry is necessary, there are the options of a serious incident investigation or service level investigation depending on the scale of the incident.

All incidents are detailed within the quarterly and annual incidents reports. The metric is present in the IPR to maintain Board oversight of child admission to adult wards. The West Yorkshire Tier 4 CAMHS beds development and lead provider collaborative should go some way to alleviating this issue in the next financial year.

Erfana Mahmood (EM) asked about complaints timescales and what was being done to tackle this issue?

TB reported proposals were being reviewed for a triaging system. Targets are to be discussed at the next Clinical Governance and Clinical Safety Committee meeting.

SYo asked if there were any additional risks as a result of the Covid-19 outbreak on Hepworth ward?

TB reported the outbreak had been managed well with assistance from Infection Prevention and Control (IPC). The cleaning regime had been followed and advice provided. TB referenced a new 28-day routine testing requirement for all service users within the unit.

<u>National Metrics</u>

Mark Brooks (MB) reported that TB has already covered the main outlier which was child admissions in adult wards. There were no questions.

<u>Locality</u>

CH provided the following update:

- Clinical supervision had been raised at previous Board meetings and feedback has been sought from each locality and updates will be included in each locality update.

<u>Barnsley community services</u>

- The system appears to be settling, but community services remain very busy.
- People being cared for in their own homes have a higher level of acuity than seen historically.
- Increased wraparound support to care homes to support residents with Covid-19.
- Mobilisation of Covid-19 vaccinations for staff in Barnsley, we will also vaccinate people who can't get out of their homes.
- Barnsley community is a hotspot for levels of clinical supervision. The way clinical supervision takes place has changed as our work has changed.
- We are now using members of the multidisciplinary team for clinical supervision and group discussions for supervision, but this is not being captured or recorded adequately. This is being resolved.

Barnsley mental health services (including inpatients):

- Memory service diagnostic clinics have been reinstated; we have capacity to address the backlog by the end of this month.
- Barnsley mental health is a hotspot for the recording of Care Programme Approach (CPA) 12-month reviews. We are using the learning identified in other areas to address this.
- There are some targeted actions to improve clinical supervision in Barnsley mental health services, but this is not an identified hotspot.

Child and adolescent mental health services (CAMHS)

- There is a continued reduction in time from referral to being seen.
- There remain challenges in waiting times for neurodevelopment assessments in Calderdale and Kirklees.
- Arrangements for clinical supervision have strengthened, again this is not an identified hotspot.

Trust wide Inpatient Services

- There have been significant pressures in the wider system. This has led to intensive work to improve pathways with the acute hospitals for attendance at A&E.
- There are a number of inter-agency improvement networks underway. Detailed reviews of waiting times in A&E are taking place so that we can help relieve pressure across the system.
- There is significant improvement in clinical supervision in this area. Individual teams have targeted action plans in place.
- Ward 19 in Dewsbury has not had a medicines omission in 12 months. This is a great achievement and we are sharing the learning and good practice with the other wards across the service.

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

- The outbreak in forensics resulted in numerous staff having to self-isolate. This has had an impact on staffing across the Forensic unit. This is a current challenge.
- We are continuing to work as lead provider for the adult secure provider collaborative across the West Yorkshire & Harrogate system.
- Clinical supervision is of a high standard in forensics services.
- In learning disability services, clinical supervision is a hotspot, and a concern. Targeted support in the teams and actions for the learning disability trio and the deputy director are being regularly monitored.

- Increased pressure in learning disability community services has led to an increase in referrals to hospital admission, following the breakdown of community placements. Learning disability services have therefore moved to OPEL 3 (Operational Pressures Escalation Level).
- The reconfiguration of assessment and treatment units across West Yorkshire continues. There is an internal steering group with input from CH, SR and the executive trio. We are working with the executive trio in Bradford to see how this can be managed in the future.

CD thanked CH for the update on clinical supervision and stated this was discussed at Clinical Governance and Clinical Safety Committee. CD reiterated how important it was for the Board to continue to monitor clinical supervision.

AM reiterated congratulations to Ward 19 on their achievements.

Priority programmes

Salma Yasmeen (SY) reported that despite the pressure, teams and people across the organisation have continued to focus on hot spot areas for improvement and are continuing to drive improvements forward despite the pandemic.

Communications

SY reported there remains a significant focus on Covid-19 and providing clarity around information in the ever-changing environment.

Work in partnerships continues in our places and we feed into the joint communications in those areas. Communications around flu vaccinations, information governance (IG) breaches and the roll out of the Formulation Informed Risk Management (FIRM) risk assessment have been recent priority work.

The Inclusion and Equality team continue to monitor the impact of Trust decisions in the current climate and update the Covid-19 equality impact assessment. They promote the use of the rapid decision-making tool and provide accessible information to our client groups.

Focus this month has been around carers and carers passports, including a positive engagement event.

MF and CD noted the high quality of recent communications.

Finance and Contracts

- MB reported this is the first month of the new financial arrangements and as such we had returned to more normal reporting.
- We are reporting against the first six months of actual performance, and the plan we all agreed at Board for the last six months of 2020/21. This approach is for the 2020/21 financial year only.
- As a result, budget variances may look unusual in this month's report.
- Income has been slightly higher than expected, some of the expected Covid-19 costs have been slightly lower.
- We have had a very positive month in reducing out of area beds.
- In summary, we have delivered a small surplus when expecting a deficit.
- This has been the first month reporting using the new SBS system.
- Cash remains strong, but we have received a months' worth of income in advance and this is expected to be addressed before the end of March 2021.

- Our capital spend has started to pick up, we have spent nearly £0.5m this month and we are still forecasting to achieve our revised plan.
- Seven days payments were on target for October. These will likely reduce next month while staff become familiar with the new system.
- We have provided some brief headlines to the Finance, Investment and Performance (FIP) Committee about headcount year on year. We have approximately 200 extra staff as a result of additional investment in mental health services, investment in Barnsley community services and better recruitment & retention.

The team that pull the IPR together are working hard to provide the report to Board as well as developing reports and updating information nationally for flu vaccinations, bed availability and preparing for the forthcoming Covid-19 vaccination programme.

AM agreed and reiterated MB's thanks to the performance and information team, and the finance team for the implementation of the SBS system.

CJ reported FIP had discussed the in-month variances and were assured, understanding why they were there. CJ added the Committee's thanks to MB and the team for the successful SBS implementation.

MF noted one of the largest variances between budget and actual figures this month was the provisions number.

MB reported when the budget was put together it included some of the possible costs to be incurred in the provisions line. The Mental Health Investment Standard (MHIS) monies had not been allocated to individual teams yet, and as such being held centrally. The variance would reduce as the year continued.

Workforce

AGD updated:

- The Workforce and Remuneration Committee (WRC) received a detailed report on absence and wellbeing.
- The combined total of Covid-19 absence and non-Covid-19 absence was just over 7% but varied daily.
- There was a strong focus on supporting staff now, but also in the longer term as Covid-19 continues.
- Work on support around physical health for staff continues, as a healthy lifestyle will assist staff to endure the pandemic.
- Estate is being reviewed to make sure that it continues to support staff wellbeing.
- Research has shown that the resilience of staff lies within teams, and teams supporting each other is crucial as demonstrated in today's Board story.
- Food safety training has been picked up as an issue to address. We have been slightly under target for the last few months. The training is to be redesigned, in line with national requirements, to make the process easier for staff to get through.

CD referenced CJ's earlier point about staffing levels in January and the impact of asymptomatic lateral flow testing. We know from finance there will be no additional Covid-19 money going forward. Are we confident with our figures and that we have the right assumptions in place?

MB reported that Covid-19 money is still available and has been allocated to us on a fair share basis by the West Yorkshire & Harrogate ICS. The difference is that it is no longer reclaimed

retrospectively as before. The use of Covid-19 money allocated to the Trust is prioritised by CH and her team in the Operational Management Group (OMG). In Month 7 we spent less than previous months.

AGD stated there is a staff supply issue, and staff will be required to support the vaccine rollout. The priority is to keep staff well and healthy and giving them the support they need will be fundamental moving into the new year.

Sam Young (SYo) reported a lengthy discussion about risk in WRC, specifically around staffing levels and wellbeing and this is being closely monitored by the Committee.

CJ reported FIP had also discussed future risks and financial opportunities, things were well balanced going forward and CJ shared MB's comfort with the current forecast.

RW stated the degree of challenge in both committees was very positive. From FIP, RW had noted MB's ongoing assessment of risks and opportunities, and for the first time in a while the balance was more towards opportunities than risk, which provided comfort around the financial forecast.

AM had noted on the "guardian of safe working" report for this quarter, the tremendous work of the rota coordination team and the medical education and medical management team. They had managed the gaps with no exception reports coming through. AM noted thanks to the team.

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

<u>Update from the IPR sub-group</u>

- MB updated following the last strategic board session it had been agreed to set up a small sub-group to look at the IPR report in totality.
- There were two aspects to this, the overall IPR report in terms of content and format, and the appropriate metrics to determine progress against our strategic objectives.
- The group met less than a month ago.
- The group includes John Laville (lead governor) and Mel Wood (Head of Performance). Mel provides guidance regarding what is achievable and what development work might be required.
- The report includes a summary of the meeting, and recommendations about how reporting against strategic objectives can be fulfilled.
- The proposal is that there is a separate page for each strategic objective which has agreed Trust priorities aligned to it. Key metrics are aligned to each priority.,
- Outcomes had not been a focus yet, the group recognised that in outcomes for improving health, there will be many other organisations and bodies that contribute to this, and we need to establish how to we can recognise our own impact.
- It is recommended we establish key metrics that we can directly influence in the short term.
- There are some principles highlighted in the report which are:
- It is important we identify how much influence and control we have over what we report against, as this is paramount in understanding our own contribution to performance.
- Ensuring the principles we have align with the other strategies we have in place. For example, the quality strategy, for which we already have a number of metrics identified.
- We will clearly define what each metric stands for and what we are using it to measure against.

- Whilst the IPR is primarily used for Board and Committees it is used for other purposes too and should be aligned to other reporting that takes place.
- We have considered the frequency of some metrics which are reported quarterly or annually.
- There are also some proposed metrics with data quality issues that will require some focus.
- Metrics for Digital priority need to reflect whether digital can improve the care we are providing, or staff efficiency and will need more thought.
- Some of these areas will evolve as we progress.
- A follow-up meeting will take place next week to look at the IPR as a whole.

SYo asked under providing care close to home there is only one metric, and asked ifo we need to include something about community staffing, or people dying in their place of choosing, which we already have?

CD asked for clarity around the second bullet point under "safely delivering services locking in safety and innovation".

MB reported this was about inequalities and access for all people. This is the executive summary so is an aggregated total. We will also develop metrics for each of our services in each place and monitor progress locally.

RW reminded the Board that the term "BAME" is being contested by some people, as it puts people in a single group who have different characteristic and experiences. This has been identified in the recent review of inequalities in the West Yorkshire & Harrogate ICS and the Public Health England work.

MB stated in the last IPR we provided an update on the development of reporting by place of access to services by gender, ethnicity and religion. This is to be overlaid with the gender, ethnicity and religion data for the population of that community which should give us some powerful information.

MF stated he is involved in this work and felt in the improving care section it needs the voice of the service user and carer. We cannot conclude on care improvement if their voice is not represented. Is there a regular metric we could use to represent this, perhaps something from customer services?

AM noted the sustainability measures were still to be included. The sustainability and green plan were still under discussion. These needed to be added once complete.

MB stated he would take Board comments in relation to the IPR metrics back into the IPR subgroup for discussion.

Action: Mark Brooks

It was resolved to NOTE the progress made to date by the working group, APPROVE the recommended metrics for measuring performance against the Trust's strategic objectives and NOTE comments from the Board.

TB/20/96b Serious Incidents Quarter 1 2020/21 (agenda item 8.2)

TB introduced the item and stated the report has been through the Clinical Governance and Clinical Safety Committee.

- TB noted there is nothing specific to highlight, which is unusual in itself, and important to note in the current climate.
- Reporting levels remain the same, which given the current clinical pressures is positive.
- We are starting accreditation in the Royal College of Psychiatry serious incident process which is positive. This will build another level of assurance into the serious incident process.
- Self-harm and suicide are being closely monitored during the pandemic so that intervention can take place where required.
- MF had raised reporting themes and actions. Where policy issues were identified it needed to be clarified if the problem was with the policy itself or the implementation of the policy.

It was RESOLVED to NOTE the quarterly report on incident management and the actions identified by the Clinical Governance and Clinical Safety Committee.

TB/20/97 Business developments (agenda item 9)

TB/20/97a South Yorkshire update including the South Yorkshire & Bassetlaw Integrated Care System (SYBICS) (agenda item 9.1)

AGD reported over recent weeks the focus of Integrated Care System (ICS) and Health Executive Group (HEG) has been on the response to Covid-19. Strong partnership working is a key focus.

Salma Yasmeen (SY) noted that work continues at the Mental Health, Learning Disability and Autism programme board, so that the system can access funding available to help with crisis and community services.

In Barnsley we have made successful bids for funding for winter planning and initiatives to support the Covid-19 pressures. We will be a key partner in the green and blue social prescribing bid, which builds on the work carried out by the Trust and Creative Minds.

RW noted there is a session today in South Yorkshire and Bassetlaw regarding the NHS England/Improvement (NHSE/I) proposals on the future of integrated care, which AM will be attending. We need to engage appropriately in conversations with partners around our response to what NHSE/I are suggesting happens with ICSs in the future.

The Trust has a positive role to play in provider alliances. Providers working across places is part of the future, and so the Mental Health, Learning Disability and Autism Provider Alliance in the SYB system is essential. Further to this, providers will be working collectively in places like Barnsley.

There will also be changes to the Clinical Commissioning Groups (CCGs) under both options in the proposals, which likely means there will be one CCG for SYB in future. There will be an acceleration of conversation about form, and the Board should note that this will happen.

AM noted there were discussions taking place today in both West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICSs that the Trust would be attending. These discussions follow positive collaborative and partnership working at both place level in Barnsley, provider collaborative level in the Mental Health, Learning Disability and Autism Alliance, and at system level, where a governance review has begun. The right things are in place to make sure we respond in the right way to the NHSE/I proposals.

RW asked to note congratulations to our CCG partners in Barnsley and South Yorkshire. Barnsley CCG was rated as "outstanding" again as were several of the other CCGs and the Board should be aware of this.

MF asked if there was to be a lead provider in the Mental Health, Learning Disability and Autism Alliance? If we were to consider being the lead would this stretch us too far?

AM reported provider collaboratives are emerging for forensics, tier 4 CAMHS and eating disorders in SYB but, unlike in West Yorkshire, The Trust is not a formal partner to any of these collaboratives in South Yorkshire currently.

The Mental Health, Learning Disability and Autism Alliance is an informal collaboration between the providers, in addition to formal pathways of care (provider collaboratives) and we need to consider while we are not part of the current formal provider collaboratives, we are part of the pathways, and we will review this through the actions on the action log.

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

TB/20/97b West Yorkshire update including the West Yorkshire & Harrogate Health & Care Partnership (WYHHCP) (agenda item 9.2)

SY highlighted the following points:

- In addition to a significant response to Covid-19 and winter planning there has been a continued focus on the "10 big ambitions" across the ICS and the work on equalities and tackling inequalities.
- Significant work completed around sustainability, which will need to feed into the strategic board discussion.
- Carers and the sustainability of the voluntary sector. The "neighbours' campaign" has been relaunched this year and is being recognised for an award.
- The system leadership regarding inequalities is also nominated for a Health Service Journal award, as well as the system work relating to carers and carers' passports.

SR asked to take the paper as read and would provide an update on the forensic provider collaborative later in the private session.

RW noted the CCGs in Kirklees have agreed to merge. This will allow then to work in a single footprint that is coterminous with the council. These place-based arrangements will fit with expected direction of travel for future commissioning arrangements in West Yorkshire.

Close to £1m has been allocated to the Partnership for staff wellbeing and the creation of wellbeing hubs.

The Partnership Board this afternoon, will discuss and agree the recommendations and actions on inequalities faced by our black, Asian and minority ethnic patients and staff. This report will deliver improvements.

Our West Yorkshire colleagues have also done well in the national CCG ratings. Wakefield is now "outstanding", and Kirklees and Calderdale are "good".

CJ asked about the ten big strategic objectives. How is the ICS managing performance against targets such as reductions in suicide and closing life expectancy gaps? What is the mutual accountability process? Is the ICS looking for us to contribute? Regarding the conversation around sustainability and the voluntary sector do we have any partners we work closely with who are at risk?

RW explained the mutual accountability arrangements. When the pandemic arrived the system oversight and assurance group was suspended. It resumed in August. RW chairs the meeting with input from the regulators, and places, sectors and system are all represented.

A report is received each month that monitors progress against key indicators and highlights indicators that require improvement.

The mutual accountability process is to review progress and then look at what we can offer, whether it be money, expertise, capacity or competence. There have been no competence issues but many opportunities to provide support.

During the pandemic, sector leads have been meeting weekly on Wednesdays, and at times there have been daily meetings, where mutual support and accountability have been required. For example, Personal Protective Equipment, vaccination, testing and performance issues.

An example would be emergency care performance which has recently been off track. The Chief Operating Officers of each acute hospital have been meeting every day, with a Chief Executive chaired meeting occurring three times a week.

Of note was mental health support in A&E and the backlog in mental health beds and the response going to be from the mental health system to address this. The system-level conversation discussed local options to see what the providers can collectively do to help. We are actively working with Mid Yorkshire Hospitals Trust on this currently.

RW queried if we had all the right indicators in place to measure some of the ambitions. Yorkshire and the Humber has recently been identified as the worst area in the country for suicide rates.

The real-time data for suicides is just starting to come online for the Trust area. This is coming to EMT and we will look at what we now know, what more can we be doing as a Trust and how does that impact the system, because we are leading on reducing suicides across the whole area.

AM noted that some of the reports that were received from the Integrated Care Systems were quite discursive and we needed to look at how they would be reflected in our performance reports. The IPR group should address this.

Action: Mark Brooks

RW continued that there was a lot of support going into the voluntary sector. There has been an increase in confidence around the sustainability of the Voluntary, Community and Social Enterprise (VCSE) sector generally, though the situation remained deeply troubling for many organisations. There was another session being held this afternoon at the partnership board.

SY added we know that our VCSE partners do provide a lot of support to people, who, as a result, do not need to utilise our services. This is an important part of the system response to people living well. As a system we support the voluntary sector by considering them as part of the integral pathway and supporting them to access the funding.

Erfana Mahmood (EM) raised the statutory footing that ICSs may have going forward, and some partners such as charities and voluntary organisations are struggling with financial sustainability. We may be asking them to engage in more formalised contracts than previously and how do we go forward with this, protect them and not lose the goodwill built up in Memorandum of Understanding arrangements.

RW stated this was something that needed to be fed back in the engagement process. From the West Yorkshire and Harrogate perspective the third sector is an equal partner in current arrangements and has representation at the partnership board, the system leadership executive and in all of the places and is providing input in all of the programmes.

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, noting the comments made.

Calderdale Care Closer to Home Alliance Partnership Agreement

SY reported that the Trust's support for the Calderdale Care Closer to Home Alliance Partnership Agreement had been discussed and agreed previously at private board and was being presented today to record that decision in public.

It was resolved to AGREE formal SUPPORT for the agreement and the Trust role within the partnership.

TB/20/97c Receipt of Partnership Board Minutes (agenda item 9.3)

AM asked to take the paper as read and receive and reference the summaries.

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

TB/20/98 Strategies and Policies (agenda item 10)

TB/20/98a Equality, Involvement, Communication and Membership Strategy (agenda item 10.1)

AM summarised this Strategy has been in development for some time and was discussed in draft form at the last Board meeting. The Board is being asked to consider and approve the final version of the strategy and delegate responsibility for sign off and monitoring off action plans to our Equality and Inclusion Committee.

TB stated this strategy had been underpinned by a strong insight process. Some important points have been made about objectives and measures and these have been addressed in the version presented today. It is important as a Board we sign this off so that we can progress action planning, with oversight in Equality and Inclusion Committee.

AM as chair of E&I Committee acknowledged the substantial amount of engagement work that had taken place around this strategy. It has been a positive, responsive and detailed process.

It was RESOLVED to APPROVE the final version of the Equality, Involvement, Communication and Membership Strategy covering the period until 31 March 2024 and to delegate full responsibility for the development, agreement and monitoring of annual action plans to the Equality and Inclusion Committee.

TB/20/98b Exclusion or addendums to Trust policies as a result of Covid-19 (agenda item 10.2)

- MB asked to take the paper as read.
- The majority of policy approvals sit with the executive through EMT (Executive Management Team)

- The paper notes that we gave six-month extensions to a number of policies at the beginning of the pandemic.

MF queried whether the amendment to the Disclosure and Barring Service (DBS) policy meant that DBS checks were no longer taking place and did this present any level of risk?

AGD confirmed that DBS checks are still taking place and a local process had been adapted from NHS Employers that allows the review of documentation online. The risk of delaying employees starting work is being balanced against the risk of online document reviews. The Trust has a good track record for the scrutiny of such items.

It was RESOLVED to NOTE the update to Trust policies as a result of Covid-19.

TB/20/99 Governance Matters (agenda item 11)

TB/20/99a Covid-19 Emergency Preparedness, Resilience & Response (EPRR) Arrangements (agenda item 11.1)

- AGD reported the end of the transition period following the European Union exit is now a matter of days away.
- The Trust has continued to be in line with local and national guidance in respect of Brexit
- The papers update the Board as to our position, noting we are now getting guidance from the centre again, given the timescales.
- The risk appears low, and stockpiling is not required locally, based on national guidance.
- A checklist was received last night, and this will be worked through to make sure we are consistent with national requirements .
- Weekly meetings are taking place to review our position.

CJ asked if there are any risks of us leaving the EU with a deal?

AGD reported deal or no deal is not the issue in terms of supply, as with either option there would now be a border which could lead to delays. A deal would likely minimise supply delay. We have reassurances around methods of transport that will maintain supply.

CJ asked what will the impact be on our service and service users?

AGD reported we will to have communicate well with our service users but the approach being taken is to minimise the impact of the EU exit on services and service users.

AM noted there were a couple of amber areas in the report, one of which was hate crimes. AGD stated there were two lines of action in relation to this. One was around the reassurance of staff and making sure they feel supported and the other was through the wider system and the local safeguarding boards.

It was RESOLVED to NOTE the content of the EPRR arrangements report and the comments made.

TB/20/99b Safer Staffing Report (Item 11.2)

TB noted the report has been through the Clinical Governance and Clinical Safety Committee.

- The report will be significantly improved having added safe care into our rostering system.
- Safer staffing establishments for community services - there has been some delay in implementation, but benchmarking data will be used to support the work in this area.

- Additions and changes to the report will provide additional assurance around cross cover arrangements as requested by the Committee.
- There had been some useful suggestions around formatting.

EM raised increasing acuity and the upskilling of staff.

TB reported safe care includes looking at need, so we know what is required to provide sustainable services rather than filling gaps when they appear. This helps our workforce planning. Our Nursing Strategy and Allied Healthcare Professionals Strategy both include upskilling the existing workforce.

CJ asked about the adequacy of community staffing and system-wide options.

TB reported that all services are working within acceptable caseload levels. This is monitored through managers and supervision so there is some assurance we are meeting needs. The safer staffing group is reviewing any further action that can be taken.

The suggestion is to use the new benchmarking data rather than start new work.

There has been some significant work completed, but around specific teams with specific needs, for example Early Intervention in Psychosis (EIP) where there are very prescribed formats. The general offer around community mental health services is far more complex.

In community physical health services, we have some good measures that link back to the safer nursing care tool and outcomes making it easier to give assurance.

CH reported the Trust is supporting a number of trainee nursing associates who then move onto pre-registered nurse training so we can increase our registered nursing skill base.

AM stated, in response to EM's comment about skill mix, we are also employing more peer support workers and utilising our volunteer workforce more creatively.

TB reported there is trainee nursing associates work and apprenticeship work. There is a revised model that will support community services better. Our volunteer workforce is more likely to be used in the community than in inpatient services.

MF stated figure 10 has been updated following discussions at Committee. MF liked the grouping of the wards. Areas were still showing as red, do they have this collaboration across different wards, and have we thought of way of demonstrating that within the graph?

TB stated some notes had been added to the graph to show how the cross-cover arrangements work and the decisions are taken using the professional tool. It is a challenge that's been put into the safer staffing group.

RW stated this was a helpful conversation in terms of two developments, our workforce strategy and plan. We now have around 100 peer support workers in the organisation, which is a significant increase.

This is in the context of supply constraints in registered staff. We have 177 registered mental health nurse (RMN) and registered learning disability nurse (RLDN) vacancies, which is a substantial gap. We need to make sure this is addressed through the workforce strategy.

These need to link into the workforce strategies for the West Yorkshire and South Yorkshire ICSs.

Applications for mental health and learning disability courses are up, placements are up and supply should be getting better.

We are doing what we can to manage a difficult time with staffing using a multi-disciplinary team approach and engaging with support workers and this needs to align with ICS needs.

AGD updated there is a West Yorkshire mental health workforce collaborative which has been looking at a number of initiatives regarding supply of staff. We have just had a bid accepted for £200k for us to be the lead employer for international recruitment.

CH reported that 33 of the registered vacancies are in inpatient forensics. Specific recruitment activity is taking place and support being given to all training opportunities for staff who want to go on to take up registered posts.

TB updated that approximately 85 of the vacancies are for registered mental health nurses.

It was RESOLVED to NOTE the report and the assurance received by the Clinical Governance & Clinical Safety Committee.

TB/20/99c Sustainability Annual Report 2019/20 and strategy update (Item 11.3)

AGD reported this has been delayed due to Covid-19. Capacity has been an issue and due to the importance of this agenda extra support has been procured and there will be a specific session at strategic board in December.

All people's behaviours are a priority as part of the green plan, not just estates. Our responsibilities are to the communities we serve.

AM noted this was an update in relation to the development of the new strategy and a brief report against specific elements of the existing sustainability strategy. Of note was the Trust's performance against its carbon footprint target for 2019/20 which has exceeded the target set out in the current strategy.

The focus is on the future and how we move forward. We welcome input from WRM, the consultants who are going to lead this work. A

RW noted there are some asks from the West Yorkshire and Harrogate ICS for organisations and we will need to consider those as part of the development of our strategy.

It was RESOLVED to SUPPORT the revised process and NOTE the Trust's performance against its carbon footprint target for 2019/20.

TB/20/100 Assurance from Trust Board Committees and Members' Council (agenda item 12)

Clinical Governance and Clinical Safety Committee 10 November 2020 (15 September 2020 minutes received)

CD highlighted the following:

- Discussion around clinical supervision and issues in Barnsley community services.
- Patient Safety Strategy - good engagement with BDUs, BDU priorities and safety huddles.
- Learning Journey report was received showing good work across the Trust.

- Ligature report was received. There was challenge regarding how we audit ligatures across the organisation.

MB asked if there were any ligature concerns identified at the Committee that the Board needed to be aware of?

CD reported that there were no ligature concerns identified. There was a good ligature audit process in place and there was discussion to make sure staff had support around ligature incidents and the capital availability when required.

Finance, Investment and Performance Committee 24 November 2020 (22 September and 26 October 2020 minutes received)

CJ highlighted the following:

- Received assurance on the explanation around extra 200 whole time equivalent staff.
- Forensic Lead Provider developments, which are a topic for the private Board session.
- Received first set of finance reports from new SBS system.
- Discussion around positive cash situation and opportunities on capital projects going forward.

Mental Health Act Committee 3 November 2020 (25 August 2020 minutes received)

KQ highlighted the following:

- Service user engagement work for BAME service users, with preliminary findings about experience of Covid-19 and care during that time.
- Some positive findings about virtual hearings but more information is required around access to solicitors and advocates.
- Mental Health admin team input. There has been a large improvement in the reading of rights from 30% to 90%. Community returns are very low and a programme of improvement is underway.
- CQC feedback was discussed and actions are underway to resolve issues raised.
- Advocacy has been picked up in a compliance report. There are issues in relation to access which has been exacerbated by Covid-19. There is positive work underway to resolve this.

TB reported the current infection prevention and control (IPC) measures for Covid-19 and support for people's rights were both high priorities. Microsoft Teams and Zoom have been used to get people the advocacy access they require.

CH reported that Deputy Director of Operations, Chris Lennox, has confirmed advocates are essential visitors and therefore will be accessing the wards. In forensic services, work has taken place with Cloverleaf (advocacy provider) to ensure we can arrange safe face to face visits. There has been positive feedback from service users.

RW reported that, as a Board, we are committed to people getting the advocacy they require, the practicalities of this can be difficult in the current circumstances and this demonstrates the need for good communication.

Workforce and Remuneration Committee 12 November 2020 (13 October 2020 minutes received)

SYo highlighted the following:

- There were focussed discussions around staff, staffing levels, staff absence, Covid-19 response, testing, staff wellbeing risks, board succession planning.

- The Organisation Development and Workforce strategies are delayed and the workplan for the Committee is currently being reviewed.

Members' Council 30 October 2020 (31 July 2020 minutes received)

AM highlighted the following:

- The Members' Council has approved a new set of objectives.
- Positive feedback on governor engagement received.
- Governor election process update.
- Highlight report on demand for mental health services discussed.
- New governor appointments approved.
- CJ as new Deputy Chair and Senior Independent Director from 1st February 2021.

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

TB/20/101 Use of Trust Seal (agenda item 13)

It was RESOLVED to NOTE that the Trust Seal has not been used since the last report on 29 September 2020.

TB/20/102 Trust Board work programme (agenda item 14)

MF asked about work programme and queried the purpose of the December board meeting. AM explained that December's meeting is strategic and not a decision-making meeting. The items in the work programme allude to the items taken through the public meetings. January is a public meeting and February is another strategic meeting.

RW noted MF's point and suggested we could identify agenda items for we are strategic board meetings in the work programme. RW suggested this could form part of the annual review of governance that Mike and the Audit Committee conduct. RW would support including the content of strategy board meetings on future agendas.

Action: Andy Lister

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

TB/20/103 Date of next meeting (agenda item 13)

The next Trust Board meeting held in public will be held on 26 January 2021, which will be a virtual meeting.

TB/20/104 Questions from the public (agenda item 14)

No questions were received.

Signed: **Date:**

South West Yorkshire Partnership NHS Foundation Trust

TRUST BOARD 1 DECEMBER 2020 – ACTION POINTS ARISING FROM THE MEETING

= completed actions

Actions from 1 December 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/91	Mike Ford asked if there was anything that could be done to acknowledge Elaine Dressers' achievements as described in her board story last month. AM asked for this to be noted and agreed to action this.	Angela Monaghan	January 2021	Propose to nominate Elaine for a British Citizen Award for either healthcare or community. https://www.britishcitizenawards.co.uk/nominate-for-a-bca/
TB/20/92	In reference to TB/20/83a – Mark Brooks (MB) reported that this action needed to be split. A discussion followed which agreed one action related to the committees in common relationships that are emerging in terms of the mental health alliance. The second action is to go back and review our relationship in the emerging provider collaboratives in South Yorkshire and assess if we should have a formal involvement in these arrangements. Separate actions to be created.	Andy Lister	January 2021	Complete as below.
TB/20/92	In reference to TB/20/83b MB stated this action needed clarity. Rob Webster (RW) reported this action related to Executive Management Team (EMT) looking at our digital strategy and seeing if it fits with the West Yorkshire and Harrogate Integrated Care System digital strategy, and the regional digital statement that has been made. Action wording to be amended.	Andy Lister	January 2021	Complete as below.

TB/20/92	AGD reported the Workforce Race Equality Standards (WRES) are well established but there is further work to be done on the Workforce Disability Equality Standards (WDES) and how it links back to the Board. AGD would be able to provide a further update at the next meeting.	Equality and Inclusion Committee	January 2021	WDES action plan approved by Equality and Inclusion. WDES Standard 10 relates to Disability representation at Board Level. In the last WDES Annual Report it was reported that no Board member had declared a disability although there was one declaration unknown.
TB/20/96	MB gave the Board a progress update from the IPR sub-group which had been formed to look at IPR metrics and the IPR report as a whole. MB agreed to take comments from the Board meeting back to IPR sub-group for further discussion.	Mark Brooks	January 2021	A separate paper is provided on the update of the IPR.
TB/20/97b	AM noted during discussion that some of the reports received from the Integrated Care Systems were quite discursive and we needed to look at how they would be reflected in our performance reports. The IPR sub-group should review this as part of their ongoing work.	Mark Brooks	January 2021	This will be considered as part of the future development. Further development of the IPR is currently paused whilst the team respond to the additional reporting requirements of the vaccination programme.
TB/20/102	RW noted MF's comments about strategic board agenda's and suggested we could identify agenda items for the strategic board meetings and include them in the work programme. RW suggested this could form part of the annual review of governance that Mike and the audit committee conduct. RW would support including the content of strategy board meetings on future agendas.	Andy Lister	April 2021	

Actions from 27 October 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/82b	Audit Committee to have oversight of the legal risks in relation to Covid-19.	Audit Committee	January 2021	Covid-19 legal risks meeting arranged for 27th January. MB and MF will be in attendance.
TB/20/83a	Oversight of what we going to sign up to in terms of a committee in common and governance arrangement in South Yorkshire.	Salma Yasmeen	January 2021	Feedback provided on draft MoU. Presentation and discussion in private Trust Board in January.

TB/20/83a	Review our relationship in the emerging provider collaboratives in South Yorkshire and assess if we should have a formal involvement in these arrangements.	Salma Yasmeen	January 2021	Discussion took place in EMT.
TB/20/83b	There has been huge progress on infrastructure against our digital strategy. We do need to think how we connect better into this work across the ICS. The Executive Management Team (EMT) should look at our digital strategy and seeing if it fits with the West Yorkshire and Harrogate Integrated Care System digital strategy, and the regional digital statement that has been made.	Mark Brooks	March 2021	This is considered in the updated digital strategy which will be form part of the papers of the March meeting.
TB/20/84a	Further review of governance arrangements given the enduring nature of Covid-19 to be monitored by the Audit Committee.	Audit Committee	January 2021	This is being built into the work programme for the Committee.
TB/20/85a	Quality account actions to be reviewed, in light of the second wave of Covid-19 and assess if March 2021 timescale is achievable for actions and if not, set a new target date.	Tim Breedon	January 2021	All actions complete except for completion of the Quality Account report which has a deadline for completion of May 2021.
TB/20/85b	Review the actions in relation to Health and Safety objectives through a “Covid-lens” as some of the previous safeguards may have changed.	Alan Davis	January 2021	The Health and Safety TAG has continued to meet throughout the pandemic and the H&S objectives takes account of all risk factors including Covid-19.
TB/20/85b	Review service visits and look how these can be completed during Covid-19 by digital means.	Clinical Governance & Clinical Safety Committee	March 2021	
TB/20/87	Look at frequency of strategic review of business and risk and see if this can be linked to the BAF, ORR and triangulation report cycle.	Salma Yasmeen/ Mark Brooks	January 2021	Provisionally we agreed to consider this report as part of the annual planning process. The next version will be presented to the Trust Board in March.

Actions from 29 September 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/66a	MB reported that if we looked at what our requirements were for demand and capacity, planning prior to Covid-19 it would be very different to what it is now. Previously if there was a tender coming up or a specific piece of work required, we would do some basic demand and capacity modelling work. The Trust was going to have to think quite carefully about how it structured some of its functions. AM summarised by saying that FIP would look at these issues in detail and we would make sure these were kept in view of the board as required.	FIP Committee	February 2021	
TB/20/66d	CD commented that the RC report was positive with 90% of staff feeling that their line manager was interested in their wellbeing. "I feel that the Trust listens when concerns are raised" seemed a bit low. Was there any comment on that? AGD reported this was one of the areas where we will want to drill down further. It is Freedom to Speak Up (FTSU) month in October, and there was going to be a real drive in this area. FTSU guardians were being spoken to with a view to them moving away from casework and into engagement. CD reported she would like to see how this impacted on the plan that was being brought to CGCS committee next time.	Alan Davis	February 2021	To be included in the FTSUG report submitted to the Clinical Governance and Clinical Safety Committee in February 2021.

TB/20/69d	AM cited a national piece of work around disability at board level and noted that might be something we wanted to formally sign up to.	Angela Monaghan	January 2021	We are part of the NHSE/I NExT Director programme in SYB, which is a positive action scheme designed to increase the talent pipeline of future NEDs from under–represented groups. We are also supporting the newly formed national disability network for NHS NEDs. The Lord Holmes Review 'Opening up public appointments to disabled people' made a number of recommendations, which we will review for inclusion in our WDES action plan.
TB/20/69d	EM asked if we were able to extend reciprocal mentoring to cover disability? AGD reported that this was something that could look to be rolled out across a number of different areas. Project Search was something that was being looked at with the Mid-Yorkshire Trust and how we could mirror that. (Project search is a training programme looking at how to support young people with learning disabilities into paid employment).	Alan Davis	January 2021	01.12.20 - Project search – we are continuing to work with mid Yorks and mirror and adapt their programme. A further update would be provided at the equality and inclusion committee. Keep open.

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

Actions from 28 July 2020

Min reference	Action	Lead	Timescale	Progress
TB/20/53a	AM reported that SYa had mentioned earlier the CIO network. At present our Trust doesn't have a Chief Clinical Information Officer (CCIO). MB explained that this appointment had been delayed as a result of Covid-19. Discussion had been held with both TB and Subha Thiyagesh (STh) and an appointment process will take place.	Tim Breedon / Subha Thiyagesh	January 2021	Update November 2020 – the job description is being finalised with a plan to advertise by the first week in December, open for two weeks. The interviews will take place in January 2021. Update January 21- Job description finalised and request for expressions of interest sent out with closing date 21 January. Interviews are scheduled for 11 February.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 7

Title:	**Chief Executive's Report**
Paper prepared by:	Chief Executive
Purpose:	To provide the strategic context for the Trust Board conversation.
Mission / values / objectives:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers / previously considered by:	This cover paper provides context to several of the papers in the public and private parts of the meeting and also external papers and links.
Executive summary:	The winter continues to be extremely challenging for the country, local communities and the health and care system. This is reflected in the latest monthly briefing for all staff attached at **[Annex 1]** as well as developments included within this report. Effective communication continues to be delivered via the publication of The Brief, The View, the weekly Coronavirus update and a weekly virtual Chief Executive Huddle open to all staff. Since my last Chief Executive's report, we have seen a return to national restrictions, and high levels of infections accompanied by record numbers of deaths of people within 28 days of a positive Covid test. This is in the context of: • **New variants of covid-19 developing which are more infectious or have the potential to be less compatible with current vaccines**. The new UK variant is up to 70% more transmissible and has led to the rapid escalation of cases particularly in London, the South East, the Midlands and the North East of England. We have also seen a rise in prevalence in all of our local places and increases in hospitalisation and deaths. This effectively means Yorkshire has entered its third wave of the pandemic. • These changes in the virus, alongside rising infections in areas placed in lower tiers of government restrictions, **led to late changes in 'Christmas bubbles' for families at the end of 2020 as well as tighter national restrictions.** These changes impacted upon our ability to staff services with some people understandably less willing to work on Christmas Day. As a Trust we introduced incentives to encourage people to work as well as giving every member of staff working on Christmas day an extra £100 in recognition of the sacrifices they were making. This action helped ease staffing pressures and ensured we got through a difficult Christmas period.

- **Prevalence of the virus in West Yorkshire and South Yorkshire is lower than elsewhere in the country but still too high**. In recent days we have seen a stabilisation and some falls in the numbers. Throughout this period staff have been working face to face where required, for example in IHBTT, district nursing, and ward-based services. We have also been supporting colleagues across the system. Pressure and acuity in our wards has meant we have given the go ahead to use out of area beds where required to facilitate patient flow and ease pressures in our hospitals.

- **The rollout of the Pfizer Biontech and Astrozeneca vaccines is progressing in all of our places.** Since the last Board meeting we have seen a welcome requirement for hospital hubs to vaccinate NHS staff and local social care colleagues. We have opened vaccination hubs at Fieldhead and Kendray Hospitals and at the time of writing have vaccinated over 20% of staff within a few days of opening. We remain on course to vaccinate all staff within the next few weeks and support delivery of vaccination to vulnerable groups by the middle of February. Our region remains the highest performer in terms of vaccinations per capita which is a credit to everyone involved and our system working.

- **Asymptomatic testing of staff continues** with around 1500 kits returned on testing days. At this stage only around 0.05% of results are positive.

- **The Trust and our partners continue to prioritise work effectively through the EPRR arrangements.** Our internal arrangements have been reconfigured to focus on flu (now concluded), Covid vaccines, Covid response and the EU Exit. It was pleasing to see the Trust's performance on flu vaccinations this year with around 90% of staff vaccinated and one of the best results in the country for trusts of our type.

- **Prioritisation is supported by an operational planning letter received from NHS England/Improvement** on 23 December 2020. A link to the NHS Confed member briefing can be found here. The guidance and subsequent communication has confirmed that the planning round for 2021/22 will not start or conclude until at least Q1 of next year.

- **There continues to be a welcome focus on the workforce and the wellbeing of staff.** As a Trust we now have around 200 more staff than last year and we have prioritised the wellbeing of our staff throughout the pandemic. This is essential and remains under constant review. For example, we have received excellent feedback on the £50 high street vouchers given to all staff in mid-January as a small boost to morale. The issues of wellbeing, recruitment and retention are managed through our HR hub. They have been strengthened by the appointment of specific posts around OD and WRES and the wellbeing of our Black, Asian and other ethnically diverse groups. The Workforce Strategy refresh will be covered by the Workforce and Remuneration Committee as part of workforce planning at its next meeting in February.

	• **We continue to deliver services at scale despite all of the restrictions placed upon us.** We have also tried to be agile in the way in which we communicate with the public, setting out what's available in a new 'choose well guide for mental health', attached at **[Annex 2]**, and quickly confirming we are still open whenever circumstances change. • **We continue to support a focus on reducing health inequalities in each of our places.** This is reflected in work in West Yorkshire & Harrogate on implementing the outcomes of the Dame Donna Kinnair Review, the need to monitor vaccine delivery by protected characteristics and the Equality Impact Assessments used on all appropriate decisions within the Trust. • **Plans for ICS legislation may be delayed due to Covid though this is yet to be confirmed.** At this stage we continue to work with partners on next steps. We have also submitted a Trust response to the consultation and contributed in both ICS' to their place-based sectoral and system responses. Winter is proving to be challenging with positive steps on the vaccine and the impact of lockdown offset by new variants and freak weather putting pressure on services. Throughout, we have continued to remain agile and focussed on the things that matter the most. This is reflected in the papers received by the Board today and in the way services continue to run, often in partnership with others. In these times the Board should continue to recognise their leadership role in systems, in supporting leadership at all levels in the Trust and remaining true to out values. Above all we continue to see how we can always help people fulfil their potential and live well in their community.
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

3 December 2020

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

With **all of us** in mind.

Today's brief

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Welcome to the Brief being delivered through Microsoft Teams.

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

Thank you for joining us for our Brief broadcast.

With **all of us** in mind.

Our mission and values

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

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

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

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

With **all of us** in mind.

Coronavirus

Keeping informed, acting responsibly

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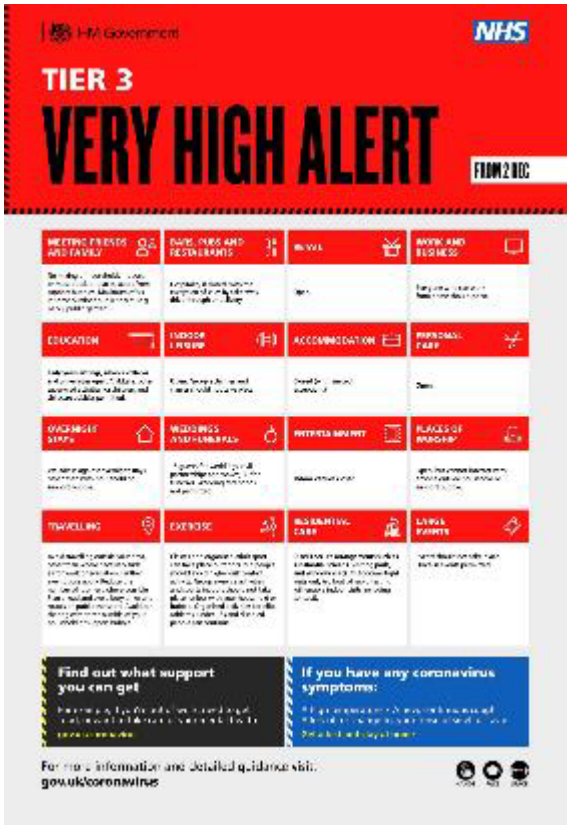
We need to stay focused and keep up to date by reading the guidance and information on the intranet, and on the Public Health and NHS England websites.

On Dec 2 we moved from being under national lockdown restrictions to a localised tier system. This means that South and West Yorkshire are now in Tier 3 – very high risk. This will be reviewed on 16 December.

Our **Gold** command meeting now meets twice a week and **Silver** command has meets three times a week. This helps us to react quickly. **Bronze** meetings continue to take place in operational and corporate services.

We continue to work in each of our local areas as part of **outbreak management measures and** are a part of weekly Gold, Silver and Bronze meetings. This means we are a part of local decisions made as part of the pandemic response.

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



With **all of us** in mind.

Coronavirus
Keeping up to date

NHS
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NHS Foundation Trust

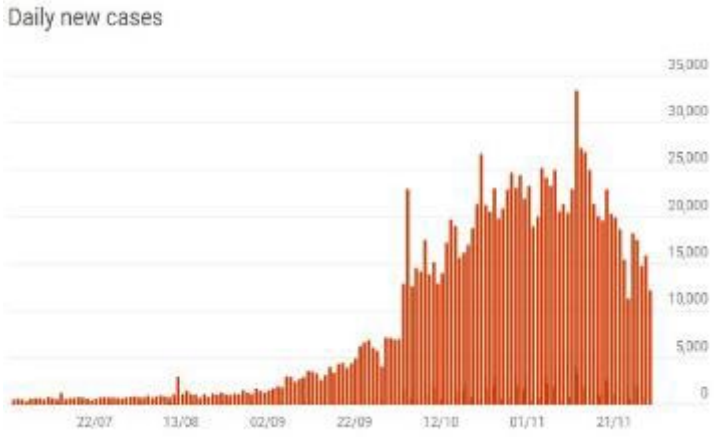
It is important to keep informed of what is happening nationally and in our local areas.

There are three **coronavirus vaccines** that have seen positive efficacy rates. The Pfizer vaccine has now been approved for use. It is anticipated this will be in phases, with healthcare workers and clinically vulnerable people prioritised. We are working hard to make sure that when the vaccine is ready to roll out we will be ready. Keep an eye out for updates in our coronavirus briefings.

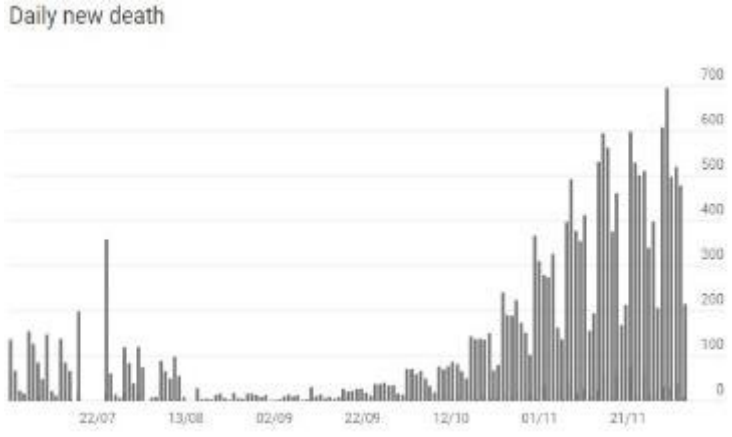
Local Authority figures per 100,000 population (as of 2 Dec):

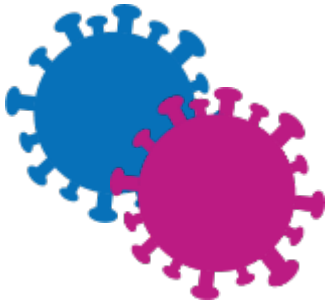
- Barnsley – 204
- Calderdale - 246
- Kirklees - 267
- Wakefield – 242

National infection rate



Daily reported deaths due to coronavirus





With **all of us** in mind.

Our proposed priority areas 2021/2022

NHS
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Understanding equality, and addressing inequality through inclusive involvement

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

#allofusimprove and be outstanding

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

With **all of us** in mind.

Improving Health:
Joining up the response in every place

West Yorkshire and Harrogate Health and Care Partnership

South Yorkshire and Bassetlaw Integrated Care System

NHS South West Yorkshire Partnership NHS Foundation Trust

Integrated care systems continue to refocus their work to ensure system support.

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

With our Alliances, CCGs and ICS' we have submitted proposals for NHS Winter pressures monies. This includes money for housing support in Barnsley, support to reduce CAMHS waiting lists, SPA in Kirklees and Wakefield, older people' outreach in North Kirklees, and enhanced psychiatric liaison in Mid Yorks

NHS lead provider collaborative for West Yorkshire adult secure services

Working with our partners in Bradford District Care, Leeds and York Partnership, and Cygnet Health Care, we have submitted a business case to be an NHS lead provider collaborative for adult secure care in West Yorkshire. We are now awaiting further discussion with NHSE to agree next steps.

Proposals have been submitted to support new and integrated models of mental health care based in and around Primary Care Networks. The funding is also for the improvement of access and treatment for adults with a diagnosis of personality disorder, eating disorder, and people with rehabilitation needs.

Improving Health:
Joining up the response in every place

NHS
South West Yorkshire Partnership
NHS Foundation Trust

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

Barnsley
We are working with Barnsley Clinical Commissioning Group (CCG) on a proposal to develop a 'Safe Space'. The new service will provide a virtual safe space for people in crisis to prevent avoidable A&E attendances. The offer will be a non-clinical alternative to A&E.

Kirklees
The two Kirklees CCGs have announced plans to merge, making one CCG responsible for Greater Huddersfield and North Kirklees.
We continue to work closely with partners on the local coronavirus response.

Calderdale
Work is progressing in Calderdale to support art and creativity to support health and wellbeing. We are also working on plans to better integrate physical health into our package of support on wellbeing, for staff and service users.

Wakefield
Wakefield has been selected to take part in an antibody research trial in the global efforts to find a way to prevent COVID-19. This is an opportunity for those living in the Wakefield District to take part in a research trial in November. Please get involved if you can.

Yorkshire Smokefree
The work on the **Quit programme** continues with the objective to make hospital sites in South Yorkshire smokefree. Yorkshire Smokefree is providing valuable support to help people stop smoking across our areas.

Improving Care:
Safety and quality

NHS
South West Yorkshire Partnership
NHS Foundation Trust

In October we had:

- 1155 incidents – 965 rated green (no/low harm)
- 182 rated yellow or amber
- 8 rated as red
- There were 2 reported serious incidents this month both of which were apparent suicides.
  All staff should complete the online Zero Suicide training, found on ESR.

We continue to monitor all incidents where **coronavirus** is noted in the Datix entry. This is so we can identify any themes and trends that require action and bring about improvements wherever we can.

There were **12 confidentiality breaches** in October, down from 19 last month. This is an improvement but is still too high. The Trust has a duty that any information we hold is safe. Everyone has a part to play. Make sure you are up to date with the advice provided on the intranet.

The male side of ward 19 in the Priestley Unit has now achieved **365 days without a medicine omission**. This was achieved by nurses checking for any omissions on medication charts and by making sure that medicines were still available for the morning, lunchtime and night time shifts to fill any gaps.

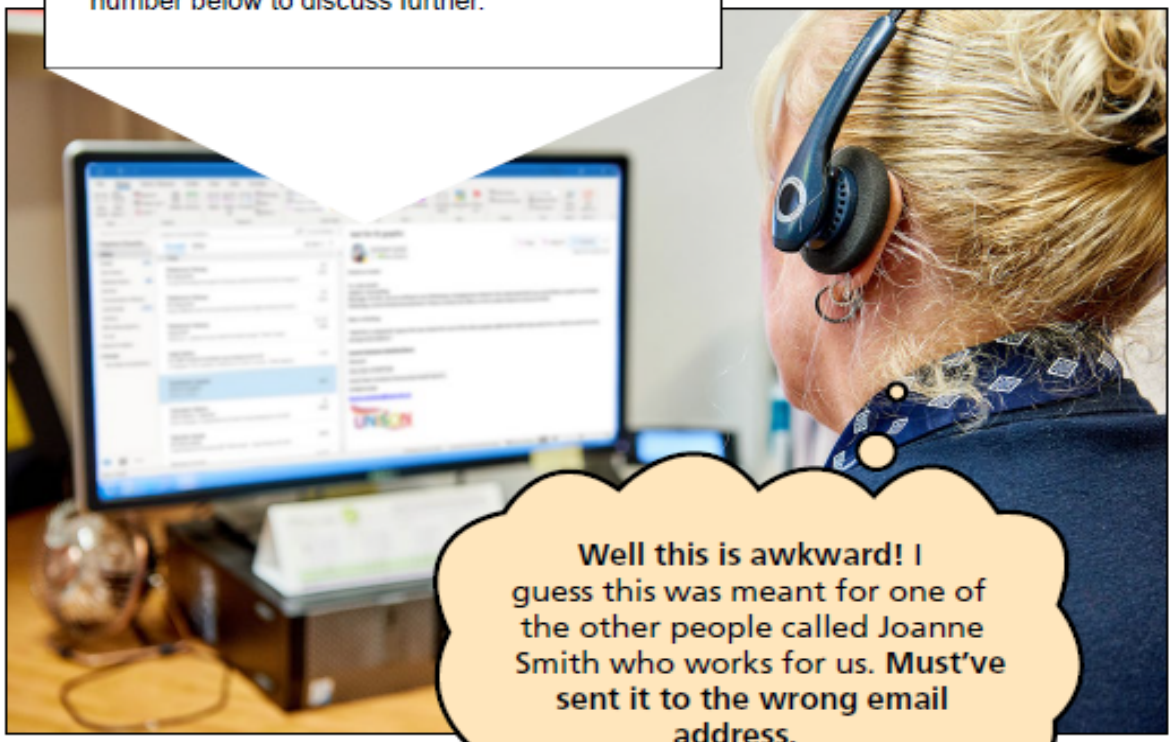
With **all of us** in mind.

Improving care:
Information governance (IG)

To: Joanne Smith
Subject: Counselling

Hi Joanne,

We are writing to you following a management referral. We understand that you would like to speak to someone following a recent family bereavement. Please contact the office on the number below to discuss further.



Well this is awkward! I guess this was meant for one of the other people called Joanne Smith who works for us. **Must've sent it to the wrong email address.**

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Careless mistakes can ruin lives

We've had a big spike in incidents of correspondence going to the wrong postal or email addresses since April

Letters and emails going outside of the Trust must be second-checked for accuracy

If you need help or advice contact Rachael Smith on 07584 331791 or rachael.smith@swyt.nhs.uk

With all of us in mind.

Improving care:
Our performance in October

NHS
South West Yorkshire Partnership
NHS Foundation Trust

- **106** inappropriate out of area bed days
- **97%** of people recommend our community services
- **84%** of people recommend our mental health services
- **1.6%** delayed transfers of care
- **64.7%** referral to treatment in CAMHS timescales
- **2** people under 18 admitted onto adult inpatient wards
- **87.5%** of prone restraint lasted less than 3 minutes
- **165** restraint incidents
- **92.7%** of people dying in a place of their choosing
- **55.4%** of people completing IAPT treatment and moving into recovery

We had 51 falls in October, up from 43 in September. We continue to investigate all falls so that we can learn lessons and reduce risks.

We had **35** attributable pressure ulcers in October and continue to review all incidents to identify themes and learning.

Our **Calderdale Individual Placement and Support Service (IPS)** has in its first year helped 19 service users into employment. Roles secured include jobs in banking, manufacturing, teaching, cleaning, and positions within the NHS. They work as part of the core and enhanced mental health teams. We have similar schemes in our other areas too.

With **all of us** in mind.

Improving care:
Our coronavirus related performance

NHS
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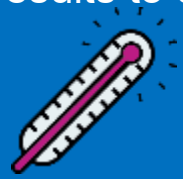
As of 2 December:

- **There are currently 246 members of staff absent or working from home due to coronavirus. This has increased from 233 last month.**
- **133 members of staff are absent and 113 are working from home.** Of those absent, **41%** are shielding, **20%** are symptomatic, **15%** have household symptoms, and **1%** have been advised to isolate by occupational health
- **We've processed 3,083 swab test results for staff and household members**, with **439** of these testing positive and **2,644** testing negative.

As of 24 November:

- **174 service users have been tested** on the wards. This is **26** more than last month. **60** of which were positive, up from 38 last month. Of these, **60** have since recovered.
- **Occupational health have taken 1,967 coronavirus calls.**

We are now asking all clinical and front line workers to **self-test for coronavirus** twice a week. This is so we can ensure staff stay well and can take quick action if they test positive. Each person involved has received 12 weeks worth of tests which they carry out at home, and then report their results to us. More info is on the intranet.



With **all of us** in mind.

It's time to get your flu jab
Clinics available for all staff

NHS
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NHS Foundation Trust

Clinics are being held regularly across our locations. You can contact a peer vaccinator if you can't find a clinic near you.

Clinic dates are on the intranet

Remember to let your manager know if you have had your jab – even if you had it outside of the Trust. It helps us to update our records and you will still count towards our 'have a vaccine, give a vaccine' total.

Book now!

You will need a 7-day break between having your flu jab and the Covid-19 vaccine, so it's a good idea to have yours as soon as you can.

Flu fact: You could be spreading flu right now. Studies show that up to 77 per cent of people with flu have no symptoms and could potentially spread it to the most vulnerable.

With **all of us** in mind.

Improving resources
Our finances in 2020/21

NHS
South West Yorkshire Partnership
NHS Foundation Trust

	Performance Indicator	Year to date	Forecast August 20
1	Surplus / Deficit	£0.1m	(£2.1m)
2	Agency Cap	£3.9m	£7m
3	Cash	£64m	£41m
5	Capital	£1.2m	£5.6m
6	Better Payment		
	30 days	97%	
	7 days	80%	

For April to September the Trust received funding to ensure a breakeven position.. For October to March the Trust has been set a financial target. In October a surplus of £0.1m has been reported compared to a £0.2m deficit target.

The Trust continues to monitor agency spend and action plans to ensure agency staffing usage and costs are appropriate. Spend in October was £0.6m.

Cash in the bank continues to be above planned levels due to use receiving one month's income in advance

We have a target to pay all our suppliers within seven days. Please continue to pay prompt attention to invoices you receive.

A revised capital forecast for 2020/21 has been produced taking account of current capital priorities and the impact of covid-19 on accessibility and costs. This has reduced the overall forecast by £1m.

80% of invoices have been paid within 7 days. The impact of the new finance and procurement system continues to be monitored.

Carers' passports
Making support more accessible

NHS
South West Yorkshire Partnership
NHS Foundation Trust

We have launched two new carers' passports to support people who provide regular help and support to their relatives, partners, friends or neighbours.

Staff passport

Enables staff to have a meaningful conversation with their manager about their caring responsibilities. It then allows for discussions around support and flexibility.

Carers' passport

Allows those in a caring role to keep contact details, useful information about themselves and the person they care for, and details of local carer support groups and services close to hand.

This forms part of our commitment to carers: We greatly value the role that family and friends have in supporting recovery and maintaining health and wellbeing.

With **all of us** in mind.

A great place to work
Priority updates

NHS
South West Yorkshire Partnership
NHS Foundation Trust

This month general staff sickness is **3.9%**. Turnover is **9.3%.** Remember there's support for **#allofus**

This month we welcome to the Trust Lindsay Jensen as our deputy director of HR and organisational development; and Darryl Thompson, our new deputy director for nursing, quality and professions.

Thank you for taking part in the annual NHS staff survey
The survey closed on 27 November, with over 1,860 staff completing this. Your feedback is vital in helping us to make the Trust a great place to work and we will share the results with you in the New Year.

The Trust is currently revising its digital strategy, which aims to set out our digital aspirations for the next 3 years. We all have a role to play in shaping how our services become 'digital'. Our questionnaire will help us obtain your feedback.

In January we will be carrying out **elections** for new governors to join our Member's Council. There will be 11 seats up for election, including 5 staff ones. This includes seats to represent allied health professionals, medicine and pharmacy, nursing, psychological therapies, and social care staff. Keep an eye out for more info nearer the time in the Headlines.

We now have a new policy designed to help staff **working from home**. This has been developed following government guidance on coronavirus. The policy is available on the intranet.

E-appraisals
New guidance on the intranet

NHS
South West Yorkshire Partnership
NHS Foundation Trust

During this Covid19 period we aim to help provide you the flexibility for appraisals to be completed without incurring extra pressure on you and your service.

This year's appraisal window has now been extended to the end of **February 2021**.
The revised guidance allows focus in appraisals to be on health and wellbeing and mandatory training as a minimum.

WorkPAL

- The new e-appraisal allows everyone to have a high quality appraisal and give us great feedback
- It is employee led and helps reduce any pre-conceived worries ahead of 1-2-1 discussions
- The actual review meeting can be done virtually
- Individuals are able to track progress against their objectives
- Line-managers are able to track progress and appraisals for all their team members in one place

With **all of us** in mind.

Freedom To Speak up Guardians
Speak up, speak out

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Estelle Myers is the Trust's new full-time FTSU guardian lead

"Speaking up is about anything that gets in the way of providing good care.

"When things go wrong, we need to make sure that lessons are learned and things are improved.

"If we think something might go wrong, it's important that we all feel able to speak up so that potential harm is prevented.

"When things are good but could be even better, we should feel able to say something and should expect that our suggestion is listened to and used as an opportunity for improvement.

"Speaking up is about all of these things."

Get in touch by calling 07795 367197 or email guardian@swyt.nhs.uk

With **all of us** in mind.

Coronavirus update

What you can do to help

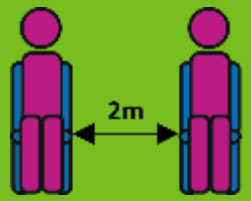
#allofusimprove and be outstanding

NHS South West Yorkshire Partnership NHS Foundation Trust

We have issued new guidance on the wearing of face masks in our buildings. Please ensure you wear a mask at all times unless you are sat at your desk.

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

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



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

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

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

Download the NHS Covid19 Test and Trace App and make sure you turn it off when you arrive in work. It isn't designed for healthcare workers to use in healthcare settings.

And to help keep you and your loved ones safe, have your flu jab.

With **all of us** in mind.

Coronavirus
Recovery and stabilisation update

#allofusimprove and be outstanding

NHS South West Yorkshire Partnership NHS Foundation Trust

While the coronavirus pandemic continues we need to ensure that we can still deliver our core services as best we can. Our recovery work runs along with our business continuity plans to ensure we can balance the needs and expectations of local people.

To ensure our service delivery continues we are working with corporate teams to identify what work is essential and needs to continue, and what can be paused to free people up to support the coronavirus response. All teams have now identified work that can be paused and where corporate staff can have most impact on supporting clinical services.

Despite the Tier 3 restrictions now in place our existing approach to maintaining face to face clinical appointments and visits continues. This helps us to support service users and ensure their existing and new health and wellbeing needs are met. You can read our guidance on the intranet.

We also looking at opportunities that the Talent Pool can provide. This is a scheme where non-clinical staff who have spare capacity, can work in clinical services that need extra support. For more information on the Talent Pool see the intranet.

With **all of us** in mind.

A great place to work
Support when you need it

#allofus
our wellbeing at work

NHS
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NHS Foundation Trust

Remember that we have support available for all of us.

Our **occupational health** team have a dedicated phone line for general advice around coronavirus - **01924 316036** (Monday-Friday, 8am - 4pm). Our **coronavirus psychological support line** has also restarted. You can all it on **07774 335800** (Monday to Friday 8am - 4pm)

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

Book your staff health check and start your journey to better health
Occupational health is resuming their staff health check programme with strict safety procedures in place. More details are on the intranet.

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

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

With **all of us** in mind.

Take home messages

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Covid-19 pressures are real. We cannot be complacent.

Safety comes first, always. We are at OPEL 3.

Always follow the rules, and for those involved do your Covid19 self-tests twice a week

Tell us if you have had your flu jab, and if you haven't yet then get one soon. You are in the minority.

The coronavirus vaccine is coming soon. We will be ready.

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

Run to be one of our staff governors on the Members' Council

Your health and wellbeing is our priority.

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

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Yorkshire Partnership
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Thank you to everyone for your response so far.

Keep doing the right thing.

With **all of us** in mind.

Cascading the Brief

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Thank you for joining us for the Brief broadcast.

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

Thankyou!

With **all of us** in mind.

Choose well for your mental health and wellbeing – a guide for adults

NHS
South West Yorkshire Partnership
NHS Foundation Trust

It's important that we look after our mental health and wellbeing the same way we do with our physical health.

If you hurt yourself physically, there would be things you could do to make yourself feel better. Say you sprained your ankle – you can rest it and take weight off it. The same is true for your mental health. If you notice changes to your mental health and wellbeing, there are things you can do to improve how you feel.

The earlier you recognise changes to how you're feeling or behaving, and begin to take steps to improve things, the less likely these will get worse.

This guide has been created to help you to choose well to support your mental health and wellbeing. Carers, friends and families can also use this guide to look out for those close to them and direct them to the right support. **It's a good idea to familiarise yourself with this so you know what to do in different situations.**

- **Self care** – things you can do to proactively look after your mental health and wellbeing
- **Mental health helpline** – someone to listen and signpost you to help or support
- **Talking therapies** – one-to-one or group therapies
- **GP practice** – your GP practice can refer you to secondary mental health services or prescribe medication
- **Secondary mental health services** – offer education and treatment on certain mental health illnesses
- **Crisis or emergencies** – it's important you know what to do in a crisis or emergency situation

December 2020

@allofusinmind #ChooseWellForMentalHealth

With **all of us** in mind.

Self care

How I might be feeling…	What can I do?
• Not feeling quite right • Feeling stressed • Feeling 'out of sorts' • Not sleeping well • Feeling isolated or lonely • Dealing with bereavement • Managing anger • Struggling with low self-esteem • Loss of interest in things you normally enjoy doing • Avoiding contact with others • Drinking more alcohol on a regular basis	**Discover the five steps to mental wellbeing:** • Connect with other people • Be physically active • Learn new skills • Give to others • Pay attention to the present moment (mindfulness) **Read up on the five steps to mental wellbeing at:** www.nhs.uk/conditions/stress-anxiety-depression/improve-mental-wellbeing **Attend FREE health and wellbeing courses at your local Recovery and Wellbeing College, or online.** Popular courses include; living with anxiety, an introduction to mindfulness, managing depression and craft and baking taster sessions: Barnsley: Website: www.barnsleyrecoverycollege.nhs.uk Telephone: 01226 730433 Calderdale and Kirklees: Website: www.calderdalekirkleesrc.nhs.uk Telephone: Calderdale: 07826 876172 and Kirklees: 07717 867911 Wakefield: Website: www.wakefieldrecoverycollege.nhs.uk Telephone: 01924 316946

Did you know?

The Choice and Medication website provides information about mental health conditions, treatments and medications.
Visit: www.choiceandmedication.org/swyp
You can also talk to your local pharmacy about medication queries.

Self care

How I might be feeling…	What can I do?
• Not feeling quite right • Feeling stressed • Feeling 'out of sorts' • Not sleeping well • Feeling isolated or lonely • Dealing with bereavement • Managing anger • Struggling with low self-esteem • Loss of interest in things you normally enjoy doing • Avoiding contact with others • Drinking more alcohol on a regular basis	**Social prescribing gives people links to, and information about, health and wellbeing support in local communities.** Barnsley: My Best Life Every GP practice in Barnsley has a My Best Life advisor. Speak to your GP practice about this. Calderdale: Staying Well Website: https://stayingwellhub.com Telephone: 01422 392767 Kirklees: Community Plus Website: www.kirklees.gov.uk/communityplus Telephone: 01484 225224 Wakefield: Live Well Wakefield Website: www.livewellwakefield.nhs.uk Telephone: 01924 255363 **Creativity can help you disconnect from stress and boost your self-esteem.** Get involved in creative activities in your community through Creative Minds - a charity linked to South West Yorkshire Partnership NHS Foundation Trust. Website: www.southwestyorkshire.nhs.uk/creative-minds Telephone: 01924 316 285 **If you're employed, your workplace may have an occupational health team or other health and wellbeing support.** You can ask your work in confidence what support is available. **The West Yorkshire and Harrogate Health and Care Partnership grief and loss support service** is available from 8am to 8pm, every day. Website www.griefandlosswyh.co.uk Freephone: 0808 1963833

Did you know?
The NHS also has resources and lots of approved apps and helplines.
Visit www.nhs.uk for more information.

Mental health helpline

How I might be feeling…	What can I do?
• Like you're at risk of developing mental health problems • That you are finding it difficult to manage a diagnosed common mental health problem • That you need support for your mental health but don't know where best to go • Experiencing mental health distress • That you need information, advice and support from a trusted source	**There is a 24-hour mental health helpline for anyone registered with a GP in Barnsley, Calderdale, Kirklees and Wakefield.** You can contact the helpline on: **0800 183 0558** The helpline is a great place to get information about local support groups, charities and other community services that could help support you with your mental health and wellbeing.

All images used in this guide were taken before the coronavirus pandemic.

Talking therapies

How I might be feeling…	What can I do?
• Low mood and tearfulness • Feeling down • Feeling anxious, including; » Panic attacks » Obsessive and compulsive thoughts and behaviour (OCD) » Phobias » Social anxiety » Health anxiety » Dealing with trauma such as post-traumatic stress disorder (PTSD) • Struggling with every-day tasks • Feeling very stressed/unable to relax • Hoarding • Insomnia and problems with sleep	**You can refer yourself into your local talking therapies service, also known as psychological therapies or IAPT, without seeing your GP.** Talking therapies provide one-to-one appointments alongside group workshops. You can find your nearest talking therapies at: www.nhs.uk/talk Not online? Contact the 24-hour mental health helpline (0800 183 0558) or your GP practice for information.

