South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board (performance and monitoring)
Tuesday 20 September 2016 at 9:00
Rooms 49/50, Folly Hall, Huddersfield, HD1 3LT

AGENDA

1. **Welcome, introduction and apologies** (verbal item)

2. **Declaration of interests** (verbal item)

3. **Minutes and matters arising from previous Trust Board meeting held on 19 July 2016** (attached)

4. **Chair and Chief Executive's remarks** (attached)

5. **Care Quality Commission inspection report**
   5.1 CQC action plan (attached)

   5.2 Safer staffing (attached)

6. **Transformation update** (attached)

7. **Performance reports month 5 2016/17**
   7.1 Performance report month 5 2016/17 (to follow)

   7.2 Finance report month 5 2016/17 (attached)

   7.3 Exception reporting and action plans
   (i) Sustainability annual report (attached)

   (ii) Medical appraisal/re-validation (attached)

   (iii) Nurse re-validation (attached)

   (iv) Workforce race equality standard (attached)

8. **Governance matters**
   8.1 Independent governance review (well-led) (attached)

9. Assurance from Trust Board committees (attached)

9.1 Clinical Governance and Clinical Safety Committee 13 September 2016 (verbal item)

9.2 Mental Health Act Committee 2 August 2016 (attached)

9.3 Information Management and Technology Forum 12 September 2016 (verbal item)

10. Use of Trust seal (attached)

11. Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 25 October 2016 in meeting room 1, Block 7, Fieldhead, Wakefield, WF1 3SP.

Minutes of Trust Board meeting held on 19 July 2016

Present:	Ian Black	Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Rachel Court	Non-Executive Director
	Julie Fox	Deputy Chair
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
	Rob Webster	Chief Executive
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Mark Brooks	Director of Finance
	Alan Davis	Director of Human Resources and Workforce Development *
Apologies:	Adrian Berry	Medical Director
In attendance:	James Drury	Interim Director, Strategic Planning and Contracting
	Kate Henry	Director, Marketing, Engagement and Commercial Development
	Dawn Stephenson	Director of Corporate Development (Company Secretary) (author)
Guests:	Amanda Miller	Team Leader, APTs, Wakefield
	Bob Mortimer	Publicly elected governor (Kirklees), Members' Council
	Jeremy Smith	Publicly elected governor (Kirklees), Members' Council

** Also interim Deputy Chief Executive*

TB/16/44 Welcome, introduction and apologies (agenda item 1)

The Chair (IB) welcomed everyone to the meeting. The apology from Adrian Berry (ABe) was noted. IB outlined his intention to focus a large part of the agenda on risk appetite, the Care Quality Commission (CQC) report and on performance.

TB/16/45 Declaration of interests (agenda item 2)

There were no declarations over and above those made in March 2016 or subsequently.

TB/16/46 Minutes and matters arising from previous Trust Board meeting held on 28 June 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 28 June 2016 as a true and accurate record of the meeting. There were no matters arising.

TB/16/47 Chair and Chief Executive's remarks (agenda item 4)

IB began his remarks by commenting that, following the announcement of the new Cabinet, Jeremy Hunt will continue as Secretary of State for Health. There are uncertain times ahead for the NHS and for this Trust and its services. When Trust Board reviews the assurance framework and risk register later on the agenda, it should consider the risks and what the implications are for the Trust in the current climate.

Rob Webster (RW) introduced his report and commented that Jeremy Hunt remaining as Secretary of State brings a degree of continuity with a continued focus on safety, openness and transparency. Other Ministers, with the exception of Lord Prior, will be changing although there is no information on portfolios as yet. The political uncertainty will continue. In the meantime, it is expected that there will be a re-setting of 2016/17 finances across the

NHS and more central intervention is expected. A pooled risk budget at West Yorkshire-level, with the budget of each clinical commissioning group (CCG) top-sliced at 1%, will be established. NHS England requires CCGs to use this collectively to manage deterioration from control totals locally rather than nationally.

RW went on to comment about the recent submission of Sustainability and Transformation Plans (STPs) and the presentations, for both South and West Yorkshire, to national NHS bodies. In West Yorkshire, which RW chairs, there is a good sense of shared ownership, with emerging governance arrangements in place to support a coherent plan with clarity around priority areas. Between now and October 2016, the focus will be on developing a draft plan with an emphasis on delivery. Links have also been made with other STPs in the North, with Manchester's plan having very similar themes to those of West Yorkshire.

IB invited comments and questions from Trust Board.

- In response to an observation from Jonathan Jones (JJ), RW commented that the STP process is trying to move to a more constructive, collaborative approach and, potentially, shared resources, such as analytics.
- JJ asked whether the West Yorkshire STP budget will come under the Leeds Local Economic Partnership in a similar way to Manchester. RW responded that Leaders of Councils have written to the Government to seek clarification on the position regarding devolution following the change of Cabinet. In South Yorkshire, there is support for devolvement of budgets; however, in West Yorkshire, the position is more complicated as the geography includes Harrogate so there are issues regarding patient flow and footfall.
- Julie Fox (JF) commented that the paper provided a good overview and asked whether it should be shared with staff. RW responded that information is shared with staff through the Huddle on a Monday morning and through the weekly 'The View'. It could also be made available through the intranet.
- Charlotte Dyson (CD) commented that she would like to understand what Trust Board will do to increase and demonstrate visible leadership. RW responded that this is through the View, the Brief and other channels. He would be happy to have a more detailed discussion with Trust Board to review what else can be done to increase visibility. He also confirmed that Trust Board would very much be involved in the staff awards in November 2016. IB added that this would also include governors, members and other stakeholders.
- JF asked if other Board members would have a role in STPs in future. RW responded that it had been discussed; however, the issue in West Yorkshire is the large number of people currently involved in decision-making. As confidence in governance develops, Non-Executive Director input and challenge would be valuable.
- Chris Jones (CJ) commented that he attended the NHS Providers conference where there was a debate on STP governance. Three models of engagement with Boards were identified to 'inform' Boards on STP discussions, for Boards to 'receive' STP updates, and for Chairs and Chief Executives to be involved; however, Boards are legal entities and have statutory duties; STPs do not. RW responded that STPs do not make decisions but make recommendations to statutory organisations. This, of course, takes time when health and social care economies should be moving at pace, presenting a strategic risk. IB commented that this Board's role is the governance of this Trust with an obvious interest in wider work.
- RW also updated Trust Board on the discussions with Leeds and York Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust about working more closely together.

- IB asked whether, if acute trusts were working more closely on a West Yorkshire footing, mental health trusts will be left behind. RW responded that there is a long-established group of mental health chief executives that meets quarterly.
- IB also asked if there was an issue for the Trust in that it crosses two STPs. RW responded that this Trust is not unique in this regard. Alan Davis (AGD) covers the South Yorkshire STP and RW has weekly calls with other STPs to make connections and foster collaborative working.
- RW also commented that the Trust is using communications and engagement to reinforce its position through, for example, work on the Trust's strategic approach and strategic objectives, the annual members' meeting, staff awards and 'The Brief'.
- JJ asked what impact the STPs would have on the Trust's budget for 2017/18 and beyond. RW responded that Trust Board will need to assess its position for next year by the autumn. STP visions will support the planning process.
- IB asked whether there was anticipation of more involvement nationally. Mark Brooks (MB) responded that a new combined framework from NHS Improvement (Monitor and NHS Trust Development Authority) has been published for consultation with additional parameters for participation in STPs and for control totals. RW added that there is an opportunity to ask for a West Yorkshire control total (an aggregation of all Trust control totals) to be managed between organisations, which would be part of a bigger picture for risk gain/risk share.
- Laurence Campbell (LC) asked if CCGs tender activity was diminishing. RW responded that it did not appear so and the Trust was seeing active examples of tendering currently. Councils' legal frameworks provide a duty to seek best value and CCGs are concerned about their legal position if they do not seek to tender services. LC commented that this was likely to hinder collaboration.
- JF asked where the top-sliced 1% of CCG budgets would go if not used for acute trusts. RW responded that most CCGs have arrangements in place locally with providers for utilisation of the monies if not used.

TB/16/48 Supporting a culture of safety and respect (agenda item 5)

AGD took Trust Board through his paper and highlighted the new role of 'Freedom to Speak Up' guardian and the use of a new self-assessment tool on raising concerns at work. A proposal will come to Trust Board for formal decision in due course. JF commented on an event she attended on Freedom to Speak Up. A national guardian, Henrietta Hughes, has been appointed. For individual organisations, it is not just a matter of appointing a guardian but also about changing culture so staff feel able to speak up. A clear link to Trust Board will be needed, in particular, to the Senior Independent Director. It was suggested at the event that the guardian should attend Trust Board meetings. There is also a clear difference between whistleblowing (extraordinary events) and Freedom to Speak Up (everyday events). The Trust is required to appoint a guardian by 1 October 2016. IB asked for a paper to Trust Board in October 2016 and that AGD involves JF in its development. IB also asked if there was a Non-Executive Director role in this appointment. RW responded that Trust Board will set the 'tone' for the fostering of an open culture. He thought the guardian should be a clinician with Non-Executive Director involvement in the self-assessment tool. AGD was asked to liaise with JF in this regard.

It was RESOLVED to SUPPORT both the use of the self-assessment tool on raising concerns at work and the development of proposals to progress a Freedom to Speak Up Guardian role with a paper to come back to Trust Board in October 2016.

TB/16/49 Risk appetite statement (agenda item 6)

Dawn Stephenson (DS) took Trust Board through the paper and commented that it is recognised that there is risk in all that the Trust does; however, this is mitigated through the risk management strategy. The paper defines the level of risk the Trust is willing to take that can then be communicated throughout the organisation. The approach is built on the Good Governance Institute's work. She also confirmed that the Executive Management Team (EMT) had discussed the approach. IB invited comments from Trust Board.

- LC commented that this is a subjective area and Trust Board needs an understanding of what it means. He added that reporting needs to be considered. Deloitte has offered training in this area. DS responded that this relates to alignment of the risk register, performance reports, etc. rather than focusing on individual targets.
- Rachel Court (RC) commented that this was a good building block and asked what the key risk indicators would be for each top-line risk that will indicate if the risk was outside the risk appetite. Also, the risk register process is 'bottom-up' and the risk appetite, 'top-down'. How would the Trust ensure these meet in the middle? DS responded that this would be demonstrated through a 'heat map' and through communication and Trust Board discussion. RC also asked what objective measures Trust Board will use to assess whether a risk is in or outside of risk appetite. MB responded that any papers for approval/consideration by Trust Board should include reference to risk appetite.
- JF commented that it would be useful to have some examples and Tim Breedon (TB) added that context would be useful.
- LC thought it was positive that Trust Board can communicate the approach to the organisation and TB that it was helpful from a clinical perspective.
- JJ suggested that the Trust Board front sheet should include an additional category for risk level/assessment and this was supported.
- RW agreed it would be useful to apply to some live examples, such as selling a piece of land as a whole as opposed to selling in two parts and the respective risks, to provide a richer picture.
- IB commented that the serious incident report is another example and he would like to see the report mapped against the risk appetite.
- He added that the Trust has two regulators, which can be at odds with each other, which creates difficulty for the Trust.
- RW commented that the risk appetite should be managed down to a level Trust Board is content with and, if this is not possible, it should be raised and discussed through Trust Board Committees and escalated to Trust Board if necessary.

It was RESOLVED to SUPPORT the approach set out in the paper and to INTRODUCE from September 2016.

TB/16/50 Strategic overview of business and associated risks (agenda item 7)

James Drury (JD) took Trust Board through the paper. IB invited comments and questions from Trust Board.

- JF asked if this had been shared with staff. JD responded that much of the content is informed by staff feedback from a variety of mediums, such as listening events; however, he thought there would be benefit from sharing with staff and JF suggested with stakeholders and partners as well.
- CD asked if the strategic direction resonates with external partners. JD responded that feedback from partnership boards and team-to-team discussions are reflected; however, he will ensure that it is tested with partners.

- JJ commented that this was a robust piece of work and any validation/questioning would be helpful. He was interested in the strategic output. JD responded that this would be through service line analysis to build plans, triangulating finance, performance, quality and delivery of cost/efficiency savings. RW commented that one of his objectives is to develop a refreshed strategy by October 2016 for approval by Trust Board in December 2016. Progress will be monitored by the EMT through revised performance reporting.
- RC commented, in relation to the SWOT analysis, that opportunities sometimes become about fixing weaknesses and the Trust (and the paper) should look at wider strategic opportunities.
- CD was still unsure whether the Trust is a mental health or community services organisation. Trust Board should be clear what it wants the Trust to be known for and how community services fit. LC suggested using the four-tier model as a starting point. RW responded that 95% of what the Trust does is in the community and there is a national drive to integrated community, physical and mental health services. The Trust's range of services positions it well in Barnsley.
- CJ commented that the 'weaknesses' provide a good start for focus and action plans. He questioned the weakness in relation to data quality. JD responded that this covered two aspects, firstly, that data requires improvement and, secondly, that some services require improvement.

It was RESOLVED to NOTE the report.

TB/16/51 Care Quality Commission inspection report (agenda item 8)

TB commented that the paper provides a further update since the last meeting in June 2016. The action plan, which includes the Trust's response to both the 'must do' and 'should do' recommendations, will be submitted to the CQC by its deadline of 8 August 2016. More detailed plans sit at BDU level; however, the CQC will look at the organisational high level plan. The plan will be aligned to the Trust's existing quality improvement plan whilst enabling the Trust to demonstrate action against the CQC findings. The CQC may want to discuss the plan with the Trust prior to final approval. The CQC will also give an indication of any plans to re-visit Trust services to check progress and how much of this will be done through regular Mental Health Act visits. IB invited questions and comments from Trust Board.

- RC commented that, under forensic safer staffing, no mention is made of long-term plans to resolve staffing issues; however, the response indicates that there is a plan in place. TB responded that safer staffing is an important area of discussion with the CQC. Although the CQC did not ask for any long-term plans for safer staffing in forensics, a copy was sent; however, the CQC has not commented that the plan is inadequate and it has accepted long-term plans in other areas. The Trust has clear evidence of what it submitted to the CQC.
- IB commented that some actions have a completion date of 31 March 2017, which is eight months after the action plan is submitted and thirteen months after the visit. He understood there was a six-month timeframe. TB responded that this is the case. The end of March 2017 timeframe refers to the dates for the Trust to audit action taken. IB asked that this distinction is clear on the action plan and shows when the Trust expects action to be completed and when it will be audited. MB asked, from a safety perspective, if timeframes were appropriate for any actions that impact on clinical safety.
- IB asked who would approve the plan for submission. TB responded that Trust Board comments will be incorporated and a revised plan will be presented to the EMT for approval. AGD, as Accounting Officer in RW's absence on leave, will agree the final submission with TB as Lead Director. IB asked that the action plan is re-circulated to

Trust Board and that there is a Chair/Accounting Officer discussion in advance of the final submission.

- It was suggested that a risk appetite analysis is undertaken and that the action plan includes an additional column to monitor progress.
- CJ commented that, for some actions, there are different responses by different BDUs. TB responded that, for example, in the case of high dose medication, it is not quite the same issue in each BDU; however, there are some areas where consistency could be improved.
- MB asked how Trust Board will be assured that outcomes have been met. IB commented that he would expect this to be through Trust Board Committees.
- AGD commented that safer staffing is not a 'static' issue and changes constantly.
- He also commented that, during environmental audits, no ligature risks were identified. The Trust will need to understand the discrepancy with the CQC's expectations and adjust internal processes accordingly.
- RC commented that, in relation to Mental Health Act/Mental Capacity Act training, the report mentions that there are no effective systems for monitoring oversight and asked where Trust Board would have oversight. TB responded that this is included in the Trust's response elsewhere and he will ensure that this is reiterated against the appropriate recommendation from individual reports.
- JF confirmed the action plan will be a key agenda item for the Clinical Governance and Clinical Safety Committee and she will discuss this with TB at the agenda setting meeting on 15 August 2016.
- RW commented that Trust Board should be assured of its oversight of the plan, the role of Committees, in particular, the Clinical Governance and Clinical Safety Committee, and the EMT. In particular, assurance is needed that all actions are on the risk register and managed appropriately within appropriate tolerances, any immediate risks have been addressed, and all actions will be addressed within six months, with any exceptions highlighted.

