With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 22 December 2015 at 13:00
Rooms 49/15, Folly Hall, Huddersfield, HD1 3LT

AGENDA

1. Welcome, introduction and apologies (verbal item)

2. Declaration of interests

3. Minutes and matters arising from previous Trust Board meeting held on 23 October 2015

4. Assurance from Trust Board committees

4.1 Audit Committee 6 October 2015 (for information only)
4.2 Clinical Governance and Clinical Safety Committee 2 November 2015
4.3 Mental Health Act Committee 10 November 2015
4.4 Remuneration and Terms of Service Committee 17 November 2015
4.5 Estates Forum 9 December 2015 (verbal update)
4.6 Equality and Inclusion Forum 14 December 2015 (verbal update)

5. Chair and Chief Executive's remarks (verbal item)

6. Transformation – update on progress and current position (to follow)

7. Performance reports month 8 2015/16

7.1 Performance report month 8 2015/16 (to follow)

7.2 Finance report month 8 2015/16 (to follow)

7.3 Exception reporting and action plans

(i) Child and adolescent mental health services progress report

(ii) Serious incidents report Q2 2015/16

(iii) Learning lessons from incidents

(iv) Community mental health survey 2015/16

(v) IT virus incident

8. Terms of reference for Executive Forum with Locala

9. Use of Trust seal

10. Date and time of next meeting

The next meeting of Trust Board will be held on Friday 29 January 2016 in the conference room, Textile Centre of Excellence, Textile House, Red Doles Lane, Huddersfield HD2 1YF

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 2

Title:	**Declaration of interests by the Chair and Directors of the Trust**
Paper prepared by:	Director of Corporate Development on behalf of the Chair of the Trust
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process undertaken annually supports this.
Any background papers/ previously considered by:	Annual declaration made by the Chair and Directors of the Trust April 2015 and subsequent declarations made.
Executive summary:	The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise, received in April 2015, and the requirement for the Chair and Directors to consider and declare any interests at each meeting. There are no legal implications; however, the requirement for the Chair and Directors of the Trust to declare interests on an annual basis and for Non-Executive Directors to declare their independence is enshrined in the Health and Social Care Act 2012 in terms of the content of the Trust's Constitution. There is also a requirement for the Trust to assure itself that members of its Board meeting the fit and proper person requirements. Declarations made by new and existing Directors are as follows. <u>Non-Executive Director – Charlotte Dyson</u> Member. Local Advisory Committee for Clinical Excellence Awards, Bradford Teaching Hospitals NHS Foundation Trust
Recommendation:	**Trust Board is asked to CONSIDER the declaration, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of Trust Board meeting held on 23 October 2015

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Rachel Court	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Steven Michael	Chief Executive
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Alex Farrell	Deputy Chief Executive/Director of Finance
Apologies:	None	
In attendance:	Kate Henry	Interim Director, Marketing, Engagement and Commercial Devel.
	Dawn Stephenson	Director of Corporate Development
	Bernie Cherriman-Sykes	Board Secretary (author)
Guests:	Simon Dale	EMIS Health

TB/15/66 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting, in particular, Rachel Court (RC) attending her first meeting as a Non-Executive Director of the Trust. There were no apologies.

IB introduced Alison Dixon and Deborah Newman, Clinical Manager, Paediatric Speech and Language Services, Barnsley. Alison spoke about her son and the family's experience of the Trust's paediatric speech and language service in Barnsley. Trust Board was also shown a film that describes the family's journey, which is also on the Trust's website.

IB went on to confirm that the Chief Executive (SM) will take voluntary early retirement at the end of March 2016. Staff, the Members' Council and stakeholders were informed the previous day and IB had also informed Monitor. He asked for the thanks and appreciation of the Board to be formally recorded.

TB/15/67 Declaration of interests (agenda item 2)

The following declarations were made over and above those made in April 2015 and subsequently.

Name	Declaration
NON-EXECUTIVE DIRECTORS	
Rachel Court	Non-Executive Director, Invesco Perpetual Life Ltd.
Julie Fox	Daughter has been appointed as an Independent Associate Hospital Manager for the Trust *(it should be noted that Julie Fox took no part in the interview or appointment process)*
COMPANY SECRETARY	
Dawn Stephenson	Chair, Kirklees Active Leisure

There were no comments or remarks made on the Declarations; therefore, **it was RESOLVED to formally NOTE the Declarations of Interest by Directors of the Trust.**

TB/15/68 Minutes of and matters arising from the Trust Board meeting held on 22 September 2015 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held on 22 September 2015 as a true and accurate record of the meeting. There were no matters arising.

TB/15/69 Assurance from Trust Board committees (agenda item 4)

TB/15/69a Audit Committee 6 October 2015 (agenda item 4.1)

Laurence Campbell (LC) highlighted the following.

- The Committee was disappointed with the lack of assurance and evidence that the patients' property policy has been embedded and consistently followed. Tim Breedon (TB) responded that the revised policy and procedure are in place. Sean Rayner, District Service Director for Barnsley and Wakefield, has agreed to lead implementation and provide assurance of its embedding and application across BDUs.
- The Committee received an update on Trust action to improve the quality of clinical information and five priorities have been identified, which will be scrutinised by the Clinical Governance and Clinical Safety Committee. The Audit Committee did ask how the priorities had been arrived at and whether they were the right areas. TB responded that the priorities were identified in terms of two drivers – areas that were identified as needing improvement and areas to support compliance. 'Trios' within BDUs will be responsible for taking these forward in the drive to improve the quality of clinical information.
- As part of its assurance on counter fraud arrangements, the Committee has asked to receive a report on the controls in place for the management of drugs at a future meeting.

TB/15/69b Feedback from Trust Board Forums – Equality and Inclusion Forum (agenda item 4.2)

IB commented that the terms of reference and membership have now been confirmed. The Forum identified four priorities for 2015/16, which were approved by Trust Board in July 2015 (new training which equips staff and managers to be effective champions of diversity, improving representation from BME communities in the workforce, targeted community engagement and increasing the percentage of service users in employment). The Forum will move to the design of a set of indicators to be measured to assess progress on a longer-term basis.

TB/15/70 Chair and Chief Executive's remarks (agenda item 5)

IB commented that the Trust has been shortlisted for the Health Service Journal awards in two categories – forensic child and adolescent mental health services in the Specialist Services Re-design category and for Board leadership. He and SM presented to the judging panel on 9 October 2015. He also commented on the recent Board-to-Board with Locala and encouraged other Non-Executive Directors to attend Board-to-Board meetings with partners.

The Chief Executive covered the following in his remarks.

- The appointment of Stephen Dorrell as Chair of the NHS Confederation, which is seen as a good appointment in a challenging time.
- The appointment of Jim Mackey as Chief Executive of NHS Improvement, which is also seen as a good appointment.

- The Trust has been informed by the Care Quality Commission (CQC) that it will undertake an inspection starting in March 2016. A communications and engagement plan is in place and the first tranche of information requested was sent to the CQC on 21 October 2015. The inspection process is very much a ward-to-board exercise and the CQC will focus on services and front-line staff. Julie Fox (JF) commented that she would like to see the message to staff continue to be about improving practice not about 'passing' the inspection. IB added that he would like more indication of when the outcome of the inspection visit will be known.

SM went on to outline changes to Executive Management Team (EMT) roles. The Remuneration and Terms of Service Committee approved a split of the Deputy Chief Executive/Director of Finance role (currently occupied by Alex Farrell (AF)). AF will focus on the Deputy Chief Executive role in terms of development of the Trust's plan and associated contracting linked to marketing and pricing strategy, and would, therefore, relinquish Director of Finance responsibilities. An interim appointment will be made to provide cover and this will not commit the organisation or the new Chief Executive to a new Director of Finance. IB, LC and SM are leading on the interim appointment. Alan Davis (AGD) will lead the process for recruitment of the Chief Executive and Director of Finance with support from recruitment consultant, Harvey Nash. It is intended to interview for the Chief Executive in early February 2016 followed by interviews for the Director of Finance in which the new Chief Executive can be involved.

Jonathan Jones (JJ) commented that this would mean the new Chief Executive would not be in post before SM retires. IB responded that this was likely and that the Trust would look at an interim arrangement. Both JF and JJ asked why it would take so long to reach the interview stage, particularly as the advertisement would appear in the Health Service Journal on 4 November 2015. JJ was also unsure that the Trust should have two posts filled on an interim basis at the same time. AGD responded that the timings were suggested by Harvey Nash; however, he took on board Trust Board's concerns and he would discuss the timescales further with Harvey Nash.

SM also commented on the Barnsley Healthy Child Programme (0-19 services). The Trust's bid was unsuccessful as it was out-with the price indicated in the tender specification. No other bids were received and the tender was, therefore, abandoned. Barnsley Council has begun discussions with the Trust as the incumbent provider. The Trust's approach remains that it will only provide a safe service and will not compromise on safety standards.

AF commented on the development of performance reporting, which was part of the recommendations made by Deloitte as part of the well-led review and will involve Non-Executive Directors and senior managers. She will provide an update at the next meeting.

TB/15/71 Strategic overview of business and associated risks (agenda item 6)

AF introduced the paper commenting that it highlights the external and internal environment in the context of the Trust's strategic plan and stratification of Trust services. It also outlines key internal risks.

JJ commented that it implies a strong expectation of the Vanguard programme. AF responded that the expectation nationally is that Vanguards will be 'scaleable' in a short space of time to engender systems change. Their success will very much depend on the capability and capacity of local leadership to drive change. SM added that the £30 billion challenge set for the NHS and the development of new organisational forms, particularly

accountable care organisations, will influence the system. He believes that the Trust is responding in the right way through its four-tier model.

JJ commented that there is a danger that Boards will 'vote with their feet' as the system changes. AF added that the local authority position will also have a big impact on the sustainability of the health and social care economy and, therefore, the Trust. Chris Jones (CJ) asked if there was any value in looking at integrated solutions such as that in Manchester. SM responded that discussions have begun but there are different approaches and stages of development. Charlotte Dyson (CD) commented that the Trust needs to be clear on what its offer is and what part of community needs it provides.

TB/15/72 Human resources and workforce development (agenda item 7)

AGD commented that this paper builds on and underpins the previous paper and outlines the major challenges for the workforce.

JJ asked whether there were any implications of a sickness target of 4.4%. AGD responded that the Trust is using the Bradford Index to identify the focus for management action. LC asked if managers are consistently good at managing sickness. AGD responded that key to the Trust's approach is a good wellbeing structure, which supports managers and provides a solid foundation for practical and constructive engagement with staff. JJ commented that this had not, however, affected a change in sickness absence over the years. AGD responded that, on the contrary, sickness absence has been on a downward trend and the Trust does well when compared to other NHS organisations but he accepted not necessarily against the private sector, which should now be the benchmark the Trust looks to. JF commented that the occupational health service forms a key part of the Trust's approach and she was impressed with the Trust's service.

Two 'red' areas were identified in relation to the registered nursing age profile and speciality doctor recruitment. JF commented that she would like to see the second as an area for Trust focus with a dedicated project in place as there are some organisations who do successfully recruit to such posts. This was supported by CD.

In relation to the four areas identified as 'amber' and 'red', IB asked to see the national picture, the specific issues for the Trust and what action the Trust is taking.

In summary, IB commented that Trust Board could take the following from the discussion on items 6 and 7 that:

- finance is under more pressure going into planning for next year than in previous years;
- quality is paramount;
- the CQC inspection will test the dual hypothesis that efficiency will improve quality.

He would like to see this picked up in the budget and planning for 2016/17. He was particularly uneasy that one aggregate rating from the CQC for the Trust across all services will impact on the Trust's position and its reputation. SM responded that the value is to look below the overall/aggregate outcome and at individual service ratings, which would form the basis of contract negotiations. The outcome can also be used as a strategic tool to identify services where, potentially, the Trust should not be providing a service and it would be better provided elsewhere.

TB/15/73 Assurance framework and risk register (agenda item 8)

Dawn Stephenson (DS) began by reminding Trust Board that the well-led review recommendations suggested that the Trust reviewed its assurance framework and the revised format was presented at this meeting. This does, however, represent work-in-progress and she will discuss further with lead Directors and with the Chairs of Committees and Forums for presentation at the quarter 3 point.

Trust Board supported the development of the framework, which it felt was easier to read, capturing and summarising the risks facing the Trust. CJ commented that he would find it useful to see a rationale for the current assurance level.

It was RESOLVED to NOTE the controls and assurances against corporate objectives for 2015/16 and to NOTE the key risks for the organisation.

TB/15/74 Performance reports month 6 2015/16 (agenda item 9)

TB/15/74a Quality performance report (agenda item 9.1)

TB raised the following.

- The detail of nurse re-validation has now been published and the impact and implications for the Trust will be assessed. No major issues are anticipated currently.
- He drew Directors attention to the end-of-life care provided in forensic services and the CQC visits to Waterton and Elmdale wards.
- He also advised that the Trust was re-introducing a ward managers' network to foster and improve engagement and communication.

TB/15/74b Finance report (agenda item 9.2)

AF commented on the following.

- The Trust financial risk rating is 4 against a plan of 4 and it is anticipated that the Trust will retain this rating to the end of the financial year.
- The year-to-date position is £0.6 million surplus. Supported by the use of provisions, the Trust is anticipating a small surplus at the year-end and this will be reflected in a revised plan to Monitor.
- The capital spend to September 2015 is £5.47 million, which is £0.61 million (10%) behind plan.
- The cost improvement programme is £121,000 behind plan and, overall, a full-year value of £1.2 million remains rated as 'red' after mitigation. The Trust is working to identify recurrent substitutions to ensure the impact on 2016/17 is minimised.
- There is an assumption in relation to the Aberford Field receipt made in the current position. Agreement has been reached regarding the sale and it is assumed that the receipt will materialise by the end of the financial year. The Trust will discuss the position with Monitor if this becomes a significant risk. Mitigation of the position would be considered through the release of balance sheet provisions to ensure a surplus. AF confirmed that, to recognise the receipt in this financial year, the Trust would be required to provide sufficient evidence for the auditor to ensure there is no misstatement of the accounts (such as, receipt before signature may be acceptable).

Trust Board was supportive of the revision to the Trust's year-end forecast to provide for a small surplus. AF was confident of achievement based on the current cost improvement programme position and any improvement would result in a higher surplus. JJ asked what was being done to address the shortfall in the cost improvement programme, particularly in Barnsley. AF responded that there has been an incremental increase in cost improvement achievement and BDUs are reviewing the potential for savings that could be made that

would not adversely affect the end-year position. She would anticipate a shortfall but it would be under the £1 million currently rated 'red' but it is difficult to assess the split between recurrent and non-recurrent savings. She also confirmed that using balance sheet provisions offers the Trust the opportunity to maintain flexibility in how it addresses its financial position and is seen as prudent financial management.

LC asked why there was no data for managing aggression and violence training. TB responded that sickness absence had affected the delivery of training; however, this has now been addressed. LC also asked what 'mandatory training' actually meant. AGD responded that there is a mandatory training policy in place; however, the Trust's approach has to be risk-based and this is not reflected in the reported figures. IB commented that he would like to see more detail in the budgeting and planning round.

CD remarked that there were still no figures for the improving access to psychological therapies (IAPT) target. AF clarified that a new national dataset will be introduced from quarter 3 and she will ensure a note is included to reflect this. AGD also agreed to follow up information on vacancy rates.

TB/15/74c Customer services report (agenda item 9.3)
JF commented that the report was really well presented, easy to read and clear on key messages. CD commented that she would like to see more information coming back to Trust Board on learning from complaints where staff attitude has been identified as an issue. DS agreed to work with TB to include in a future report.

IB commented that he would like to hear a patient/service user story at Trust Board where the experience has not been as good as the Trust would have liked. Although uncomfortable for Trust Board, he felt this would enable Directors to also reflect on where the Trust's service has not been as good as it should have been.

TB/15/74d Exception reports and action plans – Child and adolescent mental health services progress report (agenda item 9.4(i))
TB introduced the paper on behalf of Nette Carder (NC) and **it was RESOLVED to NOTE the progress report.**

TB/15/74e Exception reports and action plans – Well-led review update (agenda item 9.4(ii))
It was RESOLVED to NOTE the update and progress against the recommendations arising from the independent review of the Trust's governance arrangements.

TB/15/75 Board self-assessment of operational, clinical and quality risks (agenda item 10)

Additional areas for inclusion in the report were suggested.

JJ asked if Monitor could change the Trust's risk assessment given the changes at Chief Executive and Deputy Chief Executive level. IB responded that it could; however, the Trust has informed Monitor of the position, has provided assurance that robust and clear arrangements are in place and Trust Board has not identified the situation as a risk. JJ commented that, for Non-Executive Directors, this does represent a concern given the current challenges and a smooth transition will be vitally important. He would like to see, therefore, the recruitment process for the Chief Executive and Director of Finance expedited swiftly.

Trust Board also asked to receive the formal report and detail of the action the Trust is taking following the IT virus in August 2015.

It was RESOLVED to APPROVE the submission and exception report to Monitor.

IB returned to consideration of the organisational risk register and asked Trust Board to consider whether any of the items discussed at this meeting would warrant inclusion. He asked that EMT considers the specific workforce issues identified and whether these were of a sufficient level to be included. He also suggested that these are reviewed in more detail at the Remuneration and Terms of Service Committee to provide assurance to Trust Board. It was noted that AGD and AF are developing a framework to look at management and administrative costs, and value for money arrangements.

TB/15/76 Date and time of next meeting (agenda item 11)

The next meeting of Trust Board will be held on Tuesday 22 December 2015 in rooms 49/50, Folly Hall, St. Thomas Road, Huddersfield, HD1 3LT.

Signed …… Date ……

Trust Board 22 December 2015
Agenda item 4 – assurance from Trust Board Committees

Committee assurance

Audit Committee

Date	6 October 2015
Presented by	Laurence Campbell
Key items to raise at Trust Board	Taken at Trust Board in October 2015 – minutes for information only.

Clinical Governance and Clinical Safety Committee

Date	2 November 2015
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Managing aggression and violence training for Trust Board. ➢ Concerns raised by the Committee regarding the rising trend of suspected and actual suicides (although the Trust's positive work in this area was noted). ➢ The challenge event in Kirklees for safeguarding children arrangements within the Trust. ➢ Nurse re-validation. ➢ Ongoing progress reporting to Trust Board of child and adolescent mental health services.

Mental Health Act Committee

Date	10 November 2015
Presented by	Julie Fox
Key items to raise at Trust Board	➢ The in-depth audit of pathway leading to Mental Health Act admissions in Kirklees (which was also presented to the Equality and Inclusion Forum). ➢ The use of S136 suites and the further review requested.

Remuneration and Terms of Service Committee

Date	17 November 2015
Presented by	Ian Black
Key items to raise at Trust Board	➢ Recruitment for Chief Executive, and interim and substantive Director of Finance positions. ➢ Staff engagement key performance indicators. ➢ Implementation of the Living Wage.

Estates Forum

Date	9 December 2015
Presented by	Jonathan Jones
Key items to raise at Trust Board	➢ Community hub developments ➢ Capital programme update and associated developments

Equality and Inclusion Forum

Date	14 December 2015
Presented by	Ian Black
Key items to raise at Trust Board	➢ The in-depth audit of pathway leading to Mental Health Act admissions in Kirklees ➢ Work to support service users into employment in Barnsley ➢ Equality Delivery System 2 – health economy sharing and listening events ➢ Children's takeover day

Minutes of Audit Committee held on 6 October 2015

Present:	Laurence Campbell	Chair of the Committee
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
Apologies:	Members	
	None	
	Others	
	Mark Dalton	Manager, KPMG
	Paul Thomson	Partner, Deloitte
In attendance:	Rob Adamson	Head of Finance
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Jon Cohen	Senior Manager, KPMG
	Tony Cooper	Head of Procurement
	Rachel Court	Non-Executive Director
	Alan Davis	Director of Human Resources and Workforce Development (for item 5)
	Mike Doyle	Deputy Director of Nursing (for item 6)
	Alex Farrell	Deputy Chief Executive/Director of Finance
	Paul Hewitson	Director, Deloitte
	Mark Johnson	Interim Deputy Director of Finance
	Clare Partridge	Director, KPMG (Head of Internal Audit)
	Michael Smith	Governor, publicly elected, Calderdale
	Dawn Stephenson	Director of Corporate Development

AC/15/69 Welcome, introduction and apologies (agenda item 1)

The Chair of the Committee (LC) welcomed everyone to the meeting. The apologies, as above, were noted.

AC/15/70 Minutes of the meeting held on 7 July 2015 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the Audit Committee held on 7 July 2015 as a true and accurate record of the meeting.

AC/15/71 Matters arising from the meeting held on 7 July 2015 (agenda item 3)

AC/15/11 Annual penetration testing of IT systems (agenda item 3.1)

Alex Farrell (AF) reminded the Committee that the Trust's position was that no PEN testing would be commissioned in 2015 but would be scheduled as soon as transition work with Phoenix is complete; however, since the IT virus in August 2015, it has now been agreed to schedule the testing before the RiO upgrade in early November 2015. The outcome of the root cause analysis will be reported to Trust Board and the IM&T Forum.

Action: Alex Farrell

AC/15/59 Internal Audit charter (agenda item 3.2)

Clare Partridge (CP) confirmed that the Charter was updated to reflect the comments made at the last meeting and agreed with AF, which was noted by the Committee.

AC/15/72 Approval of Charitable Funds annual report and accounts 2014/15 (agenda item 4)

It was RESOLVED to APPROVE the Charitable Funds annual report and accounts for 2014/15.

AC/15/73 Trust arrangements for whistleblowing (agenda item 5)

Alan Davis (AGD) took the Audit Committee through the arrangements in place within the Trust to enable staff to raise issues and concerns. The variety of ways for staff to do this reflects the Trust's desire to be open and transparent and to encourage staff to raise issues and concerns in a timely and effective way through a variety of methods they are comfortable with and confident in. AGD was invited to return to the Committee in October 2016 with an update, including any monitoring information.

Action: Alan Davis

AC/15/74 Data quality (agenda item 6)

Mike Doyle took the Committee through the current arrangements in place to improve the quality of clinical information. Five priority areas have been identified:

- clients with no contact over twelve months;
- missing contacts;
- quality audit and risk assessment;
- caseload management and discharge; and
- recording physical health.

These areas will be reviewed in terms of:

- monitoring;
- support with clear guidance;
- learning from each other;
- looking for ways to improve quality; and
- championing the importance of this work.

Paul Hewitson (PH) commented that this was a very positive and helpful approach and would support the Quality Accounts testing undertaken by Deloitte. Testing has found that guidance is designed and in place; however, a key area for audit is whether it is followed and implemented. The Committee needs to have confidence in the assurance that guidance is implemented and is operating effectively.

AF commented that the paper provides assurance of the processes in place. Further information would be useful on why the five areas have been identified as a priority and the current position in order to assess progress.

Scrutiny and monitoring of the plan to address the five areas falls in the remit of the Clinical Governance and Clinical Safety Committee; however, this Committee may want to look further at the timeliness of recording and the impact on costing. The Audit Committee asked for regular feedback either through an update from or receipt of the information presented to the Clinical Governance and Clinical Safety Committee to avoid duplication between Committees. Dawn Stephenson (DS) commented that underlying principle must be to use high quality data to improve services. The concern remains the gaps in data and incomplete data recording. Mike Doyle responded that this is a key element of the ongoing plan and will also fit with the annual clinical data audit. Jon Cohen (JC) commented on the increasing use

of data quality kitemarks, which would identify indicators presenting the biggest risk and provide assurance regarding quality of data.

AC/15/75 Pricing strategy and service line reporting (agenda item 7)

This item was taken as a discussion item.

AC/15/76 Reference costs (agenda item 8)

The Committee noted that the Trust does not have any headline issues with data quality that would adversely affect the Reference Cost Collection or the subsequent output. There are issues in some areas where data is collected manually, which are being addressed along with contingency plans.

AC/15/77 Currency development (agenda item 9)

The paper was noted.

AC/15/78 Triangulation of risk, performance and governance (agenda item 10)

LC asked whether risks, for example, around the recurrence of legionella would be included. AF responded that this is a retrospective report and would be covered in appropriate directorate or BDU risk registers as they would not necessarily represent a strategic level risk. The Executive Management Team (EMT) would take a view on the impact and level of risk presenting.

AC/15/79 Treasury management update (agenda item 11)

The report was noted.

AC/15/80 Internal audit progress report (agenda item 12)

Progress report

CP took the Committee through the progress report. One report was presented from the 2014/15 internal audit programme:

- transformation, which received significant assurance with minor improvement opportunities. (The review in the 2015/16 audit programme will look at the progress of specific projects and whether the Trust is on track against its plan.)

Two reports were presented from the 2015/16 programme:

- asset safeguarding and existence, which received significant assurance with minor improvement opportunities;
- performance indicators, which received significant assurance with minor improvement opportunities.

CP added that the 2015/16 programme is on schedule and that KPMG has agreed to consider 'culture' as an integral part of all internal audit reviews in 2015/16. Jonathan Jones (JJ) asked how the plan had been arrived at. CP responded that a number of factors had been considered in consultation with Directors to develop a risk-based plan, which will be reviewed during the year to ensure the audit plan continues to address the right areas.

JJ also asked if internal audit would review implementation of the recommendations arising from the well-led review. The Committee thought it would derive assurance from inclusion in the internal audit follow up mechanisms. JJ understood the action plan would be monitored through Trust Board; however, he would prefer to see a more forensic review. AF was concerned that this would be duplication as progress will be reported to Trust Board. Independent assurance could be sought as part of the audit plan for 2016/17 in the form of a review of the implementation and embedding of the recommendations. DS added that there will be a further update to Trust Board in December 2015. The purpose is to see the Trust move from good to better through improvement activity, review and adoption of best practice. Trust Board will be involved in taking forward the actions identified.

Follow up report

LC expressed concern that the position with action against the recommendations from the patients' property follow up audit remains unchanged. LC said that he understood that the 'trios' would undertake training on the policy across the trust and conduct spot checks although MD was unable to confirm the position on this. AF responded that the issue is to produce evidence that the policy is being implemented within BDUs to support anecdotal evidence. LC asked if there should, therefore, be a further audit. CP responded that this is not currently included in the plan for 2015/16. AF added that it is planned for the Director of Nursing to undertake spotchecks within BDUs to evidence implementation. Rachel Court (RC) asked about the process for signing-off internal audit recommendations. AF responded that recommendations and timescales are agreed by the lead Director and evidence to complete an action is agreed with internal audit. This is followed up through a routine report to the EMT and action escalated if appropriate. LC commented that the Audit Committee would like to see the Trust provide evidence to support the current position and to ask KPMG to validate the evidence.

Action: Alex Farrell to ensure action through EMT

Technical update

The technical update was noted.

AC/15/81 Counter fraud (agenda item 13)

JC took the Committee through the report. He also responded to the action point from the last meeting in relation to the anticipated savings from counter fraud activity. Any recompense received is notified to the Trust; however, it is not always possible to attribute the true value as much work relates to awareness raising and counter fraud activity. NHS Protect intends to start providing information, which would allow the Trust to benchmark activity.

AC/15/82 External audit update (agenda item 14)

PH took the Committee through the sector developments paper, in particular, changes to Monitor's annual reporting manual and quality accounts, and the false or misleading information offence, which could apply to quality accounts data. Therefore, the Trust must satisfy itself that its information is right and that it has taken reasonable steps to prevent provision of false or misleading information. JJ suggested taking legal advice to confirm what is considered as 'reasonable' steps and whether this is covered by Directors' liability insurance.

Action: Dawn Stephenson

Deloitte will present a detailed audit plan, risks and control measures to the Committee in February 2016.

Action: Deloitte

AC/15/83 Procurement report (agenda item 15)

Tony Cooper (TC) took the Committee through his report. He confirmed that the contract with PF Consulting relates to a project to understand integrated mental health teams for the Vanguard project in Wakefield in conjunction with the clinical commissioning group.

In relation to non-purchase order payments, TC will provide LC with information on any invoices over £50,000.

Action: Tony Cooper

AC/15/84 Losses and special payments report (agenda item 16)

The report was noted. The Committee agreed it would be helpful to record the date of incidents and when these are resolved.

Action: Rob Adamson

LC asked whether drug loss was included and AF responded that this was not necessarily the remit of this report; however, the Committee could receive a report on controls in place for the management of drugs at a future meeting.

Action: Bernie Cherriman-Sykes (for agenda)

AC/15/85 Items to report to Trust Board (agenda item 17)

These were agreed as:

- patient's property;
- data quality (current position, future monitoring, priorities) and assurance on data quality;
- caseload management.

AC/15/86 Date of next meeting (agenda item 18)

The next meeting will be held on Tuesday 2 February 2016 at 14:00 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield. The remaining dates for 2016 were agreed as:

Tuesday 5 April 14:00, Boardroom, Kendray, Barnsley;
Tuesday 12 July 14:00, Folly Hall, Huddersfield;
Tuesday 4 October 14:00, Folly Hall, Huddersfield.

There will be an additional meeting to consider the annual report and accounts, and Quality Accounts in May 2016, which will be confirmed when Monitor releases the dates for submission.

AC/15/87 Any other business (agenda item 19)

No further business was raised,

Minutes of Clinical Governance and Clinical Safety Committee held on 2 November 2015

Present:	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair of the Trust (Chair)
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Alan Davis	Director of Human Resources and Workforce Development
	Dawn Stephenson	Director of Corporate Development
Apologies:	Ian Black	Chair of the Trust
In attendance:	Nette Carder	Interim BDU Director, CAMHS and forensic services (to item 10)
	Bernie Cherriman-Sykes	Integrated Governance Manager (author)
	Rachel Court	Non-Executive Director
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	Dave Ramsay	Deputy Director Operations (item 9)

CG/15/76 Welcome, introduction and apologies (agenda item 1)

The Chair (JF) welcomed everyone to the meeting. She welcomed Rachel Court (RC) as part of her induction as a Non-Executive Director. The apology, as above, was noted.

CG/15/77 Minutes of the previous meeting held on 8 September 2015 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 8 September 2015.

CG/15/78 Matters arising (agenda item 3)

There was one matter arising.

CG/15/58 Quality impact assessment of cost improvement programme – Calderdale and Kirklees early intervention in psychosis (agenda item 3.1)

Tim Breedon (TB) updated the Committee on behalf of Karen Taylor (KT). As a result of revised national guidance on early intervention services, the efficiency saving now relates to a different management arrangement, which has been graded 'green'.

CG/15/79 Transformation – exception report (agenda item 4)

TB advised that, for future meetings, a high-level exception report on transformation would be presented similar to that presented to the Executive Management Team (EMT) and would include the top three risks highlighted on the transformation programme risk register.

Following the detailed update to Trust Board in September 2015, there were no further risks emerging to report to the Committee.

CG/15/80 Improving clinical information (agenda item 5)

TB explained that the paper provides assurance in relation to the work with staff, through 'trios', to improve the quality of clinical information. JF commented that practice at the front-line does not necessarily reflect the arrangements set out in the paper, which was acknowledged by TB. It was agreed to bring the outcome of the internal audit of the impact

of the improvement activity back to the Committee as well as the plan for implementation of improvement activity.

Action: Tim Breedon

JF also asked if there was an update on the adaption of RiO for child and adolescent mental health services (CAMHS). Nette Carder (NC) responded that there is flexibility within RiO version 7, which the Trust will utilise; however, no wholesale re-design is intended. She would be happy to talk to Bradford District Care NHS Foundation Trust regarding its experience. She added that the key is to ensure staff use RiO effectively.

Action: Nette Carder

The Committee also raised the issue of interoperability of systems. TB assured the Committee that a clear plan is in place although no-one underestimates the vastness of the task. He commented that accessibility of information is paramount so ensuring staff record information in the right place at the right time is vital for the effective implementation of the improvement plan.

CG/15/81 Pharmacy strategy – medicines management supply services (confidential agenda item 6)

Adrian Berry (ABe) explained the rationale for the proposal approved by the EMT, which will include work to look at the feasibility of a full in-house pharmacy service. He also highlighted the key issues and risks involved.

CG/15/82 Quality Accounts 2015/16 (agenda item 7)

Mike Doyle (MD) took the Committee through the 'red' and 'amber' rated areas and mitigating action the Trust is taking on the Quality Accounts dashboard, which was tabled.

Charlotte Dyson (CD) asked whether this is where the Trust would expect to be at this point in the year. TB responded that there are a couple of areas for concern as a downward trend is not what would have been expected. Further work is in train to understand the reasons for the current position and allow for action to be taken.

CG/15/83 Creating a smoke-free environment (agenda item 8)

ABe reported that the Trust is on track to be smoke-free by 1 December 2015.

CG/15/84 Child and adolescent mental health services (CAMHS) (agenda 9)

NC introduced this item and Dave Ramsay (DR), Deputy Director Operations and on secondment to CAMHS, took the Committee through the report.

CD commented that she was surprised at the number of 'red' areas reported in Wakefield. DR responded that this reinforced the important message that the Trust should not be complacent with performance in Wakefield and he provided assurance that both managing aggression and violence training, and appraisal will report as 'green' in the next period. NC added that the position shows the need to continue to monitor performance in Wakefield closely and to continue to review the management structure for CAMHS as a whole.

The Committee was appreciative of the demonstrable improvement, which was very much seen as a team effort.

TB confirmed that the 'deep dive' into CAMHS proposed by Kirklees Council was discussed by the Kirklees Safeguarding Board at its meeting in September 2015. It was agreed that it would be better to conduct such a review, which would cover all aspects of CAMHS not just Tier 3, in 2016 to support whole system CAMHS transformation. Terms of reference for the review would be further developed and the Trust will be involved in the process. NC added that this would fit with a peer review through the Quality Network for Community CAMHS, which is a Royal College of Psychiatrists sponsored members' network working with professionals from health, social services, education and the voluntary sector to improve the quality of CAMHS. As a member, the Trust is able to access a range of learning and development resources and a process of peer review. The Committee was keen, however, that staff are not overloaded with two review processes undertaken at the same time.

Alan Davis (AGD) added that it is important to ensure that services remain attractive to staff as more funding comes into the system and more employment opportunities begin to emerge. He also commented that the Trust must be mindful of its experience with the due diligence of the CAMHS when taking on new services, such as, forensic CAMHS.

In relation to recruitment to the post of BDU Director for Forensic and Specialist Services, AGD advised that formal interviews would take place on 23 November 2015, with initial interviews on 10 November 2015 and an assessment centre on 20 November 2015. There have been seventeen applications so far and he was confident that there would be a number of high-calibre candidates to go through to final interview. JF sought assurance around transition and handover. NC responded that she had committed to remain with the Trust until the end of December 2015 when a substantive appointment is made. She added that she has every confidence in the current arrangements in place, which will ensure the transition is effective.

CG/15/85 Horizon review (agenda 10)

TB introduced this item for KT. He reported positive progress against the turnaround plan although concerns remain and close supervision continues. There will be a full update to the meeting in February 2016.

Action: Karen Taylor

CD asked how the Trust will monitor the position and ensure this does not happen elsewhere. TB responded that there is continued review and assurance through 'mock' Care Quality Commission (CQC) visits, new leadership and management arrangements, particularly the introduction of practice governance coaches, and transformation work, which has clarified the focus and purpose of the service. AGD added that there is also triangulation with other indicators and intelligence, such as the staff wellbeing survey and HR key performance indicators, which are indicators of issues within a service or team.

TB also confirmed that the challenging individual remains within the service, which continues to provide significant pressure for, and impact on, the team; however, the clinical team remains committed to the provision of the least restrictive solution.

CG/15/86 Emergency planning review of IT virus incident (agenda 11)

AGD reported that:

- an initial stocktake has been undertaken, which found that business continuity plans were effective; however, there are a number of lessons to be learnt, particularly in relation to the duration of an incident;

- a formal report from the experience of the incident within BDUs has been prepared, which will be reviewed;
- a business continuity exercise for Extended EMT on 26 November 2015 will use the IT virus and the recent incident at Mount Vernon as examples for learning.

He will bring a formal report and action plan to the Committee in February 2016.

Action: Alan Davis

CG/15/87 Clinical audit and practice effectiveness – progress report (agenda item 12)

The report and progress against the plan were noted.