GP practice

How I might be feeling…	What can I do?
• Feeling depressed for most of the day, every day for over two weeks • Anxiety which is affecting your daily life and causing you distress • Self-harming - intentionally damaging or injuring yourself • Uncontrollable worrying • Frequent obsessive thoughts and compulsive behaviours • Eating or problems with food and exercise (binge eating, deliberately being sick, exercising too much) • Memory problems that are affecting your life (or a relative or person you care for) • That you've tried other support which hasn't helped	**Book an appointment with your GP practice – you could be seen by a GP or nurse.** **A discussion and support from your GP or nurse might be all the help you need, but if not they can refer you to secondary mental health services or can prescribe medication that may help you.**

Secondary mental health services

How I might be feeling…	What can I do?
• Hearing voices or seeing, feeling, tasting or smelling things that aren't there (hallucinations) • Erratic and distressing behaviour, including impulsive actions and not being able to control your emotions • Extreme fluctuations in mood, including: » Extreme high and low moods » Suicidal thoughts that come and go • Difficulty concentrating or thinking, sometimes due to being preoccupied with unusual experiences, beliefs or fears • Risky, challenging or violent behaviour including high risk of criminal activity	**To be able to get support from secondary mental health services, you will most likely need a referral from your GP, or another health, care or public sector professional who may be supporting you with your mental health and wellbeing. This includes; hospital, GP staff, police, courts, housing associations and staff from your local council.** Secondary mental health services, also known as specialist services, can offer education and treatment on certain mental health illnesses. They can help you find ways of coping and managing your mental health and wellbeing so that you can be supported to live well in your home or community. South West Yorkshire Partnership NHS Foundation Trust provide secondary mental health services across Barnsley, Calderdale, Kirklees and Wakefield. The Trust has a customer services team who can help provide information, advice and support for people who use Trust services, alongside their families and carers. They also handle compliments and complaints about services. Find out more: www.southwestyorkshire.nhs.uk/customer-services

Did you know?
South West Yorkshire Partnership NHS Foundation Trust has developed a carers' passport for those in a caring role to keep contact details, useful information about themselves and the person they care for, and details of local carer support groups and services in a handy document. Find out more: www.southwestyorkshire.nhs.uk/carers-passport

Crisis or emergency situations

How I might be feeling…	What can I do?
• Feeling like you may seriously harm or injure yourself or other people • Feeling suicidal or like you want to die • No longer feeling able to cope or be in control of your situation • Extreme distress or extreme changes in behaviour • Seriously harmed or injured yourself	**If you or someone else has seriously harmed or injured yourself, always call 999 or go to your nearest A&E.** If you already get mental health support from a health or care organisation, please contact the team that provides you with treatment. You may have a care or safety plan already. This will help with your treatment and will tell you who to contact in a crisis. You can also get support in a mental health crisis by: • Calling NHS 111, a 24-hour helpline • Booking an emergency appointment with your GP practice. Outside of normal surgery hours you can still phone your GP, but you will usually be directed to an out-of-hours service • Contacting the 24-hour mental health helpline for anyone registered with a GP in Barnsley, Calderdale, Kirklees and Wakefield on 0800 183 0558. In order to help you manage a crisis, or for further support with your mental health, your GP or other organisation involved in your care may refer you to Single Point of Access (SPA). In some areas you can also refer yourself: **Barnsley** GP or another organisation referral only **Adults (aged 18+)** 01226 645000 **People with a learning disability** 01226 645237 **Calderdale** Self-referral available **Adults (aged 18 +)** 01924 316830 **People with a learning disability** 07795 884879 **Kirklees** Self-referral available **Adults (aged 18-65)** 01924 316830 **Older adults** 0300 304 5555 **People with a learning disability** 01924 316714 **Wakefield** Self-referral available **Adults (aged 18+)** 01924 316900 **People with a learning disability** 01977 465435

Did you know?

Charities provide support for people in a mental health crisis:

Samaritans: Free to call, 24/7, 365 days a year. Call them on 116 123

SANEline: 4.30pm – 10.30pm every day of the year. Call them on 0300 304 7000.

Planning ahead and understanding what your options are in a mental health crisis or emergency will help make sure you get the best support as quickly as possible.

Please take the time to familiarise yourself with this guide and write down who you can contact in a mental health crisis or emergency situation, alongside how other people can help you during this time.

Three numbers I can call: 

For example: my support worker, a loved one or a helpline

……

……

……

How can other people help me? 

For example: call one of my contact numbers for me or give me a quiet space

……

……

……

Mind also have lots of information to help you plan for a mental health crisis: www.mind.org.uk/information-support/guides-to-support-and-services/crisis-services

Tear this page off and keep it handy e.g. in your wallet or purse or on the fridge.

If you require a copy of this information in any other format or language please contact your healthcare worker at the Trust

W przypadku potrzeby uzyskania kopii danej informacji w jakimkolwiek innym formacie lub języku, prosimy o kontakt z pracownikiem służby medycznej w funduszu zdrowia

اگرآپ کوان معلومات کی نقل کسی اورساخت یا زُبان میں چاہیےتوبرائےمہربانی ٹرسٹ پراپنے/اپنی ہیلتھ کیئرورکرسےرابطہ کریں

در صورت نیاز به یک نسخه از این اطلاعات به هر شکل و یا زبان دیگر، لطفاً با کارمند مراقبت های بهداشتی خود در بنیاد تماس بگیرید

Potřebujete-li kopii těchto informací jakémkoli jiném formátu nebo jazyce, kontaktujte svého zdravotnického pracovníka ve společnosti Trust.

如果您需要此信息的任何其他格式或语言的版本，请联系国民医疗服务体系的医疗保健工作人员。

Ja jums nepieciešama šīs informācijas kopija jebkādā citā formātā vai valodā, lūdzu, sazinieties ar savu trasta veselības aprūpes darbinieku

ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਜਾਂ ਭਾਸ਼ਾ ਵਿਚ ਇਸ ਜਾਣਕਾਰੀ ਦੀ ਕਾਪੀ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਟਰੱਸਟ ਵਿਖੇ ਆਪਣੇ ਸਿਹਤ ਸੰਭਾਲ ਕਰਮਚਾਰੀ ਨਾਲ ਸੰਪਰਕ ਕਰੋ

إذا كنت تحتاج لهذه الرسالة بنسخة أو لغة أخرى؛ يرجى الاتصال بالعامل الصحي التابع للمؤسسة.

Si vous avez besoin d'une copie de cette information dans un autre format ou une autre langue, veuillez contacter votre profesionnel de santé à la Trust.

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Trust Board 26 January 2021
Agenda item 8.1

Title:	**Board Assurance Framework (BAF) Q3 2020/21**
Paper prepared by:	Director of Finance & Resources
Purpose:	For Trust Board to be assured that a system of control is in place with appropriate mechanisms to identify potential risks to the delivery of its strategic objectives. This document also highlights the revised strategic objectives for 2020/21 and 2021/22 and includes the impact of the Covid-19 pandemic on delivery of 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 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 comprehensive method for the effective and focused management of the risks to meeting the Trust's strategic objectives. In line with the Corporate / Organisational Risk Register (ORR), the BAF has been aligned to the Trust's strategic objectives: **Our four strategic objectives** **Improve health** / **Improve care** **Improve resources** / **Making SWYPFT a great place to work** 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. The Trust Board considered the BAF at their strategic session in May 2020 and agreed to keep the current format of the report during the Covid-19 pandemic, with a further review at the strategic Board session in September 2020. This allowed the Board to consider the impact and influence of Covid-19 on the Trust's strategic objectives

for 2020/21 and 2021/22, the risks to meeting those objectives and the approach to mitigating those risks.

Following a discussion at the Trust Board meeting in October 2020, the strategic risks listed below were agreed for inclusion in the BAF. The Executive Management Team (EMT) have reviewed each strategic risk and agreed initial:

- Key controls and / or systems the Trust has in place to support the delivery of the objectives.
- Assurance on controls received by Trust Board, its Committees or EMT.
- Gaps in control.
- Gaps in assurance.
- Actions identified to address any gaps.
- Proposed risk rating.

Individual strategic risk RAG rating and rationale for those ratings are outlined below. Trust Board members are asked to consider the initial proposed ratings below and note that most discussion and debate on ratings related to the following strategic risks:

- 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.
- 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.
- 3.3 – Capability and capacity gaps and/or capacity / resource not prioritised leading to failure to meet strategic objectives.
- 4.1 – Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience.
- 4.3 – Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.

	Strategic risk	Q3 2020/21	Rationale
	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**	Whilst recognising the direction of travel is for standardisation of commissioning across ICSs it is felt the future of commissioning is less certain currently which has resulted in the proposed amber rating.
	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**	Consistent with our previous scoring, no notable changes identified.
	1.3 Lack of or ineffective communication and engagement with our communities, service	**Y**	Good progress made, whilst recognising further work to do.

		users and carers could result in poor service delivery that does not meet the needs of the populations we serve.		
		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**	Issues highlighted during the pandemic of some communities finding it difficult to access services and the disproportionate impact on a number of groups with protected characteristics.
		2.1 Lack of suitable and robust information systems backed by strong analysis leading to lack of high-quality management and clinical information.	**Y**	Good progress made, whilst recognising further work to do in terms of use of information and embedding it.
		2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.	**G**	There is a recognised and embedded process.
		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.	**A**	Good work being carried out in meeting demand, but intense pressure in some areas, particularly inpatient and IHBT, as well as issues for children and young people and the pressure in autism services.
		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**	Good controls identified, but not without 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.	**Y**	Good financial position currently. Funding mechanisms and values for next year are not clear at this point.
		3.2 Failure to develop relationships with commissioners and other key partners to improve services and respond to local needs.	**G**	Currently good and improved relationships in place in each of our places.
		3.3 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.	**Y**	Some pressures on resources currently meaning some priorities have limited resource attached to them. Pressure could increase in the coming months as

			provider collaboratives develop
	4.1 Inability to recruit, retain, skill up appropriately qualified, trained and engaged workforce leading to poor service user experience.	**Y**	Consistent with previous rating. Notable national gaps in some specialities although we have had lower staff turnover during the past year.
	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**	Strong on compassion and values based. Diverse leadership evident in some areas and not others. Strong focus on WRES, WDES, networks and OD practitioners.
	4.3 Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.	**Y**	Strong health and wellbeing offer to our staff, whilst recognising there may need to be more offered given the impact of the Covid-19 pandemic

EMT will continue to review the strategic risks on a regular basis, taking into consideration the ongoing impact of the Covid-19 pandemic plus local and national changes, and report quarterly to Trust Board.

Further work will take place in the next quarter to tighten up the classification of controls and assurances identified, as well as constructively challenging if there are further gaps that need addressing, and whether the actions identified are sufficient to cover those gaps. It should also be noted that completion dates for some actions need to be agreed and are partly dependent on the freeing of capacity following on from the Covid-19 response and vaccination programme.

The Head of Internal Audit opinion progress report was reported to the Audit Committee on 5 January 2021. The internal auditors, 360 Assurance, provided some relatively minor recommendations on the BAF for consideration. These are being reviewed and where appropriate action will be taken before the next update. Key points included considering the classification of controls and assurances as well as identifying end dates for action completion where possible.

All controls, assurances and gaps in controls and assurances have been reviewed by EMT as part of the development of the new BAF. There are no actions overdue in the updated report. Some actions are ongoing by their nature, and some actions do not currently have a definitive completion date due to the fluctuating situation given the Covid-19 pandemic.

	In addition, the internal auditors recommended that the Audit Committee's terms of reference and work plan should be updated to reflect the Audit Committee's current responsibilities in relation to the BAF. A review of the Audit Committee's terms of reference will take place as part of the annual report process in April 2021. It is noted that as previously agreed the Trust Board continues to hold overall responsibility for oversight of the BAF to ensure it provides an effective tool for monitoring assurance and risk management, and for reviewing the content to ensure management of the Trust's strategic risks.
Recommendation:	**Trust Board is asked to** • **REVIEW and DISCUSS the proposed risk ratings for each strategic risk.** • **NOTE the controls and assurances against the Trust's strategic objectives for Quarter 3 2020/21.** • **AGREE to an ongoing target for addressing gaps in control and assurance given the nature of the gaps and risks identified.** • **NOTE the progress against the internal audit recommendations in relation to the BAF.**
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					
	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					
	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					
	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					
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					
	2.2 Failure to create a learning environment leading to lack of innovation and to repeat incidents.	23	G					
	2.3 Increased demand for services and acuity of service users exceeds supply and resources available leafing to a negative impact on quality of care.	25	A					
	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					
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					
	3.2 Failure to develop relationships with commissioners and other key partners to improve services and respond to local needs.	32	G					
	3.3 Capability and capacity gaps and / or capacity / resource not prioritised leading to failure to meet strategic objectives.	35	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					
	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					
	4.3 Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.	41	Y					

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

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

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

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

RAG ratings:

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

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

Rationale for current assurance level (strategic objective 1: improve health)
• Health & Wellbeing Board place-based plans – contributed to through board discussions and commented on. • Active and full membership of Health & Wellbeing Boards. • Care Quality Commission (CQC) visit overall rating of good including well-led review, partnership working acknowledged to be strong. • In the main, positive Friends and Family Test feedback from service users and staff. • Strong and robust partnership working with local partners, through integrated partnerships in Barnsley, Calderdale, Kirklees and Wakefield. • Partnering provider collaborative development in West Yorkshire and lead provider for forensic provider collaborative.

Rationale for current assurance level (strategic objective 1: improve health)
• Covid-19 pandemic has highlighted the disproportionate impact upon protected characteristics and specifically people with a learning disability and from the black, Asian, minority ethnic (BAME) community. • A range of executive and board arrangements with trusts, commissioners and other stakeholders in each of the place we operate. • Trust involvement and engagement with West Yorkshire & Harrogate and South Yorkshire & Bassetlaw Integrated Care Systems, especially on mental health is strong. • Trust involved in development of place-based plans and priority setting. • Involved in development of Integrated Care Partnerships in Barnsley (establishment of Integrated Care Partnership Group), Calderdale, Kirklees and Wakefield. • Mental health offer well regarded with the establishment of Mental Health Provider Alliance in Wakefield. A similar approach is being developed in Kirklees. • Stakeholder engagement plans in place. • Integrated Performance Report (IPR) summary metrics regarding improving people's health and reducing inequalities – IPR Month 8: out of area beds – amber, children and young people accommodated on an adult inpatient ward – four service users for a total of 34 days, seven day follow up – green, physical health – not reported, learning disability referrals with completed assessment, care package and commenced delivery within 18 weeks – not reported, delayed transfers of care – green. • Transformation and priority programmes, including the measurement and impact on strategic risks, reported to Trust Board through the Integrated Performance Report (IPR), Clinical Governance & Clinical Safety Committee, and Audit Committee through the triangulation report. • Internal audit reports: Governance & Risk, Policy Management Framework, Patient Safety significant assurance. • Clear value proposition for our Social Prescribing offer in Wakefield through Live Well Wakefield. • NHS Long Term Plan requires commissioners to grow investment in mental health services faster than the NHS budget overall, aligned to specific service requirements that will be common across all districts. • Joint working arrangements in response to Covid-19 pandemic. • Comprehensive creative and cultural offer through Creative Minds and recovery colleges in each of our places to diverse communities. • Compliance with the public sector equality duty. • Standard approach in place to develop an involvement plan which includes a requirement to review previous insight gathered. • Process and approach in place to support formal consultation which is used when required • Patient experience and engagement toolkit in place. • Trust website rated good on Accessible Information Standard. • Mandatory training in place for all staff on equality and diversity. • All services have a baseline Equality Impact Assessment (EIA) in place. • Deliver and report on compliance with Equality Delivery System (EDS2) annually.

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

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

Ref	Description	RAG rating
2.1	**Lack of suitable and robust information systems backed by strong analysis leading to lack of high-quality management and clinical information.**	Y
2.2	**Failure to create a learning environment leading to lack of innovation and to repeat incidents.**	G
2.3	**Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.**	A
2.4	**Risk of deliberate and malicious harm to the Trust including cyber-crime, arson and violence resulting in a loss of confidence in and access to the services the Trust provides.**	Y

Rationale for current assurance level (strategic objective 2: improve care)
• Staff 'living the values' as evidenced through values into excellence awards. • In the main, positive Friends and Family Test feedback from service users and staff. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • Care Quality Commission (CQC) assessment overall rating of good. • CQC conducted a well-led review in 2019 which contributed to the overall rating provided. • Internal audit reports – Governance & Risk, Policy Management Framework, Patient Safety Incidents – significant assurance. • Regular analysis and reporting of incidents. • Development of trust wide arrangements for learning and improving standards, recognised by CQC. • Quality Improvement culture becoming embedded and good examples have emerged on safety huddles, reducing restricted practices and flu vaccination programme and infection prevention and control response to Covid-19. • Data warehouse implementation largely complete. • Some residual data quality issues with regard to how SystmOne is used. • Focused information provided for out of area bed review to support findings and recommendations. • Integrated Performance Report (IPR) summary metrics re improving the quality and experience of all that we do – IPR for month 8 shows: Friends & Family (F&F) Test MH – green, F&F Test Community – green, safer staff fill rates – green, IG confidentiality breaches – red. • Programme of optimisation for SystmOne for mental health in place. • Testing and support for service users and staff in response to Covid-19. • Investment in IT and facility infrastructure. • Bed occupancy has been consistently high, particularly in adult acute, psychiatric intensive care units (PICU) and medium secure forensic services.

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

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

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

Rationale for current assurance level (strategic objective 3: improve resources)
• NHS Improvement Single Oversight Framework rating of 2 – targeted support.
• Impact of non-delivery of Cost Improvement Programmes (CIPs), non-recurrent CIPs and out of area placements on financial performance.
• Underlying deficit is higher than the reported number after adjusting for non-recurrent measures being taken.
• Integrated Care System (ICS) and place based driven change may impact on our service portfolio.
• Internal audit reports – CIP, Quality and Integrity of general ledger and financial reporting, financial system (accounts payable) – significant assurance.
• Integrated Performance Report (IPR) summary metrics provide assurance on majority of our performance and clearly identifies where improvement is required.
• Mental health investment standard and other recent income growth.
• Small surplus in 2019/20. Deficit plan for H2 2020/21.
• Current cash balance and cash management processes.
• Positive well-led results following Care Quality Commission (CQC) review.
• Capital investment prioritisation process.
• Updated priority programmes for 2020-22 are aligned to strategic objectives.
• Interim financial arrangements in place for 2020/21.
• Current uncertainty with regard to the financial and contracting arrangements for 2021/22.
• Partnership arrangements in each place.
• Lead provider collaboratives for forensics, CAMHS and eating disorders in West Yorkshire.
• Partnership arrangements at different stages of development in each of the places in which we provide services.

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

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

Ref	Description	RAG rating
4.1	**Inability to recruit, retain, skill up, appropriately qualified, trained and engaged workforce leading to poor service user experience.**	Y
4.2	**Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively.**	Y
4.3	**Failure to support the wellbeing of staff during a sustained and prolonged period of uncertainty through Covid-19.**	Y

Rationale for current assurance level (strategic objective 4: make this a great place to work)
• Staff 'living the values' as evidenced through values into excellence awards, consistent feedback from regulators and partners. • Award winning flu and #allofus staff wellbeing campaigns with strong impact. • Vacancies in key areas – forensics and LD, including use of medical locums. • Staff turnover rates have reduced and comparable with other trusts in Yorkshire. • Staff sickness absence slightly lower than target on sickness and Covid-19 absence, but lower than majority of other trusts in Yorkshire. • Staff survey feedback average across the Trust, with some good areas and some hot spots. • Robertson Cooper survey provides more granular information to inform local plans. • In the main, positive Friends and Family Test feedback from service users and staff. • Trio model bringing together clinical, managerial and governance roles working together at service line level, with shared accountability for delivery. • Care Quality Commission (CQC) visit overall rating of good. • Integrated Performance Report (IPR) summary. • "Hot spots" in terms of staff survey results and other workforce metrics reviewed and identified. • Support to staff during pandemic, including testing, health and wellbeing offer and BAME taskforce. • A range of staff networks in place including BAME and LGBT+.

Strategic risk 1.1 Changes to commissioning arrangements, an increasing role for each place and variations in local priorities could lead to service inequalities across the footprint.

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire mental health collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DS	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C08	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets paused during 2020/21, to return for 2021/22. *Temporarily on hold until financial and contracting arrangements are clear for 2021/22 onwards.* (I, E)	DO	1.1, 1.4, 3.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DS	1.1, 1.3, 2.3
C11	Governors' engagement and involvement on Members' Council and working groups, holding Non-Executive Directors (NEDs) to account. (I)	DFR	1.1
C12	Partnership Fora established with staff side organisations to facilitate necessary change. (I)	DHR	1.1
C13	Priority programmes supported through robust programme management approach. (I)	DS	1.1
C14	Project Boards for change programmes and work streams established, with appropriate membership skills and competencies, project initiation documents (PIDs), project plans, project governance, risk registers for key projects in place. (I)	DS	1.1, 1.2
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C16	Operational leadership structure in place to reflect the ICS boundaries (West and South) and focus on reducing unwarranted variation service wide. (E)	DO	1.1
C17	Member of South Yorkshire & Bassetlaw mental health, learning disability and autism programme board. Partner in emerging SYB provide alliance. (I, E)	DS	1.1, 1.4

Controls (strategic risk 1.1)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C18	Meetings with Healthwatch organisations in each place. (E)	DS	1.1
C19	Process and approach in place to support formal consultation. (I, E)	DS	1.1
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality & Inclusion Committee. (E & I)	DS / DNQ / MD	1.1, 1.2, 1.3, 1.4

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Impact on services as a result of local authority cuts – actions identified on the Organisational Risk Register. (Linked to ORR Risk ID 275, 1077). Increase in delayed transfers of care apparent during 2020/21.	Ongoing	DO / DS
Impact of local place-based solutions and Integrated Care System initiatives – recognition that some of this is out of our control and ensure engagement takes place in each area impacted. (Linked to ORR Risk ID 812)	Ongoing	DS / DPD
Clinical networks to be embedded across each pathway as part of the new operational leadership structure. *On hold due to the focus on the Covid-19 response.*	April 2021	DO
Provider alliance / collaborative in South Yorkshire in development for mental health, learning disability and autism.	January 2021	DS / DPD

Assurance (strategic risk 1.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A03	Care Quality Commission (CQC) registration in place and assurance provided that Trust complies with its registration.	The Trust is registered with the CQC and assurance processes are in place through the DNQ to ensure continued compliance – quarterly engagement meetings between DNQ & CQC. (P) (I)	DNQ	1.1
A04	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives.	Quarterly Board strategic meetings. (P) (I)	CEO	1.1, 1.2
A05	Enhanced internal monitoring arrangements put in each PLACE.	Estates TAG receive quarterly updates. (P) (I)	DHR	1.1, 1,2, 1.3
A06	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities.	Clinical audit and practice effectiveness (CAPE) annual evaluation plan scheduled for CG&CS Committee February 2021. (P) (I)	DNQ	1.1, 1.2, 1.3

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)**
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re. quality impact. (I)	DS	1.1, 1.2, 1.3, 2.3, 3.3
A10	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework.	Contracting risks, bids & tenders update standing item on delivery EMT agenda. (ORR 1212) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I) Report to Board bi-annually. (P, N) (I)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, Clinical Governance &Clinical Safety Committee (CGCS) and Members' Council.	Annual unannounced and planned visits programme in place and annual report is now received directly by the CG&CS Committee. The annual report was received by the CG&CS Committee in February 2020 and revised proposal for the new arrangements in November 2020. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	Monthly financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) annual and 5 year plans (P, N) (I). Financial plan for second half of 20/21 approved by Trust Board in September (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Investment for 2020/21 agreed and provided by each commissioner. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A15	Rolling programme of staff, stakeholder and service user / carer engagement and consultation events.	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

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)**
		Weekly and monthly engagement with staff (the Headlines, the View and the Brief), monthly engagement with stakeholders (the Focus), various service user & carer engagement events across the year plus Annual Members' Meeting September 2020. Engagement through Members' Council. Stakeholder engagement through involvement in new models of care in each place. (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
A18	Commissioning intentions are factored into operating plans as part of the planning process.	Mutual agreement between provider and commissioner of investment priorities including the mental health investment standard (P) (I)	DFR, DO	1.1, 1.2, 1.4, 3.2
A19	Proactively involved as a partner in integrated care partnership arrangements in each place.	Meeting minutes and papers provided and circulated (P) (I, E)	DPD / DS	1.1
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & integrated performance report (IPR) data on access & waiting times included in the new Equality & Inclusion dashboard. (P) (I)	DNQ	1.1, 1.2, 1.3, 1.4

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Development of place-based arrangements have some differences by place and are operating at different timescales	April 2021	DS / DPD
Active member of place based / ICS integrated care governance arrangements in all areas. Potential legislative and structural changes in ICS April 2021.	Ongoing	DS
The expectation is that when Covid-19 pandemic is over we will review previous plans and arrangements as part of recovery planning. It is unclear at this stage if this will be the case or if different approaches and requirements will emerge.	Ongoing	DS
Current lack of clarity of commissioning arrangements from April 2022 onwards.	Ongoing	DFR

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

Controls (strategic risk 1.2)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C07	Director lead in place to support revised service offer through transformation programme and work streams, overseen by EMT. (I)	DS	1.1, 1.2, 1.3
C14	Project Boards for change programmes and work streams established, with appropriate membership skills and competencies, project initiation documents (PIDs), project plans, project governance, risk registers for key projects in place. (I)	DS	1.1, 1.2
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality & Inclusion Committee. (E & I)	DS / DNQ / MD	1.1, 1.2, 1.3, 1.4
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C22	Operations management structure reflects an approach to ensuring consistent delivery of services. (I)	DO	1.2

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

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)**
A04	Trust Board strategy sessions ensuring clear articulation of strategic direction, alignment of strategies, agreement on key priorities underpinning delivery of objectives.	Quarterly Board strategic meetings. (P) (I)	CEO	1.1, 1.2
A05	Enhanced internal monitoring arrangements put in each PLACE.	Estates TAG receive quarterly updates. (P) (I)	DHR	1.1, 1,2, 1.3
A06	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities.	Clinical audit and practice effectiveness (CAPE) annual evaluation plan scheduled for CG&CS Committee February 2021. (P) (I)	DNQ	1.1, 1.2, 1.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re. quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A10	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework.	Contracting risks, bids & tenders update standing item on delivery EMT agenda. (ORR 1212) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I) Report to Board bi-annually. (P, N) (I)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, CG&CS and MC.	Annual unannounced and planned visits programme in place and annual report is now received directly by the CG&CS Committee. The annual report was received by the CG&CS Committee in February 2020 and revised proposal for the new arrangements in November 2020. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	Monthly financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS)	DFR	1.1, 1.2, 3.1, 3.2, 3.3

Assurance (strategic risk 1.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
		annual and 5 year plans (P, N) (I). Financial plan for second half of 2020/21 approved by Trust Board in September (E)		
A17	Reports from Barnsley, Calderdale, Kirklees and Wakefield Partnership Board.	Update reports into EMT. (P, N) (I)	DFR	1.1, 1.2
A18	Commissioning intentions are factored into operating plans as part of the planning process.	Mutual agreement between provider and commissioner of investment priorities including the mental health investment standard (P) (I)	DFR, DO	1.1, 1.2, 1.4, 3.2
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard.	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation.	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. "Our Learning Journey Report" (P, N) (I)	DNQ	1.2, 2.2
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and any action required identified. (P, N) (I, E)	DFR	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board. (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG) deviations identified, and remedial plans requested.	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I) CQUIN not currently in operation given temporary finance and contracting arrangements.	DO	1.2, 3.1, 3.3
A26	New workforce and OD strategy in development in line with national people plan.	Update reports into EMT and Workforce & Remuneration Committee. (P) (I)	DHR	1.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Assessment of place based plans in light of the impact of the NHS long term plan. Potential legislative and structural changes in ICS April 2021 to be in force by April 2022.	April 2021	DS

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
Not a scheduled programme of board to board or exec to exec meeting in place with all partners. Potential legislative and structural changes in ICS April 2021.	Ongoing	DS
The expectation is that when Covid-19 pandemic is over we will review previous plans and arrangements as part of recovery planning. It is unclear at this stage if this will be the case or if different approaches and requirements will emerge.	Ongoing	DS

Strategic risk 1.3

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

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

Gaps in control – what do we need to do to address these and by when?	Date	Director lead
Impact of local place based solutions and ICS initiatives – recognition that some of this is out of our direct control and ensure engagement takes place in each area impacted, as well as using the Long Term Plan, proposed changes to ICSs and relationships with groups of commissioners to ensure consistency. (Linked to ORR Risk ID 812).	Ongoing	DS
Trustwide Equality Impact Assessment – develop a Trustwide Equality Impact Assessment and intelligence data base to support planning.		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
A05	Enhanced internal monitoring arrangements put in each PLACE.	Estates TAG receive quarterly updates. (P) (I)	DHR	1.1, 1,2, 1.3
A06	Audit of compliance with policies and procedures in line with approved plan co-ordinated through clinical governance team in line with Trust agreed priorities.	Clinical audit and practice effectiveness (CAPE) annual evaluation plan scheduled for CG&CS Committee February 2021. (P) (I)	DNQ	1.1, 1.2, 1.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to Audit Committee and CG&CS Committee re. quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A15	Rolling programme of staff, stakeholder and service user / carer engagement and consultation events.	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed and ongoing processes established. Weekly and monthly engagement with staff (the Headlines, the View and the Brief), monthly engagement with stakeholders (the Focus), various service user & carer engagement events across the year plus Annual Members'	DHR, DS	1.1, 1.3, 1.4, 2.3

Assurance (strategic risk 1.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
		Meeting September 2020. Engagement through Members' Council. Stakeholder engagement through involvement in new models of care in each place. (P) (I, E)		
A20	Reports to Equality & Inclusion and Mental Health Act Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard.	DNQ	1.1, 1.2, 1.3, 1.4
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A27	Place based / ICS communications lead networks in place.		DS	1.3
A28	Senior level representation at Health & Wellbeing Boards in each place.		DS	1.3
A29	Ongoing meetings with Healthwatch organisations in each place.	Meeting agenda, minutes and reports. (P) (E)	DS	1.3
A30	Working with partners such as Healthwatch, public sector colleagues and ICSs to collectively capture and share insight and intelligence and avoid duplication.		DS	1.3
A31	Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) process integrated and used at gateways in transformation and change programmes.		DS	1.3
A32	Trust website rated as good on Accessible Information Standard.		DS	1.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
It is unclear at this stage of the full extent of the l impact of Covid-19 on different populations. Discussions are underway with commissioners in each place to ensure that we maximise learning from changes in service offers (e.g. increase in digital solutions). However, any variations will be based on best practice and in line with local need.	Ongoing	DO
Use of data and informatics could be more comprehensive to support engagement and service delivery. Health Intelligence and Insight Group established to consider the data and insight	Ongoing	DPD

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

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C01	Process for amending policies and procedures in place aiming for consistency of approach, with systematic process for renewal, amending and approval. (I)	DNQ / DFR	1.1, 1.2, 1.4
C02	Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C03	Senior representation on West Yorkshire mental health collaborative and associated workstreams. (I, E)	DPD	1.1, 1.4
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DS	1.1, 1.4, 2.3
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C08	Formal contract negotiation meetings with clinical commissioning groups and specialist commissioners underpinned by legal agreements to support strategic review of services. (I)	DFR	1.1,1.4, 3.2
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets paused during 2020/21, to return for 2021/22. *Temporarily on hold until financial and contracting arrangements are clear for 2021/22 onwards.* (I, E)	DO	1.1, 1.4, 3.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C17	Member of South Yorkshire & Bassetlaw mental health, learning disability and autism programme board. Partner in emerging SYB provide alliance. (I, E)	DPD	1.1, 1.4
C20	Routine monitoring of complaints, Mental Health Act (MHA) data and clinical referral data to identify themes or areas for action. Assurance via MHA and Equality & Inclusion Committee. (E & I)	DS / DNQ / MD	1.1, 1.2, 1.3, 1.4
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C26	Community reporting used as a tool to enable people to talk to members of their own community about their experience. (E)	DS	1.3, 1.4
C27	Governors supported to involve people at a locality level, toolkit in place. (I, E)	DS	1.3, 1.4
C28	Toolkit in place to capture patient stories. (I)	DS	1.3, 1.4
C30	Process to review and assure Equality Impact Assessments (EIAs) with report to Equality & Inclusion Committee. (I)	DS	1.3, 1.4
C31	JNA data reflected in all service EIAs. (I)	DS	1.3, 1.4
C36	Recovery group and Health Intelligence and Insight Group – to ensure we restore services inclusively locking in innovation. (I)	DS / DPD / DO	1.4
C37	Equality & Inclusion Committee and task force in place. (I)	DS	1.4
C38	Trust website rated good on Accessible Information Standard. (I)	DS	1.4
C39	Translation and interpretation service in place. (I)	DS	1.4

Controls (strategic risk 1.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C40	Photo symbol package available to staff. (I)	DS	1.4
C41	Patient experience and engagement toolkit in place. (I)	DS	1.4

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.	Ongoing	DS / DNQ
Equality data collection requires improvement. Campaign and behaviour change programme to be undertaken.		DS

Assurance (strategic risk 1.4)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3,1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A15	Rolling programme of staff, stakeholder and service user / carer engagement and consultation events.	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed and ongoing processes established. Weekly and monthly engagement with staff (the Headlines, the View and the Brief), monthly engagement with stakeholders (the Focus), various service user & carer engagement events across the year plus Annual Members' Meeting September 2020. Engagement through Members' Council. Stakeholder engagement through involvement in new models of care in each place. (P) (I, E)	DHR, DS	1.1, 1.3, 1.4, 2.3

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)**
A18	Commissioning intentions are factored into operating plans as part of the planning process.	Mutual agreement between provider and commissioner of investment priorities including the mental health investment standard (P) (I)	DFR, DO	1.1, 1.2, 1.4, 3.2
A20	Reports to E&I and MHA Committee on service access and experience.	Customer services report & IPR data on access & waiting times included in the new E&I dashboard.	DNQ	1.1, 1.2, 1.3, 1.4
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board. (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A33	Customer service reports to Trust Board and CG&CS Committee.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P, N) (I)	DNQ	1.4, 2.3
A34	Quality strategy implementation plan reports into CG&CS Committee.	Routine reports into CG&CS via IPR and annual report scheduled in 2020/21 work plan. (P) (I)	DNQ	1.4, 2.3
A35	Equality dashboard presented to Equality & Inclusion Committee.	Regular reports and papers provided. (P) (I)	DS	1.4
A36	All services have a baseline Equality Impact Assessment (EIA) in place.		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.	Ongoing	DS
More granular level of reporting required of access to our services by protected characteristic compared to the demographics of the communities.	April 2021	DS

Strategic risk 2.1 Lack of suitable and robust information systems back 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

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Inconsistent use of reports generated using the data warehouse tool. *Comprehensive data sets and dashboard in place. Awareness and training in use under development*	June 2021	DFR
Limited data on caseload, real time waiting list issues, face to face time. *Business Intelligence Group established as part of reset and restoration of services.*	June 2021	DPD
Use of benchmarking information not fully embedded in the Trust.	June 2021	DFR / DPD
Impact of Covid-19 has been to re-focus information requirement priorities and will potentially result in less directly comparable information year on year.	Ongoing	DFR

Assurance (strategic risk 2.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All

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)**
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A37	Data quality improvement plan monitored through Executive Management Team (EMT) deviations identified and remedial plans requested.	Included in monthly IPR to OMG, EMT and Trust Board. Regular reports to Audit Committee. (P) (I)	DNQ	2.1
A38	Progress against SystmOne optimisation plan reviewed by Programme Board, EMT and Trust Board.	Monthly priority programmes item schedule for EMT. Included as part of the IPR to EMT and Trust Board. (P) (I)	DS	2.1
A39	Quarterly Assurance Framework and Risk Register report to Board providing assurances on actions being taken.	Quarterly risk register reports to Board. Triangulation of risk, performance and governance present to each Audit Committee. (P) (I)	DFR	2.1
A40	Data quality focus at OMG and ICIG.	Regular agenda items and reporting of at ICIG and OMG. (P, N) (I)	DNQ	2.1
A41	Benchmarking reviews and deep dives conducted at Board Committees.	Reports provided regularly. (P) (I)	DNQ / DFR	2.1
A42	BDU and OMG performance management processes.	OMG notes taken into EMT, summary of finance and performance reviews into EMT monthly. (I)	DO	2.1
A43	Trust health intelligence and insight group.	Meets monthly – feeds into recovery planning group. (I)	DPD	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.	Ongoing	DFR
Level of granularity to enable effective reporting on inequalities needs to increase. *Focus being applied to what changes to reporting need to take place to report on progress against the eight urgent actions to address inequalities.*	January 2021	DFR
Process for reviewing internal benchmarking data is not applied consistently or fully embedded across the Trust.	Ongoing	DNQ / DFR
Visibility of information to a wider audience to improve understanding is required.	Ongoing	DNQ / DFR

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

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

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Monitoring of closure and evidence challenge of action plans linked to serious incident (SI) reports.	Ongoing	DNQ
Delay in embedding of quality improvement culture during Covid-19 response. Action to review all Q1 programmes and maintain where possible or prepare for reinstatement on pandemic closure.	April 2021	DNQ
Develop use of improvement case studies. Process established. Further developments to embed and effectively share		DS
Covid-19 has introduced a range of new ways of working including further use of digital technology. There is an ongoing process to identify and evaluate the learning.		DS

Assurance (strategic risk 2.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A22	Serious incidents from across the organisation reviewed through the Clinical Reference Group including the undertaking of root cause analysis and dissemination of lessons learnt and good clinical practice across the organisation.	Process in place with outcome reported through quarterly serious incident reporting including lessons learned to OMG, EMT, Clinical Governance & Clinical Safety Committee and Trust Board. "Our Learning Journey Report" (P, N) (I)	DNQ	1.2, 2.2
A44	Weekly risk scan update into EMT.	Weekly risk scan update into EMT. (P, N) (I)	DNQ	2.2
A45	Assurance reports to CG&CS Committee covering key areas of risk in the organisation seeking assurance on robustness of systems and processes in place.	Routine report to each CG&CS Committee of risks aligned to the committee for review. (P) (I)	DNQ	2.2
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P) (I)	DS	2.2, 4.1
A47	Examples of co-production in recovery colleges and Creative Minds		DS	2.2
A48	Inpatient structure provides assurance of operational grip in relation to record keeping.	Routine matron checks reported through BDU governance groups and in governance report to CG&CS. (P) (I)	DO	2.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Impact of information governance (IG) training and action plan on IG hotspots. (Linked to ORR Risk ID 852) Increase in IG breaches since the onset of Covid-19 and associated ways of working. *Updated communication & awareness plan in place*	Ongoing	DFR
Although opportunistic work has taken place on the inpatient strategy improvement plan, this is on hold given the work required to manage the Covid-19 response. To agree new date by April 2021.	April 2021	DO
It is unclear if there will be a loss of traction during and following the Covid-19 pandemic. This is being reviewed as part of the recovery and restoration plan.	Ongoing	ALL

Strategic risk 2.3 Increased demand for services and acuity of service users exceeds supply and resources available leading to a negative impact on quality of care.

Controls (strategic risk 2.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C02	Cross-BDU and Operational Management Group (OMG) performance meetings established to identify and rectify performance issues and learn from good practices in other areas. (I)	DO	1.1, 1.2, 1.4, 2.2, 2.3
C04	Senior representation on local partnership boards, building relationships, ensuring transparency of agendas and risks, facilitating joint working, cohesion of policies and strategies, ability to influence future service direction. (I, E)	DS	1.1, 1.4, 2.3
C05	Annual business planning process, ensuring consistency of approach. (I)	DFR	1.1, 1.2, 2.3, 3.1, 3.2
C06	Trust performance management system in place with KPIs covering national and local priorities reviewed by Executive Management Team (EMT) and Trust Board. (I)	DFR	1.1, 1.4, 2.3
C10	Engagement and representation on South Yorkshire / West Yorkshire integrated care system mental health work streams and partnership group. (I, E)	DS	1.1, 1.3, 2.3
C15	Equality, Involvement, Communication Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed and ongoing processes established for gaining insight and feedback, including identification of themes and reporting on how feedback has been used. (I, E) (ORR 773)	DS	1.1, 1.3, 1.4, 2.3, 4.1, 4.3
C21	Framework in place to ensure feedback from customers, both internal and external (including feedback loop) is collected, responded to, analysed and acted upon. (I, E)	DNQ	1.2, 1.4, 2.3
C47	Weekly risk scan where all red and amber incidents are reviewed for immediate learning. (I)	DNQ / MD	2.1, 2.3, 4.1
C56	Quality improvement approach and methodology. (I)	DNQ	2.2, 2.3
C63	Care Closer to Home Partnership Meeting and governance process. (I)	DO	2.3
C64	Care closer to home priority programme incorporating whole system actions with out of area bed reduction reported against trajectory. (I, E)	DO	2.3
C65	Safer staffing policies and procedures in place to respond to changes in need. (I)	DNQ	2.3
C66	TRIO management system monitoring quality, performance and activity on a routine basis. (I)	DO	2.3
C67	Use of trained and appropriately qualified temporary staffing through bank and agency system. (I)	DO	2.3
C68	Targeted improvement support in place to deliver waiting list management improvement plans to support people awaiting a service / treatment. (I) (ORR 1078, 1132)	DO	2.3
C69	Process to manage the CQC action plan. (I)	DNQ	2.3

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

Assurance (strategic risk 2.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A08	Service user survey results reported annually to Trust Board and action plans produced as applicable.	NHS Mental Health and community services service user survey results will be reported to Trust Board when available with associated plans. (P, N) (I, E)	DNQ	1.1, 1.2, 1.3, 1.4, 2.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re: quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A12	Announced and unannounced inspection visits undertaken by Care Quality Commission (CQC), independent reports on visits provided to the Trust Board, CG&CS and MC.	Annual unannounced and planned visits programme in place and annual report is now received directly by the CG&CS Committee. The annual report was received by the CG&CS Committee in February 2020 and revised proposal for the new arrangements in November 2020. (P, N) (E)	DNQ	1.1, 1.2, 2.3
A15	Rolling programme of staff, stakeholder and service user / carer engagement and consultation events.	Equality, Involvement, Communication and Membership Strategy approved for service users / carers, staff and stakeholders / partners. Annual action plans developed and ongoing processes established. Weekly and monthly engagement with staff (the Headlines, the View and the Brief), monthly engagement with stakeholders (the Focus), various service user & carer engagement events across the year plus Annual Members' Meeting September 2020. Engagement through Members' Council. Stakeholder engagement through involvement in new models of care in each place. (P) (I, E)	DHR, DS	1.1, 1.3, 1.4, 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 2020/21 work plan. (P) (I)	DNQ	1.4, 2.3

Assurance (strategic risk 2.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A49	CQC self-assessment process.	Reviewed by EMT as part of preparation for CQC inspection process. (I)	DNQ	2.3
A50	Health Watch undertake unannounced visits to services providing external assurance on standards and quality of care.	Unannounced visits as scheduled by Health Watch. (E)	DNQ	2.3
A51	The Care Closer to Home Priority Programme incorporates the outcomes from the review of the community mental health transformation review.	Reported through to Board as part of the priority programmes and to the Partnership Board with commissioners. (I)	DO	2.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
The Care Closer to Home work continues, with progress noted across the pathways. Spikes in demand still present and these are closely managed and patients are quickly repatriated to their local areas. Complaints and incidents are monitored by the service line which is Trustwide. Thus acuity and turnover has increased, adding significant pressure to the delivery system on inpatient wards. The Trust will form part of ICS wide work on PICU to improve access across West Yorkshire. The impact on SWYPFT service users is hoped to be positive but will be reviewed and considered when the work commences. (ORR 1319) date to be agreed by April 2021.	April 2021	DO
Impact of waiting list in CAMHS services. Improvements have been sustained throughout Covid-19 phase. Agreed in the CAMHS Improvement Group to review the impact of the improvement work in like with the Priority Programmes in September 2020. Additional waiting list pressures have been noted due to increased demand and reduced opportunity for observational work in ADHD / ASD pathways. Calderdale and Kirklees pathways remain challenged. Work included in CAMHS improvement plan (priority programme).	Ongoing	DO
Demand for services could increase during and after the Covid-19 pandemic. The impact of this is still to be fully understood. Noted increased in acuity and further exploratory work is underway to understand whether this relates to mode of service delivery during Covid-19 phase. This should be reviewed in April 2021.	April 2021	ALL

Strategic risk 2.4

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

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

Controls (strategic risk 2.4)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C74	Weekly fire risk scans and any issues escalated in line with the policies in place. (Linked to ORR 1159) (I)	DHR	2.4
C75	Trust smoking policies. (I)	DO	2.4
C76	Use of sprinklers and other fire suppressant systems within our estate. (I)	DHR	2.4
C77	Staff training. (I)	DHR	2.4
C78	Capital prioritisation process to ensure funds are allocated to support IT security and safety of estate. (I)	DFR	2.4

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

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

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Phishing exercise demonstrated incomplete awareness and some gaps in understanding. Regular communications and awareness raising taking place.	Ongoing	DFR
Cyber audits and penetration testing have highlighted some areas for improvements. Formal action plan in place to address.	July 2021	DFR
Not all the estate we use have sprinklers in place.	Ongoing	DHR
Actions identified from internal and independent inspections & audits have resulted in formal action plans to address identified gaps.	July 2021	DFR / DHR

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

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

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Risk of loss of business impacting on financial, operational and clinical sustainability. (Linked to ORR Risk ID 1077, 1214).	Ongoing	DFR
Risk of inability to achieve priorities identified in our plan (Linked to ORR Risk ID 695, 1114).	Ongoing	DS
Trust has a history of not fully achieving its recurrent CIP targets (Linked to ORR Risk ID 1076). *In progress - Total CIP delivery £0.5m below plan. £1.2m risk for the full year position* *Final position was that £10.7m of CIPs delivered, of which £5.6m (52%) was recurrent*	Annual target	DFR / DO
Reduction in Local Authority budgets negatively impacting on financial resource available to commission staff / deploy social care resource (Lined to ORR Risk ID 275).	Ongoing	DO
Recurrent impact of Covid-19 on underlying cost structure and financial sustainability plan not fully clear.	May 2021	DFR

Assurance (strategic risk 3.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A07	Strategic priorities and programmes monitored and scrutinised through Executive Management Team (EMT) and reported to Trust Board through IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). (P) (I)	DS	1.1, 1.2, 1.3, 1.4, 2.3, 3.1, 3.2
A10	Business cases for expansion / change of services approved by Executive Management Team (EMT) and / or Trust Board subject to delegated limits ensuring alignment with strategic direction and investment framework.	Contracting risks, bids & tenders update standing item on delivery EMT agenda. (ORR 1212) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I) Report to Board bi-annually. (P, N) (I)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	Monthly financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) annual and 5 year plans (P, N) (I). Financial plan for second half of 20/21 approved by Trust Board in September (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Investment for 2020/21 agreed and provided by each commissioner. (P) (I) (E)	DFR	1.1, 3.1, 3.2
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

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)**
A25	CQUIN performance monitored through Operational Management Group (OMG) deviations identified, and remedial plans requested.	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I)	DO	1.2, 3.1, 3.3
A57	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
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 2020/21.	Financial plan approved by Trust Board in September 2020. (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)	Ongoing	DO
Increasing expenditure on staffing in inpatient wards with spend higher than income. Ongoing raising of this issue during contract negotiations.	Ongoing	DFR
Cash position is largely dependent on us delivering a surplus. Cash balance of circa £36m at the 2019/20 year-end.	Ongoing	DFR
Financial plan for 2021/22 not yet developed. Timescale dependent on planning guidance availability	May 2021	DFR
Recurrent position is a deficit in excess of circa £4m *Ongoing - Financial sustainability work is focusing on recurrent improvement opportunities.* *Focus on the financial sustainability plan has been temporarily reduced to ensure there is clear focus on the Trust response to Covid-19.*	Ongoing	DFR
Financial arrangements for 2021/22 and recurrent cost base given the impact of Covid-19 are not yet fully known. Some update expected by the end of Q4 20/21	May 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

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

Gaps in control – what do we need to do to address these and by when?	**Date**	**Director lead**
Risk of loss of business. (Linked to ORR Risk ID 1077). Being addressed as part of the work on the LTP in each place, SY&B and WY&H.	Ongoing	DFR
Tendering activity taking place. (Linked to ORR Risk ID 1214). Partnership and collaborative arrangements in each place being used to minimise this wherever possible.	Ongoing	DFR

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. (ORR 1212) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I) Report to Board bi-annually. (P, N) (I)	DO	1.1, 1.2, 3.1, 3.2
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All

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)**
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	Monthly financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) annual and 5 year plans (P, N) (I). Financial plan for second half of 20/21 approved by Trust Board in September (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A14	Mental Health Investment Standard income and reporting of performance.	Investment for 2020/21 agreed and provided by each commissioner. (P) (I) (E)	DFR	1.1, 3.1, 3.2
A18	Commissioning intentions are factored into operating plans as part of the planning process.	Mutual agreement between provider and commissioner of investment priorities including the mental health investment standard (P) (I)	DFR, DO	1.1, 1.2, 1.4, 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
A57	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
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.	DFR	3.2
A61	Attendance at external stakeholder meetings including Health & Wellbeing boards.	Minutes and issues arising reported to Trust Board meeting on a monthly basis. (P, N) (I, E)	DO	3.2
A62	Documented update of progress made against Equality, Involvement, Communication and Membership Strategy.	Monthly IPR to Executive Management Team (EMT) and Trust Board. Quarterly report to EIC. (P, N) (I)	DS	3.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Assessment of place based plans within the Integrated Care Systems. Potential legislative and structural changes in ICS April 2021.	April 2021	DS / DPD

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

Controls (strategic risk 3.3)			
Control ref	**Systems and processes – what are we currently doing about the strategic risk?**	**Director lead**	**Strategic risk(s)**
C09	Development of joint Commissioning for Quality and Innovation (CQUIN) targets with commissioners to improve quality and performance, performance monitoring regime of compliance with CQUIN targets in place. Targets paused during 2020/21, to return for 2021/22. *Temporarily on hold until financial and contracting arrangements are clear for 2021/22 onwards.* (I, E)	DO	1.1, 1.4, 3.3
C86	Weekly Operational Management Group (OMG) chaired by Director of Operations providing overview of operational delivery, services / resources, identifying and mitigating pressures / risks. (I)	DO	3.1, 3.3
C87	Finance, Investment & Performance Committee (FIP) chaired by a non-executive director. (I)	DFR	3.1, 3.3
C94	Agreed workforce plans in place which identify staffing resources required to meet current and revised service offers. Also describe how we meet statutory requirements re training, equality and diversity. (P, N), (I)	DHR	3.3
C95	Director portfolios clearly identify director level leadership for strategic priorities. (P), (I)	CEO	3.3
C96	Integrated Change Framework in place to deliver service change and innovation with clearly articulated governance systems and processes. (P), (I)	DS	3.3
C97	Integrated Change Team in place with competencies and skills to support the Trust to make best use of its capacity and resources and to take advantage of business opportunities. (P), (I)	DS	3.3
C98	Production of annual plan and strategic plan demonstrating ability to deliver agreed service specification and activity within contracted resource envelope or investment required to achieve service levels and mitigate risks. (P), (I)	DFR	3.3
C99	Robust prioritisation process developed and used which takes into account multiple factors including capacity and resources. Process used to set 2020-22 priorities. (P), (I)	DS	3.3
C100	Integrated Change framework contains process for adding to strategic priorities within year which includes consideration as to whether a new programme becomes an additional priority or whether it replaces a current priority. (P), (I)	DS	3.3

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

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)**
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A09	Transformation change and priority programme plans monitored and scrutinised through Executive Management Team (EMT) ensuring co-ordination across directorates, identification of and mitigation of risks, reported through Change and partnership Board, OMG and EMT and IPR.	Monthly update provided to Trust Board via the IPR (reviewed monthly by EMT). Monthly update to delivery EMT. Quarterly report to CG&CS Committee re: quality impact. (P) (I)	EMT	1.1, 1.2, 1.3, 2.3, 3.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A13	Annual plan, budget and strategic plan approved by Trust Board, and, for annual plan, externally scrutinised and challenged by NHS Improvement.	Monthly financial reports to Finance, Investment & Performance Committee, Trust Board and NHS England & Improvement plus quarterly exception reports. Trust engaged in development of Integrated Care System (ICS) annual and 5 year plans (P, N) (I). Financial plan for second half of 20/21 approved by Trust Board in September (E)	DFR	1.1, 1.2, 3.1, 3.2, 3.3
A21	Annual reports of Trust Board Committees to Audit Committee, attendance by Chairs of Committees and Director leads to provide assurance against annual plan.	Audit Committee and Trust Board – annually to April Trust Board. (P) (I)	DFR	1.2, 1.3, 2.2, 3.1, 3.3
A23	Benchmarking of services and action plans in place to address variation.	Benchmarking reports are received by Finance, Investment & Performance Committee, Executive Management Team (EMT) and any action required identified. (P, N) (I, E)	DFR	1.2, 3.1, 3.2, 3.3
A24	Investment Appraisal report – covers bids and tenders activity, contract risks, and proactive business development activity.	Monthly bids and tenders report to Executive Management Team (EMT) and twice yearly to Trust Board. (P, N) (I) Investments including tenders are a regular agenda items at the Finance, Investment & Performance Committee. (P, N) (I)	DFR	1.2, 1.4, 3.1, 3.2, 3.3
A25	CQUIN performance monitored through Operational Management Group (OMG) deviations identified, and remedial plans requested.	Monthly Integrated Performance reporting (IPR) to OMG, EMT, Finance, Investment & Performance Committee and Trust Board. (P, N) (I)	DO	1.2, 3.1, 3.3
A58	Monthly focus of key financial issues including CIP delivery, out of area beds and agency costs at Operational Management Group (OMG).	Standing agenda item for OMG and Finance, Investment & Performance Committee. (P, N) (I)	DO	3.1, 3.3
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

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)**
A64	Integrated Change Framework includes gateway reviews at key points and post implementation reviews. Capacity and resources are considered at these key points.	Included as part of priority programme agenda item. (P) (I)	DS	3.3
A65	Strategic priority programmes report into CG&CS Committee and Audit Committee on regular basis to provide assurance on risk and quality issues.	Strategic priority programmes report into CG&CS Committee and Audit Committee. (P) (I)	DS	3.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Assessment of place based plans within the Integrated Care Systems and potential legislative and structural changes in ICS April 2021 to include understanding of capacity required for implementation and any implications this has on capacity overall.	July 2021	DS
Additional demands being placed on Trust resource during the year over and above planning assumptions, particularly in respect of place based developments. Ongoing - Engagement through place based Integrated Care Partnerships to agree capacity and resources to deliver on agreed change programmes. *Priorities being assessed to focus on how staff and programmes of work can support the response to Covid-19.*	Ongoing	DS
Additional capacity requirements of the pandemic response exacerbated by levels of absence. Use of command structure and business continuity plans being applied	Ongoing	DHR

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 Trustwide learning platform. (I)	DNQ	2.2, 4.1
C57	Leadership and management arrangements established and embedded at BDU and service line level with key focus on clinical engagement and delivery of services. (I)	DO	2.2, 4.1
C101	A set of leadership competencies developed as part of the leadership and management development plan supported by coherent and consistent leadership development programme. (I)	DHR	4.1, 4.2
C102	Annual learning needs analysis undertaken linked to service and financial meeting. (I)	DHR	4.1
C103	Education and training governance group established to agree and monitor annual training plans. (I)	DHR	4.1, 4.2
C104	Human Resources processes in place ensuring defined job description, roles and competencies to meet needs of service, pre-employment checks done re qualifications, DBS, work permits. (I)	DHR	4.1
C105	Mandatory clinical supervision and training standards set and monitored for service lines. (I)	DHR	4.1
C106	Medical leadership programme in place with external facilitation as and when required. (I)	MD	4.1
C107	Revising Organisational Development plan to support objectives “the how” in place with underpinning delivery plan, strategic priorities and underpinning programmes supported through robust programme management approach. (I)	DHR	4.1
C108	Recruitment and Retention action plan agreed by EMT. (I)	DHR	4.1
C109	Recruitment and Retention Task Group established. (I)	DHR	4.1
C110	Values-based appraisal process in place and monitored through Key Performance Indicators (KPIs). (I)	DHR	4.1, 4.3
C111	Values-based Trust Welcome Event in place covering mission, vision, values, key policies and procedures. (I)	DHR	4.1
C112	Workforce plans in place identifying staffing resources required to meet current and revised service offers and meeting statutory requirements regarding training, equality and diversity. (I)	DHR	4.1
C113	Regular meetings established with Sheffield and Huddersfield University to discuss undergraduate and post graduate programmes. (E)	DHR / DNQ	4.1
C114	New appraisal process to discuss individuals’ intentions regarding future career development with a view to maximise opportunities within the Trust and promote staff retention. (I)	DHR	4.1

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

Assurance (strategic risk 4.1)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A46	Priority programmes reported to Board and EMT.	Monthly reports to Board / EMT and bi-monthly into CG&CS. (P) (I)	DS	2.2, 4.1
A66	Annual Mandatory Training report goes to CG&CS Committee.	CG&CS Committee receive annual report (P) (I)	DHR	4.1
A67	Appraisal uptake included in IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	DHR	4.1
A68	ESR competency framework for all clinical posts.	Monitored through mandatory training report. (P) (I)	DHR	4.1
A69	Mandatory training compliance is part of the IPR.	Monthly IPR goes to the Trust Board and EMT. (P) (I)	DHR	4.1
A70	Recruitment and Retention performance dashboard.	Quarterly report to the Workforce and Remuneration Committee. (P, N) (I)	DHR	4.1
A71	Safer staffing reports included in IPR and reported to CG&CS Committee. (ORR 905, 1158)	Monthly IPR goes to the Trust Board and EMT six monthly report to Trust Board. (P)	DNQ	4.1
A72	Workforce Strategy performance dashboard.	Quarterly report to the WRC Committee. (P) (I)	DHR	4.1
A73	Annual appraisal, objective setting and PDPs extended to February 2021 due to the Covid-19 pandemic.	Included as part of the IPR to EMT and Trust Board. (P) (I)	DHR	4.1, 4.3
A74	Staff wellbeing survey results reported to Trust Board and / or Workforce & Remuneration Committee and action plans produced as applicable.	Results will be reported when available. (P, N) (I)	DHR	4.1, 4.3

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead
Report to Workforce and Remuneration Committee on reasons for leaving extracted from exit interviews. *WRC now receives a regular report on recruitment & retention including exit interviews*	March 2021	DHR
Supply of a range of professions including doctors and nurses is insufficient to meet demand. (Linked to ORR ID 1151).	Ongoing	DHR

Strategic risk 4.2 Failure to deliver compassionate and diverse leadership and a values-based inclusive culture meaning not everyone in the Trust is able to contribute effectively.

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

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

Assurance (strategic risk 4.2)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All
A75	HR exception report.	Report received by WRC bi-monthly. (P) (I)	DHR	4.2

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	Date	Director lead

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

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

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

Assurance (strategic risk 4.3)				
Assurance ref	**Assurance outputs – how do we know if the things we are doing are having impact (internally and externally)**	**Guidance / reports**	**Director lead**	**Strategic risk(s)**
A01	Integrated performance report (IPR) to Trust Board providing assurances on compliance with standards and identifying emerging issues and actions to be taken.	IPR reported monthly to OMG, EMT and Trust Board. (P, N) (I)	DFR	All
A02	Triangulation of risk report to Audit Committee to provide assurance of systems and processes in place.	Triangulation of risk, performance and governance report is a standing item on the agenda for Audit Committee. (P) (I)	DFR	1.1, 1.2, 2.2, 2.4, 3.1, 3.3, 4.1, 4.2, 4.3
A11	Documented review of Directors' objectives by Chief Executive ensuring delivery of key corporate objectives or early warning of problems.	Objectives set annually for all Directors. Monthly one to one meetings between Chief Executive and Directors. (P) (I)	CEO	All

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

Gaps in assurance – are the assurances effective and what additional assurances should we seek to address and close the gaps and by when?	**Date**	**Director lead**
Development around the impact of long Covid-19.	Ongoing	DHR

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 8.2

Title:	**Corporate / Organisational Risk Register Quarter 3 2020/21**
Paper prepared by:	Director of Finance and Resources
Purpose:	For Trust Board to be assured that a sound system of control is in place with appropriate mechanisms to identify potential risks to delivery of key objectives and have controls and actions in place to mitigate those risks.
Mission / values:	The risk register is part of the Trust's governance arrangements and an integral element of the Trust's system of internal control, supporting the Trust in meeting its mission and adhering to its values.
Any background papers / previously considered by:	Previous quarterly reports to Trust Board, and updates during the Covid-19 pandemic. Standing agenda item at each Board Committee meeting.
Executive summary:	**Corporate / Organisational Risk Register** The Corporate / Organisational Risk Register (ORR) records high level risks in the organisation and the controls in place to manage and mitigate the risks. The organisational level risks are aligned to the Trust's strategic objectives and to one of the board Committees for review and to ensure that the Committee is assured the current risk level is appropriate. **Our four strategic objectives** **Improve health** | **Improve care** **Improve resources** | **Making SWYPFT a great place to work** The risks are reviewed at each Committee meeting and any recommendations made to the Executive Management Team (EMT) to consider as part of the cyclical review. EMT re-assess risks based on current knowledge and proposals made in relation to this assessment, including the addition of any high level risks from Business Delivery Units (BDUs), corporate or project specific risks and the removal of risks from the register. The Covid-19 pandemic has resulted in a change in emphasis in some risks and the addition of 14 Covid-19 related risks (two of which are now within risk appetite). The full organisational risk register, including the Covid-19 related risks, are reviewed on a regular basis by EMT. This report provides a full update on the organisational risk register since the previous quarterly report in October 2020.

In addition to the updates provided below Board members should be aware that an organisational risk relating to the Covid-19 vaccination process is being developed. The Workforce & Remuneration Committee have had early oversight of this work. Given the fast-moving nature of this process, the risk and accompanying details will be circulated to all Board members when it is complete as opposed to waiting for the next Board update. The risk(s) will include such matters as patient safety, workforce safety and training, indemnity, information governance and vaccine administration processes.

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

	Risk ID	Description
	1567	Inability to meet the competing demand of responding to the second wave of the pandemic, the regulatory reporting and restoration drives.
	1568	Risk that a seclusion room will not be available when required which will place staff and service users at an increased risk of harm due to damage that has occurred to a number of seclusion rooms. The risk is present due to the current increased acuity.

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

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

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

Risks 15+

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	Controls and actions updated	Controls updated: Microsoft Windows Defender now in place and Microsoft Advanced Threat Protection (ATP) adopted. Routine reviewed of equipment and security taking place. Actions updated: annual cyber security survey underway.
	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.	Risk descrip-tion, controls and actions updated	Risk description updated. Controls updated to include stress testing, command structure and digital and telephone solutions for service users, actions updated to reflect increasing referral activity and escalation through command structure where demand exceeds capacity.

Risks below 15 (outside risk appetite):

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1511	Risk that carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical and other risk to the Trust.	Controls and actions updated	Controls updated to include Board approval and NHS England assessment process, actions updated to reflect development of opportunities for financial efficiencies.
	905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	Controls and actions updated	Controls updated to reflect safer staffing reporting, medical staff bank and AHP agency contract, action timescales updated to reflect the impact of Covid-19 and include international nurse recruitment funding and Covid-19 vaccination programme.
	1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	Controls updated	Controls updated to include ethnicity monitoring taking place, learning from business continuity plans and CAMHS Improvement Group.
	1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	Controls and actions updated	Controls updated to include ethnicity monitoring taking place, actions updated to include reporting of 'hidden waits'.
	1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.	Controls and actions updated	Risk re-opened following EMT discussion in December 2020. Risk will be closed and further discussion regarding a risk to reflect the current position relating to Brexit underway.
	1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention • Restraint reduction • Covid-19	Controls and actions updated	Controls updated to include step-up and step-down guidance, action timescales updated and includes recent learning from LeDeR reports and complaints policy review.
	1568	There is a risk that a seclusion room will not be available when required which will place staff and service users at an increased risk of harm due to damage that has	New risk	

			occurred to a number of seclusion rooms. The risk is present due to the current increased acuity.		
		522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	Controls and actions updated	Controls updated to reflect system wide funding for 2020/21, actions updated to reflect 2021/22 contract negotiations and assessment of planning guidance (when received).
		852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	Controls and actions updated	Controls updated to include use of bluelight system, actions updated: engagements with silver command around data security and confidentiality in relation to data sharing to facilitate Covid-19 testing and vaccination programmes.
		1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its capital programme, leading to an inability to pay staff and suppliers without DH support.	Controls and actions updated	Controls updated to include confirmed financial arrangements for remainder of 2020/21, actions updated to reflect assessment of planning guidance (when received), re-assessment of financial sustainability plan and update of estates strategy.
		1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	Actions updated	Actions updated to include 2021/22 contract negotiation process.
		1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	Controls and actions updated	Controls updated to include mental health investment standard and system-wide funding, actions updated to reflect assessment of planning guidance (when received).
		1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.	Controls updated	Controls updated to include succession planning discussed at Board and Workforce and Remuneration Committee.
		1158	Risk of over reliance on agency staff which could impact on quality and finances.	Controls updated	Controls updated to include targeting areas with recruitment issues and implementation of new roles.
		1214	Risk that local tendering of services will	Controls and	Controls updated to include partnership agreement in

			increase, impacting on Trust financial viability.	actions updated	Barnsley and temporary contracting arrangements for remainder of 2020/21, actions updated to include 2021/22 contract negotiation process.
		1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult 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.	Controls and actions updated	Controls updated to include additional PICU capacity, actions updated to include additional funding to support discharge packages.
		1368	Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a CAMHS bed. This could result in serious harm.	Controls and actions updated	Controls updated to include liaison teams in each place, actions updated to reflect urgent meetings to manage increase in demand and reduction in capacity.
		1567	Inability to meet the competing demand of responding to the second wave of the pandemic, the regulatory reporting and restoration drives.	New risk	
		1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	Controls and actions updated	Controls updated to include marketing the Trust as an employer of choice and development of new roles, actions updated to include international nurse recruitment funding.
		1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	Controls and actions updated	Controls updated to include BAME health and wellbeing task force, Covid-19 risk assessments completed for all staff and health and wellbeing reviews included in appraisals, actions added bronze operational workforce group to be established, roll out of staff vaccinations and review of physical health and wellbeing support.
		1157	Risk that the Trust does not have a diverse and	Controls and	Controls updated to include appointment of WRES OD lead and freedom to speak

		representative workforce and fails to achieve EDS2, WRES and WDES.	actions updated	up guardian, actions updated to include BAME talent pool.

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

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	Controls and actions updated	Controls updated to include follow up of actions and horizon scanning through command structure and membership of networks, actions updated to include update on flu vaccination update and Covid-19 vaccination plan, introduction of lateral flow testing, SBAR templates to share learning, IPC BAF review and review of IPC precautions.
	1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.	Controls updated	Controls updated to reflect support infrastructure available to operational teams, 24/7 helpline available to service users / public, Datix reporting simplified and incidents reviewed at risk plan, and that all services remain open to referrals.
	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.	Risk descript-tion, controls and actions updated	Description updated to remove staff morale. Controls updated to include forecasting and stock usage information, routine scan of national guidance and monitoring of PPE supply and demand through IPR, actions updated to include routine review of IPC guidance.
	1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.	Controls and actions updated	Controls updated to include safer staffing monitoring at OMG through IPR, bronze command for safer staffing and review of staff testing capacity through silver command, actions updated to include review of procedures in line with regional and national situation changes and timely implementation of the Covid-19 vaccination programme.
	1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service	Controls and actions updated	Controls updated to include financial and bereavement support, actions updated to reflect roll out of Covid-19 vaccination programme.

		users, their families and themselves.		
	1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	Controls and actions updated	Controls updated to include new guidance on decision making for face to face and virtual visits, actions updated to include timescales, update on strategy action plan approval and national guidance on learning from the Covid-19 pandemic.
	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.	Risk description, controls and actions updated	Risk description updated to include impact on service users with a learning disability. Controls updated to include updated Equality, Involvement, Communication and Membership (EICM) Strategy, Covid-19 information leaflets, identification of high risk groups and support for LD service users and families around shielding, actions timescales updated and includes development of easy read information, staff training on use of translation and interpretation services and non-verbal communication, review of learning disability VIP cards and implementation of Covid-19 vaccination programme.
	1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	Controls and actions updated	Controls updated to include revised guidance on clinical review, CAMHS campaign and enhanced activity data reported in IPR, actions updated to include review impact of vaccination programme and review of increased referral data.
	1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**	Controls updated	Controls updated to include updated EICM Strategy and systematic review of national guidance.
	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.	Actions updated	Actions updated to include review of essential training provision and development of wellbeing plans in each BDU.
	1536	BAME staff health and wellbeing is disproportionally	Controls and	Controls updated to include EIA for health and wellbeing and occupational

		adversely affected by the impact of the Coronavirus.	actions updated	health, actions updated to include review of BAME staff risk assessment.

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

	Risk ID	Description	Status	Update (what changed, why, assurance)
	1527	Risk that the Covid-19 testing regime is delayed or inadequate leading to sub-optimal utilisation of staff and sub-optimal care.	Actions updated	Actions updated to include review of lateral flow testing arrangements and active collaboration in South and West Yorkshire.

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.

During this recent quarter the Trust Board has met to review and update the strategic risks to be included in the Board Assurance Framework (BAF). As part of these discussions a number of potential additional and expanded risks have been identified. These are being reviewed in further detail by identified lead directors and the appropriate board committee. These include:

- How Trust estate is used given the impact of social distancing and Covid-19 secure premises.
- New or extended services requirements such as Covid-19 aftercare and long Covid-19.
- Lack of a clear and consistent strategy for community health services.
- Changes to the capital funding regime.
- Risk of a major incident.

In terms of risk profile, the consolidated risk scores has increased from 356 to 385 since the previous quarter, reflecting the ongoing challenges to the Trust in the current operating environment.

Risk appetite

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

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

ORGANISATIONAL LEVEL RISK REPORT

South West Yorkshire Partnership NHS Foundation Trust

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

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

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

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

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

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

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

Actions in green are ongoing by their nature.