TB provided an overview of the Quality Summit held on 14 July 2016. IB commented that the support from partners able to attend was reassuring.

It was RESOLVED to NOTE the high-level action plan and to APPROVE the approval process for the submission of the action plan to the CQC.

TB/16/52 Performance reports month 3 2016/17 (agenda item 9)

TB/16/52a Performance report month 3 2016/17 (agenda item 9.1)

MB explained that, due to the timing of the meeting, a detailed report was not available. It will be circulated to Trust Board following consideration by the EMT. MB presented an overview of key areas and provided assurance that the improving access to psychological therapies (IAPT) target was now at 76%, which means the Trust has achieved its target in this quarter and not failed to achieve the target for three consecutive quarters. Work is in train to ensure this level of performance is sustainable. All other NHS Improvement performance areas are currently reported as 'green'.

In terms of quality performance, TB reported on:

- good progress has been made to fill vacancies despite underlying issues;
- new training has been delivered to 78 care homes in Barnsley to support prevention of pressure ulcers; and
- although there was nothing specific to report in relation to serious incidents in Q1, a longer-term view will be taken before any conclusions are drawn from the reduction in incidents from the last quarter.

AGD reported that sickness absence has reduced in forensic services and in Barnsley due to concerted efforts to bring down absence levels; however, there are some service issues across the Trust that are driving an increase in sickness levels. The Trust continues to benchmark well with its peers.

The following were raised.

- JJ asked if Brexit had had any impact on staffing. AGD responded not as yet although the next six months will be worrying for staff affected. The Trust needs to ensure people continue to feel valued. The Trust is looking at overseas recruitment for some areas and Brexit may have an impact in terms of reluctance to take up posts.
- JJ asked if there were any contingencies in place. AGD responded that the Trust is looking at a broader staffing mix. There are also concerns in relation to other providers paying bonuses and the Trust will look at what is in its control to recruit and retain staff, including improved career structures, associate nursing roles and earlier recruitment.
- MB advised that the Trust has reported three information governance incidents to the Information Commissioner's Office in the last twelve months. The incidents are similar in nature and are from similar areas in the Trust. The Trust already has one undertaking and is now awaiting judgement for the most recent referral. One consideration is whether the information governance training is working across all parts of the organisation. Bespoke, face-to-face training is being introduced for some teams. Whilst the Trust complies in terms of the numbers of staff undergoing training, it is not clear whether this is always effective. RW commented that the position poses both a financial risk with the possibility of a fine up to £500,000, and a reputational risk. MB assured Trust Board that targeted and personalised training is in place for areas of risk.
- RW commented that the update on performance shows the Trust is delivering its targets, managing its money and has stable quality. Areas for focus are vacancies in specialist services and increasing sickness absence as well as robust management of the use of agency staff.

It was RESOLVED to RECEIVE the performance report for Q1 2016/17.

TB/16/52b Finance report month 3 2016/17 (agenda item 9.2)

MB introduced the finance report and commented that the Trust is on plan currently. He highlighted the following.

- Agency spend is increasing and a detailed review is in train to look at each individual role filled by agency staff across all BDUs.
- NHS Improvement has set criteria for providers to access the sustainability and transformation funding, which, for this Trust, is £1.35 million. Trusts will need to achieve their control totals (for this Trust £500,000), achieve access targets (acute trusts only) and ensure plans are in place to reduce agency spend and start delivering against these plans.
- The forecast projection suggests the Trust has a number of risks, which may impact on its ability to achieve its year-end target. As well as the agency position, there are risks in relation to out-of-area placements and non-achievement of the cost improvement programme. This requires more detailed analysis and a report to Trust Board in September 2016. IB suggested a discussion with NHS Improvement at the Q1 call to outline the concerns and actions being taken.

The following were raised.

- In response to an observation by LC in relation to depreciation and the impact on the Trust's income and expenditure position, MB responded that this was a timing issue in relation to the Fieldhead site and the year-end forecast remains in line with plan.
- JF asked if the Trust was talking to other Trusts within STPs about their agency spend. AGD responded that all Trusts are struggling with the level of agency spend currently and balancing this with regulatory requirements. Quality and safety are the Trust's first priority. Provider trusts do need to work more collaboratively to identify solutions and reduce competition. IB added that safety always comes first when it comes to staffing.
- JF commented that the Trust needs to think about how it attracts and retains staff. The Trust requires loyalty and people who want to stay not just for financial reasons. AGD responded that insight from the wellbeing survey will be useful.
- RW commented that one of AGD's objectives is to revise the workforce strategy by December 2016 and this will be an important component. STPs are also looking collectively at workforce and use of agency staff.
- MB commented that there is some loss of contribution relating to the loss of 0-19 services in Barnsley.
- In response to a question from CD in relation to the management and administration review, AGD commented that the Trust will need to deliver the savings non-recurrently to allow the right model to be established and to ensure there is no double counting.
- CD also asked if the Trust reviews cost savings that may have been rejected previously, particularly if there has been a change in risk appetite. AGD responded that there will be substitutions and these will be subject to the quality impact assessment process. MB added that it would be beneficial to look at previous schemes to ensure they have been delivered and this will be picked up in planning for 2017/18.
- LC asked if there was anything the Trust could do to address the delays in local authority payments. MB responded that he would discuss with finance colleagues in partner organisations and speed up the Trust's invoicing processes.

It was RESOLVED to RECEIVE the report.

TB/16/52c Customer services report Q1 2016/17 (agenda item 9.3)

DS introduced this item and advised that there will be a review of indicators, for example, the number of complaints closed in 40 days. The Trust is currently not meeting this target. BDUs are provided with a weekly monitoring report to expedite work flows. Further work is needed on equality and inclusion information, which is complicated by the complainant not always being the service user, to enable this to be used to improve services.

RC asked whether the Trust follows up on the effectiveness of actions that "remind" staff and whether this resulted in a reduction in complaints. DS responded that work is undertaken with practice governance coaches and with teams; however, it is sometimes difficult to ensure information has been disseminated due to staff changes. She thought that a more detailed piece of work might be needed and agreed to take a proposal to the Patient Experience Group.

CJ asked if the Trust has a process for people under the age of eighteen and whether this was different from other complainants. DS responded that Customer Services is working with child and adolescent mental health services (CAMHS) to develop templates for children and young people to use. The Trust is also looking at a library of easy read information. CJ also commented that two out of three complainants are female and asked whether there were any access issues for males to provide their views. DS agreed to review this.

JF asked whether the Trust is learning from positive experiences in Barnsley given the outcome of the Friends and Family Test. DS responded that Sean Rayner, District Director

for Barnsley and Wakefield, is looking at cross-BDU learning. She added that community services in general have a higher response rate.

IB commented that he would like to see a comparison of Friends and Family Test results nationally. RW commented that, as the Trust is revising its balanced scorecard, there should be a goal/aim in relation to Friends and Family Test outcomes and national comparison.

RW also commented that he was surprised by the number of cases referred to the Ombudsman. He approves all responses to complaints and ensures there is a "golden thread" running through all responses that acknowledges what has happened and provides clear information on how the Trust will learn, ensuring empathy with complainants. Regarding the cluster of complaints relating to CAMHS waiting times, it was noted that action is not in the Trust's control to resolve being a multi-disciplinary assessment process. This is frustrating for all involved in areas such as autism assessments. This reinforces the requirement to work with partners more closely. He would hope to see complaints closed more quickly in future, form 40 to 25 days, and a reduction in the numbers referred to the Ombudsman.

It was RESOLVED to NOTE the feedback received through Customer Services in Q1 of financial year 2016/17.

TB/16/53 Equality and diversity annual report (agenda item 10)

DS explained that a public-facing summary document would be produced and that the report reflects the four Equality Delivery System 2 (EDS2) objectives approved by Trust Board and the four local priorities set by the Equality and Inclusion Forum. IB commented that there is still some way to go in developing the role of, and scrutiny provided by, the Forum; however, good progress has been made. CJ commented that, in his view, the report comes across as unambitious and is light on data both from a service user and staff perspective. He did not get a sense of urgency from the report in relation to achievement of priorities. DS responded that she had tried not to replicate other reports but will take on board for future reports to the Forum and Trust Board. RW commented that, as the Trust is revising the balanced scorecard, one or two of the EDS2 indicators should be identified for regular reporting.

It was RESOLVED to NOTE the progress made during 2015/16 and the continued work in 2016/17.

TB/16/54 Assurance framework and risk register (agenda item 11)

RC asked whether both documents should be tied into the definitions in the risk appetite statement. For example, should a risk be seen as 'amber' if it is within the Trust's risk appetite? DS agreed to review in line with the risk appetite statement. RW commented that the Trust will continue to have a discipline on how risks are described in line with the risk appetite statement and those risks that are outside of appetite tolerance. TB commented that both should be aligned and provide commentary on the link to risk appetite.

It was RESOLVED to NOTE the controls and assurances against corporate objectives for Q1 2016/17 and NOTE the key risks for the organisation.

TB/16/55 NHS Improvement return for Q1 2016/17 and Board self-certification (agenda item 12)

It was RESOLVED to NOTE the report and to DELEGATE AUTHORITY to the Chair and Chief Executive to APPROVE the submission and exception report to NHS Improvement.

TB/16/56 Assurance from Trust Board committees (agenda item 13)

TB/16/56a Audit Committee 12 July 2016 (agenda item 13.1)
TB/16/56b Remuneration and Terms of Service Committee 7 July 2016 (agenda item 13.2)
TB/16/56c Equality and Inclusion Forum 21 June 2016 (agenda item 13.3)
TB/16/56d Information Management and Technology Forum 28 June 2016 (agenda item 13.3)

Trust Board noted the feedback from Committees and Forums.

JF commented that it would be useful for all members of Trust Board to see the papers in relation to Forums, particularly the independent review of the implementation of the upgrade to the Trust's clinical information system. IB agreed and asked DS, as commissioner of the review, to circulate to Trust Board. All papers for Committees are now provided on BoardPad and IB will ensure that papers for Forums are also published. IB asked for any comments from non-members to be provided to the Committee/Forum chair before the next Trust Board meeting if at all possible.

TB/16/57 Date and time of next meeting

The next meeting of Trust Board will be held on Tuesday 20 September 2016 in rooms 49/50, Folly Hall, Huddersfield, HD1 3LT.

Signed …… Date ……

Trust Board 20 September 2016
Agenda item 4

Title:	**Chief Executive's Report**
Paper prepared by:	Chief Executive
Purpose:	To describe the context within which we work to help frame the conversation at the Board
Mission/values:	The organisation can only deliver its mission if it understands the context within which it operates. In doing so, we must live our values.
Any background papers/ previously considered by:	The Brief for September (attached) 'On the day briefing' from NHS Providers on NHS Improvement Single Oversight Framework (paper can be found at NHS Providers on the day briefing NHSI single oversight framework).
Executive summary:	➢ The state of NHS finances and the future viability of services is a matter of national debate. ➢ The development of Sustainability and Transformation Plans (STPs) is under scrutiny, in particular in relation to engagement with the public. ➢ NHS Improvement has published its revised Single Oversight Framework and we will need to do an assessment of the consequences. ➢ Significant service change continues, with active tenders and strategic developments in all parts of the Trust. ➢ Director portfolios have been agreed and will come into play from October, subject to consultation. ➢ We continue to innovate and celebrate success, with notable national showcasing of our work. ➢ Revised briefing arrangements are strengthening connections across the Trust.
Recommendation:	**Trust Board is asked to NOTE the context within which we operate to help guide the judgements we will need to make.**
Private session:	Not applicable

Chief Executive's Report

Trust Board 20 September 2016

1. A written Chief Executive's report was introduced at the July Board to help frame the conversation for the Board meeting. The report aims to set out the context in which we operate and key developments which will affect our strategy and our operational delivery. Board members were positive about the introduction of the report and were keen to ensure that the report was shared across the organisation. **This report aims to build on this approach, bringing the team brief introduced in August together with some personal reflections in a single report.**

2. **The September edition of The Brief is attached for information.** It covers internal and external developments for the Trust and is cascaded across the organisation. Managers are requested to deliver a face to face local briefing using this text and some associated slides within ten days of receipt.

3. **Since publication of The Brief there have been a number of additional developments that it is worth noting**. These are set out below.

Additional points on national context

4. **Despite improvements in NHS Finances this year, there has been a significant amount of noise on NHS Funding, led by NHS Providers NHS Providers and supported by major think tanks.** This received significant coverage and centres on the fact that the NHS settlement is front loaded in 2016/17 and that pressures in social care and public health will also have an impact. This is not a new position but Simon Stevens, speaking to Andy Cowper health policy insight, set out that the NHS England position was clear that funding promises in the next three years were not in line with requirements and that a promised "extra £5bn for the NHS by 2020" had been a promise from the Brexit camp that should be delivered. The Brexit leadership has publicly abandoned its promise to put £350m a week into the NHS following Brexit Guardian brexit-camp-abandons-350-million-pound-nhs-pledge.

5. **There are risks** that all of this translates into a debate about the pressure in hospitals or that people see the forthcoming Sustainability and Transformation Plan submissions as part of a wider lobbying tactic with Treasury. As the West Yorkshire STP lead, I am continuing with a process that covers all of the services – from prevention to end-of-life and including physical, mental and social care – as we need a place-based set of plans for the future.

6. **The unprecedented level of industrial action announced by the British Medical Association following the junior doctors' vote to reject the new contract has been postponed.** The junior doctors' committee of the British Medical Association is continuing with plans for five-day strikes later this year, however. **Trust Board should note that** we will keep close to the consequences for the Trust under the leadership of the Medical Director and Director of Human Resources. NHS Employers has provided good support on the issue with up-to-date briefings NHS Employers junior doctors industrial action.

7. **Against this backdrop, NHS Improvement has published its revised regulatory framework.** This will have a material impact on the Trust and our work. The Director of Finance is undertaking a review of the impact for the Trust that will report back in October, following a desktop review and discussions with the regional team. NHS Providers' on the day briefing is here NHS Providers on the day briefing NHSI single oversight framework.

Additional points on local context

8. **The Executive have met to discuss our emerging strategy in the light of changes in each of the Boroughs that we work within.** We have:

    - met with system leaders to develop thinking around possible future options for an accountable care system in Barnsley that brings together commissioners and providers. The Trust could have a very significant role in this and **I will provide a verbal update at the Board**;
    - had discussions as leaders in Wakefield about the multi-speciality community provider (MCP) developments and system leadership, including emerging NHS England requests that a MCP contract is implemented for April 2017;
    - seen services for 0-19 year olds in Kirklees being tendered with a five-year contract with an optional five-year extension. **The Board should note we will be working on a tender for this service**;
    - child and adolescent mental health services in Calderdale have had their tender terminated. **We are actively working to understand the next steps, favouring a collaborative approach based on our bid**;
    - submitted a bid to NHS England on Perinatal Mental Health services as part of the Five Year Forward View for Mental Health. **A verbal update will be provided to the Board**;
    - continued to support our staff in decommissioned services in Wakefield and Barnsley.

9. **Trust Board should note** that we will be working to ensure that we are positioned to respond to these developments, the developments that emerge from the STP, and developments that emerge from national commissioning of specialised services.

Additional points on Trust context

10. **The revised Director Portfolios have been agreed and have now moved into a formal process of consultation for the staff affected.** The review means that we will have fewer directors in the organisation and more coherent portfolios. This will help respond to the issues raised in staff listening events. It is hoped that the process will be complete and new portfolios implemented by early October. A separate note has been sent to Board members outlining the detail.

11. **The work has also precipitated a review of internal groups that has revealed a significant opportunity to reduce the number of groups and collapse the layers of decision-making in the Trust.** The Company Secretary will be providing a set of suggested changes to the Chair and Chief Executive for consideration before a broader debate with Board members.

12. **Welcome to Emma Jones who joins us following the imminent departure of Bernie Cherriman-Sykes.** I would like to recognise the fantastic support that Bernie has given to the Trust, the Executive and the Board and to wish her well in her retirement.