CG/15/88 Care Quality Commission (agenda item 13)

Care Quality Commission – preparation for the inspection visit (agenda item 13.1)

TB provided an update for the Committee and he will provide a detailed summary of the position at the February 2016 meeting. CD asked whether Trust Board would also continue to get updates through Trust Board reporting and TB confirmed this would be the case.

Action: Tim Breedon

Care Quality Commission Mental Health Act visits – clinical and environmental (agenda item 13.2)

Clinical issues

The report was noted.

Environmental issues

AGD advised that pre-PLACE (patient-led assessment of the care environment) audits will be undertaken during November 2015.

CG/15/89 Nurse re-validation (agenda item 14)

MD confirmed that nurse re-validation will be introduced from 1 April 2016. The Trust has an action plan in place and there is relative confidence that it can be implemented effectively. JF commented that the report presented to the Committee was excellent and she had one question in relation to whether the Trust is clear what it will do if staff are not re-validated, which she asked MD to bring back to the next meeting.

Action: Mike Doyle

CG/15/90 Exceptional case update (agenda item 15)

ABe reported that the individual remains in Newton Lodge. A placement was identified but the offer withdrawn by the provider as the CCG refused to fund the care package. The CCG is now seeking an alternative provider. CD asked who was funding the Trust's provision and ABe responded that the Trust has a separate contract with commissioners to provide the package of care.

CG/15/91 Incident management (agenda item 16)

Incident management report update on 2014/15 annual report and current position at Q2 2015/16 (agenda item 16.1)

TB confirmed that the report contained an update on the issues raised at a previous meeting and during consideration of the annual report in June 2015 as well as additional information on incidents in Kirklees. He also reported a review of the investigation process in light of

new guidance and to ensure Trust arrangements continue to reflect best practice. He added that the suicide prevention strategy is currently out for consultation.

CD asked for assurance of learning between teams and BDUs. TB responded that the Trust has systems and processes in place to facilitate and foster learning but there are a number of other areas identified, which will be implemented.

JF was concerned at the level of increase in suspected and actual suicides. MD responded that, from analysis of incidents, there are no obvious trends or root causes and this is a key theme within the West Yorkshire emergency and urgent care Vanguard programme. JF asked for the trend to be closely monitored and for the Trust to review whether there was any further action it could take.

Action: Tim Breedon/Mike Doyle

CG/15/92 Sub-groups – exception reporting (agenda item 17)

Drugs and therapeutics (agenda item 17.1)
The report was noted.

Health and safety (agenda item 17.2)
The report was noted.

Infection Prevention and Control (agenda item 17.3)
The report was noted.

Safeguarding (agenda item 17.4)
TB commented on the continued monitoring and review of training for adult safeguarding. MD reported that a challenge event was held in Kirklees, which looked at the arrangements in place within agencies with responsibilities for safeguarding children. The Trust was scored highest of the twelve agencies that attended the event, providing assurance of the arrangements in place.

Managing aggression and violence (agenda item 17.5)
TB commented on the continued focus on incidences of prone restraint and the implementation of a revised seclusion policy.

CG/15/93 Annual reports (agenda item 18)

Managing aggression and violence (agenda item 18.1)
Further to the discussion during the previous item, TB and ABe explained the Trust's approach to prone restraint.

MD took the Committee through the highlights from the annual report. He commented that training attendance has improved and staff on in-patient wards are prioritised. AGD added that the Trust is developing a risk-based approach to mandatory training to ensure the focus is where it should be. The Committee asked that disciplinary issues in relation to managing aggression and violence, such as inappropriate restraint, are incorporated into reporting.

Action: Mike Doyle

JF suggested that Trust Board should undertake some form of managing aggression and violence training and TB suggested that level 1 would be an appropriate level. MD agreed to take forward.

Action: Mike Doyle

NICE (agenda item 18.2)
MD took the Committee through the key points.

JF asked how the Committee scrutinises the implementation of NICE guidance. MD responded that this would be through the NICE annual report and two further reports received each year. JF went on to ask how the Trust demonstrates whether implementation is effective. TB responded that this would be through clinical audit activity and lessons learned, Trust self-assessment and NICE audit activity. JF asked TB and MD to confirm when the routine report will come to the Committee.

Action: Tim Breedon/Mike Doyle

CG/15/94 Issues and items to bring to the attention of Trust Board (agenda item 19)

Issues were identified as:

- managing aggression and violence training for Trust Board;
- concern regarding the rising trend of suspected and actual suicides although the Trust's positive work in this area was noted;
- challenge event in Kirklees for safeguarding children arrangements within the Trust; and
- nurse re-validation.

It was agreed the JF would also raise CAMHS reporting and suggest to Trust Board that it is reviewed after its meeting in December 2015 with ongoing reporting through the Committee.

CG/15/95 Date of next meeting (agenda item 20)

The next Committee meeting will be held on Tuesday 23 February 2016 at 14:00 in rooms 49/50, Folly Hall, Huddersfield. The remaining meeting dates for 2016 were agreed as follows. All are on a Tuesday, starting at 14:00 and finishing at 17:00.

- 19 April (rooms 49/50, Folly Hall, Huddersfield);
- 14 June (Langsett room, Kendray, Barnsley);
- 13 September (training room 5, Learning and Development Centre, Fieldhead, Wakefield); and
- 8 November (rooms 49/50, Folly Hall, Huddersfield)

There will also be an additional meeting in May 2016 to approve the Quality Accounts as part of the annual reporting process.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Mental Health Act Committee Meeting held on 10 November 2015

Present:	Julie Fox	Deputy Chair (Chair)
	Jonathan Jones	Non-Executive Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
Apologies:	**Members**	
	Chris Jones	Non-Executive Director
	Adrian Berry	Medical Director
	Attendees	
	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
In attendance:	Julie Carr	Clinical Legislation Manager
	Bernie Cherriman-Sykes	Board Secretary (author)
	Alwyn Davies	Lead Professional, Safeguarding Adults, Barnsley Hospital NHS Foundation Trust – acute trust representative
	Charlotte Dyson	Non-Executive Director
	Yvonne French	Assistant Director, Legal Services
	Mike Garnham	Health Intelligence Analyst (item 10)
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Lorraine Jeffrey	Independent Associate Hospital Manager
	April Ramsden	Approved Mental Health Practitioner, Kirklees
	Stephen Thomas	MCA/MHA Team Manager (Wakefield) – local authority representative
	Farhat Uzair	Consultant Psychiatrist, Dewsbury (item 2)

MHAC/15/43 Welcome, introduction and apologies (agenda item 1)

Julie Fox (JF) welcomed everyone to the meeting. The apologies, as above, were noted.

MHAC/15/44 The Act in practice (agenda item 2)

In-depth audit of pathway leading to Mental Health Act admissions in Kirklees (agenda item 2.1)

Dawn Stephenson (DS) explained the background to the audit, the aims, methodology and key findings. She advised the Committee that, from the small sample size, it was not possible to come to definitive conclusions based on the outcomes; however, a number of recommendations could be made as a result.

1. There should be targeted promotion of mental health issues and the Trust's service offer through a range of different forums with the aim of reducing stigma, supporting access to services through signposting and information, and aiming to reduce crisis admissions with earlier presentation to services.
2. Focused educational 'Insight' events into mental health in general should be held in BME communities with the aim of improving engagement with mental health services.
3. Explore opportunities offered through Creative Minds and Recovery Colleges to ensure both foster equality of opportunity for BME communities and co-produce culturally appropriate courses.

4. Present the findings and recommendations from the audit to the Trust's Patient Experience Group and produce an action plan linked to the Trust's transformation programme and establishment of community hubs with delivery supported by the Trust's Partnership Team and BDU leadership and management teams.
5. Undertake further audit work, refining the audit methodology, to focus on discharge and targeting service users and carers after discharge.
6. Triangulate the findings from service user feedback on staff attitude with other feedback, such as complaints and the Friends and Family Test, and take actions forward with appropriate Practice Governance Coaches.

Alwyn Davies (AD) asked if there were any providers in the Trust's area delivering services primarily for BME communities. Whilst there are a number of community groups providing services, none were thought to be ethnicity specific.

Charlotte Dyson (CD) commented that the Trust must ensure it uses appropriate language and tone to target different communities. JF suggested use of volunteers or short-term appointments to support information sharing and promotion of Trust services. Jonathan Jones (JJ) suggested linking this with the work of the Equality and Inclusion Forum and he would see rigour in terms of testing through ongoing audit.

It was agreed that DS would provide an update to the Committee within twelve months, consider a re-audit and the timescale for this, and to provide a brief report to the Equality and Inclusion Forum. It was also suggested that this would be a useful item for the Members' Council to receive.

Action: Dawn Stephenson

MHAC/15/45 Legal update/horizon scanning (agenda item 3)

Mental Capacity Act and Deprivation of Liberty Standards consultation – Trust response
The Trust's response was noted.

Deprivation of Liberty Standards annual report
The analysis of national returns was noted.

MHAC/15/46 Minutes from the previous meeting held on 4 August 2015 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 4 August 2015. The Committee also RESOLVED to APPROVE the minutes from the meeting held on 5 May 2015.

MHAC/15/47 Matters arising from previous meeting (agenda item 5)

The updates contained in the action point list were noted. There were five matters arising.

MHAC/15/24 Use of S136 suites
The tabled paper was noted. The Committee asked for a further review in terms of the difference in usage and outcomes between districts with a report to come back to the next meeting, which will also demonstrate links to the Crisis Concordat.

Action: Tim Breedon

Anne Howgate (AH) reported an increase in Kirklees, particularly North Kirklees, in usage of police cells for S136 detention. TB agreed to discuss further with AH.

Action: Tim Breedon

MHAC/15/36 S132 audit update
The Committee noted the progress against the action plan for the audit.

MHAC/15/37 RiO and SystmOne integration
TB will ask Adrian Berry (ABe) to circulate an update on physical health monitoring through integration of RiO and SystmOne.

Action: Tim Breedon (for Adrian Berry)

MHAC/15/38 Ethnic group classifications
The information was noted.

MHAC/15/39 Care Quality Commission review of crisis services in Barnsley
JF asked that the Committee's appreciation of the outcome of the CQC review be passed on to staff.

Action: Tim Breedon

MHAC/15/48 Compliance and assurance (agenda item 6)

Mental Health Act Committee annual report to Trust Board (agenda item 6.1)
To be taken in February 2016.

Annual review of Independent Associate Hospital Managers' functions
The review was noted and **it was RESOLVED to APPROVE the appointment of eight new Independent Associate Hospital Managers.** The Committee noted the declaration of interest from JF in relation to her daughter's appointment as a Hospital Manager. JF took no part in the appointment process and the matter has already been reported to Trust Board.

The outcome of the Hospital Managers' reviews will be presented to the next meeting of the Hospital Managers' Forum.

Action: Yvonne French

MHAC/15/49 Transformation update (agenda item 7)

There were no further issues arising from transformation activity that would impact on the Trust's use of the Mental Health Act. It was agreed to retain this item on the Committee's agenda.

Action: Tim Breedon

MHAC/15/50 Audit and compliance reports (agenda item 8)

Understanding and interpreting trends with ethnic diversity re-audit in Wakefield (agenda item 8.1)
The Committee noted the report.

Yvonne French (YF) reported that two audits due to be presented to the Committee at this meeting were delayed due to administration difficulties and the data not collected. Both will come back to the Committee at the next meeting.

Action: Yvonne French

MHAC/15/51 – Care Quality Commission Visits (agenda item 9)

Recent visits (agenda item 9.1)
The ten monitoring visits to Ward 19, Priestley Unit, Dewsbury (20 May 2013), Enfield Down, Huddersfield (28 May 2015), Fox View, Dewsbury (27 July 2015), Trinity 2, Fieldhead,

Wakefield (12 August 2015), Ward 19, Priestley Unit, Dewsbury (14 August 2015), Melton Suite, Kendray, Barnsley (18 August 2015), Priory 2, Fieldhead, Wakefield (25 August 2015), Horizon Centre, Fieldhead, Wakefield (1 September 2015), Sandal, Bretton Centre, Fieldhead, Wakefield (23 September 2015) and Ashdale, The Dales, Halifax (28 September 2015) were noted.

Outstanding actions/progress report (agenda item 9.2)
Environmental issues
The Committee asked for an update on the action in relation to cleaning on Trinity 2 at the next meeting.

Action: Yvonne French (Alan Davis)

TB commented that, as part of the planning for the CQC inspection visit, the timescales for the patient-led assessments of the care environment (PLACE) on in-patient wards have been reviewed and it was agreed a report should come to the next meeting.

Action: Tim Breedon (Alan Davis)

Clinical issues
JF commented that she would like to see 'evidence' that actions such as policy implementation and dissemination to staff have been effective, backed up by some form of audit activity. The Committee was happy for a brief summary to be included in the report to demonstrate compliance. TB pointed out that there may be a difference between action agreed with the CQC (such as, develop a policy) and the evidence the Committee is seeking that action is effective.

Action: Yvonne French

YF took note of the areas where the Committee agreed more evidence and information is required and the recommendations should remain 'amber'.

JF also commented that there are recurring themes coming from the reports in relation to patients' rights, capacity, physical healthcare, involvement in care planning and clinical record keeping.

MHAC/15/52 Monitoring Information (agenda item 10)

Review of monitoring information
As requested by the Committee, Mike Garnham (MG) provided a summary of a review of the monitoring information received by the Committee, which it was agreed was particularly helpful. TB commented that the Committee should be mindful that the purpose of the information presented to it is to provide assurance that the Trust is using the Mental Health Act appropriately and the information should reflect this.

It was agreed that benchmarking and trend analysis would be useful, both internally and externally, with a statistical analysis and commentary on trends. CD commented that she would like to see simplification of how the information is presented and what key messages can be drawn from the information.

JF suggested that any changes would be more of a refinement of the current information given the hard work that has already gone into developing the monitoring information. She suggested setting up a task and finish group led by Diane Smith, Director of Health Intelligence and Innovation, and involving a Non-Executive Director, TB, ABe, Mike Garnham, a member of YF's team and a representative from the Hospital Managers' Forum.

Action: Tim Breedon

It was agreed that the group should also include local authority monitoring information as part of its remit and that Mike Garnham and AH should have an initial discussion.

Action: Anne Howgate

Monitoring information Trust-wide July to September 2015 (agenda item 10.1)
JF commented that "not known" under ethnicity remains high. It was noted that RiO V7 should address this and an improvement should be seen in quarter 4 reporting.

Local authority information (agenda item 10.2)
AH reported that there are still issues with full recording and she alerted the Committee to difficulties in accessing doctors, which was generally thought to be due to work pressures. TB agreed to follow this up with ABe.

Action: Tim Breedon

AH also reported on the re-modelling of the Approved Mental Health Practitioner service in tandem with the Trust's transformation work. Kirklees Council is working with the Trust to implement the changes.

Stephen Thomas (ST) commented on the continued increase in referrals, reduction in out-of-area treatment and some instances of premature use of the Mental Health Act.

Hospital Managers' Forum 18 August 2015 (agenda item 10.3)
The Forum notes from August 2015 were noted.

JF advised that she had agreed to raise an issue around social circumstances reports with local authority leads at this meeting. It was confirmed that these are prepared by a service user's care co-ordinator. The concern for Hospital Managers is the lack of information in such reports for a decision to be made if the care co-ordinator does not attend the hearing. Lorraine Jeffrey (LJ) agreed to seek further information at the next Forum meeting on 23 November 2015 as she was not entirely sure how wide an issue this actually is for Hospital Managers.

Lorraine Jeffrey

Compliments/complaints/concerns in relation to the Mental Health Act July to September 2015 (agenda item 10.4)
There were none to report.

Trust complaints report in relation to the Mental Health Act July to September 2015 (agenda item 10.5)
The report was noted.

MHAC/15/53 Partner agency update (agenda item 11)

Local authority (agenda item 11.1)
No further items were raised.

Acute health care (agenda item 11.2)
Alwyn Davies (AD) commented on the CQC inspection at Barnsley Hospital NHS Foundation Trust in July 2015. The focus was on safety, the Mental Capacity Act and safeguarding. The CQC also took note of staff comments and views. He suggested that the Trust might want to consider ensuring staff know who can respond to questions if they are unable to.

MHAC/15/54 Key messages for Trust Board (agenda item 12)

The key issues to report to Trust Board were agreed as:

- the in-depth audit of pathway leading to Mental Health Act admissions in Kirklees; and
- the use of S136 suites and the further review requested.

MHAC/15/55 Date of next meeting (agenda item 13)

The next meeting is due to be held on Tuesday 8 March 2016. It was agreed this would be discussed by the Executive Management Team as it would be during the CQC visit.

Action: Tim Breedon

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Minutes of the Remuneration and Terms of Service Committee held on 17 November 2015

Present:	Ian Black	Chair of the Trust (Chair)
	Rachel Court	Non-Executive Director
	Jonathan Jones	Non-Executive Director (by phone)
	Steven Michael	Chief Executive
Apologies:	None	
In attendance:	Alan Davis	Director of Human Resources and Workforce Development
	Bernie Cherriman-Sykes	Integrated Governance Manager

RTSC/15/52 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. There were no apologies.

RTSC/15/53 Minutes of the previous meetings (agenda item 2)

It was RESOLVED to APPROVE the minutes from the previous meeting held on 13 October 2015.

RTSC/15/54 Matters arising from the meeting on 13 October 2015 (agenda item 3)

RTSC/15/41 Clinical Excellence Awards (13 July 2015)

Alan Davis (AGD) reported that the first round of assessments under the new arrangements is underway and a further update will be provided at the next meeting.

Action: Alan Davis

IB reported that Charlotte Dyson is a lay member of Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee and he thought a discussion might be useful for future development of the scheme, comparison and benchmarking.

Action: Chair/Alan Davis

IB asked if there was an intention to introduce a similar arrangement for nursing staff. AGD responded that there are other ways for nursing staff to receive recognition and reward through, for example, professional development and career progression.

RTSC/15/43 Living wage (13 July 2015)

AGD confirmed that the Trust has implemented the living wage with a commitment to implement increases on 1 April each year. He also reported that KPMG has offered support, free of charge, to look at establishing a commitment for the Trust to work only with contractors and suppliers who also implement the living wage.

RTSC/15/48 Succession/talent planning (13 October 2015)

AGD reported that meetings will be arranged with all Directors to review potential at Director level and second tier to build a detailed picture. This will be extended to general management and clinical leads level. It was agreed to have a more detailed discussion at the next meeting.

Action: Alan Davis

RTSC/15/55 Appointment of Executive Directors (agenda item 4)

AGD confirmed there had been a further discussion with Harvey Nash on the timetable for the recruitment process following the comments made at Trust Board in October 2015. The view was that the Trust should continue with the planned timetable for the Chief Executive role with final interviews taking place in the week commencing 8 February 2016. For the Director of Finance role, IB was clear that the new Chief Executive must be involved in shortlisting and interviews, and he wanted to avoid the week of the Care Quality Commission inspection.

Rachel Court (RC) asked whether a month was really needed to agree the longlist for the Chief Executive's post and whether this provided any flexibility. AGD responded that it could be brought forward; however, it would not make much difference to the timing of the final interviews. IB asked that the interview date for the Chief Executive's post is agreed this week.

Action: Alan Davis

In terms of the panel, it was agreed that IB would chair the panel with an external assessor, a representative from the Members' Council (Lead Governor suggested), another Non-Executive Director, a senior clinical representative and a Director from a clinical commissioning group. The formal interviews will be supported by an assessment centre involving both staff, service users and carers, clinicians and partner agencies. It was also suggested that an opportunity to meet other members of Trust Board in a more informal setting might also be included as part of the process. This broader process was supported by the Committee.

The Chief Executive (SM) confirmed that he remains the appointing officer for the Director of Finance and the appointment must not extend beyond the end of the week commencing 14 March 2016.

IB and AGD reported that there has been an healthy interest in both roles and they are receiving fortnightly reports from Harvey Nash on both posts.

Interim Director of Finance

By the end of Thursday, five candidates will have been seen by the Chair and Chief Executive. Three were locally sourced and two are interims sourced through Odgers and Green Park. A decision will be made this week.

RTSC/15/56 Directors' remuneration (agenda item 5)

The Committee was supportive of the approach outlined.

RTSC/15/57 Staff engagement key performance indicators (agenda item 6)

AGD reminded the Committee that it had agreed that engagement, including staff engagement, should be a gateway objective as part of the Directors' performance related pay scheme. The paper circulated took a first look at how this could be represented by measurable key performance indicators in terms of motivation (people results), advocacy (customer results) and involvement (society results).

RC commented that she felt what was missing from the paper was consideration of how staff engage with the strategy of the organisation, their understanding and their buy-in, particularly given the outcome of the well-led review. AGD agreed to discuss with Robertson Cooper in terms of the well-being survey.

Action: Alan Davis

RC added that she would also like to see any developments aligned with revised Board reporting. Jonathan Jones (JJ) felt it was a good paper that supported the direction of travel. **The Committee was supportive of continued development.**

RTSC/15/58 Any other business (agenda item 5)

Changes to pension arrangements

It was agreed to discuss the introduction of a single state pension, its implications for the Trust's budget and finances, and the impact on staff.

Action: Alan Davis

RTSC/15/59 Date of next meeting

The next meeting will be held on Tuesday 16 February 2016 at 14:00 in the Chair's office, Block 7, Fieldhead, Wakefield. It was agreed that, as this meeting will be after the appointment of the Chief Executive, Non-Executive Directors on the Committee should meet after each Trust Board with AGD for an informal update.

Action: Chair

Trust Board 22 December 2015
Agenda item 6

Title:	**Transformation Programme Update**
Paper prepared by:	Deputy Chief Executive/Director of Finance
Purpose:	For Trust Board to note the progress with the Transformation Programme, including updates on key reconfigurations.
Mission/values:	The Transformation Programme is one of the ways in which the Trust is ensuring its services are 'fit for today and ready for tomorrow'. Within this context, one of the themes of the Programme is a movement towards a broader, system wide enabling role for many services, in line with the Trust's Mission.
Any background papers/ previously considered by:	Trust Board report June 2015 – Strategic Intent by Service Line Trust Board report September 2015 – Transformation Programme Update
Executive summary:	The purpose of the report is to provide an update on the progress of the Transformation Programme. The report covers each of the following work streams and projects, plus specific updates on service and estate reconfigurations as listed below: • Mental Health Work Stream, incorporating o Acute and Community Mental Health o Rehab and Recovery, incorporating an update on Castle Lodge o Older Peoples Mental Health, incorporating an update on Savile Park View • Learning Disabilities Work Stream, incorporating an update on Fox View and the Horizon Centre • General Community Work Stream, incorporating o Community Nursing and Long Term Conditions o Therapies o Administration Review **Key Messages:** • Mental Health Acute and Community Workstream – the 4-tier model has been translated into a workforce model across all BDUs. This is currently being evaluated for clinical and operational alignment and use of resources. The plan is to be able to generate the benefits realisation metrics and start consultation with staff in January 2016. • Rehab and Recovery – all service users who are in Trust inpatient facilities have been assessed to determine what a suitable package of care would be using the revised model which has less emphasis on inpatient beds and more on enabling people to live in their community. Whilst the principles of the new model for rehab and recovery are generally accepted by commissioners, the detail of the impact on what service are actually commissioned and the consequent funds flow is still being worked through. The need for commissioners to have a joined up

	approach on their commissioning of beds to avoid increasing clinical risks has been escalated to the Partnership Board for the West Yorkshire CCGs. • Older people – whilst this workstream is still at a relatively early stage, there are some early adopter changes in relation to the redesign of services in Wakefield. This will mean that the care which is provided by a bedded unit at Savile Park will be provided in the community. The Trust is working through the governance process for transferring services into the community and the resulting closure of the unit with the CCG and Overview and Scrutiny Committee. The Trust has also commissioned a review by Meridian which is an 18-week programme to review the clinical processes and productivity within inpatient and community services for older people. This has generated support from staff and is due to report on the efficiency and productivity opportunities from mid-January 2016. • Learning Disabilities – the new model of service has been approved by Commissioners. The Trust is currently in negotiations to determine the contracting approach and currency for inpatient and community services. Internally, the consultation with staff on the new model and impact on workforce commenced in November 2015 and is due to close by 31 December 2015. • Community Services – progress is on track for developing and implementing Therapy Admin hubs with some savings realised as at December 2015. The approach to transformation includes requirement of 5% CIP per service line. In order to support this work, the Executive Management Team has approved the engagement of Meridian in a review of community services to identify further opportunities for productivity and efficiency. The report will continue to be developed to incorporate appropriate metrics on benefits realisation and dashboards to report progress.
Recommendation:	**Trust Board is asked to note and raise any issues for clarification.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Transformation Programme

Update on progress and current position

Public Session – 22nd December 2015

Programme Management Office

Table of Contents

Section One – Aims and Scope of Report

This report provides an update on each of the Trust's current transformation projects. It is structured to offer;

- a reminder of the scope, purpose & intent of each project;
- the progress made to date;
- the intended benefits of the project for service users and impact on the financial position;
- Commentary on the next steps including significant risks and issues that are being addressed.
- It includes comments from the lead director for each scheme.

Additionally this report incorporates updates on key estates developments that are linked to these transformation projects;

- Savile Park View is covered in the Older People's Mental Health project update
- Castle Lodge is covered in the Rehabilitation & Recovery project update
- The Horizon Centre and Fox View are covered in the Learning Disabilities project update

Section Two – Mental Health Work Stream

The Trust's Mental Health Work Stream is led by Karen Taylor and guided by a Mental Health Transformation Board including the Medical Director. It consists of three major projects, including the Acute and Community Mental Health project which is significant in terms of its size and scope.

2.1 Acute and Community Mental Health

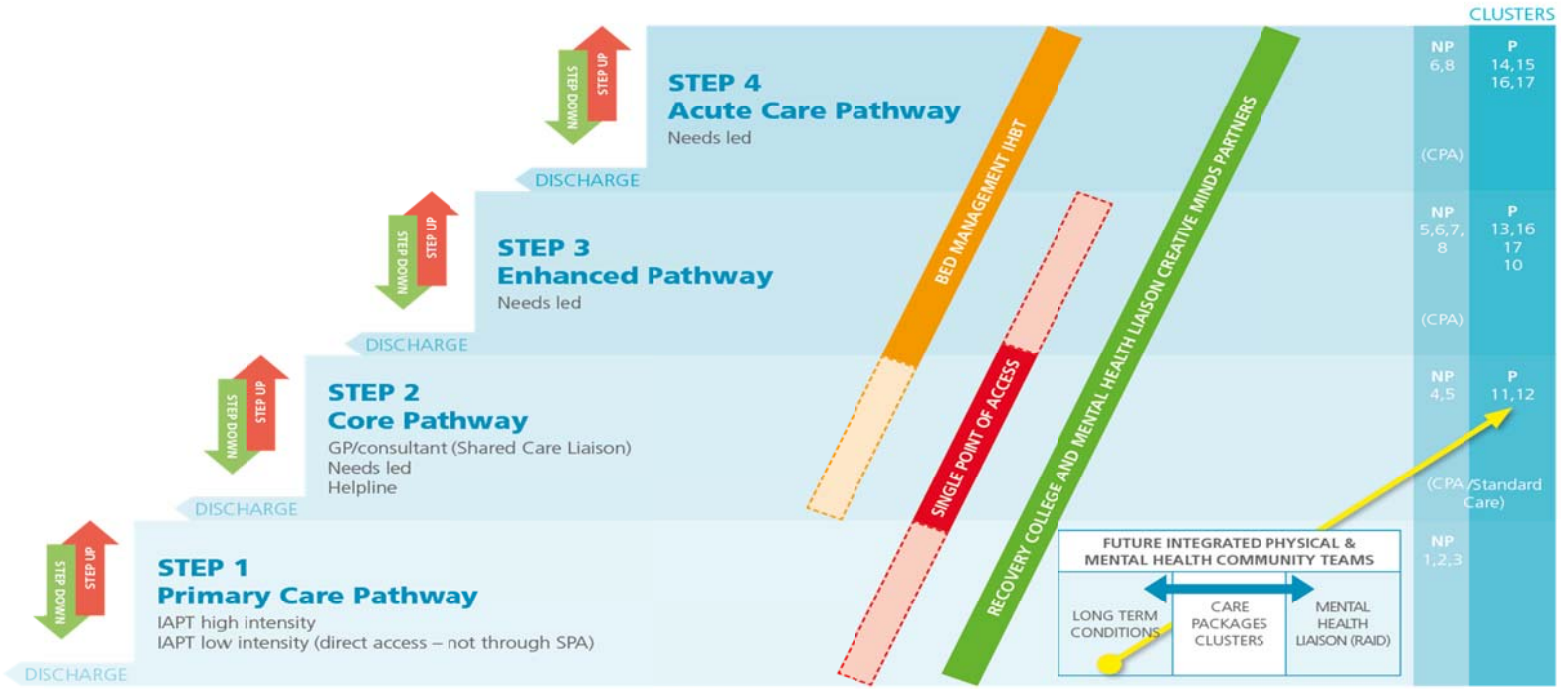
The aim of this project is to support achievement of the Trust's vision by providing mental health services that are;

- Safe and person centred
- Encourage greater control for individuals
- Emphasise recovery and positive outcomes

Therefore the project is redesigning services to deliver care to services users in a more effective and efficient way, in order to;

- Improve quality at reduced cost
- Increase links to alternative community based services, promoting partnership working
- Optimise the use of technology
- Use evidence based best practice

The redesign of services is aligned to a stepped care model described in the following graphic;



2.1.1 The Case for Change

In developing the stepped care model the project has listened carefully to people who use our services, people who work in our services, and people who we work alongside in the health and care system such as GPs. Although they told They have told us;

Service Users

- Sometimes it can feel slow to respond and or inflexible in approach
- Where specialist help is needed, I'd like faster access. Some with complex needs e.g. PD feel their needs not always met
- I value continuity of care, and sometimes this hasn't been possible

- Care Plans are best when co-produced and shared, but this doesn't always happen
- There are opportunities to reduce repetition of assessments
- There are opportunities to reduce the hand-offs within services
- Signposting to other help in and outside the Trust could be clearer and more consistent
- Sometimes people have been admitted where a less restrictive option could be made available
- People currently have a 70% chance of being admitted to their own locality, which means there is room for improvement
- Discharge planning from point of admission

Staff

- High level of referrals and 50-60% of time spent on referrals which do not progress beyond assessment
- Full caseloads can feel overwhelmed, limiting ability to support people moving on
- Acute Pathway would welcome greater continuity with care coordinators in decision making and discharge planning
- Acute system running hot

GPs

- Standard access times seem arbitrary
- In some areas would like more access to crisis teams
- Discharge communication could be improved
- Would like more direct contact with clinicians
- Sometimes unclear why referrals rejected – more communication

2.1.2 Progress to date

- Reviewed existing service provision
- Listened to partners, service users and carers and reviewed past engagement
- Staff engagement at micro and meso levels
- Designed a new model which improves access to our services
- Agreed Standards and Principles for the new model and used these to inform development of Standard Operating Procedures
- Developed and signed off Standard Operating Procedure documents
- Developed generic job descriptions
- Established an outline staff consultation document
- Established a document set for Overview and Scrutiny use

2.1.3 Next Steps

- Completion of staff consultation document
- Development and finalisation of new workforce structures
- Financial costing of current and proposed models to evidence cost savings
- Engagement of staff-side and social care colleagues prior to the start of formal consultation
- Longer term model (workforce for 17/18) and OD plan to be agreed based on refined caseload and new ways of working
- Formal staff engagement throughout consultation process
- Further staff engagement March – April onwards during implementation
- Project fully implemented through Spring / Summer 2016
- Questionnaire devised for 6mth post-implementation to ask staff how service has changed – ensure change is embedded and gather feedback to improve future transformation processes
- Questionnaire repeated at 12mth post-implementation – also include GPs at this stage to gather their views on changes

2.1.4 What will this mean for service users

- People will be able to access our services easily and, where required, services will be available 24hrs a day and there will be one phone number to access services
- Understanding of service user needs at initial assessment and appropriate signposting
- Focus on recovery
- Service users will be engaged as experts in their own mental health, putting them in charge of the care they get
- Intensive support for the most unwell people in their own homes
- Urgent response within four hours
- Face-to-face assessment for everyone before going to hospital
- Daily multiple visits if needed
- More people leaving hospital at the right time and support after leaving hospital
- Fewer people going outside their local area for care

2.1.5 What will this mean for Trust finances

- Trend towards continued expenditure on Out of Area placements will continue. In 2013/14 the Trust spent £1.3m; in 2014/15 £0.7m, and in the first five months of 2015/16 £0.1m
- Workforce re-modelling is underway aiming for a 5% reduction overall, which would save £1.4m per annum. Currently testing the impact of full implementation on quality, effectiveness and safety.

2.1.6 What will this mean for staff

- The new model means that the focus and style of working will change for many people. This will enable staff to spend more time with service users and to work innovatively and flexibly to address the changing individual needs of service users. There will be greater emphasis on relationships with other agencies and enabling them to effectively support people.
- The overall number of WTE in community mental health and SPA teams (the services in scope) is 477. The current spend on services in scope is around £30m
- Some roles will change and there will be changes to the number of posts required in some areas. Therefore the project team and all the BDU leadership Trios are working to ensure staff feel supported. So far, there have been numerous local staff engagement events and a formal consultation will happen before any changes are made. Through the consultation the will be opportunities for staff to have Q&A sessions with BDU management teams and 1 to 1 discussions with managers.

2.1.7 Addressing risks and issues

Currently the project team is actively addressing the following risks and issues;

Risks and Issues	Treatment / Mitigation
16/17 workforce models are based on existing caseloads which are not yet fully cleansed, meaning that the scale of opportunity may be underestimated	Assumptions will need to be made about future workforce based on best knowledge available. The model will then be revisited when caseload cleansing is complete.
Current projections indicate that changes proposed are likely to fall short of 5% cost saving in some BDUs.	BDUs will support each other in constructive challenge and benchmarking to identify further opportunities. Potential for delay in staff consultation.
Medical workforce agreement still being sought – under consideration by the Medical Director.	Project clinical lead working with relevant Trios; Medical Director assisting in resolution where required
Risk of challenges to initial workforce differences between BDUs.	Professional leads have been included in detailed design meetings; getting the longer term model right should give assurance that short term differences are acceptable.
Challenges in agreeing a longer term model with new ways of working.	Consideration needs to be given to the process to establish a consistent future workforce model that will give EMT and the board the required assurance.

2.1.8 Lead Director Commentary

From the onset this transformation project has been a challenging process, particularly as we were seeking to move from a position where there was no consistency in service delivery across the organisation, to one whereby we will seek to implement changes that support best practice across the Trust.

Progress has been made as identified in this report and we are in a position where we can begin to implement the required changes but as already also identified further changes will be necessary in the following 2 to 3 years to enable us to fully implement and sustain the agreed changes across the organisation.

2.2 Rehabilitation and Recovery

This project aims to ensure the Trust's rehab and recovery services support people needing longer term rehabilitation support as part of their recovery to live in their own community as far as possible. Where specialist in-patient facilities are required these should be clearly focused on recovery and as close to hoem as can be achieved within efficiency and quality parameters.

2.2.1 Case for Change

- A review of rehab and recovery services in 2014 looked at the service delivered across the Trust's inpatient units and found that they shared common issues which impacted on their ability to deliver an effective rehabilitation service.
- It found a huge variation in levels of need and acuity within inpatient units ranging from respite through to acute step down and long term care. This has been a major challenge for units trying to deliver effective outcomes for all service users.
- The service user mix and the suitability of estate in each area has also hindered the flow of service users moving from out of area placements back to their local area and into the community.
- The project recognised the need to identify potential for reducing in-patient provision and maximising capacity for supporting people in their own tenancies; and improving patient/service user flow within the pathway

2.2.2 Progress to date

- Reviewed existing service provision
- The agreed community model will establish an Intensive Community Rehab Support Service to be integrated within existing community teams in the Enhanced Pathway. The function would be to deliver intensive rehabilitation support for people in their own tenancies over and above that delivered by health and social care at present in the community.
- As an interim step it has been proposed that the trust's three existing rehab inpatient units could be consolidated into one building, resulting in a reduction in the scale or inpatient provision from 56 to 20 beds, accompanied by a commensurate increased investment in community rehabilitation support to enable more people to live independently.
- The purpose of this interim plan is to take account of all the local challenges and provide a holding position, from which we can offer (and demonstrate) a transitional phase where care is improved consistently across BDUs. This is to be followed by continued progress toward delivery of a common integrated pathway.
- In support of this plan profiling work has been undertaken in Calderdale and Kirklees to establish options for the current cohort of people in Lyndhurst and Enfield Down. There is an expectation of implementation of a new model in 2016/17.