Trust Board (business & risk) – 26 January 2021

NEW RISKS

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1567	Inability to meet the competing demand of responding to the second wave of the pandemic, the regulatory reporting and restoration drives.	• Mature command structure established and functioning well. • Clear protocol established for review of OPEL levels. • Restoration and recovery programme established within priority programmes. • Strong links to national and regional networks allowing for early alert to emerging risks / competing pressures. • History of strong partnership working arrangements with regulators. • Established arrangements for mutual aid during first wave. • Regular review of priorities at EMT. • Business continuity plans.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cautious / moderate (1 – 6)	• Escalation arrangements established. • Routine contact with key regulators to brief on current status and impact. • Recovery and restoration work subject to routine review through performance EMT. • IPR review and triangulation providing early warning of emergent pressures and risks to delivery.	EMT	Ongoing through out the pandemic	EMT Trust Board	4 Yellow / moderate (1 – 6	FIP		Every three months prior to business and risk Trust Board – January 2021 & weekly Covid-19 review
1568	Risk that a seclusion room will not be available due to damage that	• The leadership team monitor the use of seclusion across all areas and can provide immediate advice on the availability of seclusion in each area.	4 Major	3 Possible	12 Amber / high	Minimal / low – Cautious /	• OMG have commissioned a review of seclusion facilities across the Trust (DO) (February 2021)	DO	Ongoing	EMT monthly	4 Yellow /	CG&CS		Every three months prior to

	occurred placing staff and service users at an increased risk of harm.	• 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 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.			(8 – 12)	moder-ate (1 – 6)					moder ate (1 – 6)			busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

BREXIT RISK – (PREVIOUSLY CLOSED DECEMBER 2019)

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
1369	Risk that a “no-deal” Brexit has implications for the Trust including product availability, medicines availability and staffing.	• Review regular updates from regulators. • National guidance. • Workforce plans. • National work to ensure medicine supplies remain available. • Local risk register in place. • Engagement with local CCGs. • Regular completion of sit rep to Brexit lead. • Internal Brexit group.	4 Major	2 Possib le	8 Amber / high (8 – 12)	Minimal / low – cauti-ous / moder-ate (1 – 6)	• Continued engagement with national groups on Brexit planning and impact.	DHR		EMT (monthly) CG&CS (regular)	4 Yellow / moder ate (1 – 6)	CG&C S	Risk appetite: Clinical risk target 1 – 6	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk level 15+

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	• McAfee anti-virus software and 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 Windows BitLocker for encryption. • Security patching regime covering all servers, client machines and key 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 inside 14 days 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 for level 2. • Annual table-top cyber exercise scheduled with last exercise completed in January 2020. Next one scheduled for January 2021. • Windows defender advanced threat protection in place. • Strengthened password requirements in place. • Third year of IT infrastructure. improvements has been completed • 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 – some Cisco network equipment is due to be replaced during 2020/21. • Training needs, communications and guidance to staff. Remains under constant review. • Cyber SAL campaign revamped which is aimed at improving cyber awareness across the Trust. • Reinforcement and additional key messages relating to cyber security are being issued to staff as part of the Trust's Covid-19 communications. • Cyber security issues have been identified specifically relating to Zoom. An NHS Digital Care Cert alert has been issued and the Trust has implemented the necessary controls and measures meaning that Zoom is blocked from being downloaded onto Trust issued devices. • Work towards full cyber essentials certification (DFR) (March 2021) – timescales extended due to impact of Covid-19 and remain subject to confirmation - activities progressing to support this. • Annual cyber survey currently being rescheduled and planned. (DFR) (January 2021). This survey has been extended to run throughout January due to limited responded and the IT team are working with Communications colleagues on strengthening the reminders for staff to complete this survey. • Improving Clinical Information & Information Governance Group (ICIG) partly re-purposed to review additional risks and identify practical mitigations to decisions taken during the pandemic.	DFR	Ongoing	IM&T Managers Meeting (Monthly) EMT Monthly (bi-Monthly) Audit Committee (Quarterly) IT Services Department service management meetings (Trust / Daisy) (Monthly)	5 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 2 & 3 The COVID-19 situation is presenting highly challenging circumstances which means the potential threat of cyber-attack remains potent and possibly heightened. The measures that the Trust has established remain in place and all associated activities are continuing. Whilst there is a need to ensure rapid access to digital solutions and technologies which requires a less comprehensive testing approach in the short-term, security considerations remain at the forefront so as to ensure services remain safe.	Every three months prior to business and risk Trust Board – January 2021 & weekly Covid-19 review

		• Routine replacement of legacy / end of life equipment. • Regular reviews and health checks of all firewall rulesets. • Adoption of Microsoft Advanced Threat Protection (ATP) platform.												

Risk level <15 - risks outside the risk appetite

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	• Agreed joint arrangements for management and monitoring delivery of integrated teams. • Weekly risk scan by Director of Nursing & Quality and Medical Director. • BDU / commissioner forums – monitoring of performance. • Monthly review through performance monitoring governance structure via EMT of key indicators and regular review at OMG of key indicators, which would indicate if issues arose regarding delivery, such as delayed transfers of care, waiting times and service users in settled accommodation. • Regular ongoing review of contracts with local authorities. • New organisational change policy to include further support for the transfer and redeployment of staff. • Attendance at and minutes from Health & Wellbeing board meetings. • Attendance and monitoring at contract forums. • Annual planning process.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Involved with partners in the co-development of integrated care partnerships in each place as Trust priority programmes of work. (DS) • Calderdale is captured in the Calderdale Cares document and delivery is overseen through the Health and Wellbeing Board. (DNQ) • Kirklees – part of the provider development board to develop wider system integration of care closer to home and 0 – 19 services in Kirklees. (DO / DPD) • Barnsley – part of the Integrated Care Partnership and Delivery Group. (DS / CEO) • Wakefield – active involvement in the mental health provider alliance and integrated care partnership. (DPD) • Active involvement in both West and South Yorkshire integrated care systems. We have internal groups established to co-ordinate contribution and involvement in each place and in both West and South Yorkshire integrated care systems. (DO / DS / DPD) • Engagement in each place with local authority partners through meetings and joint working. (DO) • Working on a plan through command structures in each place. (DPD / DS) • Contributing to the development of recovery plans in each place with partners. (DS / DPD / DO)	DS	Ongoing risk given external influenc e outside our control	BDU (monthly) EMT (monthly) OMG (regular) Trust Board (each meeting through integrated performanc e report) Annual review of contracts and annual plan at EMT and Trust Board	6 Yellow /Moder ate (4-6)	CG&CS FIP	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1511	Risk that carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical and other risk to the Trust.	• Partnership Board. • Individual work streams. • Trust Board review and approval. • NHS England assessment process.	4 Major	3 Possible	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) • Due diligence being carried out. (DPD) (January 2021) • Development of appropriate financial risk and gain share with other providers in the collaborative. (DPD) (January 2021) • Development of quality assurance processes and monitoring across the Collaborative. (DPD) (March 2021) • Development of opportunities for financial efficiencies. (DPD) (February 2021)	DPD	Februar y 2021	EMT (monthly)	4 Yellow / moder ate (4-6)	FIP	Work re-commenced in July 2020 after being paused in April. An update on timescales was reported to Board in July 2020. Timescales for completion remain in line with previous meaning a	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
													planned go-live in April 2021. An updated business case needs to be agreed by partners and submitted to NHSE by 6 November 2020.	review
905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	• Safer staffing project manager in place with appropriate medium and longer term plans including recruitment drive and centralisation of the bank. • Safer staffing project manager is currently implementing appropriate actions. • Recruitment and retention plan agreed. • Monthly safer staffing reports to Board and OMG with appropriate escalation arrangements in place. • Biannual safer staffing report to Board and Commissioners. • Review of establishment for adult inpatient areas completed and implementation plan developed. Progress monitored through OMG & EMT. • Care hours per patient day (CHPPD) data now included in revised safer staffing six monthly board report. • Ability to move staff between wards / teams • Daily staff absence report. • Covid-19 measures involve the review of staffing in each daily Bronze command meeting. Safer staffing reported on inpatient wards to OMG via IPR. • Medical staff bank established. • Allied Health Professionals master agency contract in place.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Additional funding requests with commissioners will be maintained throughout contract negotiations for 2020/21. (DO / DFR) • Staff redeployment plan (DHR) • BDU meetings review safer staffing and take action to prioritise redeployment of staff to maintain safe staffing levels. (DNQ / DO) • Regular review of staff testing capacity through silver command to minimise staff absence with Covid-19 symptoms. (DNQ) • Pandemic flu plan response including BCP stress testing. (DHR) • Further review of forensics and older peoples' services to take place. (DNQ / DO) (review delayed and revised date now Q1 2021/22) • Safecare tool to be introduced during 2020/21 with pilot during Q4. (DNQ) • 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) (April 2021) • International nurse recruitment funding approved with recruitment activity taking place throughout 2021/22. (DHR) • Covid-19 vaccination programme established with initial doses administered 12 January 2021 (preparations led through new bronze command group). (DNQ) (regular review throughout programme).	DO / DNQ	Ongoing	EMT (monthly)	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 & 3	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	• Emergency response process in place for those on the waiting list. • Demand management process with commissioners to manage ASD waiting list within available resource. • Commissioners have established an ASD Board and local commissioning plans are in place to start to address backlog for ASD.	4 Major	2 Unlikely	8 Amber / High risk (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Recruitment to vacant positions is underway and showing successes in increasing capacity. This includes the consideration of new roles to improve opportunities to recruit. (DO) • Calderdale CCG has led on development of a new diagnostic assessment pathway and is currently considering options for investment in a waiting list initiative. (DO) (Details to be confirmed by CCG).	DO	Review every three months	Performanc e reporting to EMT - monthly Assurance report to Clinical Governanc	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2 C&K waiting list initiatives (recovery	Every three months prior to busi-ness and risk Trust Board –

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
		• 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 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.					• Improvement noted from waiting list initiatives in Wakefield and Barnsley. Work remains in place and is reported to FIP and 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)			e Committee Individual district performanc e reports reviewed by BDU			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.	January 2021 & weekly Covid-19 review
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.	4 Major	3 Possib le	12 Amber / high risk (8-12)	Minimal / low – Cauti- ous / moder- ate	• Waiting list initiatives agreed with Barnsley and Calderdale CCGs. Demand will be reported via contract meetings during 2020/21. (DFR) • Waiting lists and associated actions are monitored through the Clinical Governance and Clinical Safety Committee. (DO)	DO	Novemb er 2020	Performanc e reporting to OMG and EMT monthly.	6 Yellow / moder ate	CG&CS	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO 2	Every three months prior to busi- ness

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
		• People waiting are offered contact information if they need to contact someone urgently. • Individual bespoke arrangements are in place within services and reported through the BDU business meetings. • Bespoke arrangements to review pathways in individual services. • Additional investment secured waiting list initiatives as part of the 2019/20 contract negotiations to flex capacity across the IAPT pathway. • Review of impact and ongoing risk presented to CG&CS Committee. • Bespoke arrangements are in place in BDUs where waiting times have an impact on carers. • Waiting list initiatives have been agreed in all areas. • Work has taken place with commissioners to agree additional capacity in specific services. • Ethnicity monitoring is now in place to monitor whether there is a disproportionate impact for specific communities or groups.				(1 – 6)	• 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) (March 2021) • The reporting of 'hidden waits' where the wait is secondary to the formally reported waiting information has started within the operational performance report but embedding this into routine monitoring has been delayed due to Covid-19. This will be further reviewed in March 2021. (DO) (March 2021)			Assurance report to CG&CS Committee (CAMHS). Individual district performanc e reports reviewed by BDU.	(4-6)			and risk Trust Board – January 2021 & weekly Covid-19 review
1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	• Fire Safety Advisor produces monthly / quarterly Fire Report and Operational Fire / Unwanted Fire Activation for review / action by EFM Senior Managers. • Quarterly review undertaken by Estates TAG. • Weekly risk scan are completed by the Trust's Fire Safety Advisor and any issues or concerns raised directly with the Head of Estates and Facilities and Head of Estates Operations with the Director of HR, OD and Estates been briefed and action undertaken accordingly. • Trust smoking policies with the use of e-cigarettes agreed for a trial period. • Compliance with the following regulations: ○ The allocation and definition of responsibilities and standards for the provision, installation, testing and planned maintenance of fire safety equipment, devices, alarm and extinguishing systems;	4 Major	3 Possib le	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Smoking group established to review the smoking policy including the trial period for the use of e-cigarettes. (DO) An update report will be provided to the Clinical Governance and Clinical Safety Committee in February 2020. (deferred due to the impact of Covid-19)	DO	Ongoing	EFM (weekly and monthly) Estates TAG (quarterly) OMG (monthly)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Clinical risk target 1 – 6 Links to BAF, SO2 & 3 Note - A failure to effectively manage compliance with the Trust Fire/Smoking policies will expose the Trust to an increased risk of fire within patient care areas. This would result in injury to service users and damage to Trust property and buildings.	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		○ 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.											
1424	Risk of serious harm occurring from known patient safety. risks, with a specific focus on: • Inpatient ligature risks • Learning from deaths & complaints • Clinical risk assessment • Suicide prevention • Restraint reduction • Covid-19.	Clear policy & procedure in place providing framework for the identification and mitigation of risks in respect of: • Ligature assessment. • Blue light alerts and learning library introduced immediate lessons learnt are shared and prompt action taken to prevent recurrence of incidents. • Learning from deaths. • Complaints reviews. • Clinical risk assessment process. • Suicide prevention training. • Weekly risk scan of all red and amber patient safety incidents for immediate action.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Formulation of informed risk assessment training has commenced, plan to risk assess process and outcome included in patient safety strategy. (DNQ) • Additional support from legal team to provide timely response to clinicians in relation to MHA / MCA matters. (MD) • Internal and external regional work to ensure ECT offer remains in place. (MD) • Additional pharmacy team support to clinicians to manage Covid-19 related matters. (MD) • Recent CQC communication around ligature risks reviewed by environmental safety group and recommendations being implemented. (DNQ) • Quality improvement network focus on patient safety improvement. (DNQ) – to commence in Q1 2020/21 in line with clinical TRIO refresh. (Implementation	DNQ MD	On going	Performanc e & monitoring via EMT, OMG & TB reports e.g. quarterly Patient Safety report & incident report	6 Yellow / moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• 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 “Manchester scale” to improve reliability & validity of ligature assessment process and to prioritise remedial action. • New AMD for patient safety appointed to revised job description. • Updated clinical risk report that captures a wider range of risk information for OMG. • Mental health safety improvement partnership in place with NHS I / CQC. • Clinical risk assessment training programme. • Our Learning Journey report disseminated across all teams and discussed at team level (DNQ) (2017/18 report complete, 2018/19 report complete and being utilised). • Agency and bank staffing action plan is monitored through OMG. • Safer staffing group meets on a monthly basis to review exception reporting. • Alignment of WY&H ICS suicide prevention strategy with SWYPFT plans. • QI approach adopted on CQC areas for improvement. Detailed plan approved by CG&CS Committee. Risk assessment improvement is a key domain. • Suicide prevention strategy action plan. • CQC improvement action plans performance managed through OMG and Clinical Governance Group with escalation arrangements in place where action behind schedule. • Reducing restrictive practice and intervention (RRPI) improvement plan implementation.					plan to be reviewed in line with Covid-19 restoration and reset) (April 2021) • Recent Learning Disability Mortality Review (LeDeR) reports identifying Covid-19 impact on learning disability community are being reviewed for organisational learning opportunities and reported into EMT. (DNQ) (March 2021) • Complaints policy and metrics under review and revised proposal for new arrangements being developed. (DNQ) (March 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
		• 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.											
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	• Participation in system transformation programmes. • Robust CIP planning and implementation process. • Trust is proactive in national discussions and forums to have positive influence on upholding concept of "parity of esteem" for mental health and learning disabilities. • 5 year funding arrangements increases income allocated to mental health services. • Mental health investment standard. • Confirmed block income for remainder of 2020/21. • System wide funding provided on a fair shares basis for 2020/21.	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• The Trust is approach to change and transformation includes a communication and engagement plan to co-produce and explain the benefits of transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) • Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR) • Full engagement with ICSs in relation to system financial position and funding. (DFR) • 2021/22 contract negotiation process. (DFR) (March 2021) • Assess 2021/22 planning guidance when received. (DFR) (March 2021)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3 Funding arrangements for the remainder of 2020/21 have been provided and there is an increase in proportion of monies being channelled via the ICS. 2021/22 financial arrangements are not known at this stage.	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to	• 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.	4 Major	3 Possible	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)	DFR	ICO external monitoring of progress by external evidence / desk based reviews	Progress monitored through EMT and weekly risk scans	4 Yellow / moderate (4-6)	AC	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – January 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
	reputational and public confidence risk.	• Trust has good track record for recording incidents and all incidents are reviewed weekly with investigations carried out where needed and action plans put in place. • Improving Clinical Information and Governance group in place which is the governance group with oversight of IG issues. • Monthly report of IG issues to EMT. • Internal audit perform annual review of IG as part of DSPT Toolkit. • Internal Audit programme of work. • Use of blue light system to highlight specific breaches.					• Rebranded materials and advice to increase awareness in staff and reduce incidents. (DFR) • Increase in training available to teams including additional e-learning and self-assessment using workbooks. Face-to-face training is currently on hold due to restrictions imposed by the Covid-19 outbreak. (DFR) • Commitment to support comprehensive attendance at the ICIG meeting. (DO) • Formal decision logs to be maintained for any temporary changes to policies as a result of wider incidents. (DFR) • Ensuring that the data protection impact assessment is reviewed, updated and published as required. (DFR) • Part re-purposing of ICIG during the Covid-19 outbreak to identify IG concerns arising from rapid systems deployment and changes in policy & procedure. (DFR) • Review of incidents that have taken place during the Covid-19 outbreak to identify if additional mitigations required. (DFR) (October 2020) • Change improvement will commence a quality improvement project Trust-wide. (DFR) (March 2021) • Engagement with Silver command structure to ensure that data security and confidentiality are considered as part of decisions to share staff / patient information to facilitate the vaccination and lateral flow testing programmes. (DFR) (January 2021)							weekly Covid-19 review
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its capital programme, leading to an inability to pay staff and suppliers without DH support.	• Financial planning process includes detailed two year projection of cash flows. • Working capital management process including credit control and creditor payments to ensure income is collected on time and creditors paid appropriately. • Capital prioritisation process to ensure capital is funded where the organisation most needs it. • Stated aim of development of financial plans that achieve at least a small surplus position. • CIP identification and review process. • Treasury Management policy. • Non-Executive Director led Finance, Investment & Performance Committee. • Cash management procedures. • Financial sustainability plan. • Confirmed financial arrangements for the remainder of 2020/21.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Increased robustness of CIP and expenditure management. (DFR) • Increased focus on raising of invoices to ensure timely payment. (DFR) • Increased focus on robust financial management via training. (DFR) • Collaborative working within West Yorkshire and South Yorkshire ICSs. (DFR / CEO / DPD) • Investigate additional sources of capital funding should they be required. (DFR) • Focus on benchmarking and internal productivity. (DFR) (March 2021) • Compare CIP ideas with similar trusts in the region. (DFR) (September 2020). *Delayed to due impact of Covid-19 and temporary financial arrangements.* • Revised estates strategy being developed. (DHR) (December 2020) • Temporary contracting arrangements in place for 2020/21. Assessing impact of updated financial arrangements for H2 of 2020/21 (DFR) (October 2020)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO3	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
							• Assess 2021/22 planning guidance when received. (DFR) (January 2021) • Re-assess the financial sustainability plan in light of the impact of Covid-19. (DFR) (June 2021) • Estates strategy being updated. (DHR) (February 2021)							
1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	• Systematic and integrated monitoring of contract performance, changes in specification and commissioning intentions to identify and quantify contract risks. • Regular reporting of contract risks to EMT and Trust Board. • Play full role in ICSs in both West and South Yorkshire. • Equality, Involvement, Communication and Membership strategy. • Updated Trust strategy in place. • Approved commercial strategy. • Non-Executive Director led Finance, Investment & Performance Committee. • Prospectus and Board stakeholder engagement plan. • Annual contracting process. • Significant change programmes identified as priorities for the Trust that have high cost, high risks and / or high complexity. • Updates to Trust Board through business tendering opportunities.	3 Moder ate	3 Possib le	9 Amber / high (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Implementation of longer term financial sustainability plan. (DFR) (ongoing over three years period 2019 - 2022) • Development of targeted programme of business growth focused on specific services and markets and aligned to strategy. (DPD / DO) • Scenario planning in operational plan and strategy regarding place based developments, where this could result in step-changes in income in either direction. (DS / DPD / DO) (Ongoing – delivery dates specific to each priority programme) • Ongoing response to the rapidly changing operating environment and the role the Trust plays in each place (DS). (Ongoing – delivery dates specific to each priority programme and regular discussions at strategic Trust Board meetings.) • *In light of Covid-19 outbreak there is currently only limited tendering of services.* • Develop an understanding of clinical and operational interdependencies and minimum volumes for high quality care. (DPD / DO) • External stakeholder engagement plans will be refreshed as part of the Equality, Involvement, Communication and Membership strategy development and supporting action plans. (DS) (March 2021) • 2021/22 contract negotiation process. (DFR) (May 2021)	DFR	Ongoing	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 1 & 3	Every three months prior to busi- ness and risk Trust Board – January 2021 & weekly Covid-19 review
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	• Board and EMT oversight of progress made against transformation schemes. • Active engagement in West Yorkshire and South Yorkshire STPs / CEO leads the West Yorkshire STP. • Active engagement on place based plans. • Enhanced management of CIP programme. • Updated integrated change management processes. • 2019/20 contracts agreed and in place. • Non-Executive Director led Finance, Investment & Performance Committee. • Confirmed block income in place for 2020/21. • Mental health investment standard.	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) • Focus on benchmarking and internal productivity. (DFR) (May 2021) • Assess 2021/22 planning guidance when received. (DFR) (March 2021)	DFR	Annual review	EMT (monthly) Trust Board (quarterly)	4 Yellow /Moder ate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO 3	Every three months prior to busi- ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• System-wide funding provided on a fair shares basis.												
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.	• Monitoring turnover rates monthly. • Exit interviews. • Flexible working guidance. • Flexible working arrangements promoted. • Investment in health and well-being services. • Retire and return options. • Apprenticeship scheme balancing the age profile. • Recruitment and Retention action plan agreed. • Workforce planning includes age profile. • Bring back staff programme at national and local level. • New pension arrangements allow for easier retire and return. • All potential retirees have a discussion on options. • Board succession planning in paper discussed at Trust Board. • Second level reports succession plans discussed at Workforce and Remuneration Committee.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Refresh of workforce plans as part of operational planning process. (DHR) (March 2021)	DHR	Ongoing	EMT and Trust Board reporting through IPR (monthly) RTSC exception reports	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi- ness and risk Trust Board – January 2021 & weekly Covid-19 review
1158	Risk of over reliance on agency staff which could impact on quality and finances.	• Board self-assessment. • Reporting through IPR. • Safer Staffing Reports. • Agency induction policy. • Authorisation levels for approval of agency staff now at a senior level. • Restrictions on administration and clerical agency staff usage. • Extension of the Staff Bank. • Development of Medical Bank. • OMG to Overview. • Retention plan developed. • Recruitment to Consultant roles. • Direct engagement vendor is in place and meeting are almost complete with individual agency locums to support move to DE, with a few remaining. • Agency project group has joined with the R&R group to focus on actions to address staffing shortfalls that then lead to agency use. • Support through Bring Back Staff Programme.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti- ous / moder- ate (1 – 6)	• Business case for potential use of NHS Professionals underway. (DHR) (awaiting NHSP proposal) (delayed due to Covid-19) • Exit strategy for all agency locums has been requested from all clinical leads who refresh this on an ongoing basis. (MD)	DHR	Ongoing through agency project group and workforc e planning – worksho p	EMT (monthly) Board (monthly)	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi- ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• A dedicated recruitment resource was sourced to target areas with the greatest recruitment issues / highest agency use. • Implementation of new roles across 2020 including Nursing Associates and Advanced Clinical Practitioners.												
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 remainder of 2020/21.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• The Trust leadership is developing productive partnerships with other organisations to develop joint bids and shared services in preparation for integration of services. (DFR / DS / DPD / DO) • The Trust as part of its change approach develops communications and engagement plans that drive external engagement and communications to explain the benefits of transformation for external stakeholders. (DS) (Ongoing – delivery dates specific to each priority programme) • Annual planning process identifies financial needs and risks, enabling necessary actions to be identified. (DFR) – planning process currently suspended. • Development of Alliances in Calderdale, Kirklees and Wakefield will ensure local priorities and impact are considered. (DS / DPD / DO) • *Currently only limited tendering of services in light of Covid-19 outbreak. (DFR)* • 2021/22 contract negotiation process. (DFR) (May 2021)	DFR	Ongoing Review annually	EMT (monthly) Trust Board	6 Yellow / moderate (4-6)	FIP	Risk appetite: Financial risk target 1 – 6 Links to BAF, SO1, 2 & 3	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.	• Bed management process. • Critical to Quality map to identify priority change areas. • Joint action plan with commissioners. • Internal programme board. • Weekly oversight at OMG. • Agreed governance structure, with meetings in place, with commissioners in relation to the monitoring and management out of area cessation plans. • Workstreams in place to address specific areas as agreed following the SSG review. • Routine reviews of care whilst out of area are in place. • Pathway for people with trauma informed emotionally unstable personality disorder is in place with a programme of training ongoing. • Additional PICU capacity has been purchased to assist with managing the	3 Moderate	3 Possible	9 Amber / high (8 – 12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Development and implementation of local plans of change activity to reduce admissions and plans to reduce length of stay. (DO) • Development and implementation of local plans of change activity to reduce PICU bed usage. (DO) • Identify barriers to discharge in light of impact of Covid-19 such as availability and capacity of care homes. Identify possible mitigations. (DO) • Implementation of actions identified through independent review of our bed management processes remain a priority throughout the Covid-19 phase. (DO) • 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) work has commenced. 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	DO	Ongoing / monthly	OMG	4 Yellow /Moderate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 Reviewed in light of the current pandemic. The patient flow processes remain in place. If people need to be placed out of area to manage pressures related to Covid-19, the current control regarding routing contact	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		current Covid-19 phase as part of the mental health collaborative.					ICS to make best use of the available resources. (DO) (March 2021)						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. • 2019/20 contracts agreed and in place. • Contract arrangements for the first six months of 2020/21 to enable trusts to break even.	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) • 2020/21 contract negotiations. (DFR) (March 2020) – process suspended with temporary arrangements in place. • Consider the impact on the Trust of the cohort proposal made by Mental Health Collaborative ICS. (DO) (October 2020)	DO / DFR	Ongoing	OMG monthly EMT monthly Trust Board monthly	4 Yellow / moder ate (4-6)	FIP	Risk appetite: Financial risk 1 – 6 The Trust has remained involved with ICS proposals to purchase additional beds and contributed to the final recommendati on.	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1368	Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a CAMHS bed. This could result in serious harm.	• Bed management processes are in place as part of the new care model for Tier 4. These include exhausting out of area provision. • All community options are explored. • Where no age appropriate bed or community option is available then a bed on an adult ward is considered as the least worst option to maintain safety. • Protocol in place for admission of children and younger people on to adult wards. • The most appropriate beds identified for temporary use. • CAMHS in-reach arrange to the ward to support care planning. • Safeguarding policies and procedures. • Safer staffing escalation processes. • Regular report to board to ensure that position does not become accepted practice. • Safeguarding team scrutiny of all under 18 admissions. • Letter sent to NHS England from Director of Nursing & Quality and Medical Director expressing concerns. • Meetings led by NHSE took place. The system is better informed of the challenges with agreement to working together to best meet the needs of children and young people.	4 Major	2 Unlikel y	8 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Development of new CAMHS inpatient facility in Leeds for West Yorkshire. (DO) (2021) • Further recruitment underway. • An urgent meeting to manage an increase in demand and reduction in capacity due to Covid-19 across the mental health collaborative took place in December 2020 with further meetings planned to support the delays in discharges of young people to create capacity. (DO) (Review March 2021)	DO	Ongoing risk given external influenc e outside our control	EMT (monthly) CG&CS (regular) Trust Board (each meeting through integrated performanc e report)	4 Yellow /Moder ate (4-6)	CG&CS	Risk appetite: Clinical risk target 1 – 6 The Trust ensures children and young people are only admitted to an adult bed as least worst option and ensure full safeguarding is in place when the need arises. This is in line with our “safety first” approach.	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• All age liaison teams are now embedded in each place.												
1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	• Safer staffing levels for inpatient services agreed and monitored. • Agreed turnover and stability rates part of IPR. • Weekly risk scan by DNQ and MD to identify any emerging issues, reported weekly to EMT. • Reporting to the Board through IPR. • Datix reporting on staffing levels. • Strong links with universities. • New students supported whilst on placement. • Regular advertising. • Development of Associate Practitioner. • Workforce plans incorporated into new business cases. • Workforce strategy implementation of action plan. • Retention plan developed. • Workforce plans linked to annual business plans. • Working in partnership across West Yorkshire on international recruitment. • Inpatient ward workforce review with revised skill mix. Major recruitment drive to implement nursing associates via Trainee Nurse Associate recruitment. • Introduction of new temporary register by NMC and HCPC plus retirees return national initiative is in place and being utilised to support staffing during Covid-19 response. • Marketing of the Trust as an employer of choice. • New roles developed e.g. Advanced Nurse Practitioner.	3 Moder ate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Proposal for On Boarding System to include recruitment Microsite. (DHR) (delayed due to Covid-19) • International nurse recruitment funding bid awarded. (DHR)	DHR	Ongoing given external influenc e outside our control	BDU (weekly) EMT (monthly) Trust Board (each meeting through integrated performanc e report)	6 Yellow / moder ate (4-6)	CG&C S	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO 2 & 3 34 TNA posts recruited to (October – November 2019) both internal and external to a total establishment of 52 WTE.	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	• Absence management policy. • Occupational Health service. • Trust Board reporting. • Health and well-being survey. • Each BDU identified wellbeing groups and champions. • Enhanced occupational health service. • Well-being at Work Partnership Group. • Health trainers. • Well-being action plans. • Core skills training on absence management.	3 Moder ate	3 Possib le	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Bronze operational workforce group to be established with links into silver command. (DHR) • Roll out of vaccination programme to all staff by end of January 2021. (DHR) • Review of physical health and wellbeing support being undertaken in light of Robertson Cooper survey result. (DHR)	DHR	Ongoing	BDU (weekly) EMT (monthly) Trust Board	6 Yellow / moder ate (4-6)	WRC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly

Risk ID	Description Of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get to Target risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• Extend use of e-rostering. • Retention plan developed. • HR and service managers ensuring consistent application of sickness policy. • BAME health and wellbeing task force established. • Risk assessment process for all staff linked to Covid-19 complete. • Health and wellbeing reviews included in staff appraisals.												Covid-19 review
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	• Annual Equality Report. • Equality and Inclusion Form. • Equality Impact Assessment. • Staff Partnership Forum. • Development and delivery of joint WRES and EDS2 action plan. • Targeted career promotion in Schools. • Focus development programmes. • Review of recruitment with staff networks complete. • Actions identified in the equality and diversity annual report 2017/18. • Establishment of staff disability network and LGBT network. • Links with Universities on widening access. • Framework for bullying and harassment between colleagues. • Action plan to tackle harassment and bullying from service users and families. • Appointment of WRES OD lead. • Full time freedom to speak up guardian appointed.	3 Moderate	3 Possible	9 Amber / High (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Delivery of WRES and EDS2 action plans. (DHR) • Established BAME talent pool. (DHR)	DHR	Ongoing	EMT (quarterly) EIC Committee (quarterly)	6 Yellow / moderate (4-6)	EIC	Risk appetite: Financial / commercial risk target 1 – 6 Links to BAF, SO2 & 3	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Organisational level risks within the risk appetite

Risk ID	Description of risk	Risk level (current / pre-mitigation)	Risk appetite	Risk level (target)
695	Risk of adverse impact on clinical services if the Trust is unable to achieve the transitions identified in its strategy.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
812	Risk the creation of local place based solutions which change clinical pathways and financial flows could impact adversely on the quality and sustainability of other services.	Yellow / Moderate (4-6)	Open / High (8 - 12)	Amber / High risk (8 - 12)
773	Risk that a lack of engagement with external stakeholders and alignment with commissioning intentions results in not achieving the Trust's strategic ambition.	Yellow / Moderate (4-6)	Open / High (8 - 12)	Yellow / Moderate (4-6)
1156	Risk that decommissioning of services at short notice makes redeployment difficult and increases risk of redundancy.	Yellow / Moderate (4-6)	Minimal / low – cautious Moderate (1-6)	Yellow / Moderate (4-6)
1212	Risk that the amount of tendering activity taking place has a negative impact on staff morale which leads to sub-optimal performance and increased staff turnover.	Yellow / Moderate (4-6)	Open / high (8 - 12)	Amber / High risk (8 - 12)

1217	Risk that the Trust has insufficient capacity for change to meet its own and system-wide objectives.	Amber / High risk (8 - 12)	Open / high (8 - 12)	Amber / High risk (8 - 12)
1432	Risk of problems with succession planning / talent management.	Yellow / Moderate (4-6)	Open / high (8 - 12)	Yellow / Moderate (4-6)

COVID-19 RISKS

Risk level 15+

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1530	Risk that Covid-19 leads to a significant increase in demand for our services (as anxiety and mental health issues increases in our populations) 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. • Command structure supports the immediate management of peaks in demand. • Digital and telephone solutions are part of the standard offer for service users.	4 Major	4 Likely	16 Red / extreme / SUI risk (15-25)	Minimal / low – Cautious / moderate (1 – 6)	• Learning from Covid-19 is being captured as it becomes available. This continues to support working in a different way in the future. (DO) • Work with partners in each place to understand emerging impact of Covid-19, need and demand. (DS / DPD) • Contribute to stress testing exercises through the ICS and use learning internally. (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) • Contribute to place based planning including recovery and reset. (DS / DPD) • Business continuity plans to remain responsive to difference phases and impact of the pandemic. (DO) • Where demand exceeds capacity this will be escalated through the command structure with bespoke arrangements put in place. (DO) • Detailed activity, workforce and finance planning for remaining 2020/21 in light of increasing referral activity. (DPD)	DO	Ongoing during the Covid-19 pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS	Risk score reviewed and remains the same. The risk is being reviewed on an ongoing basis and given the increasing activity and demand in light of the second wave risk definition, controls and actions remain appropriate subject to monthly review. The executive trio are considering a separate risk related to the cumulative impact of the pandemic on service users and carers. (February 2021)	Every three months prior to business and risk Trust Board – January 2021 & weekly Covid-19 review

Risk level <15 - risks outside the risk appetite

Risk ID	Description of risk	Current control measures	Consequen-ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.	• Policies and procedures revised to take account of Covid-19. • Publication of guidance on the intranet. • Regular communication to all staff. • Application of social distancing guidance. • Provision of appropriate personal protective equipment in line with national guidance. • Bronze, silver and gold command incident processes established. • Self-isolation guidance. • Process for testing all staff established: symptomatic, asymptomatic and antibody. • Covid-19 pathway including cohorting protocol developed and implemented. • Enhanced IPC team offer to services as part of Covid-19 response. • Agreed pathway with acute providers to access clinically appropriate support for Covid-19. • Additional training and support plan for staff to respond to needs of suspected and positive Covid-19 patients. • Development of step-up and step-down guidance in partnership with acute trust colleagues. • Face masks available across the Trust for staff in line with government guidance. • Risk assessments complete to determine if areas are Covid-19 secure. • Daily follow up of actions identified through command structure. • Routine scan of national guidance as part of horizon scanning in command structure. • Membership of clinical and professional regional and national networks.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Timely action and intervention on outbreak management. (DNQ) • Timely response to change in restrictions or social distancing guidance. (DNQ) • Review of IPC precautions in light of new variant underway and national guidance awaiting – current position no change. (DNQ) • Implementation plan to ensure timely delivery of flu vaccination nearing completion with learning taken into Covid-19 vaccine preparations. (DNQ) (March 2021) • Introduction of lateral flow testing for all frontline staff commenced 7 December 2020. 100% of tests distributed, additional tests requested to expand scope, update reviewed – challenge to establish baseline, however early data suggests positive position. (DNQ) (awaiting details of LAMP testing programme, to review on receipt) • Covid-19 vaccination programme established with initial doses administered 12 January 2021 (preparations led through new bronze command group). (DNQ) (regular review throughout programme) • SBAR templates being produced to share learning from recent outbreak management investigations. (DNQ) (February 2021) • IPC BAF routine review and update into CG&CS Committee. (DNQ) (February 2021)	DNQ	Ongoing during Covid-19 pandemic	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.	• Business continuity plans. • Performance management processes. • Risk panel review process. • There is clear escalation structure. through bronze / silver / gold meetings in place. • Supporting infrastructure now available to the operational teams over seven days as / when required.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Bronze command meetings meet regularly to manage the demand in the local service and review the needs of the service users on the caseload. (DO) • Bronze / management huddles are also being used to ensure safe management, stabilisation and recovery of services in line with Covid-19 restrictions. (DO) • OMG continues to monitor performance and take appropriate actions to address areas of concern, with appropriate escalation to EMT. (DO)	DO	Ongoing through Covid-19 phase	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS	Risk score reviewed. Currently score not reduced as the focus remains on maintaining access to services whilst managing the	Every three months prior to busi-ness and risk Trust Board – 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
		• 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.					• 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) • Safe working practices in community services group established to ensure people are working safely. The group reports to OMG. (DHR / DO) (Review March 2021)						current phase of Covid-19.	2021 & weekly Covid-19 review
1524	Risk that staff do not have access to necessary personal protective equipment (PPE) during the Covid-19 outbreak leading to issues with personal safety.	• Bronze PPE group. • Trust guidance on application and use of PPE in line with national guidance. • Part of national delivery process for PPE. • Process in place for delivering to Trust services. • Confirmed delivery process with the supplier. • Mutual aid scheme across ICSs. • Development of basic forecasting and stock usage information. • Routine scan of national guidance as part of horizon scanning in command structure. • PPE supply and demand monitored through IPR.	4 Major	2 Unlikely	8 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Routine review of IPC guidance and horizon scanning. (DNQ)	DNQ	Ongoing	EMT (monthly)	4 Yellow / moder ate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.	• Safer staffing policies. • Increased supply of temporary labour through staff bank recruitment. • Ability to move staff between wards / teams. • Daily access to staff absent report by service. • Business continuity plans in place that relate to the deployment of staff towards critical (24/7) services. • Talent pool for the redeployment of staff from non-critical to critical roles. • Staff health and wellbeing offer. • Testing programme. • Retirees return and 'bring back' NHS staff programme. • New temporary register for NMC and HCPC. • Fast track recruitment process for essential roles in line with national guidance. • Staff testing arrangements in place. • Staff and managers advice line operating 7 days a week. • Integrated Health and Wellbeing support. • Reduction in mandatory refresher training to release headroom.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Training and support readily available for staff who are needed to work in a different service or a different way. (DHR) • Staff portability arrangements within each place. (DHR) • Link to national wellbeing offer to keep staff resilient. (DHR) • Procedures are reviewed as the national and regional situations change through the command structures to ensure that they reflect the current position and the impact is understood. (DHR / DNQ / DO) • Timely implementation of Covid-19 vaccination programme. (DHR) • PPE availability processes being further developed. • Safe working practices in community services group established to ensure people are working safely. The group reports to OMG. (DHR / DO) (Review March 2021)	DHR / DO	Ongoing	Command structure	8 Amber / high (8-12)	CG&CS		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• Safer staffing reported on inpatient wards to OMG monthly via IPR. • Staff Portability Agreement with West Yorkshire MH / LD Trusts. • Management guidance on supporting staff attendance. • PPE guidance. • New working from home guidance. • Process for testing all staff. • Revised equality / quality impact assessment process introduced during Covid-19 pandemic. • Staff testing arrangement available to all staff. • During Covid-19 pandemic, Bronze command meetings review safer staffing and take action to prioritise redeployment of staff to maintain safe staffing levels. • Regular review of staff testing capacity through Silver command to minimise staff absence with Covid-19 symptoms. • Testing for staff remains available throughout phase two.											
1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves.	• Pastoral care 'talk-line'. • Access to wellbeing apps. • National mental health hotline. • Occupational Health Service operating extended hours. • Coronavirus psychological support line for staff operative 7 days a week. • Support arrangements for shielded staff introduced. • Health and wellbeing support centre as part of Workforce Support Hub. • Support and advice on childcare and caring. • Staff and managers advice line operating 7 days a week. • Self help guide for managers and teams • Coaching offer to managers, team leaders and teams to support wellbeing and resilience. • Staff counselling availability. • Link to the national Health and Wellbeing offer. • Staff food provision for frontline staff. • Health lifestyle support on stop smoking and weight management. • Staff testing arrangements available to staff. • Financial support guidance. • Strengthened bereavement support.	3 Moderate	4 Likely	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Roll out of staff vaccination programme in line with national guidance (DHR)	DHR		Command structure	8 Amber / high (8-12)	WRC		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description of risk	Current control measures	Consequen-ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.	• Business continuity plans. • Performance management processes including monthly reporting on quality metrics to the Trust Board via IPR • Risk panel review process. • There is clear escalation structure through bronze / silver / gold meetings in place. Silver reviews all changes in care models. • Use of local clinical expertise in development of models. • Log of all changes made during the outbreak. • QIA process for clinical pathway changes. • EIA rapid decision making framework • Summary log of legal risks reviewed by MHAC. • An interim CEAG has been established to provide urgent ethical advice to clinical teams and provides a governance framework reporting into CG&CS Committee. • New guidance for staff on decision making regarding face to face or virtual visits has been issued. • Equality, Involvement, Communication and Membership strategy agreed.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• An enhanced risk stratification tool is being developed (DNQ) (March 2021) • 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 are being approved by E&I Committee in February 2021. (DS) (February 2021) • 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 / DO) • National guidance on integrating learning from Covid-19 pandemic to be reviewed on receipt. (DS) (April 2021)	MD / DNQ	Ongoing	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.	• Enhanced clinical risk scanning. • Engagement with staff equality networks to advise on specific issues. • Charitable funds donated to support Kirklees BAME communities and bereavement work. • Equality Impact Assessment process. • Vitamin D supplements position statement in place for all inpatient service users. • Covid-19 clinical pathways for inpatients in place. • Place based partnership working to support population health mapping and initiatives in each of our places. • Equality, Involvement, Communication and Membership Strategy approved by Trust Board 1 December 2020. • Covid-19 information leaflets provided to patients and carers. • High risk groups identified by clinical teams and treatment plans reviewed.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Timely implementation of the Covid-19 vaccination programme once national guidance is issues. (MD / DNQ) • Risk scan report into EIC committee and escalation to EMT and OMG by exception. (DNQ) • Working with commissioners and partners in both the West Yorkshire and South Yorkshire & Bassetlaw integrated care systems. (DPD / DS) • Introduction of task group to understand the impact of Covid-19 on our protected user groups. (DNQ / MD / DO) • Task group reviewed risk description and amended to incorporate protected characteristics and BAME individuals. (DNQ) • Equality action plan including annual review of EIA, improved data capture and evidence of equality considerations is being developed. (DS) (February 2021) Tools developed to capture include: ○ Checklist approach for equality, engagement and communication. ○ Equality Impact Assessment (EIA) quick decision tool and action log.	DNQ	Ongoing during Covid-19 pandemic	EMT (monthly)	4 Yellow / moderate (4-6)	EIC		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description of risk	Current control measures	Consequence (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• Support / advice provided on shielding to LD patients and their families.					○ 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. • Equality, Involvement, Communication and Membership strategy supporting delivery action plans under development following strategy approval. (DS) (February 2021) • Quality improvement initiatives to continually improve recording and insight. (DNQ) (ongoing) • Roll out and implementation of the action plan related to the Physical Health Optimisation Strategy. (MD) (April 2021) • Easy read versions of new information being developed. • Staff training plan to be initiated on use of translation and interpretation services. • PPE guidance managing communication with those who use non-verbal communication. carers assessments reviewed in context of Covid-19 support. • Additional guidance from community based learning disability teams to families and carers. • Learning disability VIP cards reviewed.							
1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.	• New ways of working introduced to enhance clinical contact. • Routine caseload risk scan by responsible clinician and local trio. • Complaint and concern monitoring. • 24 hour helpline available for service users and general public. • Revised guidance issued to clinicians to support appropriate clinical review. • CAMHS “we are still here” campaign. • Enhanced activity data reporting into IPR highlighting themes and trends. • ICS system wide working to improve awareness of secondary services being open for routine referral.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Risk to be considered as part of restoration and reset workstream. (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) (March 2021)	DNQ / MD	Ongoing	EMT (monthly)	4 Yellow / moderate (4-6)	CG&CS		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic**.**	• Process to receive and implement national guidance. • Command structure for decision-making. • Existing policies and procedures. • Decision logs. • Use of internal professional expertise. • Use of risk assessments. • Committee structure. • Trust understanding of Equality law – training / EIA process and governance.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Ongoing review of leave entitlement for inpatient service users. • Ongoing review and implementation of national guidance. • Regular reinforcement of key messages to staff. • Ongoing review of visitor policy. • Checklist approach for Equality, Engagement and Communication. • Equality Impact Assessment (EIA) quick decision tool and action log.	DFR		EMT (monthly)	6 Yellow / moderate (4-6)	AC		Every three months prior to busi-ness and risk Trust Board – January 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
		• 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.					• Consent letters and verbal contact being made with all service users in respect of sharing out of data. (March 2021) • Reset and recovery of services. • Review of estates requirements. (DHR) • Regular consideration of staff wellbeing offers. (DHR)							weekly Covid-19 review
1533	Risk that as a number of key workforce activities have stopped they could cause future problems around burnout and resilience, professional and personal development, staff and service safety.	• Workforce support to remain operational. • Additional bereavement support to be kept in place. • Great place to work to be re-focused. • Workforce planning arrangements to continue with Learning Needs Analysis. • Staff and Mangers advice line operating extended hours. • Self help guide for managers and teams. • Managers and team leaders coaching support. • Healthy teams self-help guidance. • Team coaching to support wellbeing and resilience. • Staff counselling availability. • National Health and Wellbeing offer to be maintained for at least 12 months. • Bring Back Staff support to be reviewed to support staff leave and training.	3 Moderate	3 Possible	9 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Review of essential training provision being undertaken. (DHR) • Wellbeing plans developed for each BDU. (DHR)	DHR		EMT (monthly)	4 Yellow / moderate (4-6)	WRC		Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.	• Occupational health service operating extended hours. • Coronavirus psychological support line for staff operating 7 days a week. • Support arrangements for shielded staff introduced. • Health and wellbeing support centre as part of the Workforce Support Hub. • Staff and managers advice line operating 7 days a week. • Self help guide for manager on their own and teams wellbeing and resilience. • Managers and team leaders coaching to support wellbeing and resilience. • Healthy teams self-help guidance. • Team coaching to support wellbeing and resilience. • Staff counselling availability.	4 Major	3 Possible	12 Amber / high (8-12)	Minimal / low – Cauti-ous / moder-ate (1 – 6)	• Review of BAME staff risk assessment to be undertaken. (DHR) (January 2021)	DHR	Ongoing	Command structure of Gold, Silver, Bronze (daily) Trust Board through IPR (monthly) Safer staffing reports (monthly)	8 Amber / high (8-12)	EIC	It has been agreed to ensure that workforce information is provided to the Trust Board and that the WRC will meet on an exception basis as directed by the Board. Aim is to reduce the risk level to 8 which remains outside the current risk appetite. Further	Every three months prior to busi-ness and risk Trust Board – January 2021 & weekly Covid-19 review

Risk ID	Description of risk	Current control measures	Consequen -ce (current)	Likelihood (current)	Risk level (current)	Risk appetite	Summary of Risk action Plan to get To Target Risk Level and individual risk owners	Overall Risk owner	Expected Date of completion	Assurance & monitoring	Risk level (target)	Nominated Committee	Comments	Risk review date
		• Link to the national health and wellbeing offer. • BAME staff health and wellbeing taskforce established. • Staff and BAME staff review meeting. • BAME health and wellbeing project manager appointed. • Ongoing review of national and international evidence and research. • Health lifestyle support on Stop Smoking and weight management. • Increased monitoring of Covid-19 BAME staff absence. • Staff testing arrangements available to all staff. • Support and engagement from the BAME Staff Equality Network. • Management guidance on support and risk assessment for BAME staff. • BAME staff Covid-19 risk assessment. • BAME health and wellbeing videos. • Equality Impact Assessment of staff health and wellbeing offer and occupational health.							WRC (as appropriate)			reductions may require revision on the Business Continuity Plans.	

Risks within the risk appetite

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

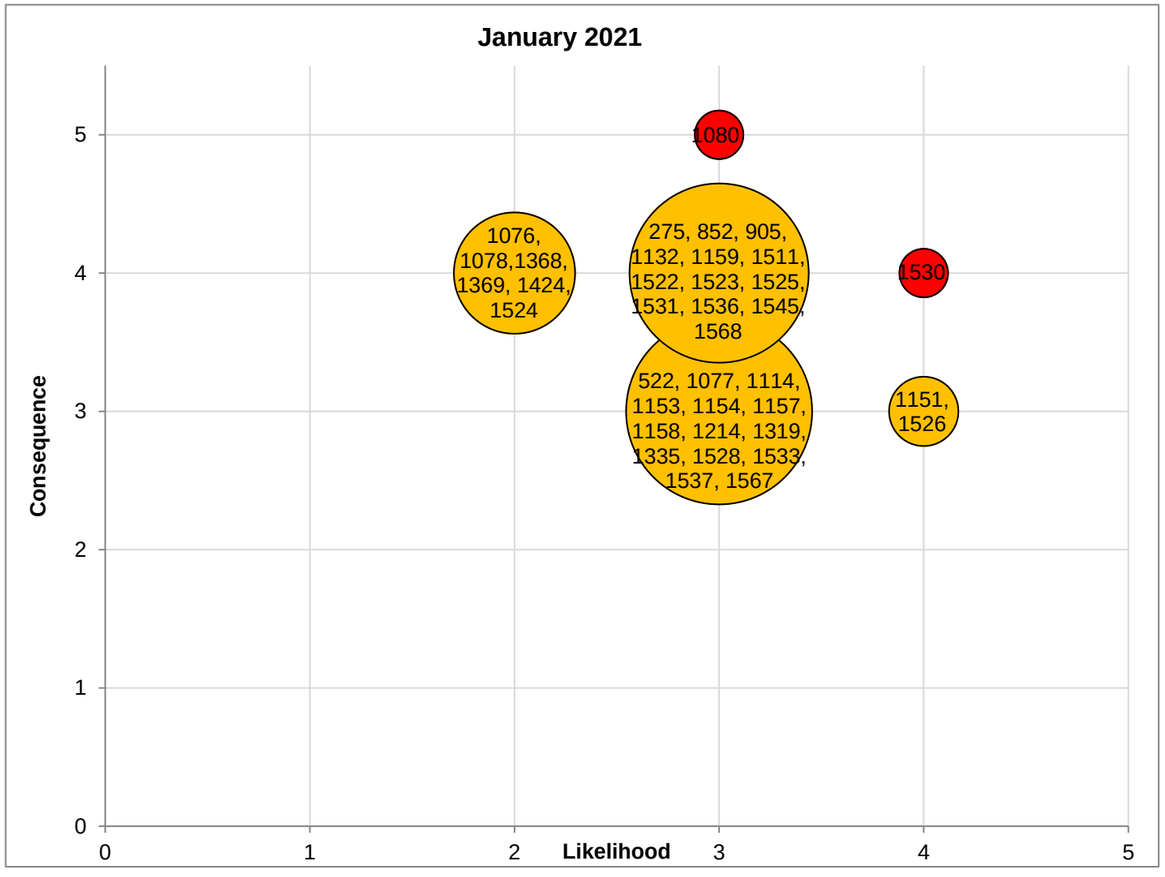
South West Yorkshire Partnership NHS Foundation Trust

Risk profile (risks outside the risk appetite) **– Trust Board 26 January 2021**

Risk ID	Risk description	Jan-20	Apr-20	Jul-20	Oct-20	Jan-21	Notes
275	Risk of deterioration in quality of care due to unavailability of resources and service provision in local authorities and other partners.	12	12	12	12	12	
522	Risk that the Trust's financial viability will be affected as a result of changes to national funding arrangements.	6	6	9	9	9	Risk level reduced Jan 20, within risk appetite Apr 20, increased Jul 20.
852	Risk of information governance breach and / or non-compliance with General Data Protection Regulations (GDPR) leading to inappropriate circulation and / or use of personal data leading to reputational and public confidence risk.	12	12	12	12	12	
905	Risk that wards are not adequately staffed and there is insufficient access to temporary staffing which may impact upon quality of care.	9	12	12	12	12	
1076	Risk that the Trust may deplete its cash given the inability to identify sufficient CIPs, the current operating environment, and its capital programme, leading to an inability to pay staff and suppliers without DH support.	8	8	8	8	8	
1077	Risk that the Trust could lose business resulting in a loss of sustainability for the full Trust from a financial, operational and clinical perspective.	9	9	9	9	9	
1078	Risk that young people will suffer serious harm as a result of waiting for treatment.	8	8	8	8	8	
1080	Risk that the Trust's IT infrastructure and information systems could be the target of cyber-crime leading to theft of personal data.	15	15	15	15	15	
1114	Risk of financial unsustainability if the Trust is unable to meet cost saving requirements and ensure income received is sufficient to pay for the services provided.	9	9	9	9	9	
1132	Risks to the confidence in services caused by long waiting lists delaying treatment and recovery.	12	12	12	12	12	
1151	Risk of being unable to recruit qualified clinical staff due to national shortages which could impact on the safety and quality of current services and future development.	12	12	12	12	12	
1153	Risk of potential loss of knowledge, skills and experience of NHS staff due to ageing workforce able to retire in the next five years.	9	9	9	9	9	
1154	Risk of loss of staff due to sickness absence leading to reduced ability to meet clinical demand etc.	9	9	9	9	9	
1157	Risk that the Trust does not have a diverse and representative workforce and fails to achieve EDS2, WRES and WDES.	9	9	9	9	9	
1158	Risk of over reliance on agency staff which could impact on quality and finances.	9	9	9	9	9	
1159	Risk of fire safety – risk of arson at Trust premises leading to loss of life, serious injury and / or reduced bed capacity.	12	12	12	12	12	
1169	Risk that improvements in performance against the metrics covering open referrals, unvalidated progress notes and un-outcomed appointments are not made leading to clinical risk and poor outcomes for service users.	9					Risk managed at BDU level.
1214	Risk that local tendering of services will increase, impacting on Trust financial viability.	9	9	9	9	9	
1216	Risk that the impact of General Data Protection Regulations (GDPR) results in additional requirements places on the Trust that are not met or result in a financial penalty.	8					Risk merged with risk ID 852 Jan 20.
1319	Risk that there will be no bed available in the Trust for someone requiring admission to hospital for PICU or mental health adult inpatient treatment and therefore they will need to be admitted to an out of area bed. The distance from home will mean that their quality of care will be compromised.	9	9	9	9	9	
1335	Risk that the use of out of area beds results in a financial overspend and the Trust not achieving its control total.	9	9	9	9	9	
1368	Risk that given demand and capacity issues across West Yorkshire and nationally, children and younger people aged 16 and 17 requiring admission to hospital will be unable to access a CAMHS bed. This could result in serious harm.	8	8	8	8	8	
1369	Risk that a "no-deal" Brexit has implications for the Trust including product availability, medicines availability and staffing.	12				8	Closed Jan 20. Re-opened Dec 20, will be closed and further risk included to reflect the current Brexit position.
1424	Risk of serious harm occurring from known patient safety risks, with a specific focus on: inpatient ligature risks, learning from deaths & complaints, clinical risk assessment, suicide prevention, restraint reduction, Covid-19.	8	8	8	8	8	
1511	Risk that carrying out the role of lead provider for forensics across West Yorkshire will result in financial, clinical and other risk to the Trust.		12	12	12	12	
1521	Risk that staff do not have appropriate IT equipment and access to facilitate home-working during the Covid-19 pandemic meaning staff unable to work effectively or provide appropriate clinical contact and key activities not delivered.		8	4			Risk level within risk appetite Jul 20.
1522	Risk of serious harm occurring to staff, service users, patients and carers whilst at work or in our care as a result of contracting Covid-19.		12	12	12	12	
1523	Risk of serious harm occurring in core services as a result of the intense focus on the management of the Covid-19 outbreak.		12	12	12	12	
1524	Risk that staff do not have access to necessary personal protective equipment (PPE) during the Covid-19 outbreak leading to issues with personal safety.		12	12	8	8	
1525	Risk the impact of Covid-19 results in the Trust having insufficient staff at work resulting in a risk to safety, quality of care and ability to provide services.		12	12	12	12	
1526	Risk that staff health and wellbeing is adversely affected by the impact of the coronavirus on service users, their families and themselves.		12	12	12	12	

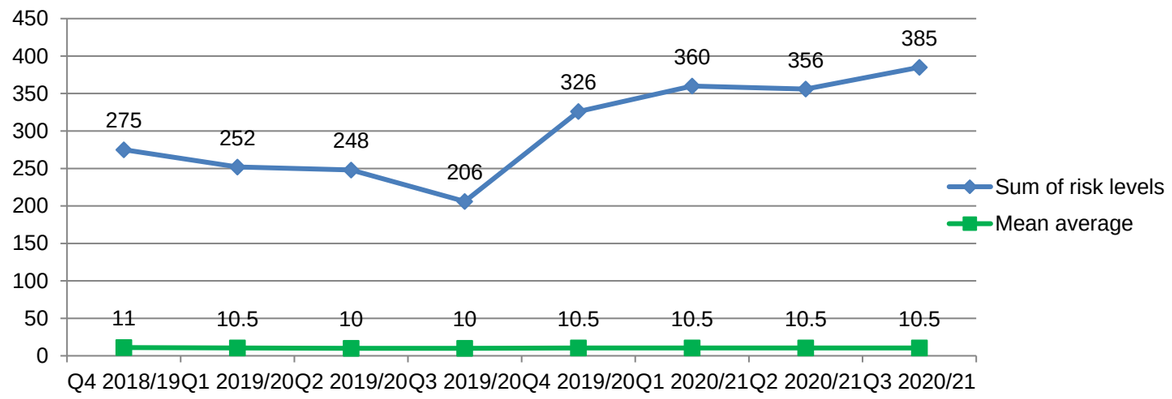
Risk profile (risks outside risk appetite) **– Trust Board 26 January 2021**

1528	Risk that new models of care arising from Covid-19 are not adequately tested, leading to a deterioration in the quality of care.		9	9	9	9
1530	Risk that Covid-19 leads to a significant increase in demand for our services (as anxiety and mental health issues increases in our populations) that cannot be met.		16	16	16	16
1531	Service users with protected characteristics and specifically from a BAME background and people with a learning disability may be disproportionately affected by Covid-19.		12	12	12	12
1533	Risk that as a number of key workforce activities have stopped they could cause future problems around burnout and resilience, professional and personal development, staff and service safety.		9	9	9	9
1536	BAME staff health and wellbeing is disproportionally adversely affected by the impact of the Coronavirus.			12	12	12
1537	Risk that Covid-19 response arrangements restrict opportunities for current service users to engage in dialogue, resulting in late presentation.			9	9	9
1545	Increased risk of legal action as a result of decisions taken or events that have taken place during the Covid-19 pandemic.			12	12	12
1567	Inability to meet the competing demand of responding to the second wave of the pandemic, the regulatory reporting and restoration drives.					9
1568	There is a risk that a seclusion room will not be available when required which will place staff and service users at an increased risk of harm due to damage that has occurred to a number of seclusion rooms. This risk is present due to the current increased acuity.					12



2018/19	2019/20				2020/21		
Q4 (25 risks)	**Q1** (24 risks)	**Q2** (24 risks)	**Q3** (21 risks)	**Q4** (31 risks)*	**Q1** (34 risks)*	**Q2** (34 risks)*	**Q3** (37 risks)*
11	**10.5**	**10**	**10**	**10.5**	**10.5**	**10.5**	**10.5**

*includes Covid-19 related risks



South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 8.3

Title:	**Infection Prevention & Control Board Assurance Framework**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To appraise and provide assurance to the Trust Board in relation to the Infection Prevention & Control Board Assurance Framework (IPC BAF).
Mission / values:	Providing safe care for people who use our services and our staff. Maintaining assurance processes to ensure we work to achieve all our Trusts values.
Any background papers / previously considered by:	Regular IPC updates provided to Clinical Governance & Clinical Safety Committee, IPC BAF process update
Executive summary:	NHS England developed the IPC BAF framework to help providers assess themselves against Public Health England national guidance that has been produced during the Covid-19 pandemic. The intention is that the framework is used as a source of internal assurance that quality standards are being maintained. The IPC legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. The IPC BAF has been structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. **In SWYPFT we have used the tool to:** • Provide assurance to trust board that organisational compliance has been systematically reviewed. • Identify areas of risk and highlight the mitigating actions we have in place. **Approach** • Key individuals (IPC specialists, estates staff, operational staff, professional advisors) have reviewed Trust evidence against the framework to provide high level assurance, assess immediate risks and consider mitigating actions. • A summary table of evidence, risk and mitigation has been completed. • The CQC have subsequently reviewed our plan.

	Findings • Updated findings are that all relevant PHE guidance, published up to 19 January 2021, has been adopted in the Trust and is being followed, mitigated, or plans are in place to address. • The emergency response framework has provided a robust structure for the organisation to follow during the Covid-19 pandemic all appropriate central and regional guidance has been scanned and actioned through command structure with a robust log of decisions and actions noted. • There is a gap in our assurance with regards to being able to isolate acutely unwell service users on our wards. We are not alone with the challenge, and a group has been established to review best practice. • The overall summary outlines key findings from their assessment, including any innovative practice or areas for improvement. **Next steps** • NHSE will update this framework as PHE guidance is being refreshed. The IPC TAG will provide the governance framework for monitoring our compliance with this document. • The SWYPFT Infection Prevention & Control Board Assurance Framework document will be reviewed on a 3 monthly basis (or sooner as required) and submitted to the Clinical Governance & Clinical Safety Committee at relevant points. **Risk Appetite** • This report provides assurance to the Trust Board in relation to the Infection Prevention & Control Board Assurance Framework. • This meets the clinical risk appetite – low and the risk target score 1-6.
Recommendation:	**Trust Board is asked to RECEIVE the IPC Board Assurance Framework as assurance that the appropriate standards are in place.**
Private session:	Not applicable.

SWYPFT Infection prevention and control board assurance framework

January 2021

SWYPFT Infection prevention and control Board Assurance Framework

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

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

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • compliance with the national guidance around discharge or transfer of COVID-19 positive patients • monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice • monitoring of compliance with personal protective equipment (PPE), consider implementing the role of PPE	SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19 includes: ○ Pre-admission screen ○ SWYPFT COVID-19 Infection Prevention and Control SOP for Inpatient areas immediately a case of COVID 19 is possible / confirmed ○ Admission principles ○ Pathway for admission ○ Action to take to reduce the risk of COVID 19 getting into the wards ○ Minimizing the impact of risk factors for serious COVID 19 disease in our patients ○ Process for symptomatic patients (protocols for testing pts on admission and leave, AWOL etc.)	No gaps noted in this domain from our internal assessment.	Not applicable.

guardians/safety champions to embed and encourage best practice • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way • changes to guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the board assurance framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens • that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient	○ Supporting people on Oxygen ○ Care planning and risk assessments ○ Mental health act/ mental capacity act ○ Management of acute distress and disturbance ○ Transfer of care ○ Discharge process ○ Care of the deceased ○ Training for staff (including PPE) ○ Staff wellbeing and support IPC monitoring compliance via ward leadership, IPC walk rounds. Environmental audits undertaken and action plans produced from finding. The Trust has followed Public Health England (PHE) guidance on PPE use IPC have provided training and guidance on putting on and removing PPE Active participant question and answer sessions and Q&A on intranet Bronze PPE cell - system for monitoring usage and stock of PEE		

protocols are activated in a timely manner. • ensure Trust Board has oversight of ongoing outbreaks and action plans.	Poster campaign on use of PPE Coronavirus dedicated Intranet information pages IPC are supporting ward managers and matrons to monitor PPE compliance, to embed practice. National guidance is regularly reviewed. COVID19 inbox is regularly monitored. Any new guidance is reviewed and effectively communicated through respective internal command structures. Ensuring timely, clear communication with staff. Board is regularly briefed on risk associate with new guidance. Action plans and assessment are produced to mitigate risk. The emergency planning structure was used to check for guidance, place it appropriately, interpret and apply to practice. Communication was through daily brief and operational structures Infection, Prevention & Control policies, procedures and guidance and training updated or		

	developed in line with national guidance. IPC colleagues supported the implementation of changes to policy and practice by floor walking exercises on clinical areas Robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens (MRSA, C-Diff, E-Coli, MSSA, CPE) The Trusts DIPC signs off data submissions and any associated sitrep. Ensuring accurate data flows, in a timely manner. Electronic reporting systems in place are DATIX, Sharepoint, SystmOne, COVID-19 email account. Reporting to PHE as per responsibilities on infections and outbreaks and RCA outbreak reports are reported into the clinical risk panel review. The		

	learning from outbreak reviews are being fed into SOP's and guidance for staff. Outbreak reports and additional actions are reported through silver and respective bronze command meetings. The trust has oversight of ongoing outbreaks and action plans.		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas • designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19 provides the evidence based to care for and treat patients in COVID 19 isolation and cohort areas Housekeepers working on the inpatient areas were fully briefed regarding required cleaning	No gaps noted in this domain from our internal assessment.	Not applicable.

• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance • increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance • cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses • Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	requirements and were supplied with PPE The evidence to support cleaning of premises and equipment can be found in the following documents, which include cleaning schedules, products to use and general guidance for staff: o Environmental Cleaning process; which includes process following a possible or confirmed case o Decontamination procedure is in place in line with National NHS England guidance and the Trust Cleaning Policy o Evidence is included in the COVID-19 Infection Prevention and Control SOP for Inpatient o Laundry and Infection Prevention and Control Policy o Medical Devices Policy Monitoring environmental cleanliness:		

• ‘frequently touched’ surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should cleaned a minimum of twice daily • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken • single use items are used where possible and according to single use policy	○ Environmental audit, including cleaning, nursing and estates remits, are undertaken by the in-house monitoring team along with IPC, with frequencies determined by risk area ○ IPC reviews of cohort areas ○ Environment monitoring is undertaken, score collated, and action plans produced. Feedback through ward managers for action. ○ A deep clean team works to an annual plan, with frequencies determined by use of area as per National Standards of Healthcare Cleanliness (awaiting final confirmation of agreed standards) ○ A full review of cleaning services, including frequencies, methodologies, functional risk areas is in progress We only use single use cleaning items of equipment.		

• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance • ensure cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment • ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air • there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	We have reviewed and ensured good ventilation in admission and waiting areas to minimise opportunistic airborne transmission Discussion took place in Silver command on the review of COVID19 patient pathways. No area assessed as low risk pathway.		