13. **During this period, we continue to have a focus on innovation and change.** We were well represented at NHS Expo 2016 (the innovation conference sponsored by NHS England). Our role in the Wakefield Vanguard and Creative Minds featured at the event, showcasing our commitment to asset-based approaches to health and to joined up care in communities. Congratulations also to the Police Liaison Team, shortlisted for a HSJ Award this year police liaison scheme nominated HSJ award and thanks also to the team working on the Fieldhead redevelopment that started in earnest this month 6m redevelopment fieldhead hospital begins.

Conclusion

14. Things around us continue to develop and change at a pace. This is in a context that remains the most difficult and unpredictable for a generation. We are improving the connections across the organisation that will help to bring people with us – with consistent communications from Board to Barnsley and all points in between.

Rob Webster

Chief Executive

September 2016

The Brief

1 September 2016

Our mission and values

We exist to help people reach their potential and live well in their community. To do this we have a strong set of values that mean:

- We must put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent in our dealings, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

What's happening externally?

Quarter 1 (Q1) NHS financial position
The quarterly financial performance for the NHS has been released by NHS Improvement. The Q1 figures for 2016/17 (Apr-Jun) show that NHS Trusts have improved their financial position compared to the previous year.

At the end of Q1 last year the overall deficit across NHS Trusts was -£930m. This year, the Q1 deficit has reduced to -£461m. Trusts have been working hard to achieve this, and have also been helped with extra money from the £1.8bn sustainability and transformation fund.

STPs in the news
We're part of two sustainability and transformation plans (STPs) – one covering West Yorkshire, and one covering South Yorkshire and Bassetlaw. Across both there is a commitment to real and proper engagement with local people and health and care staff.

STPs have been described in the news as "secret plans" designed to deliver "cuts" to services. This coverage, alongside suggestions that we will see a "glut of closures", is unhelpful as we strive to develop a meaningful and credible plan for high quality and sustainable services.

As soon as they are developed enough, STPs will be made public and shared with local people without any foregone conclusions or decisions being made. We expect that this will later this calendar year.

West Yorkshire and South Yorkshire and Bassetlaw STPs
Across both areas, partners are working together on a draft STP, due for submission to NHS England on Fri 21 Oct. The West Yorkshire plan is being led by our chief executive Rob Webster and is made up of:

- Six local plans - Wakefield, Calderdale, Kirklees, Leeds, Bradford and Craven, Harrogate and Rural District
- Eight priority areas – prevention, primary and community services, mental health, stroke, cancer, urgent and emergency care, specialised commissioning, acute reconfiguration
- Six enablers – digital, workforce, leadership and OD, communications and engagement, finance, business intelligence.

What's happening internally?

Safety and quality

Our practice governance coaches Lisa Connor, Daryl Thompson and Caroline Rogers hosted a patient safety event on 26 August on suicide prevention:

- Rob Webster gave a powerful personal perspective on suicide and the importance of leading from every seat, building a safety culture and values based leadership
- Mike Doyle, deputy director of nursing, clinical governance and safety, talked about the suicide prevention work underway across West Yorkshire and the principles of the Zero Suicide approach
- Dr Mike Ventress highlighted key elements of the Trust's suicide prevention strategy
- Dr Raghu Vutla presented a case study of an incident that a clinical team experienced, including the important lessons learned.

On 9 August we submitted our action plans to address the "must do" items identified in our Care Quality Commission (CQC) reports. We're also developing an action plan that delivers on the "should do" items and includes our approach to learning lessons from the CQC visit.

Delivery of our action plans will be overseen by out Trust Board, with BDUs leading the delivery of the actions required. We've already made significant progress and will be meeting with the CQC to discuss how the plans will be monitored and actions closed.

Performance

NHS Improvement monitors NHS Trusts against national standards for access and outcomes. Performance against the measures that are applicable to us is reviewed on a monthly basis and reported to NHS Improvement quarterly.

We achieved our targets in Q1 of this financial year, and that continued into July. There are some performance hotspots that we need to keep a close eye on, including:

- IAPT – access within six weeks
- Data completeness identifiers - valid ethnicity code

Month 4 finances (July 2016)

Our current financial position shows a surplus of £1.4m and remains ahead of plan. We're forecasting a £1.85m surplus at the end of the year. This position remains challenging with a number of risks identified.

All NHS Trusts have been set maximum agency spend caps for 2016/17 by NHS Improvement – ours is £5.1m. We're forecasting that we will exceed the cap with our agency spend expected to reach £7.1m.

Our cost improvement programmes (CIPs), which add up to £10m this year, are currently £0.4m behind plan. In addition, £1.27m of our CIPs are currently rated as red.

Change

There's lots of change happening across the Trust as we constantly improve and aim to be outstanding so that we can be relevant today, and ready for tomorrow. Some are changes that we're in charge of, and others are determined by commissioners and procurement processes:

- In Wakefield we're working closely with the council on the future of health and wellbeing services, which they have put out to tender. We're supporting our staff affected and will be bidding to continue providing the services.
- In Barnsley we're supporting our 0-19 service staff who will soon be transferring to Barnsley Council. We're also working with partners on our intermediate care services.
- In both Calderdale and Kirklees we're working hard to bid for CAMHS services.

All ideas for change are welcome – big or small. It's nearly two months since we launched our i-hub - an online space for sharing and developing ideas together. Hundreds of staff have joined and are sharing their ideas and comments. Visit https://i-hub.crowdicity.com/ and get involved.

Staffing
Our Excellence 2016 awards will be held as part of a staff achievement celebration in November. Entries are now open and there are categories for both teams and individuals. The closing date for applications is Weds 14 Sept. Visit nww.swyt.nhs.uk/excellence

The appraisal rate for staff at band 6 and above is currently 56.7%, against a target of 95% by the end of June. The appraisal rate for staff at band 5 and below is 26.8%, against a target of 95% by the end of September. The vast majority of staff reported in the recent wellbeing survey that they had effective appraisals, so please make sure you've had yours.

At the end of July we had 506 whole time equivalent vacancies (non-medical) across the Trust. We have set up a recruitment summit to address the challenges we are currently facing in this area.

Our sickness rate up to the end of July was 4.6%, which is higher than our target of 4.4%.

We're gearing up for this year's flu vaccinations with training for peer-to-peer vaccinators taking place throughout September. Details of how to get your jab will be out soon.

Dates for your diary

Following the high response to our staff wellbeing survey, we've set up some informal engagement groups to discuss the key results and identify areas for further improvement. The events are open to all. Book a place - janet.jolley@swyt.nhs.uk / 01977 605297.

- Mon 12 Sept, 2-3.30pm, small conference room, L&D, Fieldhead, Wakefield
- Tues 13 Sept, 2-3.30pm, Room 49, Folly Hall, Huddersfield
- Weds 14 Sept, 2-3.30pm, Oakdale meeting room, The Dales, Halifax
- Thurs 15 Sept, 2.30-4pm, Boardroom, Kendray Hospital, Barnsley
- Thurs 22 Sept, 2.30-4pm, Ward 19 meeting room, Priestley Unit, Dewsbury Hospital

There are a number of pastoral care events taking place at Fieldhead for staff, service users and carers. Book a place - debby.walker@swyt.nhs.uk

- Lifting your spirits - Thurs 8 Sept, 10am-1pm
- Urban 1-day retreat - Thurs 13 Sept, all day
- Spirituality and wellbeing special interest group - Thurs 29 Sept

Take home messages

1. In tough times, remember safety first, always
2. Thanks for using resources wisely to keep in budget – keep it up
3. Keep involved and up to date through briefings and events – it's your Trust
4. Make sure you've had your appraisal
5. Sign up and start sharing your ideas and suggestions on our i-hub
6. Keep an eye out for info on getting your flu jab
7. Nominate a colleague or team in our Excellence 2016 awards

Our Trust has a bright future

To deliver it, we need:

- System leadership
- Values based leadership
- Leadership from every seat in the organisation

Keep talking and get involved

Give feedback on The Brief to your line manager and/or comms@swyt.nhs.uk

The next issue of The Brief will start on 29 Sept

Trust Board 20 September 2016
Agenda item 5.1

Title:	**Care Quality Commission action plan implementation, monitoring and evaluation**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	The purpose of the paper is to provide Trust Board with an update on the ongoing CQC inspection process with specific reference to action plan implementation, monitoring and evaluation.
Mission/values:	This paper directly supports the Trust's mission and values and the strategic objectives.
Any background papers/ previously considered by:	January 2016 – CQC preparation plan June 2016 – CQC closure report
Executive summary:	The Trust was inspected by the CQC in March 2016. The scope of the inspection was vast, looking at clinical services from across the whole Trust and viewing information from corporate services. The CQC made recommendations on where the Trust needed to take action to improve the quality of its services. In response to these recommendations, the Trust has developed an action plan and a framework to manage the implementation, monitoring and evaluation of the action plan. The paper and action plan are attached. The main risk associated with the action plan is delivery of the actions against agreed timescales. The Trust has mitigated this risk by implementing a robust governance framework to monitor and evaluate these actions on an ongoing basis. Assurance against the actions will be monitored at several levels within the organisation. • Trios within BDUs will oversee the action plan at team and service level and report into BDU Governance Groups. • Respective BDU Governance Groups will monitor their action plans through each of their BDU meetings as a standing agenda item on a monthly basis. • Each BDU will be asked to provide an assurance report that highlights progress and achievements in implementing the action plan to the monthly Clinical Governance Group. • Key governance groups, such as Trust Board Committees, Trust-wide Action Groups and other identified groups) will support BDU Governance Groups to deliver their action plans. • The Clinical Governance Group will review progress and achievements, 'RAG' rate the level of assurance and escalate any concerns to the Executive Management Team (EMT) and Clinical Governance and Clinical Safety Committee. • A progress report on the implementation of the CQC action plan will be provided by the Quality Improvement and Assurance Team to EMT, the Clinical Governance and Clinical Safety Committee and Trust Board on a monthly basis. • Action plan outcomes will be evaluated through existing quality monitoring processes, such as the clinical audit programme, internal mock inspection visits, external CQC visits, CQC Mental Health Act visits and risk reporting and management system (Strategic Governance

	System).
Recommendation:	**Trust board is asked to NOTE and REVIEW the CQC action plan implementation, monitoring and evaluation arrangements and the CQC action plan, and provide feedback of any areas of concern.**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Care Quality Commission action plan implementation, monitoring and evaluation

Trust Board 20 September 2016

With **all of us** in mind.

CQC Action Plan Implementation, Monitoring and Evaluation

The following is proposed in order to ensure we have robust measures in place to respond and address the CQC requirement notices, 'must do's' and 'should do's' as identified at our recent inspection visit and ultimately to improve the service we deliver in relation to SAFE, EFFECTIVE, CARING, RESPONSIVE & WELL LED domains.

Our internal action plan (attached) includes;

- Regulatory breaches," must do" and "should do" actions
- End date and milestones identified (where provided)
- Plans that can be cut into BDU and service line specific plans
- Lead Director and responsible Deputy District Director identified, plus key individuals where appropriate
- A consistent approach to identified actions across the Trust
- Outcome measures that will be met to evidence actions have been completed.

CQC have now received all our action plans in response to their findings when they visited in March 2016. They will undertake a follow-up visit to look at whether the necessary improvements have been made to improve the quality and safety of our services. It is not clear as to when this follow-up visit will take place or how this will be done. In order to provide some clarification about this we have set up some regular meetings with our CQC links. This is intended to enhance our engagement and relationship with CQC, including clarification around their systems and processes and expectations of the NHS Improvement agency. The initial meeting with our CQC links is due to take place on 22nd September 2016.

Key responsibilities

Business delivery unit

BDU is responsible for the delivery and local monitoring of their action plan.

The teams are **r**esponsible for implementing the actions and escalating any issues, within the BDU, which may impact on actions being met.

The Trios will be responsible for ensuring that the evidence threshold is met before sign off and for escalating, to Deputy District Director & BDU governance group, where action is behind schedule.

BDU Governance group – role is to oversee and monitor the progress of the actions on the plan. This group will escalate any issues of concern to the Clinical Governance Group. (see early alert system below).

District Directors/ Deputy District Directors are responsible and accountable for the delivery of the actions and escalation of any issues to the Clinical Governance Group.

Quality Academy

The Quality Academy will provide a wide range of expertise, knowledge, advice and practical assistance to help enable BDU's to deliver their actions. Quality academy staff sit in the key governance groups and clinical governance group and will participate in the RAG rating of the action plan delivery.

The Quality Improvement and Assurance Team will co-ordinate the feedback on delivery of the action plans and identify any shortfalls within the process e.g. proposed timescales not being met etc. and produce reports for EMT, CGCSC and Trust Board

Key governance groups
These are the support groups that will provide specialist advice to assist BDU's to deliver their actions. These groups will have an oversight and monitoring function of specific Trust wide actions. Each key governance group (and BDU) will be given a list of the actions from the plan that they are expected to oversee. This group will need to maintain links with BDU governance groups, Deputy District Directors and Clinical Governance Group.

Clinical Governance Group
This group will be responsible for the overview and monitoring of the Trust wide action plan. This will include, evaluation of the evidence submitted to provide assurance that the expected outcomes are being met. A check and challenge approach will be adopted. This group is responsible for providing assurance that the action plan is being delivered and escalating any concerns to EMT and Clinical Governance and Clinical Safety Committee.

The Nursing Directorate
This team is responsible for the provision of advice and guidance around compliance and evidence required. The directorate will support any cross system learning and provide a Trust wide evaluation of progress and achievements.

Executive Management Team (EMT)
EMT will review CQC action plan progress as part of the performance reporting cycle on a monthly basis.

Clinical Governance & Clinical Safety Committee (CGCSC)
CGCSC is responsible for receiving updates on the progress of the action plans and providing assurance to Trust Board that the delivery of the actions is meeting standards of quality and safety. CGCSC are responsible for escalating any concerns to Trust Board.

Trust Board
The Trust Board is responsible for making sure the plan is being delivered to the expected standards in line with our strategic objectives, and providing assurance to our stakeholders and the public.

Process
The following mechanisms will be put into place in each BDU to monitor the progress of the action plans:

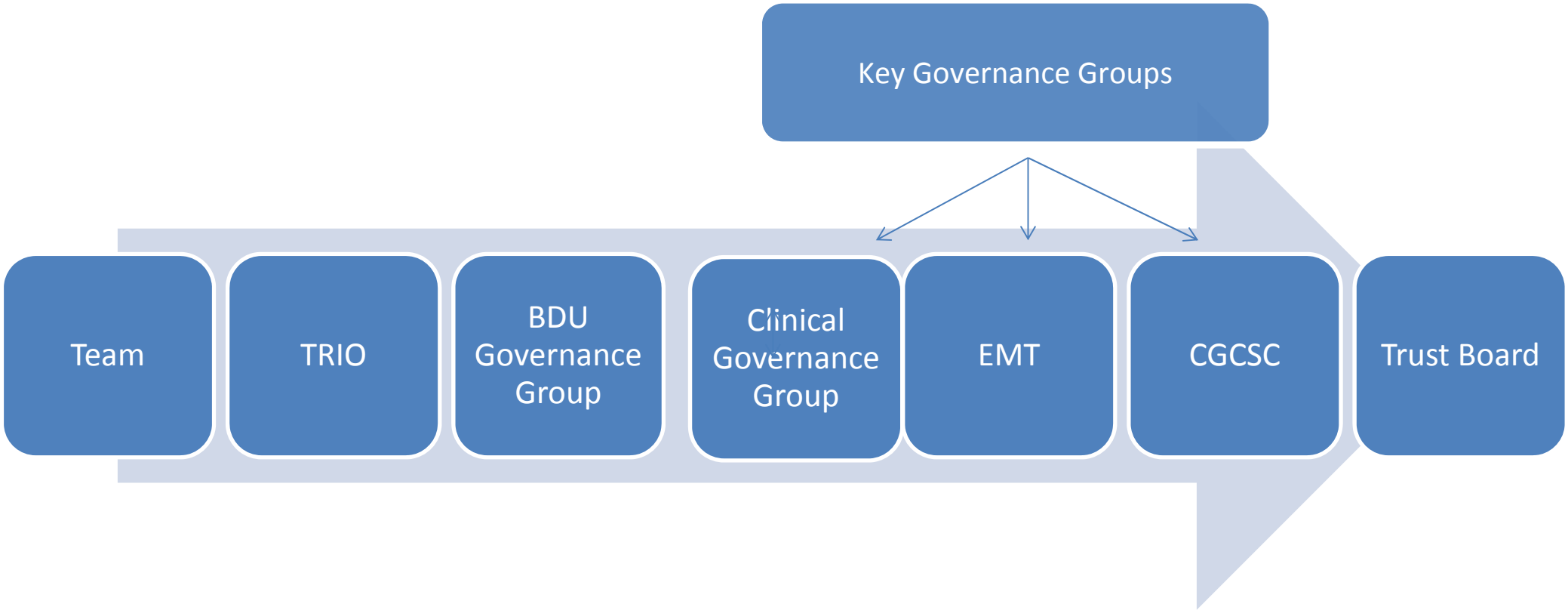
- For each core service there is a service specific action plan that can be extracted from the CQC master plan.
- The TRIO's will oversee the action plan at team and service level and report into the BDU Governance Group.
- The respective BDU Governance Groups will monitor their action plans through each of their BDU meetings as a standing agenda item on a monthly basis.
- Each BDU will be asked to provide an assurance report (using an agreed template) that highlights progress and achievements in implementing the action plan to the monthly Clinical Governance Group.
- Key governance groups (Committee's, TAGs and other identified groups) will support BDU Governance Groups to deliver their action plan.
- The Clinical Governance Group will review progress and achievements, RAG rate level of assurance and escalate any concerns to EMT & CGCSC.