2.2.3 Castle Lodge Update

- Good progress has been made in Wakefield and as of 7 December, the final person has been discharged from Castle Lodge
- Closure of Castle Lodge will proceed when formal processes including overview and scrutiny are complete
- Discussions to date have indicated that overview and scrutiny committees are reasonably comfortable with the proposed direction of travel.
- Further progress to establish how the savings will be reinvested will require alignment of commissioner positions.

2.2.4 Addressing risks and issues

Currently the project team is actively addressing the following risks and issues;

Risks and Issues	Treatment / Mitigation
A risk has been identified in relation to whether the Trust can provide a comprehensive, safe and efficient rehab service based upon a standalone locality model - or does a more corporate solution need to be found across the three BDU' s that are in scope for the interim business plan. CCGs have expressed strong preferences for local (rather than Trust-wide) solutions. This may have the unintended consequence of small standalone rehab units lacking viability, thereby increasing reliance on out of area solutions The project has not yet been able to find appropriate clinical leadership.	Executive level discussions planned with CCGs regarding the future shape of specialist rehabilitation services to ensure all stakeholders are aware of the impact that local decisions could have on the provision of services across the SWYPFT footprint. Senior clinical representatives similarly to discuss the same issues. Resolution of these matters will provide the clarity required to enable SWYPFT to continue with the transformation of trust provided inpatient rehabilitation services in a comprehensive, safe and efficient way. EMT members are considering options for clinical leadership of this work stream and how it can be strengthened in line with the agreed principles which support service transformation.

2.2.5 What will this mean for service users

- Added choice of a local community based rehabilitation service
- Improved experience for Service Users and Carers
- Reduced need for inpatient rehabilitation placements.
- Reduced duration of stay for people in inpatient rehabilitation placements
- Increased choice and control for Service Users
- More people able to return to their communities from out of area placements
- Contribution to the development of the health and social care infrastructure and social capital locally
- More people able to experience safe and effective rehabilitation as close to their home as possible and to connect people within their local community

2.2.6 What will this mean for staff

- The community reinvestment provides opportunities for some Healthcare Assistants to work as OT Assistants. There are opportunities for the nursing workforce through vacancies either in other inpatient provision or vacancies in the enhanced teams. There are also risks of redundancies.
- There are around 90 staff in roles affected by this transformation. In the future model there is a need for around 50.
- Staff have been and remain informed and engaged through the process with managers holding regular briefing sessions. Monthly drop in sessions are held at both Lyndhurst and Castle Lodge to keep both staff and service users informed of recent activity and developments

2.2.7 What will this mean for Trust finances

- Full implementation of the business case could improve the net position of rehab services across the Trust by approximately £750,000. The current exploration of variations to this plan with commissioners are likely to alter this impact over the next Quarter.
- The impact of Castle Lodge in Wakefield is to enable delivery of planned CIPs for 2015/16 (£450,000) and support achievement of CCG QIPP expectations.

2.2.8 Lead Director Commentary

The planned implementation of this project has suffered from slippage. This has mainly been a result of multiple revisions arising from the ongoing development of localised proposals with individual CCGs. EMT has agreed actions intended to secure clear alignment with and between commissioners and the Trust's proposals, thereby enabling the full implementation of the agreed interim plan.

Karen Taylor

2.3 Older People's Mental Health

The project is currently in discovery phase and objective of this work is to learn and understand the current system and identify an agreed future provision of services, a portfolio of projects required to reach the agreed future state with a business case and Project Initiation Document for delivery of the required projects.

There are 604 staff in scope of this transformation. Current spend is around £25m

2.3.1 Case for Change

The case for change will be established through discovery phase and will incorporate the outcomes from the work that is being undertaken by Meridian Productivity. Emerging opportunities/challenges include:

- Differing models for Older People's services across the SWYPFT footprint
- Approaches to in-patient care differ
- Designing a model that can cope with future demographic pressures
- To build and exploit opportunities around national and local drivers, including Vanguard projects and Care Closer to Home.

2.3.2 Progress to date

- Discovery Launch event held with staff represented from across the BDU's. Themes identified and analysed to feed into further stakeholder engagement and to inform further the Discovery phase
- Commissioner meetings have been organised and first 2 meetings held – emerging issues include a distinct emphasis on the need to work within CCG areas, in terms of understanding and responding to local need, rather than adopting a model across all CCG areas within the SWYFT footprint.

- Workshops have been held - structured around the different functions within the stepped care model (Acute Inpatient, IHBT, Community). Objectives of the sessions have been to engage frontline clinicians and managers and map the patient journey in order to identify areas for transformation at BDU and Organisation Level.
- 2 learning visits have been held – Leeds and TEWV.
- The Project Team has been engaging with the Meridian Workforce in order to align activity where possible and to consider how key learning may inform outcomes of the Discovery phase of transformation.
- Numerous Community Engagement events have been held to gain understanding of Service User viewpoints.
- Ongoing work around data and health intelligence to inform the Discovery Phase continues.
- Communications plan agreed to ensure that all stakeholders are kept well informed of progress with Discovery and are able to input views and opinions on an ongoing basis.

2.3.3 Update on Savile Park View

- As of December 2015 Savile Park View is empty, with no service users as inpatients or attending at that site. Formal closure is anticipated following completion of governance and assurance processes as agreed with commissioners and OSC.
- Staff from Savile Park have been temporarily redeployed into other older peoples mental health services in Wakefield as part of the longer term plan to enhance the community support options for older people with mental health needs that would otherwise require admission. Formal staff consultation on longer term implementation of the proposed model is scheduled for the New Year.

2.3.4 Next Steps

- Final information will be gathered in early January to inform the end of discovery phase report - due to be completed by end Jan 2015,
- It is expected that more detailed design will follow through Spring and Summer 2106.
- This will incorporate the Meridian Productivity Outcomes.
- Project will then seek to gain consensus on what the desired future provision of services will look like, including a vision and blueprint for these services. The blueprint will be a more detailed document that sets out the future operating system and the working practices and processes that are required in the future state.
- In the design phase, the options for the future model will be considered and preferred models chosen.
- Modelling activity in the design phase will focus on current workforce, the workforce that the trust transitions to in the short term and longer term future model workforce - with a plan for achieving this.
- A series of projects required to deliver the future model will be established and prioritised.
- A suite of documents will then be presented to the Transformation Programme Board which include a Business case for each project with Project Initiation Document.
- It is expected that the design phase will finish in Summer 2016 and then a series of project will be implemented, some which may move a faster pace than others.

2.3.5 Lead Director Commentary

Having reflected on the lessons that have been learnt from the current Mental Health projects it has become apparent that the most difficult phase of any project has been moving from completion of the discovery phase to completion of the design phase. In an attempt to avoid or minimise a similar risk with this project a pre design paper spelling out the “must do’s” will be agreed prior to commencement of the design phase

Karen Taylor

Section Three – Learning Disabilities Work Stream

The Trust’s Learning Disabilities Work Stream is led by Tim Breedon and guided by a Learning Disabilities Transformation Board. It in effect consists of one unified project, which is closely related to the local implementation of the national Transforming Care Partnership agenda.

There are 121 WTE in the services affected by this transformation. In the future it is proposed that this number increases to 144 WTE

3.1 Learning Disabilities

The vision of this project is to provide timely and effective specialist health services for people with learning disabilities who need extra help to live safely and well.

We identified the following reasons for change;

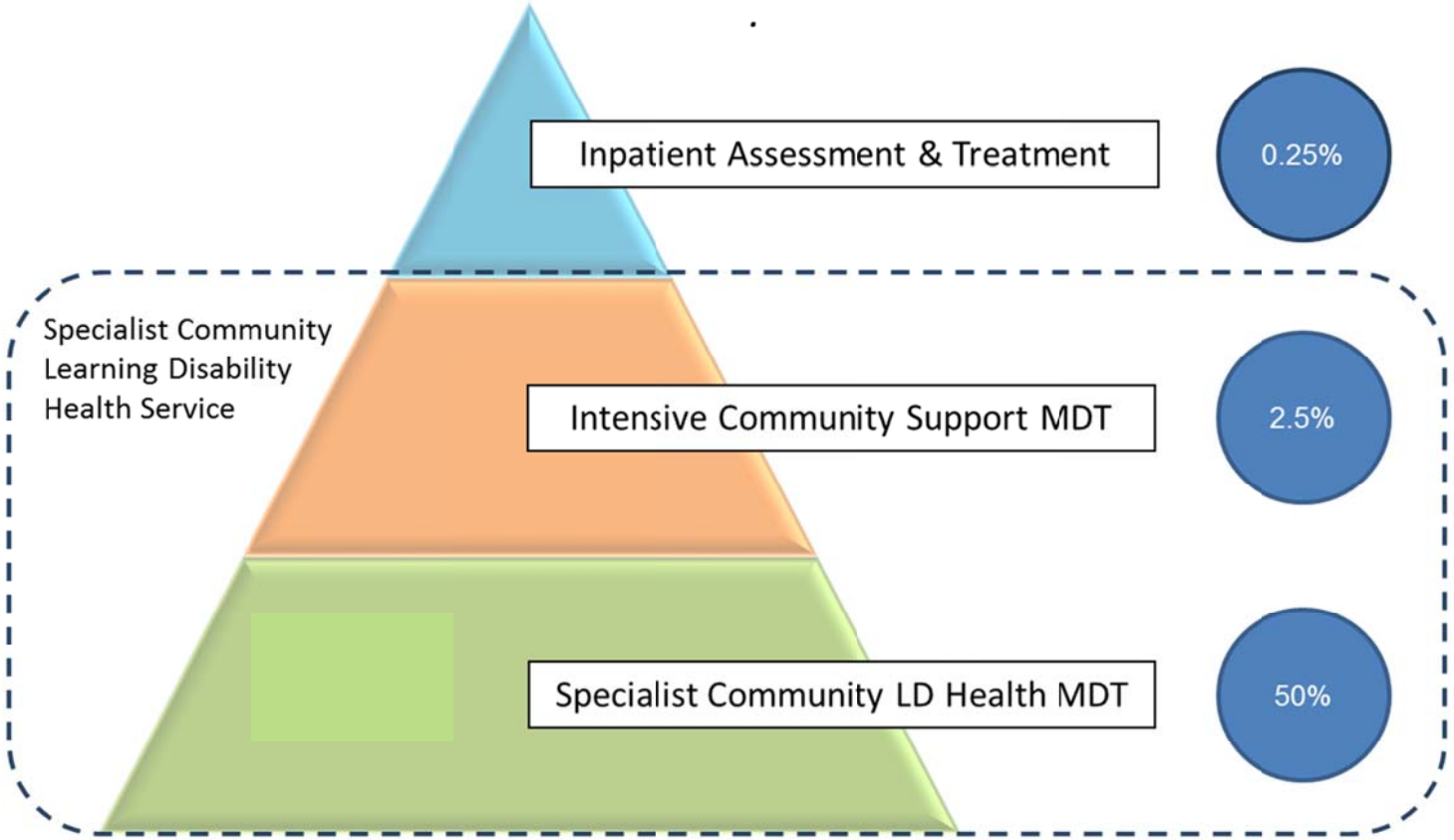
- The need to improve quality of services and health outcomes for people with learning disabilities
- Prevent hospital admission wherever possible
- Focus core business on those with the most complex needs
- Increasing demand for specialist LD services
- Changing demand for specialist LD services

And as a result propose to change the following:

- Organise services within a simple, stepped-care model which provides responsive care in the least restrictive way for people both in the community and, if required, in hospital.
- Provide a single specialist community LD health team in each locality and develop a single inpatient service which provides for people from all local areas.
- Develop dedicated MDT’s for people with LD and challenging behaviour and ensure this is able to respond to people at times of crisis (including out of hours support).
- Establish efficient single-points-of-access for specialist LD health services in each locality.

- Establish pathways through which we can support other care providers to make reasonable adjustments to their practice so they can work better with people with learning disabilities.
- Provide effective specialist interventions for people with learning disabilities whose needs cannot be met by mainstream services. Promote evidence-based contemporary practice.
- Work in partnership with other service providers (particularly local authorities) to provide a holistic and integrated care solution. Integrated delivery is not about line management.

A stepped care model is proposed as indicated by the following graphic:



3.1.2 Benefits

- Better services for service users and care partners (easier to understand, more accessible and responsive, better outcomes)
- Clearer articulation and resolution of responsibilities and accountabilities for performance of the health pathway.
- Better equipped to deliver the future LD service agenda (Winterbourne) and health performance targets.
- More efficient deployment of resources (focused activity and economies of scale, within agreed resources)
- Clearer and safer relationships with provider and LD pathway partners (improved governance)
- Align income and expenditure with required level of service expected under national commissioning guidance

3.1.3 Progress to date

- Engagement with CCG commissioners has ensured that there is a good understanding of the proposed model and what it will achieve
- There is clarification of what each commissioner requires from the Trust for their internal governance processes
- Specifications are being developed collaboratively with an assurance from commissioners that there will be no significant variance from the Trust's proposals
- An extensive staff engagement exercise took place with LD staff between June and August 2015. Four locality based staff engagement events were held. 112 staff attended.
- More than 50 face to face meetings with staff took place
- The proposed service model was reviewed and amended in line with the feedback gained from staff
- A consultation document has been produced in line with the Trust's policy on Management of Change.
- A meeting to commence the formal staff consultation process took place on 23rd November with staff side. Agreed expected duration of consultation to last until 31st December 2015.
- Much public stakeholder engagement work took place during the discovery and design phases

3.1.4 Next Steps

- Commissioner and Local Authority engagement will continue as a priority within the implementation plan
- Service offers and pricing schedules will be discussed with commissioners in the near future
- Complete staff consultation and then implement new staffing models as informed by the consultation. Expected band 7 staff will be in post during February and other staff from that point, with a target date of April 1st 2016
- Undertake OD planning work with teams to support transition and benefits realisation
- Multiple engagement events to be undertaken engaging service users and carers in implementation and pathway design

- Targeted engagement activities planned in relation to relocation of Fox View to Horizon Centre.

3.1.5 Addressing Risks and Issues

- Clarifying alignment of transformed LD community based services with the space available at the Wakefield Hub estates development
- Relocation of the service at Fox View cannot be fully implemented until the Horizon Centre can accept new admissions – service is working to find a solution that meets the clinical needs of service users
- New model highlights disparities in funding and service provision between each CCG area. Therefore transition plans different in each. Also being supported by senior level finance team communication with CCGs to understand potential to address investment inequality

3.1.6 Horizon Centre and Fox View

- The practical amalgamation of Horizon Centre and Fox View has now been achieved. This has been enabled through a clearer understanding of the changing clinical need of one patient at the Horizon Centre, and the associated development of a bespoke plan for that individuals future care needs. In turn this has facilitated the movement of two individuals from Fox View to Horizon Centre.
- Plans are now being put in place for a more appropriate bespoke individual placement for the individual at Horizon. We are working with a specialist provider to scope and prepare for transfer from Horizon Centre as soon as possible. We are also making arrangements for contingencies in the event that this bespoke package is not able to be implemented.
- The LD team are reviewing the learning from this relatively unusual situation to ensure that our approach optimized clinical quality in similarly challenging situations, with all service users able to engage in meaningful therapeutic activity, even where additional safety measures are required to support that participation.
- Additionally learning from this situation is being shared with commissioners via the Transforming Care Partnership. It is recognised that the implementation of planned movement of individuals from specialist placements is impacting on patient flow within Assessment and Treatment units across the country, as people move from secure to non-secure and then onwards to longer term community placements
- Engagement with CCGs regarding commissioning intentions for inpatient assessment and treatment services are ongoing, and are aligned to local implementation of national commissioning intentions as developed through the Transforming Care Partnerships, which set an expectation of between 10-15 CCG commissioned beds per million population. The capacity of Horizon is aligned to this expectation. Some commissioners may prefer to block purchase part of this provision from the Trust and to buy additional capacity on the open market as required. This would not preclude the Trust from offering this capacity but would alter the risk profile of the arrangement.

3.1.7 Lead Directors Comments

- Positive progress has been maintained although operational challenges have impacted upon pace
- Agreement of pricing strategy remains crucial to next steps
- Recently published National Strategy has strengthened our position as our transformation plans are well aligned
- Strategic partnerships remains critical to successful delivery

Section Four – General Community Work Stream

The Trust's General Community work stream is led by Sean Rayner and guided by a General Community Transformation Board. It in effect consists of three projects.

4.1 Admin Review

The aims of this project are

- To have a 'General Operations Central Hub' (integrated mental health and general community offer on Kendray site).
- To establish the approach of 'Single Point of Access' (0-19 yrs., Therapy, Community Nursing).

The rationale for these changes is

- Support achievement of identified CIP opportunity and respond to reduced resources available from Commissioners.
- Partner organisations reduced financial resources and service changes impact on shifting support required e.g. in LIFT buildings
- Need for modernised admin roles that meet the changing needs of the clinical workforce and the way in which they work.
- Evidence of an inconsistent offer across the locality both in terms of front of house reception services and support to clinical staff.
- Admin services delivered across a disparate foot print leading to inefficient use of resources.

4.1.1 Planned Changes

- Remodeling and integrating administrative support to service delivery in both general community and mental health services in Barnsley
- Step 1: 0-19yrs SPA / Therapy Admin SPA. Will achieve savings of £46,419 associated with movement from 10.25 to 8.75WTE
- Step 2: Kendray admin and inpatient services reception. Will achieve savings of £107,100 associated with movement from 30.32 WTE to 25.22WTE
- Step 3: Community nursing services SPA
- Step 4: Community centre hubs x 4
- There is also an opportunity to amalgamate the 0 – 19yrs, CNS & Therapy admin SPAs at a later date.
- NB: Trust wide approaches impacting on Administrative services (e.g. digital dictation, post bandings etc) are not within the scope of this Project

4.1.2 Progress to date

- Therapy Admin Hub on target for completion December 2015.
- Proposal and management of change case for 0 – 19yrs SPA & Hub prepared for submission to General Community Transformation Work Stream Board in December. Expected completion March 2016. Estimated financial savings: £46,419
- Proposal and management of change case for MH & GC single reception and general office for submission to December Transformation Board. Expected completion March 2016. Estimated financial savings: £113,100 including non-pay spend reduction

4.1.3 Anticipated impact on staff

- Roles and job descriptions will be revised in line with the future model of ways of working.
- Staff affected by creating a hub and merging receptions will be relocated. Integration brings with it a reduction in the number of posts that are required to fulfil the functions and service the clinical areas. This will be conducted in line with Trust policy and consultation with staff side.
- Staff engagement sessions have already taken place and will continue to do so throughout the project.
- A workforce skills analysis and development plan will be undertaken to enable the workforce to adopt more flexible working and transferable skills.

4.1.4 Addressing Risks and Issues

- Estates - additional signage and some building works needed – working with Estates to develop minor capital bid
- IT systems - Lack of interoperability of IT systems and poor system functionality in buildings utilised by Admin functions. Working with IT to find a solution.
- Understanding the impact of the role out of clinical agile working – Close engagement with IT team and alignment with Agile Working Project
- Impact of wider GC transformation projects diverts capacity from admin project – Deputy Director and PMO working to find a solution

4.2 Therapies Review

The aims of this project are

- Improving the quality of provision of service,
- Improving outcomes for patients and
- Improving the patient journey through any of the therapy services and on to other health care providers, whilst integrating therapy service provision across the whole health community.

The changes planned are

- Establishment of Therapy administration hub.
- Establishment of Therapy clinical centres, whilst maintaining appropriate satellite clinical provision.

4.2.1 What will this mean for service users

- Directed to most appropriate clinician, in the most appropriate service or services, first time at the right time.
- Multi-disciplinary care that improves outcomes and which reduces the number of appointments required.
- Smarter ways of working to deal with the significant increase in referrals resulting in speedier assessment and treatment and reduced waiting times.
- Joint working on clinical problems will develop better solutions together, improved knowledge and skills throughout the team, and lead to improved quality of care.

4.2.2 What will this mean for staff

- A clearer leadership structure within therapy
- The ability to sign post patients to the right services within therapy will add to the increased efficiency and effectiveness of the therapists.
- Reduction in the overall number of team leaders and therapists required
- More efficient use and increased number of therapy assistants across therapy services broadening skills and knowledge.
- More efficient use of administrative services will lead to a reduction in admin staff required.
- Increased peer support
- Speedier communication and response time to queries
- Improved staff cover for leave
- Improved future workforce sustainability

4.2.3 Progress to date

Therapy Hub for MSK, Podiatry and Admin based at New Street is on target for completion Dec 2015. Therapy Admin Hub on target for completion December 2015.

- Staff engagement events have been held with as part of communication and engagement plan.
- Benefits realisation exercise underway.
- Estimated financial savings: £35,592 associated with changes to administrative workforce and reduced use of bank and agency staff

Wider Therapies Hub: Paediatric Therapies, Community Occupational Therapy, Domiciliary Physiotherapy, Dieticians, MSK OP

- Demand & Capacity modelling commenced
- SystmOne functionality across all Therapy services underway
- Supplementary work required to support business case to be submitted to December's General Community Transformation Board.
- Expected completion date: September 2016
- Estimated financial savings: £145,083 associated with a reduction in the number of band 7 posts and an increase in the number of band 3 posts in the establishment

4.2.4 Addressing Risks and Issues

- Identification of suitable estate solution – continued dialogue and exploration of options with Estates team.
- Impact implementation of new staffing model on culture, staff morale and quality of service provision – early engagement with staff in line with Trust policy.
- The service specification for MSK is out of date, and the Commissioner is reviewing the service, with SWYPFT support including PMO and other Quality Academy functions.
- Pace of roll out of IT systems and support provided for all projects e.g. agile working and system one – working with IT and operational colleagues to identify solutions.

4.3 Community Nursing Transformation

Aims:

- Right person, right contact, right place.
- More patients treated at a reduced cost.
- Improving/equipping patients to self-care.
- Workforce fit to meet the needs of patients with long-term conditions.
- Better integration of the LTC family of services.

Objectives:

- The main Transformation work for some Long Term Conditions is being undertaken across the whole health system in Barnsley. For example, Barnsley CCG's Commissioning Intentions 2016/17 make specific reference to a Multi-Speciality Community Provider (MCP) model for Diabetes and Respiratory services
- Establish a clear Operating Framework. To have a single route into the services
- To have a Single Assessment Process which incorporates the 'Patent Activation Measure' (in place and being evaluated as part of testing phase).
- To have a MDT approach to allocation of Key Worker using the LTC Operating Framework (in place and being evaluated as part of testing phase).
- To have a single LTC Framework that is the model of care delivery (in place and the focus of our internal and external marketing strategy).
- To have a single Care Plan for each patient (early development stages).
- To have a well-defined and agreed visiting schedule tailored to patients' needs (in place and being evaluated in testing phase).
- To have a single IMT spine for the family of LTC services (achieved in part via manipulation of SystmOne by IM&T support staff (currently being evaluated as part of testing phase).
- To have improved productivity (reduction in duplication and increased skills utilisation).

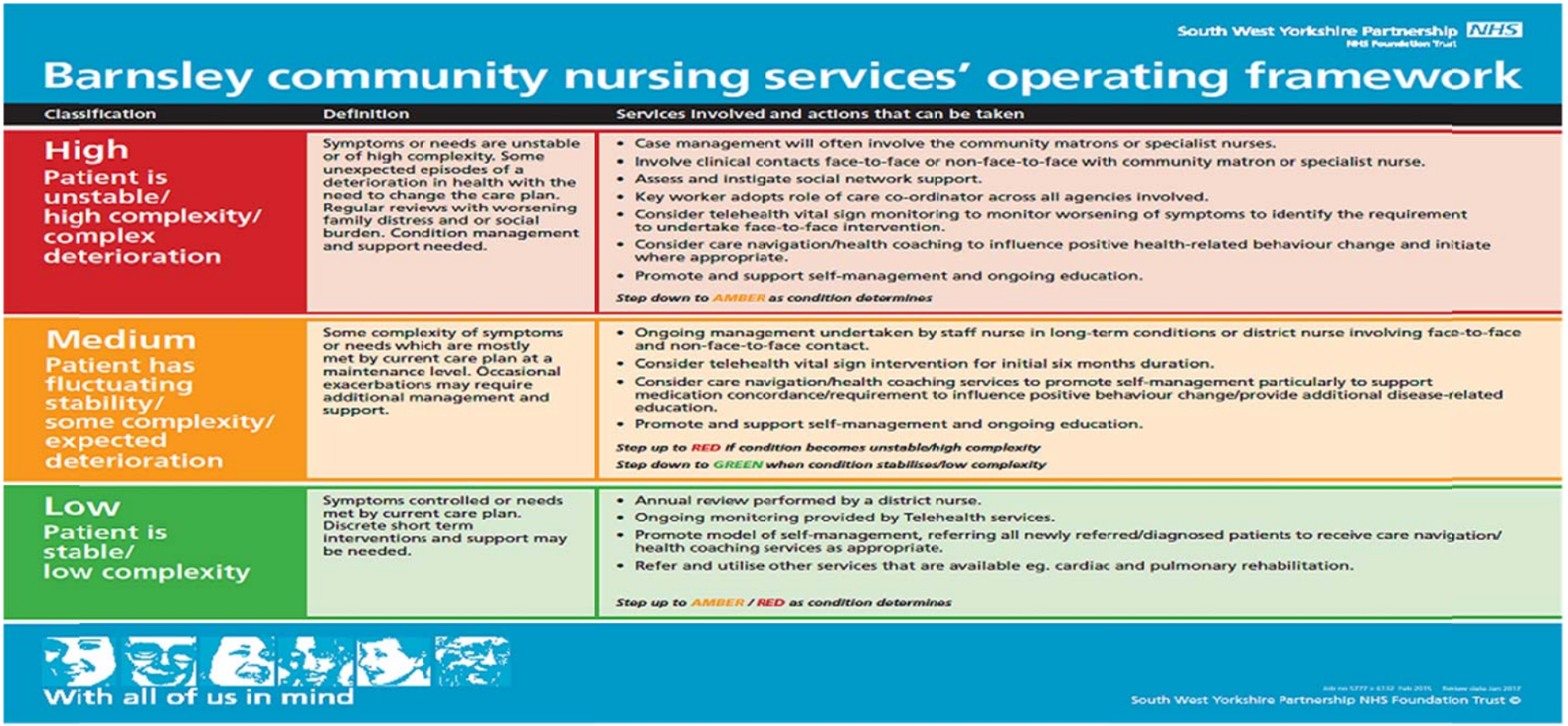
4.3.1 Progress to date

To date 21.31 WTE have been brought into scope (Community Matrons, Heart Failure, Parkinsons Disease, COPD, and LTC) proposals have been identified that would result in a future model requiring 17.53 WTE in these areas.

The service model will provide

- Community-based working in defined localities which align with primary and social care.
- Integrated community nursing and care navigation teams wrapped around the patient.
- Key Worker from within the LTC family of services that co-ordinates individual patient care.
- A flexible service that is responsive to fluctuations in demand.
- Have the right skill mix that is able to deliver the model of care through the with the Community Nursing Operating Framework.

The service model is described in the following graphic;



Progress towards implementation includes;

- Completion of a testing phase focused upon the following services:
- Community Matrons
- Heart Failure service
- Parkinson's Disease Service
- Care Navigation

This is now complete and under evaluation. Report expected to December's GC Transformation Board.

- Single Point of Access
- Single Comprehensive Assessment that includes measuring personal resilience, to support the recovery pathway and self-directed care.
- Single Integrated Care Plan
- Single fully functional spine on SytstmOne to facilitate integrated working
- Staffing model aligned to the LTC Operating Framework
- Alignment of the roles of staff providing support in the 3 Tiers of the framework
- Capacity and demand modelling to identify the staffing resource requirement

4.3.2 What will this mean for service users

- Reduced duplication - Able to tell their story once
- Reduced health inequalities - Improved quality and consistency of care
- Single Care Plan and Increase in self-directed care - Increase feeling of control, understanding and ownership of care plans
- Improved patient health and social care outcomes
- Single referral route and Single Assessment will improve productivity and efficiency in community services
- Reduced need for number of GP home visits
- Reduced need to attend at Accident & Emergency
- Reduced need for unplanned hospital admissions and re-admissions
- Reduced hospital length of stays

4.3.3 What will this mean for staff

- The future workforce requirement will be linked to the capacity and demand modelling and the alignment of the workforce to the LTC Operating Framework.
- Workforce development is a key aspect of this proposal – High Performing Teams concept is in testing phase with an number of OD workshops already been held.
- The proposed model provides clarity around roles within the new model. Job descriptions have been reviewed to reflect the knowledge and skills to deliver this model.
- Workforce change requirements are being identified as part of the testing phase. It is envisaged that the number of band 7 posts will be reduced and number of band 5 posts will increase.

4.3.4 What will this mean for the Trusts finances

- The new workforce model that fully aligns the care navigation and the LTC staff nurse services into one structure. Estimated saving: £307k
- Additional IM&T resource has been required: £75k

4.3.5 Addressing Risks and Issues

- The General Community Work stream is re-framing some models of care to reflect the BCCG commissioning intention regarding Multi-Specialty Community Provider. This will address the need for both vertical pathway integration encompassing multiple organisations, in addition to single organisation efficiency opportunities
- BCCG is reviewing Community Nursing Services (District Nursing and Community Matron Service) and may opt for service models and configurations other than those proposed through the Trust's transformation work. Therefore we are engaging with commissioners to influence this work
- The CCG's work on Diabetes pathways linked to personal health budgets and Integrated Personalised Commissioning may create greater competition than has previously been experienced, and this may lead to fragmentation. This is being addressed by engaging fully with commissioners and service users to ensure our services are integrated in local pathways and offer the best possible outcomes and experience for service users
- Impact of work in secondary care to promote discharges on all seven days of the week increases demands on community and intermediate care services at weekends
- Data sharing beyond SWYFT, i.e. primary and social care could impede wider MDT approaches
- Culture shift required in the workforce to work to the new model

4.3.6 Lead Directors Comments

- The BDU is taking an approach where "Product Lines" will have a 5% CIP target in 2016/17 (inclusive of savings identified in these Transformation Projects).
- The commissioning of projects such as Medworxx, undertaking a risk stratification of patient flows through pathways of care, is an example of a shift in Commissioning focus towards whole system approaches and MCP. It is important that the Trust maintains sight of what is happening as this may impact on the transformational process of projects such as Long Term Conditions and Intermediate Care.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Performance Report

Strategic Overview

November 2015

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Introduction

Dear Board Member/Reader

Welcome to the Trust's Integrated Performance Report: Strategic Overview for November 2015 information unless stated. The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions.

The Trust continues to improve its performance framework to deliver the Trust IM&T strategy of right information in the right format at the right time. Performance reports are now available as electronic documents that allow the reader to look at performance from different perspectives and at different levels within the organisation.

Performance is reported through a number of key performance indicators (KPIs) using the Trust's balanced score card to enable performance to be discussed and assessed with respect to

- Business Strategic Performance – Impact & Delivery
- Customer Focus
- Operational Effectiveness – Process Effectiveness
- Fit for the Future - Workforce

KPIs provide a high level view of actual performance against target and assurance to the Board about the delivery of the strategic objectives and adhere to the following principles:

- Makes a difference to measure each month
- Focus on change areas
- Focus on risk
- Key to organisational reputation
- Variation matters

Strategic Overview Dashboard

Business Strategic Performance Impact & Delivery

1	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Q1	Q2	National Average	Year End Forecast Position
2	Monitor Compliance	Monitor Governance Risk Rating (FT)	M	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		4
3		Monitor Finance Risk Rating (FT)	M	4	4	4	4	4	4	4	4	4	4	4		4
4	CQC	CQC Quality Regulations (compliance breach)	CQC	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green		4
5	CQUIN	CQUIN Barnsley	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G		3
6		CQUIN Calderdale	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G		3
7		CQUIN Kirklees	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G		3
8		CQUIN Wakefield	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Amber/G*	Amber/G	Amber/G		3
9		CQUIN Forensic	C	Green	Amber/G	Amber/G	Amber/G	Amber/G	Amber/G	*Green*	Amber/G	*Amber/G*	Amber/G	*Green*		3
10	Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	C	6	0	0	0	2	1	0	0	0	0	3		4
11	C-Diff	C Diff avoidable cases	C	0	0	0	0	0	0	0	0	0	0	0		4

Customer Focus

12	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Q1	Q2	National Average	Year End Forecast Position
13	Complaints	% Complaints with Staff Attitude as an Issue	L	< 25%	12% 8/66	14% 6/44	13% 9/69	12% 9/73	12% 5/42	15% 6/41	12% 5/42	16% 9/58	14% 23/179	13% 20/156		4
14	Service User Experience	Friends and Family Test	L	TBC	89.00%	92.00%	87.00%	93.00%	89.00%	91.00%	88.00%	Data Avail Month End	89.00%	91.00%		
15	MAV	Physical Violence - Against Patient by Patient	L	14-20	Above ER	Above ER	Above ER	Within ER	Above ER	Above ER	Above ER	Data Not Avail	Above ER	Above ER		4
16		Physical Violence - Against Staff by Patient	L	50-64	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Above ER	Data Not Avail	Above ER	Above ER		4
17	FOI	% of Requests for Information Under the Act Processed in 20 Working Days	L	100%	100% 24/24	100% 17/17	100% 24/24	100% 28/28	100% 20/20	100% 25/25	100% 19/19	100% 13/13	100% 65/65	100%73/73		4
18	Media	% of Positive Media Coverage Relating to the Trust and its Services	L	60%	92.00%	92.00%	92.00%	80.00%	75.00%	50.00%	Data Avail Month End	Data Avail Month End	92.00%	68.00%		4
19	Befriending services	% of Service Users Allocated a Befriender Within 16 Weeks	L	70%	50.00%	50.00%	50.00%	50.00%	50.00%	Data Not Avail	Data Not Avail	Data Not Avail	50.00%	20.00%		4
20		% of Service Users Requesting a Befriender Assessed Within 20 Working Days	L	80%	100%	100%	100%	100%	100%	Data Not Avail	Data Not Avail	Data Not Avail	100%	100.00%		4
21		% of Potential Volunteer Befriender Applications Processed in 20 Working Days	L	90%	100%	100%	100%	100%	100%	Data Not Avail	Data Not Avail	Data Not Avail	100%	100%		4

Operational Effectiveness: Process Effectiveness

22	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Q1	Q2	National Average	Year End Forecast Position
23	Monitor Risk Assessment Framework	Max time of 18 weeks from point of referral to treatment - non-admitted	M	95%	99.11%	100%	99.86%	100%	99.32%	98.60%	99.86%	97.64%	99.70%	99.28%		4
24		Max time of 18 weeks from point of referral to treatment - incomplete pathway	M	92%	98.06%	97%	99.82%	100%	97.31%	99.16%	98.92%	97.58%	98.35%	98.76%	93.10%	4
25		Delayed Transfers Of Care	M	7.50%	2.69%	1.64%	2.06%	1.96%	1.70%	1.80%	3.49%	2.89%	2.12%	1.83%		4
26		% Admissions Gatekept by CRS Teams	M	95%	93.28%	96.30%	97.20%	100%	95.90%	96.12%	95.49%	Data Avail Month End	95.51%	97.29%		4
27		% SU on CPA Followed up Within 7 Days of Discharge	M	95%	98.21%	100%	97.86%	97.70%	95.35%	100%	95.39%	Data Avail Month End	98.66%	97.97%	96.90%	4
28		% SU on CPA Having Formal Review Within 12 Months	M	95%	96.37%	95.18%	97.92%	96%	86.57%	98.44%	86.88%	97.52%	97.92%	98.44%	97.67%	4
29		Meeting commitment to serve new psychosis cases by early intervention teams QTD	M	95%	108.97%	102%	104.60%	147.59%	108.97%	113.25%	83.42%	99.48%	104.60%	113.25%		4
30		Data completeness: comm services - Referral to treatment information	M	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%		4
31		Data completeness: comm services - Referral information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%		4
32		Data completeness: comm services - Treatment activity information	M	50%	94.00%	94%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%	96.80%		4
33		Data completeness: Identifiers (mental health)	M	97%	99.70%	100%	99.62%	100%	99.62%	99.54%	99.65%	99.55%	99.62%	99.54%		4
34		Data completeness: Outcomes for patients on CPA	M	50%	78.83%	79.07%	77.63%	78.67%	77.64%	76.97%	78.40%	77.94%	77.63%	76.97%		4
35		Compliance with access to health care for people with a learning disability	M	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	*Compliant*	Compliant	Compliant		Compliant
36		IAPT - Treatment within 6 Weeks of referral	M	75%	Data Not Avail	Data Not Avail	Data Not Avail	Data Not Avail	53.46%	41.93%	48.33%	48.71%				
37		IAPT - Treatment within 18 weeks of referral	M	95%	Data Not Avail	Data Not Avail	Data Not Avail	Data Not Avail	77.40%	70.70%	71.81%	77.28%				
38		Early Intervention in Psychosis - 2 weeks (NICE approved care package)	M	50%	40.00%	81.82%	58.33%	56.25%	55.56%	80.00%	66.67%	84.60%				
39	Data Quality	% Valid NHS Number	C (FP)	99%	99.87%	100%	99.88%	99.71%	99.58%	99.76%	Avail Month End	Avail Month 9	99.88%			4
40		% Valid Ethnic Coding	C (FP)	90%	99.05%	95%	94.86%	94.88%	94.90%	94.83%	Avail Month End	Avail Month 9	96.28%			4

Strategic Overview Dashboard

Fit for the future Workplace

41	Section	KPI	Source	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Q1	Q2	National Average	Year End Forecast Position
42	Sickness	Sickness Absence Rate (YTD)	L	4.4%	4.80%	5.10%	5.00%	4.80%	4.80%	4.90%	4.90%	5.00%	5.00%	4.90%		1
43	Appraisal	Appraisal Rate Band 6 and above	L	95%	Avail M3	Avail M3	56.80%	72.90%	80.30%	87.30%	89.50%	91.60%	56.80%	87.30%		4
44		Appraisal Rate Band 5 and below	L	95%	Avail M6	Avail M6	Avail M6	Avail M6	Avail M6	66.30%	75.80%	80.30%	Avail M6	66.30%		4
45	Vacancy	Vacancy Rate	L	10%												4
46	Mandatory Training	Aggression Management	L	80%	73.70%	73.65%	75.83%	77.04%	78.89%	78.85%	80.38%	80.78%	75.83%	78.85%		1
47		Equality, Diversity & Inclusion	L	80%	82.30%	84.55%	84.87%	85.76%	87.17%	88.28%	88.81%	89.37%	84.87%	88.28%		4
48		Fire Safety	L	80%	86.50%	86.24%	86.31%	86.55%	86.44%	85.33%	84.60%	84.83%	86.31%	85.33%		4
53		Food Safety	L	80%	65.20%	66.89%	69.00%	70.67%	71.80%	73.06%	74.30%	74.10%	69.00%	73.06%		1
50		Infection, Prevention & Control & Hand Hygiene	L	80%	80.60%	82.09%	82.82%	83.69%	85.25%	85.55%	85.58%	84.86%	82.82%	85.55%		4
51		Information Governance	L	95%	91.90%	92.55%	92.67%	92.76%	92.73%	91.96%	91.56%	90.58%	92.67%	91.96%		4
52		Safeguarding Adults	L	80%	82.80%	82.60%	84.14%	84.95%	86.16%	86.94%	87.74%	87.34%	84.14%	86.94%		4
53		Safeguarding Children	L	80%	84.70%	85.22%	86.00%	86.39%	87.12%	87.93%	86.12%	85.54%	86.00%	87.93%		4
54		Moving & Handling	L	80%	71.80%	73.66%	75.31%	77.40%	79.32%	80.37%	82.11%	83.03%	75.31%	80.37%		1

KEY	
4	Forecast met, no plan required/plan in place likely to deliver
3	Forecast risk not met, plan in place but unlikely to deliver
2	Forecast high risk not met, plan in place but vey unlikely to deliver
1	Forecast Not met, no plan / plan will not deliver
CQC	Care Quality Commission
M	Monitor
C	Contract
C (FP)	Contract (Financial Penalty)
L	Local (Internal Target)
ER	Expected Range
N/A	Not Applicable

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 8 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent		
Trust Targets					7	6	5
1	Monitor Risk Rating			⇔			
2	REVISED £0.10m Surplus on Income & Expenditure			↓			
3	Cash Position			↓			
4	Capital Expenditure			⇔			
5	Delivery of CIP			↓			
6	Better Payment Practice Code			↑			

Key	
●	In line, or greater than plan
●	Variance from plan ranging from 5% to 15%
●	Variance from plan greater than 15%

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible) The forecast is that the Trust will retain a rating of 4 at 31st March 2016.