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

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• implementation of national guidance on visiting patients in a care setting • areas in which suspected or confirmed COVID-19 patients are being treated in	Visiting guidance (currently by appointment only), poster and leaflet available on intranet and internet with easy to read versions available	No gaps noted in this domain from our internal assessment.	Not applicable.

areas clearly marked with appropriate signage and have restricted access ● information and guidance on COVID-19 is available on all trust websites with easy read versions ● infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved ● there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Service user leaflets and guidance available in poster format on the wards and on SWYPFT website. Easy read information available Medical/nursing staff communicate with service user(s) and/or their carer's as appropriate Staff updates communicated timely via Trustwide Communications – Headlines, CE Brief, CE Update (was daily now weekly) Social media campaigns Infection status is on the intra-health care transfer form held within the IPC Risk Assessment Policy for Admission, discharge and transfer There is clear written information available for the hands, face, space guidance available for staff patients, and visitors		

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases**.** • front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non Covid- 19 cases to minimise the risk of cross-infection as per national guidance • staff are aware of agreed template for triage questions to ask • triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate	The evidence for this domain can be found in: SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19 includes: ○ Pre-admission screen ○ SWYPFT COVID-19 Infection Prevention and Control SOP for Inpatient areas immediately a case of COVID 19 is possible/ confirmed ○ Admission principles ○ Pathway for admission ○ Action to take to reduce the risk of COVID 19 getting into the wards ○ Minimizing the impact of risk factors for serious COVID 19 disease in our patients ○ Process for symptomatic patients (protocols for testing pts on admission and leave, AWOL etc.) ○ Supporting people on Oxygen	No gaps noted in this domain from our internal assessment.	Not applicable.

pathway as soon as possible • face coverings are used by all outpatients and visitors • face masks are available for patients with respiratory symptoms • provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care • ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff. • for patients with new-onset symptoms, isolation, testing and instigation of contact tracing is achieved until proven negative • patients that test negative but display or go on to develop	○ Care planning and risk assessments ○ Mental health act/ mental capacity act ○ Management of acute distress and disturbance ○ Transfer of care ○ Discharge process ○ Care of the deceased ○ Training for staff (including PPE) ○ Staff wellbeing and support COVID-19 Essential Community Visits Standard Operating Procedure COVID19 Patient/service user assessment and infection prevention and control guidance, continues agreed triage questions of clinical, competent staff to use when assessing patient/service user. Face masks are available for all patients/service users and visitor (risk assessed and if able to tolerate). There is clear guidance on the use of masks for patients/service users		

symptoms of COVID-19 are segregated and promptly re- tested and contacts traced promptly ● patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately			

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
● separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas ● all staff (clinical and non-clinical) have appropriate training, in line with latest national guidance to ensure	Separation of pathways are contained in the SWYPFT Standard Operating Procedure (SOP) - The management of a patient/ patients with possible or confirmed COVID 19. There is also operational separation, isolation, cohort, restricted access in the Outbreak Policy. There is information and clear signage is available in the	No gaps noted in this domain from our internal assessment.	Not applicable.

their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely • a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed • any incidents relating to the re- use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:	COVID19 Clinical pathway guidance document. All staff (clinical and non-clinical including bank/agency, contractors and volunteers) have appropriate training, as per guidance, to ensure their personal safety and working environment is safe; IPC training, training needs analysis for the cohort wards, additional training for medical staff, IPC walk arounds, Q&A's, Policy and Procedures on intranet, Control of Contractors document, signed by the contractor All staff (clinical and non-clinical including bank/agency) providing patient care are trained in the selection and use of PPE appropriate for the clinical situation, and on how to safely don and doff it; SOPs, Q&A on intranet, video films, posters		

• hand hygiene facilities including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas • staff regularly undertake hand hygiene and observe standard infection control precautions • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent,	ESR has records of donning & doffing, FFP3 mask fit testing and swabbing Hand hygiene is mandated training. Guidance available in poster format on the wards and on SWYPFT website PPE is not reused in the Trust Incidents related to PPE are recorded on DATIX, incident management system. A weekly report is produced for risk panel. The IPC team review every incident and offer specialist advise We have the bronze PPE meeting which is a stock audit and any concerns raised are dealt with in a timely manner. Audit of staff adherence to IPC precautions is noted visually in walk arounds by IPC and matrons– 'check and challenge'. IPC floor walkers, messages in the comms from CEO re: hand		

disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance • guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas • staff understand the requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE national guidance and other if they or a member of their household display any of the symptoms • a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset	hygiene and IPC link professionals continually reinforce IPC precaution messages. Hand dryers are in situ in Folly Hall however hand towels are also available Scrubs are being introduced in MH services where laundering facilities are used. The Trust has Standard operating procedure for staff clothing during the coronavirus pandemic. Staff understand the requirements of action to take, if they or a member of their household displays any of the symptoms. Evidence (contacts with OH, managers, HR) suggests staff are following this guidance. P&I have information recorded that supports this standard. Clear guidance, posters and leaflets are available on the control measures hand, face and space.		

cases (staff and patients/individuals) • positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. • robust policies and procedures are in place for the identification of and management of outbreaks of infection	The environment and medical devices are cleaning in-line with government guidance and trust guidance on cleaning and decontamination. There are structures in place for the continued ongoing surveillance of infection rates, through various governance structures and meetings. Internal surveillance of infection rates is undertaken by infection prevention and control team. All positive cases are reviewed. If there are two or more linked cases, outbreak procedure and policy is triggered.		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure:			
• restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID- 19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring	Discussing took place in Silver command on the review of COVID19 patient pathways. No area assessed as low risk pathway. IPC Policies and procedures in place to supplement decisions made e.g. Outbreak Management, Isolation Policy. Where possible, service users with possible or confirmed COVID-19 are isolated appropriately in designated areas as detailed in Cohort plan and Inpatient SOP IPC has inspected all cohort areas to ensure compliance with environmental requirements set out in the current PHE national guidance SWYPFT Coronavirus dedicated information pages via Intranet There has been a review of facilities for appropriate, effective isolation. This has been raised for estate capital programme to consider upgrading existing en-suite facilties.eg Sandal	Isolation of some patients can be difficult due to acuity of patient mental health presentation.	The Trust uses a person-centered plan, utilising the least restrictive option principle, necessity and proportionate for isolation of patients. The trust has formed a task and finish group to appraise and review current patient isolation processes, procedures, risks and guidance. The group will seek solutions and provide plans to gain compliance with isolation and cohorting of patients, and will report to Silver Command.

appropriate patient placement			

8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• ensure screens taken on admission given priority and reported within 24hrs • regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available • testing is undertaken by competent and trained individuals • patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance • regular monitoring and reporting that identified cases have been tested	COVID19 inpatient – screening guidance flow chart. Service user SWYPFT has a service level agreement in place with BHNFT and Mid Yorkshire Hospitals for laboratory support. Calderdale laboratory have capacity to test patients in that area. ○ There is adequate lab capacity for admission, discharges and symptomatic patients. ○ There is adequate lab capacity for outbreaks or hotspot. ○ There are also options for staff testing through pillar 1 and Pillar 2.	No gaps noted in this domain from our internal assessment.	Not applicable.

and reported in line with the testing protocols (correctly recorded data) • screening for other potential infections takes place	IPC are undertaking a review of the turnaround time of results. These laboratories operate according to relevant national accreditation bodies standards IT Surveillance system operational in Barnsley, an electronic weekly surveillance system with Mid-Yorks (has been daily during COVID-19) microbiology for any alert organisms and additionally support system for Calderdale and Kirklees with IPC team for any alert organisms There is regular monitoring and reporting of identified cases that have been tested and reported in line with the testing protocols ensuring accurate recording of data. Staff Swabbing SOP and Inpatient SOP		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help prevent and control infections

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure:			
• staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance • PPE stock is appropriately stored and accessible to staff who require it	Policies are in line with Assurance framework in the Health and Social Care Act (2008) and all IPC Policies are in date Information received via the COVID-19 email account and communicated via Silver command and comms and SOP's updated accordingly. IPC Policies and Guidance available on the Intranet IPC Quality Improvement Programme in place; policies are routinely audited to seek assurance on compliance, to identify gaps, enable robust action plans to be determined and put in place to rectify any identified issues. Action Plan outcomes are sought to collate lessons learned and improvements made	No gaps noted in this domain from our internal assessment.	Not applicable.

	Localised SOPs and Guidance created in response to COVID-19 SOP- management of MH/LD patients during COVID -19, including cohort plan and physical health management SOP - Laundering of staff clothing and scrubs The Trust waste management Policy and the IPC Community and Inpatient SOP's PPE stock is held by procurement and process managed by operational staff.		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure:			
• staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported	All staff have access to Occupational Health services Policies, procedures, guidance, dedicated support provided along with information on how to access services, self-support on the staff Intranet	No gaps noted in this domain from our internal assessment.	Not applicable.

• that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff • staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally • staff who carry out fit test training are trained and competent to do so • all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation	Risk assessment for vulnerable groups (including BAME), pregnant staff, shielded, clinical extremely vulnerable staff etc. within OH guidance and National directive – intranet well-being pages, support contact numbers Work health assessments in place Staff health and well-being have offered Antigen testing and antibody testing for staff in-line with government initiatives. Sign up to the national SIREN study FFP3 training in provided by certificated, competent personnel, a record is kept and held on ESR. Staff who fail the fit test are tested on different models and alternative FFP3 masks. Any staff that fail to be adequately fit tested are referred to Occupational health and discussion and process around redeployment are employed using a nationally agreed algorithm.		

• for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods • for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health • following consideration of reasonable adjustments e.g. respiratory hoods, personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm	Monitoring of social distancing rules by operational staff and IPC – check and challenge. We have posters displayed across the Trust and regular messages are posted in chief exec bulleting. A range of information is available to staff. Q&A's are on Trust website Occupational Health Policy and Track and Trace – information on the intranet of how to access testing Information on the intranet, IPC specialist advice and Occupational health support – all documented on Sharepoint. Clear instruction and information are provided through various media and communication channels for all staff (clinical and non-clinical staff) around COVID safety measures and the wearing of face masks for everyone. Workplace risk assessment have been undertaken to minimise and mitigate workplace risks. Robust system is in place for the absence monitoring and staff well-being who are self-isolating.		

and a record kept in staff members personal record and Occupational health service record ● boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board ● consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance ● all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas ● health and care settings are COVID-19 secure	Any staff self-isolating have access to information, COVID help line and have robust discussion with manager to aid support on return and recovery.		

workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone • staff are aware of the need to wear facemask when moving through COVID-19 secure areas. • staff absence and well-being are monitored and staff who are self- isolating are supported and able to access testing • staff who test positive have adequate information and support to aid their recovery and return to work			

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 8.4

Title:	**Ockenden Maternity report (December 2020)**
Paper prepared by:	Director of Nursing and Quality
Purpose:	The purpose of the paper is to provide an overview of the findings of the Independent Review of the Maternity services at the Shrewsbury and Telford Hospital. The identified lessons learnt and recommendations have been considered with a log of any actions that we SWYPFT are required to take or have taken to ensure that patient safety is improved.
Mission/values: ➢	• We are respectful, honest, open and transparent. • We put the person first and in the centre. • We are always improving.
Any background papers/ previously considered by:	N/A
Executive summary:	In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the Shrewsbury and Telford Hospital NHS Trust, NHS Improvement was instructed to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at the Shrewsbury and Telford Hospital NHS Trust. The learning of lessons and embedding of meaningful change at the Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future. **Points for consideration for South west Yorkshire Partnership NHS Foundation Trust** 1. Does the Trust have mechanisms in place for the governance and oversight of maternity incidents? Yes, all services are committed to a safety culture where adverse incidents, near misses and serious incidents are reported via the Trust incident reporting system, Datix. All reported incidents are reviewed and approved within seven working days from being reported. This is to verify the incident details and grade are correct and that immediate actions have been taken to identify if a further review is required. All potential serious incidents are reports on the same or next working day. Datix automatically sends an alert to inform senior managers, responsible directors and the patient safety team.

	2. Are incidents and investigations reported and conducted in line with National and Trust Policies, that are relevant at the time? Yes, all patient safety incidents recorded on Datix are routinely reported to NHS England and NHS Improvement through the National Reporting and Learning System (NRLS) by the Patient Safety Support Team following approval. These are reported onwards to the Care Quality Commission (CQC). 3. Are families involved in the investigation in an appropriate and considerate way? Yes, The Trust Being Open Policy provides staff with a set of principles that should use when communicating with service users, their families or carers following any incident in which a service user was harmed. The review of the Trusts commitment to a safety culture provides assurance that all reported incidents are reviewed and that families are involved in any investigation is conducted.
Recommendation:	**Trust Board is asked to RECEIVE and comment on the report.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Ockenden Maternity Report (December 2020)

Background

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the NHS Improvement was instructed to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

The independent maternity review is focusing on all reported cases of maternal, neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (grades 2 and 3) and other severe complications in mothers and newborn babies. A total of 1,862 families will be included in the final report, this is the findings of the first report which included a review of 250 mothers and their babies.

The methodology included:

- Listening to family voices
- Listening to the views and voices of staff working at the Trust
- Review of the Trust's maternity governance processes.

This paper has considered the report which is primarily focused on Midwifery services within Acute hospital Trusts however the learning from the report has been considered by the Nurse Advisor for Safeguarding Children and the Perinatal Mental Health Team to ensure that the findings and recommendations are introduced and embedded into practice to further improve patient safety.

Introduction

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones.

The families want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past.

The learning of lessons and embedding of meaningful change at the Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

After reviewing 250 cases and listening to many more families, this first report identifies themes and recommendations for immediate action and change, both at The Shrewsbury and Telford Hospital NHS Trust and across every maternity service in England.

With the support of the Department of Health and Social Care and NHS England and Improvement emerging findings and themes, have formed **Local Actions for Learning** and made early recommendations which are **Immediate and Essential Actions** for the hospitals but also for thorough consideration within all maternity units across England.

Neighbouring trusts and their maternity services **must** work together with immediate effect to ensure that local investigations into all serious incidents declared within their maternity services are subject to external oversight by trusts working together. This is essential to ensure that effective learning and impactful change to improve patient safety in maternity services can take effect using a system wide approach and in a timely manner.

Findings

The roles of midwives and obstetricians in the multidisciplinary maternity team

- The close working relationship that is required between midwives and obstetricians for the benefit of mothers and babies within their collective care.

Compassion and kindness

- One of the most deeply worrying themes that has emerged is the reported lack of kindness and compassion from some members of staff.
- There have been cases where women and their families raised concerns about their care and were dismissed or not listened to at all.
- There are several examples from the cases reviewed indicating that minimal learning has occurred and that this lack of compassion and kindness has persisted.

Place of birth: Assessment of risk

- Once the decision on place of birth has been made, there should be a risk assessment at each antenatal appointment to ensure the decision remains appropriate. In many cases reviewed there appears to have been little or no discussion and limited evidence of joint decision making and informed consent concerning place of birth.
- There is evidence of poor consultant oversight of mothers with high-risk pregnancies; they either remained under midwifery-led care or were managed by obstetricians in training without appropriate and timely escalation.

Escalation of concerns

- The reviewers found a significant number of instances both of failure to recognise and escalate the management of deteriorating mothers by midwives to obstetricians, and by obstetricians in training to consultants. From the 250 cases reviewed these problems appear to continue across the review period, suggesting a failure to learn from other previous serious incidents.
- Services users appeared to have little or no freedom to express a preference

Bereavement care

- The Stillbirth and Neonatal Death Society (SANDS)19 states that high quality bereavement care involves a recognition of parenthood using sensitive and effective communication. There needs to be of these key issues an awareness of the grief and trauma that families may be going through. Compassion and kindness in care and communication by all members of the maternity team, parents may encounter, is essential. Such compassion can have a positive and long-lasting influence on the experience families have at this time.
- It is well known that the provision of support following a bereavement makes a significant difference to the family and how supported they feel. The quality of bereavement care can have a significant effect on the wellbeing of parents and their families in the time immediately following the loss and in the longer term.

Summary of Recommendations

1. A thorough **risk assessment** must take place at every appointment to ensure that the plan of care remains appropriate.
2. All members of staffing teams must provide service users with accurate and contemporaneous **evidence-based information** as per national guidance. This will ensure, that where possible, service users can participate equally in all decision making processes and make informed choices about their care.
3. Maternity services must ensure that women and their families are listened to with their **voices heard**.
4. It is recommended for **lead champions**. These colleagues must have sufficient time and resource in order to carry out their duties, including ensuring services are compliant with government guidelines.
5. Regional peer reviewed **learning** and assessment must take place. These auditable recommendations must be considered by the Trust Board
6. Staff must use NICE Guidance as and where available to care. Any deviations from this guidance must be documented, agreed within a multidisciplinary framework and made available for audit and monitoring.
7. The department clinical of governance structure and team must be appropriately resourced so that **investigations** of all cases with adverse outcomes take place in a timely manner.
8. Clinical governance structure must include a **multidisciplinary team** structure, Trust risk representation, clear auditable systems of identification and review of cases of potential harm, and adverse events.

Points for consideration for South west Yorkshire Partnership NHS Foundation Trust

1. Does the Trust have mechanisms in place for the governance and oversight of maternity incidents?
   Yes, all services are committed to a safety culture where adverse incidents, near misses and serious incidents are reported via the Trust incident reporting system, Datix. All reported incidents are reviewed and approved within seven working days from being reported. This is to verify the incident details and grade are correct and that immediate actions have been taken to identify if a further review is required.
   All potential serious incidents are reports on the same or next working day. Datix automatically sends an alert to inform senior managers, responsible directors and the patient safety team.

2. Are incidents and investigations reported and conducted in line with National and Trust Policies, that are relevant at the time?
   Yes, all patient safety incidents recorded on Datix are routinely reported to NHS England and NHS Improvement through the National Reporting and Learning System (NRLS) by the Patient Safety Support Team following approval. These are reported onwards to the Care Quality Commission (CQC).

3. Are families involved in the investigation in an appropriate and considerate way?
   Yes, The Trust Being Open Policy provides staff with a set of principles that should use when communicating with service users, their families or carers following any incident in which a service user was harmed.

Conclusion

The findings of the report and the recommendations have been considered by the Trust Perinatal team and the safeguarding children nurse advisor (dual registered midwife and general adult nurse) with consideration of any actions that South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) are required to take or have taken as a result of the report. The review of the Trusts commitment to a safety culture provides assurance that all reported incidents are reviewed and that families are involved

in any investigation is conducted. This report has been shared with general managers and the safeguarding team will respond to any queries that they have.

South West Yorkshire Partnership NHS Foundation Trust Action plan

Action	Person responsible	Date of completion
To continue to risk assess at every contact. Special care attention required following pregnancy birth and loss or bereavement	Service managers Clinical leads Patient Safety Manager Trust Risk Panel Perinatal team Audits Consultants	On-going
To develop the role of lead champions.	Perinatal team manager	June 2021
To ensure that all staff members are able to provide up to date evidence based information as per national guidance.	Nursing Directorate, Patient Safety Manager Perinatal team manager Perinatal team consultant	On-going
Recording of information should be contemporaneous and accurate in recording service user views and decision around their care	Governance leads Record keeping audits	On-going January 2022
To consider adopting national bereavement pathway for bereaved parents referred into the care of mental health services.	Perinatal Lead	June 2021
Clinical governance structure should include multidisciplinary reviews in reviewing incidents, deviations from NICE guidance and complaints. Ensuring escalation process is embedded in practice	Governance team Datix teams Multidisciplinary teams including local authority, local hospitals where they are involved in the care and also other services that are involved in the care of the service users	On-going
Ensuring all members of staff are aware of the impact of the perinatal period and mental health, in terms of trauma loss and bereavement	Safeguarding team Perinatal team Care co-ordinators BDU keyworkers	On-going

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 9.1

Title:	**South Yorkshire update including the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS)**
Paper prepared by:	Director of human resources, organisational development and estates and Director of strategy
Purpose:	The purpose of this paper is to update the Trust Board on the developments within the SYB ICS and Barnsley integrated care developments.
Mission /values / objectives:	The Trust's mission to **enable people to reach their potential and live well in their communities** will require strong partnerships working across the different health economies. It is, therefore, important that the Trust plays an active role in the SYB ICS.
Any background papers / previously considered by:	The Trust Board have received regular updates on the progress and developments in the SYB ICS, including Barnsley Integrated Care Developments.
Executive summary:	This paper provides an update on key developments across the South Yorkshire and Bassetlaw Integrated Care System and Barnsley Integrated Care developments. **1. SYB ICS** Strong partnership working in response to the COVID-19 pandemic remains the focus of the recent ICS meetings. Acute Trusts have been working well together on the management of intensive and critical care beds across the region. There are clear pressures associated with staffing and partners are also working on potential mutual aid arrangements. The overall COVID trend appears to be heading in the right direction and outbreaks are reducing. Sheffield Teaching Hospital is providing mutual aid on ICU/Intensive care beds to other parts of the country. The COVID vaccination programme is operating well and nearly 100,000 people have been vaccinated to date. Supply of vaccines is still a bit of concern.

The Flu vaccinating uptake has been the highest ever and this together with the social distancing has resulted in the lowest levels of Flu.

Discussions on recovery programmes/objectives for 20/21 has commenced with a focus on COVID Response; Reducing Health Inequalities; Workforce; and Recovery of Services.

The Trust had responded to the NHSI/E consultation and this has formed part of the overall ICS response.

2 SYB ICS Mental Health, Learning Disabilities and Autism programme

The ICS Mental Health Executive steering group has a number of programmes of work and below is an update on key developments. The programme group meets monthly. In addition to this, the CEOs of Mental Health Trusts have continued to regularly meet - the focus of these meetings has been on developing the Mental Health Provider Alliance.

2.1 Transformation Funding - Community Mental Health: Crisis Alternatives:

SYB ICS submitted to NHS England the first draft Transformation Funding Plan. The plan comprised a summary of proposals that had been developed in each 'Place.'

All STPs/ICSs in England will receive their 'fair share' of central transformation funding to deliver new models of integrated primary and community mental health care for adults and older adults with severe mental health problems. The transformation funding will support:

- A new, **inclusive generic community-based offer** based on redesigning community mental health services **in and around Primary Care Networks.**

- New models will also improve access and treatment for adults and older adults with **a diagnosis of 'personality disorder**', **eating disorders** and people with **mental health community-based rehabilitation needs.**

2.2 SYB Green Prescribing bid

Partners across the ICS have worked together to develop a bid to secure funding to enhance social prescribing and its links to green spaces for the population. The SYB bid has been successful and the Trust through Creative Minds will be a key partner in this work.

	2.3 SYB ICS Mental Health Provider Alliance In January 2020, the Chief Executives and Chairs of the Mental Health Providers serving the South Yorkshire and Bassetlaw population met and agreed to develop a formal Provider Alliance. The key reasons for agreeing this in SYB are: • To increase collaboration as outlined in national policy. • Integration across services through provider collaboratives. • The need to support and maximise the capacity of the local workforce. • To reduce unwarranted variation in quality. • To achieve economies of scale and efficiency savings. • To shape and influence strategic service design and associated investment decisions. The Health Care Executive Group supported the development of a more formal Mental Health Provider Alliance to strengthen established partnership arrangements. The work to develop the approach, principles, phases as part of the draft MoU has progressed and there is an opportunity for Board members to discuss the work to date in more detail in Private Board. **3. Barnsley Integrated Care update** All partners across Barnsley continue to work together to deliver a joined-up response to Covid-19. Partnership arrangements are in place to support decision making as close to the front line as possible. Community services continue to provide care as close to home as possible, working with primary care, social care and the wider CVS. The Community teams continue to play a critical role in supporting timely discharge from Barnsley Hospital. The Integrated Care Partnership continues to meet and has collectively responded to the NHSE/I proposals for Integrated Care Systems. **Risk Appetite** This update supports the risk appetite identified in the Trust's organisational risk register.
Recommendation:	**Trust Board is asked to NOTE the update from the SYB ICS and Barnsley integrated care developments.**
Private session:	Not applicable

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 9.2

Title:	**West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships Update**
Paper prepared by:	Director of Strategy & Director of Provider Development
Purpose:	The purpose of this paper is to provide the Trust Board with: 1. An update on key developments within West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) including response to Covid-19, winter planning and transformation priorities. 2. Local Integrated Care Partnership developments in Calderdale, Wakefield and Kirklees.
Mission/values:	The development of **joined up care and response to Covid-19** through **place-based arrangements** is central to the Trust's delivery of responsive services and support in places at this time. As such, it is supportive of our mission, particularly to **help people to live well in their communities.** **The way in which the Trust approaches strategic and operational developments must be in accordance with our values**. The approach is in line with our values - **being relevant today and ready for tomorrow**.
Any background papers/ previously considered by:	Strategic discussions and updates on place-based plans and developments have taken place regularly at Trust Board, including an update to October Trust Board.
Executive summary:	The Trust's Strategy outlines the importance of the Trust's role in each place it provides services, including the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP). The Trust has continued to work as a member of the partnership. **WYH Covid-19 response and winter planning** The partnership has continued to deliver a joined up response to Covid-19 across the region and in each of the places that make up the partnership. The partnership is also currently focused on ensuring the operational priorities set out for phase 4 are reflected in the winter plans. **NHSE/I Consultation Integrated Care Systems – Next Steps** The NHSE/I proposal for Integrated Care Systems was considered and discussed in detail at the Trust Strategy Board in December 2020. The Trust has responded to this through the places that we work and as partners in two Integrated Care Systems. Links to the West Yorkshire Partnership response are included in the full paper.

	WYH Independent Review Impact of Covid-19 on BAME communities and workforce - Partnership response The action plan developed in response to the findings and recommendations from the Independent Review chaired by Professor Dame Donna Kinnair was approved by the Partnership Board in December 2020. The link to the full report and action plan is included in the main paper for Trust Board to receive. **Mental Health, Learning Disabilities and Autism Collaborative** An overview of key work streams and developments being progressed collaboratively are included in the paper, including transformation funding to support the development of community and crisis services. **Place-based developments** We continue to work with partners to develop and deliver joined up Covid-19 response and winter plans in each of the places that we provide services. We also continue to contribute to place-based recovery and reset planning where there is capacity to do so safely. **Risk Appetite** The development of the partnership's response to Covid-19 and the development and delivery of place-based arrangements and response is in line with the Trust's risk appetite.
Recommendation:	**Trust Board is asked to RECEIVE and NOTE the updates on the development of the West Yorkshire and Harrogate Health and Care Partnership and place-based developments in Calderdale, Wakefield and Kirklees.**
Private session:	Not applicable.

West Yorkshire & Harrogate Health and Care Partnership and Local Integrated Care Partnerships - Update
Trust Board 26 January 2021

1. Introduction

The purpose of this paper is to provide an update to the Trust Board on the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP), focusing on developments that are of importance or relevance to the Trust. The paper will also include a brief update on key developments in local places that the Trust provides services.

2. Background

Led by the Trust's Chief Executive, Rob Webster, West Yorkshire and Harrogate Health and Care Partnership (WYH HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). It brings together all health and care organisations in six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

The West Yorkshire and Harrogate Health and Care Partnership emphasises the importance of place-based plans where the majority of the work happens in each of the six places (Bradford, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These build on existing partnerships, relationships and health and wellbeing strategies.

Collaboration is emphasised at West Yorkshire and Harrogate (WY&H) level when it is better to provide services over a larger footprint; there is benefit in doing the work once and where 'wicked' problems can be solved collaboratively.

3. WYH Covid-19 response and Operational Priorities

We have seen West Yorkshire shift from a position last year that saw the region experience some of the highest numbers of Covid-19 infection rates in the country to currently being amongst the lowest rates, however, these still remain very high. The Strategic Health group has continued meeting weekly to ensure that there is a co-ordinated approach and response to managing Covid-19, winter pressures and demands. The weekly system briefing meetings have continued and provide up to date information on partnership priorities and Covid-19 response plans. The national phase 4 letter sets out the operational priorities, including responding to Covid-19 demand, pulling out all the stops to implement the Covid-19 vaccination programme, maximising capacity in all settings to treat non-Covid-19 patients, responding to other emergency demand and managing winter pressures, supporting the health and wellbeing of our workforce. These priorities have further been detailed in a letter sent out by the CEO Lead for the Partnership.

4. Partnership response to NHSE/I Consultation Integrated Care Systems

The NHS England/NHS Improvement proposals set out the direction of travel for integrated care systems (ICS) and proposed options for legislative change to support this. The proposals strongly reflect many elements that already define the approach that has evolved in the West Yorkshire and Harrogate Partnership. There is a strong emphasis on provider collaboration, the role of partnership working at place level (Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield) and close partnership with local councils. There also appears to be permissiveness and flexibility in the approach outlined which can be tailored to local systems' needs – which are welcomed. Please see below the links to the West Yorkshire and Harrogate Health and Care Partnership responses to NHS England/Improvement proposals. The submission date was Friday 8 January.

- West Yorkshire and Harrogate Health and Care Partnership
- The Joint Committee of Clinical Commissioning Groups
- West Yorkshire Association of Acute Trusts
- The Mental Health, Learning Disabilities and Autism Collaborative
- The West Yorkshire and Harrogate Clinical Forum

The proposals were discussed and considered by the Board at the December Strategy Board meeting and a formal response on behalf of the Board was submitted. In addition to the Trust response, we have contributed to place submissions in each of the places that we provide services and through the West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative.

5. Suicide Prevention Campaign

West Yorkshire and Harrogate Suicide Prevention Campaign (aimed at staff) has been co-produced through a multi-agency steering group and based on insight gained from staff. This campaign is a key part of the partnership ambition to reduce suicide by 10% across West Yorkshire and Harrogate by 2020/21 and achieve a 75% reduction in targeted areas by 2022. Organisations from across West Yorkshire and Harrogate have joined forces to raise awareness of the risk of suicide and to help ensure people are signposted to the right support at the right time. The campaign is focused specifically on suicide prevention. The work also links to the wider wellbeing support offers that each place/organisation has put in during the response to Covid-19. Over 120 organisations have already registered to take part. **The Trust is a key partner in the development of the campaign and implementation of the key actions as part of its overall support offer to our staff.**

6. The System Ambition to increase Leadership and Diversity and tackling Inequalities within BAME communities action plan

The findings from the Independent Review chaired by Professor Dame Donna Kinnair have informed the development of a partnership response that sets out key actions that the partnership will take forward. The Partnership's Action Plan that addresses the recommendations from the review was received and approved by the Partnership Board on 1 December 2020. The response details actions related to the four themes of the review; workforce, leadership, population planning and reducing inequalities in mental health outcomes. Significant progress is being made against all the actions - some of the actions include the launch of a BAME Fellowship programme and Anti-racism campaign as well as an insight driven approach to responding to Covid within BAME Communities. The full action plan can be found in the minutes of the WYH Partnership Board meeting papers for December 2020 West Yorkshire and Harrogate Partnership : Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues

The Trust is a key partner in this programme of work. The Trust Equality, Involvement, Communications and Membership Strategy has been approved and the annual action plans that are currently in development will support the delivery of the Partnership ambitions and action plan. Trust Board to receive the Partnership Action Plan and this to be further considered in the Equality and Inclusion Committee as part of the Trust wide action planning process.

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

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

Transformation Funding - Community Mental Health; Crisis Alternatives: WY ICS submitted to NHS England the first draft Transformation Funding Plan on 18 November 2020 in the prescribed format (3-year funding profiles). The plan comprised a summary of proposals that had been developed in each 'Place.' All STPs/ICSs in England will receive their 'fair share' of central transformation funding to deliver new models of integrated primary and community mental health care for adults and older adults with severe mental health problems. In West Yorkshire this equates to approximately 5.2 million pounds in 2021/22. This is not a competitive process between STPs/ICSs. The transformation funding will support;

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

The final WY ICS submission will be made on 20 January 2021, with confirmation of funding on 8 February 2021.

Learning Disability Mortality Review (LeDeR) programme, Action from learning: deaths of people with a learning disability from Covid-19 (NHSE): This report has been published following the University of Bristol's report into the deaths of 206 people with a learning disability at the start of the Covid-19 pandemic. A West Yorkshire (WY) Task & Finish group is being established, comprising leads from the main WY ICS workstreams, to agree actions across workstreams in the context of the report content. This group will report through the Systems Leadership Executive Group (SLEG) in February 2021.

West Yorkshire Adult Secure Lead Provider Collaborative: The NHSE North East and Yorkshire Regional Approval Panel to discuss the Business Case and next steps with the Collaborative took place on 30 November 2020. An Action Plan was agreed between NHSE and the Collaborative identifying a number of actions as being required for completion to enable the Collaborative to 'go live.' This plan is currently being progressed.

WY Mental Health, Learning Disabilities and Autism (MHLDA) Programme: A governance review of the MHLDA programme was agreed, which will involve engagement workshops over the next few months and a finalised proposition in April.

8. Local Integrated Care Partnerships - Key developments

We continue to work with partners to develop and deliver joined up Covid-19 response and stabilisation and recovery approach in each of the places that we provide services.

Calderdale

SWYPFT is a strong partner in delivering the Calderdale vision 2024 and Calderdale Cares. We have resumed partnership work that includes commissioners and providers collaborating to achieve integrated care provision driven by the needs of the local Calderdale population and involving local people to develop solutions. As part of this work, the evolving Alliance has agreed a partnership agreement that sets out the principles, approach and ways of working**.**

The Calderdale Community Collaborative Partnership Board meets monthly to deliver the agreed programme of work in line with the alliance objectives. At the meetings on 10 December and 14 January, we have discussed ageing well, Population Health Management, Pulse Oximetry, CMHT transformation and digital maturity.

The Trust is also a key partner in the Calderdale system Arts and Health programme - to ensure that arts, creativity and culture is used across Calderdale to support people's health and wellbeing. The first suite of projects/interventions to support people within Calderdale have been scoped and agreed and bids have been submitted to apply for additional funding where required.

Projects include a Couch to Creativity app, The Lullaby Project in partnership with Carnegie Hall and Art Boxes for families. A big conversation bringing together the world of Arts and Health organisations is being co-produced on several agreed themes with an initial series of podcasts scheduled to start during January/February 2021. A Thriving Communities bid has been co-ordinated from a wide range of partners within Calderdale and submitted.

We continue to be a partner in the Active Calderdale programme and have secured two years funding. Three services have been selected to pilot integrating physical activity into their systems and processes including Learning Disability, EIP and Perinatal Services. Design thinking improvement workshops commence in February 2021 with these services in partnership with Active Calderdale. A 'Moving More SWYFTly' Trust wide campaign has been launched during December to encourage staff to be more physically active and support their health and wellbeing alongside a survey to capture baseline data. 30 members of staff have signed up to the Moving Medicine online training package which supports increasing staff confidence in undertaking conversations about physical activity.

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

At the December ICP Board meeting, the meeting agenda focused primarily on the development of the ICP arrangements in the context of the recently published NHSE/I paper *Integrating Care*; Discussion and agreement to undertake a further stocktake of the position of the ICP against the ICP development framework criteria; A presentation on the development of Long Covid pathway and pulse oximetry; Update on the vaccination programme.

The Covid system response arrangements continue to be in place in Wakefield and the Trust plays an active contribution into these arrangements.

Kirklees
The Kirklees Integrated Health and Care Leadership Board continues to meet monthly. At the January meeting of the Board, there was a focus on the following: An update presentation from the Third Sector and how it had worked through Covid; Follow up updates to the December meeting's focus on health inequalities; Discussion and agreement to progress a Kirklees provider workshop to discuss future provision arrangements in Kirklees; Review of the Board's response to *Integrating Care*.

The Covid system response arrangements continue to be in place in Kirklees and the Trust plays an active contribution into these arrangements.

Recommendations

- **Trust Board is asked to receive and note the update on the development of Integrated Care Systems and collaborations:**
    - **West Yorkshire and Harrogate Health and Care Partnership**
    - **Local Integrated Care Partnerships - Calderdale, Wakefield and Kirklees**
- **Receive the minutes of relevant partnership boards.**

Appendix - Links to relevant partnership meetings and papers

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 January 2021

Agenda item 9.3 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	10 December 2020
Member	Chief Executive / Director of Strategy
Items discussed	• This meeting was a Development Session/Workshop
Minutes	Papers and draft minutes (when available): http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	15 October 2020 Next meeting scheduled for 28 January 2021
Non-Voting Member	Medical Director / Director of Nursing & Quality
Items discussed	• Personalised Care Programme and Carers Programme. • Covid-19 Impact Update. • Co-producing and Action Plan to reduce the Impact of Covid-19 on BAME Communities. • Health & Wellbeing Strategy Update. • Involving People: an update. • Implementing Calderdale Cares – The Next Steps. • Calderdale and Huddersfield Service Reconfiguration Update. • Forward Plan.
Minutes	Papers and draft minutes are available at: https://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=27436

Kirklees Health and Wellbeing Board

Date	Meeting for 28 January 2021 cancelled. Next meeting scheduled for 25 March 2021
Invited Observer	Chief Executive / Director of Nursing & Quality
Items discussed	• Agenda not available yet
Minutes	Papers and draft minutes (when available): https://democracy.kirklees.gov.uk/ieListMeetings.aspx?CId=159&Year=0

Wakefield Health and Wellbeing Board

Date	21 January 2021 (Meeting 19 November 2020 cancelled)
Member	Chief Executive / Director of Provider Development
Items discussed	• Focussed Discussion – Reducing Health Inequalities in the Wakefield Health and Care System under the Health and Wellbeing Plan Priorities
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

South Yorkshire & Bassetlaw Integrated Care System Collaborative Partnership Board

Date	11 October 2020
Member	Chief Executive
Items discussed	• ICS System Leader Update. • Priorities of Joint Working for Local Authorities. • Developing the South Yorkshire and Bassetlaw 5 Year Strategy 2019 – 2024. • ICS Finance Update. • ICS Highlight Report. • Sheffield City Region team on the Health Led Employment Trial. • Developing the ICS focus on the Voluntary and Community Sector.
Minutes	Approved Minutes of previous meetings are available at: https://www.healthandcaretogethersyb.co.uk/about-us/minutes-and-meetings

West Yorkshire & Harrogate Health & Care Partnership Board

Date	1 December 2020 Next meeting scheduled for March 2021
Member	Chief Executive
Items discussed	• Experiences of people who are Clinically Extremely Vulnerable during Covid-19 • Update from the West Yorkshire & Harrogate Partnership CEO Lead. • Review of the Public Participation at the West Yorkshire & Harrogate Health and Care Partnership Board • Voluntary, Community and Social Enterprise Sector • Developing the West Yorkshire and Harrrogate People Plan • Tackling health inequalities for Black, Asian and minority ethnic communities and colleagues Review

	• Social Care in the West Yorkshire and Harrogate Health and Care Partnership • Review of the West Yorkshire and Harrogate Health and Care Partnership's Memorandum of Understanding and Integrated Care System working arrangements
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 January 2021
Agenda item 10.1

Title:	**Emergency Preparedness, Resilience and Response (EPRR) Update: COVID and EU Exit**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	This paper updates the Board on the COVID emergency response arrangements and EU Exit
Mission/values:	This work stream is in place to ensure that the Trust can operate safely in a period of uncertainty and looks at key areas which could be affected. The work is part of wider planning at national and regional levels.
Any background papers/ previously considered by:	Executive Management Team (EMT) and Operational Management Group (OMG) are receiving updates.
Executive summary:	**COVID-19 Response** The Trust continues to operate its EPRR arrangements with Gold Command meeting twice a week, Silver Command meets 3 times a week and the frequency of the various Bronze Commands depends on need. The Trust remains at Operational Pressures Escalation Level 3. Outbreaks are continually and closely reviewed through Silver Command where any appropriate action is agreed and monitored. A major priority for the Trust has been the roll out of the Staff COVID vaccination programme which commenced on 11 January 2021 and to date over 2500 staff have been vaccinated. The pace at which the programme has been set up and rolled out has been incredible and required a lot of hard work, commitment and dedication from staff. The aim is to ensure that 100% of our staff receive their first vaccine by the 15 February 2021, if not before. The Trust has had to divert significant resources into this key priority to ensure that staff receive their vaccine in good time. Staff COVID related absence whilst not as high as April 2020 is causing significant pressure in services. **EU Exit** The transitional arrangements for Britain's exit from the EU ceased at the end of December. The departure was accompanied by a formal deal which eased this transition. The Trust had extensive plans for both a no

	deal and a deal exit. To date the scenarios that the Trust planned for in terms of disruption have not happened. The Bronze exit group continues to meet but it is anticipated that this will shortly cease and any issues around supply chain, staffing etc will become “business as usual”. Whilst there was no discernible disruption it should be noted that the extensive planning was still important and was a valuable business continuity exercise over an extended period. **Risk Appetite** This plan is in line with the Trust’s risk appetite for both clinical services and emergency planning.
Recommendation:	**Trust Board is asked to NOTE and comment on the content of the report.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board: 26 January 2021

COVID and Brexit – January 2021 update

Introduction

This paper is intended to update the Trust Board on the current situation in relation to the COVID 19 pandemic and to bring a final report on the situation with regard to EU EXIT

It will give an update on the Trust, regional and national positions.

COVID 19 Response

The Trust

The Trust is continuing to operate in the restoration phase of emergency planning with Bronze, Silver and Gold Command arrangements still operating. Operational Pressures Escalation Level (OPEL) levels are reviewed 3 times a week through the Silver Command and reported into Gold. The Trust overall OPEL remains at 3.

Since the last Board update England has been in lockdown twice with the current lockdown still in place and no clear date or detail on how it will end. New variants of the coronavirus are a cause of concern and resulted in significant pressure in some parts of the Country. The Trust is following national guidance on the handling of new variants.

Outbreaks on wards are closely monitored and reviewed and there is ongoing reinforcement of the guidance around PPE and operating procedures associated with that.

The absence levels due to Covid either through contracting the virus, isolating or shielding continues to be a focus of attention. Whilst COVID related absence has not reached the levels seen in the first surge back in April 2020 they are causing service pressures.

Staffing levels were also a cause for concern over the Christmas holiday period and the Trust introduced new incentives for inpatient staff in support of maintaining safe staffing levels.

Staff health and wellbeing remains a priority and enhanced support on physical and psychological wellbeing remains in place through Occupational Health. Further risk assessments for staff working from home have been conducted and the Trust

continues to offer practical measures such as furniture and equipment to improve conditions.

The Trust was designated a Hospital Vaccination Hub and has embarked on a COVID vaccination programme for all staff. The target is to offer all Trust staff the opportunity to make an appointment to be vaccinated the end of January 2021 with the aim of a 100% take up. The Trust's vaccination Hubs at Fieldhead and Kendray Hospitals became operational on 11 January 2021 and at the time of writing this report over 2500 staff have been vaccinated. The establishment of the vaccination hubs and commencing vaccinating staff has happened at an incredible pace and is due the tremendous hard work, commitment and dedication of staff. A Bronze vaccination group has been established reporting into Gold Command through Silver Command. As part of a Place response the Trust is looking to increase its delivery capacity to provide vaccinations to Social Care staff. The vaccination hubs are very resource heavy and this is likely to continue for the next 12 weeks.

Gold meets twice a week and Silver three times a week, bronze teams still meet at varying intervals based on need.

There are still restrictions on estate usage which means capacity is reduced and the alternative offers of video and telephone are still being rolled out. Whilst very much a positive development, the vaccination hubs have taken over space most notably in the learning and wellbeing centre with a consequent migration of training to other locations and back on-line.

The return of staff to the previous workplace has been paused and indeed reversed at present but planning continues on a phased return. The restoration groups set up for this continue to meet to oversee progress.

Regional Developments

Regionally the picture is similar to the Trust, command structures have begun to meet more regularly, and the Trust is part of the command networks in both ICS and Local Authorities.

National Issues

There has been a change of the NHS Operational Framework to planning on a national scale given significant pressures arising in parts of the country linked to the new UK variant.

The national focus is very much around vaccinations and the Trust as previously noted is a hub. The development and expansion of the programme means the Bronze group overseeing this is extremely busy as there are regular changes to accommodate. Trusts have been instructed not to hold any stockpile of vaccines and progress at pace with the vaccination programme.

Hospital Vaccination Hubs have been asked to work together to vaccinate Social Care Staff.

Key notes for the Trust Board are:

- The command structures are still in place and operating effectively.
- Restoration processes remain despite the lockdown.
- Impact of estate restrictions is yet to be finalised in terms of clinic room capacity and the use of technology.
- The vaccination programme is performing above expectations
- Welfare of staff remains a key concern.

Summary

The Staff in the Trust continue to manage the challenges they face effectively. The high pace of activity around managing the outbreak continues to put a lot of pressure on staff. The Trust has been at OPEL level 3 for a considerable period, this is reported at a regional level. The outbreaks are challenging for staff and service users alike, but the Trust has robust mitigation plans.

The vaccination programme whilst giving logistical challenges is an extremely welcome development. It has had an extremely positive impact on morale and its above expectation performance should be source of pride to the Trust a s a whole.

EU EXIT

The transitional arrangements for Britain's exit from the EU ceased at the end of December. The departure was accompanied by a formal deal which eased this transition. The Trust had extensive plans for both a no deal and a deal exit. To date the scenarios that the Trust planned for in terms of disruption have not happened. The Bronze exit group continues to meet but it is anticipated that this will shortly cease and any issues around supply chain, staffing etc will become "business as usual".

Whilst there was no discernible disruption it should be noted that the extensive planning was still important and was a valuable business continuity exercise over an extended period. It is not anticipated that further Board reports will be needed.

Recommendation

- The Trust Board is recommended to note the content of this report
- Trust Board agrees that no further EU EXIT reports are needed

Nick Phillips Head of Estates and Facilities
January 2021

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Trust Board 26 January 2021
Agenda item 10.2

Title:	**Integrated Performance Report**
Paper prepared by:	Director of Finance & Resources and Director of Nursing & Quality
Purpose:	To provide the Trust Board with the Integrated Performance Report (IPR) for December 2020.
Mission / values / objectives	All Trust objectives
Any background papers / previously considered by:	• IPR is reviewed at Trust Board each month. • IPR is reviewed regularly at the Finance Investment & Performance Committee (FIP). • IPR is reviewed at Executive Management Team (EMT) meeting on a monthly basis.
Executive summary:	The IPR for December has been prepared in line with the framework discussed at the March Trust Board meeting so as to focus on: • Covid-19 response. • Other areas of performance we need to keep in focus and under control. • Locality reports that focus on business continuity. • Priority programmes report that focus on those programmes supporting the work on Covid-19. As a direct consequence of the increase in prevalence in Covid-19, the rapid and resource intensive roll out of the vaccination programme and operational pressures not all information usually provided in the IPR is currently available. Where possible a verbal update will be provided at the Trust Board meeting. For the same reasons the development work on the IPR has been paused. Board members will be provided with a separate update on progress and timescales for implementations shortly. **Quality** • Majority of quality reporting metrics continue to be maintained during pandemic. • Safer staffing levels on inpatient wards has improved slightly with regard to registered nursing cover, although shortfalls continue to result in skill mix dilution in some areas. Workforce pressures continue to challenge delivery. • Restraint figures have slightly reduced and continue to be monitored. • Number of under 18s admitted to adult wards and length of stay remains a concern but the number of such cases reduced in December. • We continue to await the outcome of the Royal College of Psychiatrists serious incident accreditation review.

	NHSI Indicators • Two young people under the age of eighteen were admitted to an adult ward in December for a total of four days which is a significant reduction compared to November. • Inappropriate out of area bed usage increased to 122 days in December from 88 in the previous month. • Seven day discharge has achieved 100% for two consecutive months despite the impact of intense operational pressures. • Typically, performance against nationally reported targets remains positive. **Locality** • The need for self-isolation and staffing pressures in Barnsley community services is resulting in some operational challenges. • Staff absence has resulted in the neuro rehab ward in Barnsley being closed to new admissions. • Positive rating received for our stroke inpatient unit. • Evidence of pressure in the single point of access in Barnsley with referral numbers and acuity increasing. • Access to CAMHS tier 4 beds is proving problematic. • High levels of pressure and demand continue on mental health inpatient wards. • Some outbreaks of Covid-19 have resulted in temporary closure to new admissions on affected wards. • Registered nursing vacancies in forensic services continue to be a challenge. • Whilst there has been some increased demand in learning disabilities for face to face contact, the current lockdown has resulted in some service users and carers not engaging with services again. **Priority Programmes** • Work has commenced on modelling changes to mental health demand with partners. • Three services in Calderdale (learning disability, early intervention in psychosis and perinatal services have been selected to pilot integrating physical activity into their systems and processes. • Work continues to reduce CAMHS waiting times and numbers in both Barnsley and Wakefield. **Finance** • A £0.6m surplus was recorded in the month compared to a planned deficit of £0.5m. • Cumulatively there is now a surplus of £1.35m compared to a planned deficit of close to £1.0m. • Income was slightly higher than the updated plan.

	• After adjusting for one-offs, pay costs increased in December largely due to additional costs incurred in maintaining staffing numbers over the Christmas period. • Agency staffing costs increased to £0.7m in the month, the highest value of the year so far. The increase was primarily seen in the unregistered workforce. • £573k of costs were identified as being reasonably incurred as part of the Covid-19 response, including expenditure on staff health and wellbeing. • Out of area bed costs were £86k, which remains lower than plan. These costs are likely to increase in January given the impact of Covid-19 outbreaks on some wards. There also continues to be high spend on locked rehab in Barnsley. • A separate paper is being provided regarding the year-end forecast. There is a strong likelihood the year-end position will be favourable to plan. • Capital expenditure is now £1.8m and the year-end forecast has been reduced by a net £250k. There is potential that a further £0.5m will not be spent in the year due to the impact of Covid-19 and other operational and contractual issues. • The cash balance increased to £69.8m given the timing of receipt of system allocated income. The advances of income are expected to unwind by the end of the financial year. • Cumulatively 68% of all third party invoices were paid within 7 days of receipt of goods or services, with 95% paid within 30 days. The average number of days to pay suppliers in December was 15. **Workforce** • As at 19 January 2021 there were 159 staff off work and not working Covid-19 related. A further 84 were working from home. • Non Covid-19 sickness remained at 4.0% in December 2020. • 545 staff have tested positive for Covid-19, 83 of which tested positive in the last month. • Staff turnover increased to 9.9% in December 2020. **Covid-19 response** In addition to the points identified in the sections above: • Sufficient PPE remains in place. • The vaccination programme has commenced. As at 20 January 2020, 2,470 staff had received their first dose. • The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in. • Symptomatic patient testing continues to be undertaken through pillar 1 for inpatients and pillar 2 for community. • Lateral flow testing for staff has been rolled out.

	• Significant support to care homes is provided by our community teams in Barnsley. • The Trust Opel level remains at 3. • National guidance continues to be monitored, reviewed and adopted. • A range of staff and wellbeing support offers continue to be available and used.
	Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.
Private session:	Not applicable

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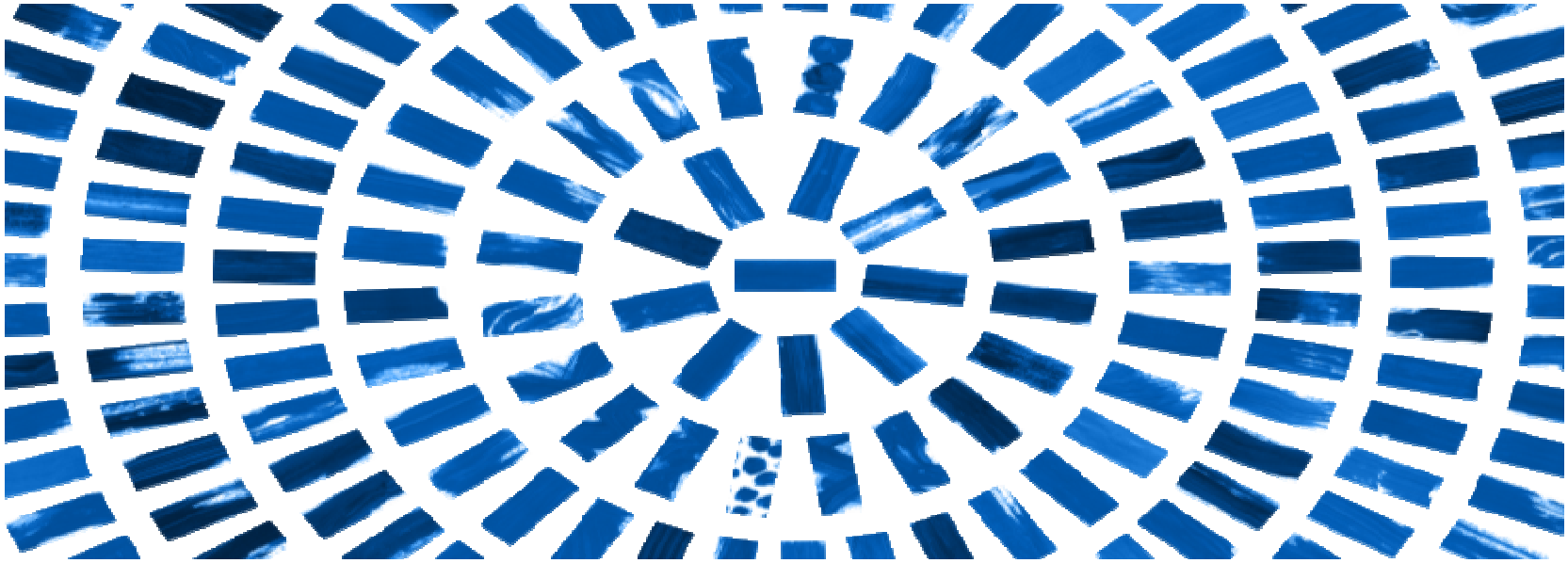
Integrated Performance Report
Strategic Overview



December 2020

With **all of us** in mind.

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Table of Contents

Introduction

Please find the Trust's Integrated Performance Report (IPR) for December 2020. Continuing with the approach established in March the report considers the response to Covid-19 as well as the majority of other regular reporting sections. In particular the aim is to provide a report that provides information on:
• The Trust's response to Covid-19
• Other areas of performance we need to keep in focus and under control
• Priority programmes in so far as they contribute to the Trust response to Covid-19
• Locality sections in terms of how business continuity plans are operating
• Restoration and reset of services

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

A separate section for the Covid-19 response has been added. The structure of this section focuses on:
• Managing the clinical response
• Supporting our staff and staff availability
• Supporting the system
• Standing up services
• Restoration and reset
• Vaccination programme

It must also be recognised that given the focus of all staff on responding to Covid-19 and the increased level of staff absence not all the normal information is necessarily readily available for the report.. The quality section remains largely unaltered given the need to ensure the Trust retains focus on the provision of its core services. The report on national metrics is again unaltered as national reporting requirements remain unchanged. Other sections remain in place sometimes with reduced content. Consideration is also being given with regard to how performance against service reset and restoration can be provided. It should be emphasised that the majority of services have continued to be provided during the pandemic, although in some cases in a different manner such as less face to face contact and in some cases referrals have been lower than historical averages. This report contains some initial information regarding the vaccination programme. The intense focus on this roll out has impacted on the availability of some information in the IPR, this month and in some cases a verbal update will be provided at the Trust Board.

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

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

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

Our integrated performance strategic overview report is publicly available on the internet.
The IPR has evolved and grown significantly in recent years. A review is taking place to ensure the report remains meaningful and meets its intended purpose. A proposed new format will be circulated to all directors shortly with an aim of updating the IPR once the high resource requirements of the vaccination programme reduce.

This dashboard represents a summary of the key metrics identified and agreed by the Trust Board to measure performance against Trust objectives. They are deliberately focussed on those metrics viewed as key priorities in 2019/20. Any change in requirement for 2020/21 will be reviewed in the coming weeks. Given the outbreak of the Covid-19 pandemic, a number of additional metrics are included in this report. These relate to the actual data as at 19th January as opposed to the end of December. A small number of metrics have been removed from the dashboard to enable greater focus on the Trust response to Covid-19. It should be noted that as well as these specific metrics many of the standard metrics used will be strongly influenced by the impact of Covid-19.

KPI	Target	As at 23rd April 2020	As at 19th May 2020	As at 17th June 2020	As at 22nd July 2020	As at 24th August 2020	As at 22nd September 2020	As at 20th October 2020	As at 24th November 2020	As at 22nd December 2020	As at 19th January 2021	Notes
Additional Metrics to Highlight Response to and Impact of Covid-19												
No of staff off sick - Covid-19 not working [7]	N/A	**154**	**204**	**112**	**48**	**26**	**82**	**108**	**161**	**81**	**159**	
Shielding		54	59	52	37	0	0	0	29	0	48	
Symptomatic		69	118	46	5	14	31	57	51	45	64	
House hold symptoms		26	24	13	4	7	29	31	25	10	19	
OH Advised Isolation		5	1	0	0	1	1	2	2	0	0	
Test & Trace Isolation		0	0	0	0	0	0	0	0	0	0	
Other Covid-19 related		0	2	1	2	4	21	18	54	25	28	
No of staff working from home - Covid-19 related [8]		**125**	**136**	**107**	**90**	**7**	**53**	**79**	**147**	**35**	**84**	
Shielding		76	78	72	71	0	0	0	77	0	49	
Symptomatic		13	28	13	5	1	14	29	16	8	9	
House hold symptoms		29	23	13	1	0	26	21	33	14	6	
OH Advised Isolation		7	6	7	3	0	1	5	1	1	4	
Test & Trace Isolation		0	0	0	7	0	0	0	0	0	0	
Other Covid-19 related		0	1	1	3	6	12	24	20	12	16	
Number of staff tested [9]		89	783	1798	2038	2162	2294	2498	2917	3098	3241	Cumulative
No of staff tested positive for Covid-19 [10]		23	103	128	130	133	149	217	398	462	545	Cumulative
No of staff returned to work (including those who were working from home)		683/962 = 71%	921/1246 = 73.9%	1183/1393 =84.9%	1310/1448 =90.5%	1498/1531 =97.8%	1547/1681 =92.0%	1771/1954 =90.6%	2027/2321 =87.3%	2339/2455 =95.3%	2381/2608 =91.3%	
No of staff returned to work (not working only) [13]		445/599 = 74%	609/807 =75%	800/908 =88.1%	872/928 =94.0%	952/979 =97.2%	992/1079 =91.9%	1122/1239 =90.6%	1295/1480 =87.5%	1492/1580 =94.4%	1533/1695 =90.4%	
No of staff still absent from work who were Covid-19 positive [12]		ata Unavailabl	27	11	2	1	5	29	32	28	43	
No of Service users tested (ward)		41	65	103	104	109	125	148	174	225	257	Symptomatic
No of service users tested positive (ward)		9	10	29	29	29	29	38	60	83	94	Cumulative
No of service users recovered		8	9	28	28	28	28	30	60	83	94	
Additional number of staff enabled to work from home		900	900	937	1003	1024	1043	1069	1095	1168	1175	Cumulative
Calls to occupational health healthline		178	576	921	1230	1450	1536	1780	1967	2109	2274	Cumulative
Making SWYPFT a great place to work	**Target**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Forecast**
Sickness absence	4.5%	3.8%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%	
Staff Turnover	10%	11.9%	8.5%	7.9%	9.8%	8.4%	9.1%	8.9%	9.3%	9.3%	9.9%	
Actual level of vacancies	tbc		8.7%	6.9%	6.0%	6.8%	7.4%	8.4%	8.0%	7.3%	6.9%	
Improve people's health and reduce inequalities	**Target**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Forecast**
% service users followed up within 7 days of discharge	95%	105/107 =98.1%	90/92 =97.8%	102/102 = 100%	105/105 = 100%	110/110 = 100%	84/85 =98.8%	106/107 =99.1%	97/98 =98.9%	103/103 =100%	101/101 =100%	1
Out of area beds [1]	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	350	167	108	140	336	224	177	106	88	122	2
IAPT - proportion of people completing treatment who move to recovery [4]	50%	55.7%	51.4%	49.1%	42.8%	50.1%	54.3%	54.1%	55.6%	56.6%	*56.0%*	1
Delayed Transfers of Care	3.50%	1.9%	2.0%	1.7%	1.4%	1.3%	1.1%	1.5%	1.6%	2.9%	2.2%	1
Improve the quality and experience of care	**Target**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Forecast**
Patient safety incidents involving moderate or severe harm or death (Degree of harm subject to change as more information becomes available) [3]	trend monitor	20	34	35	41	31	28	21	17	33	44	
IG confidentiality breaches	<=8 Green, 9 -10 Amber, 11+ Red	6	15	20	14	25	17	19	12	17	9	
Total number of Children and Younger People under 18 in adult inpatient wards	*TBC*	2	1	2	1	0	3	3	2	4	2	
CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [2]	trend monitor	41.2%	41.7%	46.5%	48.2%	47.6%	46.7%	55.4%	65.0%	70.8%	67.4%	
Improve the use of resources	**Target**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Forecast**
Surplus/(Deficit)	In line with Plan	(£968k)	-	-	-	-	-	-	£69k	£704k	£577k	(£2.1m)
Agency spend	In line with Plan	£613k	£469k	£507k	£518k	£558k	£606k	£588k	£604k	£573k	£686k	£7.3m
Single Oversight Framework metric	2	2	2	2	2	2	2	2	2	2	2	2
CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green

NHSI Ratings Key:
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures Figures in italics are provisional and may be subject to change.

Notes:

1 - Out of area beds - From April 18, in line with the national indicator this identifies the number of inappropriate out of area bed days during the reporting month - the national definition for out of area bed is: is a patient that is admitted to a unit that does not form part of the usual local network of services. This is for inappropriate admission to adult acute and psychiatric intensive care unit mental health services only.

2 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data refreshed back to April 20 each month. Excludes ASD waits and neurodevelopmental teams. Treatment waiting lists are currently impacted by data quality issues following the migration to SystmOne. Data cleansing work is ongoing within service to ensure that waiting list data is reported accurately.

3 - Further information is provided under Quality Headlines. Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm, and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.

4 - In order to provide the board with timely data, data from the IAPT dataset primary submission is used to give an indication of performance and then refreshed the following month using the refreshed dataset data. The reported figure is a Trust wide position.

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

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

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

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

9 - Count of tests undertaken for staff and/or staff family member up to and including 19th January.

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

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

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

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

Lead Director:
• This section has been developed to demonstrate progress being made against Trust objectives using a range of key metrics.
• Opportunities for benchmarking are being assessed and will be reported back as part of the development of the IPR.
• More detail on areas of underperformance are included in the relevant section of the Integrated Performance Report.

Quality
• Majority of quality reporting metrics continue to be maintained during pandemic
• Safer staffing levels on inpatient wards has slightly improved with regards to registered nurse cover, although remaining shortfalls continue to result in skill mix dilution in some areas. Workforce pressures continue to challenge delivery.
• Restraint figures have slightly reduced and continue to be monitored
• Number of under 18s admitted to adult wards and length of stay remains a concern but the number of such cases reduced in December.
• We continue to await the outcome of the Royal College of Psychiatrists serious incident accreditation review.

NHSI Indicators
• Two youg people under the age of eighteen were admitted to an adult ward in December for a total of four days which is a signifcant reduction compared to November.
• Innappropriate out of area bed useage increased to 122 days in Decmeber from 88 in the previous month.
• Seven day follow up within 7 days of discharge has achieved 100% for two consecutive months despite intense operational pressures.
I• Typically performance against nationally reported targets remains positive

Locality
• The need for self-isolation and staffing pressures in Barnsley community services is resulting in some operational challenges
• Staff absence has resulted in the neuro rehab ward in Barnsley being closed to new admissions
• Positive rating received for our stroke inpatient unit
• Evidence of pressure in the single point of access in Barnsley with referral numbers and acuity increasing
• Access to CAMHS tier 4 beds is proving problematic
• High levels of pressure and demand continue on mental health inpatient wards
• Some outbreaks of Covid-19 has resulted in temporary closure to new admissions on affected wards
• Registered nursing vacancies in forensic services continue to be a challenge.
• Whilst there has been some increased demand in learning disabilities for face to face contact, the current lockdown has resulted in some service users and carers not engaging with services again.

Priority Programmes
• Work has commenced on modelling chnages to mental health demand with partners.
• Three services in Calderdale (learning dsability,early intervention in psychosis and perintal services) have been selected to pilot integrating physical activity into their systems and processes.
• Work continues to reduce CAMHS waiting times and numbers in both Barnsley and Wakefield.

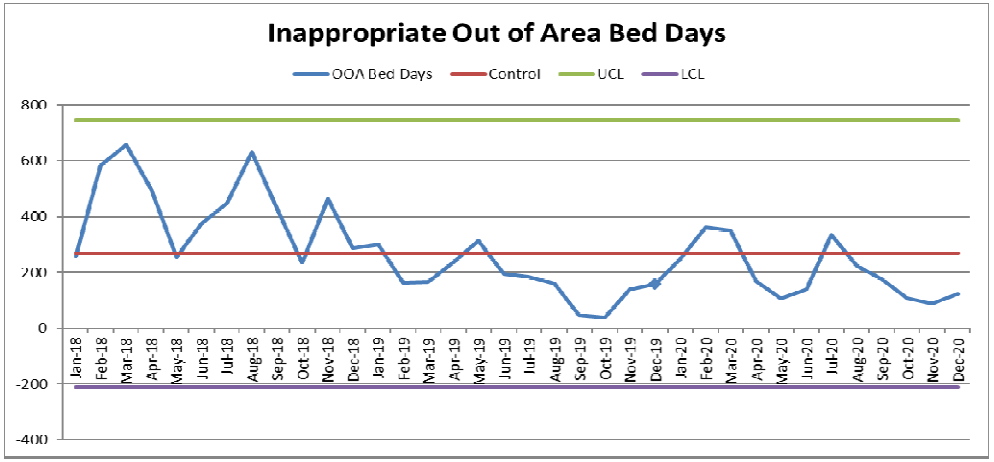
Finance
• A £0.6m surplus was recorded in the month compared to a planned deficit of £0.5m
• Cumulatively there is now a surplus of £1.35m compared to a planned deficit of close to £1.0m
• Income was slightly higher than the updated plan
• After adjusting for one-offs, pay costs increased in December largely due to additional costs incurred in maintaining staffing numbers over the Christmas period.
• Agency staffing costs increased to £0.7m in the month, the highest value of the year so far. The increase was primarily seen in the unregistered workforce.
• £573k of costs were identified as being reasonably incurred as part of the Covid-19 response, including expenditure on staff health and wellbeing
• Out of area bed costs were £86k, which remains lower than plan. These costs are likely to increase in January given the impact of Covid-19 outbreaks on some wards. There also continues to be high spend on locked rehab in Barnsley
• A separate paper is being provided regarding the year-end forecast. There is a strong likelihood the year-end position will be favourable to plan
• Capital expenditure is now £1.8m and the year-end forecast has been reduced by a net £250k. There is potential that a further £0.5m will not be spent in the year due to the impact of Covid-19 and other operational and contractual issues.
• The cash balance increased to £69.8m given the timing of receipt of system allocated income. The advances of income are expected to unwind by the end of the financial year.
• Cumulatively 68% of all third party invoices were paid within 7 days of receipt of goods or services, with 95% paid within 30 days. The average number of days to pay suppliers in December was 15.

Workforce
• As at January 19th there were 159staff off work and not working Covid-19 related. A further 84 were working from home
• Non Covid-19 sickness remained at 4.0% in December
• 545 staff have tested positive for Covid-19, 83 of which tested positive in the last month
• Staff turnover increased to 9.9% in December

Covid-19
• The vaccination programme has commenced. As at January 20th 2,470 staff have received their first dose
In addition to the points identified in the sections above:
• Sufficient PPE remains in place
• The Trust continues to fully engage with the Covid-19 response in all the places and systems it provides services in
• Symptomatic patient testing continues to be undertaken through pillar 1 for inpatients and pillar 2 for community
• Lateral flow testing for staff has been rolled out
• Significant support to care homes is provided by our community teams in Barnsley
• The Trust Opel level remains at 3
• National guidance continues to be monitored, reviewed and adopted
• A range of staff and wellbeing support offers continue to be available and used

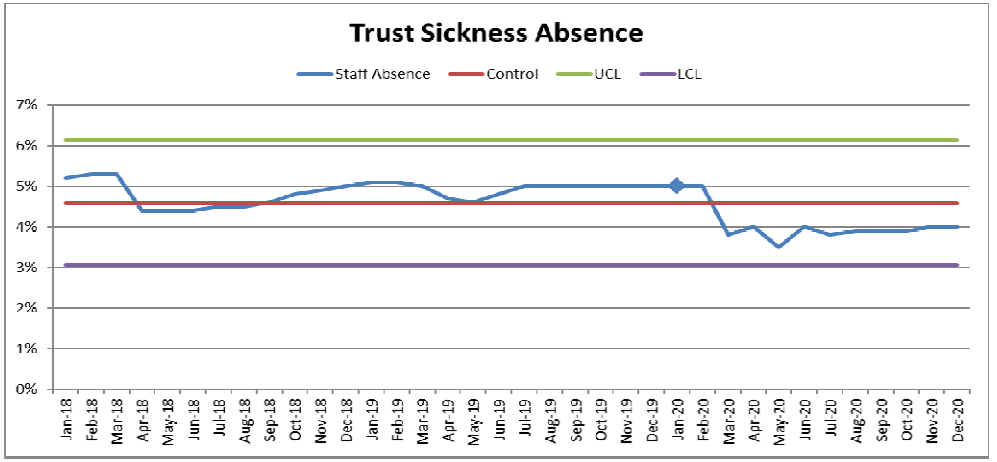
Statistical process control (SPC) is an analytical technique for plotting data over time. It helps understanding of variation and in so doing guides on the most appropriate action to take, as well as allowing tracking the impact of the changes made. The following four areas have been identified as key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

Inappropriate Out of Area Bed Days



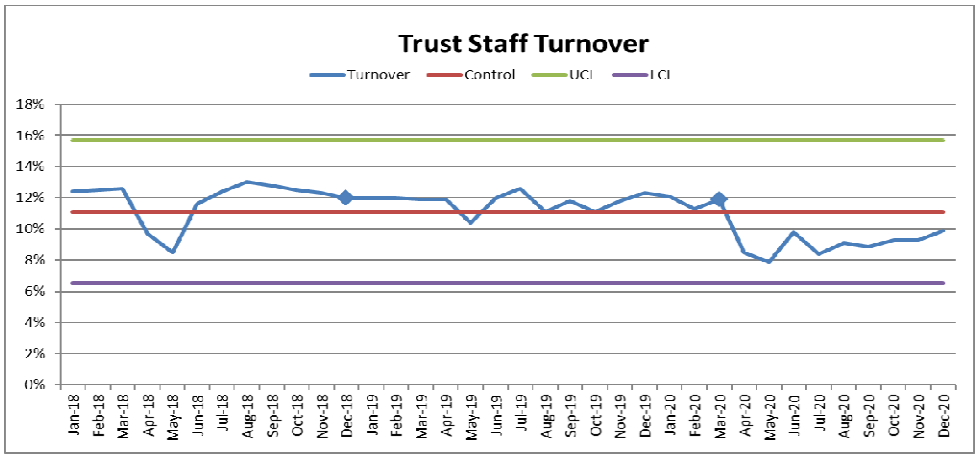
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in December 2019 has been highlighted for this reason.

Staff Sickness Absence



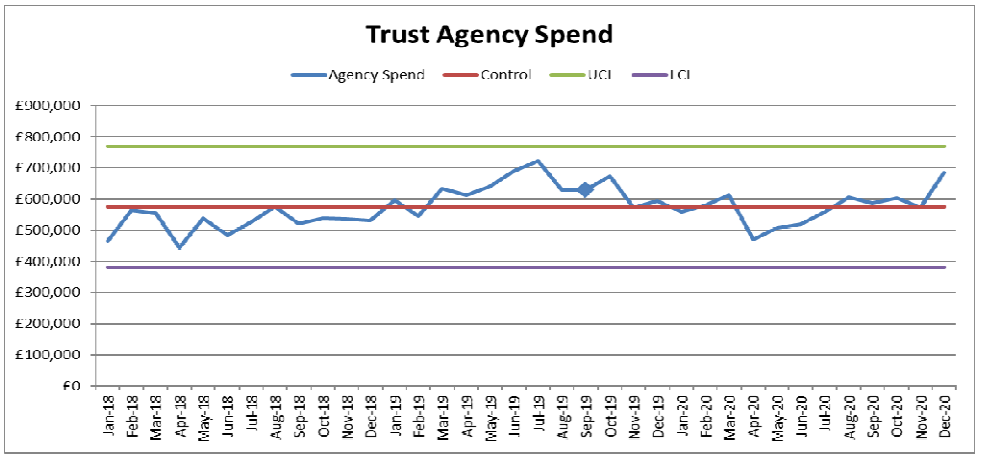
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in January 2020 has been highlighted for this reason.

Staff Turnover



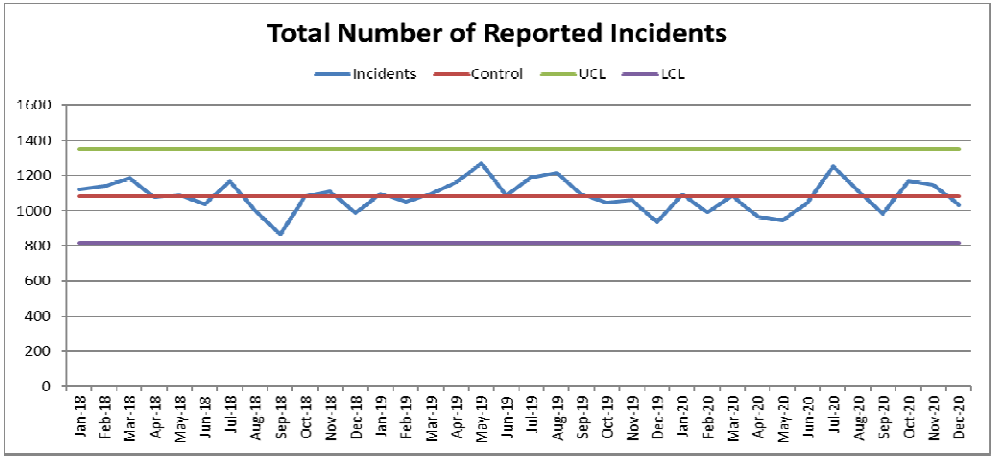
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. Turnover has been lower since the onset of the Covid-19 pandemic.