- A progress report about the implementation of the CQC action plan will be provided by the Quality Improvement and Assurance Team to EMT, Clinical Governance and Clinical Safety Committee and the Trust Board on a monthly basis.
- Strategic Governance System – action plan outcomes will be evaluated through our existing quality monitoring processes, e.g. clinical audit programme, internal mock inspection visits, external CQC visits, CQC MHA visits and risk reporting and management system.

Early alert system

Deputy District Directors/ District Directors are asked to escalate any issues of concern to the Quality Improvement & Assurance Team ***at the earliest opportunity***, in the event of them not being able to progress actions or meet given timescales.

Structure



QUALITY ACADEMY SUPPORT

SWYPFT CQC Inspection action plan

Updated 13.9.2016

Introduction

The Trust submitted our Regulation breach action plans to the CQC, as required, by 9/8/16. The Chief Executive and Director of Nursing are meeting with The CQC lead inspector and our CQC relationship manager on 22nd September to sign off the action plans, discuss the next steps in the processes, including timescales for future visits and seek clarity on who will monitor our delivery of the plan (e.g. NHS Improvement).

This is our internal action plan and includes;

- Regulatory breaches, must do" and "should do" actions
- End date and milestones identified (where provided)
- Plans that can be cut into BDU and service line specific plans
- Lead Director and responsible Deputy District Director identified, plus key individuals where appropriate
- A consistent approach to identified actions across the Trust
- Outcome measures that will be met to evidence actions have been completed.
    - Outcomes monitoring will sit locally within each BDU and be evaluated by a governance route, through our existing quality monitoring processes, e.g. clinical audit programme, internal mock inspection visits, BDU performance meetings, BDU governance groups, CQC MHA visits and risk reporting and management system.
    - Outcomes will be aligned to trust action groups, committee's and other meetings , who will be expected to monitor performance across BDU's
    - Each lead person will be asked to submit a progress against the achievement of the outcome supported by an assurance statement to the relevant group.
    - All outcomes will be reported centrally to the clinical governance group and forwarded onto Clinical Governance & Clinical Safety Committee.
- The action plan is required to be a standing agenda item on local BDU governance groups.

We will have a summary action plan, for external viewing and reporting

SWYPFT CQC Visit – CORE SERVICE Requirement Notice Action Plan

1. TRUSTWIDE

Quality report

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key Governance Group	Progress report
Three of the new non-executive directors had not had Disclosure and Barring Service checks in line with the fit and proper person requirement, which came into force for NHS bodies on the 1 October 2014. ***This is a breach of regulation 5 (3) (a)*** **Must Do** The trust must ensure that non-executive directors have checks with the disclosure and barring service	The three new non-executive directors (NED's) have had their Disclosure and Barring Service Checks completed and have been issued with their standard certificates, copies of which are held by Human Resources.	All NED's will have Disclosure and Barring Checks undertaken before any offer of appointment. Updated recruitment checklist for NED's Up to date policy.	Documented evidence in the NED personal folders that DBS checks have been satisfactorily undertaken. Review of system that has been implemented by Human Resources.	Director of Corporate Development	31st August 2016	NA	The recruitment checklist for NEDs has been updated to include the DBS checks and will be monitored by the Director of Corporate Development.

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
Mental Health Act and Mental Capacity Act training was not mandatory for any staff and was not monitored for effectiveness by senior management of the trust. ***This is a breach of regulation 18 (2)(a)*** **Must do** The trust must ensure that Mental Health Act and Mental Capacity Act training is mandatory for specified members of staff and that this is monitored for effectiveness by senior management of the trust.	1. In March 2016 Mental Health Act/Mental Capacity Act training was approved by the EMT as mandatory for all staff. 2. In April 2016 a meeting was held with Learning and Development to agree reporting arrangements through the HR performance wall. 3. The proposed MCA training plan (including Deprivation of Liberty Safeguards) was discussed with the Local Authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting has been planned for October 2016. 4. We have undertaken a review of the e-learning programme for level 1 MCA training. During June 2016 we received confirmation from SCIE Head of Digital to confirm that we can adapt the SCIE's e-learning programme. The adapted module was approved by SCIE in July 2016.	MHA/MCA training is mandated by the Trust, reported through the HR performance wall and monitored by the Mental Health Act Committee Training plans will be available and monitored by Mental Health Act Committee Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA in practice. New MHA/MCA sub-group established	HR performance wall Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)	Deputy Director of Nursing, Clinical Governance & Safety.	1 & 2..complete 3.31st October 2016 4. Complete 5. 30th September 2016 6. Complete	Mental Health Act Committee	1. Complete 2. Complete

	5. We are developing training plans for MCA using core training guidance that was issued by NHS England. Training flyers are available and training information will be advertised in weekly bulletins during August and September 2016. 6. E-learning packages are to be developed for the Mental Health Act. This training will interface with the MCA training. Training plans and dates have been put in place. 7. There is an internal Trust Training plan for MHA/MCA for all registered staff and clinical support staff working within mental health services. Training dates are available and are advertised on the trust intranet. 8. Reporting compliance with the MHA/MCA training will be sent to the Trust Board and senior managers. Reporting compliance via performance wall will be sent to individual staff and managers on a monthly basis. These reporting structures will feed into the MHA Committee. 9. A new MHA/MCA sub-group has been agreed and will report into the MHA Committee. 10. The MHA/MCA training plan will be reviewed in October 2016. 11. We will be looking at the continued implementation of the training plan including				8. Complete 9. /10 / 11/12 & 13 . 31st October 2016		

	refresher dates in October 2016. 12. There are plans to establish practical scenario based refresher training for all registered and support staff (clinical) by October 2016. 13. Plans have been developed to include mental capacity in the medics induction programme. This will include training on assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and DOLS.						

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence of how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The 2015 MHA code of practice had not been implemented across all services of the trust. ***This is a breach of regulation 17(2)(a)*** **Must do** The trust must ensure the 2015 MHA code of practice is implemented across all services of the trust	As a trust wide approach we are taking the following actions: 1. We are commissioning a MHA/MCA clinical reference group. 2. All areas have removed outdated MHA Code of Practice information. 3. We have sent reminders to staff that the MHA Code of Practice 2015 is available on the intranet. Information will also be provided in weekly bulletins during August and September 2016. BDU Deputy Directors will include the MHA Code of Practice as an agenda item within their respective BDU meetings.	MHA/ MCA clinical reference group established. Staff will apply their knowledge of MHA/ MCA in practice. Audit programme in place to monitor compliance with code of practice.	Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available) Audit reports and action plans	Deputy Director of Nursing, Clinical Governance & Safety.	31st December 2016	Mental Health Act Committee	

	4. MHA Code of Practice training is now mandatory and training is in place. New doctors will attend induction training which now incorporates a dedicated MHA session. 5. In February 2015 we developed a MHA Code of Practice policy action plan which had identified leads. Following the visit this was sent to all identified leads for review and action. 6. BDU's were asked to review all operational procedures to ensure compliance with the MHA Code of Practice 2015. . 7. We are planning a baseline audit of awareness of the current MHA Code of Practice. These audits will be carried out every 3-6 months and have already started. There will be an overall overview in 12 months' time and this will be aligned to the training plan						

Regulation breach	**Action**	**Outcomes** **How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key Governance Group**	**Progress report**
Care records were both electronic and paper based and staff did not have access to contemporary, accurate and comprehensive patient's records.	The Trust has an improving clinical information working group and action plan. 'Multiple records' as described , is one of the areas that the Trust has identified for action, with an ultimate aim of meeting the National target to have a	Action plan will be formulated detailing the transition to a paper free NHS. Staff will have access to standard operating procedures to guide their	Action plan Standard operating procedure Review of care records Speak with staff	Director of Nursing, Clinical Governanc e & Safety & BDU District	Operating policy standard - 31 October 2016 Paperless NHS transition	Improving Clinical Information Group	

This is a breach of Regulation 17(2)(c) **Must do** The trust must ensure care records are up to date and accessible in order to deliver people's care and treatment in a way that meets their needs and keeps them safe.	paperless NHS by 2020. The aim is to ensure our clinical record keeping system RIO is the one place for storage of all clinical records. 1. We will develop, by December 2016, a detailed action plan to outline our transition from paper to electronic records, which will include developing procedures for putting letters on the electronic system (and not on shared drives), guidance on document upload, store and forward processes. 2. The systems we currently have in place for staff to access contemporary, accurate and comprehensive patient records will be reviewed with each core service to ensure we have a standard operating procedures to guide staff on how to access care records (RiO), which includes ensuring there is a log on the electronic record of where paper records are held and monitoring of, how contemporaneous the care records are. 3. We will work with staff to develop the standard operating procedure and undertake a communication campaign to ensure trust staff are aware of the procedure to minimise risk to patient care	practice Staff will improve their clinical record keeping and data inputting entries.	Clinical record keeping audit Incidents recorded as clinical record keeping issues on risk management system	Directors	plan to be developed - 31 December 2016		

SHOULD DO'S	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key group	Progress report
The trust should ensure that they comply with the requirements of regulation 20 of the Health and Social Care Act 2008 (regulated activities) regulations 2014, duty of candour. They should ensure that there is a clear written apology sent to patients, relatives in carers and details. They should also ensure that written details of the investigation into the incident, and the findings, are sent to the patients, relative or carer.	Monthly training is available for staff to book on to. Bespoke training is offered to teams as requested. Included in the training is the need to offer a written apology and details of any investigations. Duty of Candour incidents are monitored for actions taken.	Duty of candour incidents will all offer apology in writing which will be provided if required. Details of investigations will be provided by feedback to relevant person.	Sample audit of letters against Duty of candour standard. Review datix incidents	Deputy Director of Nursing Clinical Governanc e & safety	31ST October 2016	Patient Safety Implementation Group	
The trust should ensure data collected regarding the use of restraint, seclusion and long-term segregation is accurate.	The system for collecting restraint data has been reviewed. Clarity has been provided to the clinical teams.	Effective system in place to accurately collect data. Staff record data accurately	Review of care records against information supplied to performance and information	Deputy Director of Nursing Clinical Governanc e & safety	30th September 2016	Management of violence and aggression TAG	

2. Mental Health Core Services

Inpatient wards - Adult & PICU

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
Patients on ward 18, Priestley Unit, Dewsbury did not have risk assessments that had been fully completed or completed within trust policies and procedures.	**Risk assessments** We have emphasised the need for fully documented risk assessment information within the trust policies and procedures with all qualified practitioners through targeted communication i.e. directly by e-mail and within staff meetings. Implement risk assessment and care plan standards. A BDU inpatient discharge planning group is being formed to learn from SI incidents to improve discharge planning which includes updating risk assessments, working in a whole systems way. The Community and Acute Practice Governance Coaches' are setting up a small working group to review how the whole system achieves best practice standards for improving risk assessments, especially at the discharge planning stage.	All people admitted to ward 18 will have a risk assessments that has been completed in line with the Trusts policy.	Risk assessment available in care record. Case track a person who is due to be discharged. Speak with staff to check understanding of Trust policy and how they implement in practice CQC mental health act visits.	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	Action complete	Acute Care Forum	

Staff did not have clear lines of sight on Trinity 2, Fieldhead Hospital and Ashdale and Elmdale wards at The Dales. **Must do** The trust must ensure that staff are able to observe all areas of the ward on Trinity 2, Ashdale, Elmdale and Priory 2.	**Lines of sight** Wakefield and Kirklees/Calderdale 1.We are carrying out an environmental risk assessment to determine whether additional mirrors are needed to help line of sight. 2. Where improvements are identified, we will liaise with the Estates department to install the mirrors in the areas identified.	Environment risk assessments complete. Mirror fittings are in place as identified in the environmental audit.	Check environmental risk assessment for issues relating to lines of sight, and actions to address any identified shortfalls. Look at the risk management plan to improve lines of sight and check whether these are being followed in practice. Observe the environment to see if the measures are sufficient in meeting any identified shortfalls. Speak with staff. Look at incident records in relation to self-harm and/or injury in relation to observation issues.		**Lines of sight** 30/9/16	Estates TAG	
Not all ligature risks had been identified on Beamshaw and Clarke ward at Kendray Hospital. This is a breach of Regulation 12 (2)(a)(b) No Must do actions	**Ligature risks** •All teams were asked to review their ligature assessments immediately following the CQC inspection visit. •A Trust wide review is being undertaken in relation to environmental ligature risks. Barnsley (Beamshaw and Clark wards) •On completion of the review we will complete an environmental ligature risk assessment of Beamshaw and	All teams will have an updated ligature risk assessment which is complaint with the trusts policy and implemented by staff.	Look at the updated ligature risk assessment to see if it meets the Trust's policy. Where shortfalls/changes have been identified and/or made, check whether these are effective in maximising service users' safety. Look around the environment. Speak with staff about		**Ligature risks** 30/09/16	Estates TAG	