2. The year to date position, as at November 2015 , is a deficit of £0.08m. As part of the Month 6 Monitor return the Trust confirmed a revised plan of £100k surplus.This year to date position is £0.02m ahead of this revised plan.

Supported by the utilisation of Trust provisions the Trust are confident that the financial plan for 2015 / 2016 will be achieved. If the current trend continues this would enable the Trust to achieve a small surplus rather than a deficit. The Trust will continue to validate this position, and the risks contained within, and will update to Board accordingly.

3. At November 2015 the cash position is £28.91m which is £1.65m ahead of plan.

4. Capital spend to November 2015 is £7.14m which is £0.14m (2%) behind the Trust capital plan.

5. At November 2015 the Cost Improvement Programme is £673k behind plan. Overall a Full Year Value of £1451k (15%) has been rated as red, after mitigations. A red rating indicates that the CIP opportunity does not currently have an implementation plan and therefore carries a high risk on non achievement.

6. As at November 2015 92% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be an improvement from previous months.

Contracting

Trust Summary by BDU - Current Contract Performance

Contract Variations	
BBDU NHSE National Childhood Flu Immunisation (3 yr contract) - completed	£60.9
BCCG & Associates CV 1 Various received not signed	£359.1
C&K CAMHS: Awaiting signed 2015-16 deed of variation from Commissioners	
WBDU WCCG Portrait of a Life - Care Home Vanguard (signed 11-11)	£67.0
SBDU WCCG offer tbc to fund 12-18mths Psychologist support to reduce ASD backlog	£61.4

CQUIN Performance **Q3 Forecast based on**

Quarter	Quarter 2 £000s	Achieved	Variance	M7 Performance	Vari
Barnsley	£411.8	£315.8	-£96.0	£402.6	-£24.0
Wakefield	£190.0	£128.0	-£61.9	£92.4	-£15.3
Kirklees	£214.7	£126.7	-£88.0	£103.4	-£17.6
Calderdale	£96.3	£30.4	-£65.9	£46.4	-£7.9
Specialised	£75.4	£75.4	£0.0	£56.5	-£18.9
Forensics	£120.0	£120.0	£0.0	£22.5	£0.0
Trust Total	£1,108.2	£796.3	-£311.9	£723.9	-£83.7

CQUIN Performance Year-end Forecast

Quarter	Annual £000s	Forecast Achievement	Variance
Barnsley	£1,790.1	£1,529.3	-£260.8
Wakefield	£793.9	£485.9	-£308.0
Kirklees	£878.2	£519.4	-£358.9
Calderdale	£394.1	£206.7	-£187.4
Specialised	£301.7	£263.9	-£37.8
Forensics	£562.3	£528.6	-£33.7
Trust Total	£4,720.4	£3,533.7	-£1,186.7

CQUIN Performance Q3

West CCGs: MH Clustering - Q2, 3 out of 4 indicators failed for C &K, 2 out of 4 for W. Remedial work in place. Reason for non achievement is recording/data reporting
Care Planning - Partial achievement for W & K. No achievement for C. Action Plan to be completed in preparation of Q4 audit.
Improving Physical Healthcare: Partial Achievement. Performance low against target.
BBDU: MH Clustering - The BDU only met the target for % in crisis plans for Q2, it failed all other targets. A recovery plan has been produced and work is still ongoing with the Teams to achieve this CQUIN & to achieved crisis plan target in Q3

Report continues with Contract Issues

QIPP Targets & Delivery for 2015/16

CCG	Target £000s	Planned £000s	Remainder £000s	RAG	
Wakefield*	£1,790.0	£1,843.3	£53.3		***
Kirklees**	£1,000.0	£571.6	-£428.4		
Calderdale	£0.0	£0.0	£0.0		
TOTAL £000s	£2,790.0	£2,414.8	-£375.2		

* W target is cumulative covering 2014/15 & 2015/16: ** K includes Specialist LD scheme
*** W RAG remains at R as risks identified ~ see summary below

Proposals under the QIPP scheme -

W:- £1.79m in total. OOA Bed Mgt - above plan: OPS Reconfiguration (Savile Park) - on target: MH contract reduction - delivered: OAPs for LD & CHC (CCG held budgets)- high risk: Castle Lodge (CCG budget - prevention client OOA) ~ CCG contesting this £47k : Repricing LD beds - ongoing: Risk within plan as includes £41k for use of Barnsley PICU bed & SWYPFT funded £338k from contract growth for ADHD sustainable case & backlog clearance ~tbc by CCG
C:- 15/16 Schemes to be identified by end of Q1. Potential Productivity Schemes identified, not finalised/agreed.
K:- £1m in total: 1) Reduction on OOA spend for Specialist Rehabilitation & Recovery placements £500k, 2) Reduction in OOA LD Specialist placements £500k (CCG budgets), both schemes required to generate in excess of £1m, for reinvestment in new service models. Below target

KPIs and Penalties

Commissioner	Penalty £000s	Comment
Barnsley CCG	£3.0	MSK as at Mth 7

Contract Performance Information - based on month 7

Key areas where performance is above contracted levels

· Acute MH Inpatient services for adults of working age across W,K,C BDUs
· MH PICU Inpatient services for adults of working age in Wakefield
· Older People's MH inpatients services in Wakefield
· Older People's Memory services in Calderdale
· Intermediate Care in Barnsley

Key areas where performance is below contracted levels

· MH PICU Inpatient services for adults of working age in C & K
· K IAPT Below target for recovery, 6 week & 18 week waits (ref to entering IAPT treatment)
· MH Adult Crisis Resolution services in Wakefield
· MH Adult Rehabilitation services in W & C
· Older People's Memory services in Wakefield
· Diabetes nursing and MSK in Barnsley

Contracting

Trust Summary by BDU - continued

Contract Issues - Specialist

West CAMHS: Future in Minds report returns were submitted by Commissioners Fri 16th Oct. 5yrs allocation of funding available. Wakefield submission accepted.
C&K CAMHS: DoV still awaiting signature from Commissioners.
Wakefield CAMHS: Urgent Assessments: Agreement for 2-3 patients p/a to be seen by service at LA request. process be defined. Proposed revision of CQUIN descriptor for 15/16 accepted by WCCG.
Wakefield LD: Developing suite of data to reflect performance against service specification.
Calderdale LD: SWYPFT team delivering on timescales. Positive feedback and service being recognised as good practice.

Contract Performance Issues

Health & Wellbeing - There are still issues with meeting activity targets as the targets contracted for were arrived at prior to the national downturn in activity

Forensics:- National procurement now identified for 2015/16/17 for Medium & Low Secure MH Services. Joint Commissioner / Provider review of Outreach services & pathways to verify funding Joint Review of Service Unit Prices to inform future Commissioning and service delivery Commissioners identified Re-procurement of Forensic CAMHs Services

Discussions held with Commissioner re medium secure occupancy being below 90% at present NHSE not concerned given pressure on beds nationally. However BDU expect additional referrals in next few months to achieve threshold.

Key Contract Issues - Calderdale

IHBT: CCCG only commissioner that has not commissioned 24/7 IHBT service.
Business case submitted, CCCG requesting further details regarding funding impact. End of Nov.
No contentious elements relating to quality.
Mental Health Liaison: Ongoing discussion re provision. CCCG & KCCG to discuss separately. SWYPFT to review specification and core 24hr cover and ascertain what can be provided within current financial envelope.
Police Liaison: Service to work up what £150k would fund in provision.
Rehab & Recovery: CCCG clear about intentions re redesign of pathway. Joint pathway with health & social care. Move from bed based approach and moving to community rehab model.
Psychology: CCCG looking at new model going forward and considering funding implications.
IAPT (AQP): DoV outstanding. Service out to procurement Dec/Jan 16
ED: CCCG would like 'basic' service initially. SWYPFT to work with Commissioners focussing on primary care and supporting patients through need.

Key Contract Issues - Kirklees BDU

MHL: KCCG proposed to take £500k out of the C&K psychiatric liaison team baseline. Intention to re-invest in SWYPFT contract. Still not received baseline evidence & new/revised specification requested from CCG. SWYPFT to review specification and core 24hr cover and ascertain what can be provided within current financial envelope.
Police Liaison: Separate conversations started with CCCG. Service to pick up with KCCG requirements for their element of the funding.
Psychology: 18 week pathway holding although there has been an increase in referrals. Waiting lists beginning to reduce.
IAPT: Below target for recovery, 6 week & 18 week waits (ref to entering IAPT treatment)

Currency Development - Payment by Results (PbR)

Mental Health Currency Development

The Trust has been a key member of the Care Packages and Pathway Project (CPPP) - a consortium of organisations in the Yorkshire & Humber and North East SHA areas who have been working together to develop National Currencies and Local Tariffs for Mental Health.

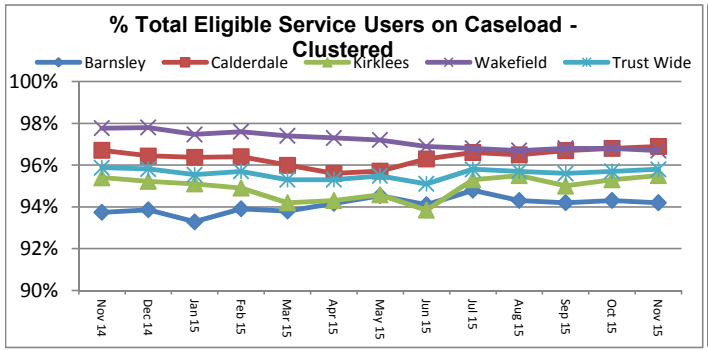
The currency for most mental health services for working age adults and older people has been defined as the 'clusters'. That means that service users have to be assessed and allocated to a cluster by their mental health provider, and that this assessment must be regularly reviewed in line with the timing and protocols. It is the intention that clusters will form the basis of the contracting arrangements between commissioners and providers, the commencement of this is not yet clear. This will mean that for working age adults and older people that fall within the scope of the mental health currencies the activity value will be agreed based on the clusters, and a price will be agreed for each cluster review period. The cluster review period is the time between reassessments and their is some protocol behind this. The mental health clustering tool (MHCT) guidance booklet has recently been revised to update the care transition protocols.

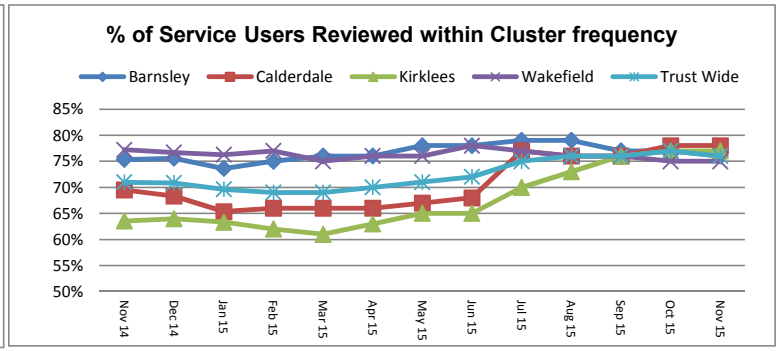
In the Trusts two main contracts for 2015/16 are a set of Quality (CQUIN) indicators related to MH Clustering, this will assist the Trust in preparedness.

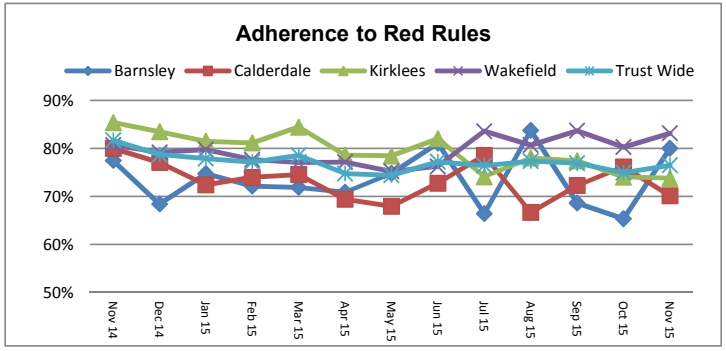
The CQUINs have 3 common elements:
Clustering of Initial Referral Assessments - 98% to be clustered within 8 weeks of 'eligible' initial referral assessments
Review of Service Users and Clusters - agreed % to be reviewed by March 2016.
Adherence to Red Rules (assurance that the cluster is accurate, complete and of high quality)
The West contract includes the development of a PbR Dashboard and this will be an interactive reporting tool. Developments are on track and requirements have been met to end of quarter 2.

There has been some underperformance against the contracts in all BDU's and a detailed action plan is in place which is being monitored locally.

MH Currency Indicators - November 2015







IAPT & Forensic Secure Services and Clustering

The scope of PbR was extended into other areas of Mental Health such as Forensic, IAPT and Children and Adolescent Mental Health Services during 2015/16.
All IAPT clients entering treatment from 1st April 2015 must be clustered. The trust are participating in the Forensic PbR Pilot submission and submitting data on a regular basis into the pilot. The datasets have been flowing from April 15 and internal monitoring of the completeness of this data has been taking place during 15/16. From quarter 2 the monitoring of clustering for these services was included in the relevant BDU dashboards.

The implementation of clustering for Learning Disabilities service users, in relation to the CP&PP LD pilot, has been slower than anticipated, the service are now planning to commence data collection in January 2016 which will then enable data to flow into the pilot.

Currency Development - Payment by Results (PbR)

Monitors Payment Proposals for Adult Mental Health Care 2016/17

Monitor are proposing changes to Local Payment Rules covering Mental health care contracts for 2016/17 because block contracts do not incentivise delivery of the objectives in the Five Year Forward View and do not facilitate timely evidence based care.

The aim of the new payment system is to increase equity of access to evidence based services with a focus on prevention and to reward quality and outcomes.

Monitor are proposing that there will be NO un-accountable block contracts or payment based on cluster days for 2016/17 and have suggested two payment approaches to adopt:-
• A Payment approach based on a pathway / year of care or episode of treatment as appropriate to each MH cluster with a proportion linked to outcomes
(This is suitable where CCGs are not providing integrated care – i.e. across mental, physical and community healthcare)

• A Payment approach based on capitation – informed by care cluster data and other evidence required to understand population needs – with a proportion linked to outcomes
(This would require the outcomes based element across one of more providers and a lead provider arrangement to monitor performance)

Under both approaches an element for payment should be linked to achievement of agreed quality and outcome measures including patient experience, achievement of MH access and waiting time standards (ex IAPTS and EIS) and measures that support the delivery of NICE concordant care.

A gain and loss share arrangement would be required to limit providers and commissioners financial risk due to any unanticipated changes in demand.

Data reporting requirements based on MH Cluster will remain the same.

Secure Services, CAMHS are not part of this payment system and IAPTs services are being looked at separately.

Feedback from providers and commissioners about the proposals has to be returned to Monitor by 19th November and will inform the Formal 2016/17 national tariff guidance and sector support materials.

The Trust is currently reviewing the Draft Reference Cost Guidance for 2015/16. Issues to note relate to IAPT services - proposal that these will be reported in a similar way to the main mental health cluster collection,

Community Currency Development

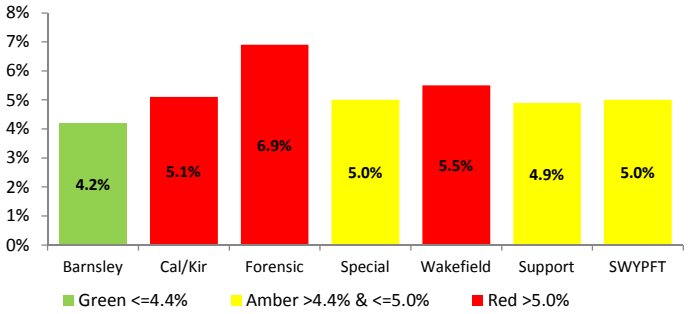
The trust recently attended a workshop event in London hosted by NHS England to begin looking at Community Currency Development. The Trust has expressed an interest in being involved in the national project for this and further updates will be available as the project progresses.

The aims of the event were to undertake joint work to agree the dataset, develop the currencies and outcome indicators for community services and to develop payment approaches for community services. To provide an overview of the work that is currently taking place; to ensure the current work is co-ordinated and aligned and consider future steps to deliver the work; to understand how to involve community services in the work; to capture local innovation and best practice.

Workforce

Human Resources Performance Dashboard - November 2015

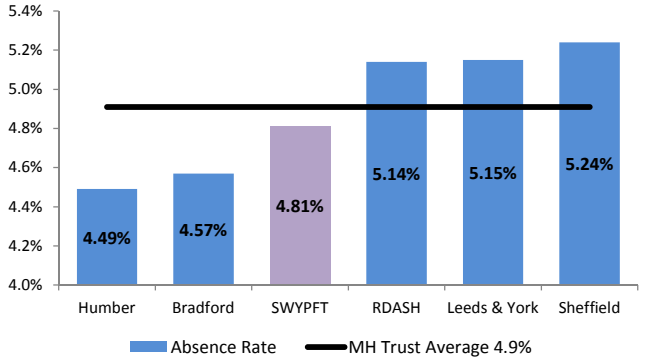
Sickness Absence



Current Absence Position - October 2015

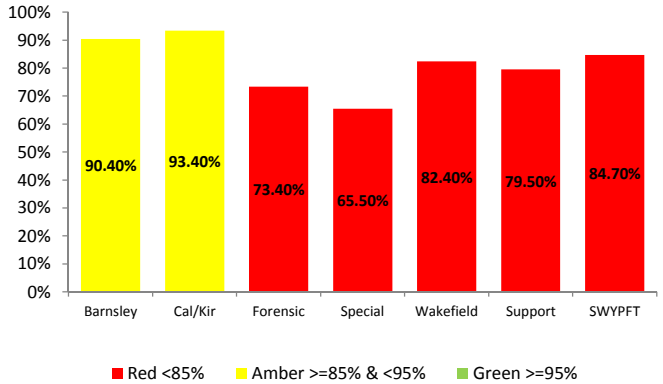
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	4.6%	6.8%	5.6%	4.6%	6.3%	5.5%	5.4%
Trend	↓	↓	↑	↑	↔	↑	↓

The Trust YTD absence levels in October 2015 (chart above) were above the 4.4% target at 5%.



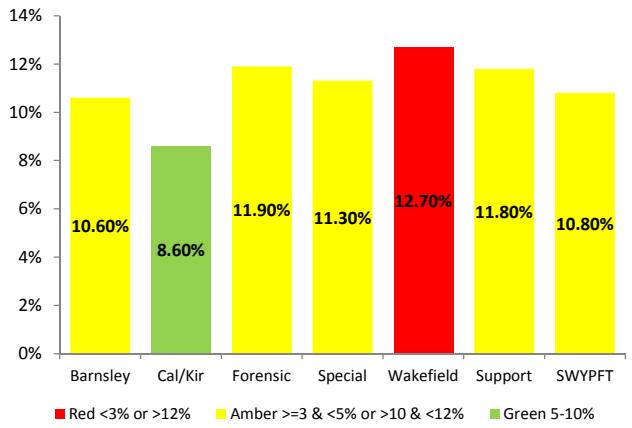
The above chart shows the YTD absence levels in MH/LD Trusts in our region to the end of June 2015. During this time the Trust's absence rate was 4.81% which is below the regional average of 4.91%.

Appraisals - All Staff

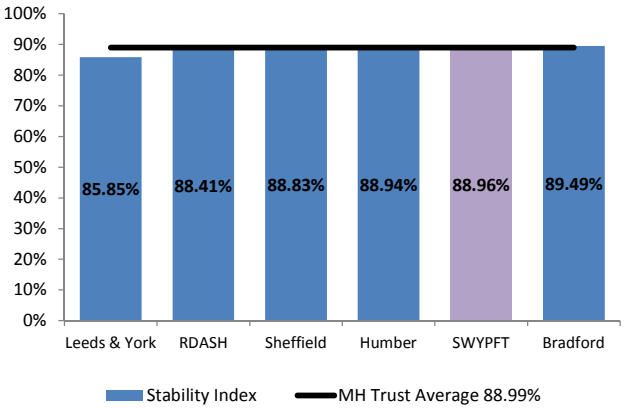


The above chart shows the YTD appraisal rates for all Trust staff to the end of November 2015.
The Trust's target for appraisals is 95% or above.
The total percentages have decreased slightly since the inclusion of Bands 1 to 5 in the figures in September but all areas have shown improvement each month since then.

Turnover and Stability Rate Benchmark

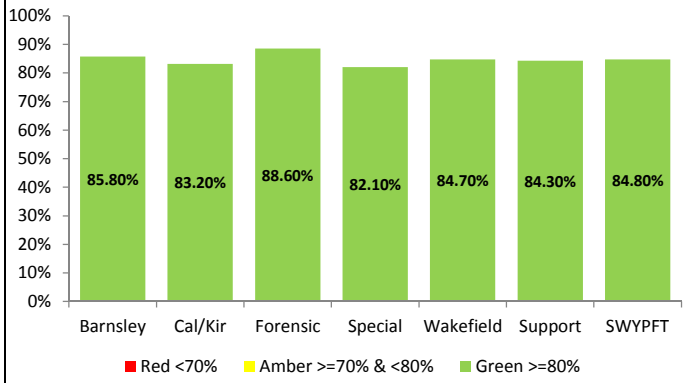


This chart shows the YTD turnover levels up to the end of November 2015.
The higher level of turnover in Wakefield BDU is due to the number of staff leaving through retirement or redundancy since 1st April.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in May 2015. The stability rate shows the percentage of staff employed with over a year's service. The Trust's rate is at the average compared with other MH/LD Trusts in our region.

Fire Lecture Attendance



The chart shows the YTD fire lecture figures to the end of November 2015.
The Trust continues to achieve its 80% target for fire lecture training, with all areas having maintained their figures above target for several months.

Workforce - Performance Wall

Trust Performance Wall

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	4.90%	4.80%	4.80%	4.80%	4.90%	5.00%
Sickness (Monthly)	<=4.4%	4.80%	4.60%	4.80%	4.90%	5.00%	5.40%
Appraisals (Band 6 and above)	>=95%	56.70%	73.30%	80.30%	87.30%	89.50%	91.60%
Appraisals (Band 5 and below)	>=95%	16.90%	28.00%	42.10%	66.30%	75.80%	80.10%
Aggression Management	>=80%	75.80%	77.00%	78.90%	78.90%	80.40%	80.80%
Equality and Diversity	>=80%	84.90%	85.80%	87.20%	88.30%	88.80%	89.40%
Fire Safety	>=80%	86.30%	86.60%	86.40%	85.30%	84.60%	84.80%
Food Safety	>=80%	69.00%	70.70%	71.80%	73.10%	74.30%	74.10%
Infection Control and Hand Hygiene	>=80%	82.80%	83.70%	85.30%	85.50%	85.60%	84.90%
Information Governance	>=95%	92.70%	92.80%	92.70%	92.00%	91.60%	90.60%
Moving and Handling	>=80%	75.30%	77.40%	79.30%	80.40%	82.10%	83.00%
Safeguarding Adults	>=80%	84.10%	84.90%	86.20%	86.90%	87.70%	87.30%
Safeguarding Children	>=80%	86.00%	86.40%	87.10%	87.90%	86.10%	85.50%
Bank Cost		£398k	£473k	£445k	£488k	£478k	£428k
Agency Cost		£608k	£694k	£566k	£637k	£772k	£770k
Overtime Cost		£16k	£8k	£26k	£38k	£30k	£37k
Additional Hours Cost		£90k	£89k	£83k	£67k	£74k	£87k
Sickness Cost (Monthly)		£504k	£458k	£473k	£483k	£481k	£553k
Vacancies (Non-Medical) (WTE)		328.68	351.53	353.84	351.54	324.2	306.5
Business Miles		305k	313k	340k	270k	333k	347k

Barnsley District

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	4.30%	4.10%	4.20%	4.10%	4.20%	4.20%
Sickness (Monthly)	<=4.4%	4.10%	3.90%	4.20%	4.10%	4.20%	4.60%
Appraisals (Band 6 and above)	>=95%	58.90%	78.00%	83.60%	90.50%	92.10%	94.40%
Appraisals (Band 5 and below)	>=95%	18.80%	32.10%	51.90%	73.40%	83.30%	87.50%
Aggression Management	>=80%	81.80%	82.00%	84.30%	83.60%	83.50%	82.90%
Equality and Diversity	>=80%	86.70%	87.60%	89.20%	90.40%	90.70%	91.30%
Fire Safety	>=80%	84.20%	85.10%	86.60%	85.90%	84.70%	85.80%
Food Safety	>=80%	77.80%	81.10%	80.50%	80.70%	80.10%	75.70%
Infection Control and Hand Hygiene	>=80%	83.70%	84.40%	85.60%	86.60%	86.40%	87.00%
Information Governance	>=95%	90.40%	91.50%	91.80%	91.70%	92.10%	90.90%
Moving and Handling	>=80%	77.70%	80.00%	81.70%	82.60%	84.50%	85.10%
Safeguarding Adults	>=80%	86.80%	87.30%	87.90%	88.90%	90.00%	89.30%
Safeguarding Children	>=80%	86.10%	86.70%	88.30%	89.20%	87.90%	87.40%
Bank Cost		£71k	£67K	£70K	£84k	£85k	£75k
Agency Cost		£214k	£151K	£77K	£157k	£119k	£200k
Overtime Cost		£10k	£3K	£17K	£19k	£10k	£17k
Additional Hours Cost		£43k	£40K	£47K	£31k	£35k	£40k
Sickness Cost (Monthly)		£151k	£132K	£144K	£137k	£139k	£156k
Vacancies (Non-Medical) (WTE)		105.51	111.96	116	100.85	92.75	85.33
Business Miles		128k	139K	137K	111k	144k	148k

Calderdale and Kirklees District

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	4.60%	4.60%	4.60%	4.70%	4.80%	5.00%
Sickness (Monthly)	<=4.4%	4.20%	4.60%	4.40%	5.20%	5.20%	6.80%
Appraisals (Band 6 and above)	>=95%	65.50%	79.40%	90.60%	97.50%	98.80%	99.70%
Appraisals (Band 5 and below)	>=95%	22.70%	33.90%	49.50%	76.50%	85.00%	88.80%
Aggression Management	>=80%	79.50%	81.10%	82.60%	83.00%	83.20%	82.80%
Equality and Diversity	>=80%	85.90%	86.60%	87.70%	89.80%	90.60%	91.60%
Fire Safety	>=80%	88.60%	87.70%	87.20%	85.40%	83.00%	83.20%
Food Safety	>=80%	64.90%	65.90%	66.80%	67.70%	69.50%	70.20%
Infection Control and Hand Hygiene	>=80%	84.30%	85.70%	87.20%	88.60%	88.60%	90.00%
Information Governance	>=95%	94.60%	93.70%	93.60%	92.80%	90.40%	89.80%
Moving and Handling	>=80%	72.20%	75.40%	77.50%	78.80%	81.30%	82.70%
Safeguarding Adults	>=80%	80.90%	81.40%	83.00%	85.20%	86.60%	86.80%
Safeguarding Children	>=80%	85.30%	86.00%	85.50%	87.20%	86.20%	86.50%
Bank Cost		£104k	£131K	£123K	£134k	£117k	£124k
Agency Cost		£57k	£167K	£110K	£141k	£199k	£173k
Overtime Cost		£3k	£2K	£1K	£1k	£1k	£2k
Additional Hours Cost		£5k	£7K	£4K	£2k	£2k	£3k
Sickness Cost (Monthly)		£90K	£95K	£88K	£104k	£102k	£147k
Vacancies (Non-Medical) (WTE)		83.33	77.32	82.59	82.93	71.14	75.66
Business Miles		61k	64K	77K	57k	65k	73k

Forensic Services

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	8.20%	7.90%	7.60%	7.30%	7.20%	7.00%
Sickness (Monthly)	<=4.4%	8.20%	7.30%	6.60%	6.00%	6.70%	5.60%
Appraisals (Band 6 and above)	>=95%	43.10%	58.70%	65.20%	68.60%	70.00%	74.70%
Appraisals (Band 5 and below)	>=95%	6.80%	14.00%	29.30%	61.00%	66.20%	71.50%
Aggression Management	>=80%	77.00%	78.80%	78.40%	77.40%	78.20%	80.70%
Equality and Diversity	>=80%	89.30%	89.70%	90.20%	89.20%	90.40%	92.40%
Fire Safety	>=80%	88.00%	88.20%	87.20%	85.50%	87.30%	88.60%
Food Safety	>=80%	57.60%	59.50%	63.20%	65.40%	70.60%	73.50%
Infection Control and Hand Hygiene	>=80%	84.90%	86.00%	87.80%	85.80%	85.30%	84.40%
Information Governance	>=95%	93.40%	94.10%	92.70%	90.70%	91.70%	91.90%
Moving and Handling	>=80%	80.20%	81.50%	83.90%	84.00%	85.80%	87.60%
Safeguarding Adults	>=80%	87.00%	87.40%	88.40%	85.50%	88.50%	89.90%
Safeguarding Children	>=80%	85.00%	85.10%	85.70%	84.50%	85.30%	85.90%
Bank Cost		£82k	£95K	£99K	£114k	£114k	£97k
Agency Cost		£91k	£93K	£77K	£96k	£122k	£68k
Additional Hours Cost		£3k	£0K	£0K	£0k	£0k	£0k
Sickness Cost (Monthly)		£77k	£65K	£58K	£56k	£58k	£51k
Vacancies (Non-Medical) (WTE)		16.7	20.56	28.42	14.34	24.94	24.54
Business Miles		4k	3K	6K	3k	9k	9k

Workforce - Performance Wall cont…

Specialist Services

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	5.70%	5.40%	5.20%	5.10%	5.10%	5.00%
Sickness (Monthly)	<=4.4%	5.50%	4.80%	4.50%	5.00%	4.70%	4.60%
Appraisals (Band 6 and above)	>=95%	33.50%	39.80%	45.40%	60.50%	68.70%	73.80%
Appraisals (Band 5 and below)	>=95%	9.40%	13.10%	21.50%	44.00%	47.50%	53.60%
Aggression Management	>=80%	70.60%	70.30%	73.80%	73.40%	76.40%	77.10%
Equality and Diversity	>=80%	87.30%	88.20%	89.60%	89.60%	89.90%	90.00%
Fire Safety	>=80%	85.10%	83.70%	85.90%	82.20%	83.20%	82.10%
Food Safety	>=80%	72.70%	72.20%	72.20%	69.10%	69.00%	71.20%
Infection Control and Hand Hygiene	>=80%	81.10%	81.60%	83.30%	83.80%	84.00%	84.30%
Information Governance	>=95%	91.10%	90.10%	90.80%	89.10%	90.10%	90.20%
Moving and Handling	>=80%	74.80%	76.70%	79.70%	82.20%	82.50%	83.10%
Safeguarding Adults	>=80%	80.40%	81.50%	83.20%	84.70%	83.20%	82.00%
Safeguarding Children	>=80%	84.30%	82.70%	82.90%	85.40%	84.90%	81.30%
Bank Cost		£33k	£44k	£33k	£38k	£31k	£28k
Agency Cost		£195k	£195k	£208k	£127k	£228k	£216
Overtime Cost		£2k	£2k	£2k	£2k	£1k	£1k
Additional Hours Cost		£7k	£11k	£5k	£7k	£5k	£7k
Sickness Cost (Monthly)		£56k	£50k	£56k	£54k	£52k	£55k
Vacancies (Non-Medical) (WTE)		52.47	52.66	44.93	50.41	45.31	44.39
Business Miles		38k	32k	30k	29K	30k	39k

Support Services

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	4.10%	4.30%	4.60%	4.70%	4.70%	4.80%
Sickness (Monthly)	<=4.4%	4.30%	4.50%	5.40%	5.30%	4.90%	5.50%
Appraisals (Band 6 and above)	>=95%	66.80%	86.20%	91.80%	94.80%	95.90%	96.50%
Appraisals (Band 5 and below)	>=95%	11.90%	20.70%	26.60%	54.80%	71.10%	72.70%
Aggression Management	>=80%	57.10%	60.10%	65.10%	68.60%	72.40%	74.30%
Equality and Diversity	>=80%	73.20%	74.60%	76.20%	78.10%	78.70%	78.90%
Fire Safety	>=80%	87.50%	87.70%	85.30%	86.00%	84.60%	84.30%
Food Safety	>=80%	90.20%	95.50%	95.50%	93.60%	90.10%	89.20%
Infection Control and Hand Hygiene	>=80%	78.90%	79.90%	80.90%	81.20%	82.30%	76.80%
Information Governance	>=95%	94.80%	94.90%	94.60%	92.80%	91.70%	89.60%
Moving and Handling	>=80%	74.90%	76.70%	77.70%	78.80%	81.10%	81.50%
Safeguarding Adults	>=80%	81.60%	83.60%	84.70%	84.80%	84.90%	84.50%
Safeguarding Children	>=80%	87.80%	88.70%	89.80%	90.30%	83.70%	82.80%
Bank Cost		£38k	£40k	£36k	£35k	£60k	£14k
Agency Cost		£27k	£16k	£27k	£103k	£71k	£40k
Additional Hours Cost		£23k	£21k	£18k	£19k	£22k	£19k
Sickness Cost (Monthly)		£64k	£63k	£75k	£71k	£62k	£69k
Vacancies (Non-Medical) (WTE)		24.8	36.6	36.53	42.54	51.48	36.73
Business Miles		34k	36k	47k	38k	42k	35k

Wakefield District

Month		Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Sickness (YTD)	<=4.4%	5.30%	5.10%	5.20%	5.30%	5.40%	5.50%
Sickness (Monthly)	<=4.4%	5.10%	4.80%	5.30%	5.70%	5.70%	6.30%
Appraisals (Band 6 and above)	>=95%	54.80%	78.30%	83.20%	87.40%	88.10%	90.20%
Appraisals (Band 5 and below)	>=95%	25.60%	41.40%	50.00%	64.34%	68.40%	76.70%
Aggression Management	>=80%	80.40%	81.00%	81.30%	79.30%	82.90%	82.80%
Equality and Diversity	>=80%	89.50%	89.80%	91.70%	91.70%	92.20%	92.20%
Fire Safety	>=80%	87.10%	88.70%	86.20%	84.60%	86.10%	84.70%
Food Safety	>=80%	62.40%	60.30%	61.70%	67.60%	68.60%	69.70%
Infection Control and Hand Hygiene	>=80%	83.20%	83.30%	86.50%	84.10%	83.80%	81.80%
Information Governance	>=95%	94.20%	93.00%	92.90%	93.30%	92.60%	91.50%
Moving and Handling	>=80%	70.60%	71.10%	73.50%	73.60%	74.00%	75.70%
Safeguarding Adults	>=80%	85.70%	86.70%	88.80%	89.70%	89.70%	88.90%
Safeguarding Children	>=80%	86.10%	86.50%	86.60%	86.40%	85.60%	85.30%
Bank Cost		£69k	£97k	£85k	£83k	£71k	£90k
Agency Cost		£24k	£71k	£67k	£12k	£34k	£73k
Additional Hours Cost		£9k	£9k	£8k	£9k	£9k	£13k
Sickness Cost (Monthly)		£59k	£54k	£57k	£60k	£66k	£75k
Vacancies (Non-Medical) (WTE)		47.87	50.63	43.37	55.47	36.58	34.71
Business Miles		40k	40k	42k	31k	43k	44k

Publication Summary

Monitor

Quarterly report on the performance of the NHS foundation trusts and NHS trusts: 6 months ended 30 September 2015

This report finds that NHS providers - both trusts and foundation trusts - are facing significant challenges on both finance and operational performance against key national standards at the mid-point of the year. The figures show that it recorded a half year (1 April to 30 September 2015) deficit of £1.6 billion. While between 1 July to 30 September 2015 - many providers struggled to achieve several key national healthcare standards.