Agency Spend



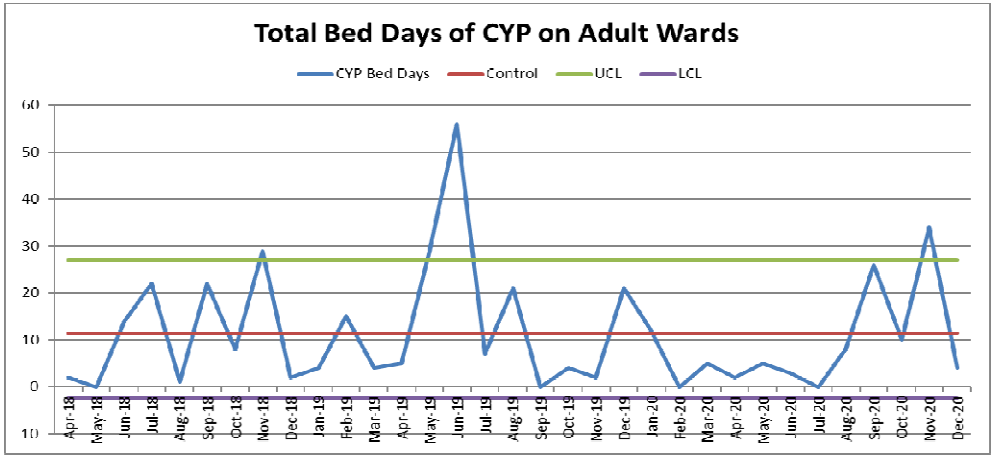
SPC guidance indicates that a period of 7 or more data points consistently either above or below the control line indicates that special cause variation exists in the system that should be investigated further. The data point in September 2019 has been highlighted for this reason.

Incidents



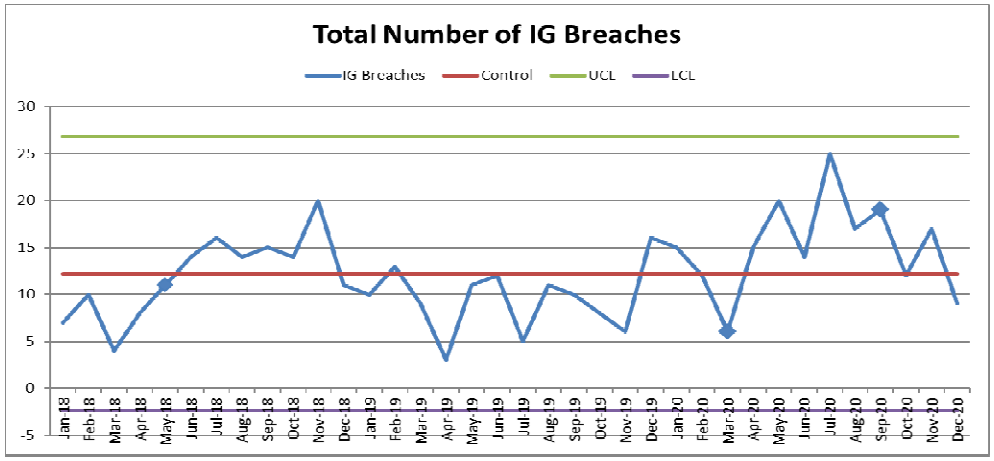
All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported incident levels are within the expected range.

Total bed days of CYP on adult wards



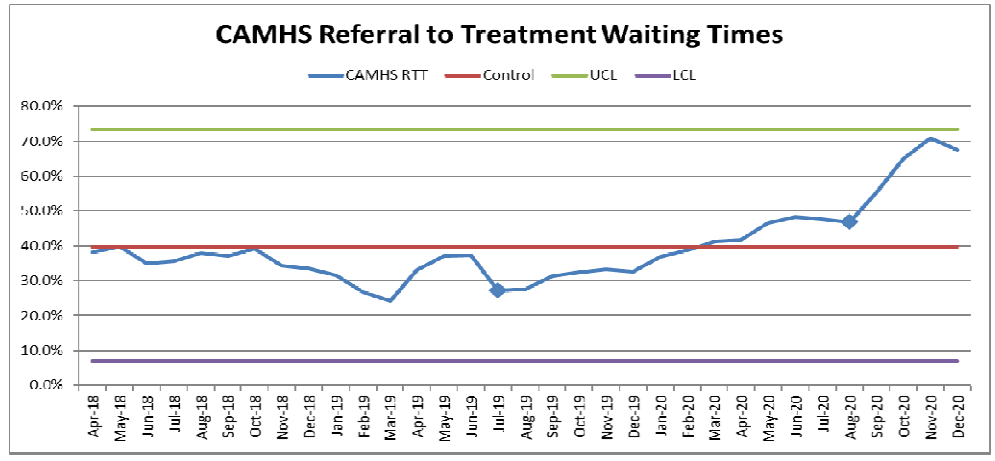
The majority of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported bed days are within the expected range with the exception of Nov-18 and Jun-19.

IG Breaches



All of the data points remain within, and show random variation between, the upper and lower control levels. This therefore indicates that reported IG breaches are within the expected range. The data point in May 2018 has been highlighted to indicate the introduction on GDPR.
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 2020 has been highlighted given the start of the refreshed awareness and communication plan.
The data point in March 2020 highlights the start of the Covid-19 pandemic.

CAMHS Referral to treatment waiting times



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

Covid-19 response

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

Managing the clinical response

IPC response – guidance
IPC team continue to review and respond to guidance issued which is then implemented via silver command.

Patient testing & pathway/Outbreak response & management
Symptomatic patient testing is being undertaken and revised regime under review.
Outbreaks continue to be managed by the infection prevetion and control team.

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

PPE position
• National deliveries of PPE have been sufficient to maintain good stock levels
• Medium size gloves are most commonly used and we have 30 days worth of stock

PPE Levels	Approx days stock as at 14-Jul	Approx days stock as at 17-Aug	Approx days stock as at 15-Sep	Approx days stock as at 13-Oct	Approx days stock as at 10-Nov	Approx days stock as at 22-Dec	Approx days stock as at 12-Jan
Surgical masks	30	22	12	14	33	45	43
Respirator masks	80	23	39	90	100	90	142
Aprons	11	8	20	25	33	32	30
Gowns	95	132	119	115	14	159	66
Gloves	28	26	24	32	41	35	35
Visors	100	115	156	121	46	43	132

Supporting our staff and staff availability

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

Staff
• Swabbing for symptomatic testing - access via pillar 2 or through internal testing route. Testing staff per and post-operative and procedures
• Hotspot outbreak management testing is provided through internal testing route, with adequate capacity from local labs.
• Trust committed to the national SIREN study, which will include fortnightly swabbing and antibody testing.
• Barnsley BDU staff that visit over 65s carehomes are subject to weekly antigen testing.

Staff testing report – current position
Lateral flow testing has been implemented, 100% test kits have been distributed and a system established to confirm usage. Current information suggests that low levels (below 1%) are showing as positive, this is being monitored.

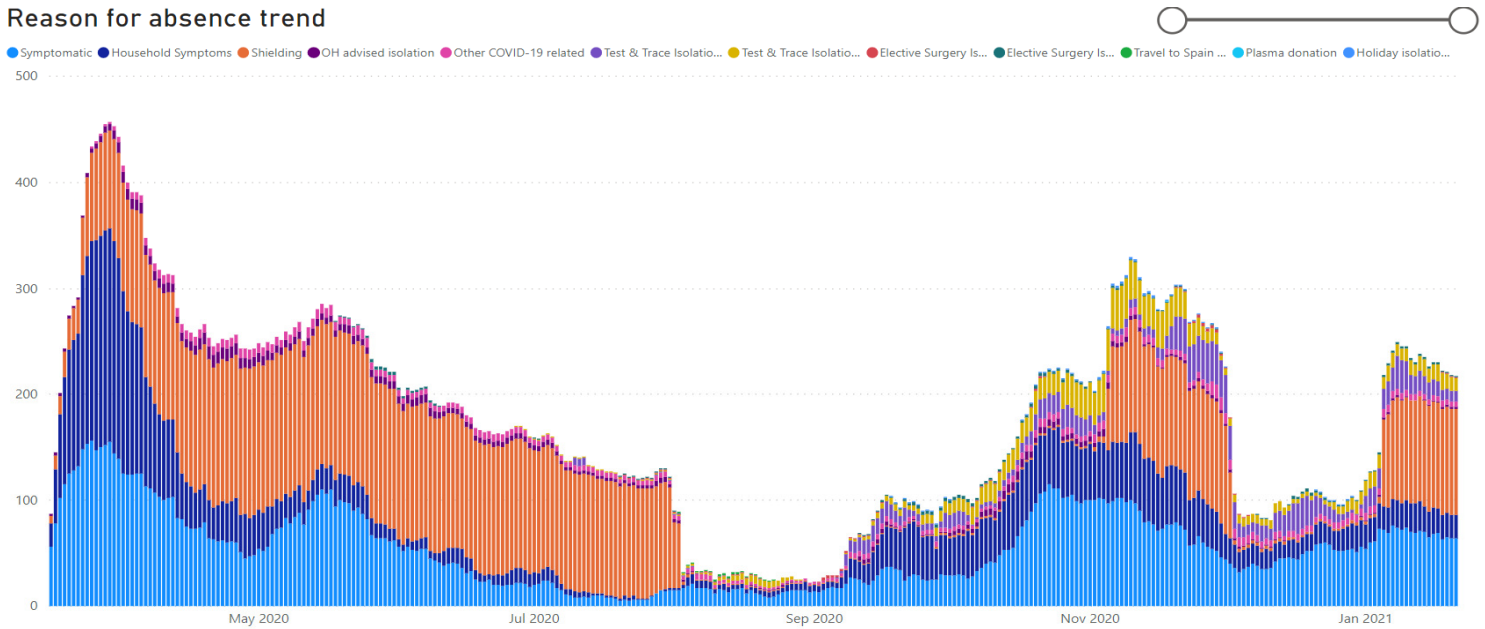
Vaccinations
• Staff vaccination programme commenced on January 11th.
• Cohorts for priority reciept of vaccinations is based on national guidance.
• As at January 20th 1963 staff have vaccinated their first dose vaccination within the Trust with a further 507 staff having recieved it from another source.

Covid-19 response

Staffing Issues

Our current response to the increase in infections, local restrictive measures and increased pressures on service areas

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



Supporting the system

The Trust continues to fully engage with the Covid-19 response in all places and systems it provides services in.

Care home support offer

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

ICS stress test and outbreak support

- We continue to work closely with partners in outbreak support response in each of our four places
- Strong leadership from the Infection Prevention & Control (IPC) team continues so we ensure appropriate IPC measures are in place
- We provide input and support in to the communication and engagement cells in each of our places to support the covid management and outbreak response.

Covid-19 response

Standing up services

A number of areas have been highlighted in the NHS repsonse to phase 3 of the covid-19 pandemic. The Trusts position on this has been highlighted in the appropriate sections below:

Trust activity and demand (phase 3 response)

• Referral information for Trust services is now being used by the reset and restoration group. The Trust is generally seeing an increase in referrals back to pre-covid-19 levels across the majority of areas. Some work is being undertaken in the Trust to look at forecast surpressed demand and to review the impact this may have on services.
• This section of the report will be developed over the next few months.

Staff Health & Well Being

• To ensure the health, safety and wellbeing of our workforce a comprehensive risk assessment has been completed for all BAME colleagues, pregnant staff, staff who have been shielding and over 70s. Managers have been asked to keep these under constant review. All Trust employees and bank only colleagues have been offered a risk assessment. A self-assessment questionnaire has been circulated to all staff which indicates their personal risk level, those in medium/high risk levels are offered a full risk assessment . Over 4000 colleagues have completed either a full risk assessment or a self assessment. In addition, we have maintained contact with all shielded staff via Trust managers and an Occupational Health well-being check. We also have a working from home/MSK risk assessment process.
• To accelerate preventative programmes for our workforce who are at greatest risk of poor health outcomes we have established a BAME health and wellbeing taskforce and have invested in our Occupational Health service by appointing a Health and Wellbeing practitioner for the BAME workforce. We also offer our colleagues support to maintain a healthy weight and offer smoking cessation support. There is a robust plan for this year's flu vaccination in place and the Trust has met its targets for vaccinations in previous years. The Trust has conducted our wellbeing at work survey with Robertson Cooper to inform our planning and results of this are now being analysed and formulated into action plans. 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.

Volunteers

• All volunteers are being risk assessed using the staff risk assessment tool prior to reintroduction back into Trust services
• Currently we have 176 volunteers, 7 are active and a further 47 are waiting to be processed or have been placed on hold

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

• The Trust is operating at OPEL 3 due to staffing pressures and the number of active outbreaks across the Trust. This will support decision making and the standing down of non-essential services to support critical functions. A piece of work is underway to outline the Trust's priorities and subsequent support mechanisms. Silver command calls have remain at 3 per week and Gold meetings are twice weekly. The ICC/SPOC has been stood up 7 days per week. The ICC/SPOC and Silver Command meetings all now cover COVID-19, EU Exit and Winter Pressures

Restoration and reset

Key priorities and progress made

• Review and revise governance systems in light of learning from covid. Learning from Covid has been pulled together and shared with each subcommittee of the Board
• Progress the identified clinical priority areas for restoration and reset
• Evaluate estate requirements and capacity in light of health & safety restrictions
• Work with partners in each place as well as both ICS systems to support restoration and recovery in each place
• Evaluate the new clinical models and digital approaches that we have used during the pandemic. Recovery planning toolkit developed, agreed and now being used
• Continue work to ensure this is great place to work
• Deliver the requirements in the phase three planning guidance. Work has been undertaken to analyse and plan for the requirements in phase three
• Updated priority programmes have been agreed by the Trust Board.

Digital response

• Total activity reduced in December given the impact of the holiday period
• The number of AccuRX video consultations remains consistent

Digital - Summary Metrics	Jul	Aug	Sep	Oct	Nov	Dec
Total numbers of tickets logged with service desk:	4,849	4,539	6,044	6,065	5,329	3,834
Total phone calls to service desk:	2,176	2,503	3,121	3,387	2,535	2,163
Number of SystmOne tickets (day to day system requests/amendments):	381	375	408	536	407	322
Number of smartcard related tickets:	407	251	366	255	215	268
Additional VPN licences since March	1,024	1,043	1,069	1,095	1,168	1,175
Average number of daily VPN connections	2,347	1,958	2,144	2,150	2,373	2,024
Microsoft Teams - meetings participated	14,604	14,701	14,845	17,070	19,756	13,066
Airmid video consultations (average/week)	5	1	1	0	2	0
AccuRX video consultations (average/week)	148	164	177	185	215	178

Quality Headlines

Section	KPI	Objective	CQC Domain	Owner	Target	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Year End Forecast
Quality	CAMHS Referral to Treatment - Percentage of clients waiting less than 18 weeks [5]	Improving Health	Responsive	CH	TBC	41.7%	46.5%	48.2%	47.6%	46.7%	55.4%	65.0%	70.8%	67.4%	N/A
Complaints	% of feedback with staff attitude as an issue	Improving Health	Caring	AD	< 20%	10.0%	0% 0/14	17% 5/29	12% 3/25	30% 8/27	19% 6/32	4% 1/24	22% 4/18	8% 2/25	1
	Number of compliments received	Improving Health	Caring	TB	N/A	13	13	41	34	18	19	21	28	45	N/A
	Number of Duty of Candour applicable incidents [4]	Improving Health	Caring	TB	trend monitor	34	35	41	29	27	19	19	34	Due Feb 21	
	Duty of Candour - Number of Stage One exceptions [4]	Improving Health	Caring	TB	trend monitor	5	0	7	1	1	0	1	0		N/A
	Duty of Candour - Number of Stage One breaches [4]	Improving Health	Caring	TB	0	0	0	0	0	0	0	0	0		1
	% Service users on CPA offered a copy of their care plan	Improving Care	Caring	CH	80%	40.3%	40.2%	40.4%	39.6%	39.3%	39.5%	39.2%	38.6%	39.0%	2
	Number of Information Governance breaches [3]	Improving Health	Effective	MB	<=9	15	20	14	25	17	19	12	17	9	2
	Delayed Transfers of Care [10]	Improving Care	Effective	CH	3.5%	2.0%	1.7%	1.4%	1.3%	1.1%	1.5%	1.6%	2.9%	2.2%	1
	Number of records with up to date risk assessment - Inpatient [11]	Improving Care	Effective	CH	95%	90.4%	91.5%	89.4%	84.3%	93.4%	81.0%	Reporting currently under development			N/A
	Number of records with up to date risk assessment - Community [11]	Improving Care	Effective	CH	95%	71.2%	83.3%	79.1%	70.0%	74.6%	77.4%				N/A
	Total number of reported incidents	Improving Care	Safety Domain	TB	trend monitor	968	946	1047	1253	1113	981	1168	1149	1034	
	Total number of patient safety incidents resulting in Moderate harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	32	27	30	21	19	18	11	22	29	
Quality	Total number of patient safety incidents resulting in severe harm. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	1	3	3	4	3	1	2	2	7	
	Total number of patient safety incidents resulting in death. (Degree of harm subject to change as more information becomes available) [9]	Improving Care	Safety Domain	TB	trend monitor	1	5	8	6	6	2	4	9	8	
	MH Safety thermometer - Medicine Omissions [15]	Improving Care	Safety Domain	TB	*17.7%*	No longer available									2
	Safer staff fill rates	Improving Care	Safety Domain	TB	90%	115.1%	119.4%	123.3%	120.5%	118.0%	114.4%	114.0%	114.0%	115.6%	1
	Safer Staffing % Fill Rate Registered Nurses	Improving Care	Safety Domain	TB	80%	95.7%	94.3%	93.9%	90.9%	88.6%	85.6%	90.1%	92.2%	90.9%	
	Number of pressure ulcers (attributable) [1]	Improving Care	Safety Domain	TB	trend monitor	45	44	36	29	34	38	35	42	33	
	Number of pressure ulcers (avoidable) [2]	Improving Care	Safety Domain	TB	0	3			0	0	0	0	1	0	1
	Eliminating Mixed Sex Accommodation Breaches	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	1
	% of prone restraint with duration of 3 minutes or less [8]	Improving Care	Safety Domain	CH	90%	93.0%	91.5%	90.0%	80.0%	94.5%	94.0%	87.5%	100%	90.2%	1
	Number of Falls (inpatients)	Improving Care	Safety Domain	TB	trend monitor	36	39	40	30	43	42	56	40	44	
	Number of restraint incidents	Improving Care	Safety Domain	TB	trend monitor	121	111	137	188	138	125	165	202	189	
	% people dying in a place of their choosing	Improving Care	Caring	CH	80%	95.3%	91.5%	90.2%	87.8%	84.4%	94.1%	92.7%	86.8%	85.7%	1
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Improving Care	Safety Domain	TB	6	0	0	0	0	0	0	0	0	0	1
	C Diff avoidable cases	Improving Care	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	1

** See key included in glossary*
Figures in italics are not finalised
*** - figures not finalised, outstanding work related to 'catch up' activities in relation to the SystmOne implementation impacting on reported performance.*

1 - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYPFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary
2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYPFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage
3 - The IG breach target is based on a year on year reduction of the number of confidentiality breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches
4 - These incidents are those where Duty of Candour is applicable. A review has been undertaken of the data and some issues identified with completeness and timeliness. To mitigate this, the data will now be reported a month in arrears. Target only applicable to breaches.
5 - CAMHS Referral to treatment - the figure shown is the proportion of clients waiting for treatment as at the end of the reporting period who at that point had waited less than 18 weeks from their referral receipt date. Data quality (DQ) issues are impacting on the reported data from March 19. Some improvement in dq has seen in recent months and this is expected to continue. Excludes ASD waits and neurodevelopmental teams.
8 - The threshold has been locally identified and it is recognised that this is a challenge. The monthly data reported is a rolling 3 month position.
9 - Data is extracted from a live system, and correct at the time of reporting. The degree of harm is initially recorded based on the potential level of harm and is subject to change as further information becomes available e.g. when actual injuries or cause of death are confirmed. Trend reviewed in risk panel and clinical governance and clinical safety group. Initial reporting is upwardly biased, and staff are encouraged to do this. Once reviewed and information gathered, this can change, hence the figures may differ in each report.
9 - Patient safety incidents resulting in death (subject to change as more information comes available).
10 - In the 2017/18 mandate to NHS England, the Department of Health set a target for delayed transfers to be reduced to no more than 3.5 per cent of all hospital bed days by September 2017. The Trust's contracts have not been varied to reflect this, however the Trust now monitors performance against 3.5%.
11. Number of records with up to date risk assessment. 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. Reporting is currently being updated given the recent implementation of the FIRM risk assessment tool.
14 - This is the count of written complaints/count of whole time equivalent staff as reported via the Trusts national complaints return and is monitored under the NHS oversight framework.
15 - The medicine omissions data was taken from the NHS Safety thermometer tool. This data collection ended at the end of March 20 and therefore data for this metric is no longer available.

Quality Headlines

Please see the points below for indicators that are performing outside expected levels or where additional supporting information is available.

• Number of restraint incidents - the number of restraint incidents during December decreased from 202 to 189. Further detail can be seen in the managing violence and aggression section of this report.

• NHS Safety Thermometer - medicine omissions. It has been decided by NHS Improvement that the safety thermometers are to cease being used and they are currently working on a replacement. Therefore staff no longer need to collect monthly data or input onto the national site. Alternative patient safety measures are being explored.

• Number of falls (inpatients) – Total number of falls was 44 in December which is broadly in line with the previous month . All falls are reviewed to identify measures required to prevent reoccurrence and more serious falls are subject to investigation.

• Staffing fill rates are provided for the last 2 months where new planned staffing in acute mental health wards is included and fill rates measured against these.

• Patient safety incidents involving moderate or severe harm or death fluctuated over recent months (see section below). Increases mainly due to increased number of unavoidable pressure ulcers and slips, trips and falls. Increase in number of deaths although important to note that deaths are often re-graded upon receipt of cause of death/clarification of circumstances.

• Duty of candour - there were no breaches

• % Service users on CPA offered a copy of their care plan - Reporting has now been developed to enable us to monitor performance against this metric. To meet the standard all care plans for an individual have to have been identified as offered to the service user. For example, if an individual has 5 care plans, all of these must be marked as offered to the service user for this to achieve the standard. Work is ongoing to improve data quality.

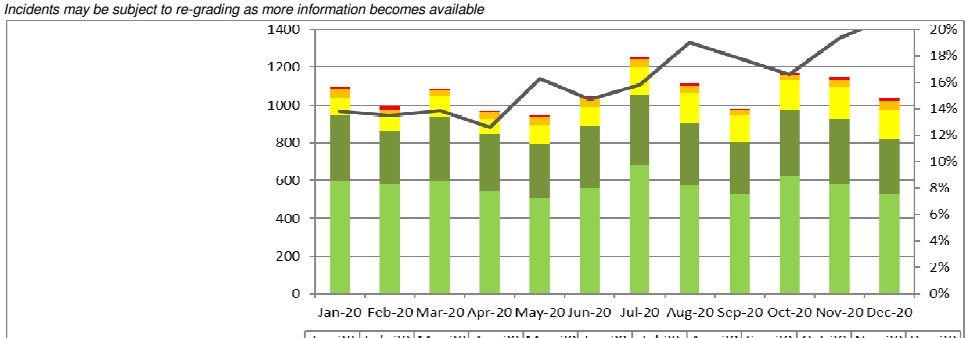
• Number of pressure ulcers (avoidable) - there were no incidences of avoidable pressure ulcers to report during December.

NHS Improvement - the development of new programmes introduced in the NHS patient safety strategy are either continuing with amended timescales to be confirmed, or paused. The latest development is the Trust has provided names of our nominated patient safety specialist/s to NHS England: Dr Kiran Rele, Associate Medical Director and Helen Roberts, Patient Safety Manager. Both are now part of the Patient Safety Specialist networks and invites received to join various groups about the upcoming developments in the NHS patient safety strategy and workstreams.
The Trust took part in the Serious Incident Review Accreditation Network to work towards having our serious incident investigation process accredited by the Royal College of Psychiatrists. We had a peer review visit (virtually) on 22 December 2020. The feedback session at the end of the day was positive with some areas for improvement identified. We expect the draft report by the end of January for response/comments.
360 Assurance audit of patient safety - focus on incidents; The Trust received significant assurance. Work continues to implement actions, extended until 31/3/2021. This work includes reviewing policies:
Incident reporting and management policy - policy redrafted. Will be sent to BDUs for consultation towards the end of January. A document detailing proposed changes to Datix has gone out for comments to all staff via Headlines and direct to BDUs. Changes will come into effect from 1/2/2021.
Investigating and analysing incidents policy - policy redraft underway. Will be sent to BDUs for consultation during February.

Safety First

Summary of Incidents January 2019 - December 2020

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



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Red (should not be compared with SIs)	11	13	11	5	10	11	11	10	7	8	13	9
Amber	47	41	30	35	41	48	41	37	32	25	42	50
Yellow	93	80	110	82	103	95	146	165	136	161	167	158
Green	347	276	338	299	282	334	370	328	276	350	344	285
Green no harm	596	581	598	547	510	559	685	573	530	624	583	532
Total	1094	991	1087	968	946	1047	1253	1113	981	1168	1149	1034
Percentage of total that are Red/Amber/Yellow *	13.8%	13.5%	13.9%	12.6%	16.3%	14.7%	15.8%	19.0%	17.8%	16.6%	19.3%	21.0%

Degree of harm analysis:

Degree of harm analysis: Degree of harm will be updated when more information emerges. The patient safety support team add a provisional degree of harm at the point of an incident being reported based on information recorded at that point, and what the harm could potentially be. This is checked and revised when an incident is finally approved, after the manager has reviewed and added the outcome. This can be delayed due to length of time to review incidents, and volumes. This is a constantly changing position and the data was accurate at the time of extraction (12/01/21).

Deaths: of the 8 deaths that were recorded for December 2020, there are 4 deaths awaiting confirmation. These were recorded 1 each at Enhanced Team North,, Enhanced Team South Kirklees, Enhanced Team West - Kendray, Barnsley, and Intensive Home Based Treatment Team - Wakefield (OPS) . The degree of harm of these 4 deaths awaiting confirmaion are subject to change as further information becomes available There were also 2 suicide (incl apparent) - community team care - current episode incidents reported for the month of December. These were recorded 1 each at Core Team East – Wakefield and Core Team – Barnsley. There was 1 suicide (incl apparent) - community team care – discharged incident recorded at CMHT East Calderdale (OPS) and 1 Suicide (incl apparent) - inpatient care - current episode recorded at Clark Ward – Barnsley.

Severe: of the 7 severe incidents recorded for the month of December 2020, these were 4 pressure ulcers incidents category 4 recorded for the neighbourhood teams in Barnsley, 1 unwell/illness incident recorded for sandal ward Bretton centre) and 1 tissue viability incident record for- Barnsley and 1 actual self harm incident recorded for Sandal ward

Moderate: of the 29 moderate harm incidents, there were 21 pressure ulcer category 3 incidents and 2 tissue visibility incidents recorded across, Barnsley neighbourhood team These have been checked and they are attributable to SWYPFT care but there was no laspe in the care provided for any of them. There were also 2 Self harm (actual harm) incidents, 1 each recorded at Enhanced Team South – and Beamshaw Ward – Barnsley. 1 Slip, trip or fall – patient incident, recorded at Elmdale Inpatient Services Ward. There was 1 physical violence (contact made) against patient by patient incident recorded at Stanley Ward, Wakefield. 1 Unconfirmed self-harm incident (reported by self/3rd party) recorded at Intensive Home Based Treatment Team (IHBTT) – Wakefield, 1 security incident recorded at Stanley Ward Wakefield.

** A high level of incident reporting, particularly of less severe incidents is an indication of a strong safety culture (National Patient Safety Agency, 2004: Seven Steps to Patient Safety).*
The distribution of these incidents shows 86% are low or no harm incidents.

Safety First cont…

Summary of Serious Incidents (SI) by category

	20/21 Q1	20/21 Q2	20/21 Q3	19/20 Q4	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20
Administration/supply of medication from a clinical area	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
Damage (deliberate - e.g Vandalism)	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
Death - cause of death unknown/ unexplained/ awaiting confirmation	1	0	1	2	1	0	0	0	0	0	0	1	0	0	0	2
Death - confirmed from physical/natural causes	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Death - confirmed related to substance misuse (drug and/or alcohol)	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
Security - Other	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Self harm (actual harm) with suicidal intent	0	0	2	0	0	0	0	0	0	0	1	0	1	0	0	0
Slip, trip or fall - patient	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Substance Misuse	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Suicide (incl apparent) - community team care - current episode	8	3	2	4	4	2	2	0	2	1	0	2	0	2	2	0
Suicide (incl apparent) - community team care - discharged	0	1	0	1	0	0	0	0	0	1	0	0	0	0	1	0
Suicide (incl apparent) - inpatient care - current episode	1	0	1	1	1	0	0	0	0	0	1	0	0	0	0	1
Unintended/Accidental injury	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Physical violence (contact made) against staff by patient	2	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0
Physical violence (contact made) against other by patient	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0
Pressure Ulcer - Category 3	0	2	1	0	0	0	0	0	0	2	1	0	0	0	0	0
Total	15	8	11	8	9	4	2	0	4	4	3	6	2	2	3	3

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

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

Mortality

Learning: Thematic learning work is underway for sharing during Q4. Clinical mortality review group has been postponed during to Covid 19 pressures on services, although learning continues to be shared through the production of SBAR's which are shared via the learning library.
Regional work: no updates, meetings suspended at present time
Reporting: Q3 2020/21 data for learning from deaths included in Q3 incident report.
Structured judgement reviews: 2 SJRs for allocation at 11/1/21.

Safer Staffing Inpatients

In January 2021, as well as continuing to deliver all our services, we continue to face ever increasing staffing challenges associated with the second pandemic "wave" and, in particular, staff self-isolating, covid outbreaks and positive Service Users. We continue to have inpatient outbreaks which the operational services, with the support of our internal mechanisms and support services, which are being well managed. The roll out of the vaccination process, whilst being key to recovery, also brings added staffing resource challenges. There is also evidence of a sustained increase in acuity within the services.

We continue with recruitment into our registered work force (27 staff recruited since September) and have just completed a substantive and bank health care assistant (HCA) recruitment process. BDU and team business continuity plans have remained resilient in the face of significant challenges. We continue to utilise the temporary staffing workforce as well as overtime and time owing to cover our inpatient areas.

Two wards have fallen below the 90% overall fill rate threshold in December. They were Chippendale within the forensic BDU and Willow ward in the Barnsley BDU. Of the 31 inpatient areas, 20 (64%), a decrease of two on the previous month, achieved 100% or more. Indeed, of those 20 wards, 10 (a decrease of one ward) achieved greater than 120% fill rate. The main reason for this being cited as acuity, observation and external escorts.

Registered on Days -Trust Total 86.5% (a decrease of 4.2%). The number of wards that have failed to achieve 80% registered nurses increased by two to 13 (41.6%). Nine wards were within the Forensic BDU, one in Barnsley and three in Calderdale and Kirklees. The situation is perpetuated by outbreaks with these areas that led to large numbers of staff having to self-isolate. Although our overall fill rates remain high, all inpatient areas remain under pressure from a registered staffing perspective. This is often compensated by increasing the number of HCAs per shift. Contributory factors included high levels of acuity, high sickness/absence and existing vacancies. Tailored localised adverts have proving beneficial to recruitment of band 5 RNs with some success. We are also sourcing block bookings for the areas from both bank and agency. Due to the Covid 19 pandemic we have flattened the recruitment processes further whilst ensuring compliance with NHS employer checks, have also accelerated the leaver and return process and bank registration.

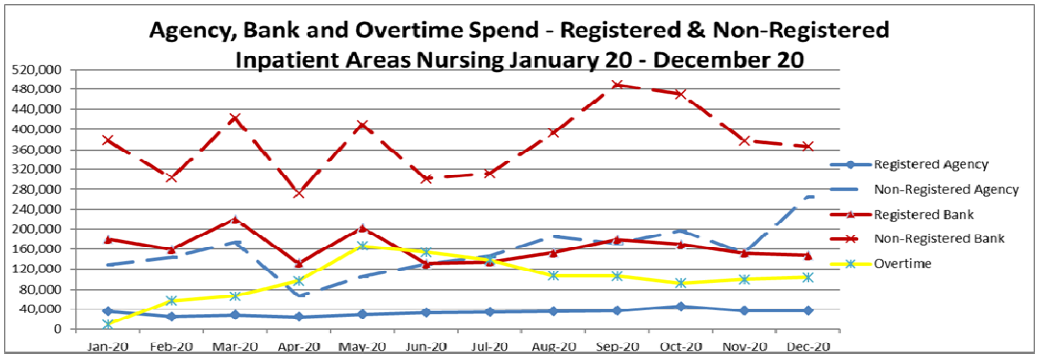
Registered on Nights- Trust Total 95.2% (a decrease of 2.7%). Three wards (9.6%), a decrease of one on the previous month, fell below the 80% fill rate in the month of December. All were within the forensic BDU. This was due to a number of reasons reflective of the reasons in the section above. The number of wards who are achieving 100% and above fill rate on nights increased by seven to 15 (48%). One ward utilised in excess of 120% and these were within the Forensic BDU.

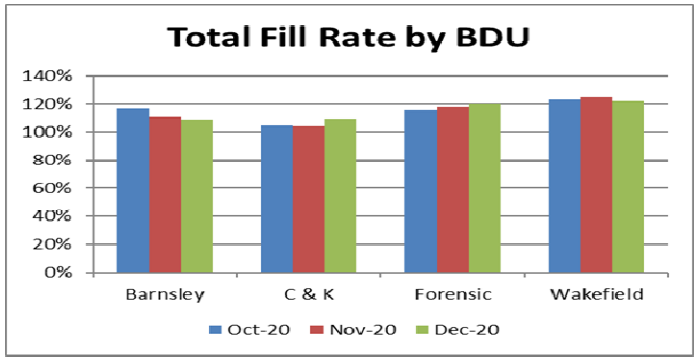
Overall fill rate for registered staff increased by 1.3% to 90.9%.

Overall fill rate for all staff within inpatient areas increased to at 115.6%.

Ward Name	Average Fill Rate - All Staff (%)	Average Fill Rate - All Staff (%)	Average Fill Rate - All Staff (%)
Beamshaw	106.0%	111.6%	109.1%
Clark	111.1%	96.8%	96.1%
Melton Suite PICU	122.1%	123.2%	136.6%
Neuro Rehab Unit	136.4%	139.0%	135.2%
Stroke Rehab Unit	111.8%	93.7%	93.0%
Willow Ward	118.5%	104.2%	84.0%
Ashdale	94.9%	97.9%	103.1%
Beechdale	150.2%	143.4%	156.5%
Elmdale	93.8%	98.6%	114.4%
Enfield Down	94.6%	93.6%	95.2%
Lyndhurst	100.9%	101.8%	99.6%
Ward 18	106.4%	107.4%	120.9%
Ward 19 - Female	105.3%	92.0%	90.1%
Ward 19 - Male	105.5%	105.1%	96.8%
Appleton	92.2%	95.8%	97.9%
Bronte	126.6%	112.2%	117.1%
Chippendale	94.8%	100.6%	80.6%
Hepworth	103.2%	125.5%	117.3%
Gaskell	168.7%	152.7%	158.9%
Newhaven	97.0%	103.8%	96.9%
Priestley	94.3%	92.4%	142.8%
Ryburn	99.1%	97.7%	100.3%
Sandal	119.6%	128.3%	141.8%
Thornhill	98.0%	100.0%	95.4%
Waterton	114.5%	118.0%	117.6%
Crofton	107.4%	115.2%	111.8%
Horizon	140.0%	148.3%	142.6%
Nostell	111.0%	121.5%	125.8%
Poplars	143.3%	127.0%	147.1%
Stanley	136.5%	123.5%	113.2%
Walton PICU	120.0%	132.2%	117.1%
All Wards	114.0%	114.0%	115.6%

Fill Rate Key for All Staff:	
	Less than 90% fill rate
	Greater than or equal to 120% fill rate





Throughout December the main wards where staffing was a raised concern were Ward 19, Ashdale, and Newton Lodge. Shifts were picked up quickly and the fill rate of requested flexible staffing shifts remained high as can be seen in the figures below. Theses figures do not include OT shifts.

Unfilled Shifts

	No. Of Shift	Total Hours	
Registered	408 (-168)	4,378,83	39.9% +14.3%)
Unregistered	730 (-343)	8,337,50	19.7% (+7.8%)
Grand Total	1138	12,716,33	23.9%

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.

In December the number of shifts that were requested of the flexible staffing increased compared to the month before and this led to an increase in bank, OT and agency spend of £101k. This was broken down into: Agency increased by £114k and bank decreased by £16k whilst overtime increased by £4k. Substantive spend on staffing has risen by £5k.

The main impact was the self-isolation of our own bank staff who were paid and then their shift back filled often with agency staff. There is no impact on our spend when agency staff are advised to self-isolate.

Information Governance

December saw a decrease in the total number of reported incidents from 19 to 12 compared to the previous month. 10 incidents of information being disclosed in error were reported, which continues to be the most reported category. These typically relate to letters being sent to the wrong GP or service user address, and other patients' data being included in service user correspondence.

The action plan to raise awareness of the consequences of incidents continues to progress. Communications demonstrating the impact of breaches on individuals' lives are included in The Brief, and change improvement workshops are being arranged, although these are being impacted by operational and resource pressures.

The Information Commissioner's Office (ICO) has closed the incident that was reported during November with some recommendations made which will be enacted.

Commissioning for Quality and Innovation (CQUIN)

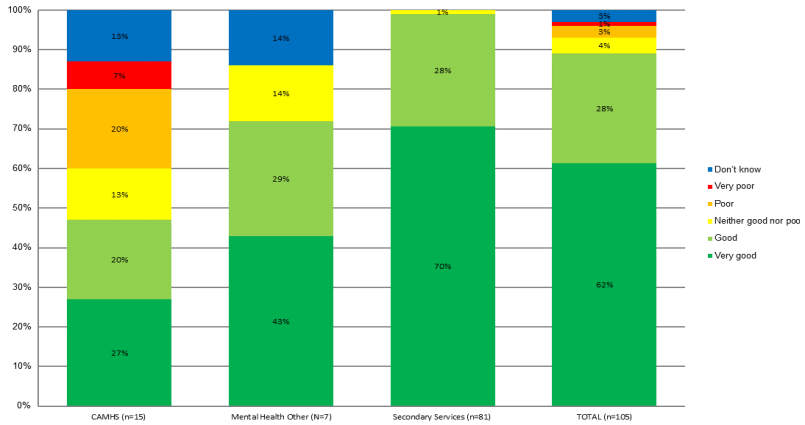
Schemes for 20/21 have been suspended during the Covid-19 pandemic period.

Patient Experience

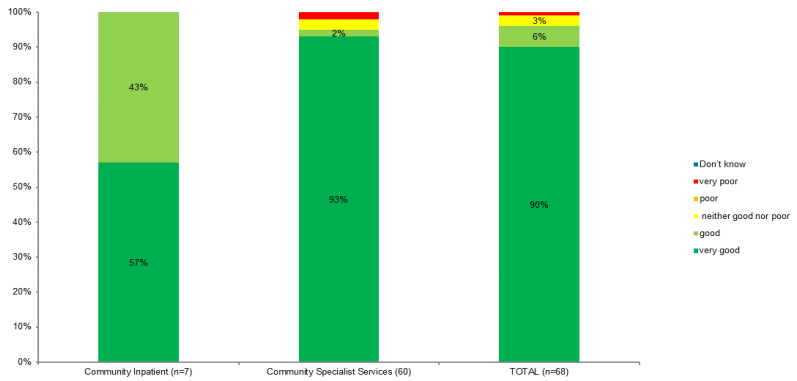
Friends and family test shows

- 96% would recommend community services.
- 90% would recommend mental health services

Mental Health Services



Community Services



•91% (176) of respondents felt that their experience of services had been very good or good across Trust services.
•96% (n=68) of respondents felt that their experience had been very good or good across community services.
•90% (n=105) of respondents felt that their experience had been very good or good across mental health services.

•The text messaging service was taken offline in November, whilst the Trust transitioned to the new patient experience system. This will now resume in January.
•The pilot of the new patient experience system continues within QIAT. Testing has been successful so far. Devices have been deployed to mental health inpatient wards in Wakefield and the occupational Therapy Team in Calderdale and Kirklees. Devices for Barnsley Community are still being tested within support teams.
• Please note that our figures remain low for December as the text messaging service is offline whilst we transfer across to a new patient experience system. We expect the text messaging system to be back up and running in January.

Care Quality Commission (CQC)

CQC improvement plan
Alongside our Covid-19 response we continue to collate evidence against our progress with regards to our CQC actions, and our next steps will include which of the actions have accrued sufficient evidence to be closed.

Safeguarding

Safeguarding remains a critical service, all statutory duties have been maintained, data flow (internally and externally) has continued in a timely manner and the team have continued to provide supervision. Level 3 Safeguarding adults and children training continues to be delivered virtually via MS Teams. This has been positively received although further work to support interaction is being undertaken. Levels 1 and 2 have been accessed via e-learning with all mandatory courses (including PREVENT) reported above the 80% mandatory training target. The team are currently reviewing the parental mental health package with the intention to deliver Trust-wide. The Domestic Abuse presentation (West Yorkshire Quality Mark) has been well received.
The ICON training and the lasting impact of femal genital mutilation (FGM) presentations were delivered to the link practitioner forum.
The team continue to review Datix and clinical records as part of internal quality monitoring and in preparation for external CQC and Ofsted inspections. Additionally, members of staff continue to provide support to the wider Trust priorities including supporting the Covid-19 vaccination programme.
External information gathering requests have been responded to and the team have continued to attend Child Safeguarding Practice Review panels, Safeguarding Adult Review panels and a Domestic Abuse panel.
The team have supported clinical activity through attendance at multi-disciplinary meetings, professional meetings and Best Interest meetings and chaired a Professionals meeting on behalf of Wakefield CAMHS of a young person in hospital with complex needs
All members of the team have attended virtual webinars and or training sessions, along with task and finish groups to ensure that their practice, the training material and advice provided is up to date and relevant.

Infection Prevention Control (IPC)

Ongoing work for Covid-19 pandemic

Surveillance: For November there has been zero cases of C difficile, MRSA Bacteraemia and MSSA bacteraemia. There has been one ecoli bacteraemia in on SRU in November 2020 which was deemed unavoidable.

Mandatory training figures are healthy:

Hand Hygiene-Trust wide Total –98%
Infection Prevention and Control- Trust wide Total –96%

Policies and procedures are up to date.

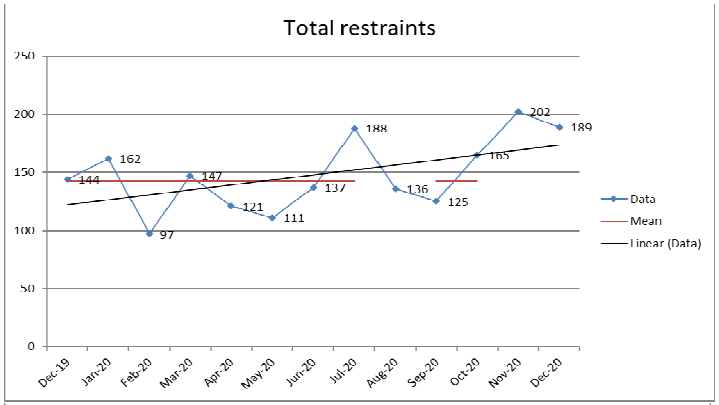
Complaints

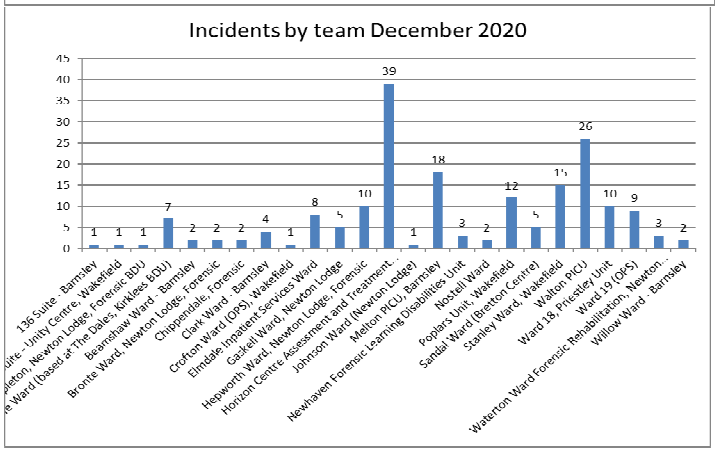
There were 25 new formal complaints in December 2020. Of these 4 have a timescales start date, 3 have been closed as no consent/contact and 18 are awaiting consent/questions
8% of new formal complaints (n=2) had staff attitude as a primary subject
45 compliments were received
9 formal complaints were closed in December 2020. Of these, 11% of complaints (n=1) were closed within 40 working days. Of the 8 complaints that exceeded 40 working days, the average working days to close was 70 days. The reasons why complaints exceeded the 40 day target included delays in receiving the completed investigation from clinical services due to clinical pressures and issues with the quality of information received in the completed investigation alongside delays in receiving the required approval during sign off.
2 reopened complaints were closed in December 2020 and both achieved the 40 working day target.

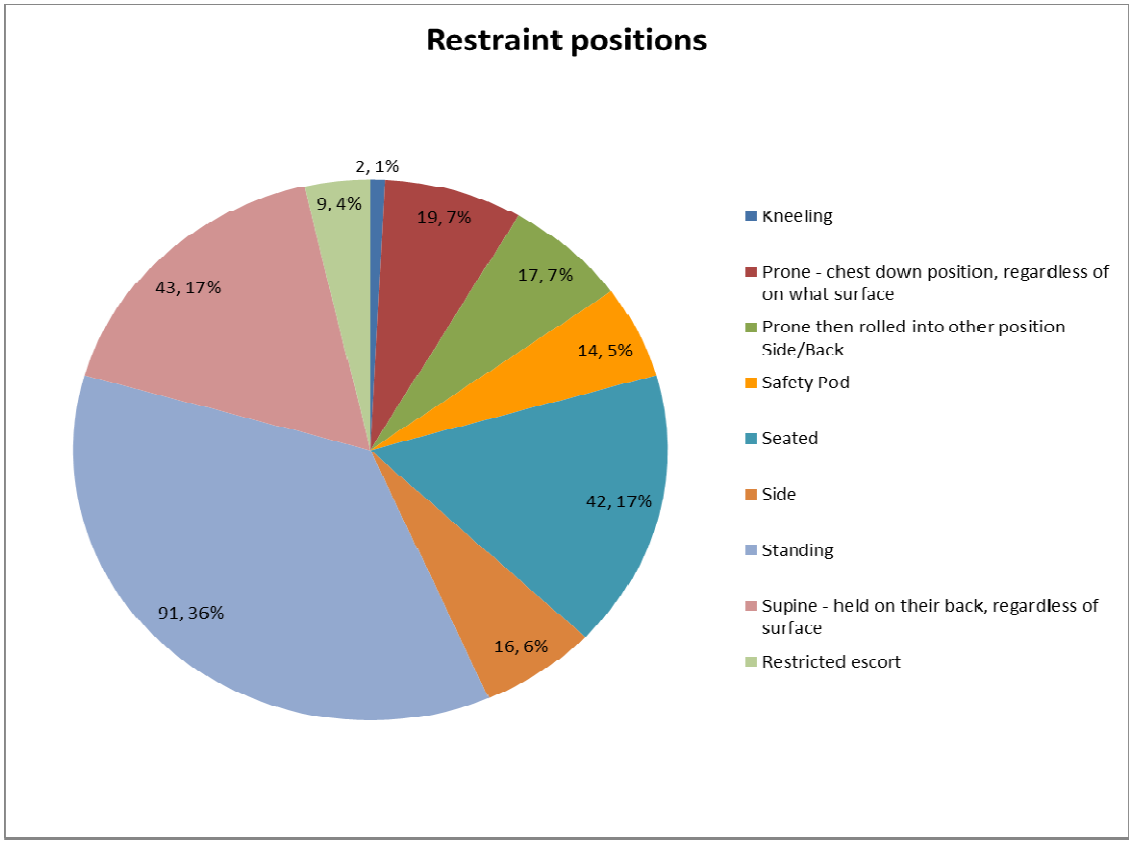
Reducing Restrictive Physical Intervention (RRPI)

There were 189 reported incidents of Reducing Restrictive Physical Interventions used in December 2020 this is a decrease of 13 (6.4%) incidents since November 2020 which stood at 202 incidents.
Of the different restraint positions used in the 189 incidents, standing position was used most often 91 (36%) followed by supine at 43 (17%). Supine restraints remain high due to service users who were either moved from a seated to a supine position or during an incident placed themselves into a supine position to manage risks. It is also evident that clinical interventions such as taking bloods or individualised choices of position impact on the figures
Prone restraint was reported 19 (7%) times in December 2020, this is an increase of three (12.5%) from last month. Data suggests that seclusion exit techniques and or the enforced method of medication administration have contributed to this increase.
Incidents where prone descent immediately turned into a supine position were recorded at 17 (7%) this is a separate entity to prone restraint.
Wakefield BDU recorded seven prone restraints, forensic had five, Barnsley three, Calderdale two, specialist services recorded one, Kirklees reported no incidents of prone restraint.
The Trust target of 90% of prone restraints lasting under 3 minutes and the importance of striving to maintain this is strongly emphasised. In December the percentage of prone restraints lasting under 3 minutes was 90.2% which is a decrease of 9.8% from the previous month. This is due to the challenging nature of individuals in separate incidents where complicated and lengthy restraints necessitated the use of seclusion and administration of medication to manage acute behavioural disturbances
Despite the above paragraph, and the documented challenges of complex individuals that are currently being cared for in inpatient areas, the use of seclusion has decreased by 12 from the previous month.
The RRPI team continue to provide face to face training inline with current IPC guidance. Although Covid-19 restrictions have impacted on our delivery we have maintained a compliance of over 80% in all courses.

The refresher courses will be re-introduced in April this year with update periods extended by 12 months from March 2020.
Other courses such as personal safety and de-escalation and breakaway courses have been adapted to workbooks and e-learning packages, the practical face to face elements will be delivered as one -hour sessions over a day in each location from April 2021.

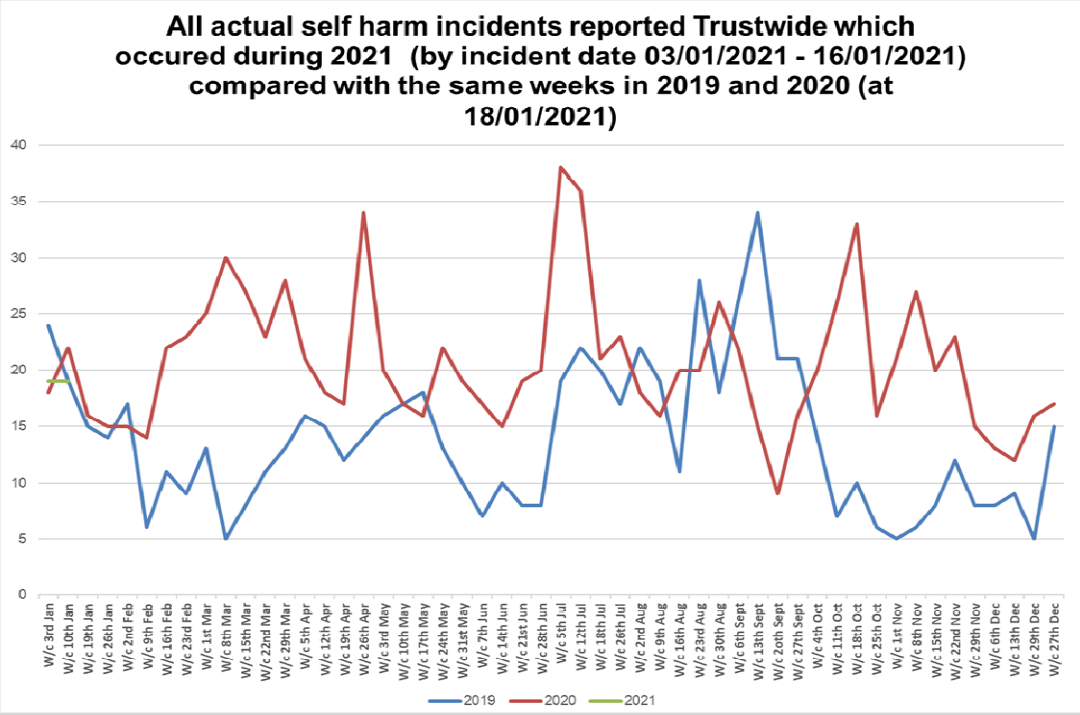






Self Harm

Actual self-harm incidents reported on Datix occurring between 03/01/2021 and 16/1/2021 at 18/01/2021, compared with incidents occurring in the same period in 2019 and 2020



Actual Self Harm comparison

Week Commencing	2019	2020	2021
03-Jan	24	18	19
10-Jan	19	22	19
19-Jan	15	16	
26-Jan	14	15	
02-Feb	17	15	
09-Feb	6	14	
16-Feb	11	22	
23-Feb	9	23	
01-Mar	13	25	
08-Mar	5	30	
15-Mar	8	27	
22-Mar	11	23	
29-Mar	13	28	
05-Apr	16	21	
12-Apr	15	18	
19-Apr	12	17	
26-Apr	14	34	
03-May	16	20	
10-May	17	17	
17-May	18	16	
24-May	13	22	
31-May	10	19	
07-Jun	7	17	
14-Jun	10	15	
21-Jun	8	19	
28-Jun	8	20	
05-Jul	19	38	
12-Jul	22	36	
19-Jul	20	21	
26-Jul	17	23	
02-Aug	22	18	
09-Aug	19	16	
16-Aug	11	20	
23-Aug	28	20	
30-Aug	18	26	
06-Sep	26	22	
13-Sep	34	15	
20-Sep	21	9	
27-Sep	21	16	
04-Oct	14	20	
11-Oct	7	26	
18-Oct	10	33	
25-Oct	6	16	
01-Nov	5	21	
08-Nov	6	27	
15-Nov	8	20	
22-Nov	12	23	
29-Nov	8	15	
06-Dec	8	13	
13-Dec	9	12	
20-Dec	5	16	
27-Dec	15	17	
Total	720	1072	38

Please note:

To ensure this data is accurate as possible, it includes all actual self harm incidents even where the incident has not yet been approved by managers (0 in total pending review). Figures may change as incidents are reviewed and approved.

Peak in July

The peak in July 2020 has been explored further and analysis has shown that between July - August there was a total of 135 incidents of actual self-harm. This involved 34 patients. 27 patients had 3 or less self harm incidents in the period. There were 6 patients who had more than 3 incidents. Of these, one patient had 30 incidents (28 on Clark, 2 on Beamshaw), Another patient had 30 incidents (Elmdale). The next highest total of self harm in the period was for a patient with 12 incidents (10 on Clark and 2 on Ward 18).

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

Ongoing analysis

Analysis of the data from 2020 shows that there are two subcategories of self harm that are higher than other methods. These are self strangulation, which is the highest subcategory of self harm incident (307 incidents). There was a peak in July where there were 63 incidents, this figure has now reduced August (9), September (11) and October (29).

Analysis of incidents shows that a small number of individual service users account for this higher number of incidents.

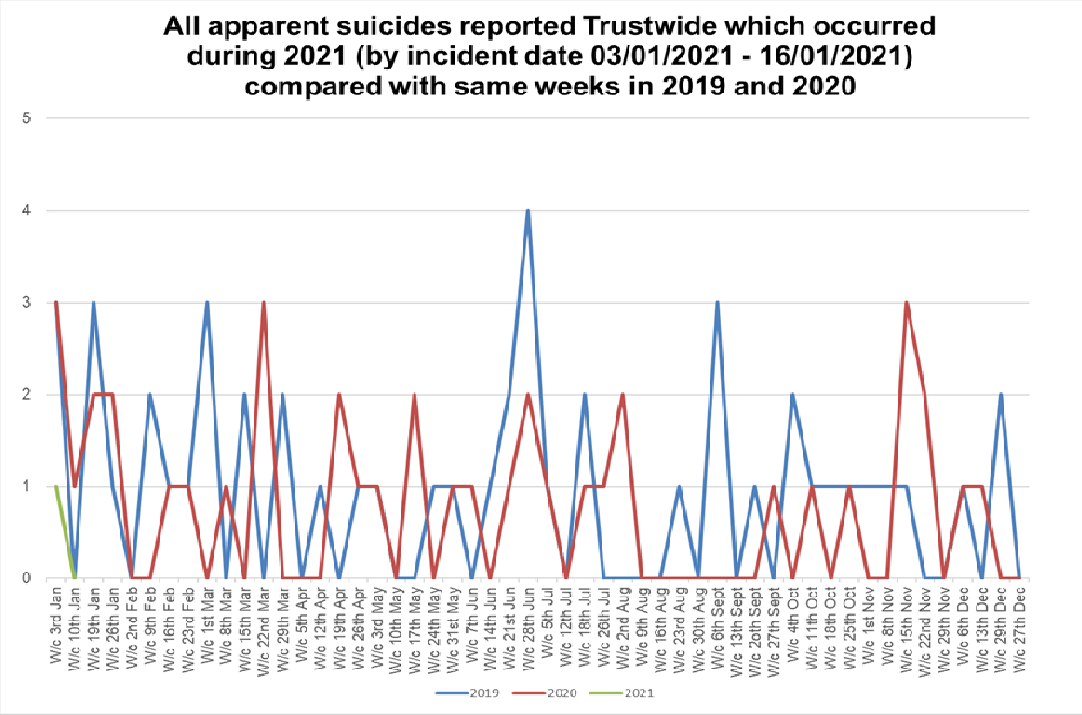
The next highest subcategory is by cutting (193 incidents). This varies across months ranging from 14 - 27 incidents. Following this, the third highest subcategory is 'headbanging' with 61 incidents. The headbanging incidents are across a range of units, but Ward 18 had the highest number (20).

Update 9 November 20

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

Apparent Suicide

Apparent suicides reported on Datix occurring between 03/01/2021 and 16/01/2021 at 18/01/2021, compared with incidents occurring in the same periods in 2019 and 2020



Apparent suicide comparison

Week Commencing	2019	2020	2021
03-Jan	3	3	1
10-Jan	0	1	0
19-Jan	3	2	
26-Jan	1	2	
02-Feb	0	0	
09-Feb	2	0	
16-Feb	1	1	
23-Feb	1	1	
01-Mar	3	0	
08-Mar	0	1	
15-Mar	2	0	
22-Mar	0	3	
29-Mar	2	0	
05-Apr	0	0	
12-Apr	1	0	
19-Apr	0	2	
26-Apr	1	1	
03-May	1	1	
10-May	0	0	
17-May	0	2	
24-May	1	0	
31-May	1	1	
07-Jun	0	1	
14-Jun	1	0	
21-Jun	2	1	
28-Jun	4	2	
05-Jul	1	1	
12-Jul	0	0	
19-Jul	2	1	
26-Jul	0	1	
02-Aug	0	2	
09-Aug	0	0	
16-Aug	0	0	
23-Aug	1	0	
30-Aug	0	0	
06-Sep	3	0	
13-Sep	0	0	
20-Sep	1	0	
27-Sep	0	1	
04-Oct	2	0	
11-Oct	1	1	
18-Oct	1	0	
25-Oct	1	1	
01-Nov	1	0	
08-Nov	1	0	
15-Nov	1	3	
22-Nov	0	2	
29-Nov	0	0	
06-Dec	1	1	
13-Dec	0	1	
20-Dec	2	0	
27-Dec	0	0	
Total	49	40	1

Please note:

Data refreshed and verified on 18th January 2021 from Datix for both 2019 and 2020 data.

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

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

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

Covid-19 related incident reporting

226 incidents reported between 1/3/20-11/01/21 where 'Covid' or 'Corona' was used in the description or action taken fields. These incidents have been themed as below. One incident may have more than one theme.

268 Incidents	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Total
Coronavirus or Covid 19 used in threat against patient	1	1	0	0	0	0	0	0	0	0	0	**2**
Coronavirus or Covid 19 used in threat against staff	3	2	1	0	0	0	1	1	0	1	0	**9**
Death of community patient from suspected Covid 19 - no underlying health conditions	0	0	1	0	0	0	0	0	0	3	0	**4**
Death of community patient from suspected Covid 19 - underlying health conditions	2	16	3	1	0	0	0	0	2	1	2	**27**
Death of community patient from suspected Covid 19 related death - pending further info	0	7	5	3	1	0	0	1	4	4	1	**26**
Impact of coronavirus/Covid 19 on patient and staff safety	4	5	9	3	0	2	12	10	8	13	6	**72**
Impact of Covid 19 on community patient, changes to care delivery	2	2	2	1	2	3	0	0	0	1	0	**13**
Impact of Covid 19 on patient's mental health	2	2	1	0	2	0	1	0	1	1	0	**10**
Issues relating to PPE equipment	1	1	1	0	0	2	0	1	0	1	0	**7**
Non-compliance with social distancing - inpatient area	1	7	4	8	3	3	3	4	7	4	4	**48**
Patient being nursed in isolation	5	4	3	4	2	4	3	3	3	6	3	**40**
Patient in contact with symptomatic person	0	0	2	0	0	0	2	0	1	0	0	**5**
Staff in contact with colleague displaying Covid-19 symptoms	0	0	0	0	1	0	3	1	1	0	1	**7**
Staff in contact with other person displaying Covid-19 symptoms	1	0	2	0	0	0	2	1	1	1	0	**8**
Staff in contact with patient displaying Covid-19 symptoms	2	8	5	3	2	2	3	1	2	3	0	**31**
Staff member on swabbing team exposed to Covid 19	0	1	0	0	0	0	0	0	0	0	0	**1**
Staff presenting with Covid 19 symptoms	1	1	1	0	2	0	7	2	2	2	1	**19**
Not direct clinical impact of Covid 19	0	0	0	0	0	0	0	0	0	1	0	**1**
Total	**25**	**57**	**40**	**23**	**15**	**16**	**37**	**25**	**32**	**42**	**18**	**330**

Mental Health Act

This section provides some key metrics related to performance against the Mental Health Act (MHA) requirements. Development of these has been taking place over the last few months. Monthly reporting of performance against Section 17 leave is now available. With reference to Section 132 patient rights:

- The Trust section 132 policy and additional document amendments have been completed and agreed with the practice governance coach and the matrons.
- The Mental Health Act (MHA) administrators have started attending the wards and meeting with registered staff to show them the new process, where to record on SystmOne and where to access The SystmOne white board (dashboard) so that the registered staff can at a glance and in real-time see what the activity is and what needs addressing / where the hotspots are.
- The MHA administrators will be developing a process to keep this under review and send reminders where needed to registered staff alerting that a patients' rights are due. Further update regarding this can be seen below.

Section 17 leave

The Care Quality Commission have regularly raised an issue with the non completion of page 2 of the Section 17 leave forms. The recording of who has been informed of the leave and the involvement of the service users is a requirement of the MHA code of practice 2015.
This data indicates that the forms are being reviewed by the MHA administrators and where required are returned to the clinical team for action and completion.
It is important to note that this report is monitoring the amount of s17 leave forms that require MHA administration intervention. With the intervention of the MHA office staff we should be achieving 100% compliance.
The ward managers within the forensic service have now been tasked with undertaking weekly checks of the forms. This is also the case within in patient services across the Trust.
The practice governance coaches and matrons will continue to dip sample records and have oversight of the process.
Training on the completion of the S17 forms by the MHA admin team has been offered to clinical services.
Inclusion of the purpose, use and completion of the S17 leave forms is included in staff induction and the mandatory training provided within the Trust.

	Jul-20			Aug-20			Sep-20			Oct-20			Nov-20			Dec-20		
	Section 17 form			Section 17 form			Section 17 form			Section 17 form			Section 17 form			Section 17 form		
Service	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete	Forms Received	Forms complete	% complete
Older people services Trustwide	33	30	90.9%	74	68	91.9%	82	68	82.9%	48	43	89.6%	89	80	89.9%	34	30	88.2%
Working age adult - Trustwide	203	169	83.3%	269	195	72.5%	295	246	83.4%	163	137	84.0%	169	150	88.8%	124	105	84.7%
Specialist Forensic services	11	11	100%	135	107	79.3%	248	193	77.8%	118	87	73.7%	78	73	93.6%	114	89	78.1%
Rehabilitation services - trustwide	20	20	100%	13	13	100%	13	13	100%	7	7	100%	5	5	100%	7	7	100%

Patients rights

Work is progressing on reporting for the adherence to reading of patients' rights. This data is now being recorded on SystmOne. We are now in the process of writing a report to flow this data.
There is currently a manual process in place monitoring the reading of patients' rights which is being undertaken by the mental health act administrators in conjunction with the wards.

This section of the report outlines the Trust's performance against a number of national metrics. These have been categorised into metrics relating to:
• NHS Improvement Oversight Framework - NHS providers must strive to meet key national access standards, including those in the NHS Constitution. One element of the framework relates to operational performance and this is be measured using a range of existing nationally collected and evaluated datasets, where possible. The table below lists the metrics that are monitored and identifies baseline data where available and identifies performance against threshold.
• Mental Health Five Year Forward View programme – a number of metrics were identified by the mental health taskforce to assist in the monitoring of the achievement of the recommendations of the national strategy. The following table outlines the Trust's performance against these metrics that are not already included elsewhere in the report.
• NHS Standard Contract against which the Trust is monitored by its commissioners. Metrics from these categories may already exist in other sections of the report.
The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

NHS Improvement - Oversight Framework Metrics - Operational Performance

KPI	Objective	CQC Domain	Owner	Target	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Data quality rating [8]	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Improving Care	Responsive	CH	92%	97.8%	90.0%	98.7%	99.2%	97.0%	95.6%	90.0%	94.9%	96.8%	98.7%	98.5%	98.9%	99.2%		
Maximum 6-week wait for diagnostic procedures	Improving Care	Responsive	CH	99%	100.0%	28.5%	43.8%	56.8%	55.2%	31.4%	28.5%	26.2%	33.9%	43.8%	42.9%	49.5%	56.8%		
% Admissions Gate kept by CRS Teams	Improving Care	Responsive	CH	95%	97.9%	100%	96.1%	98.7%	99.0%	99.2%	100%	96.8%	96.4%	95.2%	100%	100%	96.1%		
% SU on CPA Followed up Within 7 Days of Discharge	Improving Care	Safe	CH	95%	269/279 =96.4%	297/299 = 99.3%	300/302 =99.3%	301/302 =99.7%	90/92 =97.8%	102/102 = 100%	105/105 = 100%	110/110 = 100%	84/85 =98.8%	106/107 =99.1%	97/98 =98.9%	103/103 =100%	101/101 =100%		
Data Quality Maturity Index [4]	Improving Health	Responsive	CH	95%	#DIV/0!	98.5%	*98.5%*	*98.9%*	98.5%	98.5%	98.6%	98.7%	98.7%	*98.0%*	*98.9%*	*98.9%*	*98.8%*		
Out of area bed days [5]	Improving Care	Responsive	CH	20/21 - Q1 247, Q2 165, Q3 82, Q4 0	958	415	737	316	167	108	140	336	224	177	106	88	122		
IAPT - proportion of people completing treatment who move to recovery [1]	Improving Health	Responsive	CH	50%	54.3%	46.6%	52.7%	*55.9%*	51.4%	49.1%	42.8%	50.1%	54.3%	54.1%	55.6%	56.6%	*56.0%*		
IAPT - Treatment within 6 Weeks of referral [1]	Improving Health	Responsive	CH	75%	85.3%	88.3%	92.8%	*96.5%*	86.3%	88.1%	89.7%	91.1%	92.8%	94.5%	95.2%	97.0%	*97.6%*		
IAPT - Treatment within 18 weeks of referral [1]	Improving Health	Responsive	CH	95%	98.9%	98.9%	99.1%	*99.9%*	99.3%	98.5%	98.9%	98.5%	99.2%	99.6%	99.8%	100.0%	*100.0%*		
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Improving Care	Responsive	CH	60%	85.6%	84.6%	87.0%	94.4%	70.7%	95.8%	92.3%	87.8%	79.5%	94.3%	97.0%	91.3%	95.6%		
% clients in settled accommodation	Improving Health	Responsive	CH	*60%*	91.3%	91.3%	91.1%	*91.7%*	91.3%	91.2%	91.2%	91.1%	91.1%	91.1%	91.3%	91.9%	*91.8%*	⚠	
% clients in employment [6]	Improving Health	Responsive	CH	*10%*	12.1%	12.5%	12.6%	*12.5%*	12.3%	12.3%	12.7%	12.6%	12.6%	12.6%	12.6%	12.5%	*12.4%*	⚠	

Mental Health Five Year Forward View	Objective	CQC Domain	Owner	Target	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Data quality rating [8]	Trend
Total bed days of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	0	10	34	48	2	5	3	0	8	26	10	34	4		
Total number of Children and Younger People under 18 in adult inpatient wards	Improving Care	Safe	CH	*TBC*	0	4	6	8	1	2	1	0	3	3	2	4	2		
Number of detentions under the Mental Health Act	Improving Care	Safe	CH	*Trend Monitor*	180	258	205	210	258			205			210				
Proportion of people detained under the MHA who are BAME [2]	Improving Care	Safe	CH	*Trend Monitor*	10.0%	14.7%	13.7%	18.1%	14.7%			13.7%			18.1%				

NHS Standard Contract	Objective	CQC Domain	Owner	Target	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Data quality rating [8]	Trend
Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance [1]	Improving Health	Responsive	CH	90%	99.3%	99.1%	99.8%	*99.4%*	99.5%	98.7%	99.0%	99.3%	100%	100%	100%	9925.0%	*99.6%*		
Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	99%	99.9%	99.9%	99.9%	*99.9%*	99.9%	99.9%	99.9%	99.9%	100%	99.9%	99.9%	99.9%	*99.9%*		
Completion of Mental Health Services Data Set ethnicity coding for all Service Users, as defined in Contract Technical Guidance	Improving Health	Responsive	CH	90%	98.8%	98.7%	98.4%	*98.0%*	98.8%	98.7%	98.6%	97.8%	97.9%	98.2%	98.3%	98.0%	*97.9%*		

** 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 increased to 99.2% in December, remaining above the target threshold.
- The percentage of service users seen for a diagnostic appointment within 6 weeks remains well below target at 56.8% . This is a consequence of the impact of Covid-19 and represents an improvement against the previous month and a recovery plan is in place.
- Inappropriate out of area bed placements amounted to 122 days in in December. This is an increase from 88 in November.
- During December 2020, there were 2 service users aged under 18 years placed in an adult inpatient ward for a total of 4 days. The Trust has robust governance arrangements in place to safeguard young people; this includes guidance for staff on legal, safeguarding and care and treatment reviews. Admissions are due to the national unavailability of a bed for young people to meet their specific needs. We routinely notify the Care Quality Commission (CQC) of these admissions and discuss the detail in our liaison meetings, actioning any points that the CQC request. This issue does have an impact on total Trust bed availability and therefore the use of out of area bed placements. In addition, the Trust's operational management group have recently signed off a new standard operating procedure for admitting young people to adult wards which has now been put into operation.
- % clients in employment- the Trust is involved in a West Yorkshire and Harrogate Health & Care Partnership wave 1 three-year funding initiative, led by Bradford District Care, to promote, establish and implement an Individual Placement Support (IPS) scheme. IPS is evidence based vocational scheme to support people with mental health problems to gain and keep paid employment. Work is currently ongoing in Calderdale to expand the opportunities we can offer people under this scheme. A South Yorkshire & Bassetlaw partnership bid for individual placement support wave 2 funding has been successful which will see the creation of additional employment workers to support secondary care mental health services in Barnsley. There are some data completeness issues that may be impacting on the reported position of this indicator.
- The scope of the data quality maturity index changed in July 2019 as part of a national CQUIN, though the target has remained the same. The Trust has been consistently achieving this target.
- IAPT treatment within 6 weeks of referral has achieved the 75% target.
- The proportion of people detained under the Mental Health Act who are from a BAME background increased from 13.7% to 18.1% quarter on quarter.