	Clark Wards. •On completion of the review we will complete a risk management plan to manage or mitigate any ligature points identified. Disseminate ligature point assessment and risk management plan to all ward staff.		their understanding of the changes made and changes to their practice through this. Look at incident records in relation to ligature points, self-harm attempts, near misses etc.				
Regulation breach	**Action**	**Outcomes How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key governance group**	**Progress report**
High dose medication was not routinely monitored across all wards. There were no completed monitoring forms and no information in patient records. This is a breach of Regulation 12 (2)(g) **Must do** The trust must ensure high doses of medication are monitored	Trust wide We will work in partnership with the Pharmacy team to ensure, our policy: '*Antipsychotics in clinical practice: Guidelines for safe and effective use in adults with schizophrenia and includes information on the early onset psychosis in adolescence*' is correctly practiced (includes guidance on high dose medication). This will include reinforcing good practices with staff from inpatient teams (Medics & Registered Nurses). Representatives from the BDU's and pharmacy colleagues will develop a working group. This group will be led by the Lead Pharmacist and a Clinical Lead and will oversee adherence to policy and audit the compliance, be responsible for raising staff awareness provide additional guidance to support staff in the use of the updated	The high dose medication monitoring form will be in the clinical records.	Check a sample of care records to see if they include the high dose monitoring form (for service users on high dose medications). Check the high dose monitoring records for content. Speak with staff about their understanding of high dose medication monitoring and pharmacy support in delivering this. Look at the working group minutes. Look at findings from the high dose monitoring audit to check whether policies and guidance are being followed in practice; and to see if any shortfalls have been identified and	Deputy District Directors (Calderdale, Kirklees Barnsley, and Wakefield) Chief Pharmacist	30th November 2016	Drugs and Therapeutics committee	

	policy		are being addressed.				
Regulation breach	**Action**	**Outcomes How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key governance group**	**Progress report**
Staff supervisions had not been completed across all wards for in some cases over 12 months. **Must do** The trust must ensure that staff receive appropriate supervision on all wards ***This is a breach of Regulation 18 (1)(2)(a)***	**Staff Supervision** 1. The BDU's will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported by structured approaches with supervisors the supervisee holds a contract with. 2. We will be reinforcing supervision standards in the Acute Service Line meetings. 3. Implement updated supervision policy with staff supervision passport.	Staff supervision is accessed by all trust staff in line with the clinical supervision policy. Performance is reported through the HR performance wall.	Look at the Trust's centralised supervision database to check if this captures all the relevant supervision information. Look at supervision records within individual teams. Speak with staff about their supervision. Look at a sample of staff supervision passports within individual teams.	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	31st October 2016	Nursing Quality Group	
Staffing levels and staff skill mix did not meet the trust's minimum staffing levels at times on Ashdale	**Staffing levels** 1. Ongoing work with the Trust's Safer staffing Group to promote safer staffing through	Each ward will have the required skill mix and staffing levels to meet clinical need.	Look at staff duty rotas. Speak with the manager/senior staff			Safer Staffing Group	

and Elmdale wards at The Dales Hospital and Trinity 1 and Priory 2 at Fieldhead Hospital. ***This is a breach of Regulation 18 (1)(2)(a)*** **Must do** The trust must ensure that staffing levels, skill mix and how staff are deployed is appropriate on all wards.	recruitment and retention with ongoing monitoring. 2. Review of the wards Minimum staffing levels and monthly safer staffing reports 3. Locality meetings are being held to help in the management of acuity/pressures. 4.We are using the RAG rated system to identify potential deficits so actions can be taken in a timely manner to address any issues. 5. Staffing resources including manpower are being used in a flexible manner to maintain patient safety at all times. 6. Use of agency/bank when appropriate. We are implementing the use of Peripatetic Workers in some areas beginning in August 2016 and in all areas commencing September 2016. This will increase the BDUs ability in dealing with short-term acuity as well as longer-term absences.		member about recruitment, vacancies, staff turnover and sickness levels. Look at monthly staffing reports to see how any identified shortfalls are being properly addressed? Speak with staff about the impact of Peripatetic workers. Look at incident records in relation to staffing issues. Look at section 17 leave records to see if any leave has had to be cancelled because of staffing issues. Look at the activity programme and check whether this is being fully followed. Speak to service users about such things as access to staff etc.				
Must do The trust **must** ensure that consent to treatment and where appropriate, capacity assessments are completed and recorded appropriately.	• Staff have been reminded about the consent to treatment and capacity assessment guidance and the need to record this appropriately. • It has been reinforced to staff that information in relation to the MHA Code of Practice is available on the intranet and information about this will also	Staff will apply their knowledge of MHA/ MCA in practice.	Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	30th September 2016	Mental Health Act Committee	

	be provided within weekly bulletins in August and September 2016. • The MHA Code of Practice will be an agenda item within the respective BDU meetings. • MHA and MCA training has now been made mandatory and is in place. New doctors will attend induction training that now includes a MHA session. • Compliance with the MHA Code of Practice will be monitored through our governance systems (see Trust wide actions)		Audit reports and action plans				

SHOULD DO'S	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The provider should ensure that ligature risks are mitigated on all wards where possible.	Refer to ligature assessments on page 10.						
The provider should ensure patients are able, with appropriate risk assessments, to have a bath without supervision on Beamshaw and Clarke ward.	Work is ongoing with Estates department as to the feasibility of installing assisted baths that are ligature free	Ligature free baths installed.	Speak with staff about how they support service users to shower. Speak with service. Users. Look at the changes to the shower part of the environment. Look at care records to	Deputy District Director Barnsley & Wakefield	31st December 2016	Estates TAG	

			see if risk assessments are in place where service users need supervision whilst bathing.				
The provider should ensure the complaints policy is on display on all wards.	Review of wards to ensure that all display information about how to make a complaint	Complaints procedure is displayed on the wards	Look around the environment to see where the complaints procedure is located. Speak with service users to check out if they are aware of how to complain? Check complaints records.	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	30th September 2016	Acute Care Forum	
The provider should ensure where possible that a bed is available for patients when they return from leave.	Review of the Trust Bed Management Policy	Trust Bed Management Policy will have been updated so it is fir for purpose.	Speak with staff Look at records to show if patients are being accommodated on other parts of the ward other than their bedroom.	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	30th November 2016	Acute Care Forum	
The provider should ensure that activities are available seven days a week and on Beamish and Clarke ward patients should be able to use the gym at weekends.	The availability of the 'live arts' café has been extended to cover weekends.	Activity programme available that cover 7 days per week.	Look at the activity programme and see if this is being adhered to. Speak with service users. Speak with staff. Look at care records for evidence of activities.	Deputy District Director Barnsley & Wakefield	30th September 2016	Acute Care Forum	

			Activity records (if available).				
The provider should have systems in place to ensure staff, where necessary, are aware of and working in accordance with current guidance in relation to the Mental Health Act and the Mental Capacity Act.	The Trust has made MHA & MCA Training Mandatory for all clinical staff. This will support staff to have up to date knowledge and skills in making sure the principles of the MHA Code of Practice are implemented within their daily care practices and this is recorded appropriately at all times. 2. Achievement of training for the service will monitored in BDU monthly meetings and action implemented to ensure this is consistently achieved.	MHA/MCA training is mandated by the Trust, reported through the HR performance wall and monitored by Forensic service line. Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA in practice	Evidence Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	Monitoring of training in monthly BDU meetings from 30th September 2016	Mental Health Act Committee	

Children & Adolescent Mental Health Services

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
Risk concerns had been documented within the clinical record but not been completed using the appropriate risk screening or comprehensive risk assessment tool in all cases. This was the case at each of the community bases. Following assessment and	We are taking the following actions in response to this regulation: 1.Implementation of the case recording audit action plan 2. Implementation of a robust RiO training programme for staff - incorporating guidance/support in completion of comprehensive and risk assessments. 3. Implementation of a system	Completed risk assessments in the clinical record. Risk process/ procedure is available to assist staff to manage risk whilst people are on the waiting list.	Look at care records to see if risk is being recorded in the appropriate place. Check case recording audit action plan and adherence to this within practice. Look at the risk procedure for managing people on	District Director/ Deputy District Director CAMHS	31 October 2016	Improving Clinical Information Group	

placement upon a waiting list for treatment there was no system to proactively monitor changes in these assessed levels of risk. This was the case at each of the community bases. ***This is a breach of Regulation 12(2)(b)*** **Must do** The trust must devise a proactive system for monitoring risks of young people waiting to be seen.	of case review to proactively manage risk whilst children/young people and their families are waiting.		the waiting list. Speak with staff.				

Regulation breach	**Action**	**Outcomes** **How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key governance group**	**Progress report**
Waiting times for treatment were high with an average wait in excess of five months for the Wakefield CAMHS service. The trust could not provide comparable data relating to the Barnsley CAMHS waiting lists. This was because there were problems extracting accurate information. **Must do** The trust must take action to improve the overall waiting time for young	**Waiting times** Actions with regard to waiting times include; 1.Development of shared data set - numbers waiting and average waiting time from referral to choice/initial assessment; numbers waiting and waiting times (0-3 months, 3-6 months, 6-9 months, 9-12 months and 12+ months) from referral to treatment. 2.Redesign of care pathways to improve process efficiency and service outcomes. This will include review of skill mix.	Performance report detailing waiting times for access to CAMHS services Reduction in the waiting times for access to CAMHS services (to bring inline or perform better than national goals)	Look at the data set in relation to waiting times and referral to treatment times. Speak with staff about their understanding of the data. Look at the changes to the care pathway design and impact from this. Look at the data set for waiting times for treatment.	District Director/ Deputy District Director CAMHS	31st December 2016 31st October 2016	BDU Performance Meeting Improving Clinical Information Group	

people accessing treatment. The trust was not regularly undertaking audits to determine new systems and processes were being embedded into practice. This was the case at each of the community bases.	3. Implementation of agreed F*uture in Mind* service development plans, specifically in relation to community eating disorder and earlier intervention services. **Audit** Actions with regard to audit include; 1.Establish an annually reviewed CAMHS-wide audit programme 2.Implement the agreed action plan in relation to clinical record keeping **Lone worker policy** Actions with regard to lone working arrangements include; 1.Review protocols in relation to lone working, specifically in relation to use of the lone worker devices	Clinical audit plan in place, with audit cycle being implemented and monitored.	Look at the audit programme and monitoring systems Speak with staff.				
Examples of this were the lack of improvement in clinical record standards. Also an admission by a number of staff they were not following the trust **lone worker policy**	2.Implement a robust programme of training regarding lone working arrangements 3.Undertake an audit of practice against the lone worker protocol	Staff adherence to the lone working policy.	Speak with staff about lone working policy. Look at lone working training records. Look at the findings from the clinical record keeping audit and see if the actions have been implemented within practice. Check audit records of	District Director/ Deputy Director CAMHS	31st January 2017	Improving Clinical Information Group BDU Performance Meeting	

Inconsistent understanding of the requirements of the completion and storage of FP10 prescription pads. This is a breach of Regulation 17(2)(a)(b)(c) **Must do** The trust must ensure audits are undertaken to ensure new systems and ways of working become embedded in practice and quality standards are being followed	**Storage of prescription pads** 1.Action taken with regard to storage of FP10 prescription p 2.Advise regarding the secure storage of FP10 prescription pads issued by CAMHS Clinical Lead.	Staff adherence to medicines code storage of FP10.	lone working. Look at where FP10 prescription pads are being stored. Speak with medics about their practices re: FP10 pads.	District Director/ Deputy Director CAMHS	Completed	Drugs and Therapeutics Committee	

SHOULD DO'S	**Action**	**Outcomes How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key governance group**	**Progress report**
The trust should continue to implement their own identified recovery plans in relation to waiting list management.	Significant improvements in waiting times for initial assessment achieved/ maintained. Waiting time data available by 29/7/16 and on monthly basis. Pathway redesign work completed across all services (by 31/10/16)	Performance report detailing waiting times for access to CAMHS services Reduction in the waiting times for access to CAMHS services (to bring inline or perform better than national goals)	Look at the data set in relation to waiting times and referral to treatment times. Speak with staff about their understanding of the data. Look at the changes to the care pathway design and impact from this. Look at the data set for	District Director/ Deputy District Director CAMHS	31st October 2016	BDU Performance Group	

			waiting times for treatment.				
The trust should review and continue to improve access to contemporaneous clinical records.	Implementation of robust RiO training programme.	Staff will be able to access contemporaneous clinical records at all times.	Look at clinical records Speak with staff Record keeping audits	District Director/ Deputy District Director CAMHS	31st October 2016	Improving Clinical Information Group	
The trust should closely monitor the action plan to reduce information governance breaches and undertake regular audit to seek assurances that safeguards are being maintained.	Action plan in place and audit planned.	There will be clear evidence to show a satisfactory reduction in the number of information governance breaches.	Datix records Speak with staff Look at complaints records	District Director/ Deputy District Director CAMHS	30th November 2016	BDU Performance Group	
The trust should ensure staff are up to date with basic life support training.	The ILS training has only recently mandated. Staff are now attending regular training. A 80% target to be achieved by 30/9/16.	At least 80% of the workforce will have had ILS training by 30/9/16.	Staff training records Speak with staff Performance dashboard	District Director/ Deputy District Director CAMHS	30th September 2016	BDU Performance Meeting	
The trust should ensure environmental risk assessments have been completed for each of the community bases.	All risk assessments will have been completed by 30/9/16 to identify any risks so appropriate actions can be taken.	Any actions identified from risk assessments will have been put in place to ensure the safety of each of the community bases.	Look at risk environmental risk assessments. Incident records Speak with staff	District Director/ Deputy District Director CAMHS	30th September 2016	Estates TAG	
The trust should ensure team managers undertake an audit of compliance with the lone worker policy and review the policy in line with appropriate staff feedback.	Review lone working protocols specifically in relation to use of the lone worker devices and implement robust training programme (30/9/16)	All staff will be adhering to the lone working policy which will be regularly reviewed in line with appropriate staff feedback.	Lone worker compliance audit records Speak with staff Incident records	District Director/ Deputy District Director CAMHS	31st January 2017	BDU Performance Group	

	Undertake an audit of practice against the lone worker protocol (by 31/1/17)						
The trust should ensure regular audits of clinical records are undertaken to monitor compliance with trust policy.	Implementation of robust RiO training programme by 31/10/16 Action plan in place and audit to be completed by 30/11/16	Regular clinical records audits will be taking place to monitor compliance with the Trust policy.	Clinical record keeping audits Training records Look at sample of clinical records	District Director/ Deputy District Director CAMHS	30th November 2016	BDU Performance meeting	
The trust should ensure regular audits of FP10 prescription use are carried out to ensure safe and appropriate issuing and storage.	Audits will be undertaken on a regular basis, the initial being done by 30/11/16.	FP10 prescription pads are being used to ensure safe and appropriate issuing and storage.	FP10 audit Speak with medics Observe practice	District Director/ Deputy District Director CAMHS	30th November 2016	BDU Performance meeting	
The trust should consider moving the weighing scales in the team bases into more private areas.	All scales are in private clinical areas	People will all be weighed in private areas only.	Observation of environments	District Director/ Deputy District Director CAMHS	Completed		

Community mental health services for adults

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The provider did not ensure there was equitable access to psychological therapies across localities or that this was provided in a timely manner. Waiting times to access psychological therapies was high. Within the Barnsley business delivery unit the average wait was 54 weeks. Psychological provision to the South Kirklees assertive outreach team was also insufficient. This had the potential to impact upon individual's recovery. This is a breach of Regulation 9 (3) (b) Must do's The provider must ensure equitable and timely access to psychological therapies	**Trust wide** There is a Trust wide approach to managing risks from the psychological therapies waiting list. This supports early identification of potential risk and provides an opportunity to advise people regarding potential waits for treatment and self-management strategies. Contact details are also provided should further advice be needed or presenting needs change. **Kirklees Community Services-Adults of Working Age** • Following our transformation process, the psychological therapy resource will be allocated to both the Enhanced and Core Pathways which will work with people with a psychotic and non-psychotic diagnosis according to complexity of need. • The APTS staff will work as integrated team members and be available for not only direct clinical work with both client groups, but indirect clinical consultation work to ensure care packages are psychologically informed. This	People accessing psychological therapies will not wait longer than 18 weeks (referral to treatment)	Look at the data set for PT waiting times across the Trust Look at the new care pathways and discuss the impact of these with Trios and staff. Speak with staff about integrated working and impact from this. Discuss and look at the risk assessment process for managing risk on the waiting list and its effectiveness. Review any incidents relating to service users on the waiting list. Commissioner arrangements with Calderdale to address shortfalls and their effectiveness. Look at staff vacancies and recruitment into posts.	Deputy Directors-Wakefield, Kirklees and Barnsley BDU's	Kirklees-Team by team implementation until March 2017 Barnsley-The additional capacity actions will be met by November 2016. The efficiency savings by September 2016. Unable to provide a timescale for the work around backlog until this has been discussed with CCG. Wakefield-Completed	BDU Performance Meeting	

	will enhance the ability of other practitioners to deliver low level psychological interventions and also improve patients adherence to intervention once psychological intervention commences. • The Assertive Outreach teams will no longer exist as discrete teams but will be incorporated into the Enhanced Pathway where the Flexible Assertive Community Treatment function will provide intensified input where clinical need dictates. This will include psychological therapy and Psychological Therapy consultation where appropriate. • The trio will work closely with the psychology leads to develop a pathway that will adhere to the 18 week pathway where resources are available. Calderdale psychological services are not fully funded to deliver services. In this instance there are discussions with the commissioners for appropriate funding to deliver services. **Barnsley Community Services- Adults of Working Age** Within Barnsley additional capacity is being provided through the following actions:						

	• An additional 3.5 therapy posts will be recruited bringing the total up to 14. Posts are currently out to advert and new staff are expected in post by November 2016. Efficiencies are being introduced: • Increased use of group interventions: A Behaviour Therapy skills group and a Mindfulness Based Cognitive Therapy group have been introduced. • Aligned pathways with IAPT to ensure those whose needs can be managed outside specialist services receive the appropriate care (from September 2016) • Managed Clinics (Lean principles) to replace clinician/admin led process (from September 2016) • An innovative 3-stage recovery pathway (stabilisation/treatment/recovery) aims to provide meaningful support to people waiting for therapy, including interventions to support stabilisation and to help people prepare for therapy Managing the backlog:						

	We are confident that our plans can deliver productivity at a level that meets demand but we have a significant backlog to address. A proposed solution based on a non-recurrent resource is under discussion with the CCG. **Wakefield Community Services- Adults of Working Age** Wakefield has 100% of individuals assessed within 14 days and 100% receiving treatment within 18 weeks.						