Click here for report

Monitor

Rules for all agency staff working in the NHS

This collection of guidance and resources aims to provide support on the new cap on the amount of money that trusts can pay per hour for agency staff within the NHS which was implemented with effect from 23 November 2015.

Click here for report

Monitor

NHS foundation trusts: annual reporting manual 2015/16

All NHS foundation trusts must publish annual reports and accounts to allow scrutiny of the year's operations and outcomes. This guidance outlines the process foundation trusts should follow when producing and submitting these documents.

Click here for link

National Institute for Health and Care Excellence (NICE)

Transition between inpatient hospital settings and community or care home settings for adults with social care needs

This guideline covers the transition between inpatient hospital settings and community or care homes for adults with social care needs. It aims to improve people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.

Click here for guidance

Glossary

ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
AQP	Any Qualified Provider
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
C&K	Calderdale & Kirklees
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
DTOC	Delayed Transfers of Care
DQ	Data Quality
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FT	Foundation Trust
HONOS	Health of the Nation Outcome Scales
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LD	Learning Disability
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
NICE	National Institute for Clinical Excellence
NHSE	National Health Service England
NHS TDA	National Health Service Trust Development Authority
NK	North Kirklees
OPS	Older People's Services
OOA	Out of Area
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
SK	South Kirklees
SMU	Substance Misuse Unit
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
SU	Service Users
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 8 (2015 / 2016)

Contents

Overall Financial Performance 2015 / 2016

Performance Indicator		Month 8 Performance	Annual Forecast	Trend from last month	Last 3 Months - Most recent		
Trust Targets					7	6	5
1	Monitor Risk Rating	●	●	⇔	●	●	●
2	REVISED £0.10m Surplus on Income & Expenditure	●	●	↓	●	●	●
3	Cash Position	●	●	↓	●	●	●
4	Capital Expenditure	●	●	⇔	●	●	●
5	Delivery of CIP	●	●	↓	●	●	●
6	Better Payment Practice Code	●	●	↑	●	●	●

Key		
	●	In line, or greater than plan
	●	Variance from plan ranging from 5% to 15%
	●	Variance from plan greater than 15%

Summary Financial Performance

These Key Performance Indicators (KPI's) help the Trust to monitor progress against each element of our financial strategy.

1. The Trust Financial Risk Rating is 4 against a plan level of 4. (A score of 4 is the highest possible) The forecast is that the Trust will retain a rating of 4 at 31st March 2016.

2. The year to date position, as at November 2015 , is a deficit of £0.08m. As part of the Month 6 Monitor return the Trust confirmed a revised plan of £100k surplus.This year to date position is £0.02m ahead of this revised plan.

Supported by the utilisation of Trust provisions the Trust are confident that the financial plan for 2015 / 2016 will be achieved. If the current trend continues this would enable the Trust to achieve a small surplus rather than a deficit. The Trust will continue to validate this position, and the risks contained within, and will update to Board accordingly.

3. At November 2015 the cash position is £28.91m which is £1.65m ahead of plan.

4. Capital spend to November 2015 is £7.14m which is £0.14m (2%) behind the Trust capital plan.

5. At November 2015 the Cost Improvement Programme is £673k behind plan. Overall a Full Year Value of £1451k (15%) has been rated as red, after mitigations. A red rating indicates that the CIP opportunity does not currently have an implementation plan and therefore carries a high risk on non achievement.

6. As at November 2015 92% of NHS and 96% of non NHS invoices have achieved the 30 day payment target (95%). This continues to be an improvement from previous months.

Monitor Risk Rating

As per the Risk assessment Framework, updated August 2015, the financial performance of the Trust is monitored through a number of financial sustainability risk ratings.

This revision increased the number of metrics from 2 to 4. This retains the original 2 which focus on the Continuity of Services and add 2 further in relation to Financial Efficiency. A further metric in relation to capital expenditure performance against plan was proposed but has not been adopted.

				Actual Performance		Annual Plan	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	25%	Capital Service Capacity	3.1	4	2.1	3
	Liquidity	25%	Liquidity (Days)	16.1	4	13.3	4
	Weighted Average - Continuity of Services Risk Rating				4		4
Financial Efficiency	Underlying Performance	25%	I & E Margin	0.4%	3		
	Variance from Plan	25%	Variance in I & E Margin as a % of income	1.4%	4		
	Weighted Average - Financial Sustainability Risk Rating				4		

Definitions

Capital Servicing Capacity - the degree to which the Trust's generated income covers its financing obligations; rating from 1 to 4 relates to the multiple of cover.

Liquidity - how many days expenditure can be covered by readily available resources; rating from 1 to 4 relates to the number of days cover.

I & E Margin - the degree to which the organisation is operating at a surplus / deficit

I & E Variance - variance between a foundation Trust's planned I & E margin and actual I & E margin within the year.

Risk Rating 4 - No evident Concerns

Risk Rating 3 - Emerging or minor concern potentially requiring scrutiny.

Monitor Benchmarking

All Foundation Trusts

		Governance Rating			
		No Evident Concerns	Issues Identified	Enforcement Action	Total
Continuity	4	35	2	2	39
	3	41	14	4	59
	2	8	8	8	24
	1	2	2	25	29
	Total	86	26	39	151

Mental Health Foundation Trusts

		Governance Rating			
		No Evident Concerns	Issues Identified	Enforcement Action	Total
Continuity	4	21	0	1	22
	3	14	3	0	17
	2	2	1	1	4
	1				0
	Total	37	4	2	43

As at 23rd November 2015 there are 151 Foundation Trusts, with Risk Ratings, monitored by Monitor. There are 43 Mental Health Trusts.

The tables to the left show that the Trust remains in the upper quadrant of this analysis with a Continuity of Service Rating of 4 and a Green Governance rating.

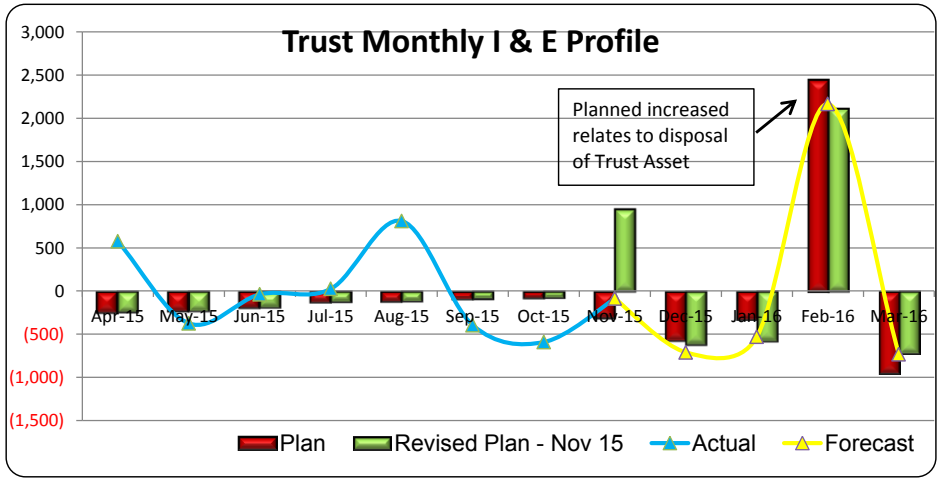
Monitor have now published the Sector performance reports for Quarter 2 (April - September 2015) and additionally the HFMA have published their NHS Financial Temperature check as at November 2015.

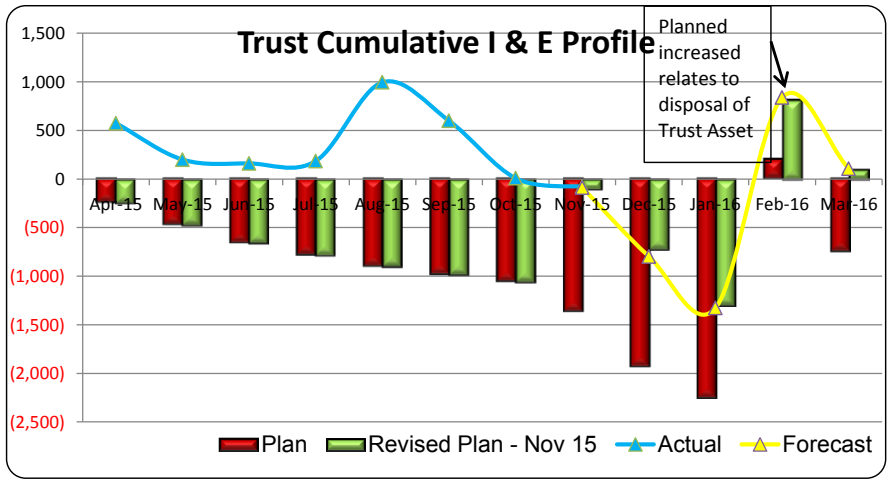
These reports confirmed that the sectors financial and operational performance have declined further and that NHSFT's are under severe pressure. As such Monitor are taking actions, such as a cap on agency rates, to help Trusts improve financial performance.

* Net deficit £729m (Q1 - £445m) and £169m worse than planned
* 110 Trusts in deficit (reducing from 118 at Q1).
* The main reason continues to be flagged as pay pressures arising from the requirement to utilise agency staff (at a premium) to cover shortages in permanent workforces.

Income & Expenditure Position 2015 / 2016

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date 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**
				(17,527)	(17,592)	(65)	Clinical Revenue	(141,012)	(140,350)	662	(210,715)	(210,009)	706
				(17,527)	**(17,592)**	**(65)**	**Total Clinical Revenue**	**(141,012)**	**(140,350)**	**662**	**(210,715)**	**(210,009)**	**706**
				(1,216)	(1,290)	(75)	Other Operating Revenue	(10,893)	(11,118)	(225)	(15,663)	(16,065)	(403)
				(18,743)	**(18,882)**	**(139)**	**Total Revenue**	**(151,905)**	**(151,468)**	**437**	**(226,377)**	**(226,074)**	**303**
4,375	4,240	(135)	3.1%	14,125	14,272	147	BDU Expenditure - Pay	114,595	113,973	(621)	171,054	171,216	162
				3,798	3,819	21	BDU Expenditure - Non Pay	30,325	29,635	(690)	45,108	46,521	1,413
				(836)	191	1,027	Provisions	1,435	2,446	1,012	4,335	2,604	(1,732)
4,375	**4,240**	**(135)**	**3.1%**	**17,087**	**18,282**	**1,195**	**Total Operating Expenses**	**146,354**	**146,054**	**(299)**	**220,497**	**220,340**	**(157)**
4,375	**4,240**	**(135)**	**3.1%**	**(1,656)**	**(600)**	**1,055**	**EBITDA**	**(5,551)**	**(5,414)**	**138**	**(5,880)**	**(5,734)**	**146**
				456	450	(7)	Depreciation	3,650	3,590	(61)	5,475	5,415	(61)
				257	245	(12)	PDC Paid	2,053	1,960	(93)	3,080	2,987	(93)
				(6)	(7)	(1)	Interest Received	(50)	(57)	(7)	(75)	(82)	(7)
				0	0	0	Revaluation of Assets	0	0	0	(2,700)	(2,700)	0
4,375	**4,240**	**(135)**	**3.1%**	**(949)**	**87**	**1,036**	**Deficit / (Surplus)**	**102**	**79**	**(23)**	**(100)**	**(114)**	**(14)**





Income & Expenditure Position 2015 / 2016

Month 8

The year to date position, as at Month 8, reflects a deficit position of £0.08m. This is currently £0.02m ahead of the revised Trust plan. This revised plan was communicated to Monitor as part of the Quarter 2 trust submission.

Due to the revision of this plan, and the fact that the plan has been amended through the utilisation of provisions, there shows a large in month movement against the provisions line. This is budgetary changes and the actual expenditure included remains consistent with previous months.

As such both pay and non pay have continued to overspend in month and are forecast to continue to do so; in particular for non pay expenditure. As such discretionary spend is challenged to ensure that the Trust plan can be achieved.

Forecast

At month 6 the Trust informed Monitor of a revised forecast year end position of £100k surplus. This was an improvement of £842k from the original plan. The forecast outturn position for 2015 / 2016 is a surplus position of £0.11m. This is in line with the revised plan.

Based upon the current forecasts, funds within provisions (£1.73m) are being used in order to support this position. This will continue to be assessed alongside BDU forecasts. This is broadly in line with the utilisation of provisions highlighted at month 7.

BDU's have forecast increased levels of expenditure during the remainder of the year. These run rates and assumptions continue to be reviewed and refined. Currently pay, non pay and income are all individually forecast to overspend against plan. These positions include the impact of non delivery against CIP plans.

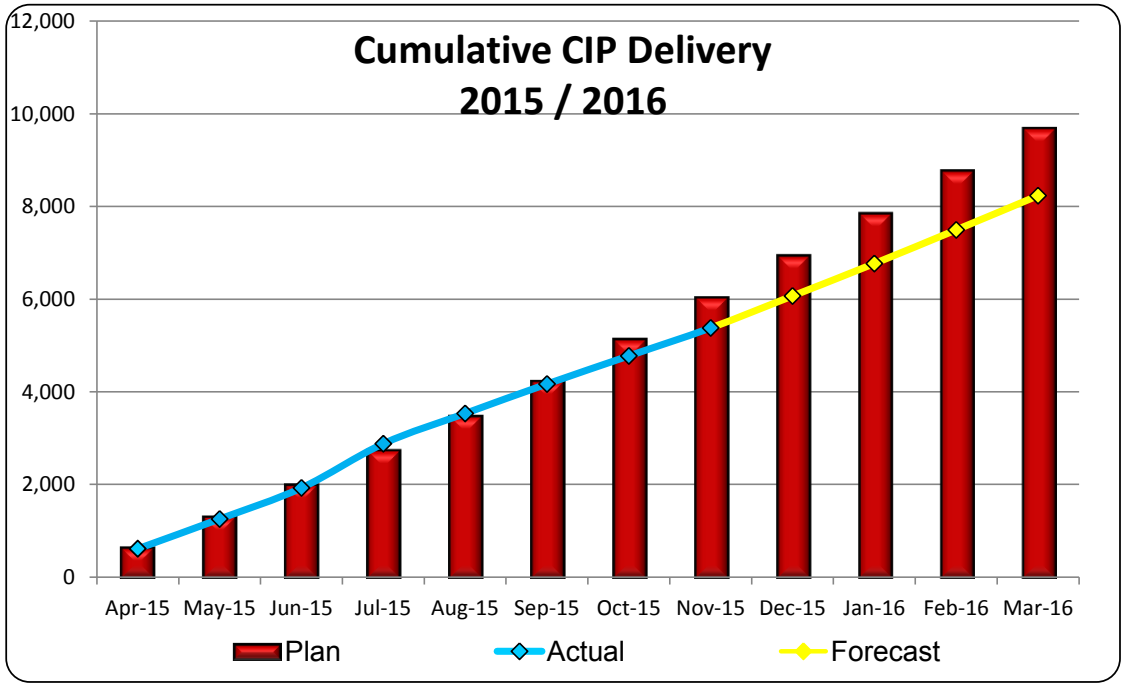
Delivery of this position incorporates the following assumptions; the most significant of which are:

*	£1.45m	Assumption that CIP's, classified as red, will not be achieved. Work is ongoing to find substitutions.
*	£0.23m	Assumption that CIP's, classified as amber, will be delivered in full during 2015 / 2016.
*	£2.7m	The planned disposal of a Trust asset during 2015 / 2016 will occur and cash payment will be received.
*	tbc	Impairments / revaluations / demolition - these risks continue to be assessed and quantified. As such they are not reflected in the current forecast.

Provisions will continue to be monitored and managed in order to ensure that this position is achieved.

Cost Improvement Programme 2015 / 2016

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Forecast
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
Target - Recurrent	606	613	642	686	690	705	845	850	849	856	856	864	5,636	9,061
Target - Non Recurrent	52	52	52	52	52	52	52	52	52	52	52	52	415	622
Target - Monitor Submission	657	664	694	738	742	756	897	902	901	908	908	916	6,051	9,683
Target - Cumulative	657	1,322	2,016	2,754	3,496	4,252	5,149	6,051	6,951	7,859	8,767	9,683	6,051	9,683
Delivery as planned	400	824	1,244	1,768	2,213	2,658	3,114	3,576	4,341	5,119	5,924	6,741	3,576	6,741
Mitigations - Recurrent	11	22	32	43	54	65	76	87	97	108	119	130	87	130
Mitigations - Non Recurrent	200	408	648	1,068	1,265	1,445	1,584	1,716	1,630	1,541	1,451	1,362	1,716	1,362
Total Delivery	**611**	**1,254**	**1,925**	**2,880**	**3,532**	**4,167**	**4,774**	**5,378**	**6,068**	**6,768**	**7,494**	**8,233**	**5,378**	**8,233**
Shortfall / Unidentified	46	68	90	(126)	(36)	85	375	673	883	1,091	1,273	1,451	673	1,451



The profile of the Trust Cost Improvement Programme for 2015 / 2016 is outlined above. This follows a detailed bottom up process conducted as part of the Trust Annual Plan; one which was subjected to an external review.

Year to Date

For the Year to Date £5.38m CIP has been achieved out of the £6.05m target. (89%) It is £673k behind plan.

The CIP acheivement includes £1716k non recurrent substitutions (32% of total delivered).

Forecast

The current forecast is that £8.23m out of £9.68m will be achieved in 15/16. This leaves a forecast shortfall of £1.45m (15%) and this is reflected in the Trust overall forecast position.

Within this forecast £1.36m is non recurrent and therefore the highline risk carried forward to 2016 / 2017 is currently £2.81m.

Balance Sheet 2015 / 2016

	2014 / 2015 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	106,649	110,204	109,909	1
Current Assets				
Inventories & Work in Progress	204	204	204	
NHS Trade Receivables (Debtors)	3,015	2,065	1,191	2
Other Receivables (Debtors)	4,963	5,113	6,416	2
Cash and Cash Equivalents	32,617	27,263	28,912	3
Total Current Assets	**40,799**	**34,645**	**36,722**	
Current Liabilities				
Trade Payables (Creditors)	(5,851)	(5,851)	(4,563)	4
Other Payables (Creditors)	(3,621)	(4,135)	(3,294)	4
Capital Payables (Creditors)	(770)	(1,120)	(759)	
Accruals	(10,335)	(9,035)	(12,125)	5
Deferred Income	(751)	(751)	(725)	
Total Current Liabilities	**(21,328)**	**(20,892)**	**(21,465)**	
Net Current Assets/Liabilities	**19,471**	**13,753**	**15,257**	
Total Assets less Current Liabilities	**126,120**	**123,957**	**125,167**	
Provisions for Liabilities	(8,104)	(7,422)	(7,230)	
Total Net Assets/(Liabilities)	**118,016**	**116,535**	**117,937**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	16,780	16,780	17,089	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	52,524	51,043	52,135	6
Total Taxpayers' Equity	**118,016**	**116,535**	**117,937**	

The Balance Sheet analysis compares the current month end position to that within the Monitor Annual Plan, submitted May 2015. The previous year end position is included for information.

1. Fixed Assets are currently slightly behind plan; as noted within the capital programme.

2. Debtors continue to be proactively chased. The largest element remains non NHS; specifically delays in block payments from Local Authority Commissioners.

3. 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 on page 12.

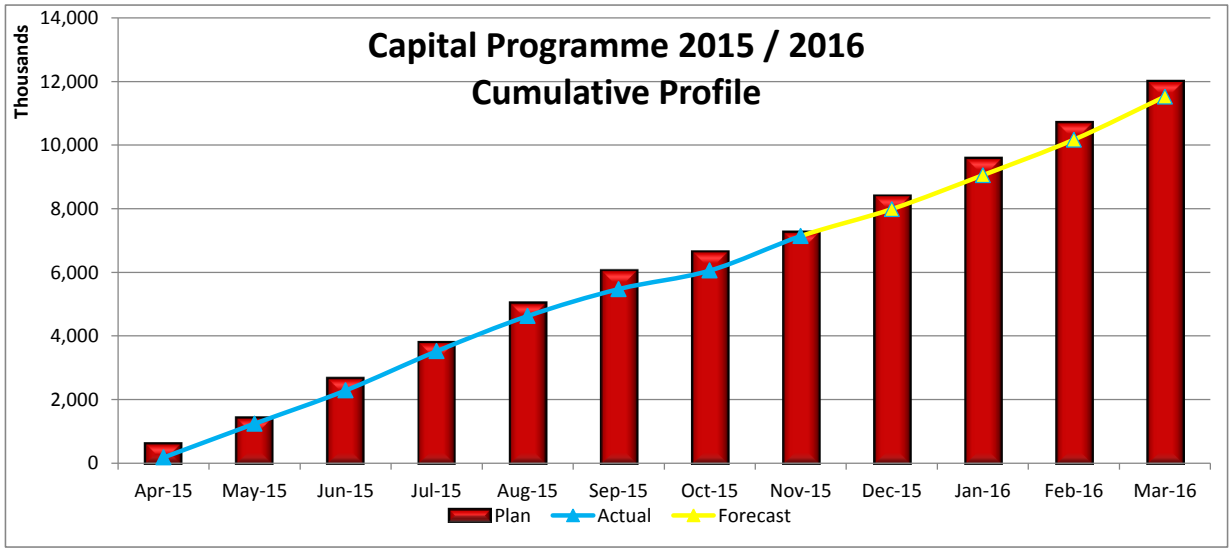
4. Creditors remain lower than planned as the Trust continues to proactively pay invoices. Work continues to ensure that the Trust does not hold any old creditor values / unresolved issues.

5. Accruals remain higher than planned as the Trust is still awaiting invoices.

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

Capital Programme 2015 / 2016

	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	2,200	1,331	1,216	(116)	2,362	162	4
IM&T	2,348	1,070	347	(723)	1,807	(541)	3
Total Minor Capital & IM &T	**4,548**	**2,401**	**1,563**	**(839)**	**4,169**	**(379)**	
Major Capital Schemes							
Barnsley Hub	950	950	1,168	218	1,172	222	5
Halifax Hub	4,052	3,726	3,651	(75)	4,100	48	6
Hub Development	1,450	0	516	516	1,658	208	7
Fieldhead Development	1,000	200	330	130	427	(573)	8
Total Major Schemes	**7,452**	**4,876**	**5,665**	**789**	**7,356**	**(96)**	
VAT Refunds	0	0	(90)	(90)	0	0	
TOTALS	**12,000**	**7,277**	**7,138**	**(139)**	**11,525**	**(475)**	



Capital Expenditure 2015 / 2016

1. The Trust Capital Programme for 2015 / 2016 is £12.0m and schemes are guided by the overall Trust Estates Strategy.

2. The year to date position is £0.14m under plan (2%). The current full year forecast is £11.53m.

Monitor has written to all Foundation Trusts during October and November 2015 to confirm capital expenditure plans and any potential deferment which can be undertaken. This position reflects the current Trust position.

3. IM & T spend has been reviewed and forecast reflects current expenditure levels.

Finalisation of several IM & T contracts have resulted in improved costs than expected from the original market testing prices used to formulate the capital programme.

4. Minor works schemes are forecast to marginally overspend.

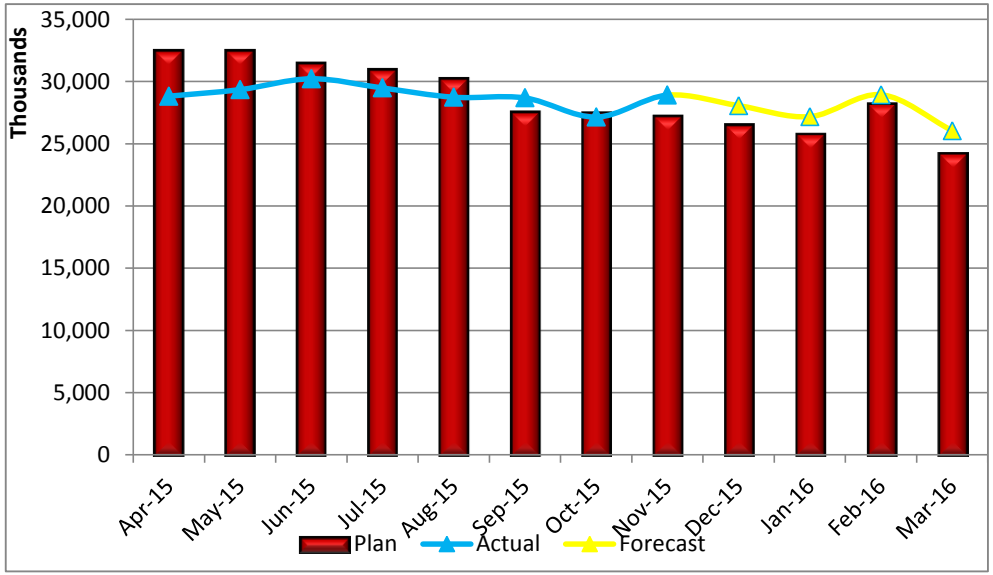
5. The Barnsley Hub is complete and the final account is currently being agreed.

6. The Halifax Hub will hand over on 18th december 2015 and the final account will be agreed after this date.

7. The Pontefract Hub scheme has commenced. And will spend to profile per the Business Case.

8. Expenditue on the Fieldhead Development (Non secure) remains a risk pending Trust Board decision.

Cash Flow & Cash Flow Forecast 2015 / 2016



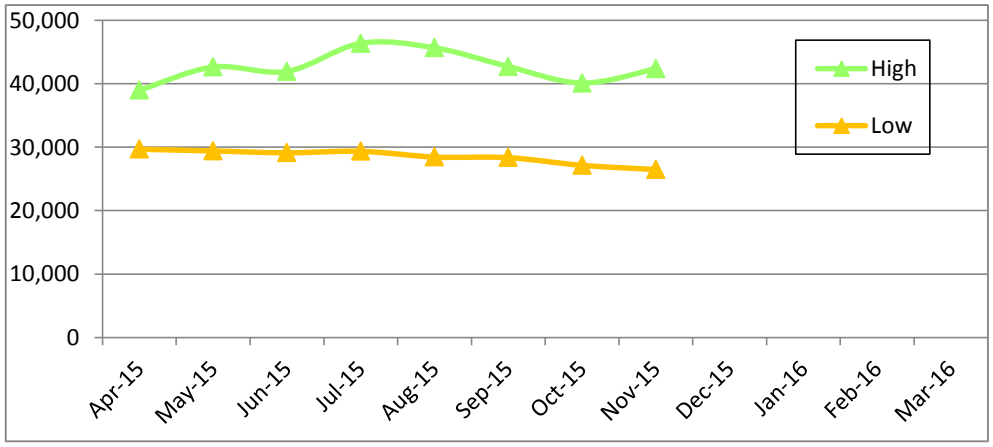
	Plan £k	Actual £k	Variance £k
Opening Balance	32,617	32,617	
Closing Balance	27,263	28,912	1,649

The Cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.
Weekly review of actions ensures that the cash position for the Trust is maximised.

Overall the cash position is £28.91m which is £1.65m higher than planned.

A detailed reconciliation of working capital compared to plan is presented at page 12.

Due to changes in the interest rates offered, the Trust is planning to utilise the National Loan Fund scheme to invest cash. This remains low risk investment but will attract improved rates of interest.



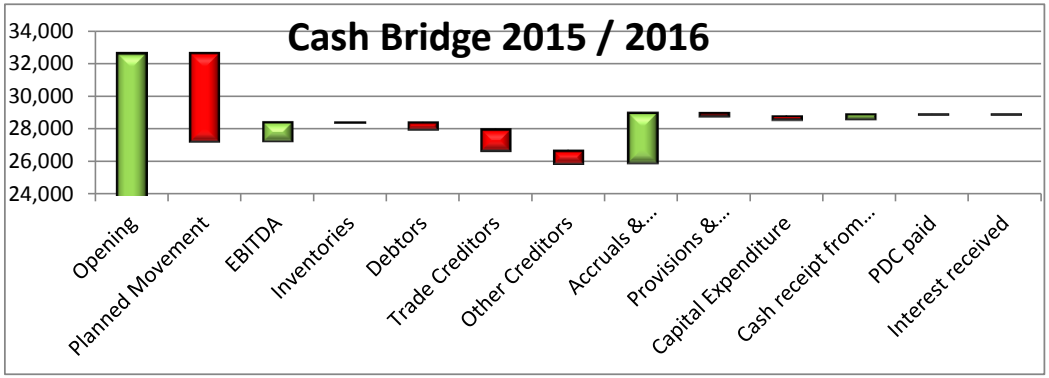
The graph to the left demonstrates the highest and lowest cash balances with each month. This is important to ensure that cash is available as required.

The highest balance is:	£42.39m
The lowest balance is:	£26.48m

This reflects cash balances built up from historical surpluses that are available to finance capital expenditure in the future.

Reconciliation of Cashflow to Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**32,617**	**32,617**		
Surplus (Exc. non-cash items & revaluation)	4,245	5,408	1,163	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	800	371	(429)	4
Trade Payables (Creditors)	0	(1,288)	(1,288)	5
Other Payables (Creditors)	0	(771)	(771)	
Accruals & Deferred income	(1,300)	1,763	3,063	2
Provisions & Liabilities	(682)	(874)	(192)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(6,927)	(7,149)	(222)	3
Cash receipts from asset sales	0	294	294	
PDC Dividends paid	(1,540)	(1,516)	24	
PDC Received	0		0	
Interest (paid)/ received	50	57	7	
Closing Balances	**27,263**	**28,912**	**1,649**	



The Plan value reflects the May 2015 submission to Monitor.

Factors which increase the cash positon against plan:

1. EBITDA, arising from the current operational I & E position, is better than planned. This is shown within the overall Trust financial position.

2. Accruals remain higher than planned. This gives the Trust a cash benefit as we have yet to receive and pay expected invoices. This includes c. £1m for SLA's which have not yet been invoiced.

Factors which decrease the cash position against plan:

3. Although the capital programme overall is behind plan the level of capital creditors is also lower than planned which have a negative impact on cash.

4 . Debtor levels overall are lower than planned. In particular non NHS continues to be the area of focus.

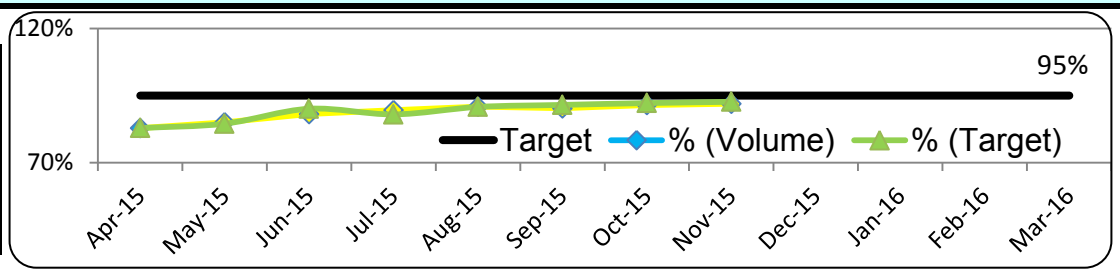
5. Creditors remain lower than planned as the Trust continues to proactively pay invoices as soon as possible. This is being reviewed in line with the Trust overall cash position.

The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

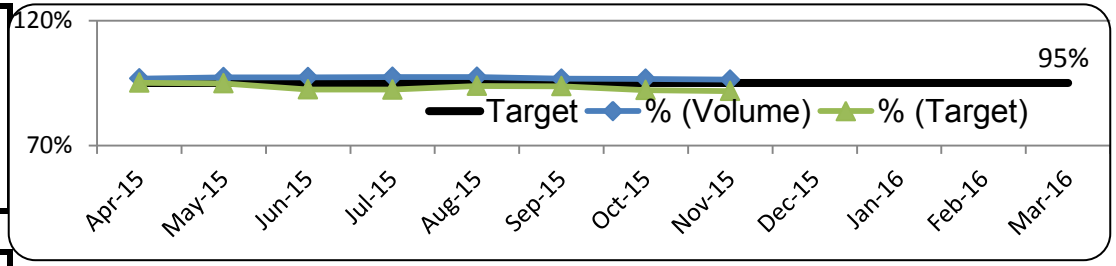
Better Payment Practice Code

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.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delviery of the 95% target and identify solutions to problems and bottlenecks in the process.