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 December the following data quality issues have been identified in the reporting:

- The reporting for employment and accommodation for December shows 11.4% of records have an unknown or missing employment and/or accommodation status, this is an decrease compared to November which showed 13.2% of records have an unknown or missing employment and/or accommodation status. This has therefore been flagged as a data quality issue and work takes place within business delivery units to review this data and improve completeness.

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

Barnsley general community services

Key Issues
- The need for self-isolation and working from home is causing some operational challenges for the Urban House team which is being managed
- Health and Wellbeing / Children's Services - sickness absence in some services is again causing some operational delivery challenges and again is being managed as effectively as possible.
- Continued pressure in the system as the local hospital remains full and increased discharges are picked up by community teams
- Sustained continuation of OPEL level 3 now for 9 weeks; unprecedented pressure
- Covid-19 vaccination programme has commenced. There have been some initial challenges in interpreting guidance and therefore fully understanding patient cohorts
- The level of staff absence on the neuro rehabilitation unit has resulted in it closing to admissions

Strengths
- All services have again had excellent client feedback
- Supported establishment of 3 community hubs for Covid-19 vaccination programme, supporting care homes and housebound patients, alongside clinical and admin staff supporting our staff vaccination hubs
- Continued flow of patients from BHNFT into community care and keeping patients in the most appropriate and safe place for their care/rehabilitation
- Our stroke inpatient unit has just received an A rating for latest SSNAP report
- Our early supported discharge (ESD) community team are achieving
  - all patients contact made on day of referral
  - 24 patients had goals set within 24 hours of admission to team
  - meeting or exceeding recommended 45 mis per day of therapy

Challenges
- Neighbourhood rehabilitation service - to get a consistent capacity to be able to plan rehab support worker input for rehabilitation therapy rather than working on a day by day basis.
- Review podiatry provision to both BHNFT and in wound care due to an increase in demand in this area of podiatric medicine and the increasing acuity of these patients.
- Increased numbers of staff shielding given the third lock down
- Continuing to support increased numbers of patients on the last days of life pathway

Areas of Focus
- We will continue to support the health integration team to deliver safe services in Urban House and the hotel.
- Work continues to review existing neurological rehabilitation pathways with a view to improving integration of multiple service elements including inpatient beds and outpatient provision.
- New model of discharge to assess (D2A) agreeing finance with BHNFT and working towards recruitment of band 3 posts in community
- New accommodation for allied health professionals (AHPs) moving from Mapplewell to Kendray hospital.
- Support the system to deliver the Covid-19 vaccination programme to patients and staff in Barnsley

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

Mental Health:

Strengths
- Mental health transformation Investment plans agreed with Barnsley CCG and submitted to the South Yorkshire & Bassetlaw ICS for further consideration. Transformation activity to be focused on place-based integration of mental health services with primary care and local community organisations.
- Business continuity plans have to date been effective. Community contacts remain above target with the majority provided via telephone/video-link. Face to face contact increasing and offered where clinically required.

Areas of focus
- Effective project management of transformation agenda will be essential.
- Work progressing to improve approach regarding access to out of area locked rehabilitation beds (including associated financial pressures)
- Recoding issues being addressed in relation to improving urgent access (assessment within 4 hours) KPI target. Currently below target of 95% (end November 90.74%). Expected improvement in Dec/Jan data.
- Early intervention in psychosis (EIP) performance against cardio metabolic assessment and the plan to address backlog by end December 2020 has been compromised by Covid-19 restrictions and associated staff availability.
- Evident pressure at single point of access (SPA). Referral numbers and acuity increasing.

CAMHS

Strengths
- Business continuity plans have to date been effective.
- Trend in waiting numbers from referral to treatment in Barnsley/Wakefield remains positive.
- SWYPFT has recently agreed to take on lead provider responsibility for the Kirklees mental health support team trailblazer initiative.
- Business case regarding ASC/ADHD waiting list initiative submitted to Calderdale CCG. Operational detail being agreed.

Areas of focus
- Waiting numbers for ASC/ADHD (neuro-developmental) diagnostic assessment in Calderdale and Kirklees have significantly increased – with escalating demand outsripping commissioned capacity. Now a focus of CAMHS Improvement Board and business case submitted in Calderdale.
- Referral numbers across all services increasing – but not exceeding previous levels.
- Access to tier 4 beds isproblematic. Covid-19 restrictions and associated staff availability have reduced capacity and led to inappropriate stays for young people on paediatric and adult mental health wards. Work being progressed with NHSE and local systems to address – but limited potential for early resolution.
- Continuing to work with Barnsley CCG in responding to the new service specification. Working to agree costed model by end January 2021.

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:

Key Issues

Forensics

- Staffing levels remain highly challenging
- All areas of the service have high levels of acuity.
- Levels of Covid-19 related absence remain consistently high within the service. Whilst the service has no current outbreaks, we are experiencing some short-term sickness following vaccine administration.
- Mobilisation of the specialist community forensic team continues and is going well despite the pandemic.
- Work to support the development of the forensics provider collaborative continues.

Learning Disabilities

- Horizon has had a Covid-19 outbreak with 1 staff member and 1 service user testing positive. Extra measures and support put in place to support the service. This also resulted in an increase in staff absence.
- Work on the assessment and treatment unit reconfiguration across West Yorkshire continues.
- Whilst there has been some increased demand for face to face contact, the current lockdown has resulted in some service users and carers not engaging with services again
- Staff absences have increased resulting in the mobilisation of our business continuity planning in terms of utilising community nursing to support our impatient ward
- Intensive support and community teams continue to work hard to prevent hospital admissions
- Our well-being agenda to better support our staff has commenced
- OPEL Level increased to level 3 due to high levels of acuity in both community and inpatient settings.

ADHD/ASD

- Operational activity is on track for commissioned activity.
- Business plans have been submitted and being drafted for service expansion across the footprint and ICS.
- Recruitment to key posts continues with progress evident

Strengths

Forensics

- Mandatory training figures remain at a consistently good level.
- Positive response from staff regarding the rollout of the vaccine with most staff very enthusiastic to receive it.
- Appointments to staff vacancies in all disciplines except nursing looks positive.
- Supervision levels range from 86% to 100% across the services

Learning Disabilities

- The Wakefield strategic health facilitator has successfully obtained Queens Nursing Innovation funding to run a project to reduce unplanned hospital admissions by recognising respiratory conditions as a complex need for people with learning disabilities in primary care.
- A nurse in the Wakefield community team has been accepted onto the Foundation of Nursing Studies learning disability fellowship
- Calderdale community team jointly with Creative Minds are running some virtual fun days.
- Staff continue to work in an innovative and creative way to support service users and carers in challenging circumstances.
- Our learning disability wellbeing program is now underway with well-being champions in place in all teams

ADHD/ASD

- All KPIs deliverable despite pandemic.
- Referral rates remain good.
- Mandatory training levels excellent.
- Supervision level 93.3%.

Challenges

Forensics

- Maintaining safer staffing levels with the number of registered nurse vacancies. Internal measures have been increased to mitigate.
- Absence levels remain higher than the Trust average.
- Retention of registered nurses.
- Clinical acuity remains high across all services.

Learning Disabilities

- Accommodation for Wakefield community continues to be a challenge.
- Staff absence levels remain unpredictable and high levels of bank and agency are being used.
- High levels of acuity on both Horizon and in community settings.
- Management of the outbreak on Horizon.
- Supervision levels are lower than expected at 77.5% with plans in place to improve.

ADHD/ASD

- Maintaining performance in line with key performance indicators and aspirations of expansion during a pandemic.
- Maintaining required level of contact and competing for clinical space to do that.

Areas of Focus

Forensic

- Preparation for role as lead provider of forensic services of the West Yorkshire provider collaborative.
- Forensic development plan - work continues and is progressing.
- Recruitment and retention of staff supported by HR.
- Staff wellbeing.

Learning Disabilities

- Restoration and recovery remains a priority.
- West Yorkshire collaboration regarding development of an assessment and treatment unit model.
- Some interrogation regarding waiting lists is required. Whilst figures for those individuals in receipt of the service are good there are areas where there is a delay in delivery of an intervention e.g. psychology.

ADHD/ASD

- Staff wellbeing a key focus.
- Positive use of digital technology to support service delivery.
- Maintenance of activity levels despite challenges.

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

Inpatient, Wakefield, Kirklees & Calderdale business delivery unit:

Inpatient:

• Maintaining patient flow and facilitating sufficient ward capacity has been extremely challenging, although the use of acute beds out of area has been kept to a minimum. The use of PICU (psychiatric intensive care unit) out of area beds has remained stable and mainly attributable to gender specific and safeguarding clinical reasons rather than shortage of beds. High demand for inpatient beds continues. Concerted work on optimising patient flow is continuing and the service is now fully recruited and moving towards 7 day working, with formal consultation due to finish this month.

• Some wards have been impacted upon by outbreaks of Covid-19 and the requirements for isolation and quarantining. This has affected more than one ward at a time, leading to intense pressures. Cohorting standard operating procedures that support the separation of people with symptoms or a positive Covid-19 diagnosis are in place for acute and older people's services together with an inpatient clinical pathway for Covid-19 positive patients. This is proving a robust framework although it is challenged by demand and limitations on estate. The position is reviewed daily by the matrons to determine how care can be delivered and services managed.

• Acute wards continue to see high levels of acuity and service user distress, with further challenges as above in managing isolated and cohorted patients. The difficulties have been compounded at times by the need for staff isolation and staff absence leading to staffing shortages. Staffing levels have had to be maintained with growth in bank and agency usage. Continued weekly meetings taking place with mental health partners across the integrated care system have enabled the strengthening of collaborative approaches, shared learning and innovative practice developments.

• Work continues to consolidate progress on improvement in clinical supervision rates and quarter 3 performance for the inpatient service line stands at 90.8%. Levels are being tracked weekly across services The essential importance of supervision in terms of safe practice and individual well-being has been emphasised. Work has been underway to address any recording issues and to ensure all colleagues receive supervision in line with policy requirements. Hotspots and wards have been identified and have action plans in place. Where variations and particular challenges exist this is being addressed with cross working between team managers, matrons and ward managers to promote improvement and shared approaches.

Community:

• Intensive input continues in front line services to adopt collaborative approaches to care planning, to build community resilience, and to explore all possible alternatives to hospital admission for people who need acute care. This has included developments in the trauma informed personality disorder (TIPD) pathway. Work is underway in the intensive home based treatment teams (IHBT) to look at building up early discharge, alternatives to admission and to ensure robust gatekeeping.

• Community services continue to provide assessment, care management and interventions with service users utilising a range of innovative means of communication and ensuring face to face contacts take place when these are clinically indicated. Work is underway to optimise the use of our building spaces so that group work and more face to face therapies can be delivered.

• The action plan and training around care programme approach (CPA) reviews is showing positive impact, and is being closely monitored and supported at trio level. Performance reporting issues were identified and teams have worked closely together to address these. Wakefield has achieved 98.9% performance in Q3, Calderdale 94.1%; and Kirklees 95.6%. Work continues to intensify the action plan and improvement, including with specific teams and at practitioner level where needed.

• Progress on improvement in clinical supervision rates continues and is tracked weekly across services. The Quarter 3 performance for the community service lines in the BDU for Calderdale and Kirklees was 95.09% and for Wakefield 89.81%.

Communications, Engagement and Involvement

Communications, Engagement and Involvement

• Bronze command meeting taking place internally for communication and engagement. Participation in Trustwide Silver.
• Coronavirus updates circulated regularly to all staff and governors
• Coronavirus sections on the intranet and website maintained and updated
• Sharing of staff and service user good news stories, internally, externally and through social media channels
• Coronavirus vaccination comms, launch of vaccine programme in the Trust
• Launch of 'Choose Well for Mental Health' guide; on social media channels and with partners, including MPs
• Staff wellbeing initiatives promoted
• Design and print of materials continuing for services and corporate functions, including coronavirus materials for inpatients and staff
• CAMHS:
    oWakefield CAMHS: continued support for transformation work (e.g. ReACH and eating disorder teams)
    o C&K CAMHS: crisis advice line launch
• Awareness days and weeks supported on social media and in internal communication channels
• Information governance campaign supported
• Forensic improvement programme supported
• Partner Bronze command meetings continue to taking place in all areas
• Support provided to EyUp Charity (e.g. case studies), Creative Minds (e.g. website, socials) and Spirit in Mind (e.g. event support)
• New intranet development project supported – spec produced for procurement
• Promotion of West Yorkshire and Harrogate and South Yorkshire and Bassetlaw ICSs' initiatives and campaigns, including preparations for a staff focused suicide prevention campaign launching in February.

Engagement, Equality and volunteering update

• •Equality, Engagement, Communication and Membership (EECM) Trust wide strategy signed off at Trust Board and published on the intranet
•Action plans for equality and engagement (including carers and peer support) have been developed in draft and shared for comment with E&I (Equality and inclusion) Committee. A date to sign the action plans off at E&I Committee in January is being progressed. Actions will include capturing wider comments from internal teams and ensuring plans accurately reflect a Trust wide approach.
• Trust wide EECM strategy short film and image, easy read and summary all being progressed as part of a full website content refresh
• Work continues to support recovery planning using insight and intelligence to inform decision making
• Business proposal to mainstream the offer for 'Virtual Visitor' now approved.
• COVID equality imapct assessment (EIA) now at version 3 and research tool updated this quarter with emerging intelligence
• EIA for the roll out of the COVID19 vaccination programme developed and approved by Silver Command
• Engagement plan developed and delivery to support involvement in the digital strategy taking place
• Engagement plan to support involvement in a 'Smoke Free' site in place
• Process to support SEQUIN submission for secure services now in place and monthly updates are part of core work
• Passport for Carers has now led to the development of the passport which is published on the internet and intranet following an event in December to launch
• Payment for involvement policy now being looked at and a draft will be circulated for comment by EMT in the next month
• Continue to link into wider volunteering approaches and supporting partners such as Barnsley council to mobilise volunteer opportunities
• Review of the partnership work with Barnsley community and voluntary services (CVS), council and SWYPFTT colleagues to mobilise a preventative mental health support network along the lines of Virtual visitor being progressed to identify future use
• Successful bid to charities commission and staff recruited and in post – our involvement has secured 2 posts focussed on BAME staff and BAME communities. A further bid to support carers is being progressed and will identify a full time post to support carers of people who use our services and staff who are carers.
• Peer support worker report, action plan now been developed, promoting the opportunities for BDUs to host a peer worker post in any vacant posts going forward. A number of presentations are planned.
• Draft strategy for volunteering developed and a framework to support volunteers is in place, further work to develop the strategy in ongoing.
• All volunteers are being risk assessed using the staff risk assessment tool prior to reintroduction back into Trust services
• Boundary training has been co-designed with HR and Safeguarding times to support both volunteer and staff roles
• Work ongoing to address diversity in volunteering
• Currently we have 176 volunteers, 7 are active and a further 47 are waiting to be processed or have been placed on hold

This is the January 2021 priority programme progress update for the integrated performance report. It is a summary of the activity conducted in the period for November 2020. The Trust priority programmes were reviewed, and changes made in September and approved at Trust Board in October 2020. The following programmes of work are reported in this section of the IPR this month:

- Improving Health - Work with our partners in Barnsley, Kirklees, Calderdale, Wakefield, West Yorkshire and South Yorkshire contributing to their 5-year plans and improving outcomes for people with mental health and learning disabilities.
- Improving Health - Enhance creative, cultural and digital offers
- Improve Care - Deliver improvements in CAMHS.

Reported elsewhere in the IPR this month are:

- Improve care - Patient safety approach and ongoing response to managing covid-19.
- Improve care - Provide care as close to home as possible.
- Improve care - Safely deliver and restore services.
- Improve care - Deliver improvements in forensic services.
- Improve Resources - Digital by default.
- Improve Resources - Spend money wisely and reduce waste.
- Make this a great place to work - support the provision of a healthy, resilient, and safe workforce.
- Make this a great place to work - Refresh our environmental sustainability strategy and action plan.

Priority	Improvement Aims, Outcomes, and Key Deliverables	SRO	Change Manager	Governance Route	Narrative Update	Progress RAG rating
IMPROVE HEALTH						
Work with partners in Barnsley, South Yorkshire, Kirklees, Calderdale, Wakefield, West Yorkshire contributing to their 5 year plans and improving outcomes for people with mental health and learning disabilities.	Improvement Aims: • A trusted provider of general community and wellbeing services delivering integrated care. • A strong partner in mental health and learning disability service provision across South Yorkshire and West Yorkshire. • A trusted host or partner in our four local integrated care partnerships. • A compassionate and innovative organisation with equality, recovery, coproduction, and creativity at its heart. Outcomes and deliverables by April 2021 include: • Take an active and 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. • Develop and deliver a more robust internal approach to all WY&H and SY&B ICS Projects. • Internal place based groups are established and coordinate: - SWYPFT contribution as a key partner in the development of Mental Health Provider Alliances in each of our Places and systems - Working in partnership to reduce health inequalities in line with national guidance.	Sean Rayner / Salma Yasmeen	Sharon Carter	EMT	West Yorkshire mental health, learning disability and autism (MHLDA) programme services and the specialised MHLDA programme board are both progressing. Work continues to deliver the priority work programme, as previously agreed. In addition, we are actively working as a partner in all our local systems to manage and mitigate the impact of a rise in Covid-19 cases, including our system-level surge/escalation approach, and manage the impact on the restoration of non-Covid-19 health services. The strategic health group has resumed meeting weekly to ensure that there is a coordinated approach and response to managing Covid-19, winter pressures and demands. Work has commenced on modelling changes to mental health demand with partners, focusing on Barnsley data and working alongside Barnsley CCG. Submissions have been made for transformation funding to NHS England for community mental health. Work has commenced to act on the findings of the learning disability mortality review. Work is progressing in line with the plans for the West Yorkshire adult secure lead provider collaborative. Metrics and measurements include: • Agree inequalities programme of work priorities and outcomes for all place and ICSs by end January 2021 • In Barnsley - a shared leadership model and partnership agreement is in place with the Primary Care Network by end January 2021 • In Calderdale -Arts & health programme manager recruited and plan in place with identified outcomes and metrics by end December 2021 - Deliver the Active Calderdale programme of work by April 2021 • In Wakefield - Take the lead partnership role in getting the MH Alliance work programme updated and fully mobilised with KPIs and monitoring of achievement agreed by end March 2021 • In Kirklees - Full mobilisation of alliance partnership by end January 2021 • In WY&H ICS - Forensic lead provider collaborative mobilised by April 2021	

Enhance creative, cultural and digital offers	Improvement Aim: Enhance creative, cultural and digital offers through our wellbeing services, linked charities, and recovery colleges as part of a comprehensive offer to provide support to vulnerable groups and address inequalities in each of our places. Outcomes and deliverables by April 2021: Establish routine collection of data and information and populate and report on the Creative Minds performance framework by January 2021 Develop closer working between Creative Minds and the Recovery Colleges, increase partnership working with Trust services and organisations in the local community, and provide a learning environment that promotes equality, wellness and wellbeing Establishing links to Calderdale Arts & Health programme Alignment of creative, cultural and digital offers to develop a more comprehensive portfolio.				Active Calderdale Three services within Calderdale have now been selected to pilot integrating physical activity into their systems and processes including learning disability, early intervention in psychosis (EIP) and perinatal services and design thinking improvement workshops commence in February 2021 with these services in partnership with Active Calderdale. A 'Moving More SWYFTly' trust wide campaign launched during December to encourage staff to be more physically active and support their health and well-being alongside a survey to capture baseline data. 30 members of staff have signed up to the moving medicine online training package which supports increasing staff confidence in undertaking conversations about physical activity. The outcomes from the training package is being evaluated in partnership with Leeds Beckett University. Creativity & Health First suite of projects/ interventions to support targeted interventions within Calderdale have been scoped and agreed and bids have been submitted to apply for additional funding where required. Projects include a Couch to Creativity app, The Lullaby Project in partnership with Carnegie Hall and Art Boxes for families. A big conversation bringing together the world of arts and health organisations is being co-produced on a number of agreed themes with an initial series of podcasts scheduled to start during January/February 2021. A Thriving Communities bid has been co-ordinated from a wide range of partners within Calderdale and submitted. The bid seeks to develop a project to ensure culture and creativity are incorporated into health sector approaches resulting in longer lives better lived and stronger, more connected communities. Digital Inclusion A project is being scoped to harness the potential of digital technology to improve lives and create opportunities for the people we care for. The project will include a focus on digital devices, digital access, digital literacy and support mechanisms. Equality, Engagement and Communications: Work continues on aligning the equality engagement, comms and membership strategy and resulting action plans. The action plans are being populated with deadlines and owners to enable easy monitoring and successful delivery Measures as set out in the newly developed Creative Minds performance framework and reported into Charitable Funds Committee. These include: - Number of new projects developed from April 2020 in response to Covid 19 - Number of Projects becoming peer led or sustained in the last 6 months - Total number of beneficiaries in last 6 months - Number of external partners currently working with Number of SWYPFT internal services currently benefitting

IMPROVE CARE

Deliver Improvements in CAMHS	Improvement Aim: To deliver an accessible and outstanding service for children, young people and their families. Outcomes and deliverables by March 2022 include: • Refreshed Improvement plan and associated action plans in place to include Kirklees and Calderdale by end October 2020. • Continue the work to reduce the numbers of Children & Young People (C&YP) waiting to receive treatment or diagnosis including an analysis of equity of access for individuals with protected characteristics. • All Age MH Liaison Services (AAMHLS) in place with the relevant Acute Hospitals as well as extended functionality of the C&HBTT by October 2020. • Work together with Barnsley Commissioners to develop a future service model to the timeline identified. • Agree action plans with Kirklees and Calderdale commissioners regarding neurodevelopment pathway. • Work together with partner agencies to improve response to C&YP in crisis and meet key deliverables for all age. • Mechanisms supporting and developing staff including recruitment to enable achievement of project scope of waiting list reductions and are embedded into practice. • Build mechanisms to maintain relationships with partners, including education, to achieve project scope of waiting list reductions. • CYP engagement and involvement are embedded into practice.	Carol Harris	Carmain Gibson-Holmes (Wakefield), Kate Jones /Maeve Boyle (Barnsley), Linda Moon/Sharon Carter (Kirklees and Calderdale)	CAMHS Improvement Group, OMG	Work has continued on project set up for CAMHS neuro-pathway waiting lists for both Calderdale and Kirklees. Further activity has taken place in Calderdale on modelling expected demand and agreement now needs to be reached on resourcing required to deliver the waiting list initiative . A trajectory and tracking system can then be established. In Kirklees, commissioners are currently considering how available funding could be used to support activity to reduce the waiting list. The project team are determining required resource to support the this work and also considering how elements of the assessment process could be improved to be more efficient. An initial meeting on workforce development has taken place. Immediate activity will involve supporting difficult to recruit to psychology posts before support to establish a sustainable workforce for the service. Work is continuing with reducing the waiting times and numbers on the waiting list (WL) for both Wakefield and Barnsley. Both services have undertaken a mini review of cases accepted for assessment and treatment to explore the reasons for higher numbers. Following this exercise, both areas confirm this reflects a 'true' picture of a higher number requiring CAMHS input. Wakefield has re-affirmed the threshold criteria for accepting referrals for CAMHS input as opposed to following the FIM consultation and treatment model in the first instance. FIM model has been impacted on by school closures and this is impacting the universal early help offer. 'Informal feedback has been sought from staff regarding the summary paper capturing all the changes made by all of the CAMHS services (previously presented to CAMHS Improvement Board (CIB) meeting in October 2020) which will be incorporated into the existing summary report prior to sharing wider within the Trust and externally. Following agreement at the November 2020 meeting, nominations have been sought from all CAMHS services to scope out the work for considering routine outcome measures and how they may evidence the effectiveness of virtual technology . This work is seen to be complementary to the work that has recently commenced regarding children and young people's (and their families) feedback of CAMHS services. Barnsley New CAMHS Model - Pathways for new CAMHS model were agreed in principle at joint steering group (CYPMHS) meeting (held on 10th December 2020). Pathways have been costed and were presented for consideration at a contracting meeting with the CCG. Internal re-visit of Trust's demand and capacity modelling and planning assumptions is in progress as per contracting meeting in parallel with CCG progressing their work to identify additional financial resources for CAMHS as part of MH investment for 2021/22 onwards. The refreshed Wakefield CAMHS improvement plan was presented and approved at the December 2020 CIB meeting. A high-level plan for Barnsley CAMHS has been completed. The next iteration of the high-level plan to include the mobilisation of the mental health support teams (MHST) and will be monitored at the CYPMHS meetings. A detailed improvement plan will be completed internally for the CAMHS service. The relationships with psychiatric liaison in Wakefield are good and an exploratory review of the work undertaken out of hours shows good outcomes	Progress Against Plan	
					Potential risk in light of waiting list numbers for CAMHS neuro pathways (for Calderdale and Kirklees). Kirklees waiting list has more than trebled in the previous 12 months and joint activity with commissioners is being prioritised to establish most appropriate options to reduce. Significant progress has been made in relation to the waiting list times and numbers in Barnsley due to temporary additional resources which need to be maintained as a minimum to avoid any 'slippage' on progress made.	Management of Risk	
					Implementation plan/key milestones include: By 31/12/20 Evaluation of 3 virtual groups within Barnsley completed based on PDSA model approach to assist with wider learning within all CAMHS services. By 31/01/21 Options developed to effectively manage demand for CAMHS neuro-pathway (for Calderdale and Kirklees) coming into the system and to increase capacity that will enable to services to establish sustainable systems whilst reducing waiting lists in the short term. Activity to review internal processes and how we can maximise the use of resources is planned. By 31/01/21 The current CAMHS improvement plans for Barnsley and Wakefield will have been reviewed and updated for review and approval by the CAMHS Improvement Board. By 28/02/21 CAMHS improvement plans will have been developed for Calderdale and Kirklees building upon experience of existing CAMHS improvement plans for consideration and approval by the CAMHS Improvement Board.		

Progress against plan rating	
	On target to deliver within agreed timescales / project tolerances
	ability/confidence to deliver actions within agreed timescales / project tolerances
	ability/capacity to deliver actions within agreed timescales / project tolerances
	Actions will not be delivered within agreed timescales / project tolerances
	Action complete

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

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

Glossary of terms:	
AMHP Approved Mental Health Professional	MH Mental Health
ATU Assessment and Treatment Unit	MOU Memorandum of Understanding
Bassetlaw	NHS National Health Service
BDCFT Bradford District Care Trust	NHSE/I National Health Service England/ NHS Improvement
C&YP Children and Young People	NMOC New model of care
CCG Clinical Commissioning Group	OMG Organisational Management Group
CSDG Clinical Safety Design Group	OPS Older Peoples Services
DBT Dialectic Behavioural Therapy	P&I Performance and Information
EMT Executive Management Team	PCH Primary Car Hub (also referred to as Primary Care Network)
ESD Early Supported Discharge	PCN Primary Care network (also referred to as Primary Care Hub)
FIRM Formulation Informed Risk Assessment	QI Quality Improvement
GP General Practitioner	QSIR Quality, Service Improvement and Re-design
HASU Hyper Acute Stroke Unit	RACI Roles and responsibilities indicator
HCP Healthcare Partnership	SBAR Situation - Background - Assessment - Recommendation quality improvement tool
IAPT Improving access to Psychological Therapies	SPA Single Point of Access
ICS Integrated Care System	SPC Statistical Process Control
ICT Integrated Change Team	SRU Stroke Rehabilitation Unit
IHBT Intensive Home Based Treatment	SSG an external consultant agency
IHI Institute for Health Improvement	SWYPFT South West Yorkshire Partnership Foundation Trust
IM&T Information management and technology	TIPD Trauma Informed Personality Disorder
IPS Individual Placement Support	UEC Urgent and Emergency Care
LD Learning Disabilities	VCS Voluntary and Community Sector
LTC Long Term Conditions	WY West Yorkshire

Overall Financial Performance 2020/21

Executive Summary / Key Performance Indicators

Performance Indicator		Year to date	Forecast 2020/21	Narrative
1	Surplus / Deficit	£1.4m	(£2.1m)	In December a surplus of £0.6m has been reported which is favourable to plan. The forecast position continues to be assessed.
2	Agency Cap	£5.1m	£7.3m	Whilst there is currently no NHS Improvement agency cap set for 2020/21 the Trust continues to monitor agency spend and action plans remain to ensure agency staffing usage and costs are appropriate. Spend in December is £0.7m, which is approximately £0.1m higher than previous months.
3	Cash	£69.8m	£45.1m	Cash in the bank continues to be above planned levels. The main reason is the timing of block income payments (which are a month in advance).
5	Capital	£1.8m	£5.4m	The capital forecast continues to be reviewed to take account of current capital priorities and the impact of covid-19 on accessibility and costs. There is increased spend forecast for Q4 with orders in place. Overall the forecast is £1.2m less than May 2020 plan.
6	Better Payment			This performance is based upon a combined NHS / Non NHS value and demonstrates that 68% of invoices have been paid within 7 days for the year to date. The impact of the new finance and procurement system has had an impact and we are assessing how we can improve performance back to previous levels. 30 day performance has been maintained.
	30 days	95%		
	7 days	68%		

Red	Variance from plan greater than 15%	Plan
Amber	Variance from plan ranging from 5% to 15%	Actual
Green	In line, or greater than plan	Forecast

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Improving Resources	Well Led	AD	<=4.5%	5.0%	5.0%	4.9%	4.0%	3.9%	3.9%	3.9%	3.9%	3.9%	3.9%	4.0%	4.0%
Sickness (Monthly)	Improving Resources	Well Led	AD	<=4.4%	5.0%	4.6%	4.2%	3.9%	3.9%	4.0%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%
Aggression Management	Improving Care	Well Led	AD	>=80%	80.9%	81.6%	85.5%	85.5%	85.5%	85.5%	85.5%	86.5%	86.0%	86.3%	85.4%	Data unavailable at the time of producing this report
Cardiopulmonary Resuscitation	Improving Care	Well Led	AD	>=80% by 31/3/17	81.2%	80.9%	89.4%	89.4%	89.4%	89.4%	89.4%	90.3%	89.4%	88.7%	88.2%	
Clinical Risk	Improving Care	Well Led	AD	>=80% by 31/3/17	89.2%	89.0%	93.7%	93.7%	93.7%	93.7%	93.7%	93.8%	93.6%	93.3%	93.2%	
Equality and Diversity	Improving Health	Well Led	AD	>=80%	92.6%	92.4%	95.2%	95.2%	95.2%	95.2%	95.2%	95.7%	95.7%	96.0%	95.7%	
Fire Safety	Improving Care	Well Led	AD	>=80%	88.3%	88.3%	93.7%	93.7%	93.7%	93.7%	93.7%	93.9%	93.4%	92.8%	91.8%	
Food Safety	Improving Care	Well Led	AD	>=80%	82.3%	81.6%	76.9%	76.9%	76.9%	76.9%	76.9%	78.3%	76.7%	76.8%	76.5%	
Infection Control and Hand Hygiene	Improving Care	Well Led	AD	>=80%	90.4%	89.1%	95.8%	95.8%	95.8%	95.8%	95.8%	96.2%	96.0%	96.1%	96.0%	
Information Governance	Improving Care	Well Led	AD	>=95%	90.4%	98.0%	98.2%	98.2%	98.2%	98.2%	98.2%	98.8%	98.8%	98.9%	98.8%	
Moving and Handling	Improving Resources	Well Led	AD	>=80%	92.1%	92.2%	95.0%	95.0%	95.0%	95.0%	95.0%	95.5%	95.6%	95.5%	95.1%	
Mental Capacity Act/DOLS	Improving Care	Well Led	AD	>=80% by 31/3/17	92.3%	90.5%	93.3%	93.3%	93.3%	93.3%	93.3%	94.6%	94.3%	94.8%	94.9%	
Mental Health Act	Improving Care	Well Led	AD	>=80% by 31/3/17	90.1%	87.2%	89.5%	89.5%	89.5%	89.5%	89.5%	91.2%	90.8%	91.4%	91.9%	
No of staff receiving supervision within policy guidance	Quality & Experience	Well Led	AD	>=80%	73.3%			74.5%			77.8%			77.2%		
Prevent	Improving Care	Well Led	AD	>=80%	90.8%	91.1%	93.2%	93.2%	93.2%	93.2%	93.2%	94.6%	94.6%	94.4%	95.3%	Data unavailable at the time of producing this report
Safeguarding Adults	Improving Care	Well Led	AD	>=80%	94.0%	94.3%	96.2%	96.2%	96.2%	96.2%	96.2%	92.8%	92.8%	93.0%	92.8%	
Safeguarding Children	Improving Care	Well Led	AD	>=80%	89.8%	90.7%	92.4%	92.4%	92.4%	92.4%	92.4%	93.6%	93.6%	93.3%	92.8%	
Sainsbury's clinical risk assessment tool	Improving Care	Well Led	AD	>=80%	97.3%	97.1%	96.9%	96.9%	96.9%	96.9%	96.9%	96.8%	96.8%	No longer used		
Bank Cost	Improving Resources	Well Led	AD	-	£769k	£685k	£1,241k	£727k	£866k	£721k	£687k	£778k	£907k	£915k	£889k	
Agency Cost	Improving Resources	Effective	AD	-	£537k	£581k	£613k	£469k	£507k	£518k	£558k	£606k	£588k	£604k	£573k	£686k
Overtime Costs	Improving Resources	Effective	AD	-	£15k	£69k	£191k	£196k	£382k	£342k	£257k	£276k	£213k	Data unavailable at the time of producing this report		
Additional Hours Costs	Improving Resources	Effective	AD	-	£37k	£42k	£58k	£58k	£61k	£66k	£71k	£59k	£53k			
Sickness Cost (Monthly)	Improving Resources	Effective	AD	-	£510k	£429k	£435k	£374k	£388k	£399k	£408k	£411k	£387k			
Vacancies (Non-Medical) (WTE)	Improving Resources	Well Led	AD	-	467.2	511.2	528.0	222.1	222.1	192.3	208.9	205.9	234.0			
Business Miles	Improving Resources	Effective	AD	-	273k	302k	312k	193k	149k	138k	164k	166k	147k			
Health & Safety																
Number of RIDDOR incidents (reporting of injuries, diseases and dangerous occurrences regulations)	Improving Resources	Effective	AD	-	15			7								

1 - this does not include data for medical staffing.

- As at 19th January, 159 staff off work Covid-19 related, not working which compares to 81 one month earlier. A further 84 were working from home.
- 3241 staff tested for Covid-19 as at 19th January.
- 545 staff have tested positive for Covid-19, 83 of which tested positive within the last month.
- Staff turnover increased to 9.9% in December.
- Non-Covid sickness absence was 4.0% in December and stands at the same percentage cumulatively. This compares favourably to previous years.

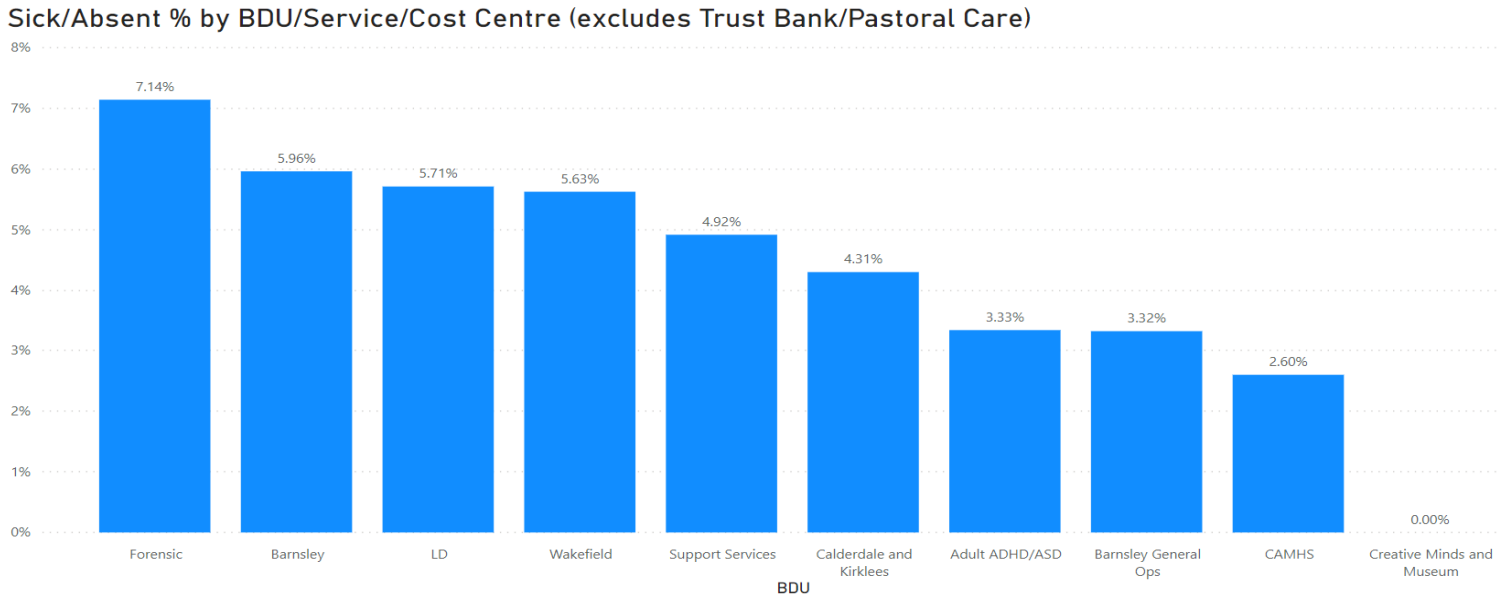
Sickness reporting

As at 19th January, the Trust has 243 staff absent or working from home due to Covid-19. This makes up 4.7% of the workforce. Of those absent, 30.0% are symptomatic and 10.3% have household symptoms. The business delivery unit (BDU) with the biggest impact is Forensic with 7.1% of staff impacted (29/406). This is obviously having a significant impact on operational services and resources are being deployed accordingly to ensure patient and staff safety during this challenging period.

- The Trust continues to use a Gold, Silver and Bronze command structure.
- Bank and agency availability is being 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 symptoms (based on absence start date) (January is a to date figure)

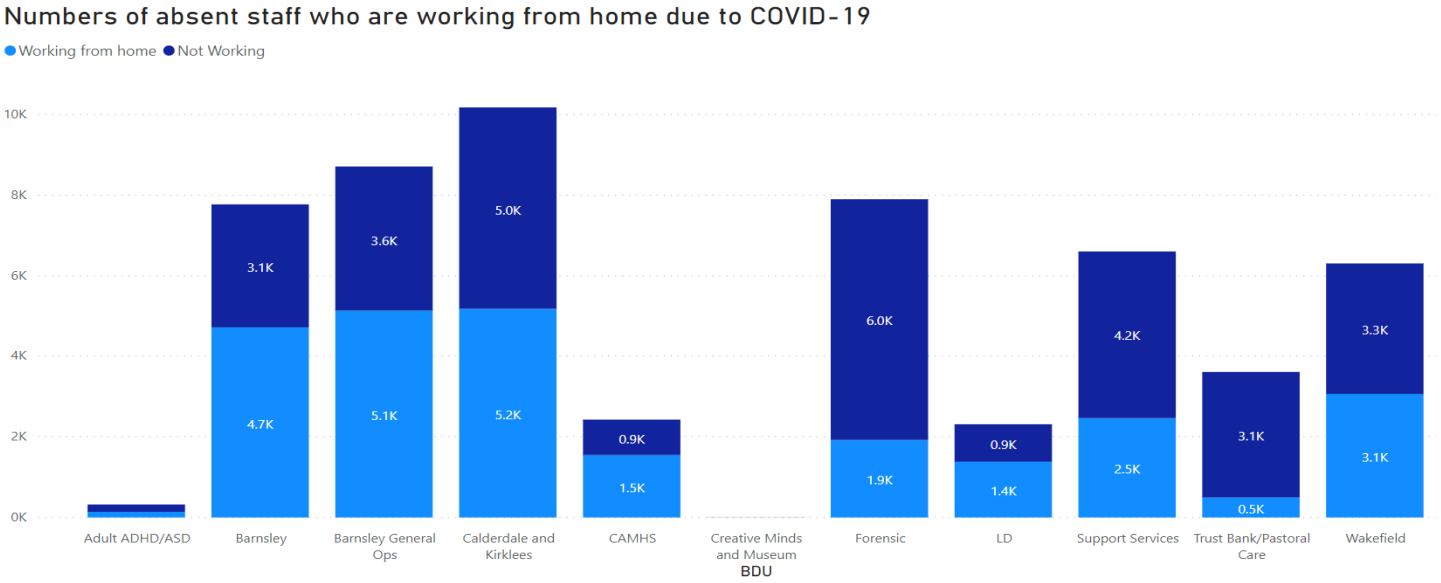
Mar 10.3 days, Jun 7.4 days, Sep 6.9, Dec 9.9, Jan 5.9

The following graph show the percentage of staff absences attributed to Covid-19 as a proportion of the BDU headcount.



The following graph shows the reasons for Covid-19 absence by BDU.

The following chart shows Covid-19 staff absences over the period 16th March - 19th January:



Publication Summary

This section of the report identifies any national guidance that may be applicable to the Trust.

Department of health and social care

How the NHS charges overseas visitors for NHS healthcare
This summary sets out the way the NHS charges overseas visitors for NHS health care. It has been updated with information how charges for NHS health care will apply to overseas visitors now the Brexit transition period has ended, reflecting the terms of the UK–EU Trade and Co-operation Agreement on reciprocal health care arrangements.
Click here for link to guidance

NHS England
Draft NHS Standard Contract 2021/22: a consultation
This consultation document describes the main proposed changes to the NHS Standard Contract for 2021/22. Comments from stakeholders on the proposals, along with any other suggestions for improvement, will be accepted up until 5 February 2021.

Click here for the link to the guidance

Department of Health and Social Care
Reforming the Mental Health Act
An independent review of the Mental Health Act 1983 (MHA), published in 2017, looked at how it's used and made suggestions for improvement. It concluded that the MHA does not always work as well as it should for patients, their families and their carers. This White Paper proposes a range of changes, based on four principles that have been developed with people with lived experience of the MHA. They are: choice and autonomy; least restriction; therapeutic benefit; and the person as an individual. The consultation on these proposals closes on 21 April 2021

Click here for the link to consultation.

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

Seasonal flu vaccine uptake in healthcare workers 2020 to 2021: provisional monthly data for 1 September 2020 to 30 November 2020
NHS workforce statistics: September 2020

South West Yorkshire Partnership NHS Foundation Trust

Finance Report

Month 9
(2020 / 21)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0	Executive Summary / Key Performance Indicators

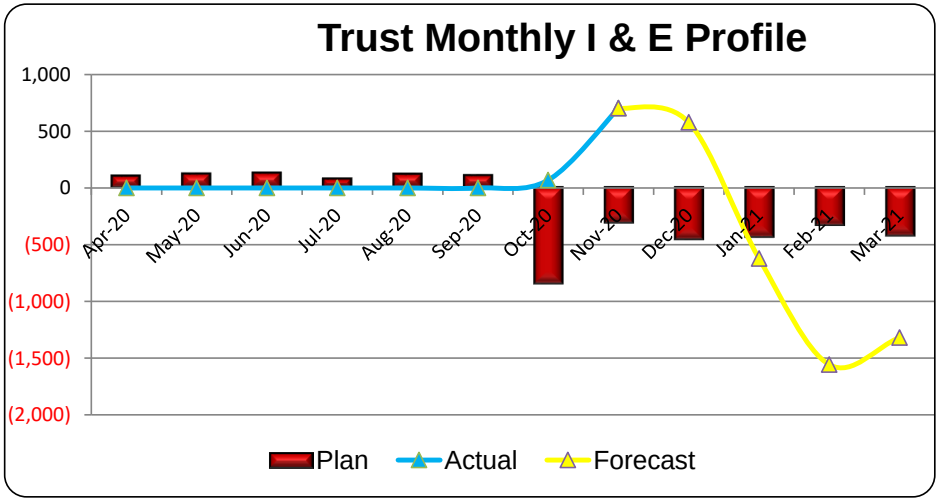
Performance Indicator		Year to Date	Forecast 2020 / 21	Narrative
1	Surplus / (Deficit)	£1.4m	(£2.1m)	In December a surplus of £0.6m has been reported which is favourable to plan. The forecast position continues to be assessed.
2	Agency Spend	£5.1m	£7.3m	Whilst there is currently no NHS Improvement agency cap set for 2020/21 the Trust continues to monitor agency spend and action plans remain to ensure agency staffing usage and costs are appropriate. Spend in December is £0.7m, which is approximately £0.1m higher than previous months.
3	Cash	£69.8m	£45.1m	Cash in the bank continues to be above planned levels. The main reason is the timing of block income payments (which are a month in advance).
4	Capital	£1.8m	£5.4m	The capital forecast continues to be reviewed to take account of current capital priorities and the impact of covid-19 on accessibility and costs. There is increased spend forecast for Q4 with orders in place. Overall the forecast is £1.2m less than May 2020 plan.
5	Better Payment			
	30 days	95%		This performance is based upon a combined NHS / Non NHS value and demonstrates that 68% of invoices have been paid within 7 days for the year to date. The impact of the new finance and procurement system has had an impact and we are assessing how we can improve performance back to previous levels. 30 day performance has been maintained.
	7 days	68%		

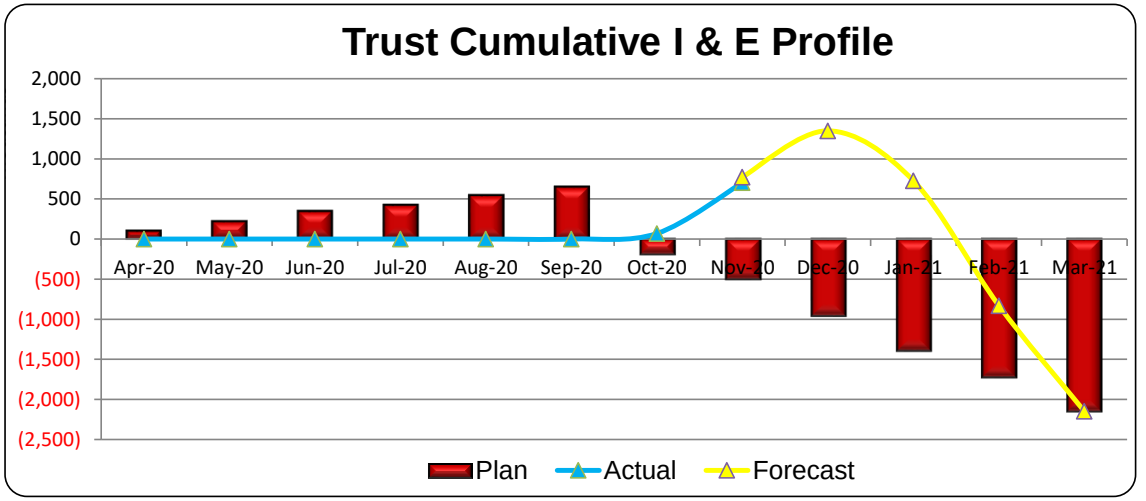
Red	Variance from plan greater than 15%, exceptional downward trend requiring immediate action, outside Trust objective levels
Amber	Variance from plan ranging from 5% to 15%, downward trend requiring corrective action, outside Trust objective levels
Green	In line, or greater than plan

2.0 Income & Expenditure Position 2020 / 2021

Budget Staff	Actual worked	Variance		Month Budget	Month Actual	Month Variance	Description	Year to Date Draft Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				20,218	20,344	126	Clinical Revenue	171,795	171,580	(215)	232,451	232,446	(5)
				20,218	**20,344**	**126**	**Total Clinical Revenue**	**171,795**	**171,580**	**(215)**	**232,451**	**232,446**	**(5)**
				1,165	1,482	317	Other Operating Revenue	13,809	14,314	505	17,701	18,246	545
				21,384	**21,827**	**443**	**Total Revenue**	**185,604**	**185,894**	**290**	**250,151**	**250,692**	**540**
4,315	4,363	49	1.1%	(16,413)	(16,199)	214	Pay Costs	(143,511)	(142,969)	542	(193,261)	(192,769)	492
				(4,091)	(3,925)	166	Non Pay Costs	(33,870)	(33,318)	552	(45,946)	(45,654)	292
				(573)	(407)	166	Provisions	(2,326)	(1,508)	818	(3,980)	(5,390)	(1,410)
				0	0	0	Gain / (loss) on disposal	0	(23)	(23)	0	(23)	(23)
4,315	**4,363**	**49**	**-1.1%**	**(21,077)**	**(20,531)**	**546**	**Total Operating Expenses**	**(179,707)**	**(177,819)**	**1,889**	**(243,187)**	**(243,836)**	**(649)**
4,315	**4,363**	**49**	**-1.1%**	**306**	**1,296**	**989**	**EBITDA**	**5,896**	**8,075**	**2,179**	**6,964**	**6,856**	**(109)**
				(516)	(523)	(7)	Depreciation	(4,647)	(4,668)	(21)	(6,168)	(6,211)	(43)
				(245)	(195)	50	PDC Paid	(2,209)	(2,057)	152	(2,945)	(2,793)	152
				0	0	0	Interest Received	0	0	0	0	0	0
4,315	**4,363**	**49**	**-1.1%**	**(455)**	**577**	**1,033**	**Surplus / (Deficit)**	**(959)**	**1,350**	**2,309**	**(2,148)**	**(2,148)**	**0**
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,315	**4,363**	**49**	**-1.1%**	**(455)**	**577**	**1,033**	**Surplus / (Deficit)**	**(959)**	**1,350**	**2,309**	**(2,148)**	**(2,148)**	**0**

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





Income & Expenditure Position 2019 / 20

The Trust reported a breakeven position for April to September 2020 enabled by national funding. For October 2020 to March 2021 we have an operational plan for a £2.1m deficit.

For October 2020 to March 2021 the Trust has an operational plan to deliver a deficit of £2.1m. This is based on expenditure run rates and updated funding available.

Income

Whilst block income arrangements remain in place, they have been updated to reflect planned Mental Health Investment Standard (MHIS) funding for October 2020 until March 2021. There is also Integrated Care System (ICS) funding allocated to the Trust on a 'fair shares' basis.

Income is in line with this revised plan and is forecast to deliver in year. There is a process for agreeing any further funding changes in year with commissioners and these will be reflected as and when agreed. For example in January we expect to include additional MHIS and winter pressure funding from all commissioners.

Pay

Pay spend in December was £16.2m which, excluding one off payments last month, is slightly higher than previously. This is normal for this time of year and includes estimates for shifts worked in December andover the christmas period.

Staffing levels, continuing to focus on appropriate safe levels for inpatient wards. They are currently being assessed for longer term planning. This includes assessing the impact of covid-19 absences. Whole time equivalent headcount numbers in December were higher than plan reflecting the impact of Covid-19, pressure on services and lower than expected staff turnover

Non Pay

Non Pay spend continues to experience both cost pressures and savings within the overall position. Based on the revised budget for the second half of there is a £0.5m saving in Q3.

Healthcare subcontracts (out of area placements and the purchase of locked rehab beds) continue to be volatile and out of area placements are considered in more detail at page 11.

Covid-19 Financial Impact

Covid-19 is a key contributor to the financial position and the table below highlights the areas where the Trust has incurred incremental costs as part of its response. These costs have been identified as additional and reasonable in line with national guidance.

Costs identified for April to September 2020 (H1) have been reimbursed from nationally funding. Costs incurred for October 2020 to March 2021 must be contained within the overall Trust operational plan. No additional top ups will be possible for this element.

Additional costs, with funding yet to be confirmed, for covid vaccination programmes are also included below. Staff vaccination, at 2 sites, commenced early January 2021.

		H1	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Total
Heading	**Description**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
Staffing	Backfill of shifts due to covid (sickness, isolation, shielding). This includes premium payments to support safer staffing levels.	780	211	292	252				**1,535**
Staffing – community	Community additional shifts	249	0	0	0				**249**
Staffing – cohort	Dedicated ward within Forensics required due to positive covid cases	77	0	0	0				**77**
Staffing - students	Costs of student nurses and medics over and above previous	480	0	0	0				**480**
Staffing – out of area	Costs of out of area placement providers to provide additional staff due to potential covid cases	53	0	37	0				**90**
Total – Pay		**1,639**	**211**	**329**	**252**	**0**	**0**	**0**	**2,431**
IM & T	Equipment to support new ways of working, from home, video conferencing, increased telecommunications	441	161	0	4				**606**
Laundry	In house laundry service including scrubs	331	4	74	14				**423**
Infection Control	Central store of additional infection control supplies (wipes, cleaning products)	249	1	6	3				**259**
Catering	Staff meals - those working on inpatient wards and in the community. Supply of refreshments	69	0	0	0				**69**
Discharge Equipment	Purchase of additional equipment to support hospital discharges	71	0	0	0				**71**
Communications	Consent to share letter	40	0	0	0				**40**
Lateral Flow Testing	Distribution of kits to staff	0	0	0	50				**50**
Misc / other	Other general non pay not captured in the headings above	158	5	0	250				**413**
Total – Non Pay		**1,359**	**171**	**80**	**321**	**0**	**0**	**0**	**1,931**
Total cost recovery		**2,998**	**382**	**409**	**573**	**0**	**0**	**0**	**4,362**

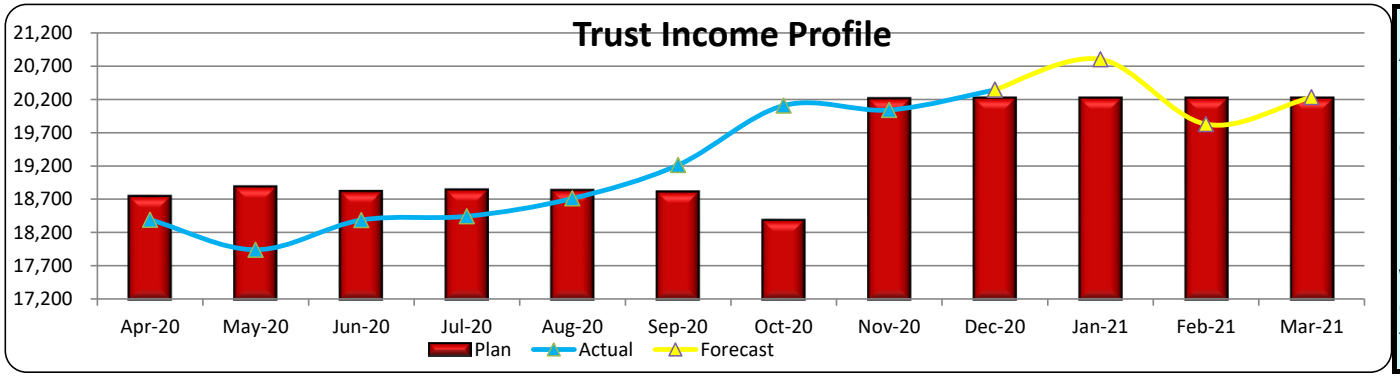
2.1 Income Information

As part of the reset for the Trust operational plan the contracting arrangements for October 2020 to March 2021 have also been updated. The nationally calculated block income (based on 2019/20 plus 2.8% uplift) remains and has been supplemented by additional funding for the Mental Health Investment Standard (MHIS). This was agreed with commissioners. There is a process for amending these values for further changes in investment.

In addition to main commissioner income further funding has flowed through the Integrated Care System (ICS) on an allocations basis. This included funding to cover all covid related additional expenditure and this now shows as CCG income as it flows through a lead local CCG.

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

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k	Total 19/20 £k
CCG	14,530	13,924	14,321	14,361	14,000	14,278	16,696	16,501	16,421	17,310	16,346	16,751	**185,437**	**171,720**
Specialist Commissioner	2,322	2,322	2,322	2,322	2,322	2,322	2,322	2,453	2,505	2,405	2,393	2,393	**28,405**	**27,895**
Local Authority	335	473	409	439	419	417	430	408	437	417	417	417	**5,017**	**7,755**
Partnerships	619	637	597	628	639	625	625	625	625	631	631	631	**7,514**	**7,673**
Top Up	550	550	702	658	1,254	1,537	0	0	309	0	0	0	**5,560**	**0**
Other	35	35	35	35	76	35	35	55	48	41	41	41	**511**	**418**
Total	**18,391**	**17,940**	**18,386**	**18,443**	**18,711**	**19,214**	**20,108**	**20,041**	**20,344**	**20,805**	**19,828**	**20,233**	**232,446**	**215,461**
19/20	17,509	17,502	17,373	17,646	17,765	17,628	17,906	17,572	18,061	19,031	18,334	19,134	**215,461**	



All budgets have been realigned for the updated operational plan. This shows the increase in contract income received and now includes all income (previously covid was received directly against operational spend but is now from the lead commissioner). No variance is expected.

Contracts are expected to be in place from 1st April 2021 which will built on the mental health investment made during the current year plus continued investment in key targeted areas such as perinatal mental health.

2.2 Pay Information

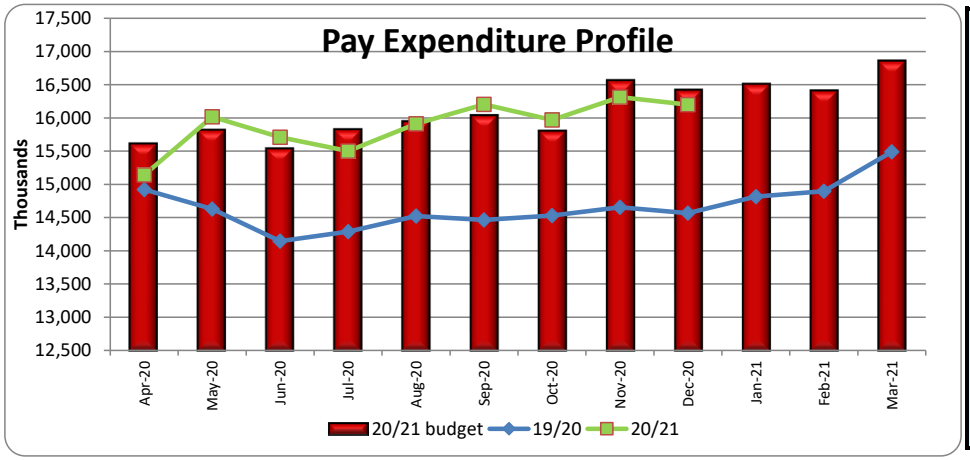
Our workforce is our greatest asset and one in which we continue to invest in, ensuring that we have the right workforce in place to deliver safe and quality services. In total workforce spend accounts for 79% of our budgeted total expenditure.

Current expenditure patterns highlight the usage of temporary staff (through either internal sources such as Trust bank or through external agencies). Actions are focussed on providing the most cost effective workforce solution to meet the service needs.

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
Substantive	13,947	14,646	14,470	14,256	14,462	14,647	14,450	14,851	14,569				**130,296**
Bank & Locum	727	866	721	687	844	971	915	889	944				**7,564**
Agency	469	507	518	558	606	588	604	573	686				**5,109**
Total	**15,142**	**16,019**	**15,709**	**15,501**	**15,912**	**16,205**	**15,969**	**16,313**	**16,199**	**0**	**0**	**0**	**142,969**
19/20	14,923	14,629	14,145	14,288	14,522	14,463	14,531	14,656	14,568	14,815	14,896	15,490	**168,476**

Bank as %	4.8%	5.4%	4.6%	4.4%	5.3%	6.0%	5.7%	5.5%	5.8%				5.3%
Agency as %	3.1%	3.2%	3.3%	3.6%	3.8%	3.6%	3.8%	3.5%	4.2%				3.6%

	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	Current
Substantive	3,900	4,004	4,026	4,026	4,006	3,965	4,263	4,293	4,255				**4,026**
Bank & Locum	203	253	193	197	244	225	277	240	303				**193**
Agency	68	75	83	90	108	93	121	100	120				**83**
Total	**4,171**	**4,332**	**4,302**	**4,312**	**4,357**	**4,283**	**4,661**	**4,634**	**4,678**	**0**	**0**	**0**	**4,302**
19/20	3,989	4,013	4,002	4,002	4,057	4,069	4,119	4,191	4,138	4,152	4,160	4,285	**4,098**



As shown in the table and graph pay costs overall have increased from 2019/20 (average run rate £14.7m per month). Of this annual pay awards and increments are estimated at £500k per month.

There was a one off clinical excellence award payment made in November (£0.2m). Excluding this overall pay expenditure has increased from November to December. Estimates have been made for the impact of bank holiday and agreed safer staffing premium payments over the Christmas period. As normal all December shifts will be paid in January when the full impact will be known.

This assessment is included within the increased bank and agency expenditure levels with continued usage required to support safer staffing levels. Elements of this are covid related with increased backfill requirements in December from previous months due to staff absence. This continues to be reviewed as part of the operational response to covid and the impact this has on staffing levels and service requirements.

2.2 Agency Expenditure Focus

Agency spend is £686k in December.

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.

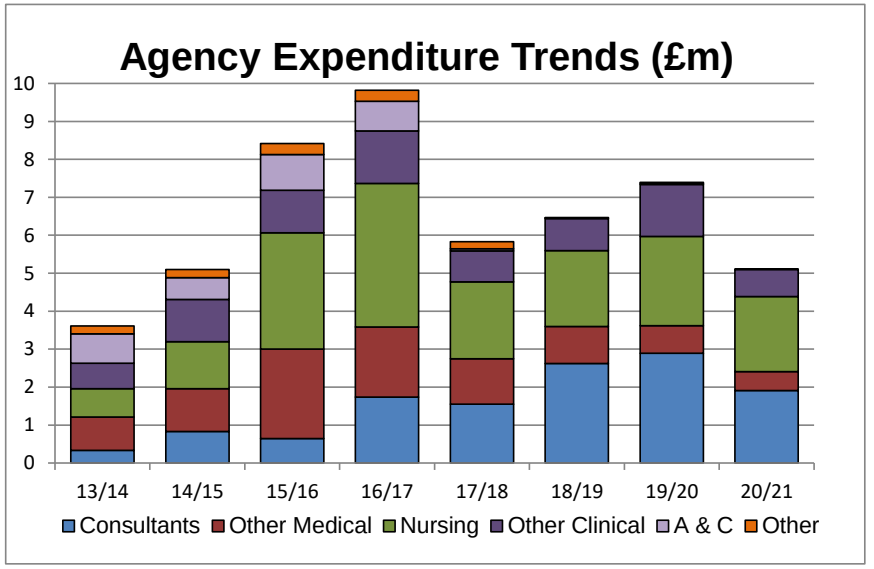
The financial implications, alongside clinical and other considerations, continues to be a high priority area. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible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

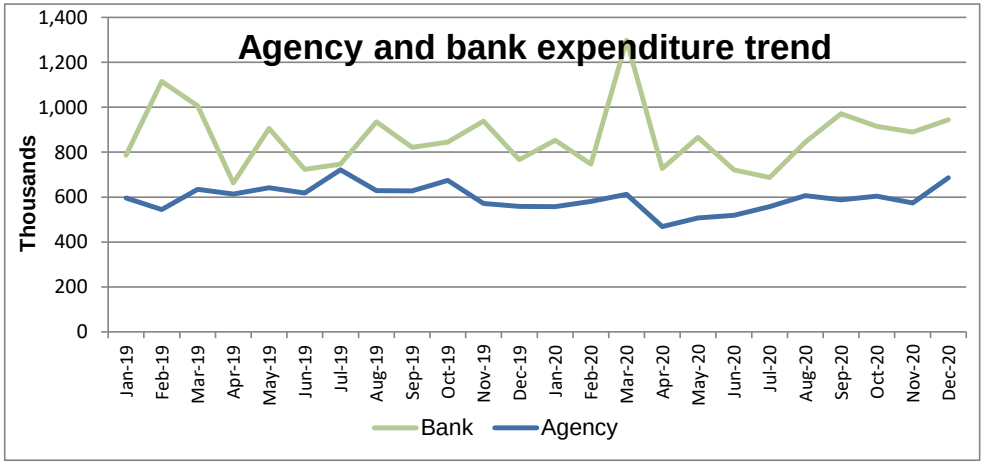
NHS E & I introduced a set of rules in April 2016 to support trusts to reduce agency spend and move towards a sustainable model of temporary staffing. Part of this support has been through the introduction of agency spend caps and suggested maximum pay rates.

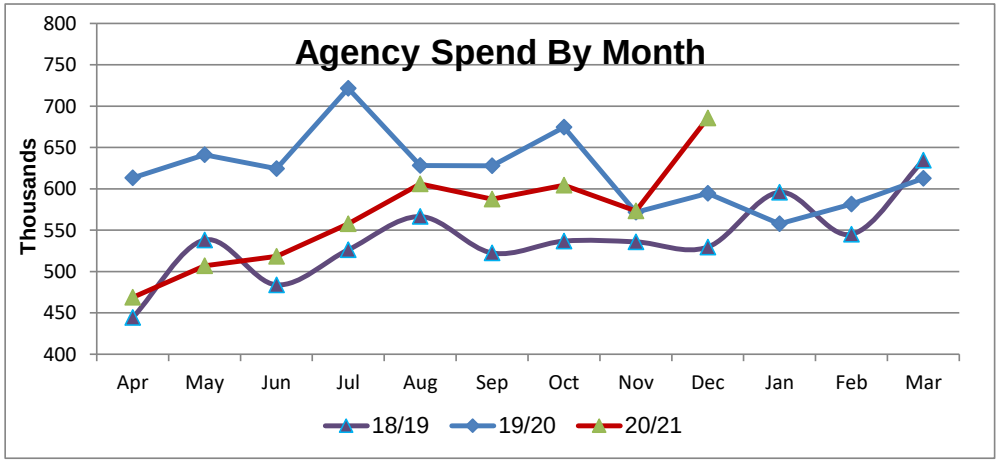
Due to covid 19 there is currently no agency cap for 2020/21, however controls remain the same. The Trust continue to submit the same detailed agency information to NHSI on a weekly basis. This information monitors both the volume of agency shifts utilised and performance against suggested maximum agency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

December 2020 spend is £686k which is higher than previous run rates. (2019/20 average was £617k per month). This is primarily due to increased unregistered nursing staff required to support staffing levels. For example unregistered spend in Forensics was £118k and adult acute inpatient was £90k in December alone.

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





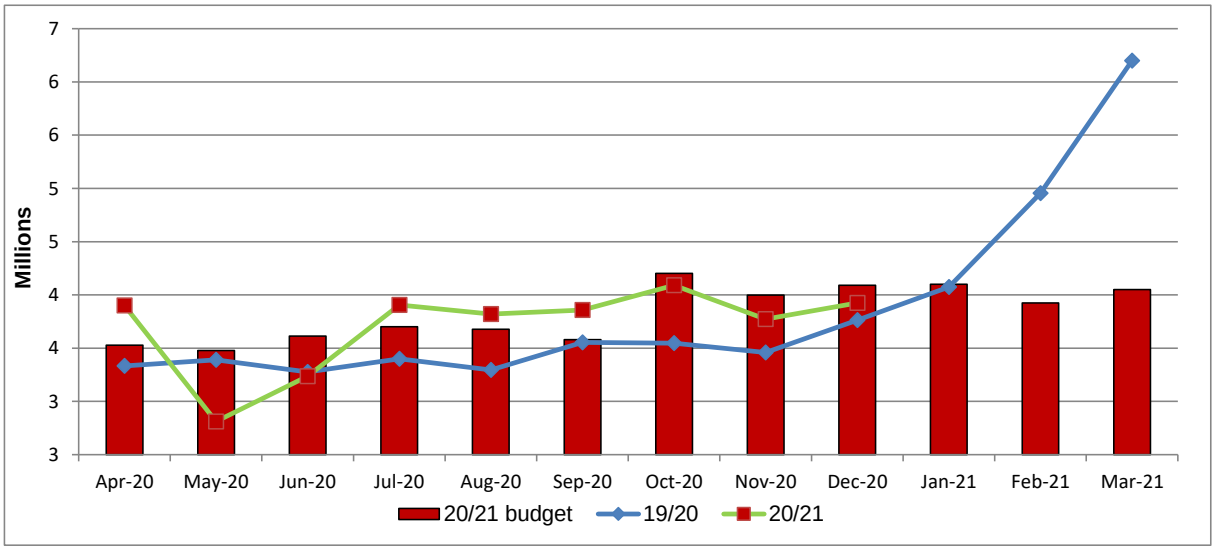


2.3 Non Pay Expenditure

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

	Apr-20 £k	May-20 £k	Jun-20 £k	Jul-20 £k	Aug-20 £k	Sep-20 £k	Oct-20 £k	Nov-20 £k	Dec-20 £k	Jan-21 £k	Feb-21 £k	Mar-21 £k	Total £k
2020/21	3,900	2,811	3,236	3,906	3,821	3,857	4,090	3,772	3,925				**33,318**
2019/20	3,333	3,391	3,276	3,400	3,295	3,554	3,547	3,458	3,762	4,073	4,954	6,200	**46,244**

	Budget Year to date	Actual Year to date	Variance
Non Pay Category	**£k**	**£k**	**£k**
Clinical Supplies	2,205	2,652	(447)
Drugs	2,565	2,523	42
Healthcare subcontracting	5,374	4,864	510
Hotel Services	1,569	1,611	(42)
Office Supplies	4,530	5,137	(607)
Other Costs	3,727	4,193	(466)
Property Costs	4,876	8,026	(3,149)
Service Level Agreements	4,729	0	4,729
Training & Education	620	736	(116)
Travel & Subsistence	1,895	1,848	48
Utilities	964	950	14
Vehicle Costs	815	778	37
Total	**33,871**	**33,318**	**552**
Total Excl OOA and Drugs	**25,932**	**25,931**	**1**



Key Messages

Due to the update in Trust finance and procurement system the chart of accounts used to categorise non- pay spend has changed. The mapping and alignment of this continues to ensure that we have the level of breakdown previously provided. The main example of this is service level agreements which have been split depending on what the agreement covered and is therefore included in other headings (primarily property and other costs).