SHOULD DO'S	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The provider should ensure the RIO electronic care records system is robust and reduce susceptibility to down time	An outstanding issue close down plan has been developed and is being worked through in conjunction with the system supplier. A number of technical changes have been implemented from early July 2016 and this has had a positive impact in terms of reducing down the occurrences of system performance related issues.	Monitoring of calls to the service desk and volumes of occurrence. Identification of RCA and resolution by system supplier Confirmation and feedback from RiO system end user community – survey planned for end September 2016 to aid	Speak with Rio team. Speak with clinical leads about impact of changes made. Look at incidents in relation to Rio issues. Speak with staff. Look at the results from the Rio user survey (completed in Sept	AP/PF	30/09/2016	Clinical Reference Group	The Trust Systems Development Board are actively monitoring progress and receive regular updates relating to issue resolution following the RiO V7 upgrade.

	There are currently only 5 outstanding issues remaining which it is planned to address by 31/08/2016. 2 issues relate to remaining performance issues being encountered for which additional technical investigations are ongoing regarding root cause analysis (RCA) of remaining occurrences of the issues, albeit greatly reduced in number. The remaining 3 issues are awaiting development finalisation from the system supplier and are set to be available to the Trust during w/c 22/8/2016 to commence testing, followed by their application to the live RiO system (this is being scheduled at a time that has least impact to clinical services as the RiO system will be unavailable for approximately 3 hours (dates TBC) Discussions are ongoing at Director Level between the Trust and the system supplier	capture of this information	2106).				

	Weekly calls between clinical service leads and IM&T continuing on a weekly basis and weekly update communications issued subsequently.						
The provider should ensure that they continue to work with commissioning bodies to reduce waiting times to the ADHD and autism service	The service continues to work with commissioners to reduce the waiting lists. Local plans are in place for 2016/167 with commissioners that fund work to address the backlog and waiting lists and create sustainable models to manage demand.	People accessing ADHD/Autism service will not wait longer than 18 weeks (referral to treatment)	Look at the data set in relation to waiting times to the ADHD and Autism service. Speak with staff about their understanding of the data and impact from commissioner funding.	District Director for Specialist Services	Ongoing	BDU Performance Meeting	
The provider should ensure that staff are provided with appropriate training to manage clients with comorbidities such as learning disabilities.	**Learning Disability Awareness** training is a Core training requirement. This training is currently being updated with a view to beginning roll out in Sept 2016. In one locality there is a MH/LD Interface group that ensures that issues of access to services, training and reasonable adjustments are addressed Representatives from LD, MH and CAHMS attend this monthly meeting. Assessment against the Greenlight Toolkit. Is a Trust priority for 2016-17 , actions from this will be monitored via the Trust wide clinical governance group	Staff will have appropriate knowledge and skill to manage comorbidities.	Look at staff training records. Look at assessment results from the Greenlight Toolkit and check whether any actions from this have been acted on. Speak with staff.	Deputy District Director's (Calderdale& Kirklees and Barnsley & Wakefield) .	Training to be updated by 30th September 2016 All teams to receive training by September 2017	Clinical Governance Group	
The provider should ensure staff in the	Refer to pages 3, 4 & 5 of this document – MHA/MCA	MHA/MCA training is mandated by the Trust,	HR performance wall			Mental Health Act	

Barnsley AOT, Wakefield SPA, Kirklees AOT and ADHD and autism service receive training on the Mental Health Act and Mental Capacity Act.	regulatory breaches.	reported through the HR performance wall and monitored by the Mental Health Act Committee Training plans will be available and monitored by Mental Health Act Committee Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA in practice. New MHA/MCA sub-group established	Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)			Committee	
The provider should ensure that there is effective communication and consultation with staff around the transformation programme	The acute and community MH transformation project has recently completed formal consultation with over 500 staff affected by the planned changes. • Staff from all professional groups have been engaged throughout the consultation period which took place over nearly 2 months, with over 60 comments received and responded to individually. • In addition to individual responses, the project team will share with all teams, a summary of the points which have been clarified through the	Staff will be informed of the changes in relation to transformation through a variety of communication methods – on a regular basis	Look at communication messages to all staff. Look at the transformation project team records. Speak with staff.	Initial actions completed .		EMT	

	consultation process. This will accompany the communication of next steps into implementation. • For some staff, their job banding will change as a result of this process. Individual communications are underway to support colleagues through the transition in line with our Trust policies. • Recruitment processes will be undertaken in a coordinated way to avoid destabilising teams in other parts of our system. • Equally, Staff Side has highlighted the preference of many of their members to proceed swiftly to recruit to posts which have been held pending the agreement of the new workforce model • In the implementation phase the project team will work with all multi-disciplinary teams to support the behavior change that will be necessary for effective implementation and planned reduction in overall caseload. This will involve: o Supporting staff to develop new ways of working (i.e. transition of people back to primary care or co care with primary care, when it is appropriate) o Working with Consultants to develop caseloads of about 100, with caseload support						

	from other disciplines o Developing an implementation and transition plan with all the multi-disciplinary teams to get to a manageable caseload. The phasing of activity within the implementation stage is as follows: July to September - Complete communications with individual colleagues regarding the personal impact of the new model on their role - Agree redeployment moves between teams.						

Forensic services

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
We found that there was not enough nursing staff to ensure that important nursing tasks were completed. • Meaningful activity targets were not being met. • There was a high level of bank and agency staff used who were unfamiliar with the wards. • Data provided by the trust showed that the wards were regularly	Meaningful Activity: The current process of reporting will be reviewed: A task and finish activity will raise awareness across the service about the importance of meaningful, recovery based activity and how to record this effectively. 100% activity levels will be achieved. To be linked to the Forensic Induction Programme. Safer Staffing: 1. Ongoing work with the	Each ward will have the required skill mix and staffing levels to meet clinical need and provide meaningful activity	Look at staff duty rotas. Speak with the manager/senior staff member about recruitment, vacancies, staff turnover and sickness levels. Look at monthly staffing reports to see how any identified shortfalls are being properly addressed? Speak with staff about the	Deputy Director of Forensic Services	31st March 2017	Safer Staffing Group	

breaching their own targets on minimum staffing levels. • Patients we spoke to told us there was not enough staff and too many agency workers. • There was no long term plan to resolve the staffing problems. This meant that patient activities and leave entitlement were often cancelled due to the lack of staff. ***This was a breach of regulation 18 (1)*** **Must do's** The trust must ensure that staffing levels are appropriate to meet the needs of the patients.	Trust's Safer staffing Group to promote safer staffing through recruitment and retention with ongoing monitoring. 2.Review of the wards Minimum staffing levels and monthly safer staffing reports 3. Locality meetings are being held to help in the management of acuity/pressures. 4. We are using the RAG rated system to identify potential deficits so actions can be taken in a timely manner to address any issues. 5. Staffing resources including manpower are being used in a flexible manner to maintain patient safety at all times. 6. Use of agency/bank when appropriate. 7. There is a Trust Group for Safer Staffing which the Forensic Services attend. 8. There is regular monitoring of safer staffing levels. 9. There are Workforce Meetings for the Forensic Services which are held fortnightly. 10. A Business Case is being developed to address deficits in the Women's Service and improve the establishment to meet need. 11.Sickness / absence management is robust. 12. There is an ongoing programme of over recruitment to offset ongoing fluctuations in		impact of Peripatetic workers. Look at incident records in relation to staffing issues. Look at section 17 leave records to see if any leave has had to be cancelled because of staffing issues. Look at the activity programme and check whether this is being fully followed. Speak to service users about such things as access to staff etc.				

	establishment. 13.The Forensic Service is currently managing through a process of workforce re-design with emergent band 2 opportunities and band 4 developments. 14.Bank shifts are being paid at an enhanced level between the months of June and September to attract regular staff and reduce agency use. A reduction in agency use will ensure that access to patient records is available for the • majority of staff in order to provide safe patient care. Electronic Clinical Record (RiO) training is being implemented for regular agency staff, to ensure they can more effectively meet patient need, than relying on supported access through regular staff.. 15. A therapy services review is underway and this will help to maximise use of resources. 16. A management and administration review is also underway to support the process. Improving communication and engagement with staff to ensure they are updated effectively of plans and how issues are being addressed.						

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
We found that medicines were not being stored in a safe way. • The temperature recorded in the clinic room regularly exceeded the maximum level. • There was no climate regulation in the clinic room. This meant that medicines were not being stored at the correct temperature to maintain their stability and effectiveness. This was a breach of regulation 12 (2) (g) **Must do** The trust must ensure that the clinic room temperature is safe for the storage of medicines.	This issue was specific in one of the 12 clinic rooms in relation to temperature recordings. This particular clinic is on a 6 bedded pre-discharge area and only contains the medicines for one service user as all others are self-medicating. All clinics are recording temperatures which are safe for the storage of medicines. (Risk Management of Medicines stored in Clinical Areas. Temperature Control Edition 1 2015. NHS Pharmaceutical Quality Assurance Committee 2015). It is recognised higher temperatures for one week consistently may reduce the expiry date by a two weeks. However all medicines are cycled quickly and tend to be used well in advance of the expiry date, therefore this is not a risk. We are continuing to maintain and look at ways of improving our existing standards around storage of medications. We are looking at the following additional options in order to achieve this: 1. The use of a smaller fridge = reduced heat radiation. 2. Air conditioning installation. Improved ventilation. 3. Alternative storage	Medicines will be stored at the correct temperature.	Look at the clinic room. Look at medication storage arrangements. Look at medication temperature check records. Speak with staff. Incident records relating to medication issues re: temperatures. Has a fridge and cooling system being implemented and have these achieved the desired effect? Look at alternative storage arrangements if these are being used.		New fridge to be purchased- 30 September 2016.	Drugs and Therapeutics Committee	

	arrangements for the medication. A review will be undertaken to assess the impact of adjustments to the current equipment and environment in August 2016. If lower temperatures cannot be achieved, the plan will be to progress towards identifying this as a priority in the minor capital programme process.						
We found that patients with learning disability or autism did not have positive behaviour support (PBS) plans or equivalent. • Care records showed that very few patients had PBS plans or equivalent. • The trust had not implemented PBS plans or equivalent until recently. • Staff showed a lack of knowledge and understanding of PBS plans or equivalent. This meant that patients with learning disability and autism were not receiving the correct care and treatment as recommended by the Mental Health Act Code of Practice. ***This was a breach of regulation 9***	1. A template has been developed which all staff will use for development and completion of PBS plans. 2. A briefing paper is being developed for staff , outlining what Positive Behaviour Support Plans are and their benefits to service users. 3. All plans will be clearly labelled as PBS plans. The planned roll out of PBS plans will continue	All people admitted to Forensic services with a learning disability will have a PBS plan that has been completed in line with Trust policy.	Look at care records. Speak with staff. Look at the new template and check this is being used appropriately.	Deputy Director of Forensic Services	31 October 2016	BDU Governance Group	

Must do The trust must ensure that positive behaviour support plans or equivalent are implemented for all patients with learning disability or autism							

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
We found that there were no effective systems in place for the trust to maintain oversight in relation to staff training and staff supervision. • The trust did not collate figures on Mental Health Act, Mental Capacity Act and immediate life support training at a governance level. • The trust did not record data regarding staff supervision rates at a governance level. This meant that the trust was not assured that staff were adequately trained or supervised. This was a breach of regulation 17 (2) (a)	1. The Trust has made MHA, MCA and Life Support Training Mandatory for all staff. This will support staff to have up to date knowledge and skills in making sure the principles of the MHA Code of Practice are implemented within their daily care practices and this is recorded appropriately at all times. 2. Achievement of training for the service will monitored in Forensic BDU monthly meetings and action implemented to ensure this is consistently achieved. 3. The BDU will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a	MHA/MCA & ILS training is mandated by the Trust, reported through the HR performance wall and monitored by Forensic service line. Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA & ILS in practice	HR performance wall Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available) Look at the Trust's centralised supervision database to check if this captures all the relevant supervision information. Look at supervision	Deputy Director of Forensic Services	MCA/MHS ?ILS training - completed Monitoring of training in BDU monthly meetings 30th September 2016 Clinical supervision central recording – 30th October 2016	Mental Health Act Committee Resus TAG (ILS) Nursing Quality Group (supervision)	

Must do The trust must ensure that there are effective systems in place to record levels of staff training and supervision. The trust must continue with plans to improve the consistency of Mental Health Act, Mental Capacity Act and immediate life support training.	system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. 4. The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported by structured approaches with supervisors the supervisee holds a contract with.		records within individual teams. Speak with staff about their supervision. Look at a sample of staff supervision passports within individual teams.				

SHOULD DO'S	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The trust should ensure that the care and treatment of individuals in long-term segregation complies with Mental Health Act (MHA) code of practice.	The BDU will raise awareness of requirements in relation to Long Term Segregation and will ensure that all Long Term Segregation is compliant with the guidance set out in the Code Of Practice. A Communication will be developed and circulated.	Staff will apply their knowledge of LTS practice	Look at information and guidance provided to staff about this. Observe practices Speak with staff Information from CQC MHA visits (where available)	Deputy Director of Forensic Services	Initial actions for person in LTS complete. Raising awareness in staff teams August 2016	Mental Health Act Committee	
The trust should ensure that the food provision is of good quality.	The BDU will continue to manage all issues related to the quality of food and subsequent improvement through existing business processes.	Food meets people's requirements. The number of complaints/ concerns raised about food will	Complaints records re: food quality. Speak with service users.	Deputy Director of Forensic Services	Completed	BDU Governance Group	

		decline.	Observe meal time				
The trust should ensure that staff inform patients of their rights and record this in patient notes at regular intervals as set out in the MHA code of practice.	All wards have processes for checking that patient's rights are recorded at regular intervals as set out in the Code of Practice. This area will continue to be monitored for compliance via participation in the Trust Audit process.	Staff will apply their knowledge of patient rights into practice	Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available) Audit reports and action plans	Deputy Director of Forensic Services	Completed	Mental Health Act Committee	
The trust should ensure that consent and capacity to consent should be assessed and recorded in patient notes in accordance with the MHA code of practice.	All medical staff are aware of their responsibilities in the assessment and recording of consent and capacity in the clinical record in accordance with the MHA Code of Practice. Medical Clinical Leads will continue to promote best practice with their colleagues. Compliance will be monitored through participation in the Trust Audit Plan for this practice area.	Staff will apply their knowledge of consent and capacity to consents into practice	Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available) Audit reports and action plans	Deputy Director of Forensic Services	Completed	Mental Health Act Committee	
The trust should ensure that access to patient records is available for all relevant staff in order for staff to provide safe patient care.	The BDU have applied for access to the RIO system for a number of agency workers who have been working with the unit consistently. The overarching plan for reducing the number of agency staff is being monitored through the workforce plan.	Agency staff have access to care records.	Observe practices Speak with agency and permanent staff. Care records Staff rotas to show usage of agency staff.	Deputy Director of Forensic Services	September 2016	Clinical Reference Group	