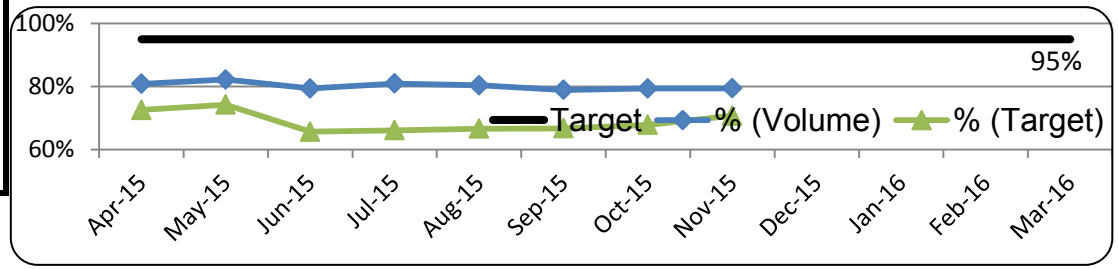
NHS	Number %	Value %
Year to October 2015	91%	92%
Year to November 2015	92%	93%



Non NHS	Number %	Value %
Year to October 2015	97%	92%
Year to November 2015	96%	92%



Local Suppliers	Number %	Value %
Year to October 2015	79%	68%
Year to November 2015	79%	71%



Transparency Disclosure

As part of the Government's commitment to greater transparency, there is a requirement to publish online, central government expenditure over £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.

At the current time Monitor 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.

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
16/11/2015	Availability Charge SLA	Calderdale	Calderdale and Huddersfield NHS Fou	8146730	208,398
04/11/2015	Staff Recharge	Barnsley	Barnsley Metropolitan Borough Counci	2191054	171,770
20/10/2015	Rent	Kirklees	Kirklees Council	2190448	59,241
26/10/2015	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	2190546	54,649
26/10/2015	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	2190546	51,824
16/11/2015	Legal/Prof Fees	Trustwide	NHS Litigation Authority	8146580	29,048
09/11/2015	Rent	Barnsley	NHS Property Services Ltd	2191323	27,704
04/11/2015	Local Authority - Admin & Cleri	Barnsley	Barnsley Metropolitan Borough Counci	2191055	26,970
10/11/2015	Staff benefits expenses	Trustwide	Childcare Vouchers Ltd	2191624	25,222

Glossary

* Recurrent - action or decision that has a continuing financial effect

* Non-Recurrent - 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

* 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 - This is the surplus we expect to make for the financial year

* Target Surplus - This is the surplus 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. Recently this has been set as part of the IBP/LTFM process. Previously we aimed to achieve breakeven.

* 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 pat of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - We only agree actions which have a recurring effect, so these savings are part of our Recurrent Underlying Surplus.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. This Trust has historically only approved recurrent CIP's. 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.

* IFRS - International Financial Reporting Standards, there are the guidance and rules by which financial accounts have to be prepared.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 7.3(i)

Title:	**Calderdale and Kirklees Child and Adolescent Mental Health Services (CAMHS) – progress report**
Paper prepared by:	Director of Nursing, Medical Director and Interim Director of CAMHS
Purpose:	To provide an update on progress in CAMHS service improvement
Mission/values:	Improve and be outstanding in relation to the delivery of services Open, honest and transparent in terms of public reporting
Any background papers/ previously considered by:	Regular reports previously provided to Trust Board, most recently in October 2015
Executive summary:	Following a successful tender bid, Calderdale and Kirklees CAMHS services transferred to the Trust in April 2013. As the work to transform services commenced, the scale of the challenge became clearer and a recovery plan was developed in February 2014. Following concerns from the Trust and Commissioners about the scale and pace of change, a series of multi-agency 'Summit' meetings have been held throughout this year to jointly oversee CAMHS improvement within the whole health and social care economy. Additional investment has been in agreed with Commissioners for a Crisis/Home-Based Treatment service for children and young people in Calderdale and Kirklees. Following the report of the National Taskforce and 'Future in Mind', the Government has also agreed additional investment nationally in children and young people's mental health and wellbeing. This paper provides a progress update and a verbal update will be provided following the CAMHS Summit on 18 December 2015. The Trust's Clinical Governance and Clinical Safety Committee monitors CAMHS performance across the Trust and received a detailed update on the Trust's portfolio of CAMHS in Barnsley, Calderdale and Kirklees, and Wakefield at its meeting on 2 November 2015.
Recommendation:	**Trust Board is asked to NOTE the progress report**
Private session:	Not applicable

Trust Board 22nd December 2015
Child and Adolescent Mental Health Services in Calderdale & Kirklees
Progress Report

Introduction

The Trust took on the responsibility for the provision of Tier 3 CAMHS in Calderdale & Kirklees in April 2013, following a successful tender bid. Both commissioners and the Trust have been clear that the scale of the challenge to remodel and transform the service was initially underestimated and a Recovery plan was implemented in February 2014.

In January 2015, the Trust invested in additional CAMHS management capacity and raised its concerns formally with Commissioners. This resulted in a programme of CAMHS 'Summits' with the CCG CEOs and local authorities looking to produce a joint resolution. The next meeting is planned for 18th December.

Formal Trust monitoring of all the Trust's CAMHS services now takes place through the Trust's Clinical Governance and Clinical Safety Committee, which received detailed reports in June, September and November 2016.

National Context

Following the Health Select Committee report in November 2014 and the National Task Force which reported in March 2015, mental health services for children and young people are now an important national priority. Significant investment in services for children and young people is now planned over the next 5 years, with £2.3 million available across Calderdale, Kirklees, Barnsley and Wakefield in 2016/17. As part of the national strategy, 'Future in Mind', all CCGs, including Calderdale and Kirklees CCGs, were required to identify a Lead Commissioner and complete Transformation Plans which set out how the new investment would be spent.

In Calderdale it was agreed that the Lead Commissioner would be the local authority, whilst in Kirklees it is the CCGs. The Transformation plans have now been completed, assured by NHS England and will all be published on the CCG websites. Key national priorities are the development of Eating Disorder services, Children & Young People's IAPT services and perinatal mental health.

There is every indication that mental health services for Children and Young People will remain a high profile service locally and nationally. Trust CAMHS staff are meeting with Kirklees Scrutiny councillors on 14th December and meet with other key stakeholders as requested.

SWYPFT and CCG Commissioners

As reported verbally to the Trust Board, the Summit meeting of 18th September acknowledged the work that had been done by the Trust and the improvements that had been made in the functioning of the service. It was agreed that a further meeting to consider progress would take place in December, by which time the CCG's Transformation Plans

would have been through the assurance process. This meeting is scheduled for 18th December and a verbal update will be provided to the Trust Board on 22nd December.

A 'Deep Dive' into the CAMHS service which proposed by Kirklees Council to the Kirklees Safeguarding Board in September was agreed to be undertaken – and to cover all aspects of CAMHS and not just Tier 3 - in 2016, in order to support the whole systems CAMHS transformation process. SWYPFT are now involved in developing the Terms of Reference for the review.

Commissioners and the Trust have reviewed the Recovery Plan and agreed that this phase of the work is now complete. Both are now working on a revised Action Plan, which reflects the actions now needed to improve the service – given the investment, Commissioner visits and the Transformation agenda.

The five CCGs have proposed in their Transformation Plans that they work together to commission a service for children and young people with Eating Disorders – and have indicated that they would wish to work with SWYPFT to develop such a service. The additional funding for Eating Disorders is £666,231 across the five CCGs. There is clear and detailed national guidance on developing such a community based service for Eating Disorders, which will support some of our most vulnerable children and young people.

The CCG have reiterated their commitment to contracting with the Trust in 2016/17, following the expiry of the original 3 year contract. This remains the intention of both parties, although the exact contractual mechanism to enact this intention remains to be finalised before 1st April 2016.

Very long waiting lists remain in Calderdale & Kirklees for a diagnosis of Autistic Spectrum Disorder. Diagnosis is a complex multi-agency process, involving schools and a variety of professional staff, such as paediatricians, psychologists and speech and language therapists. SWYPFT provides psychology input into this process, but currently commissioned capacity cannot keep pace with demand. Commissioners are now looking at options to reduce the current waiting lists and to put in place a clear pathway for the provision of ASD services in the future and the Trust will work to support this.

Service Development & Leadership

It is planned to move the main administrative and office base for Calderdale & Kirklees CAMHS from Broad Street Plaza to Laura Mitchell House in the week beginning 21st December 2016. Laura Mitchell House is a purpose built Trust building which will provide a much better reception and environment for those children and young people who need CAMHS services.

On 11th December the Calderdale & Kirklees staff met together to review the past year and to plan further how the service can best put the child at the centre of all its work. It is clear that the service – with the recruitment of new permanent staff (including the General Manager and Practice Governance Coach) and the development of the Crisis and Home Based Treatment Team – has changed and developed, with new staff and a noticeable improvement in staff morale.

The post of Director of Forensic and Specialist Services - which will have the responsibility for CAMHS services - has now been appointed to. The interim Director will work to ensure a smooth and effective transition of responsibilities over the coming weeks.

Conclusion

There is still work to be done to develop and improve the service, to see the impact of that improvement consistently in our metrics and to meet our aim of being a leading provider of CAMHS where children, young people and their families come first. However, over the past year, solid foundations have been laid in Calderdale and Kirklees, in partnership with our commissioners and partners, for the development of a service that can offer a more responsive and effective service to children, young people and their families.

This is complemented by the increased national profile that mental health services for children and young people now occupy and the significant additional investment that is now materialising. That the contribution and importance of CAMHS services – as part of the whole systems that supports good emotional health and wellbeing in children and young people – is more fully recognised and acknowledged is to be welcomed.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 7.3(ii)

Title:	**Serious incident report Q2 2015/16**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	This report provides overall information in relation to incidents in Quarter 2 and more detailed information in relation to serious incidents.
Mission and values:	• Honest, Open and Transparent • Person First and in the Centre
Any background papers/ previously considered by:	A more detailed report is sent quarterly to the Clinical Governance and Clinical Safety Committee and previous quarterly reports have been presented to Trust Board. The annual report is submitted to the Committee, Trust Board and the Members' Council.
Executive summary:	➢ The report contains overall figures for incident reporting. Trust reporting is similar to previous quarters with 2,911 incidents in Q2. ➢ Physical violence (contact made) by patient against staff was the most reported category, reflecting the previous two quarters. ➢ There have been no 'Never Events' reported in the Trust during Q2. ➢ There have been 23 serious incidents during Q2. The highest category of serious incident is apparent suicides of current service users (seven). ➢ The number of serious incidents is higher this year than in previous years; however, the category of apparent suicide at point of reporting is similar to numbers in the rolling last four quarters. This remains a higher level of expected cases based on National Confidential Inquiry numbers. A detailed piece of work has been completed in relation to Kirklees Q1 incidents and no themes were identified with some reports on the incidents producing no recommendations. This report was shared with the Clinical Governance and Clinical Safety Committee. ➢ The independent review process was completed in relation to the Kirklees Homicide cases 2010.9926, 2011.11370 and 2011.11502. The review is classed as level C which is mainly desktop with some interviews. The report has been presented to Trust Board. NHS England also requested that the investigation covered the learning outcomes from three previous Kirklees homicides that took place in 2007/08. An action plan has been developed and is being monitored through Clinical Governance and Clinical Safety Committee and the Quality Board with commissioners. This is now almost complete and should be signed off as 'complete' by commissioners before the financial year-end.
Recommendation:	**Trust Board is asked to Trust Board is asked to NOTE the report and identify any areas that may require further review by the Clinical Governance and Clinical Safety Committee**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

TRUST-WIDE INCIDENT MANAGEMENT SUMMARY REPORT

QUARTERLY REPORT FOR THE PERIOD 1 JULY 2015 – 30 SEPTEMBER 2015

(QTR 2)

This summary report has been prepared by the Patient Safety Support Team to bring together Trust wide information on incident activity during Quarter 2 (July 2015 to September 2015), including reported serious incidents.

Please note that figures within this report may vary slightly from the individual BDU Reports due to movement/grading changes of incidents whilst producing the reports.

The content of the report has been structured into separate report sections, which can be accessed within this report

1 UPDATES FROM THE PATIENT SAFETY SUPPORT TEAM

1.1 INCIDENT REPORTING AND DATIXWEB UPDATES

- The Datix team have continued to provide Datix Reports Training where Datix users have the opportunity to learn how to analyse their team's data in either the work place or a classroom environment.

- Training for managers and specialist advisors on how to review incidents and navigate around Datix continues. This takes various forms such as one to one sessions and phone coaching and advice.

- For managers and specialist advisors who need Datix training (new staff or refresher) please contact 01226 434779/01422 222931 or email Datix@swyt.nhs.uk.

- The Incident Management Annual Report has been completed. A learning report is also available, which is available on the Patient Safety intranet pages - click here

- Work is underway on the Datix Dashboards project. Specialist Advisors and all Trios have been given access to their Dashboards and to date the feedback is very positive. The next phase will involve giving ward and team managers access to ward/team specific Dashboards. Video guides to support this new feature have been developed.

- Duty of Candour (Being Open) monitoring continues. This will support the Trust in meeting its value of being open, honest and transparent. The performance measure in relation to duty of candour support regulatory requirements being met.

- The National Benchmarking has been completed for CAMHS, Restraints, Community Hospitals, General Community services.

- On 6th October 2015, Datix was successfully upgraded. Further information on the changes is available here.

- The categories of medication incidents have been changed in light of advice from the National Reporting and Learning System (NRLS) and to match national categories. The controlled drug category has been removed and incidents should be categorised according to the appropriate step in the medicines management process e.g. prescribing, dispensing or administration. Controlled drugs are identified by a separate question in the medication section which will be completed by pharmacist specialist advisors.

1.2 WORK IN PROGRESS FOR IMPLEMENTATION IN QUARTER 3

- SI Additional Information field will include details of Information Governance Incidents that require reporting as Serious Incidents.

- Implementation of new features in Datix following the upgrade.

- Work is underway to develop ways of providing teams with refresher training on incident reporting. Various methods are being developed, such as Video guides, which are already available here on the Intranet. Another area for development is using Datix Champions – someone in a team/service who can be trained and supported by the Datix team to cascade the requirements to the rest of their team.

1.3 CHANGES IN SERVICES IN QUARTER 2

The Patient Safety Support Team is not aware of any changes.

1.4 INCIDENT ANALYSIS AND TRAINING REQUESTS FROM BDU'S

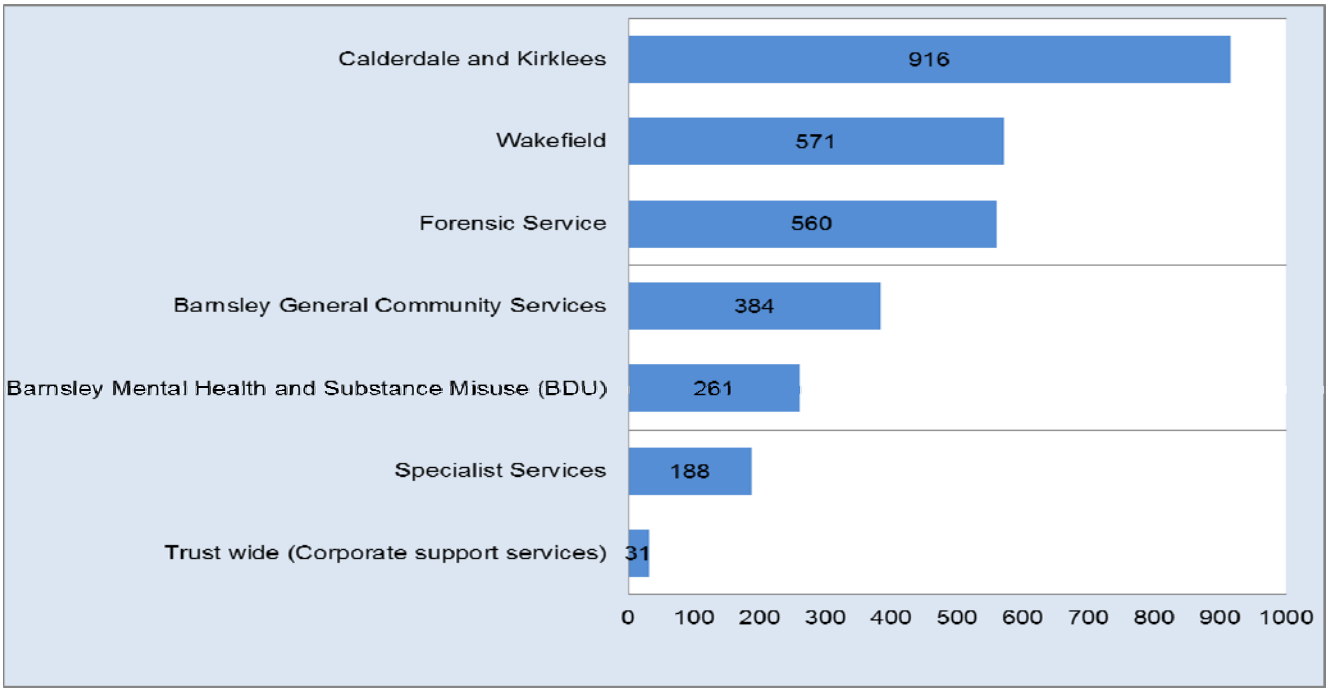
During Quarter 2, the Patient Safety Support Team has received the following requests for analysis of incident data and training:

BDU	**Quarter 2 14/15**
Kirklees and Calderdale BDU	Reports for specific patient related incident activity Training for CMHT community Therapies, Kirklees Listing report for patient related incident activity
Wakefield BDU	No requests received
Barnsley BDU	Number and Category of incidents for 0-19 services
Forensic BDU	Request for data relating to V&A pre and post smoking ban
Corporate Services	Claims & Inquests opened/closed for fin. years 2010 through 2015 Details of inquests open 2010 to 2015 Falls data for Falls Summit Suicide data for Kirklees to support Agile working Request for incidents and categories - Sept 04 - Aug 05 for Agile working
Specialist Services	CAMHS Wakefield – incident data CAMHS Barnsley – incident data Training for LD staff on Datix analysis to support Trios
Trust wide	Restraint Benchmarking – August 2015 Falls data for Falls summit

1.5 FREEDOM OF INFORMATION REQUESTS RECEIVED WITHIN QUARTER 2

Request Reference	Information Requested
FOI 1007 7/7/15	The total number of deaths per year since 2011 The total number of deaths per year since 2011 that have been investigated The total number of deaths per year since 2011 that have been recorded as 'unexpected' The total number of deaths per year since 2011 that have been recorded as 'unexpected' and have subsequently been investigated. The number of serious incidents recorded per year since 2011. The number of serious incidents recorded per year since 2011 that have been investigated. The total number of deaths per year since 2011 The total number of deaths per year since 2011 that have been investigated The total number of deaths per year since 2011 that have been recorded as 'unexpected' The total number of deaths per year since 2011 that have been recorded as 'unexpected' and have subsequently been investigated. The number of serious incidents recorded per year since 2011. The number of serious incidents recorded per year since 2011 that have been investigated.
FOI 1021 24/07/2015	The number of incidents recorded that have included the word “selfie” in 2014 and 2015. That information broken down into the date of the incident, where it was and the nature of the incident.
FOI 1048 09/09/2015	How many service users (patients) who were not detained under the Mental Health Act, in an inpatient facility at your trust have died at that facility in the following years and was the death natural, suicide or accident? (If none of those categories are available please still include the figure and if possible please list by the facilities name) a) 2013 b) 2014 c) So far 2015 How many service users (patients) have died in the community within a month of being discharged as an inpatient from a facility within your trust and was the death natural, suicide or accident? (If none of those categories are available please still include the figure and if possible please list by the facilities name from where the service user was an inpatient) a) 2013 b) 2014 c) So far 2015
FOI 1052 08/09/2015	A breakdown of the amount of attempted suicides by patients under the care of your trust A breakdown of the amount of patients who successfully killed themselves under the care of your trust

2. INCIDENTS REPORTED TRUSTWIDE WITHIN THE QUARTER BY BDU



2.1 TRUSTWIDE COMPARATIVE DATA 01 JULY 2014 TO 30 SEPTEMBER 2015 (ROLLING 5 QUARTERS)

	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16
Total Incidents Reported	2854	2681	2674	3013	2911
Total Number of Green (No Harm Incidents Reported)	1522	1486	1474	1620	1543
Total Number of Green (Low Harm Incidents Reported)	895	793	823	941	909
Total Number of Moderate (Yellow) Incidents Reported	377	342	315	377	355
Total Number of Amber Incidents Reported	44	35	42	58	79
Total number of red incidents reported	16	25	20	17	25
Most Reported Category of Incident	Physical aggression/threat (no physical contact): by patient	Physical aggression/threat (no physical contact): by patient	Physical violence (contact made) against staff by patient	Physical violence (contact made) against staff by patient	Physical violence (contact made) against staff by patient
Team who reported most signifcant number of incidents	Elmdale Inpatient Services Ward	Elmdale Inpatient Services Ward	Beechdale Ward, The Dales Unit	Ward 19 - Priestley Unit (OPS)	PICU unit (Trinity 1) - trustwide
How many "Lessons Learnt were extracted from the incidents reported within the quarter (note more than one "Lessons Learnt" can be selected. Not all incidents will have included Lessons Learnt)	945	824	956	966	853
Most Frequent Lessons Learned Theme is	Risk assessment	Patient engagement	No recommendations	Risk assessment	Patient engagement

3. LEARNING IDENTIFIED BY SPECIALIST ADVISORS

Specialist Advisors have been asked to provide the Patient Safety Support Team with information on any significant learning, identified peaks, notable advice given, on a quarterly basis.

There was no learning provided this quarter.

4. DUTY OF CANDOUR RESULTS FOR QUARTER 2 2015/16

The Trust now has a statutory duty to be open, honest and transparent in our communication with service users (and their families or carers where necessary) whenever moderate harm or above harm has occurred. This is known as Duty of Candour. This involves providing information and an explanation about what has happened, what further enquiries will be made, and where appropriate, an apology. It also involves providing updates on the investigation or review and discussing the outcome. Ideally this should be in writing.

BDU	No of Incidents where the degree of harm was moderate, severe or resulted in Death (Caused by Patient Safety Incident)	Initial Duty of Candour met	Feedback of Outcome of the investigation met	Feedback of Outcome of the investigation to be completed via SI Process	Comments/Exceptions
Barnsley General Community Services	28	28	27	0	1 investigation is ongoing
Barnsley MH&SMS	2	2	0	1	1 investigation is ongoing
Calderdale and Kirklees	17	16	9	7	1 exception in relation to safeguarding incident
Wakefield	7	7	1	3	1 – awaiting update as there is no evidence on Datix that a discussion took place in relation to the outcome of the investigation 1 – attempts being made to contact family 1 – query on degree of harm
Forensic Services	0	0	0	0	
Specialist Services	0	0	0	0	
Total	**54**	**53**	**37**	**11**	

*The Degree of harm is used to report incidents to the National Reporting and Learning system and is completed by PSST from information provided.

5. TRUST WIDE SERIOUS INCIDENT (SI) REPORT FOR QUARTER 2 2015/16 (DATA AS AT 1/10/2015)

The SI figures given in different reports can vary slightly. This report is based on the date the SIs were reported to the CCG via the DOH database, STEIS.

1. Never Events

Never Events is a list (DOH) of serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Quarter 1 15/16	Quarter 2 15/16	Quarter 3 15/16	Quarter 4 15/16
0	0		

2. Serious Incidents reported to the Commissioners

During Quarter 2 there have been 23 serious incidents reported on STEIS.

Total SIs reported to the Commissioner by financial year and quarter up to the date of this report (2011/12 - 2015/16)					
Financial quarter	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**
Quarter 1	12	15	14	31	18
Quarter 2	12	7	27	24	23
Quarter 3	18	10	31	30	
Quarter 4	6	12	29	21	
Totals	**48**	**44**	**101***	**106**	**41**

SIs reported by team types and BDU for Q2	Barnsley Mental Health & Substance Misuse	Barnsley General Community	Calderdale	Kirklees	Wakefield	Specialist Services	Corporate support services	Total
Acute Inpatients (Adult)	0	0	0	1	0	0	0	1
Assertive Outreach Team (Adult)	0	0	0	1	0	0	0	1
CAMHS - Calderdale and Kirklees	0	0	0	0	0	1	0	1
CMHTs (Adult)	1	0	2	3	2	0	0	8
CMHT's (OPS)	0	0	0	2	0	0	0	2
Crisis/IHBTT (Adult)	0	0	0	0	3	0	0	3
District Nursing	0	1	0	0	0	0	0	1
Early Intervention Services	0	0	0	0	2	0	0	2
Information Management and Technology	0	0	0	0	0	0	1	1
Liaison Services	0	0	0	1	1	0	0	2
Inpatient Assessment and Treatment (PLD)	0	0	0	0	0	1	0	1
Total	1	1	2	8	8	2	1	23

SIs reported by Incident type and BDU for Q2	Barnsley Mental Health & Substance Misuse	Barnsley General Community	Calderdale	Kirklees	Wakefield	Specialist Services	Corporate support services	Total
Confidentiality issues	0	0	0	0	0	1	0	1
Death - other cause	0	0	1	0	1	0	0	2
Fire / Fire alarm related incidents	0	0	0	0	1	0	0	1
Other	0	0	1	0	0	0	0	1
Physical violence (contact made) against patient by patient	0	0	0	1	0	0	0	1
Physical violence (contact made) against staff by patient	0	0	0	0	0	1	0	1
Physical/sexual violence by patient	0	0	0	1	0	0	0	1
Self harm (actual harm) with suicidal intent	0	0	0	2	1	0	0	3
Suicide (incl apparent) - community team care - current episode	1	0	0	4	2	0	0	7
Suicide (incl apparent) - community team care - discharged	0	0	0	0	3	0	0	3
Virus	0	0	0	0	0	0	1	1
Pressure Ulcer - grade 3	0	1	0	0	0	0	0	1
Total	1	1	2	8	8	2	1	23

From February 2015 the reporting of pressure ulcers as serious incidents changed. From this date, only pressure ulcers that are attributable to SWYPFT services and are avoidable are reportable as serious incidents. During Quarter 2, there was only one pressure ulcer incident that met the criteria.

The highest category of serious incidents during Quarter 2 is apparent suicides of current community service users (7), followed by self harm with suicidal intent (3).

3. **Suspected Suicide reported to the Commissioners**

The National Confidential Inquiry figures **July 2015** indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2003 to 2013 there are approximately 10.1 suicides per 100,000 general populations each year. (range 9.4-10.6) (West Yorkshire 9.9 and South Yorkshire & Bassetlaw 9.4
- On average during 2003-2013 patient suicides accounted for 28% of the general population suicide figures

The table below shows the populations of the BDUs and some average suicide rates which would be consistent with the figures produced by the NCI.

District	Population ONS – population estimates Mid 2014	General population suicide rate (NCI) 10.1 per 100,000	Patient suicide rate (28% general pop) (NCI)
Barnsley	237,843	24	7
Calderdale	207,376	21	6
Kirklees	431,020	43-44	12
Wakefield	331,379	33-34	9
Trustwide	1,207,616	122	34

ONS – Office of National Statistics
NCI – National Confidential Inquiry into Suicide and Homicide by people with Mental Illness

Suspected Suicides reported on STEIS between 1/10/14 – 30/9/15

	Barnsley Mental Health & Substance Misuse	Calderdale	Kirklees	Wakefield	Forensic Service	Total
14/15 Q3	3	3	2	3	0	11
14/15 Q4	3	1	6	2	0	12
15/16 Q1	2	0	8	1	1	12
15/16 Q2	1	0	4	5	0	10
Total	9	4	20	11	1	45

Breakdown of Suspected Suicides in Quarter 2 15/16 by Subcategory

	Barnsley Mental Health and Substance Misuse	Kirklees	Wakefield	Total
Burning - self injury	0	0	1	1
Cutting - self injury	0	1	0	1
Drowning - self injury	0	0	1	1
Hanging - self injury	1	3	2	6
Method unknown - self injury	0	0	1	1
Total	1	4	5	10

All serious incidents are subject to investigations**. It must be noted that the figures above are apparent suicides and not confirmed by the Coroner**. The total figure must be viewed with caution as the national figures above are 2 years out of date when produced so can only be indicative. The yearly figures appear to be higher than those based on National Confidential Inquiry figures for a population the size of the Trust and patient suicide (28%).

Performance Management of Serious incidents

- **15** SI reports have been completed this quarter and sent to the Commissioners
- **15** SI reports have been closed by the Commissioners during the quarter
- There are currently **29** open SI investigations taking place across the Trust which are at the following stages (as at 1.10.15):

	Barnsley Mental Health & Substance	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Corporate support services	Total
Lead Investigator being allocated	1	0	4	1	0	0	1	7
Investigation within 60 working days and on track	0	1	2	6	0	2	0	11
Investigation within 60 working days but off track	0	1	2	1	0	0	0	4
Investigation report over 60 working days, no extension agreed	0	0	0	0	1	0	1	2
Investigation report over 60 working days but extension agreed	1	0	2	0	1	0	0	4
Investigation sign off process - on track	0	0	1	0	0	0	0	1
Total	**2**	**2**	**11**	**8**	**2**	**2**	**2**	**29**

Breakdown of those over original timescale

Overdue breakdown:	Barnsley MH &SMS	Barnsley Community	Calderdale	Wakefield	Kirklees	Forensic Service	Specialist Services	Corporate Services	Total
4-6 months since reported on STEIS	1				3	1			**5**
7-9 months since reported on STEIS						1			**1**
10-12 months since reported on STEIS								1	**1**
Total	**1**				**3**	**2**		**1**	**7**

From 1 April 2015, the national policy (Serious Incident Framework, NHS England) was updated, and the timescales for completion was revised to complete investigations within 60 working days. While the Trust tries to achieve this, it has the support of commissioners to complete a quality report above a timely report.

The 7 reports that are more than 3 months (60 working days) since the incident was reported are:-

- 10-12 months -1 information governance incident that was a legacy case that the Trust is still assessing information from a third party to see if this is an incident. The Commissioners have put this incident on hold until we get more information.
- 7-9 months –a management investigation
- 4-6 months there are 6 reports. All these are expected to be delivered within the 4th month. The delays are due to complexity and being able to interview staff over the main holiday period.

The patient safety team are experiencing difficulties in allocating investigations due to the increase in reported serious incidents. This is due to a vacancy of a lead investigator post. The post has been recruited but the person has yet to start in the post. The trust is also reviewing the investigation process in light of national guidance that came out in April.

4. SI Action plans

Each BDU monitors the implementation of action plans. The Patient Safety Support Team send out information on the current position status based on information completed on Datix each month in the Incident management monthly edition of the SI information and a detailed report to Directors and Deputy Directors of the BDUs. This is providing real time data more regularly and reducing overdue action plans. The Clinical Support Unit is randomly reviewing completed action plans to provide Clinical Commissioning Group Assurance.

5. Updates on other SIs

Independent Reviews (DOH guidance HSG (94)27)

The independent review process has been completed in relation to the Kirklees cases listed below. The review is level C which is mainly desktop with some interviews. The investigation reports were published in January 2015. NHS England has also requested the investigations covers the learning outcomes from 3 previous Kirklees homicides that took place in 2007/8.

- **Kirklees BDU: 2010/9926** – A Kirklees CMHT service user being convicted of the murder of a neighbour and sent to prison. An internal investigation was completed in Feb 2011, and the action plan to address the recommendations has been implemented by the BDU and has evidence to demonstrate this.

- **Kirklees BDU: 2011/11370 and 2011/11502 -** 2 recent alleged homicides by ex-service users have been confirmed as homicide cases. The internal Trust investigations into these cases are completed and action plans are being implemented. 2011/11370 has been subjected to a domestic homicide review which is a multi-agency review and overseen by the Home Office.

  The action plan will be monitored through the clinical governance and clinical safety committee and with the Commissioners through the quality board. The action plan is nearing completion.

6. Serious Incident Learning

Reporting on SI learning is included in this report and the annual report.

Following on from the increased incidents in Kirklees BDU last quarter a further review has taken place of these cases with the BDU. The report will be submitted to the Clinical Governance and Clinical Safety Committee.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 7.3(iii)

Title:	**Learning lessons report April to September 2015**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	To demonstrate the Trust's continued commitment to learning lessons from incident reporting.
Mission and values:	• Honest, Open and Transparent • Person First and in the Centre
Any background papers/ previously considered by:	The annual and quarterly incident reports report are presented to Trust Board and the Clinical Governance and Clinical Safety Committee.
Executive summary:	This is the second edition of "Our learning journey from incidents" report. The report will develop over time as one of the mechanisms to share learning across the Trust. Lead investigators have worked with Practice Governance Coaches to capture this work. The report has some general developments to support learning lessons, such as the roll-out of the Datix dashboard, which provides up-to-date information on incidents, information on the National Confidential Inquiry key findings and then a section for each BDU about incidents and general developments and BDU learning events. Pharmacy colleagues have undertaken work to ensure the message about opiates and suicide is communicated internally and shared with clinical commissioning groups (CCGs) so CCGs can escalate in primary care. It also includes learning specific to BDUs, such as: - including an invitation for people to be accompanied to appointments in appointment letters or offers made by telephone; - within the tissue viability service, documenting areas of skin that have been inspected and are in intact to improve the quality of record keeping in relation to pressure area management; - changes to how the Trust reviews and manages drugs such as Dosulepin and how service users are specifically offered information regarding their medication; - improvements to administrative processes following a number of incidents relating to information governance, including revision of the process for generating letters through the Trust's clinical information system, RiO; - improving the systems in place to ensure that medical staff have undertaken mandatory training.
Recommendation:	**Trust Board is asked to RECEIVE the report and NOTE the contents**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Our Learning Journey from Incidents

April to September 2015

Contents

Introduction

Welcome to the second edition of the Trust learning report, a lot has been happening and this report captures a few of these things.

The Trust continues to learn from incidents and developing a learning culture. This report captures some of the changes to support learning that has taken place from incidents reported in the last six months with the Trust.

This report is based on the completed investigation reports that have been submitted to the Commissioners between 1st April 2015 and September 30th 2015 from a Business Delivery Unit perspective.

The report will also bring you a flavour of the changes that have taken place in practise as a result of the action plans being implemented and the future development plans within the Business Delivery Units.

The report should be read alongside the quarter 1 and 2 incident reports.

The Lead Investigators have worked with the Practice Governance Coaches to capture this work.

There were a total of 34 investigation reports completed between 1st April 2015 and 30st March 2015.

Of the 34 investigations sent to the commissioners in this period, 22 resulted in an action plan, which led to 44 recommendations being made. 12 reports made no recommendations.

General developments

DatixWeb dashboards are being developed and rolled out following a successful business case. The dashboards provide visually displayed, real time data on incidents that are configured to meet the needs the end user. To date all Consultants, specialist advisors and management Trio's(service manager, practice governance coach and clinical lead) have access to dashboards to support their work. The feedback has been really positive from reduction in the amount of time taken by specialist advisors to produce reports to a practice governance coaches and managers commenting on how useful to be able to see trends.

The next step is to roll this out to team/ward managers in November.

Restraint work in the Trust receives national recognition

The work the MAV team and the patient safety support team have undertaken over a number of years to capture rich data following a restraint incident on DatixWeb has been positively commented on by the Department of health and have requested the George Smith the assistant director of nursing present this at meeting in January 2015 at a Champions' Network event to share the Trust approach.

National confidential inquiry into suicide and homicide by people with mental health

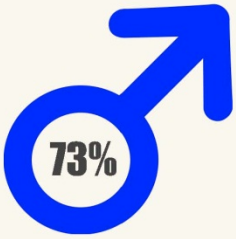
This report is publishes annually in July. Some staff members went to the launch event in July which had a number of interesting presentations. The link below takes you to the full report, a PowerPoint presentation, service user information and the informatics poster which has key headlines. We think this is so helpful that we have added this as the next two pages of this report.
http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Key Findings - Annual Report 2015

Suicide in male patients

There has been a 73% increase in suicides in male patients aged 45-54 in the UK since 2006.