Non Pay spend over the last 6 months has remained relatively steady including Trust spend on covid-19. It must be remember that additional PPE and cleaning materials have been provided at nil cost to the Trust from the national supply of key product lines. Local purchases however have been required to supplement this supply. Given some wards are unable to accept admissions due to outbreaks of Covid-19 it is likely that out of area bed usage will increase in January

2.3 Out of Area Beds Expenditure Focus

In this context the term out of area expenditure refers to spend incurred in order to provide clinical care to adult acute and PICU service users in non-Trust facilities. The reasons for taking this course of action can often be varied but some key reasons are highlighted below.

- Specialist health care requirements of the service user not available directly from the Trust or not specifically commissioned.
- No current bed capacity to provide appropriate care

On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Wherever possible service users are placed within the Trust geographical footprint.

This analysis is for the out of area placements relating to adult acute beds including PICU in all areas. This excludes activity relating to locked rehab in Barnsley or the purchase of other healthcare services.

Out of Area Expenditure Trend (£)

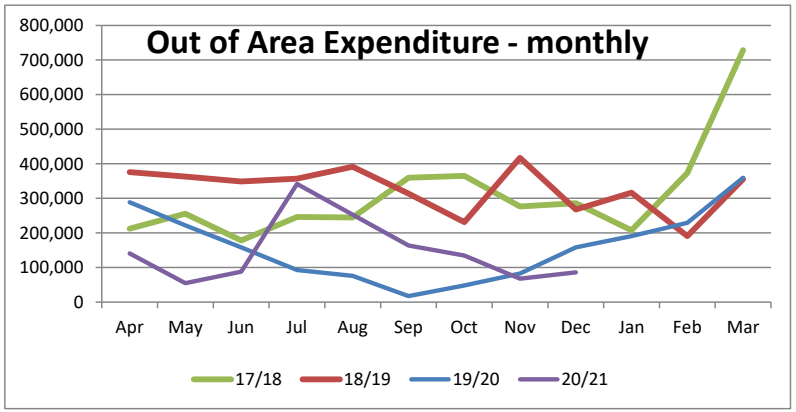
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
17/18	212	255	178	246	245	359	365	277	286	208	373	729	**3,733**
18/19	376	363	349	357	392	314	232	417	268	317	191	355	**3,929**
19/20	289	222	158	93	76	17	48	82	158	191	230	359	**1,924**
20/21	141	55	88	342	253	164	135	68	86				**1,331**

Bed Day Trend Information

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
17/18	282	367	253	351	373	427	479	434	414	276	626	762	**5,044**
18/19	607	374	412	501	680	473	245	508	329	358	197	220	**4,904**
19/20	282	354	238	206	156	28	53	129	166	216	305	275	**2,408**
20/21	110	54	120	305	147	76	108	102	141				**1,163**

Bed Day Information 2020 / 2021 (by category)

PICU	92	45	34	113	102	53	106	102	141				**788**
Acute	18	9	86	192	45	23	2	0	0				**375**
Total	110	54	120	305	147	76	108	102	141	0	0	0	**1,163**



The overall delivery of activity remains a challenge for the Trust and, to date performance has been exceptional in ensuring that as many people as possible are supported within the Trust bed base especially considering the impact that covid has had. This includes reduced internal bed capacity for cohorting purposes, pressures on staff numbers and the changes in acuity experienced over the past 9 months.

Bed days have increased in December and continue to be for PICU placements. As at 31st December 2020 there were 3 placements, 2 of which were gender specific requirements which the Trust does not provide.

Demand remains volatile and increased demand could quickly result in increased expenditure. Given some wards are unable to accept admissions due to outbreaks of covid-19 it is likely that out of area beds usage will increase in January.

3.0 Balance Sheet 2020 / 2021

	2019 / 2020 £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	108,146	105,132	1
Current Assets			
Inventories & Work in Progress	238	238	
NHS Trade Receivables (Debtors)	6,048	1,938	2
Non NHS Trade Receivables (Debtors)	953	1,321	3
Prepayments, Bad Debt, VAT	2,219	2,821	
Accrued Income	1,904	1,747	4
Cash and Cash Equivalents	36,417	69,805	5
Total Current Assets	**47,778**	**77,870**	
Current Liabilities			
Trade Payables (Creditors)	(4,102)	(6,541)	6
Capital Payables (Creditors)	(272)	(346)	
Tax, NI, Pension Payables, PDC	(6,311)	(3,979)	
Accruals	(10,869)	(15,191)	7
Deferred Income	(1,462)	(22,919)	
Total Current Liabilities	**(23,016)**	**(48,976)**	
Net Current Assets/Liabilities	**24,763**	**28,894**	
Total Assets less Current Liabilities	**132,909**	**134,026**	
Provisions for Liabilities	(8,724)	(8,491)	
Total Net Assets/(Liabilities)	**124,185**	**125,535**	
Taxpayers' Equity			
Public Dividend Capital	44,971	44,971	
Revaluation Reserve	12,763	12,397	
Other Reserves	5,220	4,876	
Income & Expenditure Reserve	61,231	63,291	8
Total Taxpayers' Equity	**124,185**	**125,535**	

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

1. Capital expenditure is detailed on page 13. The asset value is reducing due to depreciation charges and limited capital spend year-to-date.

2. NHS Debtors are predominately 1 invoice which has been agreed as payable in March 2021 (£1.6m). Due to the block nature there is very little outstanding.

3. Non NHS debtors remain low and any timing issues from the move to the new system appears to have been resolved.

4. Accrued income has reduced as all covid-19 cost retrospective funding has now been received. Invoices continue to be raised in a timely manner.

5. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 15.

6. The impact of the system change on the Better Payment Practice Code (page 17) continues to be assessed.

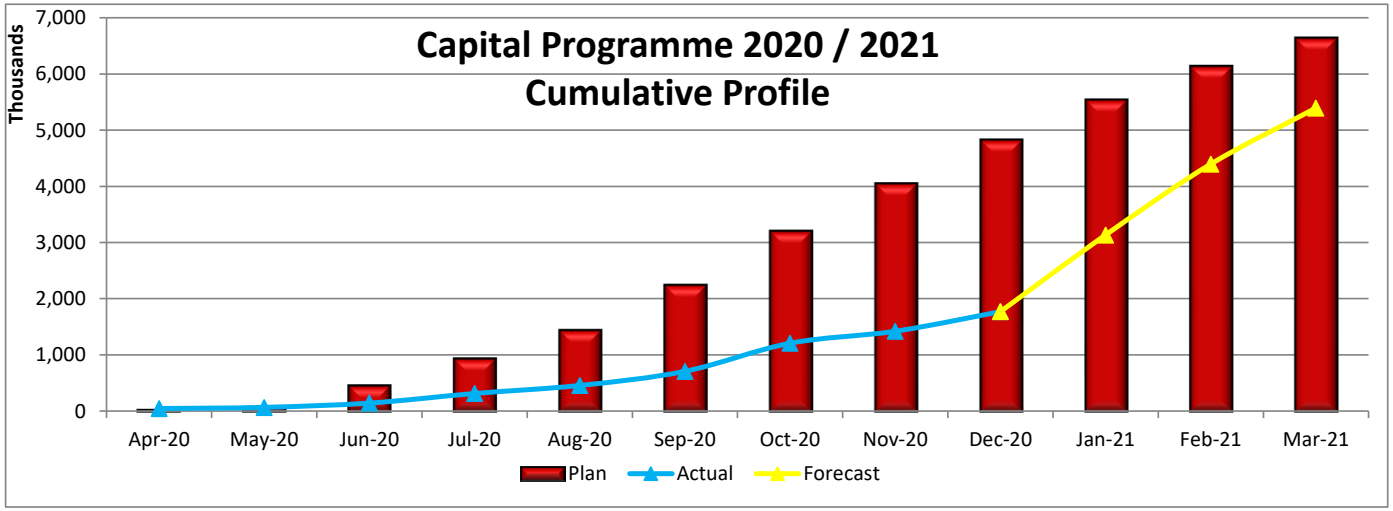
7. Accruals are higher than year end as the Trust awaits invoices for goods and services received.

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

3.1 Capital Programme 2020 / 2021

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	3,479	2,421	860	(1,560)	3,052	(427)	
Equipment Replacement	100	75	87	12	247	147	
IM&T	2,455	2,231	823	(1,408)	2,095	(360)	
Major Capital Schemes							
Hub Development	600	100	0	(100)	0	(600)	
						0	
						0	
VAT Refunds			0			0	
TOTALS	**6,634**	**4,827**	**1,770**	**(3,057)**	**5,394**	**(1,240)**	

Spend in December is £0.3m. Orders are placed for £3m spend. Timing issues due to covid and brexit are being experienced.



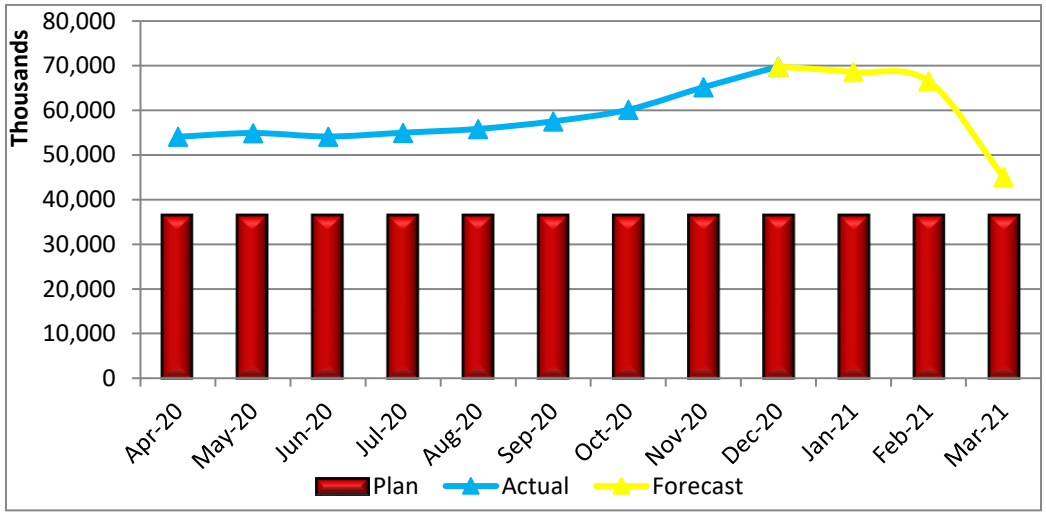
Capital Expenditure 2020 / 21

The Trust submitted a revised capital plan in May 2020 of £6.6m. This represents a 15% reduction from the original £7.8m. A further £4k has been added from the national backlog maintenance programme.

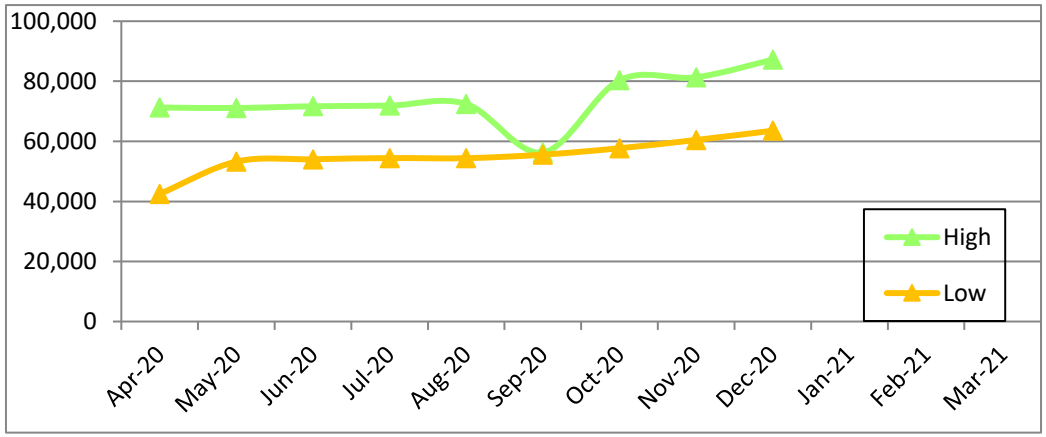
The overall capital programme continues to be reviewed on a live basis taking into account accessibility, timescales and ensuring that the Trust receive value for money.

Taking this into account the forecast has reduced by £250k from November. There is a further risk of circa £0.5m due to the impact of Covid-19 on some suppliers and internal services, initial tender responses and contractual issues.

3.2 Cash Flow & Cash Flow Forecast 2020 / 2021



	Plan £k	Actual £k	Variance £k
Opening Balance	22,617	36,417	
Closing Balance	36,417	69,805	33,388



Cash remains higher than 2019/20. The main factor is the timing of block payments which are a month in advance.

Even though block contract payments are being received a month in advance, which has a positive impact on the cash position, the Trust continues to look to maximise cash.

A detailed reconciliation of working capital compared to plan is presented on page 15.

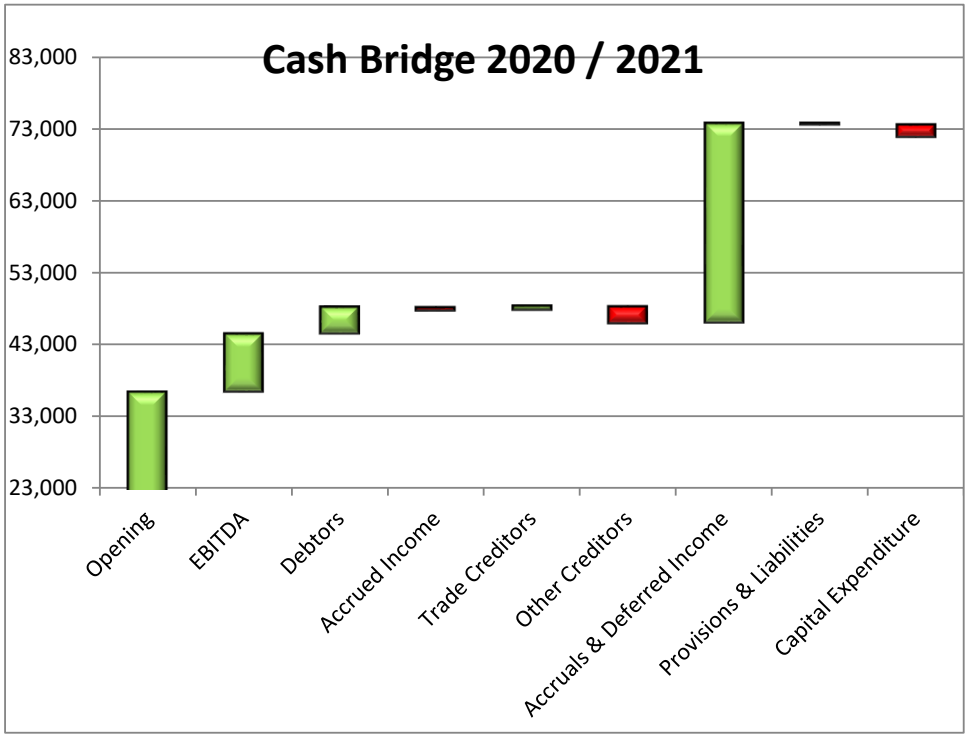
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £87.2m
The lowest balance is: £63.5m

This reflects cash balances built up from historical surpluses.

3.3 Reconciliation of Cashflow to Cashflow Plan

	Actual £k	Note
Opening Balances	**36,417**	
Surplus / Deficit (Exc. non-cash items & revaluation)	8,100	
Movement in working capital:		
Inventories & Work in Progress	0	
Receivables (Debtors)	3,742	
Accrued Income / Prepayments	(445)	
Trade Payables (Creditors)	576	
Other Payables (Creditors)	(2,332)	
Accruals & Deferred income	27,704	
Provisions & Liabilities	(233)	
Movement in LT Receivables:		
Capital expenditure & capital creditors	(1,695)	
Cash receipts from asset sales	91	
PDC Dividends paid	(2,119)	
PDC Dividends received		
Interest (paid)/ received		
Closing Balances	**69,805**	



The table above summarises the reasons for the movement in the Trust cash position during 2020 / 2021. This is also presented graphically within the cash bridge.

The surplus / deficit movement is the Trust I & E position adjusted for depreciation which is non cash and adding back in PDC as this only generates a cash impact on a 6 monthly basis and is shown separately.

This highlights the largest positive cash impact is within accruals and deferred income. Of this £21.2m relates to the receipt of January 2020 block invoices during December in line with national guidance. This is higher than previous months as it includes mental health investment standard and ICS prospective funding.

4.0 Better Payment Practice Code

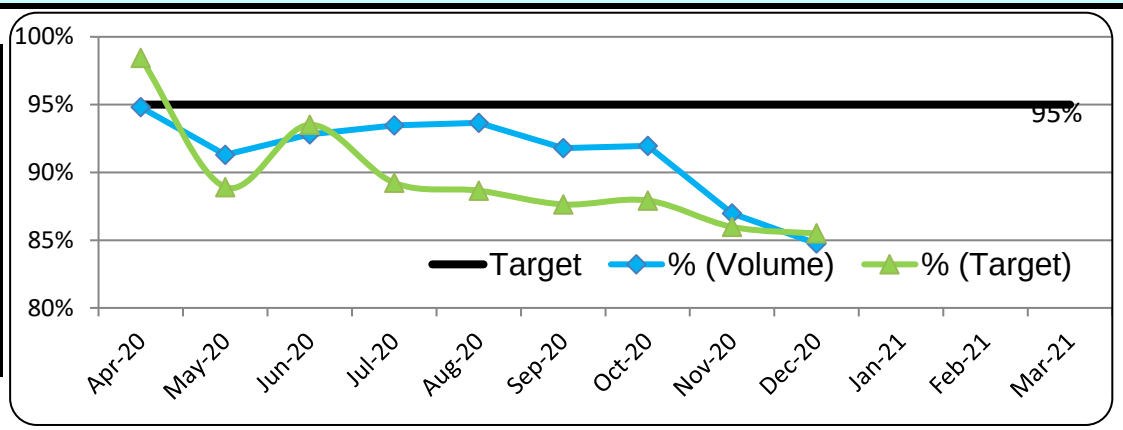
The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.

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

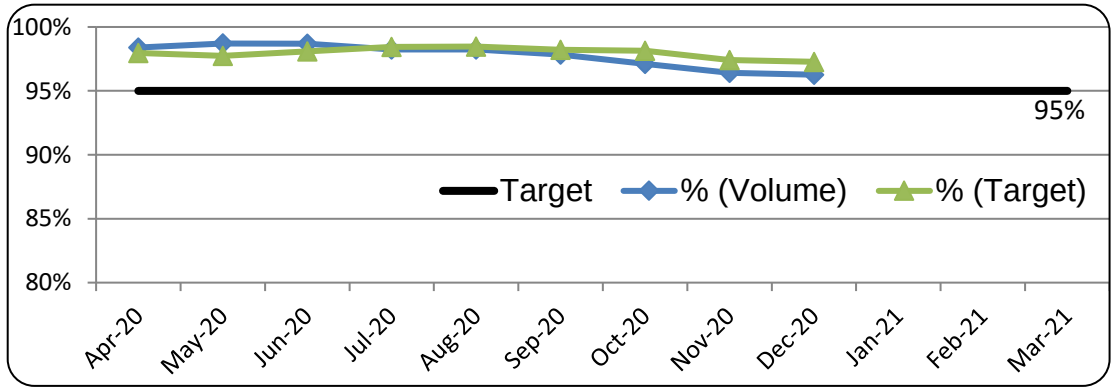
As part of the national response to the impact of COVID-19 all NHS Trusts were asked to pay suppliers within 7 days. Processes were reviewed to ensure that this could be supported and monitoring commenced immediately (20th April 2020).

To date, by value, we have paid 50% of NHS invoices and 71% of non NHS invoices within this 7 day target. It is expected this performance will continue to reduce as invoices within SBS, which have already failed this target, are paid. We continue to review processes within the new finance and procurement system to pay valid invoices as soon as possible.

NHS	Number	Value
30 days	**%**	**%**
Year to November 2020	87%	86%
Year to December 2020	85%	85%
7 days		
Year to November 2020	48%	52%
Year to December 2020	44%	50%



Non NHS	Number	Value
30 days	**%**	**%**
Year to November 2020	96%	97%
Year to December 2020	96%	97%
7 days		
Year to November 2020	64%	77%
Year to December 2020	58%	71%



4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.

The transparency information for the current month is shown in the table below.

Invoice Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
12-Dec-20	Property Rental	Wakefield	Bradbury Investments Ltd	1534	118,518
01-Dec-20	Rates	Wakefield	Wakefield Council	3156503008033001003	97,280
30-Dec-20	Drugs	Trustwide	Bradford Hospitals NHS Trust	318011	93,937
03-Dec-20	Drugs	Trustwide	Bradford Hospitals NHS Trust	317934	93,374
09-Dec-20	IT Services	Trustwide	Daisy Corporate Services	3I463788	90,250
01-Dec-20	Rates	Barnsley	Barnsley Metropolitan Borough Council	5101012197819803032	74,240
07-Dec-20	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	994638	55,602
14-Dec-20	Purchase of Healthcare	Trustwide	Kirklees Council	8606002899	53,812
29-Dec-20	Property Rental	Barnsley	Community Health Partnerships	0060180671	40,723
05-Dec-20	Drugs	Trustwide	NHS Business Services Authority	1000066914	36,415
16-Dec-20	Drugs	Trustwide	NHS Business Services Authority	1000067251	35,709
21-Dec-20	Purchase of Healthcare	Forensics	Cloverleaf Advocacy	9676	32,358
29-Dec-20	Property Rental	Barnsley	Community Health Partnerships	0060180670	31,555
12-Dec-20	Purchase of Healthcare	Trustwide	Calderdale Metropolitan Borough Council	IN20101351	31,420
31-Dec-20	Telecoms	Trustwide	Vodafone	96673557	29,882
02-Dec-20	Telecoms	Trustwide	Vodafone	96464056	29,218
21-Dec-20	Utilities	Trustwide	EDF Energy	000008781202	28,262
18-Dec-20	Utilities	Trustwide	EDF Energy	000008824418	27,827
21-Dec-20	Property Rental	Wakefield	Bradbury Investments Ltd	1535	27,758

4.2 Glossary

* Recurrent - an action or decision that has a continuing financial effect

* Non-Recurrent - an action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* Surplus - Trust income is greater than costs

* Deficit - Trust costs are greater than income

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

* Forecast Surplus / Deficit - This is the surplus or deficit we expect to make for the financial year

* Target Surplus / Deficit - This is the surplus or deficit the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	4.2%	4.1%	4.0%	4.1%	4.7%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	3.8%	3.8%	3.6%	4.1%	4.3%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.0%	86.0%	86.8%	86.2%	86.7%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	91.7%	92.1%	91.7%	91.0%	91.2%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.4%	90.8%	92.1%	92.9%	93.3%	
Equality and Diversity	Resources	Well Led	AD	>=80%	97.3%	97.4%	98.0%	98.2%	97.7%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	94.6%	94.1%	93.9%	93.3%	91.6%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.7%	79.9%	78.5%	79.0%	78.2%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	97.9%	97.9%	98.2%	98.4%	98.0%	
Information Governance	Resources	Well Led	AD	>=95%	98.9%	99.1%	99.0%	99.1%	99.0%	
Moving and Handling	Resources	Well Led	AD	>=80%	92.6%	92.2%	91.8%	91.3%	90.4%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.2%	94.7%	94.4%	94.6%	94.7%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	91.6%	92.0%	91.8%	93.0%	94.0%	
Prevent	Improving Care	Well Led	AD	>=80%	94.5%	95.3%	95.3%	95.7%	96.2%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.1%	92.9%	92.9%	93.2%	93.4%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	94.4%	95.5%	95.5%	95.1%	94.8%	
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	98.7%	98.4%	98.4%	No longer used		
Bank Cost	Resources	Well Led	AD		£79k	£102k	£87k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£58k	£56k	£60k			
Overtime Costs	Resources	Effective	AD		£43k	£48k	£18k			
Additional Hours Costs	Resources	Effective	AD		£27k	£24k	£18k			
Sickness Cost (Monthly)	Resources	Effective	AD		£98k	£99k	£89k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		0.51	3.59	-1.37			
Business Miles	Resources	Effective	AD		84k	85k	74k			

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	3.1%	3.1%	3.1%	3.1%	3.1%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.7%	3.0%	3.2%	3.1%	3.1%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.2%	86.6%	85.5%	85.6%	83.1%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.6%	89.8%	89.0%	87.9%	86.3%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	96.2%	95.7%	94.9%	94.6%	93.3%	
Equality and Diversity	Resources	Well Led	AD	>=80%	96.0%	96.8%	96.7%	97.2%	96.6%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	95.3%	95.0%	95.0%	95.2%	93.0%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.5%	78.2%	77.2%	76.9%	76.2%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led		>=80%	95.5%	96.2%	95.6%	96.5%	96.5%	
Information Governance	Resources	Well Led	AD	>=95%	98.5%	99.4%	99.3%	99.4%	99.1%	
Moving and Handling	Resources	Well Led	AD	>=80%	95.1%	95.6%	95.4%	95.3%	94.7%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	94.0%	95.6%	94.8%	95.8%	95.6%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	92.1%	93.5%	93.6%	94.4%	93.9%	
Prevent	Improving Care	Well Led	AD	>=80%	93.1%	95.2%	95.2%	95.5%	95.3%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	96.2%	89.7%	89.7%	91.0%	90.9%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	92.6%	94.2%	94.2%	94.1%	93.1%	
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	96.6%	96.9%	96.9%	No longer used		
Bank Cost	Resources	Well Led	AD		£90k	£130k	£141k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£40k	£67k	£50k			
Overtime Costs	Resources	Effective	AD		£26k	£25k	£26k			
Additional Hours Costs	Resources	Effective	AD		£2k	£1k	£1k			
Sickness Cost (Monthly)	Resources	Effective	AD		£71k	£83k	£75k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		37.74	36.11	39.69			
Business Miles	Resources	Effective	AD		32k	27k	26k			

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

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Resources	Well Led	AD	<=5.4%	5.4%	5.4%	5.4%	5.3%	5.6%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=5.4%	5.5%	5.4%	5.4%	5.3%	5.5%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.9%	86.9%	85.5%	87.4%	86.8%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	89.4%	92.3%	90.9%	91.6%	90.5%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.0%	95.1%	93.8%	95.1%	94.8%	
Equality and Diversity	Resources	Well Led	AD	>=80%	94.3%	95.6%	94.5%	95.0%	94.9%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.9%	94.3%	93.0%	93.7%	93.1%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	69.2%	72.3%	70.4%	69.7%	68.4%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	94.9%	96.0%	95.6%	95.8%	95.5%	
Information Governance	Resources	Well Led	AD	>=95%	97.1%	98.5%	98.2%	98.4%	98.3%	
Moving and Handling	Resources	Well Led	AD	>=80%	95.4%	96.9%	96.4%	96.9%	96.8%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	90.1%	93.0%	92.1%	92.6%	93.1%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	86.0%	89.8%	88.0%	87.5%	89.0%	
Prevent	Improving Care	Well Led	AD	>=80%	90.2%	92.5%	92.5%	92.5%	92.6%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	94.9%	91.9%	91.9%	91.6%	91.2%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	88.2%	89.0%	89.0%	88.2%	87.9%	
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	98.6%	98.6%	98.6%	No longer used		
Bank Cost	Resources	Well Led	AD		£204k	£239k	£291k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£183k	£190k	£207k			
Overtime Costs	Resources	Effective	AD		£86k	£74k	£79k			
Additional Hours Costs	Resources	Effective	AD		£8k	£5k	£5k			
Sickness Cost (Monthly)	Resources	Effective	AD		£83k	£84k	£78k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		114.49	107.62	106.84			
Business Miles	Resources	Effective	AD		9k	12k	11k			

CAMHS

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	2.4%	2.5%	2.6%	2.8%	3.2%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	2.3%	2.8%	3.5%	2.8%	2.9%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	76.1%	75.6%	76.6%	75.5%	76.6%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	84.8%	83.3%	81.1%	79.9%	80.6%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	89.6%	91.2%	92.7%	94.3%	95.9%	
Equality and Diversity	Resources	Well Led	AD	>=80%	93.2%	93.7%	93.7%	94.2%	93.9%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	90.4%	89.5%	91.3%	91.1%	91.1%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	25.0%	25.0%	0.0%	0.0%	0.0%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	92.9%	92.3%	93.4%	93.5%	92.8%	
Information Governance	Resources	Well Led	AD	>=95%	96.6%	96.8%	96.9%	96.9%	97.6%	
Moving and Handling	Resources	Well Led	AD	>=80%	96.8%	96.5%	97.6%	97.3%	97.3%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	91.1%	91.2%	91.9%	92.4%	93.5%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.8%	88.4%	88.9%	89.0%	90.2%	
Prevent	Improving Care	Well Led	AD	>=80%	92.4%	93.3%	93.3%	92.4%	93.1%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	93.6%	90.6%	90.6%	90.1%	90.1%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	90.4%	92.0%	92.0%	92.1%	90.1%	
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	95.6%	95.0%	95.0%	No longer used		
Bank Cost	Resources	Well Led	AD		£16k	£13k	£16k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£153k	£154k	£144k			
Overtime Costs	Resources	Effective	AD		£23k	£36k	£26k			
Additional Hours Costs	Resources	Effective	AD		£5k	£4k	£5k			
Sickness Cost (Monthly)	Resources	Effective	AD		£19k	£23k	£30k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		49.63	46.44	2923.0%			
Business Miles	Resources	Effective	AD		7k	6k	5k			

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

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Resources	Well Led	AD	<=4.0%	3.1%	3.1%	3.3%	3.3%	3.5%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=4.0%	3.2%	3.3%	3.8%	3.3%	3.3%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	92.1%	92.9%	92.3%	93.9%	92.7%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.7%	89.7%	87.1%	87.5%	87.1%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	66.7%	100.0%	100.0%	80.0%	80.0%	
Equality and Diversity	Resources	Well Led	AD	>=80%	92.3%	92.3%	92.0%	91.8%	91.4%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	93.8%	93.9%	92.8%	90.8%	90.3%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	93.7%	97.2%	97.8%	97.1%	97.8%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.2%	95.4%	94.8%	94.2%	93.8%	
Information Governance	Resources	Well Led	AD	>=95%	98.1%	98.4%	99.0%	99.3%	99.5%	
Moving and Handling	Resources	Well Led	AD	>=80%	96.4%	97.0%	98.6%	98.6%	98.6%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	99.0%	99.0%	98.8%	98.8%	98.9%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	87.0%	90.5%	81.8%	86.4%	90.5%	
Prevent	Improving Care	Well Led	AD	>=80%	96.7%	97.9%	97.9%	98.2%	98.2%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	97.3%	98.5%	98.5%	98.4%	97.7%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	96.6%	98.2%	98.2%	98.1%	97.7%	
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	60.0%	100.0%	100.0%	No longer used		
Bank Cost	Resources	Well Led	AD		£45k	£32k	£47k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£23k	£10k	£12k			
Overtime Costs	Resources	Effective	AD		£8k	£13k	£9k			
Additional Hours Costs	Resources	Effective	AD		£22k	£20k	£19k			
Sickness Cost (Monthly)	Resources	Effective	AD		£49k	£48k	£55k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		-53.95	-42.87	11.15			
Business Miles	Resources	Effective	AD		8k	12k	8k			

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20
Sickness (YTD)	Resources	Well Led	AD	<=4.6%	2.7%	2.8%	2.8%	2.9%	4.1%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=4.6%	4.1%	3.2%	2.7%	2.9%	3.0%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	88.2%	88.3%	88.0%	87.9%	87.2%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	88.9%	90.4%	88.8%	88.1%	87.9%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	91.6%	92.1%	91.4%	91.5%	90.7%	
Equality and Diversity	Resources	Well Led	AD	>=80%	95.5%	96.8%	96.1%	96.1%	96.6%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.1%	92.8%	93.5%	90.0%	90.4%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	80.6%	81.9%	73.2%	76.5%	78.1%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.5%	96.8%	95.5%	95.3%	95.6%	
Information Governance	Resources	Well Led	AD	>=95%	99.2%	99.7%	99.2%	99.0%	98.4%	
Moving and Handling	Resources	Well Led	AD	>=80%	96.3%	97.3%	96.6%	96.9%	96.9%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	93.6%	94.9%	94.8%	94.8%	94.0%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	93.4%	94.6%	93.5%	94.1%	93.0%	
Prevent	Improving Care	Well Led	AD	>=80%	90.7%	91.6%	91.6%	93.2%	94.0%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	96.3%	91.6%	91.6%	93.1%	92.7%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	93.4%	92.1%	92.1%	92.7%	92.5%	
Sainsbury's clinical risk assessment	Quality & Experience	Well Led	AD	>=80%	96.6%	95.0%	95.0%	No longer used		
Bank Cost	Resources	Well Led	AD		£58k	£63k	£57k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£38k	£32k	£45k			
Overtime Costs	Resources	Effective	AD		£15k	£30k	£21k			
Additional Hours Costs	Resources	Effective	AD		£3k	£2k	£2k			
Sickness Cost (Monthly)	Resources	Effective	AD		£37k	£29k	£22k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		16.10	11.31	0.59			
Business Miles	Resources	Effective	AD		22k	24k	25k			

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

Inpatient Service										
Month	**Objective**	**CQC Domain**	**Owner**	**Threshold**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**
Sickness (YTD)	Resources	Well Led	AD	<=4.5%	5.7%	5.6%	5.4%	5.4%	4.6%	Data unavailable at the time of producing this report
Sickness (Monthly)	Resources	Well Led	AD	<=4.5%	5.5%	5.1%	4.7%	5.4%	5.2%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	85.6%	87.2%	87.1%	86.4%	86.3%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	86.7%	88.2%	87.8%	87.1%	86.7%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	95.0%	94.3%	95.3%	88.0%	91.1%	
Equality and Diversity	Resources	Well Led	AD	>=80%	95.3%	96.3%	96.5%	97.7%	97.8%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	92.5%	94.9%	92.1%	91.7%	92.6%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	73.6%	73.5%	73.3%	73.9%	75.0%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	95.3%	96.1%	95.9%	95.7%	96.7%	
Information Governance	Resources	Well Led	AD	>=95%	97.4%	98.0%	98.8%	98.6%	98.6%	
Moving and Handling	Resources	Well Led	AD	>=80%	96.3%	97.5%	97.7%	97.2%	97.6%	
Mental Capacity Act/DOLS	Health & Wellbeing	Well Led	AD	>=80%	84.6%	87.6%	89.2%	90.0%	91.0%	
Mental Health Act	Health & Wellbeing	Well Led	AD	>=80%	85.2%	86.5%	87.3%	88.1%	90.1%	
Prevent				>=80%	90.9%	92.2%	92.2%	92.6%	94.3%	
Safeguarding Adults	Quality & Experience	Well Led	AD	>=80%	95.5%	93.3%	93.3%	91.2%	90.7%	
Safeguarding Children	Quality & Experience	Well Led	AD	>=80%	86.3%	87.5%	87.5%	86.6%	86.9%	
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	96.9%	96.6%	96.6%	No longer used		
Bank Cost	Resources	Well Led	AD		£164k	£200k	£268k	Data unavailable at the time of producing this report		
Agency Cost	Resources	Effective	AD		£63k	£96k	£69k			
Overtime Costs	Resources	Effective	AD		£57k	£51k	£32k			
Additional Hours Costs	Resources	Effective	AD		£4k	£4k	£3k			
Sickness Cost (Monthly)	Resources	Effective	AD		£50k	£46k	£37k			
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		44.33	43.74	47.83			
Business Miles	Resources	Effective	AD		0k	0k	0k			

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

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Trust Board 26 January 2021
Agenda item 11.1

Title:	**Scheme of Delegation**
Paper prepared by:	Director of Finance and Resources
Purpose:	Update to the Trust Scheme of Delegation
Mission/values:	• Respectful, honest, open and transparent. • Relevant today and ready for tomorrow.
Any background papers/ previously considered by:	• Considered by the Executive Management Team (EMT) and Audit Committee on a regular basis. • Recommended for approval by the Audit Committee at its meeting on 5 January 2021.
Executive summary:	• Under the Standing Orders for the practice and procedure of the Trust Board within the Trust's Constitution, Standing Order 3.14 provides that, subject to directions given by the Secretary of State for Health or NHS Improvement, Trust Board may make arrangements for any of its functions to be carried out on its behalf by a Committee or sub-committee or by the Chair or by a director or any officer of the Trust, in each case subject to restrictions and conditions determined by Trust Board. • All changes are shown using tracked changes so as to clearly identify them. • The Scheme of Delegation (SoD) or reservation of powers to trust Board and delegation of powers is a key document used in the governance of the Trust. • This report provides an update to the SoD based on any improvements identified, clarification of roles and general updates. • The full SoD is attached and the recommended changes are highlighted using track changes. Where appropriate explanatory comments are provided to explain the rationale. • The impact of some key changes is included in the update such as the introduction of the new Oracle finance & procurement ledger and reporting system, the development of lead provider collaboratives and increases in partnership arrangements with other organisations. • Recognition of Board approval for changes to organisational structure is provided. • Disciplinary procedures for directors are brought in line with the Trust's approved disciplinary procedure. • Recommended updates to strategy approvals are highlighted. • The introduction of the Finance, Investment & Performance Committee and its role is included.

	• There is a further requirement for the Members' Council to approve the Trust's Scheme of Delegation changes. • Updates to requisition, purchase order and invoice approval levels are listed. These have been agreed with the Operational Management Group (OMG) and EMT.
Recommendation:	**Trust Board is asked to REVIEW and DISCUSS this document and APPROVE the proposed changes to the scheme of delegation.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Scheme of Delegation Update

Each year the Trust is required to review and if necessary, update its approved scheme of delegation. Whilst ultimate approval of this key governance document belongs to the Trust Board and members' council, the Audit Committee have a responsibility to review and make a recommendation. Following discussion and agreement with members of the Executive Management Team (EMT) and Operations Management Group (OMG) a small number of changes are proposed to be incorporated in the scheme of delegation. These proposed updates are highlighted in this paper and in the revised scheme of delegation document. Track changes is used to make clear what the proposed changes are.

It is worth noting that given the regularity of this review, it is considered the document remains fit for purpose. The document was not updated in January 2020 due to the fact discussions were taking place regarding the relationship between the Trust and Barnsley Healthcare Federation, which at that time were expected to be completed in readiness for April 2020. Since then the outbreak of the Covid-19 pandemic delayed that agreement, which has recently been approved by the Trust Board. Key changes that have arisen over the period of time since the previous update include:

- The implementation of the new Oracle finance and procurement ledger system.
- Temporary changes to approval levels agreed during the Covid-19 pandemic.
- Agreement to jointly manage community services funding in Barnsley with the Barnsley Healthcare Federation.
- The introduction of the Finance, Investment & Performance Committee (FIP)

In summary the following are highlighted as updates to the document:

- Consideration has been made for decision-making required given the introduction of the lead provider collaborative models for forensics, eating disorder and CAMHS.
- On a similar theme a section has been added to recognise the role the Board needs to play in any partnering arrangements or structural changes.
- The current scheme of delegation states it is a responsibility of the Trust Board to 'discipline members of the Board or employees who are in breach of statutory requirements of standing orders.' This needs to be in line with the Trust's disciplinary procedure which outlines the line management responsibility for disciplinary actions.
- Similarly, the current document states the Trust Board has responsibility for appointing, disciplining, and dismissing the secretary (delegated to workforce & remuneration committee). This is again considered a line management responsibility, with the Workforce & Remuneration Committee notified of any such incident and sanction.
- Currently the document states it is the Board's responsibility to approve arrangements relating to the discharge of the Trust's responsibilities for patients' property. It is recommended it is more appropriate that this is delegated to the Audit Committee.
- The document is added to making it clear it is the Board's responsibility to approve any changes to organisational structure e.g. joint ventures, mergers, acquisitions.
- The involvement of any external parties in any decision-making within the Trust such as the Barnsley Healthcare Federation has been recognised in this update. This is in line with the partnership agreement.

- Recognition has been given to any changes in strategies.
- The Finance, Investment & Performance Committee (FIP) and its decisions/duties delegated by the Trust Board has been added.
- Currently approval is required for the Trust Board in terms of income generating activities above £500k. It is proposed this approval is delegated to the FIP.
- Currently Trust Board approval is required for any procurement contracts that commit the Trust to spend of £500k or more over three years or less. It is proposed FIP has delegated authority for £500k to £1m and the Trust Board over £1m.
- In terms of requisitioning and approving invoices the current delegated limits were temporarily increased for budget holders from £500 to £1,000 at the onset of the pandemic. There does not appear to be any reason for reversing this change, particularly given the fact that requisitioners cannot approve in the SBS system. There is currently also a notable gap between a general manager approval at £5k and deputy director at £50k. This is resulting in deputy directors needing to approve a higher number of requisitions and invoices. In order to reduce this, it is recommended the approval level for general managers increases to £10k. There is also facility with the SBS system to provide specific limits for individuals if this is appropriate. This could help with processing of higher volume purchases such as some estates costs, catering, and community equipment. These specific requirements are being identified and it is recommended any such use of this facility is approved by the Director of Finance in the first instance and ratified by the Audit Committee. This will be capped at a maximum value of £15k. These will be an exception as opposed to being the rule.

Given the current consultation taking place on the role and structure of integrated care systems it may well be the case that further updates to this document are required during the course of 2021. If this proves necessary, the same process will be followed at the appropriate time.

This paper and its accompanying attachments were considered by the Audit Committee on 5 January 2021 and recommended for approval.

Summary and Recommendation

The Trust Board is asked to consider the above and attached document and confirm agreement with the proposed changes to recommend for ultimate approval by the Members' Council.

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Reservation of Powers to Trust Board and Delegation of Powers

Under the Standing Orders for the practice and procedure of the Trust Board within the Trust's Constitution, Standing Order 3.14 provides that, subject to directions given by the Secretary of State for Health or NHS Improvement, Trust Board may make arrangements for any of its functions to be carried out on its behalf by a Committee or sub-committee or by the Chair or by a director or any officer of the Trust, in each case subject to restrictions and conditions determined by Trust Board.

The purpose of this document is to describe those powers that are reserved to Trust Board (generally those matters for which the Trust is accountable to the Secretary of State or to NHS Improvement) whilst at the same time delegating the detailed application of Trust policies and procedures to the appropriate level. Trust Board remains accountable for all its functions, even those delegated to the Chair, individual directors or officers, and will put in place arrangements to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

- Part 1 – Reservation of powers to the Trust Board and Scheme of Delegation general provisions
- Part 2 – Decisions/duties delegated by the Trust Board to Committees
- Part 3 – Scheme of Delegation derived from the Accounting Officer's Memorandum
- Part 4 – Delegation of duties relating to Corporate Governance
- Part 5 – Scheme of Delegation from the Trust's Constitution Standing Orders
- Part 5 – Scheme of Delegation from the Trust's Standing Financial Instructions

Role of the Chief Executive
All powers of the Trust that have not been retained by Trust Board or delegated to a Committee will be exercised on behalf of Trust Board by the Chief Executive. The Chief Executive will prepare a scheme of delegation identifying the functions he/she will perform personally and those which will be delegated to other directors or officers. All powers delegated by the Chief Executive can be reassumed by him/her at any time. The Chief Executive is the Accounting Officer for the Trust and is accountable to Parliament for the efficient and effective use of the Trust's resources.

Caution over the use of delegated powers
Powers are delegated to directors and officers on the understanding that they be exercised responsibly.

Directors' ability to delegate their own delegated powers
The Scheme of Delegation shows the delegation from Trust Board to Committees and Executive Directors. The Scheme should be used in conjunction with the system of budgetary control and other established procedures within the Trust (Standing Financial Instructions) and any further scheme of delegation developed to support arrangements within Business Delivery Units and to support Service Line Management.

Absence of directors to whom powers have been delegated
In the absence of a director or officer to whom powers have been delegated those powers will be exercised by the director or officer's designated deputy unless alternative arrangements have been approved by Trust Board.

Matters reserved for Trust Board and those matters that are delegated by Trust Board to Committees or Executive Directors are detailed in the attached Scheme of Delegation schedule.

RESERVATION OF POWERS TO THE TRUST BOARD AND SCHEME OF DELEGATION GENERAL PROVISIONS

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
	Trust Board	**General Enabling Provision** Trust Board may make decisions on any matter for which it has delegated or statutory authority, in full session within its statutory powers.
	Trust Board	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chair and Chief Executive. 5. Approve a Scheme of Delegation of powers from Trust Board to committees. (Decisions taken by Committees within their delegated powers will be regarded as having been taken by Trust Board). 6. Establish terms of reference and reporting arrangements of all Committees and sub-committees that are established by Trust Board. 7. Grant delegated authority to the Chair or other directors to approve actions on its behalf, subject to ratification at a future meeting of Trust Board. 8. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications to them. 9. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 10. Require and receive the declaration of interests for staff that may conflict with those of the Trust. 11. Approve arrangements for dealing with complaints. 12. Authorise use of the seal (delegated to Chief Executive / Executive Director). 13. Ratify or otherwise, instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 6.6. ~~14. Discipline members of the Board or employees who are in breach of statutory requirements or SOs.~~ 14. Receive notification of any disciplinary action taken against members of the Board who are in significant breach of statutory requirements or standing orders in line with the Trust's disciplinary procedure

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REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		executive powers. 17. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 18. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.(delegated to the Audit Committee)
	Trust Board	**Appointments/dismissals** 1. Appoint and dismiss committees (and individual directors) that are directly accountable to Trust Board. 2. Approve proposals regarding the Chief Executive, directors, senior employees (delegated to Workforce and Remuneration Committee). 3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies where they are a voting member. 4. Appoint, discipline and dismiss the Secretary (delegated to Workforce and Remuneration Committee).
	Trust Board	**Strategy, Plans and Budgets** 1. Define and set the Trust's strategy, the strategic aims and objectives. 2. Approve the Business Plan or equivalent as required by NHS England & Improvement (NHSE&I). 3. Approve the Trust's annual financial plan. 4. Receive and approve the Trust's Annual Report and Annual Accounts. 5. Receive and approve the Trust's Annual Quality Accounts ~~6. Approve the Trust's Communication, Engagement and Involvement Strategy.~~ ~~7.~~6. Agree the Trust's Counter Fraud Strategy (delegated to the Audit Committee). ~~8.~~7. Agree the Trust's Creative Minds Strategy (delegated to the Charitable Funds Committee). ~~9.~~8. Agree the Trust's Equality, Involvement, Communication & Membership ~~First~~ Strategy (delegated to the Equality and Inclusion Committee and Executive Management Team) ~~10. Agree the Trust's Food and Drink Strategy (delegated to the Executive Management Team).~~ ~~11.~~9. Approve the Trust's Digital Strategy. ~~12.~~10. Agree the Medicines Management Strategy (delegated to the Executive Management Team). ~~13.~~11. Approve the Trust's Organisational Development Strategy. ~~14.~~12. Agree the Trust's Procurement Strategy (delegated to the Audit Committee). ~~15.~~13. Approve the Trust's Quality Strategy. ~~16.~~14. Approve the Trust's Corporate Risk Management Strategy.

REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		17. Approve the Trust's Workforce Strategy 18. Approve the Trust's Estates ~~& Environment~~ Strategy ~~18.~~19. Approve the Trust's Sustainability Strategy ~~19. Approve the Trust's Innovation & Change Strategy~~ 20. Agree other Trust strategies (delegated to the Executive Management Team). 21. Approve an annual plan for each Committee of Trust Board. 22. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State. 23. Approve arrangements for agreeing action on litigation against or on behalf of the Trust. 24. Approve outline and final Business Cases for capital investment above £500,000 or a series of projects for which the combined value would exceed £1 million. 25. Ratify proposals for acquisition, disposal and final sale of land and/or buildings 26. Ratify proposals for change of use of land and/or buildings where that land and/or building has a value above £500,000 27. Approve PFI proposals. 28. Approve the opening of bank accounts (on recommendation of the Audit Committee) 29. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 over a 3 year period or the period of the contract if longer. 30. Review use of NHS Resolution risk pooling schemes. 31. Approve individual compensation payments not covered by the NHS LA risk pooling scheme above £5,000 (delegated to the Audit Committee, unless in relation to employment which is delegated to the Workforce and Remuneration ~~and Terms of Service~~ Committee~~)~~.
	Trust Board	**Policy Determination** 1. Approve the process for approval, dissemination and implementation of policies and procedures. 2. Approve the arrangements for dealing with complaints. 3. Approve Human Resources policies relating to the arrangements for the appointment, removal and remuneration of staff not covered by the Workforce and Remuneration Committee. 4. Approve the Treasury Management Policy.(on recommendation of the Audit Committee) 5. Approve Procurement policies (delegated to the Audit Committee), including tendering and quotation procedures that form part of the Standing Financial Instructions. 6. Approve policies relating to people's detention under the Mental Health Act (delegated to the Mental Health Act Committee). 7. Approve policies relating to statutory compliance.

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REF	TRUST BOARD	DECISIONS RESERVED TO THE BOARD
		8. Approve the policy and procedures for dealing with serious untoward incidents. 9. Approve policies relating to the management of clinical risk and clinical safety (delegated EMT with support from ~~to~~ the Clinical Governance and Clinical Safety Committee). 10. Approve the Standards of Business Conduct in Public Service Policy.
	Trust Board	**Audit** 1. Receive the ISA260 (or equivalent) received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate of the Audit Committee.
	Trust Board	**Annual Reports and Accounts** 1. Receive and approve the Trust's Annual Report and accounts including the Quality Account. 2. Receive and approve the Annual Report and accounts for charitable funds held on trust as the Corporate Trustee.
	Trust Board	**Monitoring** 1. Receive such reports as Trust Board sees fit from committees in respect of their exercise of delegated powers, including an annual report of activities undertaken by the committee. 2. Continuous appraisal of the affairs of the Trust by means of the provision to Trust Board as Trust Board may require from Directors, committees, and officers of the Trust as set out in management policy statements. 3. Receive performance reports on performance against annual and five year plans (or equivalent) and key performance indicators as agreed by Trust Board. 4. Receive and approve key reports as required including reports to and from NHS Improvement, reports on compliance with the NHS Improvement Single Oversight Framework (or equivalent), the terms of the Trust's Licence, and Care Quality Commission.

	Trust Board	**Partnering Agreements and Structural Changes** **1.** Authorise, or mandate the Trust representative to authorise any Trust decision required in the context of the governance arrangements for collaboratives **2.** Approve any changes to organisational structure including mergers, joint ventures, acquisitions or divestments in line with national guidance following agreement with the Members' Council **3.** Approve any partnership arrangements which provide external parties with influence over how Trust funds are spent **4.** Agree terms of reference for place based integrated care partnerships **5.** Approve the governance arrangements to oversee the effective management of risks and arrangements against lead provide contracts (delegated to Finance, Investment & Performance Committee)

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DECISIONS/DUTIES DELEGATED BY THE TRUST BOARD TO COMMITTEES

(Committee Terms of Reference: http://www.southwestyorkshire.nhs.uk/about-us/how-we-are-run/trust-board/trust-board-committees/)

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
Standing Order (SO) 5.8.1 Standing Financial Instructions (SFI) 4.1	Audit Committee	The terms of reference of the Audit Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.4	Workforce and Remuneration Committee	The terms of reference of the Workforce and Remuneration Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.2	Clinical Governance and Clinical Safety Committee	The terms of reference of the Clinical Governance and Clinical Safety Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
	Equality and Inclusion Committee	The terms of reference of the Equality and Inclusion Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.3	Mental Health Act Committee	The terms of reference of the Mental Health Act Committee describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.
	West Yorkshire Mental Health Services Collaborative Committees in Common	The terms of reference of the West Yorkshire Mental Health Services Collaborative Committees in Common describe the functions that have been delegated to the Committee by Trust Board. Refer to the current Terms of Reference on the Trust's website.

REF	COMMITTEE	DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SO 5.8.6 SFI 21	Charitable Funds Committee	The terms of reference of the Charitable Funds Committee describe the functions that have been delegated to the Committee by the Corporate Trustee for Charitable Funds. Refer to the current Terms of Reference on the Trust's website.
SO 5.8.5	Nominations Committee	The terms of reference of the Nominations Committee describe the functions that have been delegated to the Committee by the Members' Council. Refer to the current Terms of Reference on the Trust's website.
	Finance, Investment & Performance Committee	The terms of reference of the Finance, Investment & Performance Committee describe the functions that have been delegated to the Committee by the Trust Board. Refer to the current Terms of Reference on the Trust's website

SCHEME OF DELEGATION DERIVED FROM THE ACCOUNTING OFFICER'S MEMORANDUM

(Accounting Officer's Memorandum: https://www.gov.uk/government/publications/nhs-foundation-trusts-accounting-officers-responsibilities)

REF	DELEGATED TO	ACCOUNTING OFFICER'S MEMORANDUM DUTIES DELEGATED
Accounting Officer's Memorandum (AOM) 1	Chief Executive (CE)	The National Health Service Act 2006 (the Act) designates the chief executive of an NHS foundation trust as the accounting officer.
AOM 7	CE	The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that: • there is a high standard of financial management in the NHS foundation trust as a whole • the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation • financial considerations are fully taken into account in decisions by the NHS foundation trust.
AOM 8	CE	The essence of the accounting officer's role is a personal responsibility for: • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts • prudent and economical administration in line with the principles set out in managing public money. • the avoidance of waste and extravagance • the efficient and effective use of all the resources in their charge.
	CE	Refer to Accounting Officer's Memorandum for full details of the Accounting Officer's responsibilities.

DELEGATION OF DUTIES RELATING TO CORPORATE GOVERNANCE

(Code of Governance: https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance)

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
	Trust Board	Ensure the organisation is compliant with the Terms of Authorisation and is financially viable, legally constituted, well governed and that the organisation complies with the constitution, mandatory guidance issued by NHS Improvement, relevant statutory requirements and contractual obligations.
Code of Governance (COG) A.1.a & b main principals	Trust Board	Every NHS foundation trust should be headed by an effective board of directors (Trust Board). The board is collectively responsible for the performance of the NHS foundation trust. The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public.
COG A.3.a main principals	Chair	The chairperson is responsible for leadership of the board of directors (Trust Board) and the council of governors (Members' Council), ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.
COG A.4.a main principals	Non-Executive Directors	As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of the board as a unitary board.
COG A.4.1 Standing Order (SO) 3.11	Senior Independent Director	The senior independent director has a role to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary, including: • acting as a source of reference for the staff governors/Freedom to Speak up Guardians where there are concerns about the Chair or the Chief Executive. • being available to staff and governors if they have concerns relating to the Chair, Chief Executive, Director of Finance, or the board of directors (Trust Board) as a whole, compliance with the terms of authorisation, or the welfare of the Trust when contact through the normal channels has failed to resolve or for which such contact is inappropriate. • leading the evaluation of the Chair's appraisal from governors, executive Directors, and Non-Executives in consultation with the council of governors (Members' Council) and the setting of the

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
		Chair's objectives.
COG A.5.a, b, c main principals	Governors	The council of governors (Members' Council) has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors (Trust Board). This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust. The council of governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct. Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.
COG		Refer to the Code of Governance for full details of the responsibilities.
	All directors	Constructively challenge the decisions of Trust Board, monitor the performance of the organisation and make decisions objectively in the interests of the Trust.
	Non-Executive Directors	Non-Executive Directors are appointed by the Members' Council to bring independent judgement to bear on issues of strategy and performance.
SO 8.3	Trust Board	Approve the Standards of Business Conduct in Public Service Policy.
	Trust Board	Ensure proper and widely publicised procedures for voicing complaints, concerns about misadministration, breaches of Code of Conduct, and other ethical concerns.
SO 8	Chair and Directors	Declaration of conflict of interests.

REF	DELEGATED TO	GOVERNANCE AUTHORITIES/DUTIES DELEGATED
	Trust Board	Trust Boards must comply with legislation and guidance issued by the Department of Health on behalf of the Secretary of State, respect agreements entered into by themselves or on their behalf, and establish terms and conditions of service that are fair to the staff and represent good value for taxpayers' money.

SCHEME OF DELEGATION FROM SOUTH WEST YORKSHIRE PARTNERSHIPS NHS FOUNDATION TRUST CONSTITUTION STANDING ORDERS

(Trust Constitution including Standing Orders: http://www.southwestyorkshire.nhs.uk/about-us/how-we-are-run/trust-board/constitution-self-certification/)

REF	DELEGATED TO	STANDING ORDERS AUTHORITIES/DUTIES DELEGATED
Standing Order (SO) 4.9	Chair	Final authority in interpretation of Standing Orders (SOes).
SO 3.9	Members' Council	Appoint and removal of the Chair and Executive Directors.
SO 3.10	Members' Council	Appointment of Deputy Chair.
S 3.11	Trust Board	Appointment of Senior Independent Director.
SO 4.1.2	Chair	Call meetings.
SO 3.2	Chair	Chair all Board meetings and all meetings of the Members' Council.
SO 4.9	Chair	Give final ruling in questions of order, relevancey and regularity of meetings.
SO 4.11.2	Chair	Having a second or casting vote.
SO 4.13	Trust Board	Suspension of Standing Orders.
SO 4.13.4	Audit Committee	Audit Committee will review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board).
SO 4.14	Trust Board	Variation or amendment of Standing Orders.
SO 5	Trust Board	Formal delegation of powers to sub committees or joint committees and approval of their terms of reference.

REF	DELEGATED TO	STANDING ORDERS AUTHORITIES/DUTIES DELEGATED
SO 6.2	Chair & Chief Executive (CE)	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
SO 6.4.2	CE	The Chief Executive shall prepare a Scheme of Delegation identifying decision making rights and accountability.
SO 6.6	All	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
SO 8.1	Trust Board	Declare relevant and material interests.
SO 8.2	CE	Maintain Register(s) of Interests.
SO 8.3	All staff	Comply with national guidance contained in circular HSG 1993/5 "Standards of Business Conduct for NHS Staff".
SO 8.3.3	All	Disclose relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board.)
SO 10	CE	Keep seal in safe place and maintain a register of sealing.
SO 10.4	CE / Executive Directors	Approve and sign all documents which will be necessary in legal proceedings unless any enactment other requires or authorises.

SCHEME OF DELEGATION FROM SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST STANDING FINANCIAL INSTRUCTIONS

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
Standing Financial Instructions (SFI) 1	Director of Finance (DoF)	Advice on interpretation or application of SFIs.
SFI 1	All members of the Trust Board and employees	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.
SFI 3.2	Chief Executive (CE)	Responsible as the Accounting Officer to ensure the effective and efficient use of resources and for the overall System of Internal Control, which must be reviewed annually.
SFI 3.2	CE & DoF	Accountable for financial control and for putting in place appropriate arrangements for delegation of financial management.
SFI 3.2	CE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
SFI 3.3	DoF	Responsible for: a) implementing the Trust's financial policies and coordinating corrective action; b) maintaining an effective system of financial control including ensuring detailed financial procedures and systems are prepared and documented; c) design and supervision of systems of internal financial control; d) ensuring that sufficient records are maintained to explain Trust's transactions and financial position; e) providing financial advice to members of Board and staff; f) preparation and maintenance of accounts, certificates etc. as are required for the Trust to carry out its statutory duties; g) lead the development of the Trust's financial strategy
SFI 3.4	All members of the Trust	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
	Board and employees	resources and conforming to Standing Orders, Financial Instructions and financial procedures.
SFI 3.4	CE	Ensure that any 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 are made aware of these instructions and their requirement to comply.
SFI 4.1	Audit Committee	Provide independent and objective view on internal control and probity.
SFI 4.1	Chair of Audit Committee	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
SFI 4.2	DoF	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. This will be after discussion with the NHS Counter Fraud Authority where appropriate. In cases of fraud and corruption DoF must inform the relevant Local Counter Fraud Specialists (LCFS) and NHS Counter Fraud Authority in line with SOs directions.
SFI 4.2	DoF	Notify LCFS and External Audit of all frauds.
SFI 4.4	DoF	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.)
SFI 4.3	DoF	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption.
SFI 4.5	Internal Auditor	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
SFI 4.6	Audit Committee	Ensure the External Auditors' work presents value for money.
SFI 4.2	CE & DoF	Monitor and ensure compliance with SofS Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 5.1	CE	Compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
SFI 5.1	DoF	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
SFI 5.1	DoF	Ensure adequate training is delivered on an on going basis to budget holders.
SFI 5.2	CE	Delegate budget to budget holders.
SFI 5.2	CE & Budget Holders	Must not exceed the budgetary total or virement limits set by the Board.
SFI 5.3	DoF	Devise and maintain systems of budgetary control.
SFI 5.3	CE or nominated officers	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without consent of Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources
SFI 5.3	CE	Identify and implement cost improvements and income generation activities in line with the Annual Plan
SFI 6	DoF	Preparation of annual accounts and reports.
SFI 7	DoF	Managing the banking arrangements, which have been approved by Trust Board, including: 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.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 8	DoF	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
SFI 8.2	All employees	Duty to inform DoF of money due from transactions which they initiate/deal with.
SFI 8.2	Trust Board	Approval of income generating activities attracting an income of £500,000 or above (delegated to the Finance, Investment & Performance Committee).
SFI 9	CE	Negotiating contracts for the provision of healthcare services in accordance with the business plan, and for establishing the arrangements for extra-contractual services.
SFI 10.1	Trust Board	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Workforce and Remuneration Committee.
SFI 10.4	Director of HR	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions
SFI 10.4	Director of HR	Ensure that the chosen method for payroll processing 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.
SFI 10.5	Director of HR	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation and deal with variations to, or termination of, contracts of employment.
SFI 11.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
SFI 11.1	Trust Board	Agreeing the Trust's the Procurement Strategy(delegated to Audit Committee)

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 11.2	Trust Board	Approve any procurement arrangement that commits the Trust to expenditure above £500,000 over three or less years. (delegated to Finance, Investment & Performance Committee. Approve any procurement arrangement that commits the Trust to expenditure above £1,000,000 over three of less years
	DoF	To manage procurement of goods and services in accordance with the strategy and policies approved by Trust Board.
SFI 11.2	DoF	Responsible for the prompt payment of accounts and claims.
SFI 11.2	~~Appropriate Executive Director~~DoF	Make a written case to support the need for a prepayment.
SFI 11.2	DoF	Approve proposed prepayment arrangements.
SFI 11.2	DoF	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
SFI 12	DoF	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained. b) Prepare 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. e) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment. f) Instructions to employees regarding the handling and payment of accounts within the Finance Department. g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received.
SFI 12	CE	Tendering and contract procedure.

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REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 12.5	DoF	Responsible for the receipt, endorsement and safe custody of tenders received.
SFI 12.5	DoF	Shall maintain a register to show each set of competitive tender invitations despatched.
SFI 12.5	CE and DoF	Where one tender is received will assess for value for money and fair price.
SFI 12.7	CE or DoF	Waive formal tendering procedures.
SFI 12.7	DoF	Report waivers of tendering procedures to the next formal meeting of the Audit Committee.
SFI 12.7	DoF	Where a supplier is chosen that is not on the approved list the reason ~~shall~~ should be recorded in writing to the CE.
SFI 12.11	Trust Board	Approval of partnerships 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 £250,000, including setting the timescale for its review and renewal.
SFI 13.1	DoF	The DoF will advise the Board on the Trust's ability to pay interest and repay and will report, periodically, any external borrowing
SFI 13.1	DoF	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
SFI 14	Trust Board	Approve treasury management policy (as recommended by Audit Committee)
SFI 14	DoF	Prepare detailed procedural instructions on the operation of investments held.
SFI 15	DoF	Ensure that the Trust Board are aware of the prevailing instructions and guidance of the Independent Regulatory, and any statutory or regulatory requirements, regarding the financial management and financial duties of the Trust.
SFI 16.1	Trust Board	Approval of all decisions relating to capital investment above £500,000.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 16.1	CE	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 Risk Rating.
SFI 16.1	DoF	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
SFI 16.1	CE	Issue procedures for management of contracts involving stage payments.
SFI 16.1	DoF	Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
SFI 16.1	CE	Issue the manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
SFI 16.1	DoF	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
SFI 16.2	CE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
SFI 16.2	Trust Board	The Trust Board will approve all PFI proposals or proposals to enter into a contract that commits the Foundation trust to long term (15 years or more) arrangements for capital assets with a lifetime value in excess of £500,000.
SFI 16.2	Trust Board	Any individual capital development that forms part of an arrangement under PFI or a partnership described above.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
	CE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
	CE	Must ensure the Trust enters into suitable contracts with commissioners for the provision of NHS services
	~~CE~~DoF	Ensure that regular reports are provided to the Board detailing actual and forecast income from contracts
SFI 16.2	DoF	Demonstrate that the use of private finance is fully assessed against alternative routes and follows with prevailing guidance.
SFI 16.3	CE	Overall responsibility for fixed assets and maintenance of asset registers (on advice from DoF).
SFI 16.3	DoF	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
SFI 17.1	CE	Delegate overall responsibility for control of stores (subject to DoF responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
SFI 18.1	DoF	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
SFI 18.1	Trust Board	Approval of disposal of assets with a Net Book Value in excess of £50,000.
SFI 18.2	DoF	Prepare procedures for recording and accounting for losses, special payments and informing counter fraud and police in cases of suspected arson or theft.
SFI 18.2	DoF	Notify Board and External Auditor of losses caused by theft, arson, neglect of duty or gross carelessness (unless trivial).
SFI 18.2	DoF	Consider whether any insurance claim can be made.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 18.2	DoF	Maintain losses and special payments register.
SFI 18.2	Audit Committee	Approve write off of losses (within limits delegated by the Department of Health).
SFI 19	DoF	Responsible for accuracy and security of computerised financial data.
SFI 19	DoF	Satisfy himself 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 must be obtained from them prior to implementation.
SFI 19	DoF	Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation.
SFI 19	DoF	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
SFI 20	CE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
SFI 20	DoF	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.
SFI 21	DoF	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.

REF	DELEGATED TO	STANDING FINANCIAL INSTRUCTIONS AUTHORITIES/DUTIES DELEGATED
SFI 22	CE	Retention of document procedures in accordance with the Trust Non-Clinical Records Management Policy
SFI 23	CE	Implementation of the Risk management strategy
SFI 23	Trust Board	Approve and monitor risk management strategy
SFI 23	Trust Board	Decide whether the Trust will use the risk pooling schemes administered by NHS Resolution or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
SFI 23	DoF	Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for any one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
SFI 23	DoF	Ensure documented procedures cover management of claims and payments below the deductible amount.

Financial approvals hierarchy

The following limits are applied for both requisitioning and approving of invoices. .A system of conscious delegation will operate for each cost centre with approvals agreed by the appropriate Deputy Director and Deputy Director of Finance

DELEGATED TO	LIMIT
2 Directors (normally the relevant Director and Director of Finance)	Greater than £75,000
Director	£75,000
Deputy Director	£50,000
Typically General Manager	£105,000
Budget holder (as approved by Directors annually)	£1,05500
~~Senior Requestioner~~	~~£100~~

Specific limits to be agreed for individuals e.g. estates, catering, community equipment

From 2021/22 onwards the Barnsley Healthcare Federation and the Trust have entered into a partnership agreement which allows for joint decision-making in regard to how the income received for Barnsley community services will be allocated to services. Any such decisions will be made in line with the partnership agreement and individual organisation schemes of delegation.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 26 January 2021
Agenda item 12 – Assurance from Trust Board Committees

Audit Committee

Date	5 January 2021
Presented by	Mike Ford, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	<u>For Action</u> • Committees to complete self-assessments process to timetable agreed and communicated. • Response to questionnaire re. IA – *although deadline has now passed.* <u>To Alert & Advise</u> • Updated Scheme of Delegation reviewed and approved. • Update on delay to agreement of year-end timetable driven by forthcoming change to Deloitte partner / additional Audit Committee meeting to be held in February / no issues with year-end timetable anticipated. • Response to Patient Money's internal audit – actions to address recommendations in progress. • Further to a recent tribunal decision, VAT will be no longer applied on salary sacrifice cars and a reclaim will be made for historical deductions which will be then repaid to the staff. <u>To Assure</u> • The Committee reviewed the Trust's Legal risks for first time. • Additional data privacy risk identified as a result of the vaccination programme. • Positive assurance received from external health-check of the Trust's cyber security arrangements. • Positive assurance received from Internal Audit update including Phase 1 of overall Head of Internal Audit opinion.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 13 October 2020 attached.

Equality & Inclusion Committee

Date	8 December 2020
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	• Risks have been reviewed in detail. • Discussed draft of Equality and Inclusion Action Plan Sep 2020-March 2022 in support of EICM strategy. • Discussed E&I performance dashboard, plus performance updates against WRES and WDES targets. • Received an annual report on the Commitment to Carers work and supported recommendations on the way forward

	• Received feedback from service users, staff equality networks and BDU forums.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 22 September 2020 attached.