Intensive home based services and health based places of safety

SHOULD DO's	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The provider should ensure risk assessments are reviewed in a timely manner.	Reinforce policy and procedure with clinical staff Monitor that risk assessments are completed in a timely way and that care plans are updated to reflect current management of risks.	People will have risk assessments that have been completed in line with the Trusts policy.	Care records Speak with staff CQC mental health act visits (if available).	Deputy Directors- Wakefield, Kirklees and Barnsley BDU's	30th September 2016	Acute Care Forum	
The provider should have processes in place which enables all teams monitor training around the Mental Health Act and Mental Capacity Act.	The Trust has made MHA & MCA Training Mandatory for all clinical staff. This will support staff to have up to date knowledge and skills in making sure the principles of the MHA Code of Practice are implemented within their daily care practices and this is recorded appropriately at all times. 2. Achievement of training for the service will monitored in BDU monthly meetings and action implemented to ensure this is consistently achieved.	MHA/MCA training is mandated by the Trust, reported through the HR performance wall and monitored by Forensic service line. Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA in practice	Evidence Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)	Deputy District Directors (Calderdale, Kirklees, Barnsley & Wakefield)	Monitoring of training in monthly BDU meetings from 30th September 2016	Mental Health Act Committee	
The provider should ensure that appraisals are completed equally across the teams.	System for monitoring appraisals is in place across the Trust Continued monitoring of performance on workforce dashboard by all BDU's	Appraisal targets are achieved across all teams.	Look at appraisal figures across the teams. Speak with staff	Deputy Directors- Wakefield, Kirklees and Barnsley BDU's	30th September 2016	Acute Care Forum	

The provider should provide easy read leaflets about its services in ways that meets the needs of different people, i.e. a different language.	**Trust IHBTT services** to look at options for having the leaflet translated into different languages (to discuss with Comms). IHBT team managers to discuss the feasibility of having just one team leaflet for the trust to enable a more consistent and cost effective method of obtaining leaflets	Trust wide IHBTT leaflet available.	Look at the leaflets provided	Deputy Directors- Wakefield, Kirklees and Barnsley BDU's	30th September 2016	Equality and Inclusion Forum	

Inpatient services for people with a learning disability or autism

SHOULD DO's	Actions	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The provider should ensure its planned improvement to provide more accessible patient information is fully actioned.	There is a development group set up on the unit working on this to look at making the environment and care plans much more accessible. In addition Development Group members have undertaken training on accessible information and communication. There is also an accessible information group led from corporate services which staff are involved in and feedback is provided to the LD Governance Meeting	Accessible information will be available	Speak with the Development Group members about actions taken to make the environment and care plans more accessible. Look at the information produced. Speak with staff Speak with service users	District Director for Specialist services	31st October 2016	Equality and Inclusion Forum	
The provider should ensure data collected regarding the use of restraint and seclusion is accurate.	The system for collecting restraint data has been reviewed. Clarity has been provided to the clinical teams.	Effective system in place to accurately collect data. Staff record data accurately	Review of care records against information supplied to performance and information.	District Director for Specialist services	1st September 2016 & ongoing	Management of violence and aggression TAG	
The provider should improve its process for recording non mandatory training such as Mental Health Act and Mental Capacity Act.	1. In March 2016 Mental Health Act/Mental Capacity Act training was approved by the EMT as mandatory for all staff. 2. In April 2016 a meeting was held with Learning and Development to agree reporting arrangements through the HR performance wall. 3. The proposed MCA training plan (including Deprivation of Liberty Safeguards) was discussed with the Local	MHA/MCA training is mandated by the Trust, reported through the HR performance wall and monitored by the Mental Health Act Committee Training plans will be available and monitored by Mental Health Act Committee Staff attend training in accordance with identified	HR performance wall Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)			Mental Health Act Committee	

	Authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting has been planned for October 2016.	need. Staff will apply their knowledge of MHA/ MCA in practice.	 New MHA/MCA sub-committee established.				
The provider should consider the benefits of providing mandatory Mental Health Act and Mental Capacity Act training to staff.	1. In March 2016 Mental Health Act/Mental Capacity Act training was approved by the EMT as mandatory for all staff. 2. In April 2016 a meeting was held with Learning and Development to agree reporting arrangements through the HR performance wall. 3. The proposed MCA training plan (including Deprivation of Liberty Safeguards) was discussed with the Local Authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting has been planned for October 2016. 4. We have undertaken a review of the e-learning programme for level 1 MCA training. During June 2016 we received confirmation from SCIE Head of Digital to confirm that we can adapt the SCIE's e-learning programme. The adapted module was approved by SCIE in July 2016. 5. We are developing training plans for MCA using core	MHA/MCA training is mandated by the Trust, reported through the HR performance wall and monitored by the Mental Health Act Committee Training plans will be available and monitored by Mental Health Act Committee Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA in practice.	HR performance wall Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available) New MHA/MCA sub-committee established.			Mental Health Act Committee	

	training guidance that was issued by NHS England. Training flyers are available and training information will be advertised in weekly bulletins during August and September 2016. 6. E-learning packages are to be developed for the Mental Health Act. This training will interface with the MCA training. Training plans and dates have been put in place. 7. There is an internal Trust Training plan for MHA/MCA for all registered staff and clinical support staff working within mental health services. Training dates are available and are advertised on the trust intranet. 8. Reporting compliance with the MHA/MCA training will be sent to the Trust Board and senior managers. Reporting compliance via performance wall will be sent to individual staff and managers on a monthly basis. These reporting structures will feed into the MHA Committee. 9. A new MHA/MCA sub-group has been agreed and will report into the MHA Committee. 10. The MHA/MCA training plan will be reviewed in October 2016. 11. We will be looking at the continued implementation of the training plan including refresher dates in October 2016.						

	12. There are plans to establish practical scenario based refresher training for all registered and support staff (clinical) by October 2016. 13. Plans have been developed to include mental capacity in the medics induction programme. This will include training on assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and DOLS.						
The provider should ensure that missed medication doses are reported on the incident reporting system.	Discussion with Pharmacy required to ensure that weekly visits by pharmacy cover checking the prescription cards for any missed doses and completion of Datix if any found	DATIX incidents for missing doses will decline.	Check weekly pharmacy check records Review incidents for any medication errors Check medication records	District Director for Specialist services	31st August 2016	Drugs and Therapeutics Committee	
The provider should ensure accurate recording of checking of emergency equipment.	Daily and weekly checklists are now in place for recording of this information. Patient safety champion audits the recording sheets to ensure they are completed	System to be in place for checking emergency equipment. System adhered to by staff	Look at emergency equipment checking records Speak with staff about the process for checking emergency equipment.	District Director for Specialist services	Completed	Health and Safety and Emergency Preparedness TAG	

Community services for people with learning disability or autism

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
We found that waiting times to access psychological therapies was high. This had the potential to impact upon individual's wellbeing. This is a breach of Regulation 9 (3) (b) Must do The provider must ensure timely access to psychological therapies.	Access to Psychological therapies action we will take are:- Reducing waiting times for Autism Assessments – Trust wide 1.Review existing clinical pathways for diagnosis of Autism Spectrum Conditions (ASC) across the Trust and align to most recent professional and clinical practice guidance for efficient diagnostic procedures. (Apply a tiered approach: Screening, Interview, Observation, MDT discussion). 2. Conduct skills analysis of the learning disability MDTs with a view to broadening responsibility for autism diagnosis to the whole clinical MDT rather than solely with clinical psychology services. 3. Establish a robust, multi-disciplinary, ASC diagnostic assessment clinic drawing on clinical resources from across the whole Trust (rather than solely within localities). Reducing waiting times for Psychological Therapies in Wakefield community team 4. More robust application of	People accessing psychological therapies will not wait longer than 18 weeks (referral to treatment)	Look at the data set for PT waiting times across the Trust Look at the new care pathways and discuss the impact of these with Trios and staff. Speak with staff about integrated working and impact from this. Discuss and look at the risk assessment process for managing risk on the waiting list and its effectiveness. Review any incidents relating to service users on the waiting list. Commissioner arrangements with Calderdale to address shortfalls and their effectiveness. Look at staff vacancies and recruitment into posts.	District Director of Specialist Services	31 December 2016	BDU Performance Meeting	

	the eligibility criteria for accessing specialist psychological services for adults with learning disabilities is being adhered to. 5.The existing waiting list is being reviewed and triaged by the Wakefield Psychology Team to ensure appropriateness of cases currently waiting for services. 6.The caseloads of Postgraduate Psychologists in Clinical Training working in the Wakefield psychology service will be increased in line with other departments in the Trust. This work will continue to be overseen by a qualified clinical psychologist with appropriate supervision training and skills. 7. Recruitment of a new full-time Assistant Psychologist to the Wakefield community team is underway. This will assist greatly in increasing the number of available assessment sessions provided by the service and in turn release some capacity in qualified clinician time to offer increased sessions of psychological therapy.						
We found that the use of key performance indicators was inconsistent across the service. Teams co-located in local authority teams were not required to provide KPI information	All Learning Disability staff in integrated teams will come back under the line management of SWYPFT and record on RiO by end of December 2016 to enable more effective information to be provided against KPI's	Key performance data will be collected by all LD community teams and monitored through BDU systems	Look at the KPI's within integrated teams. Speak to staff.	District Director for specialist services	31st December 2016	BDU Performance Meetings	

beyond the use of CQUIN outcomes to enable the trust to monitor and improve the quality and safety of the services. This is a breach of Regulation 17 (2) (a) The provider must ensure systems and processes are in place to monitor the quality and safety of services integrated with local authority services.							

SHOULD DO's	Actions	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The provider should ensure their risk assessment tool is used consistently across the service.	All staff in learning disability services will be moving onto RIO to input clinical information which means there will be a consistent approach across the service once the transfer has been made	All people in contact with CTLD will have a risk assessment that has been completed in line with the Trusts policy.	Look at care records to see if risk is being recorded in the appropriate place. Check case recording audit action plan and adherence to this within practice. Speak with staff.	District Director for specialist services	30th November 2016	BDU Governance Group	
The provider should ensure staff consistently record details of decisions within capacity assessments.	A quarterly random audit will be undertaken on clinical records to provide assurance on capacity and consent	Staff will apply their knowledge of MHA/ MCA in practice	Observation of practice/ speak to staff Speak with service users Review of care records	District Director for specialist services	30th November 2016	Mental Health Act Committee	

			Information from CQC MHA visits (where available) Audit reports and action plans				
The provider should ensure there is a process for all staff to access information held in client's electronic records.	All staff in learning disability services will be moving onto RIO to input clinical information which means there will be a consistent approach across the service once the transfer has been made	All staff will record their clinical records on RIO.	Observe practices Speak with agency and permanent staff. Care records Staff rotas to show usage of agency staff.	District Director for specialist services	30th November 2016	Improving Clinical Information Group	

Long stay rehabilitation services

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
We found that at Enfield Down the clinical team did not undertake regular reviews of patient risk assessments following incidents or when there was a change in presentation. They did not undertake physical health monitoring including electrocardiograms for patients prescribed high dose antipsychotic medication. This is a breach of Regulation 12(2)(a)(g) **Must do** The trust must ensure that risk assessments are completed on admission and updated at regular intervals in addition to being updated following incidents and changes in presentation. The trust must ensure that patients who are prescribed high dose antipsychotic medication are subject to physical	**Risk assessment** 1. Individual risk assessments will be undertaken as part of the care planning approach, regular care reviews, and MDT meetings and discussed with staff within their individual supervision sessions. 2. Risk assessments will be developed in a person centred way to meet the patient's individual needs as required. 3. Risk assessments will be updated as individual's circumstance change.	All people admitted to Enfield Down will have risk assessments that have been completed in line with the Trust's policy. All people admitted to Enfield Down will have physical health checks that have been completed in line with the Trusts policy.	Care records Speak with staff Speak with service users MDT review records Risk assessment available in care record. Case track a person who is due to be discharged. Speak with staff to check understanding of Trust policy and how they implement in practice. Look at weekly medicine management review records.	Deputy District Director - Calderdale & Kirklees	Completed	Health and Safety TAG Nursing Quality Group	

health monitoring including electrocardiograms in line with national guidance.	**Physical health monitoring** Senior staff nurses will undertake a weekly medicine management review so that physical monitoring takes place and appropriate actions can be taken as needed to address any concerns within a timely manner. A member of staff is to receive specialised training in relation to electrocardiograms		Speak with staff member with responsibility for electrocardiograms CQC mental health act visits.				

Regulation breach	**Action**	**Outcomes** **How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key governance group**	**Progress report**
We found that at Enfield Down did not undertake regular MDT reviews to ensure timely and appropriate treatment plans. This is a breach of regulation 9 (1)(a)(b) Must do The trust must ensure that patients have regular multidisciplinary review meetings to ensure timely and appropriate review of care and treatment.	The Community Service Manager has nominated an identified Care co-coordinator for all in-patients at Enfield Down. This person will attend all MDT meetings and be responsible for co-ordinating all patients' CPA reviews Confirmed the availability of medical staff to attend the MDT meetings or make alternative arrangements if there are difficulties with this to ensure there is medical input into the meetings	MDT reviews occur weekly at Enfield Down. These must include a member of medical staff.	MDT review records. Care records. Speak with staff. Speak with service users.	Deputy District Director - Calderdale & Kirklees	Completed	BDU Governance Groups	
We found that the long stay / rehabilitation service did not have sufficient governance structures in place ensure effective monitoring of	Leadership of clinical services have been reviewed within the band 6 and band 7 roles and responsibilities. Bands 6 and 7 have taken on individual responsibilities for	A robust system for governance is in place within Enfield Down that the Director of Nursing and Trust Board are assured by.	Look at governance structures for the service. Speak with manager. Speak with staff.	Deputy District Director - Calderdale & Kirklees	Completed	Clinical Governance Group	

the service. The service currently lacked governance lead post and had failed to identify failings in the service. This is a breach of regulation 17(1)(2)(b) **Must do** The trust must ensure that appropriate leadership is in place to ensure that governance structures in place to monitor and improve the service.	the 7 pillars of governance and the day to day responsibility for a defined group of service users. We have appointed a full-time Practice Governance Coach who has now commenced in post	A practice Governance Coach is in post..	Look at what quality assurance systems are in place to monitor quality and safety.				
We found that the long stay / rehabilitation service did not ensure staff were adequately trained in the MHA and MCA This is a breach of regulation18 (2)(a) Must do The trust must ensure all staff receive training in the MHA and MCA.	1. In March 2016 Mental Health Act/Mental Capacity Act training was approved by the EMT as mandatory for all staff. 2. In April 2016 a meeting was held with Learning and Development to agree reporting arrangements through the HR performance wall. 3. The proposed MCA training plan (including Deprivation of Liberty Safeguards) was discussed with the Local Authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting has been planned for October 2016. 4. We have undertaken a review of the e-learning	MHA/MCA training is mandated by the Trust, reported through the HR performance wall and monitored by the Mental Health Act Committee Training plans will be available and monitored by Mental Health Act Committee Staff attend training in accordance with identified need. Staff will apply their knowledge of MHA/ MCA in practice. New MHA/MCA sub-	HR performance wall Training records Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available)			Mental Health Act Committee	

	programme for level 1 MCA training. During June 2016 we received confirmation from SCIE Head of Digital to confirm that we can adapt the SCIE's e-learning programme. The adapted module was approved by SCIE in July 2016. 5. We are developing training plans for MCA using core training guidance that was issued by NHS England. Training flyers are available and training information will be advertised in weekly bulletins during August and September 2016. 6. E-learning packages are to be developed for the Mental Health Act. This training will interface with the MCA training. Training plans and dates have been put in place. 7. There is an internal Trust Training plan for MHA/MCA for all registered staff and clinical support staff working within mental health services. Training dates are available and are advertised on the trust intranet. 8. Reporting compliance with the MHA/MCA training will be sent to the Trust Board and senior managers. Reporting compliance via performance wall will be sent to individual staff and managers on a monthly basis. These reporting structures will feed into the MHA Committee.	group established					