Pressures on acute mental health care

There is continuing concern over suicide in acute care, particularly the increase in deaths under crisis resolution / home treatment teams in England.

Patient suicide in acute care in England

9%
In-patients

14%
Crisis Resolution / Home Treatment

17%
Recently discharged patients

Suicide by opiate overdose

Opiates are the most common type of drug taken in fatal overdose in the UK.

Number of patient suicide by opiates in the UK

2003 2013

Stranger homicides

7% of stranger homicides are committed by mental health patients. The figure has fallen from a peak in 2006.

7%
Percentage of stranger homicide committed by mental health patients in the UK

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness

Key Findings - Annual Report 2015

Working with families

Families could play a greater part in suicide prevention.

Families and carers are an under used resource

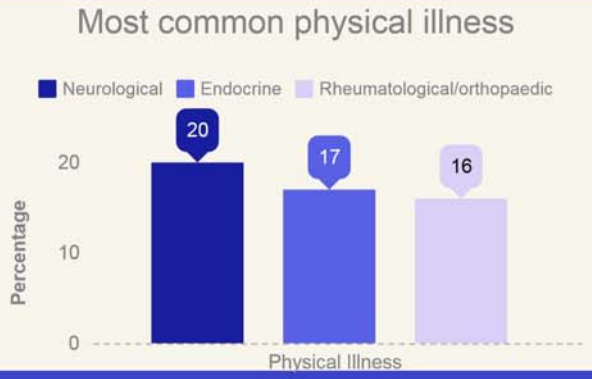
Staff told us closer contact with patient's families in their view could have reduced risk in:

14%
Patient suicides

18%
Patient homicides

Physical illness

In the UK around a quarter of patients who die by suicide have a major physical illness.



Sudden Unexplained Death in In-patients in England and Wales

Most SUDs in younger patients (<45 years) have a lower rate of known physical illness and a higher rate of polypharmacy.

9 sudden unexplained deaths per year in patients <45 years

24%
Cardiovascular disease

20%
Respiratory disease

13%
Epilepsy

Barnsley Business Delivery Unit

Mental Health Services

Barnsley Mental Health Services submitted 4 completed investigation reports to the Commissioners in the period 1st April 2015 to 30th September 2015.

Speciality where the incident was identified.

Table 1 below shows the speciality of the team for where the completed investigation took place, the incident details and if a recommendation was identified.

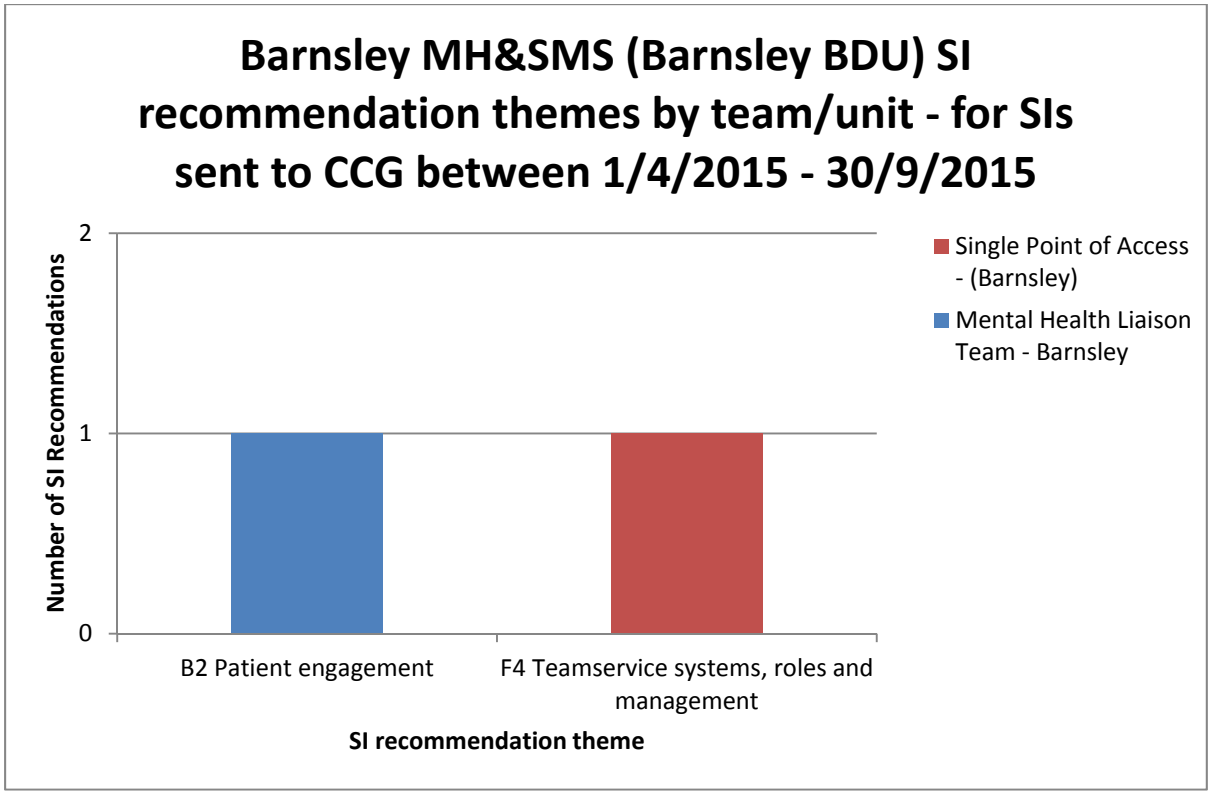
Table 1: Speciality for where investigation completed/incident/demographics and recommendations made

	Speciality	Detail of incident	Demographics for apparent suicides	Recommendation made (yes/no)
1	Mental Health Liaison Team	Hanging	Male Aged 67 Married : lived with wife Retired	Yes
2	Community Mental Health Team North Barnsley	Overdose of Nefopam	Male: Aged 45 Single: Lived alone Unemployed	No
3	Intensive Home Based Treatment Team Barnsley	Serious self-harm Service user fell from 1st floor window of house	Female Aged 50 Married: lived with husband Unemployed	No
4	Single Point of Access Barnsley	Overdose of unknown substance	Male Aged 45 Married : lived with wife Unemployed	Yes

Recommendations

Only two of the investigations made any recommendations for which there were a total of two.

The below chart shows the details of the recommendations made for the Barnsley Business Delivery Unit from the investigations.



As there were only two recommendations and they relate to separate areas, no themes have been identified.

Lessons learned

Three out of the four completed investigations identified lessons learned. These are summarised below:

- Where it is possible, obtaining collateral history from relatives or significant others may provide a comprehensive assessment of mental health issues and risks.
- One investigation highlighted the challenges for mental health teams in assessing and supporting people with a combination of emotionally unstable personality disorder, alcohol and prescribed medication misuse due to the associated risk factors. It reminded practitioners that Alcohol use is associated with increased risk of unintentional injury and increased risk taking behaviours, which can have negative consequences for physical and mental health.
- When a service user is subject of an assessment a letter is normally sent to the GP providing details of the assessment. The benefit of sending a similar letter to those people who refuse or decline treatment, future assessments and support for their mental health needs which would also include information on how to access the service for this support or advice in the future was recognised.

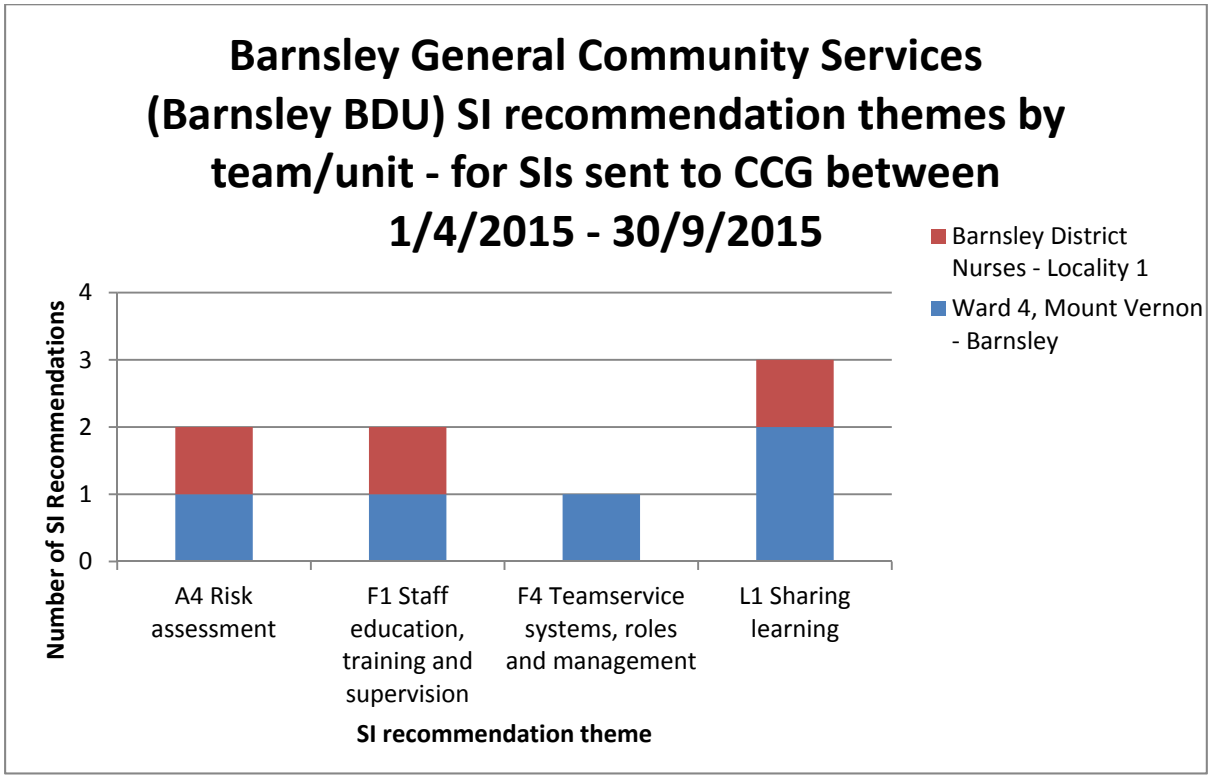
Notable good practice

Although the clinical practice in all of the investigations was found to be in keeping with the expected standards, there were two examples of notable good practice identified.

- The Community Mental Health Team used a professionals meeting in order to establish the most appropriate support for the service user.
- The Intermediate Care Team had acknowledged that the service user had taken an overdose in December 2014 and enquired if he required any further support from mental health services.

Barnsley General Community Services

Within this period Barnsley General Community Services submitted six completed investigation reports to the Commissioners all of which related to pressure ulcers. It should be noted that the process and grounds for the reporting pressure ulcers has changed which has resulted in lower numbers than in the past.
Eight recommendations were made in response to the findings of three investigations. Three investigations made no recommendations at all.
The below chart shows the themes of the recommendations and the locality they relate to.



There are only four thematic areas that the recommendations relate to. Only two of the recommendations are the same and these relate to the sharing of lessons which both relate to the incident being discussed at the Sisters meeting and then cascaded to staff. The other recommendations are not similar to one another therefor no theme relating to the same issue has been identified.

Governance for learning lessons update:

Changes have been introduced across both the mental health and general community services in response to lessons learned from incidents of all grades.

- Tissue viability - Staff are now documenting the areas of the skin that have been inspected and are intact, this has improved the quality of record keeping in regards to pressure area management

- Linked to an incident of serious self-harm by a service user under the care of a Community Mental Health Team which was investigated locally, it was identified that three days before the incident the Care Coordinator and the service user had completed a suicide safety plan. In response to the discussions during the learning event which took place in a team development meeting staff began using the safety plan for clients where there were concerns. This has been subject of review and the feedback from clients has been positive as they are able to use this as a tool which they can work through when distressed or at risk of acting on suicidal ideas. A psychotherapist from within the team has offered individual supervision and advice on the use of the safety plans and has arranged to discuss the theory of these plans in a future team development meeting with all the team.

- In response to a spike in self-harm reporting which had been identified as being linked to a small number of service users a review was conducted in response to linked medication errors. It was identified that these were related to third party errors that related to the contracted work with a named pharmacy or other community pharmacies. In response to this a Trust senior pharmacist has been working with the named pharmacy which has seen a reduction in incidents this quarter. Staff have been asked to remain vigilant in respect of the other community pharmacies.

- In response to the pharmacy dispensing errors the Outreach Team when delivering medication to service users now conduct a physical check of the dispensed drugs they are delivering to ensure that it is the correct prescribed medication.

- Single Point of Access have added to the invitation that is within their written appointment letters for people to be accompanied to the appointment should they wish to be, this is also included with their telephone offers of appointments.

- Within the general inpatient services there has been an initiative commenced in response to listening to the complaints, concerns and comments from service users, their families, friends and staff. These have been introduced to confirm the Business Development Units commitment to patient's privacy and dignity on wards and units, to improve the patient experience and to show to service user that their comments and suggestions on how to improve the service can be improved. The initiative has been to display posters in public areas one entitled 'The Always Events' and the other 'You said, we listened'.

- Work is ongoing within the Business Development Unit around sharing lessons learned around trends. This is conducted by a review of all incidents logged on Datix on a quarterly basis and the lessons learned and good practice is highlighted with the intention that services can build upon the findings.

Calderdale and Kirklees Business Delivery Unit

Calderdale

Calderdale submitted 4 completed investigation reports to the Commissioners in the period 1 April 2015 to 30 September 2015.

Specialty where the incident was identified

Table 1 below shows the speciality of the team for where the completed investigation took place, the incident detail and if a recommendation was identified.

Table 1: Speciality for where investigation completed/incident/demographics and recommendations made

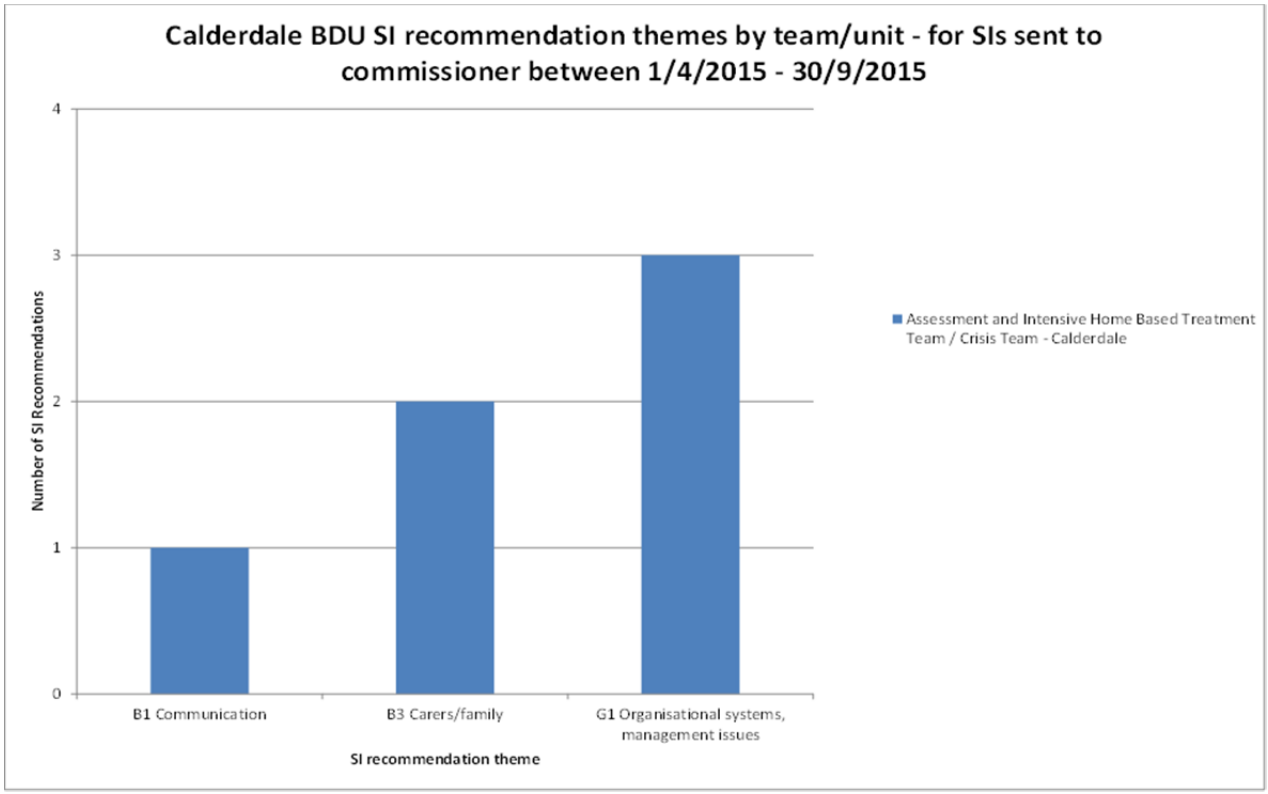
	Speciality	Detail of incident	Demographics for apparent suicides	Recommendation made (yes/no)
1	Assessment and Intensive Home Based Treatment Team / Crisis Team, Calderdale	Suicide (including apparent) - community team care - current episode	Male: Aged 26: Single: Lived alone: Unemployed/University student	Yes
2	Assessment and Intensive Home Based Treatment Team / Crisis Team, Calderdale	Self-harm (actual harm)	Male: Aged 29: lived with partner: Unemployed	Yes
3	Improving Access to Psychological Therapies Team Calderdale	Physical violence (contact made) against other by patient	Male: Aged 45: Single: Lived alone: Unemployed	No
4	Early Intervention Service (Insight) Calderdale	Suicide (incl apparent) - community team care - current episode	Male: Aged 23:lived with his partner and daughter: employed	No

Recommendations

A total of 6 recommendations were made in relation to 2 of the completed investigations. The remaining 2 investigations did not identify any recommendations.

Chart 1 below shows the Calderdale Business Delivery Unit serious incident recommendations by team/unit for completed investigation reports sent to the Commissioners between 1 April 2015 to 30 September 2015.

Chart 1



As seen in **Chart 1** above, there was a range of recommendation themes with organisational systems and management issues ranking first , second carers/family and third communication between staff in the same services. Analysis of the recommendations does not appear to highlight any immediate themes.

Note that the National Confidential Inquiry 2015 suggest that closer working with families would have safety benefits and that services should consult with families from first contact, throughout the care pathway and when preparing plans for hospital discharge and crisis plans. Staff should also make it easier for families to pass on concerns about suicide risk and be prepared to share their own concerns.

As a result of the recommendations practitioners now record carer engagement and involvement on service user RiO records. Contact with carers will be revisited throughout the episode of care to ensure that carer involvement is maintained and how if needed, carers can access the team and any support if required.

A review of the current Intensive Home Based Treatment Team information leaflet will ensure that up-to date information (last updated Nov 2012) for both service users and carers including contact details are recorded. A meeting planned with the Trust wide Intensive Home Based Treatment Team group will review this information leaflet to ensure consistency across the teams. The Trusts Communications team will produce the new leaflet.

The Intensive Home Based Treatment Team will also evaluate their service delivery offer utilising the Trust Standard Operating Procedure (TSOP) currently being developed for Intensive Home Based Treatment Team services across the Trust.

Lessons learned

All of the completed investigation reports identified lessons learned and these are summarised below.

That when a service user is being seen by more than one service it is important that the services involved work together with the provision of care.

That the importance of clear communication with carers and involving them in any care planning and discharge decisions where appropriate is considered.

The Single Point of Access service and the Improving Access to Psychological Therapies service consider during the screening referral process if the appropriate service intervention for the service user has been requested which has to be balanced against the current interventions already offered to the service user as well as the risks and complexity of the presentation.

That all faxed referrals to the Single Point of Access Team/Intensive Home Based Treatment Team and Crisis Team should be followed up with a telephone call to the referrer to ensure safe receipt.

That the assessment of a service user alcohol intake and dependency along with the recent history of eating problems must be explored to further inform immediate and future management/interventions.

Noticeable good practice

In 2 of the completed investigations noticeable good practice was identified in the report. These included:

The support provided to the Attention Deficit Hyperactivity Disorder service by the staff from the Insight Team in obtaining medical notes, being present during the initial assessment and the support provided to all parties throughout the assessment process.

The Psychologist continued to provide contact, support and intervention to the service user during the inpatient admission.

Kirklees Business Delivery Unit

Kirklees submitted 14 completed investigation reports to the Commissioners in the period 1 April 2015 to 30 September 2015.

Specialty where the incident was identified

Table 1 below shows the speciality of the team for where the completed investigation took place, the incident detail and if a recommendation was identified.

Table 1: Speciality for where investigation completed/incident/demographics and recommendations made

	Speciality	Detail of incident	Demographics for apparent suicides	Recommendation made (yes/no)
1	Psychology Services - Kirklees (Adult)	Suicide (including apparent) - community team care - current episode	Female: 41 year old single, unemployed	Yes
2	CMHT - Care Management Team (South Kirklees)	Suicide (including apparent) - community team care - current episode	Female: 38 year old single who was employed and lived alone.	Yes
3	Psychology Services - Kirklees (Adult)	Suicide (incl apparent) - community team care - current episode	Female:24 year old, had a partner and was employed	Yes
4	CMHT – Community Therapies Team (South Kirklees)	Self-harm, actual. Attempted Suicide by Outpatient (in receipt)	Male: 53 year, single in full time employment.	Yes

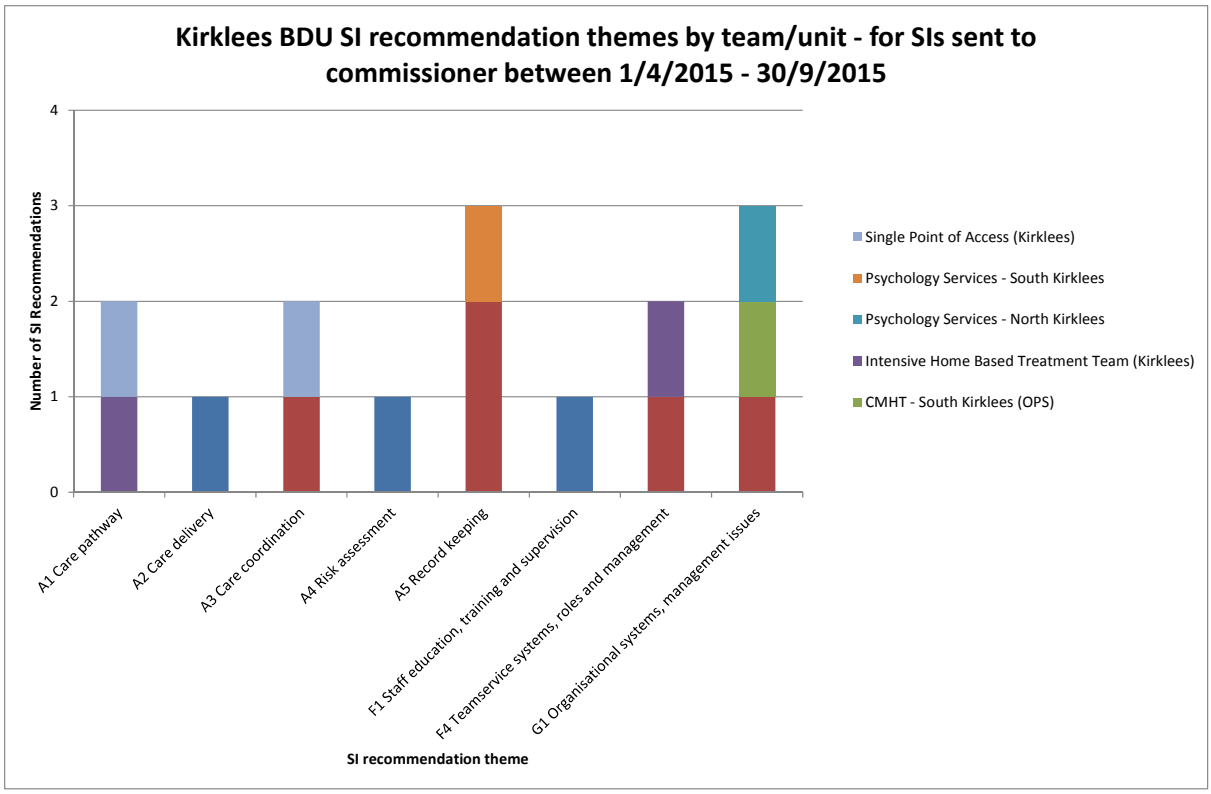
5	CMHT - Care Management Team (South Kirklees)	Suicide (incl apparent) - community team care - current episode	Male:60 year old, married and retired	Yes
6	CMHT – Community Therapies Team (South Kirklees)	Suicide (incl apparent) - community team care - current episode	Male:55 years old, divorced, lived alone and was unemployed	Yes
7	Single Point of Access Kirklees	Suicide (incl apparent) - community team care - current episode	21 year old single male who lived with his parents. He was in full time employment.	Yes
8	CMHT - South Kirklees (OPS)	Suicide (incl apparent) - community team care - current episode	Female;72 years old , widowed and lived alone	Yes
9	Intensive Home Based Treatment Team	Suicide (incl apparent) - community team care - current episode	Female:32 year old, single lady, lived alone and was a university student	Yes
10	CMHT - South Kirklees (OPS)	Suicide (incl apparent) - community team care - current episode	Female:67, widowed and lived alone	No
11	Single Point of Access	Suicide (incl apparent) - community team care - discharged	Male:27 single, university student , living alone	No
12	CMHT - Care Management Team (South Kirklees)	Suicide (incl apparent) - community team care - current episode	Male: 40 year old unemployed single male	No
13	Early intervention services	Suicide (incl apparent) - community team care - current episode	Male: 23 year old, single, unemployed, who lived with his mother and younger sister in their family home	No
14	CMHT - South Kirklees (OPS)	Suicide (incl apparent) - community team care - discharged	Male: 73 year old retired married man	No

Recommendations

A total of 15 recommendations were made in relation to 9 of the completed investigations. The remaining 5 investigations did not identify any recommendations.

Chart 1 below shows the Kirklees Business Delivery Unit serious incident recommendations by team/unit for completed investigation reports sent to the Commissioners between 1 April 2015 to 30 September 2015.

Chart 1



As seen in **Chart 1** above, there was a range of recommendation themes with organisational systems and record keeping ranking first, second care co-ordination, care pathway and team/service, roles and management.

The delivery of care from the Community Mental Health Teams services in adult services in Kirklees had the most recommendations. The teams are split into community therapies and case management. Community therapies works predominately with individual with non-psychosis and care management works with individuals with predominately Psychosis.

The community therapies team works with a high number of individuals that fall within the diagnosis range of personality disorder and can present with significant self-harm issues and are generally a high risk group. Community therapies team also has the highest caseload and referrals into services.

As a result of the recommendations the following actions/processes have been implemented:

1. The Community Transformation Trust wide Single Point of Access work stream are developing an Operational Policy which states what functions are delivered by the Single Point of Access , what resources are required to deliver these and to what standards.
2. SI recommendations are included in the medical staffs induction programme and nurse's medicines management update. This also shared at the pharmacist's clinical forum.
3. A Single Point of Access Team referral template was introduced on 27/04/15. This template is used for all referrals into the Kirklees Single Point of Access Team. An audit was completed on 23/06/15. The audit reviewed the assessment, documentation and the risk escalation process in the Kirklees Single Point of Access. The audit results and the template will be shared with the Trust's Practice Governance Coaches. The audit will be occur again 12/12/15.
4. Individual clinicians bring key dates reports into caseload management and supervision with the team leader to identify any standards of practice relating to care delivery and documentation of care plans.
5. Service users accepted by the community therapies team from the Intensive Home Based Treatment Team will receive a medical review of any psychotropic medication prescribed by SWYPFT Mental Health services. An audit of 10 case records in January 2016 will occur.
6. Notes taken at Multi-Disciplinary Team meetings pertaining to individuals will be recorded in the progress notes relating to them on RiO
7. For individual Single Point of Access clinicians to document when they have accessed crisis and contingency plans in progress notes and inform Single Point of Access team manager where there are no crisis and or contingency plan or that they are in need of review.
8. To review the discharge letter in Calderdale and Kirklees BDU against best practice guidelines.
9. To review supervision arrangements between Consultants and Doctors in training ensure monitoring of completed discharge letters.
10. The existing referral process between the Single Point of Access and the Adult Psychological Therapy Service was reviewed and amended.
11. Review of Triage Template was conducted, amended and incorporated into RiO information.
12. A baseline audit identified those service users recorded on the clinical query forms as being prescribed Dosulepin by Trust medical staff. That these prescriptions are actively reviewed by the prescriber, and a less toxic alternative prescribed unless there are clear and unequivocal reasons to continue and evidence of valid consent from the service user.

That the medical management Joint Academic Psychiatry Seminar meetings provide feedback from SIs/complaints about high risk medicines and reminds medical staff of the need to use the clinical queries mechanism for Dosulepin prescribing. That the Drug and Therapeutic newsletter is sent to all Trust staff via the weekly email communication contains updates from all SI's in relation to medication management. The slides/talk regards medication management for Doctors' induction sessions is maintained. That service users are specifically offered information regarding their medication. The feasibility of identifying those service users prescribed Dosulepin by their GP will be explored.

Lessons learned

10 of the completed investigation reports identified lessons learned and these are summarised below.

1. The importance of recording relevant clinical discussion.
2. The importance of recording keeping cannot be underestimated. The paucity of the records made it difficult to establish precisely what happened during the period under investigation.
3. That Service users are asked if they consent to the sharing of their Mental Health information with family/NOK/Carers and this is recorded on RiO. The acknowledgement that family etc can provide collateral information which adds to the bigger picture is a question that also needs to be asked.
4. During the time of organisational change it is essential that the staffing of services is maintained at an effective level.
5. When caseloads are high it is important that the documentation of all care being provided to service users is accurately documented.
   Supervisors and managers should ensure that systems are in place to ensure that practitioners are both providing care and documenting this in line with their clinical responsibilities and Trust policy.
6. The importance of previous risk history when assessing current risks is identified in this instance.
7. The difficulties in coordinating care between two mental health trusts. There had also been challenges in achieving a smooth transition between the various teams involved in the persons care. It is prudent that a clear transition pathway is agreed with the involvement of respective Consultants quite early on in the process of transition between the trusts and also during the process of transition between teams.
8. The importance of ensuring that partner organisations are aware of the functions of the service provided by different teams within the organisation and how they may relate to each other is noted. The Directors should consider this in relation to communication in the transformation process.
9. The need to document the assessment of capacity when service users decline or non-adhere to treatment.

10. The value of the ability to have easy access to face to face discussion between clinicians regarding cases for which there is some complexity or uncertainty is identified within this case. The circumstances of this case emphasis the difficulties of assessing suicide risk.

Noticeable good practice

The Psychological Therapist provided a detailed discharge letter to the GP with advice on physical assessment and relevant NICE guidance in relation to the person's eating disorder.

The investigators noted the Care Coordinators long term commitment and maintaining the person on their caseload.

The Pathways Practitioner ensured the collection of information and recognised that coordinating a timely and appropriate transfer of care was required.

The support given to the person by the Intensive Home Based Treatment Team Practitioners was very collaborative. The record keeping was extremely comprehensive and demonstrated that psychological approaches were utilised.

There was evidence of excellent communication and discussion between the Single Point of Access Team, Early Intervention in Psychosis Team and Community Treatment Team to ensure the most appropriate pathway of care.

The investigators noted the quality of the initial detailed assessment, including the use of depression/anxiety rating scale and formal mini mental state examination.

Governance update

The quarterly lessons learned events for both CBDU & KBDU which began in 2012 continue to be well attended by staff from both BDU's and include a mixture of professionals from both health and social care settings. The most recent event held on 29/09/15 focused on a presentation delivered by the Rehab and Recovery Pathway Services and covered the impact of Datix on being able to review incidents involving an individual and how this supported discussion /care planning in managing identified risks and understanding the effectiveness of interventions put in place.

The Datix Dashboard Module has now been successfully rolled out to the Trios and Consultants and they are in the process of making themselves familiar with the system. The event discussed the DATIX dashboard, staff agreed that the dashboard will enable teams to better analyse incidents, understand them, plan to reduce harm and improve service user care.

At each event the incident management quarterly report is discussed as are the SI's and associated recommendations/ and actions. The Practice Governance Coaches summarise using a word document the SI's and associated themes/lessons learned, this is shared via email to the wider BDU team managers who share the information with their teams.

Specialist Services Business Delivery Unit

Child and Adolescent Mental Health Services

The Trusts Child and Adolescent Mental Health Services did not submit any completed investigation reports to the Commissioners in the period 1 April 2015 to 30 September 2015.

Lessons learned

In March 2015 The Child and Adolescent Mental Health Services held their first learning event to share the learning from Datix analysis work and identify good practice. The next learning event is booked for 11/12/15.

In July 2015 The Child and Adolescent Mental Health Services identified a role/person that pulls Datix data, this is then analysed by the Trio (general manager, clinical lead and practice governance coach) and shared across the whole service via existing structures such as the service line, governance and team meetings. The reviewing of incidents is monitored by this new role/person; they have the authority to escalate any outstanding Datix incidents to the Trio. Each part of the service is at different levels of implementation.

For example:

1. On a monthly basis Barnsley Child and Adolescent Mental Health Services Datix incidents reported within each calendar month are discussed at the their service line meeting ,all staff can attend this meeting. As each incident is discussed the learning is identified and any outcomes that were not apparent when the initial immediate action was taken are also agreed and actioned. This information gained will enable the services to report better to the quarterly outcome requests.
2. Calderdale/Kirklees and Wakefield Child and Adolescent Mental Health Services. The process adopted by the Barnsley Child and Adolescent Mental Health Services has been shared with the Clinical Governance Group; this will be replicated across all service lines.

Information Governance themes have been identified as one of the services priorities. A dedicated administration role was identified for the Autistic Spectrum Disorder pathway when it was noted that service user documentation and demographic data were inaccurate. For example an appointment letter was sent to a wrong address. The recipient opened the letter and contacted the service to inform them of the error.

Administration procedures were revisited and staff are now use editable letters on RIO which pull service user demographics into letters to avoid typing errors.

Also additional administration roles were assigned to the Single Point of Access team to work on outcomes of service user assessments and subsequent timely follow up appointments.

The Practice Governance Coach for C&KBDU has set up work streams on the mental health assessment A. This involves meeting with staff having discussion about the assessment and enabling staff to make it a meaningful ‘tool’ that can be positively used in practice.

Other work streams have focused on supervision, child and adult safeguarding, appraisal and supporting staff during the transformation agendas.

Along with other BDUs’ the Datix Dashboard Module which has now been successfully rolled out will enable teams to better analyse incidents, understand them, plan to reduce harm and improve service user care.

Learning Disabilities

The Trusts Learning Disabilities Services did not submit any completed investigation reports to the Commissioners in the period 1 April 2015 to 30 September 2015.

Lessons learned

Due to the transformation agenda it was decided by the Learning Disabilities Director, Clinical Lead and Practice Governance Coach that an event would be planned for the spring of 2016.

The lead investigator linked to Learning Disabilities Services has been working since spring 2015 with the Practice Governance Coach, they have begun work on analysis of Datix themes/ trends etc and these are shared at the service line and governance meetings. In addition the service has identified 4 staff who have been trained by the Datix team to pull reports from Datix which the services analyse in each team and share across the whole service. The lead investigator and the Practice Governance Coach will continue to support this work

The services are eager to progress this work and with the roll out of the Datix Dashboard Module it will enable teams to better analyse incidents, understand them, plan to reduce harm and improve service user care.

Discussions with theTrio have begun regarding the governance arrangements of the incidents that occur in integrated teams that go through the local authority reporting route. The joint processes for closing the information loop on these incidents will be discussed as part of the transformation agenda.

Regarding specific lessons learned in connection with Datix incidents there has been joint working with the in-patient services, the Practice Governance Coach and the Management of Violence and Aggression Team specifically about the care of one service user. This involved discussion about the mutually agreed information required on a Datix incident form and importantly the subsequent care of the service user.

Forensic Business Delivery Unit

In Forensic Services a total of 1 serious incident that met the requirements for NHS Commissioning Board Serious Incident (SI) Framework and were reported to the Clinical Commissioning Group via the Department of Health database STEIS.