Finance, Investment & Performance Committee

Date	25 January 2021
Presented by	Chris Jones, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Verbal update to be given at meeting.
Approved Minutes of previous meeting/s for receiving	No meeting held December 2020. Minutes of the Committee meeting held on 24 November 2020 will be included with March 2020 paper.

Workforce & Remuneration Committee

Date	19 January 2021
Presented by	Sam Young, Non-Executive Director (Chair of Committee)
Key items to raise at Trust Board	• Integrated Performance Report – focus on staff absence and vaccination. • Workforce Strategy – update on progress and the Strategy to come back to the next WRC. • Wellbeing guardian – recommending it is Sam Young for the time being with a possibility new NED with HR speciality. • Review of Trust's disciplinary procedure in line with national guidance. • Workforce risk register – early sight of risks associated with the COVID vaccination programme.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 12 November 2020 attached.

West Yorkshire Mental Health, Learning Disability and Autism Services Collaborative Committees in Common

Date	21 January 2021
Presented by	Angela Monaghan, Chair (Chair of Committee)
Key items to raise at Trust Board	• Verbal update to be given at meeting.
Approved Minutes of previous meeting/s for receiving	Minutes of the Committee meeting held on 22 October 2020 to follow.

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 October 2020 (Virtual meeting, via Microsoft Teams)

Present:	Mike Ford	Non-Executive Director (Chair of the Committee)
	Chris Jones	Non-Executive Director
	Sam Young	Non-Executive Director
Apologies:	Members	
	Nil	
In attendance:	Rob Adamson	Deputy Director of Finance
	Mark Brooks	Director of Finance and Resources (lead Director)
	Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
	Caroline Jamieson	Senior Manager, Deloitte
	Leanne Hawkes	Deputy Director, 360 Assurance
	Andy Lister	Head of Corporate Governance
	Lianne Richards	Client Manager, 360 Assurance
	Jane Wilson	PA to the Director of Finance and Resources (author)

AC/20/77 Welcome, introduction and apologies (agenda item 1)

The new Chair of the Committee, Mike Ford (MF) welcomed everyone to the meeting. There were no apologies received.

It was noted that the meeting was quorate.

AC/20/78 Declaration of interests (agenda item 2)

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

AC/20/79 Minutes from the meeting held on 14th July 2020 (agenda item 3)

It was RESOLVED to APPROVE the Minutes from the meeting held on 14th July 2020

AC/20/80 Matters arising from the meetings held on 14th July 2020 (agenda item 4)

Action log

Progress against actions in the action log were noted.

MB agreed to forward a copy of the penetration test report to MF.

ACTION: Mark Brooks

AC/20/63 Declarations of interest for staff

MF commented that this action did cause concern in the fact that up to 5 email chasers had been sent to individuals who had not responded. AL advised that responses were now

starting to come through as a result of this. MB commented that given the number of non-responders he would personally send the next email to those members of staff. AL to provide MB with a list of names for follow up.

ACTION: Mark Brooks / Andy Lister

AC/20/81 Consideration of items from the organisational risk register relevant to the remit of the Audit Committee (agenda item 5)

MB advised MF that risks had been allocated to all individual committee meetings of the board, and that as a result the audit committee only had a relatively small number for review. He confirmed that an update of each risk was provided at every audit committee meeting.

MB confirmed that the risk relating to IT equipment and access was well within the risk appetite. He advised MF that twice yearly update reports on the cyber risk were provided to the committee and that these included measures in place and actions being taken.

MB stated that since the previous meeting the Windows 10 rollout was now complete, he advised that this process had been suspended due to Covid-19 and completion alleviates one level of risk.

MB stated that the cyber campaign had being revisited and there had been a lot of fraud alerts recently that staff have been made aware of. He advised that the 'pen' test provided good assurance each year as well as providing areas of improvement to focus on. He confirmed the risk score remains high which is a result of the potential consequence of an incident and the sophistication of cyber criminals.

MF asked if the Windows 10 rollout included back office functions. MB confirmed it covered all devices in the Trust. He added that separate work was being carried out in relation to servers and other infrastructure. MB offered to forward a copy of the last cyber update report to MF.

ACTION: Mark Brooks

MB stated that with regard to the information governance (IG) risk there has undoubtedly been an increase in IG breaches since the start of the pandemic. He advised that there has been a reinforcement of the awareness campaign highlighting the impact this can have on individuals. He advised that given the inability to currently provide face to face training additional e-learning training is being made available as well as self-assessment using workbooks. MB confirmed that the Improving Clinical Information and Governance group (ICIG) had oversight of IG issues, and explained that if there are particular issues within a business delivery unit (BDU) or team then learning from improvements made will be shared at the ICIG.

MF asked MB if any incidents had been reported to the commissioner. MB replied that three had been reported this calendar year. No further action has been taken with any of them.

MF commented that in Rob Webster's brief a few weeks ago there was a suggestion that people do not use autofill on emails, he asked if any thought had been given to disabling autofill.

MB replied that as the majority of breaches were not related to this issue it is not something being actively pursued at the moment. The focus is very much on awareness and changes to ways of working since the onset of the pandemic. MB agreed to forward a copy a previous detailed IG breaches review report to MF.

ACTION: Mark Brooks

In respect of risk 1217 relating to capacity, MB advised that since the onset of the pandemic much attention has been focused on this with a number of programmes either paused or proceeding with reduced focus and pace.

SY asked in relation to the information governance risk if any further consideration had been given to the CCIO (chief clinical information officer) role. MB confirmed that he had recently forwarded the job description to Dr Subha Thiyagesh (ST) and Tim Breedon (TB). Recruitment will commence shortly.

MF asked if the trust had a CISO (chief information security officer). MB replied he is the senior information risk owner (SIRO) and Tim Breedon, Director of Nursing & Quality is the Caldicott Guardian.

MF asked if this was consistent with what other trusts do. MB replied that it was and is also what they are required to do.

MF raised the point that SY had mentioned previously regarding how staff are feeling at the moment, the weariness around Covid-19 and to the work associated with reset and restoration of services. MB suggested this is probably an issue for discussion at the Workforce and Remuneration Committee (WRC).

MF asked MB how many items were on the risk register. MB replied that there are typically approximately 30 risks. There are currently more due to the number of risks relating to Covid-19. MF commented that he was slightly surprised that only 4 have audit committee responsibility and asked CJ & SY if they felt this was the right balance. MF stated that in previous organisations finance risks were overseen by the Audit Committee. CJ explained that finance risks are covered by the Finance, Investment & Performance Committee (FIP). MB added there is not an organisational risk relating to financial controls.

CJ re-iterated that it was only high-level risks that are included in the organisational risk register, and that this worked well and ensured focus is not diluted.

MB advised that in terms of overall committee effectiveness the annual self-assessment of the audit committee takes place annually in February/March along with a review of effectiveness of all board committees.

MF advised that he would review the risks on the organisational risk register (ORR) and pick up separately with MB.

ACTION: Mike Ford

Leanne Hawkes (LH) 360 Assurance stated that in other organisations it was typical that strategic level risks owned at audit committee were either very few or none.

It was RESOLVED to NOTE the current Trust-wide Corporate / Organisational level risks relevant to this Committee and be ASSURED that the current risk level, although above the Trust risk appetite, given the current environment is appropriate.

AC/20/82 Triangulation of risk performance and governance report (agenda item 6)

MB advised that in terms of background the purpose of the report is to triangulate performance, risk and governance to demonstrate that:

- All key strategic risks are captured by the risk management process.

- Risks are appropriately highlighted and managed through the governance committees and operational meetings.
- There is a clear link between risk management and identifying areas where performance targets are not being met by cross referencing the content of the performance report to the risk register.

MB advised the triangulation report is a standing item at the Audit Committee but that given both the need to focus on the response to Covid-19 and the suspension of some reporting during the pandemic this report has not been produced for the past nine months. AL stated that whilst not all the previously used information was currently available a report has been generated using the information available. The report has therefore re-commenced the process to ensure a triangulation exercise takes place as part of our risk identification exercise.

AL advised that no notable exceptions had been identified.

MF asked if this was the full report. MB explained there was detail behind it, but he felt it contained too much detail for the committee. He stated the report provided to the committee would always highlight any exceptions and any potential additional risks for inclusion in the risk register or reported on in the IPR.

MF commented that of the 43 risks on the organisational risk register (ORR) 28 can be linked to IPR and he asked why the other 15 were not linked to the IPR. MB replied that 14 of these related specifically to the Covid-19 response, and there is a specific section in the IPR regarding the Trust's response to the pandemic.

MF asked about the importance and level of focus on the triangulation report. He commented that during his handover with Laurence Campbell (LC) this appeared to be a real focus of his and that having read a note from CJ it appeared to be less of an issue. CJ explained that if there was scope to carry out this exercise without causing colleagues too much work, he was happy with this, but that he was also happy to receive it in its current form with exceptions being highlighted.

SY stated that she agreed with CJ comments.

MF asked LH if this was something she saw happening in other trusts. LH replied that this report was generally over and above what other trusts did, and that it is often something that 360 Assurance have to do themselves.

MF stated that it feels like we have reached the appropriate balance with this piece of work.

It was RESOLVED to NOTE the update and reinstate the risk triangulation report at future meetings.

AC/20/83 Audit Committee draft terms of reference (agenda item 7)

MB confirmed the most notable change related to the appointment of MF as new chair of the committee.

LH confirmed there is a guide available which detailed what should be in the terms of reference.

LH advised there was no mention of the counter fraud officer and some other minor points she would send directly to MB & AL. MB confirmed that upon receipt of this information the terms of reference would be updated accordingly.

ACTION: Mark Brooks / Leanne Hawkes / Andy Lister

It was RESOLVED to RECEIVE the Audit Committee draft terms of reference which subject to minor changes will be approved by the Trust Board on 27th October.

AC/20/84 Interim governance arrangements (agenda item 8)

Andy Lister (AL) presented a brief update to the Audit Committee on the interim governance arrangements.

AL stated that reporting on interim governance arrangements commenced at the beginning of the pandemic. Reporting has been provided to both the Audit Committee and Trust Board. He advised agendas are now returning to normal. He confirmed that the Trust Board and committee meetings continue to take place virtually. He added that there are plans in place to enable members of staff and the public to listen to the meetings and submit questions at the end of each meeting.

AL confirmed that since the beginning of July 2020 Trust Board meetings have been recorded to assist the administration of the minutes, and that members of the meeting are informed by the chair at the beginning of the meeting that it is being recorded and of the purpose of the recording.

MF commented that as someone new to the Trust he did not feel like he had stepped into an organisation that did not have things in hand, stating this was a testament to everyone that everything was working so smoothly and effectively.

SY commented that some governance arrangements had been stepped down but that typically it was more a case of everyone working differently, i.e. having meetings using Teams as opposed to holding meetings face to face.

MF asked MB if he felt it was too much of a burden to support this. MB replied that at the height of the pandemic it was extra work, as it would have been for most organisations. He added it was probably proportionate to the circumstances. AL commented that he had only been in the role since the start of the pandemic so felt he could not really comment.

LH advised that 360 Assurance had carried out a benchmarking piece of work during the pandemic, and that SWYPFT were very much in line with other organisations.

MF stated that on behalf of the non-executive directors he would like to say thank you to the corporate governance team for making this work so successful in such a difficult period.

MF confirmed he would ask MB for copies of other reports he would like to see.

ACTION: Mike Ford

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

SY left the meeting at this point.

AC/20/85 Finance ledger system implementation update (agenda item 9)
Rob Adamson (RA) presented the update stating the paper provided the key points.

RA said he was conscious that at the last Audit Committee meeting in July the project was in its very early stages and that today, three months later, the update is that the system has gone live, which is really positive.

RA confirmed that regular updates had been provided to the Finance, Investment and Performance (FIP) committee. He advised that the go live decision was made at the end of September and that a raft of go live criteria had been met.

RA stated that as detailed in the paper there had been a couple of last minute issues which related to BACS payments and further testing with office 365. He advised that the biggest challenge related to changes on the catalogue ordering system and he confirmed that it had not been possible to fully implement Edge for Health (E4H) in the manner originally intended, but that an alternative approach had been identified and implemented.

RA reported that it was still very early days as in effect we have only practically gone live with ordering and invoicing, but he felt that since the system had gone live there had been a number of positives. He added that communication into the Trust was continuing, to enable people to use the system as efficiently as possible. He advised that the number of queries was reducing and highlighted the fact that this had been a fundamental change, as the previous system had been in situ for 14 years. He explained that the system was intuitive to use but was also very different from the previous agresso system.

MF commented that under normal circumstances when undertaking a project of this size there would have been floor walkers to ensure things were going okay, but he appreciated that in the current circumstances this was not possible. He asked RA if it had been possible to still engage with staff. RA advised that it had been possible and that the work had all been carried out remotely, and that the finance and procurement teams were doing a great job sorting out day to day issues. He stated there was also a generic mailbox should people have any issues. He commented that the training document was also very comprehensive and easy to follow, and that it will help when people start to use the system more.

MF asked if finance had been through any key milestones yet. RA replied not as yet with October being the first month that reporting will be conducted using SBS.

LH confirmed that Lianne Richards from 360 Assurance had been involved in the project board meetings throughout the project.

CJ reported that MB had informed him separately regarding how the issues raised at FIP had been resolved.

MF questioned whether Deloitte would conduct a review of implementation and cutover.
He also asked if the journal approvals issue would be resolved with the new system. RA confirmed that all journals require approval using SBS.

MF stated on behalf of the committee he would like to thank everyone who had been involved with the successful implementation to date of this project.

It was resolved to NOTE the progress made with the implementation of the SBS finance and procurement ledger and reporting system.

AC/20/86 IFRS 16 Accounting for leases update (agenda item 10)

RA presented the update explaining the original go live date was April 2020, but has been suspended for one year nationally in the NHS as a consequence of Covid-19 He explained that the Trust has carried out much preparation work previously and this remained valid. He felt this would enable the finance team to effectively roll forward this information in readiness for the revised go live in April 2021.

MF asked if there had been any previous papers on this and had they gone to the Finance, Investment and Performance (FIP) meetings. MB confirmed that there had been papers and that they had been provided to and reviewed by the Audit Committee.

MF asked with regards to the change in accounting standard for leases does this mean our public dividend capital (PDC) charges will increase?. RA replied that there were definitely some assets that this did impact upon and he would incorporate and financial impact in the next update.

Action: Rob Adamson

Caroline Jamieson (CJa), Deloitte, confirmed that they would be revisiting lease accouting during their planning work.

It was resolved to NOTE the update.

AC/20/87 Proposed meeting dates 2021/22 (agenda item 11)

MB suggested careful consideration be given to the meeting date for May 2021 to ensure appropriate alignment for year-end accounting and reporting processes and approvals. He agreed to liaise with AL to arrange a suitable date for this meeting. Once this has been agreed Jane Wilson (JW) will send out the official meeting invitations for 2021/22.

It was RESOLVED to NOTE the suggested 2021/22 meeting dates, subject to the May meeting being amended.

ACTION: Mark Brooks / Andy Lister

AC/20/88 Procurement update (agenda item 12)

MB provided the update and confirmed this was a standing item for which a report came to the committee each month.

Key headlines:-

- Seven major contracts let with a value of just over £817k including external audit services £412k, homecare pharmacy service £300k, supply and installation of seclusion doors £44k.
- Two contracts are currently in progress: main kitchen floor repairs £44k, installation and commission of fire suppression system £107k.
- A total of £14k cash releasing savings with a further £16k cost avoidance savings have been recorded and achieved within the second quarter.
- The continuation of the PPE supplies undertaken in line with national and regional guidance. An internal audit of the Trust's system is currently taking place.
- Continued participation in the response to Covid-19 in relation to sourcing of key products and services
- Go-live of the new SBS finance ledger and procurement system at the end of the quarter

MB confirmed that some contracts had been renewed, one of them being medical locums. He confirmed there was insufficient capacity in the wider team to go out to tender in light of the Covid-19 pandemic, so a decision was taken and approved to extend these contracts.

MB advised that most of the procurement focus in recent weeks has been on the implementation of SBS along with sourcing and managing PPE.

MB advised a potential information governance issue had been identified with regard to the new multi-functional devices. He explained this related to the scanning process and confirmed a resolution had been identified and is being implemented.

MB confirmed that details of single tender waivers were included in a separate appendix within the report.

MF asked LH if this was an area that 360 Assurance had covered as part of their internal audit framework. LH confirmed that all areas are considered during the internal audit risk-based planning process. There had been specific reviews in the past. LH advised that 360 Assurance had not reviewed the full procurement process.

MF suggested that from his initial views main audit risks would include payroll, agency and staffing etc. MB explained that in terms of audit planning each year he has a meeting with them as does the chair of the audit committee. Proposals are taken through EMT to ensure there is a fairly holistic view of risk before approval by the audit committee.

CJ stated that the regular internal audit update report provides a great level of assurance to the committee.

CJ commented that he attended a call recently on behalf of Angela Monaghan and asked if we are able to control our level of PPE stocks. MB replied only to an extent as demand can change quite rapidly given such matters as how staff are working and national guidance. In addition, we are somewhat dependent on national delivery levels. He stated that demand for some PPE items had been high and more of a challenge recently, but we have not been in a position where we have not had sufficient stock to meet need. He confirmed that a stock count is conducted each week which provides a good indication of where we may need to supplement if necessary. MB added that a mutual aid process is in operation in each ICS.

MF asked in respect of transaction transparency what the Trust needed to disclose. MB replied that we do make procurement disclosures on our website. RA confirmed that any single payment over the value of £25k needed to be disclosed.

It was RESOLVED to NOTE the update.

AC/20/89 Treasury management update (agenda item 13)

RA confirmed that he provided a regular update on treasury management to the Audit Committee.

He explained that all funds remain within the Government Banking Service (GBS) unless invested with the National Loan Fund. Unless external investment rates exceed 3.5% plus GBS rate this will continue to be the case. We currently have no funds invested and given the reduction in the GBS interest rate to 0% no interest income is expected in 2020/21.

RA stated that given current interest rates there is unlikely to be much change in this report in the coming months. He commented that interest received for 2019/20 was £244k and that it is unlikely we will receive anything in 20/21given the 0% interest rate.

MF asked RA whether finance would look to invest in anything else. RA replied in theory yes, but it had not been worthwhile investing anywhere.

MF also asked RA whether we could get charged for having cash. RA replied yes this could potentially happen if interest rates were to go negative.

It was RESOLVED to NOTE the update.

AC/20/90 Internal audit progress report (agenda item 14)

Lianne Richards (LR) provided the update stating there has been a good process on gaining traction on the plan in recent weeks, and that she continues to liaise regularly with the Director of Finance and Resources. It was agreed at the last meeting that some changes were required to the plan in light of Covid-19 and these changes are outlined in the detailed report. Agreement was received from the Director of Finance and previous chair of the audit committee that these changes were appropriate and formal approval is now required from the committee. This was provided.

MF commented that we touched on capacity and fatigue earlier and are we comfortable that we are going to be able to deliver the full plan this year given the impact of the pandemic. LH replied that the intention is to deliver as much of the plan as possible whilst recognising the situation with Covid-19 and so they continue to have regular updates with MB.

Two reports have been issued since the last meeting: -

- Digital strategy (stage 1 – advisory).
- Service users' monies and property which provided limited assurance.
- LR confirmed that forwards had been visited and these had been agreed with the Trust.

LH advised that 360 Assurance are currently developing a report on the first draft of Head of Internal Audit Opinion.

<u>Action tracking</u>
83% of internal audit recommendations have been implemented within originally agreed timeframes

<u>Appendix C</u>
360 Assurance are doing a supportive piece of work on the development of a digital strategy

CJ asked in respect of the audit on patient monies and property how do we compare with other trusts. Our cash losses tend to be small, so can we realistically get any better?. CJ suggested one approach is to reinforce the process as it is and questioned the benefits of it being perpetually audited.

MB confirmed that he agreed with much of what CJ had stated, but also reinforced the duty of care we have to safeguard people's property.

MB explained one action being taken is to provide a one or two page summary of key points rather than requiring staff to read through lengthy SFIs. Whilst low in number he is aware of

some cash reported as going missing. He was also aware of piece of jewellery of notable sentimental value reported as lost. He commented that in busy wards there is always a risk this may happen to a degree but raised the question of whether we are really doing enough to prevent it from happening. CJ commented that from his personal experience, he is mindful of not setting ourselves up to fail on this matter.

MF asked if records were kept on what percentage of property we lose. MB replied that a record is kept on what has been lost and this is provided in the losses and special payments report included in each audit committee agenda. He stated that in terms of complaints over the past twelve months there had been one for loss of money and two for losses of property. MB commented that it is important to remind staff of our responsibilities and the need to strive to get better. MF agreed.

LH stated 360 Assurance were following up recommendations as part of the follow-up process, and that evidence needs to be provided to verify compliance.

CJ commented in relation to the proposed remote consultations audit this felt a good approach.

CJ asked LH if there is anything 360 Assurance can provide in terms of benchmarking to see what other trusts have done, so we could compare and learn from others. LH replied that SWYPFT was the first trust to approach them to undertake this piece of work, although she has had two conversations with other trusts both of which are showing an interest in a similar piece of work.

MF commented that there is an audit on equality and inclusion and asked if 360 Assurance brought in a specialist skill set for that piece of work. LH replied that yes, they use specialist resource when required.

MF commented that there is an historic action relating to strong passwords for Agresso. RA explained the new system will reinforce this which is something the previous system could not do. As such we will now be able to operate in line with policy including forced period password changes.

It was RESOLVED to NOTE the update.

AC/20/91 Counter fraud progress report (agenda item 15)

Shaun Fleming (SF) presented the progress report which included the following key highlights:

- As it is now unlikely that any face to face presentations will be permitted during the current year there will be a Microsoft Teams conference calls approach to presentation delivery and staff have been informed of this via 'The Headlines' newsletter. A programme is being developed and SF is contacting team managers to encourage delivery to specific staff groupings. Finance sessions are in the diary.
- The quarterly local Counter Fraud Newsletter is forwarded to the communications team for distribution to staff. The newsletters have covered a number of Covid-19 specific topics.
- There have been eight fraud alerts issued to the Trust since the last Audit Committee including a number of phishing emails.

AL stated that there are a number of documents on the intranet that need review and update and SF will be looking at these over the forthcoming weeks.

There are currently 3 investigations ongoing:

- Passport investigation - trial date set for 8th March 2021.
- Agency timesheets - still waiting for interview under caution.
- Working elsewhere whilst on sick leave - to date the case is proving more complex than initially thought and the subject appears to have worked at the two organisations prior to sick leave for a considerable period of time. Detailed analysis of timesheets, IT records and annual leave / sick leave archives is underway at both NHS organisations and the employment agency.

MF asked MB what his view was. MB replied that SF was right in the fact that we have very few prosecutions. We do not get a huge number of referrals, probably due to the type of services we provide meaning there are not a huge number of opportunities for fraud. We do need to pursue existing cases. MB stated that whilst we cannot conduct awareness sessions and training face to face it is important we do not to lose any momentum of Counter Fraud and must remain ever vigilant. We need to maintain our focus, messaging and level of awareness.

MF noted in relation to passport case that the employee was dismissed, he asked if this is publicised or not. SF replied that without a criminal prosecution it is very difficult. MB stated we can be creative with messaging rather without giving personal details. MF confirmed that he was pleased we take this view as deterrent is a key part of the work.

SF stated that phishing emails are the highest fraud risk at the moment, and that every year cyber risks increase.

Standard government functional standards

In April 2021 all NHS organisations will be required to provide a return against the Counter Fraud Functional Standard. As with the NHSCFA Standards return, this process should be overseen by the organisation's finance director and audit committee chair in line with the organisation's existing approach to counter fraud assurance.

SF stated that the NHS is well placed as our standards are similar to the new standards. Steve Moss at Audit Yorkshire has been attending meetings on the introduction of these standards. SF commented that from the information he is aware of at this point in time we comply with about 85% of the standards. He will be able to confirm this when the final requirements are provided.

MF asked who will have the additional work as a result of this. SF replied that it would be him and that typically he will require support from finance.

ACTION: Shaun Fleming

It was RESOLVED to RECEIVE the update.

AC/20/92 External audit update (agenda item 16)

Caroline Jamieson (CJa), Deloitte, provided the update, stating the report sets out and confirms opinions provided on the 2019/20 accounts. CJa confirmed that Deloitte have attended a meeting with the district valuer regarding their approach to revaluation of property, plant and equipment and have held discussions with the Trust regarding the audit approach to the new ledger system.

In relation to the charitable fund's accounts CJa confirmed that Deloitte is awaiting the final signed version from Susan Baines.

CJa stated sector updates were also provided for information. MF asked about the impact of the Redmond review on NHS. CJa stated that this was still being worked through and that as soon as further information was available this would be provided to the Committee.

It was RESOLVED to RECEIVE the update.

AC/20/93 Losses and special payments (agenda item 17)

RA confirmed the report provided details of the payments made since the last report to the Committee on 14th July 2020 and covers payments made to 30th September 2020.

In total the Trust has made payments of £1,130 since the last report to Audit Committee.

A number of these are covered within the service user property policy which has recently been subject to an internal audit, with limited assurance provided. Actions are being undertaken to meet the recommendations in that report. However, this will not directly address the current largest areas of cost which relate to damaged items.

Over the course of the past 12 months the Trust has received one formal complaint regarding missing money, two formal complaints about missing property and had two informal concerns also relating to missing property.

RA reported that the report does highlight a couple of cash balances which are exceptional.

MF commented that judging whether this is acceptable level of cost, the question is how much more work would have to be done to make this list even smaller.

MF asked who claimants are. MB confirmed that in most cases they are service users or staff members.

It was RESOLVED to NOTE the contents of the report.

AC/20/94 Breaches of standing financial instructions (agenda item 18)

RA confirmed that he had brought a paper to the last committee meeting for the first time and that it was very much identified as a work in progress. He stated that it had been a very busy quarter, and that there had not been a lot of progress made.

MF asked RA if he could forward him a list of the key types of breaches that could be reported. MB agreed to circulate a paper previously provided to the audit committee on this subject. He added there was also a need for a review of the scheme of delegation in light of the move to the new SBS system and other governance changes. This is currently scheduled to come to the committee in January.

MF asked how the issue in the report has been identified. RA replied that it was identified during as a result of a coding issue.

MF asked what approach other trusts take. LH confirmed that this is good practice and more than other trusts typically report on.

CJ stated that we need to reflect that we are still in early stages of developing this reporting. He said he was not sure that a breach of £400 should be reported to the Audit Committee.

MF asked RA if when people leave can they still place orders. MB replied that this does not happen, but there can be an issue around salary overpayments if leavers' forms are not received on time.

It was RESOLVED to NOTE this report relating to identified breaches of standing financial instructions and to recognise future actions being taken to capture such occurrences

AC/20/95 Any other business (agenda item 19)

Financial envelope and system financial plan

A letter regarding the West Yorkshire ICS draft financial plan was received.

CJ explained FIP will be more at the forefront of understanding the implications of the financial settlement and outcome of letter and next stages. There is an additional board meeting scheduled to discuss and approve the Trust's plan submission.

AC/20/96 Items to report to Trust Board (agenda item 20)

The following items were agreed as being reportable to the Trust Board:

- Risk triangulation report completed to provide assurance regarding the Trust's risk management and performance reporting processes.
- Internal Audit of "Service User's Monies and Property" provided **"**Limited Assurance". Management to take appropriate action.
- 360 Assurance presented paper on how they will reach their annual Head of Internal Audit Opinion.
- Successful initial implementation of new finance ledger system.
- Update of the interim governance arrangements.
- Personal letters to be sent to those members of staff who have not responded to repeated requests for updated DOI declarations.
- Main points on fraud relate to delivery of awareness and training sessions via Teams, alerts provided relating to potential frauds during the pandemic, 3 cases at different stages of the process and implementation of the counter fraud functional standard planned for April 2021.

AC/20/97 Work programme (agenda item 21)

MB confirmed that the work programme was agreed at the audit committee meeting prior to the year commencing. He stated that the work plan had been followed and that there had only been one report that had not come to recent meetings and this was the triangulation report. He said we will look at any specific actions today but would normally look at setting the work plans for 2021/22 in January.

MF suggested trying to carve out some time quarterly to do a deep dive presentation on a selected risk topic and asked MB if there would be any merit in spending half an hour on cyber to allow the committee to have a more in-depth review.

MB stated that key risks such as cyber and information governance reports came to the committee regularly. For example, cyber updates are provided every six months. He added that in the past Deloitte had attended audit committee meetings to give formal training and one of these sessions covered cyber. MB stated that an in-depth report has been provided on information governance but that we may need to factor in another to maintain oversight and focus.

MF asked if there were any other topics that might merit a slightly deeper dive on.
CJ responded that in principle this is a good idea, and that there were similar objectives on the FIP agenda.

SY stated that she echoed this and there was nothing in her mind that was missing, but she is happy to think on it further.

MF commented that it might be an idea if non-executive directors look into deep dives and then decide which committees to take these to.

It was agreed that delivering service change should be removed from the work plan. Also, that the Cyber update should be moved to January.

ACTION: Jane Wilson

MB explained that each committee reviews its own programmes, but he was happy for the post implementation review of SBS to come to the audit committee.

MF suggested that the workplan be updated and brought back to the meeting in January.

ACTION: Mark Brooks / Andy Lister / Jane Wilson

AC/20/98 Date of next meeting (agenda item 22)

The next meeting of the Committee will be held on Tuesday 5th January 2021 at 2.00pm.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Minutes of Equality and Inclusion Committee held on 22 September 2020 Via Microsoft Teams

Present:	Angela Monaghan (AM)	Chair of the Trust (Chair of Committee)
	Tim Breedon (TB)	Director of Nursing and Quality (Lead Director)
	Alan Davis (AD)	Director of Human Resources, Organisational Development and Estates
	Erfana Mahmood (EM)	Non-Executive Director
	Chris Jones (CJ)	Non-Executive Director
	Rob Webster (RW)	Chief Executive
Apologies:	Attendees	
	Donna Somers	LGBT+ staff network/Matron
In attendance:	Aboobaker Bhana (ABB)	Equality and Engagement Manager
	Mike Ford (MF)	Non-Executive Director
	Claire Hartland (CH)	HR Business Manager
	Chris Lennox (CL)	Deputy Director of Operations
	Zahida Mallard (ZM)	Equality and Engagement Manager
	Tim Mellard (TM)	LGBT+ staff network/Matron
	Sarah Millar (SM)	PA to Medical Director (author)
	Dawn Pearson (DP)	Marketing, Communications, Engagement and Inclusion Lead
	Nick Phillips (NP)	Head of Estates and Facilities
	Elaine Shelton (ES)	Unison Branch Secretary
	Christine Symonds (CS)	Disability staff network/Senior Finance Manager
	Dr Subha Thiyagesh (SThi)	Medical Director (to item 6)
	Cherill Watterston (CW)	BAME staff network/Specialist Physiotherapist

EIC/20/35 Welcome, introductions and apologies (agenda item 1)

The Chair Angela Monaghan (AM) welcomed everyone to the meeting and noted apologies. It was noted that due notice had been given to those entitled to receive it and that, with quorum present, the meeting could proceed.

AM advised that Mike Ford (MF) was attending as an observer of the Committee as part of his induction as a recently appointed Non-Executive Director and MF introduced himself.

EIC/20/36 Declarations of interest (agenda item 2)

The Committee noted that there were no further declarations over and above those made in the annual return to Trust Board in March 2020 or subsequently.

EIC/20/37 Minutes of previous meeting held on 2 June 2020 (agenda item 3)

Minutes of the previous meeting were agreed as a correct record.

It was RESOLVED to APPROVE the minutes of the meeting held on 2 June 2020.

EIC/20/38 Matters arising and action log (agenda item 4)

Actions from the meeting held on 2 June 2020 were noted and the action log was updated as appropriate.

- EIC/20/26 Feedback from Staff Equality Networks - Alan Davis (AD) reported that Occupational Health referrals had been monitored and since March there had been 222 referrals, of which 25 related to BAME members of staff. Committee noted that this represented 11% of the workforce which was only slightly over the average. AD advised that a BAME Health and Wellbeing Practitioner had been appointed and added that we had been asked to share our job description with other local trusts who were considering appointing to a similar role.

- EIC/20/28 Feedback from Business Delivery Unit Equality Forums – AD confirmed that the Risk Assessment was for use by integrated teams including social care staff although it was acknowledged that their own organisations may have separate arrangements. Support has been offered to social care and bank staff to complete the Risk Assessment and whilst these are not recorded in the same way as Trust staff, the framework encourages individuals to complete a Risk Assessment.

- EIC/20/29 National and Regional issues and impact locally – AD advised that Dawn Pearson (DP) was leading on a piece of work to review representation and diversity in the decision making and command structures in the Trust. The first step is to consider the available data and DP is working with the BAME Task Force and network to come up with suggestions on a best approach.

  AD added that there were two parts to the work, one in the shorter term to consider a more diverse attendance at Silver Command meetings and a longer term review of the role of networks in decision making fora.

  Committee discussed the importance of more equal and inclusive representation when making key decisions and Rob Webster (RW) highlighted that nationally the government response to Covid-19 had been headed up by mostly white males and that whilst SWYPFT had good representation on its Board in terms of gender and ethnicity, we could do better.

  It was acknowledged that it would not be enough to simply ‘plug the gap’ and there would need to be a culture change in all parts of our organisation so that a more diverse workforce would naturally flow through.

  Committee agreed to keep the action open in order to receive regular updates and to change the wording to read “To have more systematic and robust processes in place to review and monitor representation across all characteristics in both the short and longer term”. Consideration will also be given to adding more information to the dashboard, particularly to include more protected characteristics, and to be clearer on what outcome measures we are reporting on.

- EIC/19/54 Performance dashboard – Chris Lennox (CL) gave an update from the Barnsley & Wakefield and Calderdale & Kirklees Equality and Inclusion Action Groups with the former looking to improve input from front line staff and the latter having good representation and engagement.

CL advised that the Specialist Service group had not met since March and Aboobaker Bhana (ABB) raised that whilst there had been some input from Forensic services, CAMHS and LD had shown little inclination to take ownership of the equality and inclusion agenda despite this being highlighted a number of times.

It was agreed to keep the action open and to bring an update from Specialist Services to the next meeting.

- EIC/20/06 Equality Standards updates (WRES, WDES) – DP gave an update to Committee on Peer Support Workers. A recruitment programme has been set up and 5 Peer Support Workers have been recruited to the Trust so far with plans to appoint to a lead post who would take responsibility for expanding the programme. Committee acknowledged the significant progress that had been made since the last meeting and it was agreed that a full update for discussion would come to the next meeting.

ACTION: CH

EIC/20/39 Review of Committee related risks and any exception reports as required (agenda item 5)

Tim Breedon (TB) referred to Risk ID 1531 – Risk that Covid-19 response disproportionately affects people with protected characteristics leading to poorer quality of care. TB reported that there had been much discussion on how best to describe this risk in relation to protected characteristics for both staff and service users and it had been acknowledged that those from a BAME background had been more adversely impacted by Covid-19.

Erfana Mahmood (EM) raised that people with LD have also been significantly affected by Coronavirus and TB advised that LD is included in this Risk ID and the impact on that cohort had also been discussed in a recent Physical Health Optimisation meeting.

EM suggested that as LD is classed as a protected characteristic and LD and Autism is a specific indicator then it should have a separate action like BAME.

RW asked that the risk and actions be updated ahead of next week's Trust Board meeting. RW added that that it was clear from the Integrated Care System (ICS) work in Yorkshire & Humber that there had been a disproportionate impact on particular groups during the pandemic and our response could have been better. RW went on to say that highlighting evidence does not reduce the risk and therefore the risk level should remain at 8-12.

Committee noted that the national inequalities work requires us as a Trust to monitor and report on inequalities due to Covid and to provide assurance against a number of protected characteristics.

Chris Jones (CJ) queried what specific actions have been identified to mitigate the risk to BAME service users from Covid-19 given that we have known for a number of months that this cohort are adversely affected. DP advised that there were many mitigating actions in the revised version of the Equality Impact Assessment tool including many actions that are not reflected in this version of the risk register. The Risk Register will be updated ahead of next week's Board meeting.

Action: Tim Breedon

AM noted that Committee receives the risk information after it has been to Board rather than receiving an update which would then go into Board and suggested that it may be useful for the Committee schedule to be revised.

ACTION: Angela Monaghan/Tim Breedon

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 level, although above the Trust risk appetite, given the current environment, is appropriate.

EIC/20/40 Context report – national, regional and local (agenda item 6)

TB reported that he had spent some time considering the Phase 3 letter and People Plan and actions from both documents that were relevant to Equality and Inclusion Committee (EIC)

Of note, there was a significant change in some of the language used, particularly in the Phase 3 letter which talked about inclusion and valuing differences. There was also a focus on prevention.

Data collection and data quality is a clear area for development and an important element when working with partners to make system wide improvements. Data in relation to service users is a particular area that needs to be addressed.

DP indicated that it was essential that we understand our communities so we are able to identify where the gaps are and to make progress with developing our services. AM went on to say that the Phase 3 letter reinforces a lot of what we are already doing but also highlights that there is a lot of work still to do.

RW indicated that the draft of the final West Yorkshire and Harrogate ICS review report, on tackling health inequalities for black, Asian and minority ethnic communities and colleagues, refers to the work already done in relation to BAME staff and our population and also what we need to do next, including improving access to mental health services and considering the impact of Covid-19 on mental wellbeing. The final report and actions are due on 22 October.

Committee noted that SWYPFT has working good relationships with local universities and there are plans to develop a Yorkshire based workforce observatory which will give us greater access to support and planning.

CJ indicated that there is a long way to go in terms of improving our data and suggested that deprivation could be added as a protected characteristic given that we already have one for carers that is outside of the standard.

Committee agreed that this work needs high level ownership, however Zahida Mallard (ZM) raised that if the same people were discussing the issues together and making decisions together, with no diversity of thought or experience the prevention aspect may not work well and that is was easy to make a statement about changing the way we do things but the change would need to be embedded.

TB will share the presentation with an overview of actions relevant to EIC.

Action: Tim Breedon

EIC/20/41 Equality, Involvement, Communication and Membership Strategy (agenda item 7)

DP presented the draft Equality, Involvement, Communication and Membership Strategy which had been shared with various stakeholders with some positive feedback and challenge being received.

The brief from the Trust had been to create a document that provided an all-inclusive, values based approach to support its mission and values and to help SWYPFT to improve and develop its services by working alongside its diverse communities.

DP plans to also create a summary, an easy read version and to produce a short film to bring key elements of the document to life in order to reach as many people as possible.

The final strategy will also be accompanied by action plans which are likely to be updated annually.

The strategy was taken as read and AM asked EIC for comments:

- EM suggested that the objectives could be clearer.
- CJ indicated that it was a well written document with lots of ideas for equality and diversity and improvements we can make as a Trust although it could be clearer on engagement and include more data.
- MF queried how the strategy would be communicated and how people would be engaged with it.
- AM noted that the strategy talks about the principles that drive the work we do and we need to have a culture of improvement and learning from mistakes that has a direct link back to our values. AM also agreed that there should be clear and measurable objectives and actions.
- CJ questioned that, if the aim of the document was to address inequalities in services, did it achieve this.
- Cherill Watterston (CW) suggested that the BAME network may believe that the equality part had been lost.
- EM agreed that the strategy needs to be clearer in relation to inequalities.

EIC noted that the strategy is an overarching document with four key strands of work within it. An action plan and implementation plan will sit underneath it to include each element of the strategy and to specifically address the concerns around inequalities and engagement. The progress on action plans would be monitored at Committee. It was agreed that the strategy would have a three or four year timeline but be refreshed after a year.

DP advised that the aim had been to not just replace but to combine the previous strategies to take an integrated approach and that many people had been asked for feedback. It was noted that the strategy had been written during the Covid pandemic and some of the narrative may need to be strengthened given the experiences over the past months.

Post meeting note: the draft version of the Equality, Involvement, Communication and Membership Strategy will go to the Board on 29 September, with comments from the EIC.

The team would then circulate a revised version to EIC members for final comment, before it goes back to the Board for approval on 1 December.

The Committee RECEIVED and COMMENTED on the Equality, Involvement, Communication and Membership Strategy.

EIC/20/42 Disability Policy development (agenda item 8.1)

Christine Symonds (CS) reported that the policy had been drafted and that time had been spent with Staff Side going through the detail. The draft was updated following feedback from various stakeholders and CS is meeting with a human resources colleague this week to finalise the policy. The plan is to develop a health passport that would accompany the disability policy.

AM indicated that E&I Committee only receive policies by exception and these are otherwise taken through EMT who take an overview.

The Committee RECEIVED and NOTED the update.

EIC/20/43 Disability Audit (agenda item 8.2)

Nick Phillips (NP) advised that disability audits had now been completed for the Fieldhead and Kendray hospital sites and that £450k would be required to make appropriate adjustments. This work was split into high (£118k), medium (£285k) and low (£48k) categories and NP confirmed that some urgent work had been completed straight away.

EIC noted that some funding would come from minor capital, some from budgets and NP would submit a paper with recommendations to OMG and EMT to cover any outstanding costs.

Audits on the other SWYPFT sites would be completed in due course and EIC would be updated on progress.

The Committee RECEIVED and NOTED the update.

EIC/20/44 Performance Dashboard (agenda item 9)

TB presented the current dashboard which had been deferred in June due to Covid 19. It was noted that there had been previous discussions at Committee about what should be included and CAMHS access data had been added to this version. EIA completion had been removed and was included in a separate report.

In response to a query on the bullying and harassment statistics, AD advised that the Trust was required to publish a very detailed annual workforce report and the information in the dashboard was a summary of incidents in Quarter 1.

MF raised that the data appeared to be ‘flat’ and he would expect to see targets to determine whether we are performing well. TB indicated that the report was still being developed and a number of next steps had been identified including the use of statistical process control (SPC) charts to improve understanding and to increase the narrative associated with access data.

CJ suggested that benchmarks could be added so it would be clear where there were differences and Committee would prompted to agree how to address these.

TB advised that it had been agreed to include place-based population data in comparison with Trust data and that this should reflecting partnership working as well as the national ask.

It was acknowledged that Performance and Information (P&I) support was stretched and TB would bring a summary of what is possible to the next meeting.

Action: Tim Breedon

The Committee RECEIVED and NOTED the update.

EIC/20/45 Equality Standard updates (WRES, WDES) (agenda item 10)

AD presented the update and indicated that it was important for Committee to continue to move forward with the WRES workforce action plan and the WDES action plan which was introduced last year.

AD talked about changing and embedding new cultural approaches and gave an example of how the BAME risk assessment, which was developed in response to the pandemic, had evolved to become the BAME and vulnerable staff risk assessment thereby impacting on other protected characteristics.

AD reported that the Trust had appointed a BAME health and wellbeing practitioner and were in the process of recruiting a WRES OD lead. AD was clear that these roles would be part of the HR function and not work in isolation.

It was noted that work around the Equality Guardian and bullying and harassment had lost pace and this would need to be re-focused.

Zahida Mallard (ZM) raised that it appeared that BAME staff were accessing twice as much mandatory training including some BAME specific training. AD indicated that bespoke training was a positive issue and there was nothing to suggest that this was a negative point. AD indicated that it may be possible to drill down into the data and separate out specific training.

ZM advised that more BAME candidates were being shortlisted and interviewed but not being appointed and it appeared that something was preventing the appointments being made. AD agreed and noted there needed to be a fundamental review of the way we recruit including the make up of panels. This would be part of the remit of the WRES OD role..

CJ referred to the statistics of bullying and harassment by managers and noted that BAME people were twice as likely to be bullied than white people. AD acknowledged that bullying and harassment was a problem in the NHS in general and in SWYPFT and it needed to be resolved. However, most people in this Trust who get bullied and harassed are white. Committee agreed that whilst there are lower levels of bullying and harassment of BAME people in the Trust, it was still not good enough and was part of the agenda of this group to drive change.

In relation to WRES it was acknowledged that there were some BAME people in middle and higher management roles in the Trust and the issue had been addressed to some degree.

For WDES, the Staff Equality Network would help to make the agenda more stable. It was noted that accessibility was a big issue for disability networks and there were some more fundamental issues that needed to be addressed as well as potential significant costs. Also, the experience of disabled staff in the organisation was a lot less positive than for BAME, white and non-disabled staff.

MF queried whether the audit work covered access to technology. AD advised that the audit related mainly to estates and that we needed to consider what we could do support certain staff groups in the Trust who do not have regular access to technology e.g. housekeepers, porters, etc. AD gave a recent example of a Robertson Cooper survey where those groups were given a paper survey to complete. It was acknowledged, however, that that does not address the issues and it would be considered as part of the wider inclusion work.

The Committee NOTED the contents of the update and APPROVED the WRES and WDES action plans at items 21 and 22 of the agenda.

EIC/20/46 Equality Impact Assessments (EIA) update (agenda item 11)

The full report for this item will come to the next meeting.

EIC/20/47 Equality Delivery System 2 (EDS2) (agenda item 12)

DP presented the update to Committee on EDS2 including a proposal on how the tool could further embed and support the Trust to work in partnership with local stakeholders, to review and improve its performance for individuals and groups protected by the Equality Act 2010 and to support the Trust in meeting the Public Sector Equality Duty.

Committee considered the report and noted the ask to agree the overall Trust grading for EDS2 for 2019/20.

It was noted that the aim of the EDS2 was to embed equality into business practice and to foster a culture of transparency and accountability in the Trust. In relation to better health outcomes and improved patient access and experience we were achieving our goals. However, in relation to a represented and supported workforce and inclusive leadership we were developing so the grading appeared to be split. It was noted that the gradings had been established via self-assessment and a grading panel.

There was also a set of recommendations for the 2020/21 submission and in particular that there was Trust-wide ownership of the tool.

RW indicated that the commissioners and regulators had been less interested in assessments of this type although the CQC will consider the impact of the assessment. It was also agreed that Trust Board should take an interest in the tool.

The Committee RECEIVED the EDS2 report for 2019/20, AGREED the overall Trust grading as DEVELOPING and APPROVED the future approach.

EIC/20/48 Equality, Engagement and Inclusion Strategy Implementation Plan Report (agenda item 13)

This would be worked into the Strategy which E&I Committee had already received.

EIC/20/49 Internal Audit Reports (agenda item 14)

There were no reports to note.

EIC/20/50 Update Report on Commitment to Carers (agenda item 15)

This item was deferred to the next meeting.

EIC/20/51 Service User feedback (agenda item 16)

There was no feedback for this item.

EIC/20/52 Feedback from Staff Equality Networks (agenda item 17)

LGBT+

Tim Mellard (TM) gave an update to Committee:

- Continue to recruit to the steering group.
- Continue to encourage everyone to take a pledge for a rainbow badge. Rainbow lanyards are also available and requests are being processed.
- Work ongoing with NP in Estates to establish gender neutral toilets and rainbow crossings.
- There is a second LGBT+ flag at Kendray Hospital.
- There has been further networking across the ICS and in particular with West Yorkshire Police and Mid Yorks.
- There may be changes to plans to allow self-identification and a further update will be brought to the next meeting once the implications are better understood.
- Those from LGBT+ backgrounds have been affected by Covid 19 and should be supported.
- Members of the LGBT+ network will join Trust Board members to speak about their personal experiences.

BAME

CW gave an update to Committee:

- The steering group had almost completed the nominations process for the new steering group and the successful people would be made aware and announcements made.
- In relation to nursing preceptorships, it had been reported that BAME staff were not being signed off at the same rate as white staff.
- There had been some disruption to the first cohort for reciprocal mentoring due to Covid. Some themes had been identified – lack of inclusivity, microaggression and bias. It had been noted that there was also a split between the language used in corporate and clinical services and a lack of time to discuss race related issues had been raised.
- There were now some BAME representatives on the EyUp! Committee agreeing charity funding in the Trust.
- ICS research had noted a lack of diversity in Allied Health Professionals (AHPs). There were BAME representatives involved in the ICS work also.
- The Board sessions with networks were welcomed.
- A health and wellbeing task force was being developed.
- Risk assessments have been completed for all BAME members of staff.

- Equality Impact assessments were being completed.
- The network supports Charlene Sibanda in her new role in the Trust as the BAME health and wellbeing practitioner.
- There is a celebration event on 12 October and several speakers would be attending. There would be recognition for the strong support to the network and that people do the work in their own time on top of their paid jobs.

EIC acknowledged CW's support to strengthen the group over the past two years and thanked her for her leadership, noting that she had taken over as Vice Chair of Race Forward as well as sitting on panels for two senior appointments.

AM indicated that she is looking forward to the celebration event and EIC will continue to support the networks. AM added that she hopes the issues that had been raised were being picked up in the right areas. It was noted that there was a broader piece of work around reciprocal mentoring and the LGBT+ network was also taking this up.

Disability

CS gave an update to Committee:

- The disability network was having some difficulty getting people interested in becoming members of the group and there were only two active members.
- There had been positive progress with improving access.

AM indicated that it was important that a way of strengthening the network was established so that it could make more progress and keep disability issues visible.

Working Carers

EIC noted that the Working Carers Network was not currently operating. ABB reported that there were many staff members who were juggling work and caring for family members and there were plans to work towards an unpaid carer's passport for staff, policies and more flexible working options. It was estimated that around 1/7 colleagues regularly cares for someone which equates to more than 400 people.

Committee agreed to focus on the deferred Update Report on Commitment to Carers (agenda item 15) at the next meeting.

The Committee RECEIVED and NOTED the updates from the staff networks.

EIC/20/53 Feedback from BDU Forums (agenda item 18)

Barnsley and Wakefield

Chris Lennox (CL) gave an update to Committee:

- There had been a Barnsley and Wakefield Forum meeting on 18 August and the focus was on Covid 19, recovery and building that into the EIA process.
- There is an EIA analysis and update workshop planned for 5 October.
- The group representation is expanding and the Terms of Reference have been updated.
- Work on digital inclusion has been shared and feedback will be sought from service users and carers shortly.

Calderdale and Kirklees

CL gave an update to Committee:

- The last meeting had been on 17 September and also focused on Covid 19 and recovery.
- There had been a guest speaker from CHART, the specialist drug and alcohol service in Kirklees.
- There were good reports from frontline staff on levels of engagement with risk assessments of vulnerable people.
- There are plans to develop a rehab service as part of community services in Calderdale.
- Calderdale and Kirklees are also joining the EIA workshop on 5 October.

Forensics and Specialist
There was no update for this meeting.

Support
There was no update for this meeting.

The Committee NOTED the updates.

EIC/20/54 Inclusive Leadership and Development update – RACE Forward update (agenda item 19)

This item was deferred to the next meeting.

EIC/20/55 Workforce Disability Equality Standard (WDES) for Trust Board (agenda item 20)

This item was taken along with agenda item 10.

EIC/20/56 Workforce RACE Equality Standard (WRES) for Trust Board (agenda item 21)

This item was taken along with agenda item 10.

EIC/20/57 Governance (agenda item 22)

EIC/20/57a Revised Committee Membership (agenda item 22.1)

Committee had welcomed MF who would be joining future meetings as an additional Non-Executive Director. It was noted that Sean Rayner (SR) was stepping down from EIC and executive representation would be from RW, TB and AD as well as SThi who was not a member but invited to join as an attendee.

The Committee NOTED and AGREED the revised membership.

EIC/20/57b Terms of Reference (agenda item 22.2)

It was suggested that the word 'involvement' could be included in the title of the Committee and it was agreed that this would be an action to discuss further at the next meeting.

Action: All

The Committee NOTED and AGREED to recommend the revised Terms of Reference to the Board for approval.

EIC/20/57c Learning for Committees (agenda item 22.3)
This item was deferred to the next meeting.

EIC/20/58 Items to bring to the attention of Trust Board or other Committees (agenda item 23)

Post meeting note – the following were agreed by AM and TB to go to Board under committee assurance:

- *Reviewed committee assigned risks, including new risk 1536. Identified possible gaps in risk descriptions and actions, for further review.*
- *Discussed and supported the draft Equality, Involvement, Communication and Membership Strategy and requested further amendment before final approval.*
- *Reviewed and approved the WRES and WDES summary reports and action plans.*
- *Received the Trust's EDS2 report for 2019/20 and recommendations for 2020/21 and onwards, and agreed an overall Trust grading of developing.*
- *Received updates from the Trust's staff networks (Disability, BAME, LGBT+ and working carers) and BDU equality forums.*
- *Agreed to recommend changes to the committee's terms of reference, including membership.*

EIC/20/59 Return to review of risks in light of Committee discussion (agenda item 24)

TB advised that the agenda setting meeting for the December Committee would consider anything that had been noted today and would require full attention at the next meeting.

EIC/20/60 Date of next meeting (agenda item 25)

The next meeting will be 8 December 2020.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Minutes of the Workforce and Remuneration Committee held on 12 November 2020

Present:	Sam Young	Non-Executive Director (Chair)
	Angela Monaghan	Chair of the Trust
	Charlotte Dyson	Non-Executive Director (Vice-Chair)
	Rob Webster	Chief Executive
In attendance:	Alan Davis	Director of HR, OD and Estates
	Janice White	PA to Director of HR, OD and Estates (author)

WRC/20/43 Welcome, Introductions and Apologies (agenda item 1)
The Chair, Sam Young (SY) welcomed everyone to the meeting. No apologies were received.

It was noted that the meeting was quorate and could proceed.

WRC/20/44 Declaration of Interests (verbal item) (agenda item 2)
All members of the Committee present declared that they had an interest as part of agenda item 8: Board Succession and Talent Management. There were no further declarations over and above those made in the annual return to the Trust Board in March 2020 or subsequently.

WRC/20/45 Minutes of the meeting held on 13 October 2020 (agenda item 3)
The Committee confirmed that these were an accurate reflection.

The Committee RESOLVED to APPROVE the minutes of the meeting held on 13 October 2020.

WRC/20/46 Matters arising (agenda item 4)

The Committee discussed the schedule of actions from the previous meeting. It was noted that the majority of actions had been moved to January.

(a) WRC/20/28 Workforce Risk Register (agenda item 12)

AGD informed the Committee that he had started to work on the Risk Register but due to the rapidly changing environment in terms of Covid and not a lot of clarity in the system regarding the EU Exit arrangements the Executive Management Team (EMT) are still in the process of updating the Trust Risk Register. He is working through the processes with a view to taking the Risk Register to the EMT. AGD agreed to try and circulate the Risk Register to members of this Committee for comments prior to the next meeting.

Action: Alan Davis

(b) WRC/20/29 Annual Work Programme 2020/21 (agenda item 13)

SY informed the Committee that the Work Programme for 2020/21 is missing from the pack for today's meeting as herself and AGD had not yet had chance to re-visit it and wanted to highlight that.

Action: Alan Davis/Sam Young

WRC/20/47 Integrated Workforce Performance Report: Review of workforce performance indicators during the pandemic (agenda item 5)

AGD produced a report for the Committee which reviewed workforce performance indicators during the pandemic. SY said she thought these slides were really good and liked this approach in presenting back into this Committee. AGD said the aim of this report is to get a more detailed understanding of what is going on during the pandemic and it is clear at the moment the biggest limiting factor is staff availability rather than beds. He updated the Committee on the position of staff who have been designated as Clinically Extremely Vulnerable and that following receipt of new guidance that they had all been sent home as a precaution whilst the detail was being worked through.

AM mentioned that from the recent Silver Command report on staff absence, figures have risen and are still rising by a substantial amount and she was concerned we had not yet seen the peak in terms of our staff absenteeism.

AGD also mentioned there is likely to be an impact from staff testing on absence as it will pick up those staff who come into work who are asymptomatic and that even a small percentage will put further pressure on the system. AM asked when this will be starting and if we will be monitoring home testing. AGD said the testing is due to start shortly but we were still awaiting the kits and that it will be monitored through Silver Command.

AGD updated the Committee on the flu vaccine uptake and that although the uptake was greater than this time last year, the programme was being accelerated to ensure that it both protected staff as well as not delaying any COVID vaccine, as the most recent briefing suggested that there has to be 21 days between each vaccination.

AGD informed the Committee that we have done another round of bring back staff who have recently retired. There are about 20 clinical staff who have retired within the last six months who have been written to and we are waiting a response.

AM also said she wanted to raise on page 16 of the Diligent pack in relation to BAME staff absence in CAMHS, Support Services and Barnsley Community where it appears to be higher than the rest of the staff population. AGD said that there has been growing evidence that COVID does have a disproportionate impact on the BAME community and the absence figures seems to support this. He said that this is the reason the Trust established the BAME Health and Wellbeing Task Group at the start of the pandemic and it has continued to meet regularly. The task force was key in the appointment of Charlene Sibanda, the BAME Health and Wellbeing Practitioner who will be focusing on support to BAME colleagues.

AGD said whilst the Trust has always seen staff health and wellbeing as a high priority, it was important we learn the lessons from COVID and continue to move this agenda forward. He referred to the Robertson-Cooper survey which highlighted that physical health had deteriorated more than psychological health. AGD said we need to re-focus and try to get people to think about their lifestyle during this period. AGD said the COVID risk assessments that were undertaken earlier in the year identified 50% of staff were saying they were overweight. AM asked if all staff had repeated the risk assessment and have we got the right mitigating steps in place for the BAME staff who are particularly vulnerable. AGD said the risk assessments should be subject to review when there is a change e.g. further guidance, change of role or in health and there have been a number of reminders for staff and managers about keeping risk assessments up to date. It was noted that BAME colleagues responded very positively to the risk assessment process but it was felt this is something we could follow up. Alan agreed to pick this up with the BAME Health and Wellbeing Task Force Group.

Action: Alan Davis

CD mentioned that at Clinical Governance and Clinical Safety Committee they had a lengthy discussion about pressures in the Barnsley Community in terms of physical health and psychological health and what might be done to support this service and how to reflect this in the Risk Register. AM said there had been discussions about clinical supervision, in particular in relation to the Barnsley Community team and capacity and the pressures on the supervisors and the supervisees but that the team are looking at every opportunity of getting the supervision levels up.

SY mentioned slide 18 with the combined sickness figures looking at 10% on average but it ranged between 9% and 15% and that these combined totals are a real cause of concern. AGD said that a slight note of caution in that some people who are off are working from home, but it is still a real cause of concern. He said that once we get the Clinically Extremely Vulnerable position sorted some staff will come back into the system. He also mentioned that normally flu and colds have as big an impact over the Winter period but in theory given the increased uptake of flu vaccinations and the social distancing measures we have got in place, this should have less of an impact. Also, managers have been asked to be more active in giving people who are off meaningful work to do at home.

SY confirmed she found the format of the report really helpful.

The Committee NOTED and COMMENTED on the Performance Report.

WRC/20/48: Staff Wellbeing Update (agenda item 6)

AGD introduced the Staff Wellbeing report and said we start from a strong position as staff wellbeing has always been a key element of our Workforce Strategy. The staff engagement exercise undertaken last year as part of developing the new Workforce Strategy, reinforced the importance of supporting staff and this has been amplified during the pandemic. He said the five key themes of Feeling Safe; Supportive Teams; Positive Health and Wellbeing; Developing My Potential; and My Voice Counts that came from staff in what makes A Great Place to Work has stood the test of time during the Covid response.

AGD updated the Committee on two key appointments which would have an important role in the broader staff health and wellbeing offer. Cherill Watterston has been appointed as WRES OD lead and she starts on 14th December 2020 and a large element of her role is around BAME staff wellbeing. A number of organisations have approached us to share the job description and appointment process of the WRES OD Lead. Also, Estelle Myers has been appointed as the full time Freedom to Speak Up Guardian Lead and starts on the 1st December 2020.

AGD said the Insight events have been really helpful and were into two themes, one was service based, and one based on the five themes of A Great Place to Work. In support of this we also had a manager, deputy directors and staff side Insight event and asked what we can do to support that. The wellbeing plans are being developed locally to ensure greater ownership in the services.

AM said she thought this was really helpful. She said that page 25 of the Diligent pack when looking at the BDU breakdown, Adult Mental Health Inpatient stands out as being mostly red and amber and asked what is happening to address that. AGD said there had been a separate insight session for inpatient services, and it is clear there is still a lot of pressure on staffing levels due to COVID and the wearing of PPE has also made it difficult. The General Managers and Matrons are developing a wellbeing plan and Ashley Hambling is providing support.

It was also mentioned that Barnsley Community Services seem to be experiencing some aggression from service users and there also seems to have been issues in the primary care with patients getting frustrated about not getting the services. It was felt that one of the differences between the first phase and second phase of COVID is that people are not

tolerating some of the things they tolerated initially and are taking it out on the staff at the frontline. AGD will pick this up with Carol Harris to see what further support and communications could be put in place.

Action: Alan Davis

RW said there are a couple of actions. There is a piece of work going on around how we reduce pressure on acute inpatients, potentially working with others and one of the things being looked at is sharing capacity or buying more independent sector beds which could reduce the pressure on inpatient staff. RW said there is a significant worry from the inpatient services that using the independent sector could be a backward step given all of the out of area work. RW informed the Committee that it looks like nationally they are going to fund some additional independent sector capacity in mental health up to about £50million and we will get a share of that in West Yorkshire which might help. On the aggression and violence towards staff he has heard anecdotes about this i.e. GPs in Barnsley being faced with baseball bats demanding tests and whilst these stories are powerful, he would like to see the evidence. It was agreed that it might be helpful to see what is being reported on Datix in the first instance.

Action: Alan Davis

The Committee NOTED and COMMENTED on the Staff Wellbeing Report.

WRC/20/49: Development of Workforce Strategy and Organisational Development Strategy (agenda item 7)

It was agreed that discussions on the Workforce Strategy would be deferred until January 2021. The OD Strategy will come to March's Committee with a view to going to the Trust Board for approval in early 2021/2022

The Committee AGREED that the Workforce Strategy would be deferred until the WRC meeting in January and the Organisational Strategy would be deferred to the WRC meeting in March with a view to Trust Board approval in early 2021/2022.

WRC/20/50 Board Development Succession Planning and Talent Management (agenda item 8)

AGD introduced this paper and said this is a draft and follows on from a number of conversations, one of which is from the previous Workforce and Remuneration Committee meeting where it was felt that it was important to re-visit the Board succession planning. Following a meeting with AM and RW it was agreed the paper should cover the whole Board and for it to be on the private Board agenda. AGD also said that Andrew Cribbis has been having conversations with directors about the next level and tried to capture that in the dashboard to give the Committee an oversight. SY said she thought this was a good overview. AM said she agreed and thought it was a really good summary and important to have a discussion at the Board as these dates are not very far away. The Committee agreed that this needs to be discussed at Trust Board.

The Committee RESOLVED to NOTE the Board Succession and Talent Management paper and AGREED for this to be discussed at Trust Board.

WRC/20/52 Employment Law Update (agenda item 10)

AGD confirmed there was no update to report to the Committee

WRC/20/53 Workforce Risk Register (agenda item 11)

SY said the Workforce Risk Register was discussed earlier on the agenda and it was agreed that when finalised AGD would try and circulate the updated Risk Register to members of this Committee for comments prior to the next meeting.

Action: Alan Davis

15/25: 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

The Committee discussed the Clinical Governance Risk around whether there was a need to increase the risk score based on staff absence figures. The Committee after a detailed discussion felt that the current risk score of 12 was right given absence levels are below April's rate and this was the level at that time. However, the Committee thought that this risk needed to be kept under close review and the control and mitigations actions needed to be reviewed and updated.

AGD said he is happy to pick this up through EMT and reflect the outcome back to Board.

Action: Alan Davis

The Committee RESOLVED to NOTE that Alan Davis will update the Workforce Risk Register and try to circulate to the Committee and to take the comments discussed above to the Executive Management Team and report back to the Trust Board.

WRC/20/54 Annual Work Programme 2020/21 (agenda item 12)

SY said this was mentioned earlier in the agenda and agreed that herself and AGD will re-visit this in light of Covid and bring back to the Committee.

Action: Alan Davis/Sam Young

The Committee RESOLVED to AGREE that Sam Young and Alan Davis will re-visit the Annual Work Programme in light of Covid and bring back to the Committee.

WRC/20/55 Matters to Report to the Trust Board and other Committees (agenda item 13)

- Integrated Workforce Performance Report – impact on staff health and wellbeing and absence
- Staff Wellbeing – update on Robertson-Cooper survey and actions in response to staff feedback
- Development of Workforce and OD Strategy – Deferred due to Covid
- Board Succession Planning – Paper to go to private session of the Trust Board
- Workforce Risk Register – EMT to review workforce risks in light of Covid second wave
- Annual Work Programme – SY and AGD to review in light of Covid

WRC/20/57 Date and Time of next meeting
The next meeting will be held on the 19 January 2021 at 11.30am by Microsoft Teams.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board annual work programme 2020-21

! – item amended to focus on Covid-19 and business continuity
 # - item deferred
Note that some items may be verbal

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Standing items													
	Declarations of interest	✘	✘	✘	✘		✘	✘	✘		✘		✘	
	Minutes of previous meeting	✘		✘	✘		✘	✘	✘		✘		✘	
	Chair and Chief Executive's report	!		!	✘		✘	✘	✘		✘		✘	
	Business developments	!		!	✘		✘	✘	✘		✘		✘	
	STP / ICS developments	!		!	✘		✘	✘	✘		✘		✘	
	Integrated performance report (IPR)	!		!	✘		✘	✘	✘		✘		✘	
	Serious Incidents (private session) - verbal	✘		✘	✘		✘	✘	✘		✘		✘	
	Assurance from Trust Board committees	✘		✘	✘		✘	✘	✘		✘		✘	
	Receipt of minutes of partnership boards	✘		✘	✘		✘	✘	✘		✘		✘	
	Questions from the public (to receive in writing during Covid-19 pandemic)	✘		✘	✘		✘	✘	✘		✘		✘	

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Quarterly items													
	Corporate / organisational risk register	!	!	✘ update	✘			✘			✘			
	Board assurance framework	!	✘		✘			✘			✘			
	Serious incidents quarterly report			✘			✘		✘				✘	
	Emergency Preparedness, Resilience & Response (EPRR) Compliance – Covid-19 response update?			!			✘		✘				✘	
	Use of Trust Seal			✘			✘		✘				✘	
	Corporate Trustees for Charitable Funds# (annual accounts presented in July)			!			✘		✘				✘	
	Half yearly items													
	Strategic overview of business and associated risks	#									#		✘	
	Investment appraisal framework (private session)	#						✘						
	Safer staffing report	✘!							✘					
	Digital strategy (including IMT) update	#			✘									
	Estates strategy update				#				#		#		✘	
	Annual items													
	Draft Annual Governance Statement	✘												
	Audit Committee annual report including committee annual reports	✘												
	Compliance with NHS provider licence conditions and code of governance - self-certifications *(date to be confirmed by NHS Improvement)*	✘												
	Guardian of safe work hours	✘												

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs	#							✘ (KPI's)					
	Review of Risk Appetite Statement	#									#			
	Annual report, accounts and quality accounts - update on submission		✘	✘?			✘ (QA)	✘ (QA)						
	Health and safety annual report			#?				✘						
	Patient Experience annual report			#			✘							
	Serious incidents annual report			✘										
	Equality and diversity annual report (included in new strategy)				✘?				✘					
	Medical appraisal / revalidation annual report				#		✘							
	Sustainability annual report						#		✘					
	Workforce Equality Standards						✘							
	Assessment against NHS Constitution								#		✘?		✘	
	Eliminating mixed sex accommodation (EMSA) declaration												✘	
	Data Security and Protection toolkit												✘	
	Strategic objectives												✘	
	Trust Board annual work programme	✘!	✘!									✘ (draft)	✘	
	Operational plan										✘ (draft / private)	✘ (draft / private)	✘ (draft / private)	
	Five year plan													
	Board development													
	TBC		✘			✘				✘		✘		

SO	Agenda item / issue	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Deferred Covid-19
	Policies and strategies													
	Constitution (including Standing Orders) and Scheme of Delegation *(January 2020)* *(deferred to April 2021)*	# (if req'd)						✘			✘ SOD			
	Digital Strategy *(January 2021)*										#		✘	
	Customer Services policy *(June 2020)*			#						?				
	Estates strategy *(July 2022)*			#										
	Equality, Involvement, Communication and Membership Strategy *(NEW – will replace Communication, Engagement and Involvement, Equality and Membership strategies)*	# (if req'd)					✘ (update)		✘					
	Sustainability strategy *(June 2020)*			#					✘ (update)			✘		
	Organisational Development Strategy*(June 2020)*			#					#		#		✘	
	Workforce strategy								#		#		✘	
	Quality strategy *(March 2021)*												✘	
	Trust Board declaration and register of fit and proper persons, interests and independence policy *(March 2021)*												✘	

Policy / strategy review dates:

- Trust Strategy *(reviewed as required)*
- Standing Financial Instructions *(delegated approval authority to Audit Committee, reviewed as required)*
- Treasury management strategy and policy *(delegated approval authority to Audit Committee, reviewed as required)*
- Constitution *(January 2020) – under review* (March/April 2021)(Scheme of Delegation to look at which strategies can be signed off by committee rather than Board)
- Communication, Engagement and Involvement strategy *(to be merged with the Equality, Involvement, Communication and Membership Strategy)*(also to be taken as E and D annual report)
- Customer Services Policy *(next due for review in June 2020, extended to October 2020)*
- Digital Strategy *(next due for review in January 2021)*
- Equality Strategy *(next due for review in July 2020, to be merged with Equality, Involvement, Communication and Membership Strategy)*
- Estates Strategy *(next due for review in July 2022)*
- Learning from Healthcare Deaths Policy *(next due for review in January 2022)*
- Membership Strategy *(next due for review in April 2020, to be merged with Equality, Involvement, Communication and Membership Strategy)*
- Organisational Development Strategy *(next due for review in June 2020)*

- Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(next due for review in February2023)*
- Procurement Strategy *(next due for review in June 2021)*
- Quality Strategy *(next due for review in March 2021)*
- Risk management strategy *(next due for review in April 2022)*
- Standards of Conduct in Public Service Policy (conflicts of interest) *(next due for review in March 2022)*
- Sustainability Strategy *(to be reviewed with the Estates Strategy, by July 2022)*
- Trust Board declaration and register of fit and proper persons, interests and independence policy *(next due for review in March 2021)*
- Workforce Strategy *(next due for review in March 2023 (if approved at Board March 2020))*