- 1 incident was in community team

The investigation into this incident has not yet been submitted. The action plan in relation to this incident is in formulation and requires a coordinated response from both the community team and in-patient services, as recommendations were made in relation to transition from ward to community and improving communication flows with significant professionals to ensure a safe transition and discharge home.

There has not been any STEIS reported incident investigation reports sent to the Commissioners since April 2015. All action plans related to previous incidents reported on STEIS have been completed.

Between April 2015-September 2015, there have been eight incidents graded at **AMBER** across the service, four occurring in the Medium Secure Service and four in the Low Secure Service. There were no serious incidents in the Forensic CAMHs Service.

Incident	Service Line	Theme	Investigation Progress
Seclusion Room	Low Secure	Environment	Investigation complete
Awol	Low Secure	Fact Find	Investigation complete
Staff injury – slip/trip/fall	Low Secure	Fact Find Environment	Investigation complete
Safeguarding Incident	Low Secure	✓ Management Process	✓ Ongoing
AWOLs	Medium Secure	Fact Find	Investigation complete
Workshop	Medium Secure	✓ Management Process	✓ Ongoing
Sprinkler System	Medium Secure	Environment	Investigation complete
Staff Injury	Medium Secure	✓	✓ Ongoing

- Of these incidents, three remain in active investigation processes, two being processed under the Trust Disciplinary Policy. All other incidents have completed investigations.

- Two incidents relate to service users being AWOL. Both service users failed to return appropriately from periods of Section 17 leave, one running off from a member of staff on escorted leave and the other did not arrive at a planned destination as part of a graded leave programme. Neither of these incidents progressed to detailed investigation processes and were understood through fact find reports. Individual amendments were made to treatment plans in response to the two incidents and there were no broader lessons to share with the service.
- There were three incidents relating to environment: The activation of the sprinkler system on a ward in the medium secure service resulted in disruption to service and the temporary accommodation of service users in other wards within the service overnight.
- A further incident related to a faulty light fitting in a seclusion room, which resulted in it being used as an item to cause damage to the room and threaten staff. A full investigation has been concluded. Themes focussed largely on environment and security issues. Principally, the light fitting in this particular seclusion area had two faulty screws, allowing the light fitting to be accessed by a patient, who proceeded to damage it and pull large pieces of metal down and use these to threaten staff and cause further damage to the seclusion area. A full review of this fitting was undertaken across the Trust. It is safe, however, it's failure on this occasion related to missing screws. A checking process has been introduced to monitor this equipment in seclusion areas.
- The third incident was a fall sustained by a member of staff. The floor was wet in a bedroom area following a service user utilising the en-suite room, resulting in the fall.

Governance development

The Medium Secure service line continues to work through a range of action plans in response to a number of incidents which were off track and outstanding from the 2014-15 period. All outstanding incidents have now been investigated, except one, which will be an investigation process along the lines of the Trust Disciplinary process.

The Low Secure Service has been on track with incident investigation and satisfactory progress is underway with conclusion, action planning and completion of action plans.

The BDU had identified improved incident management as a high priority as part of annual planning and governance processes. The improved governance processes implemented into the Forensic BDU have contributed to improved tracking of all incidents and action plans in the service throughout the year. These continue to be tabled for review at key meetings and the message in the service this year

underlines greater awareness of incident management processes, regular review of incident investigation progress, review of action plans and broad sharing of information across the service lines contributing to learning and sharing.

The governance report for the end of the year will indicate that much has been achieved in the BDU to assure that all incidents requiring investigation have been investigated and that action plans are being completed with available evidence supporting changes and service improvement.

A culture of broad and regular communication in the system for incident management has been enhanced in the service, with greater awareness for team / department leads of incidents and their outcomes. There is still work to improve greater awareness and ownership for incidents and action plans at ward level.

Learning Lessons Briefs shared widely have gone some way to improve awareness about the outcomes of investigation and subsequent learning. Learning Lessons has been added as an agenda item on ward meeting structures, to afford regular opportunities for discussion and reflection on incidents.

The outcome of a Patient Safety Pilot which was undertaken in the Low Secure Services indicated that staff wanted more information about incidents and what happens following their input of reports into the Datix system. All of the above activities have been focussed on to improve this awareness and learning.

A further initiative will be the hosting of a Learning Lessons event in the BDU in November 2015, encouraging as many practitioners and members of staff as possible to attend. Any materials developed for this event will also be shared across the service. This will be a significant event for sharing for incident data and themes and it is hoped this will be established into the annual calendar going forward.

In reviewing ongoing incident management, it was established that not many practitioners had undertaken any training in this area. In order to enhance high quality investigation and learning, a root cause analysis training event was held in July 2015, attended by 15 members of staff. It is hoped that this will not only enhance the availability of practitioners to undertake investigations, but will have the added benefits in enhancing the quality of investigations and report writing.

Going forward, there will be a continued high profile and priority given to transparent and shared ownership across the service of all incident management and action plans. All department leads and ward managers have access to all incident reports and action plans. This enables awareness across the service of incidents.

As mentioned above, a Learning Lessons Brief is developed and communicated across the service, again in the spirit of shared learning and awareness. The brief broad messages captured in the briefing are designed to be accessible for all staff, with limited time for extensive reading and as a means to ensure that broad awareness and messages filter down to all levels.

Theme Identification in Green Incidents.

The BDU does not solely concentrate efforts in service improvement for its more serious incidents. There is a huge amount of work aimed at identifying improvement actions for all incidents, particularly when themes emerge. The vast majority of incidents in the Forensic services are graded at Green. Each month in the Security Committees held in each service line, there is a review of incidents on all wards for the preceding month and there is a rolling programme of identification of themes. Below are some examples of work undertaken following identification.

- The management of patient's property, particularly money. There had been a number of Datix reports which revolved around issues in missing monies or discrepancies in recorded monies held in ward safes. This issue was picked up in the BDU and a programme of audit, awareness and reinforcement of practice issues was undertaken, supported further with a Learning Lessons Brief to alert staff that this has been a theme in the BDU.
- Record keeping, following a number of issues which emerged as themes in Datix. This was actioned through the development of a learning lessons brief which was widely shared across the service, encouraging people to adopt more vigilant activity in record keeping.
- Information governance issues. A project piece of work has been commenced looking at how administration workers can strengthen their information governance behaviours through a process of increased checking procedures.

Another initiative that has recently started in the BDU centres on sharing the headline governance messages with all staff following the BDU Governance Group. Incident management has been a headline issue on our governance messages with regard to focus on completion and evidence gathering for completed action plans.

Going Forward

The Forensic BDU is focussed on continuing to concentrate efforts of all the above activities and review successes through the end of year governance report. Significant progress has been achieved in the year so far and this will celebrated, however, it is important to continue to build on this very high priority patient safety issue and continue with our learning culture.

Wakefield Business Delivery Unit

Wakefield submitted 9 completed investigation reports to the Commissioners in the period 1 April 2015 to 30 September 2015.

Specialty where the incident was identified

Table 1 below shows the speciality of the team for where the completed investigation took place, the incident detail and if a recommendation was identified.

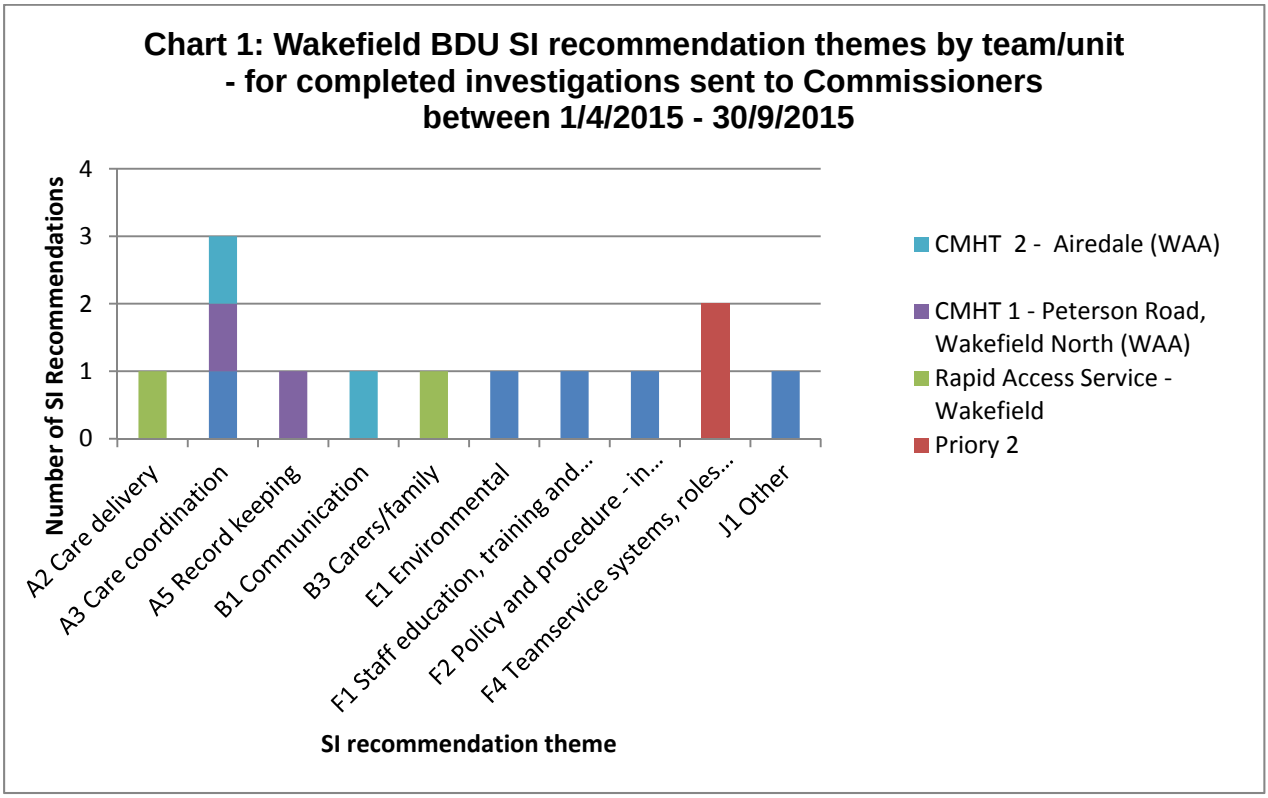
Table 1: Speciality for where investigation completed

	Speciality	Detail of incident	Recommendation made (yes/no)
1	Adult CMHT	Amphetamine toxicity	Yes
2	Adult CMHT	Overdose of Methadone, Morphine and Tramadol	Yes
3	Adult CMHT	Hanging	No
4	Adult Inpatient	Assault (not a death related incident)	Yes
5	OPS CMHT	Hanging	No
6	OPS Inpatient	Fractured neck of femur. Death occurred after surgery.	Yes
7	OPS Inpatient	Fractured neck of femur. Death occurred after surgery.	Yes
8	OPS Rapid Access Service	Hanging	Yes
9	Early Intervention Team	Mephedrone toxicity	No

Recommendations

A total of 13 recommendations were made in relation to 6 of the completed investigations. The remaining 3 investigations did not identify any recommendations.

Chart 1 below shows the Wakefield Business Delivery Unit serious incident recommendations by team/unit for completed investigation reports sent to the Commissioners between 1 April 2015 to 30 September 2015.



As seen in **Chart 1** above there was a range of recommendation themes with care co-ordination and team service, systems, roles and management ranking first and second in frequency respectively. Analysis of the recommendations does not appear to highlight any immediate themes.

Lessons learned

In 6 out of 9 of the completed investigations the report identified lessons learned and these are summarised below.

On occasions despite assertive attempts by mental health services to make contact with services users in order to provide mental health interventions, the complexity of people's lifestyles sometimes negates these attempts. In particular the possible on-going use of illicit substances can make assessing the impact of this on a mental disorder and the fluctuating risks difficult.

When service users obtain treatment from the Accident and Emergency Department or other health care providers the details of this should be obtained and documented on RiO to allow for this to be included care planning.

All clinicians have a professional responsibility to ensure that all examinations of service users are documented.

Processes should be in place to ensure that even in times of emergency the documentation of decisions made under the Mental Health Act should be correctly documented.

The difficulties presented to Practitioners in assessing and supporting people with complex needs. In this particular case the service user had an extensive and enduring history of illicit drug use and associated mental health needs and their mental health presentation been stable prior to the incident.

The impact of change within a patient's care plan cannot be underestimated. The nature, though not severity, of the behaviour demonstrated by the service user was predictable and consideration to these needs to be considered.

The importance of meeting timescales for referrals with consideration to be given for commencement of treatment for people suspected of having a mental disorder as early as possible.

A robust system should be in place to ensure that medical staff have undertaken mandatory training.

A system should be in place to ensure all staff working in inpatient areas carry personal alarms.

Noticeable good practice

In 7 out of the 9 completed investigations noticeable good practice was identified in the report. These included:

The support provided to a family member by the Team Manager following the incident being identified.

The support provided to and the relationship with the mother of a service user during their contact with the team was seen as being of a high standard and was complimented by the mother when she spoke to the investigation team.

The older people's service governance meeting reviews on a monthly basis all recorded patient safety incidents and specifically includes slips, trips and falls.

During an inpatient episode of care a service user was reviewed by a Consultant in Elderly Medicine from the local acute Hospital and the medication regime was amended. The Consultant in Elderly Medicine visits the inpatient ward weekly to review new admissions. This practice was identified as not being replicated in any other older person's wards in the Trust.

The response time to attend the inpatient ward by the on call Doctor was noted as being excellent due to the on call base being at the main hospital site;. this was nine miles away from ward area.

Immediately following the incident the Ward Manager obtained statements from the night staff who had been on duty.

On the same day of the incident the bathroom door had the existing lock replaced with a digital lock.

It was acknowledged by the service users' parents that there had been a positive relationship between the Care Co-ordinator, Community Mental Health Team and themselves.

There was evidence that all appropriate care pathways were considered with the service user and family being involved in the decision making progress.

The letter sent to the service user by the Care co-ordinator provided them with the message that the Community Mental Health Team was able to offer practical support specifically around his housing needs. It was a very well worded letter that showed a caring person centred approach from the team

Governance for learning lessons update:

The serious incident process and governance frameworks for completion and monitoring of action plans is embedded in the Business Delivery Unit. However, it has been highlighted that although learning lessons events do always take place following the completion of an investigation the venues where these are held can be away from team bases. This has resulted in limiting attendance to those people who had direct involvement with the service user and the investigation process. The aim over the next 6 months will be to have all learning events held at the team base in order that as many of the team members where the incident took place can be involved and contribute to the learning event.

A series of risk training sessions have been commissioned entitled 'Best Practice in Managing Risk' commencing in November 2015.

The one day programme will cover the following areas:

Over of Risk, Mental Health Act Guiding Principles, Best Practice in Managing Risk (DoH, 2007), Level 1 and Level 2 risk tools, Broad Risk Categories and Associated Risk Factors, Service user Engagement and Participation, Communication Perceptions of Likelihood, Identifying and Working with Service User Strengths, Risk Formulation, The Use of 'Checklists' within Clinical Practice.

The Datix Dashboard Module has now been successfully rolled out to the Trios and Consultants and they are in the process of making themselves familiar with the system. Initial feedback has been positive and the impact of this in relation to how it has been used in practice will be reviewed over the next 6 months.

The various methods of how lessons can be shared across the Business Delivery Unit continue to be discussed and explored. A Practice Governance Coach is exploring the use of infographics as a medium to use graphic visual representations of patient safety information and for sharing of lessons learned. The aim is to present data or knowledge information quickly and clearly without lots of heavy reading being required. It is hoped that the progress of this development along with evaluation of the effectiveness of this medium can be reported at year end.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 7.3(iv)

Title:	**NHS Community Mental Health Survey 2015/16**
Paper prepared by:	Director of Corporate Development
Purpose:	To inform Trust Board of the outcome of the NHS Community Mental Health Survey 2015/16 and the relevant follow up actions.
Values/goals:	The paper supports the Trust's values of person first and in the centre, listening to feedback and taking action to improve and be outstanding.
Any background papers/ previously considered by:	Annual survey report to Trust Board
Executive summary:	The community mental health survey is an annual survey conducted by the Care Quality Commission. It represents the experiences of people who received specialist care or treatment for a mental health condition. Nationally, the Trust scored 'about the same as most other Trusts' on 31 out of 33 questions and 'better than most Trusts' on two of 33 questions. Although not an outlier in these 31 areas, the Trust has declined in two areas by more than 5% over the 2014 survey in respect of the number of people getting the help needed when trying to contact crisis care (69% in 2014; 61% in 2015) and the number of people being given information about new medicines in a way they could understand (75% in 2014; 70% in 2015). To try and mitigate any further decline in performance these areas are being picked up through the Customer Experience Group and action plans developed. The attached report and 'infogram' sets out further details of the survey.
Recommendation:	**Trust Board is asked to NOTE the outcomes of the survey, which are, in the main, positive and reflect the Trust' on-going journey to listen and respond to patient feedback.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

The NHS Community Mental Health Service User Survey Results 2015

The community mental health survey is an annual survey conducted by the CQC. It represents the experiences of over 13,000 people who received specialist care or treatment for a mental health condition in 55 Trusts in England between September and November 2014.

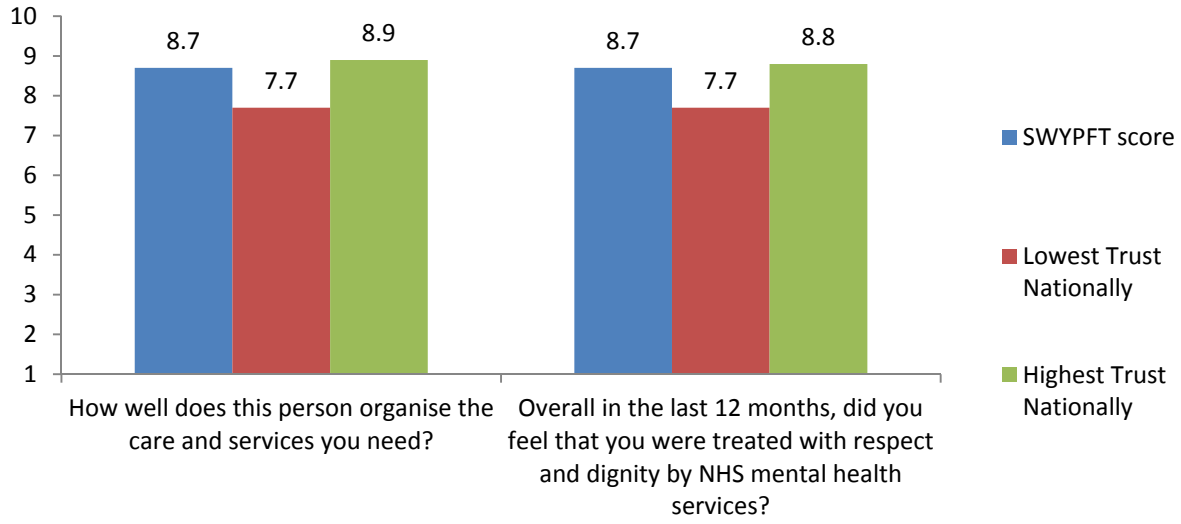
South West Yorkshire Partnership NHS Foundation Trust commissioned The Picker Institute to conduct the survey on the Trusts behalf. Questionnaires were sent to people aged 18 years or over between February and July 2015. 236 responses were received in total from 839 distributed questionnaires – giving a response rate of 28% (national response rate 29%).

The CQC's key findings for England are:

"While the survey shows that the majority of people are reporting positive experiences overall, performance across the survey shows substantial concerns about the quality of care people using community mental health services receive. There has been no notable improvement in the last year and for many questions, a slightly higher proportion of people have reported a poor experience"

Nationally, SWYPFT scored 'about the same as most other Trusts' on 31/33 questions and 'better than most Trusts' on 2/33 questions.

The graph below illustrates the two better than most areas:



IN the CQC's response to the survey it recognised SWYPFT as a Trust that performed better than expected in regards to the dignity and respect question:

Caring: Kindness, dignity, respect and compassion

Q42: Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Trusts better than expected

- Cheshire and Wirral Partnership NHS Foundation Trust
- Dorset Healthcare University NHS Foundation Trust
- Mersey Care NHS Trust
- NAVIGO Health and Social Care CIC
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust
- South West Yorkshire Partnership NHS Foundation Trust

Trusts worse than expected

- Barnet, Enfield and Haringey Mental Health NHS Trust
- Coventry and Warwickshire Partnership NHS Trust
- North Essex Partnership University NHS Foundation Trust

Of the 33 questions asked SWYPFT improved on 19 questions, stayed the same on 3 questions and deteriorated slightly on 11 questions (since 2014), areas of significant change (over 5%) are set out below:

Areas of significant improvement (>5%)

- Increase in people reporting they had formal meeting with SWYPFT staff within the last 12 months to discuss how their care is working
- increase in SWYPFT mental health services supporting people to take part in local activities
- increase in the number of people reporting they knew who was in charge of organising their care whilst in transition
- increase in the number of people reporting they had been given information by mental health services about getting support from people with experience of the same mental health needs
- Increase in the number of people reporting SWYPFT mental health services helped to find them support in the last 12 months for:
    - Financial advice or benefits
    - Physical health needs
    - Finding or keeping work
    - Finding or keeping accommodation

Areas of significant decline (>5%)

- 8% decrease in the number of people getting the help needed when trying to contact crisis care (69% in 2014, 61% in 2015)
- 5% decrease in the number of people being given information about new medicines in a way they could understand (75% in 2014, 70% in 2015)

Action plan

The results of this survey have been distributed to BDU's and the Customer Experience Group (CEG). The CEG recognised the two areas of decline as areas of action. The drop in the percentage of people receiving information about new medicines is being taken up through pharmacy services. Further work will be commissioned to look at the areas of decline around the intensive home based treatment teams.

For further information from the CQC on the national perspective please see the report below:

http://www.cqc.org.uk/sites/default/files/20151020_mh15_cqc_comment.v1.2.pdf

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

2015 NHS Community Mental Health Service User Survey Results

236/839 completed surveys

28% response rate

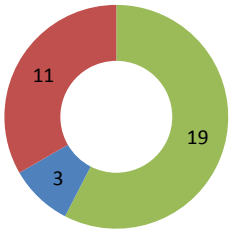
Data collection in April 2015

Retrospective sample of people who accessed services in September / November 2014

KEY FINDINGS FOR ENGLAND (CQC)

While the survey shows that the majority of people are reporting positive experiences overall, performance across the survey shows substantial concerns about the quality of care people using community mental health services receive. There has been no notable improvement in the last year and for many questions, a slightly higher proportion of people have reported a poor experience.

SWYPFT scores

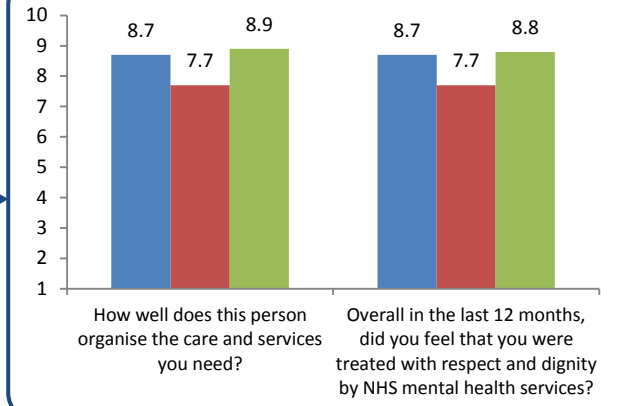


- Scores higher than 2014
- Scores the same as 2014
- Scores lower than 2014

2/33 scores Better than most other Trusts

31/33 scores About The Same as most other Trusts

Better than average nationally



Areas of significant improvement

10% increase in the number of people reporting they had a formal meeting with SWYPFT staff within the last 12 months to discuss how their care is working
(64% in 2014, 74% in 2015)

10% increase in SWYPFT Mental Health services supporting people to take part in an activity locally
(39% in 2014, 49% in 2015)

Increase in the number of people stating SWYPFT Mental Health services helped to find support in the last 12 months for:

- Financial advice or benefits +8%
- Physical health needs +5%
- Finding or keeping work +3%
- Finding or keeping accommodation +2%

Areas of significant decline

5% decrease in the number of people being given information about new medicines in a way they could understand
(75% in 2014, 70% in 2015)
(Nat. low 57% Nat. high 80%)

8% decrease in the number of people getting the help needed when trying to contact crisis care
(69% in 2014, 61% in 2015)
(Nat. low 37% Nat. high 76%)

Trust Board 22 December 2015
Agenda item 7.3(v)

Title:	**IT virus incident – update report**
Paper prepared by:	Deputy Chief Executive
Purpose:	To update Trust Board on the review of the serious incident following the virus attack on 27 August 2015, the actions taken and lessons learned.
Vision/goals:	This paper supports the Trust in working towards achieving its strategic vision and objectives by ensuring that its IT infrastructure and corporate and clinical systems are protecting service user information and are relevant for today and ready for tomorrow.
Any background papers/ previously considered by:	Not applicable
Executive summary:	The attached paper summarises the virus attack that occurred in August 2015 and the actions undertaken by the Trust and the IT Support Service provider to resolve this issue and prevent future attacks. On 27 August 2015 significant issues with the Trust IT network were being reported and immediately it was identified that these issues were the result of a virus attack. The impact of this virus attack resulted in staff being disconnected from the network and not being able to log back on. By the morning of 28 August 2015, a fix had been identified that was subsequently applied manually to all infected machines across the network over the course of the following two weeks. The virus attack highlighted a number of gaps in Trust business continuity documentation and processes. For example, no comprehensive list of all Trust sites and service locations, or details of priority clinical areas, was available. **Actions taken since the incident** The gaps identified as a result of this virus attack have been reviewed and procedures and solutions have been implemented. **Gaps identified and resolved** Lack of comprehensive site and contact information At the time of the virus the IM&T department created working documentation detailing site information and contact details. This document has since been redesigned by the IM&T department to create a template for Trust-wide services to incorporate into their Business Continuity documentation. This document is now with the Emergency Planning team for enhancement to cover a range of emergency situations. Assurance Threat Management Procedures appropriate The Trust, in conjunction with the IT Support provider (Phoenix), has reviewed the existing threat management process/procedures, business continuity and disaster recovery documentation to ensure there is clear clarity around roles, responsibilities and additional options going forward. Enhanced security and protection to detect viruses Phoenix has installed software which provides the Trust/Phoenix with the ability to prevent the delivery of emails containing suspicious attachments or remove attachments from emails but continues to deliver the emails

	themselves, therefore providing the required additional levels of security and enhanced threat detection capabilities. <u>Audit of Virus Software</u> An independent audit of virus software used by the Trust (McAfee) has been undertaken to identify any potential risks. The audit identified a small number of changes that were required to bring the McAfee platform in line with the best practice recommendation. It is important to note there were and remain no major issues or inherent flaws with the McAfee platform that the Trust currently uses. The impact of the serious incident and assurance regarding security and safety of records will be continue to be reviewed by the Board-level IM&T Forum and by the Audit Committee in its review of the information governance toolkit report from internal audit (March 2016).
Recommendations:	**Trust Board is asked to NOTE the contents of the report and the actions undertaken by the Trust to mitigate any future virus attacks.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
SWYPFT Virus Incident 27 August 2015
Update report

Introduction

On Thursday 27 August 2015 at approximately 12:20 Trust staff were reporting significant issues with the Trust IT network, a result of a virus attack. The impact of this virus attack resulted in staff being disconnected from the network and staff subsequently not being able to log back onto the network.

By the morning of Friday 28 August 2015, a fix had been identified that was subsequently applied manually to all infected machines across the network over the course of the following two weeks.

From 28 August 2015, the Deputy Chief Executive instigated a formal executive process to monitor impact and the implementation of continuity plans, and ensure progress and actions were communicated across the organisation and to partners.

Phoenix, in conjunction with the IM&T department, has produced a comprehensive incident report detailing the exact timeline of events, which has been reviewed by the Executive Management Team.

Initial Findings

The incident highlighted a number of gaps in Trust Business Continuity documentation. There was no comprehensive list of fax numbers for clinical areas which hampered the IM&T department's ability to send out resolution documentation to clinical areas who did not have access to Blackberry's. In addition, there was no comprehensive list of all Trust sites and service locations, or details of priority clinical areas.

There was a lack of timely and accessible inventory information available from Phoenix IT Services.

SWYPFT IM&T Business Continuity procedures were out of date and relied on staff collective knowledge/experience. It also became clear that the Service Desk inter-working operational procedures and communications needed to be more effective.

Actions

As a result of the gaps highlighted in the Trust's Business Continuity documentation the IM&T department created working documentation at the time of the Virus detailing site information and contact details. This document has since been redesigned by the IM&T department to create a template for Trust wide services to incorporate into their Business Continuity documentation. This document was then handed over to the Emergency Planning team so it could be enhanced to cover a range of emergency situations, and subsequent distribution across the BDU's. The

documentation will be owned by the individual BDUs and a copy will be shared with both the IM&T department and Emergency Planning team to support a timelier response to emergency situations going forward.

The IM&T department has a session booked with Phoenix to review existing threat management process/procedures, business continuity and disaster recovery documentation to ensure there is clear clarity around roles, responsibilities and additional options going forward.

The IM&T department has begun redrafting its business continuity processes and a number of changes, such as storing hard copies of information and backup hardware across multiple sites have already been put in place. The completion of this documentation has been pending the lessons learned feedback from the BDUs, requested as part of the Health, Safety & Emergency Preparedness TAG. The feedback from that forum will then be incorporated into the IM&T departments Business Continuity processes. This work is now complete and is subject to feedback from all services. Going forward this documentation will then be reviewed on an annual basis.

A review of the Service Desk inter-working operational procedures and communications has taken placed, which has resulted in a small number of operational changes for both the Trust Service Desk and the Phoenix Service Desk.

At the beginning of October 2015 the IM&T department commissioned a project to install an additional email gateway that sits between the NHS relay and the Trusts email servers. This McAfee email gateway (MEG) now provides the Trust/Phoenix with the ability to prevent the delivery of emails containing suspicious attachments or remove attachments from emails but continue to deliver the emails themselves, therefore providing additional levels of security and enhanced threat detection capabilities.

Finally, an independent McAfee audit conducted by Axial, who are a McAfee accredited partner, has now taken place. The IM&T department has reviewed the document in conjunction with Phoenix and has agreed in principle to implement a number of changes to bring the McAfee platform in line with the best practise recommendation.

Phoenix provided a project plan for the implementation of the changes in early November 2015. The IM&T department will then agree the tasks and associated timelines for testing and implementation, and would expect to implement the changes by the end of December 2015. It is vital that thorough Change Control processes are followed to ensure there is no adverse impact on the end user experience or the existing McAfee platform. It is important to note that while there are a relevantly small number of best practise recommendations identified in the Axial report, there are no major issues or inherent flaws with the McAfee platform that the Trust currently uses.

Actions Summary

Action	Status
IM&T to provide Business Continuity support document to Emergency Planning team	Complete
IM&T department and Phoenix to review threat management processes/procedures, business continuity and disaster recovery documentation to clarify roles and responsibilities.	Review booked 3rd November. To be completed by 30th November
IM&T to update Business Continuity processes, incorporating feedback from BDU's.	To be completed by 30th November
Service Desk Inter-working operation procedures and communication to be reviewed	Complete
IM&T department and Phoenix to install an additional email gateway (MEG)	Complete
Independent (Axial) review of McAfee platform	Complete
Implementation of McAfee changes recommended by Axial	To be implemented by 31st December

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 8

Title:	**Locala and SWYPFT Executive Programme Board draft Terms of Reference**
Paper prepared by:	Director of Corporate Development
Purpose:	To receive and approve the draft terms of reference for the Locala and SWYPFT Executive Programme Board
Values/goals:	The paper supports the Trust's approach to strategic partnering.
Any background papers/ previously considered by:	Not applicable
Executive summary:	The Executive Programme Board (EPB) was established by Locala and the Trust at a joint Board-to-Board meeting in October 2015 for a twelve-month period, subject to review. The Executive Programme Board's (EPB) prime purpose is to ensure that Locala and the Trust build on the relationships developed through the Care Closer To Home process (CC2H) to establish a number of programmes as part of the Multi-specialty Community Provider (MCP) model.
Recommendation:	**Trust Board is asked to approve the draft terms of reference, which are also being presented to the Locala Board for approval.**
Private session:	Not applicable

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Locala

Executive Programme Board
DRAFT Terms of Reference

The Executive Programme Board (EPB) was established by Locala and SWYPFT, October 2015 for a twelve month period, subject to review. The EPB is a joint executive committee of the two organisations; it has no decision making powers other than those specifically delegated in these terms of reference and as appropriate, by the Boards of Locala and SWYPFT in accordance with their Standing Orders and Standing Financial Instructions.

Purpose
The Executive Programme Board's (EPB) prime purpose is to ensure that Locala and SWYPFT build on the relationships developed through the Care Closer 2 Home process (CC2H), to establish a number of programmes as part of the Multispecialty Community Provider (MCP) model, including but not limited to:

- Shared business and technical resources focusing on economies of scale
- Inward investment, focusing on development of partnerships, researching and commissioning innovative solutions, investing in future developments together.
- Organisational and business development
- Models of care transformed through connecting CC2H with a number of individual projects that will grow the MCP model.

Membership
The Executive Programme Board will be chaired by a Chief Executive on a hosted rotational basis.

Membership as at October 2015
Chief Executive Director- Locala
Chief Executive Director - SWYPFT
Executive Director of Transformation - Locala
Deputy Chief Executive, Director of Finance, Performance and Information - SWYPFT
Company Secretary - Locala
Director of Corporate Development - SWYPFT

- Business support will be provided by the Deputy Director of Strategic Planning (SWYPFT) and the Head of Business Development and Performance (Locala).
- The EPB will ensure the appropriate clinical governance and clinical engagement systems are in place relevant to programme work streams.
- Programme leads will attend meetings as appropriate when matters pertaining to their area are included on the agenda.
- Administrative support will be provided by the host Programme Management Office.
- The membership will be reviewed after 6 months in respect of the inclusion of other key stakeholders as applicable.
- It was agreed that declarations of interest would be a standing item where individual declarations would be made, together with exploring areas of organisational conflict and areas of common interest.

Quorum
The quorum will be two representatives from each organisation; one of whom must be an executive director of the organisation, members are expected to attend all meetings. In the unusual event that the Chair is absent from the meeting, the Forum will agree another Director to take the chair.

Frequency of meetings
The Committee will meet on a monthly basis reviewable after six months.

Duties
- To commission programmes of work that align with the strategic direction, vision and values of both organisations.
- To ensure a co-ordinated approach to the development of joint ventures in partnership with other key stakeholders including service users, carers and staff.
- To receive, review and authorise project management documentation including but not limited to Project initiation Documents, Business Cases and Project Plans.
- To receive, review and seek assurance regarding the delivery of specific work streams to budget and timescales.
- To receive regular reports around key risks to work streams and mitigating actions being taken.
- To commission through respective Board Company Secretaries, the establishment of any necessary Joint Venture Vehicles required to deliver the individual work streams.
- To ensure the commissioned programmes of work address the needs of the diverse communities served by both organisations ensure equality and inclusion for all.
- To ensure that commissioned programmes of work comply with legal and national guidance.
- To commission programmes of work covering locality working and the impact on local communities.

Reporting
To ensure effective links between the EPB, respective Executive Management Teams and Trust Boards and other local economy programmes as applicable, ensuring alignment of outcomes.

The EPB has a responsibility to ensure actions identified and agreed are placed within their organisations, through Executive Management Teams or other internal groups as applicable. The EPB will report through respective organisations governance arrangements with regular updates to the joint Board to Board.

Authority
The Committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is also authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

With all of us in mind

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 22 December 2015
Agenda item 9

Title:	**Use of Trust seal**
Paper prepared by:	Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Values/goals:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used twice since the report to Trust Board in September 2015 in respect of the following. - Technology Produce Framework Agreement between the Trust and Insight Direct (UK) Limited for clinical information systems integration and portal development solution. - Land Registry Transfer of Title for 29-31, Queens Road, Barnsley to Finmil Ltd.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in September 2015.**
Private session:	Not applicable