	9. A new MHA/MCA sub-group has been agreed and will report into the MHA Committee. 10. The MHA/MCA training plan will be reviewed in October 2016. 11. We will be looking at the continued implementation of the training plan including refresher dates in October 2016. 12. There are plans to establish practical scenario based refresher training for all registered and support staff (clinical) by October 2016. 13. Plans have been developed to include mental capacity in the medics induction programme. This will include training on assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and DOLS.						
We found that at Enfield Down, staff did not ensure that T2 (consent to treatment) forms were completed accurately. This was a breach of regulation 11 (1) **Must do** The trust must ensure T2 certificates are completed accurately and reviewed for errors.	1.We have developed a written process and guidance for staff to follow to ensure T2 forms are completed accurately. 2.This guidance will be on display in prominent places so the information is easy to access. Remind staff to prompt medical staff to check for accuracy when completing forms so that information is clear and easy to understand.	Staff will apply their knowledge of MHA Code of Practice	Observation of practice/ speak to staff Speak with service users Review of care records Information from CQC MHA visits (where available) Audit reports and action plans	Deputy District Director - Calderdale & Kirklees	Completed	Mental Health Act Committee	
Ensure there is adequate	Empty bedroom identified and	Clinic room space to be	Look at clinic room.	Deputy	31st August		

space in the clinic room to carry out physical health examinations and care.	will be converted to clinic room that will have space for examinations	available.	Speak with staff Speak with service users. Care records	District Director – Calderdale & Kirklees	2016		

Inpatient wards for older people

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
On The Poplars, Ward 19 and Chantry Unit the ward layout did not allow staff to observe all parts of the ward. This was not mitigated by the use of mirrors on Chantry Unit or Ward 19. The use of observations did not include staff being present in those areas on a routine basis and on the day of our inspection staff were not present in those areas. Risk assessments of patients did not refer to the blind spots within the wards when considering the risks to and from that patient. This meant that the ward was not doing all that was practicably possible to reduce the risk of harm to patient	We intend to improve the observation of patients on our Older Persons inpatient units by Improving the lines of sight Trust wide the following action will be taken: 1. We have carried out an environmental risk assessment to determine whether additional mirrors are needed to help line of sight. 2. Ward risk assessments have been reviewed to include consideration and mitigation of environmental factors impacting on service user risk. 3. Areas for mirrors to be located have been identified. 4. A plan is in place to have mirrors fitted by September 2016.	Environment risk assessments complete. Mirror fittings are in place as identified in the environmental audit.	Check environmental risk assessment for issues relating to lines of sight, and actions to address any identified shortfalls. Look at the risk management plan to improve lines of sight and check whether these are being followed in practice. Observe the environment to see if the measures are sufficient in meeting any identified shortfalls. Speak with staff. Look at incident records in relation to self-harm and/or injury in relation to	Deputy Directors of Calderdale , Kirklees and Wakefield	30th September 2016	Estates TAG	

s and staff. This was a breach of regulation 12(2)(b) **Must do** The trust must ensure that there are clear lines of sight on (The Poplars, Ward 19 and Chantry Unit).			observation issues.				
On Ward 19 the bedrooms door handles were a ligature risk. Although this was identified on the annual ligature risk assessment to be managed locally there were no bedrooms without these door handles. This meant that if patients were a high risk of self-harm they would need to be nursed on close observations which was not the least restrictive option. Furthermore this meant that patients who had no previously identified risk of self-harm were not routinely risk assessed for the ligature risk inside their bedroom leaving them with easy access to ligature points. This was a breach of regulation 15(1)(C) **Must do**	We will reduce the ligature risk by replacing bedroom door handles. A Trust wide review has been completed and a preferred safer product agreed.	All doors will have 'ligature free' furniture	Look at the updated ligature risk assessment to see if it meets the Trust's policy. Where shortfalls/changes have been identified and/or made, check whether these are effective in maximising service users' safety. Look around the environment. Speak with staff about their understanding of the changes made and changes to their practice through this. Look at incident records in relation to ligature points, self-harm attempts, near misses etc.	Deputy District Director (Calderdale & Kirklees) & Head of Estates.	31st October 2016	Estates Forum	

The trust must review the door handles on ward 19 to ensure the safety of the patients							

Community mental health services for older people

Regulation breach	Action	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
Patients were not able to access services in a timely manner. Referral to treatment times exceeded the 18 week target. This is a breach of regulation 9(1)(b Must do The trust must ensure they reduce the waiting times from referral to treatment	Within our CQC report it was noted that Barnsley and Kirklees Outreach Team were meeting their referral to treatment time targets. This information was accurate. However, the referral time figures for North Kirklees CMHT and Ossett CMHT were inaccurate. The referral to treatment time for North Kirklees CMHT was 69 days and Ossett CMHT 53 days. Therefore all of our teams were meeting the 18 week target. This was explained within our Factual Accuracy Comments following receipt of our draft report, where we said that the data we had supplied had been miscalculated. This change was not accepted. Because of the above we do believe we are not in breach of the HSCA Regulations 2014 in relation to this specific matter	People accessing psychological therapies will not wait longer than 18 weeks (referral to treatment)	Look at the data set for PT waiting times across the Trust Look at the new care pathways and discuss the impact of these with Trios and staff. Speak with staff about integrated working and impact from this. Discuss and look at the risk assessment process for managing risk on the waiting list and its effectiveness. Review any incidents relating to service users on the waiting list. Look at staff vacancies and recruitment into posts.	Deputy District Directors (Calderdale& Kirklees, Barnsley & Wakefield)	Completed	BDU Performance Meeting	

	and will strive to continue to maintain and improve our existing standards. As was explained within the CQC report, we continue to respond to risk in a timely manner to make sure our service users receive a safe and responsive service to meet their personalised needs.						
	Calderdale & Kirklees BDU - Kirklees OPS have a team call Kirklees Outreach team who provide an intensive home based treatment model between the hours of 8am & 8pm, 7 days a week. Outside of these hours an all age crisis response is provided by the AWA IHBTT. Calderdale OPS CMHT have dedicated staff who provide an intensive home based treatment model up to 8pm during the week and up to 5pm at weekends. Outside of the hours an all age crisis response is provided by the AWA IHBTT.			Deputy District Directors (Calderdale& Kirklees, Barnsley & Wakefield)	Completed		

SHOULD DO's	**Actions**	**Outcomes How will we know when this action is complete**	**Evidence to show how outcomes have been met**	**Lead**	**Completion date**	**Key governance group**	**Progress report**
The trust should ensure they involve staff in learning from incidents.	1.All staff are encouraged to attend serious incident post investigation meeting to share learning 2.To increase the participation/involvement of	All staff are involved in learning lessons from incidents	Records of attendance at serious incident post investigation meetings. Speak with staff.	Deputy District Directors (Calderdale& Kirklees,	31st October 2016	Patient Safety Group	

	all staff , all serious incidents (and any related learning/recommendations) are discussed at service line meeting, 3. Learning from incidents will then be further disseminated by team managers at team based business meetings. (this can then be audited via inclusion in team business minutes) 4. The PGC for the BDU plan and hold quarterly leaning events, all service lines contribute to this process, agenda items are inclusive of best practice guidance, themes and trends that are related to risk. 5. Learning from serious incidents are discussed and shared within the learning events, which can include incidents that occurred within host BDU, other BDU's within the trust and external organisations.		Staff supervision records.	Barnsley & Wakefield			
The trust should consider how staff throughout the trust are made aware of lessons learnt following an incident.	1.Quarterly incident reports 2.Bi annual learning lesson reports/ 'Our journey' 3. BDU governance groups have learning lessons on as a standard agenda item 4. Bespoke learning events across the Trust	Staff understand about learning from incidents and are able to demonstrate this learning through their care practices.	Awareness of Trust wide information about lessons learned from incidents e.g. Our Learning Journey' and outcomes from these. Records of attendance	Deputy District Directors (Calderdale& Kirklees, Barnsley & Wakefield	31st October 2016	Patient Safety Group	

			at serious incident post investigation meetings. Speak with staff. Staff supervision records.				

Community Health Services CHS - Adults

SHOULD DO's	Actions	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The trust should ensure that lines of accountability to the senior management team are clear to staff in front line community services.	Service managers and governance coaches to ensure that staff are reminded of governance structures within the Trust. Clinical Governance intranet pages to be highlighted at team meetings and professional forums	Staff will understand the lines of accountability within the Trust.	Look at team and professional forum meeting minutes.. Look at accountability structure. Speak with staff.	Deputy Director of CHS	Completed & ongoing	BDU Performance Meeting	
The trust should ensure that community services staff are fully engaged and consulted as to the transformation of community services.	Community Services Transformation pages on Trust intranet have a 'Ask any questions' section. Community nursing to establish an intranet page/social media and bulletins. Drop In Transformation events have been held for staff (including suggestions/comments boxes Individual transformation work streams have included front line staff on workgroups Transformation Event held on	Staff will be informed of the changes in relation to transformation through regular communications	Look at communication messages to all staff. Look at the transformation project team records. Speak with staff.	Deputy Director of CHS	Completed & ongoing	EMT	

	15 June 2016 involving Community Nursing Staff Transformation Working Group has front line clinical representation Communication via Communications and Marketing Teams e.g. The Headlines						
The trust should ensure community clinics provided by the district nursing service are reviewed in liaison with practice nursing provided by primary care to ensure community nursing consistently prioritises housebound patients.	This is being reviewed and will be addressed via the CCG led Community Nursing Review	The review will have been completed and this will have led to community nurses prioritising housebound patients.	Discuss with management outcomes from CCG led Community Nursing Review	Deputy Director of CHS	31st Oct0ber 2016	BDU Performance Meeting	
The trust should ensure that the podiatry service is staffed to planned establishment levels.	Ongoing Recruitment underway to replace vacant posts. Meanwhile utilisation of agency staff to cover demands. Continual monitoring undertaken to ensure service demands and staffing levels appropriate to meet contract obligation in the meantime.	Staffing establishment is complete- all post recruited to.	Staffing rotas. Discuss with manager recruitment and staff vacancies. Waiting list times. Speak with staff.	Deputy Director CHS	31st October 2016	BDU Performance Meeting	
The trust should ensure the staff intranet and trust internet reflect the full range of community services available for patients.	CSMs to check that all services are showing on Trust Internet Directory Pages. Communications team to update as necessary.	Information to be available on the Trust's intranet	Look at information on the Trust internet Monitoring systems to make sure information on the intern et is kept up to date. Speak with staff.	Deputy Director of CHS	31st October 2016	BDU Performance Meeting	
The trust should ensure	All PGDs up to date, as is	All PGD's will be up to	Look at information on	Chief	Completed	BDU	

that Patient Group Directions are up to date.	database and this has been audited. Resent list of PGDs to all services that use them for them to check that the ones they are using are in date	date and a process in place to ensure this is sustained.	the Trust internet Monitoring systems to make sure information on the intern et is kept up to date. Speak with staff.	pharmacist		Performance Meeting	
The trust should ensure that the policy for lone working in up to date.	Trust wide lone worker policy was reviewed and updated January 2016. Next review due January 2019. Community managers to check that any printed versions of the policy held by services are the current version.	Staff to work in accordance with the Lone Worker policy.	Look at existing lone worker policy to make sure it is up to date. Speak with staff..	Deputy Director of CHS	Completed	BDU Performance Meeting	
The trust should ensure arrangements to record clinical supervision are in place.	• The BDU's will comply with the Trusts initiatives to centrally store supervision figures. A database was developed in 2016 (January-March) and is currently under pilot. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, or where this is not happening across individuals and teams. • The database will facilitate an audit of supervision to be planned and completed against the clear standard stipulated in the policy, including ensuring that where impromptu and a more informal style is accessed, this is supported	Staff supervision is accessed by all trust staff in line with the clinical supervision policy. Performance is reported through the HR performance wall and monitored at service line and BDU governance meetings.	Look at the Trust's centralised supervision database to check if this captures all the relevant supervision information. Look at supervision records within individual teams. Speak with staff about their supervision. Look at a sample of staff supervision passports within individual teams.	Deputy Director of CHS / Deputy Director of Nursing Clinical Governanc e & Safety	31st October 2016	Nursing Quality Group	

	by structured approaches with supervisors the supervisee holds a contract with.						

CHS - Inpatient services

SHOULD DO's	Actions	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The trust should consider recording patients' goals and discharge plans to ensure that patients are able to review the details.	Review of SystmOne underway and ongoing. New care plans commenced 27th June 2016	Clinical records will include goals and discharge plans	Look at care records. Speak with staff. Speak with service users.	Deputy Director of CHS	Completed	BDU Performance Meeting	
The trust should ensure that early warning scores are recorded consistently across all community inpatient wards.	They are all recorded on news charts and in care plans on all our wards	Early warning scores will be clearly documented in line with Trust policy.	Look at care records. Speak with staff.	Deputy Director of CHS	Completed	BDU Performance Meeting	
The trust should ensure that on ward 4 early warning scores are recorded on the EWS chart rather than retrospectively on the care plan.	They are all recorded on news charts and in care plans on all our wards	Early warning scores will be clearly documented in line with Trust policy.	Look at care records. Speak with staff.	Deputy Director of CHS	Completed	BDU Performance Meeting	
The trust should review the availability of therapies and activities in the afternoon to ensure that patients have a	A full range is available on wards and on the therapy suite. Participation is patient choice. However, we are a rehabilitation ward and	Patients can access a wide range of activities in an afternoon.	Look at activity records. Look at care records. Speak with staff	Deputy Director of CHS	Completed	BDU Performance Meeting	

sufficient range of activities.	encourage rest periods in an afternoon. Re-profiling underway in terms of skill mix availability in afternoons		Speak with service users. Observe the environment				
The trust should take action to reduce the length of stay.	Monitoring via CCG Strategic Intermediate Care Group (DIG) and SWYPFT Performance and Finance internal group now data flows are in place. Currently in early stages of Medworx implementation.	The average length of stay will decline.	Look at length of stay data flows. Speak with staff. Look at impact of Medworx implementation.	Deputy Director of CHS	Completed	BDU Performance Meeting	
The trust should review the roles of healthcare assistants in community inpatients services to ensure that there is consistency across the wards.	All staff have same job descriptions, some are more experienced and have attended more training. EMT approved clinical Bands 2-4 support worker plan	Implementation of Trust plans to develop band 2-4 posts.	Look at training records. Speak with staff Look at recruitment and staff vacancies.	Deputy Director of CHS	Completed	BDU Performance Meeting	
The trust should consider improving the environment for dementia patients in community in patient services.	Extra toilet signage ordered. Possible relocation imminent to new purpose designed unit.	Assessment of environment against dementia friendly toolkit Improved environment in line with Dementia friendly toolkit guidance	Observe the environment Look at the signage Review incident records Speak with staff	Deputy Director of CHS	Sep-16	BDU Performance Meeting	

CHS – children, young people and families

SHOULD DO's	Actions	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The trust should ensure that all staff adhere to infection protection and	Ensure that staff are up to date with relevant mandatory training. Professional Lead to	Staff are achieving their personal mandatory training needs and	Training records Observe practice	Deputy Director of CHS	Completed	Infection Prevention and Control	

control guidelines, in particular bare below elbows, in community clinics.	work with IPC Team to audit staff compliance with infection protection and control guidelines. Feedback information at 0 to 19 professional forums	implementing their knowledge in practice.	IPC Audit outcomes Professional Forum minutes Speak with staff			TAG	
The trust should risk assess school nurse staffing vacancies to ensure that there is sufficient capacity to safely manage safeguarding concerns.	Quality impact assessment and risk log completed and reviewed on a fortnightly basis. Recruitment underway	??	Staff rotas Staff caseloads Waiting lists Recruitment and staff vacancies Incident records	Deputy Director of CHS	Completed	Safer staffing	
The trust should work to reduce the referral to treatment times for children's therapy services.	A significant increase in referrals has caused the wait for treatment (659 more referrals than 3 years ago, 110% increase), the department are working more efficiently, as their waiting time has reduced despite of this increase. A review of the service is ongoing at present to investigate if any further efficiencies can be made and discussions with the Children's Commissioning Group continue.	People accessing the service will not wait longer than the national referral to treatment time.	Outcome from the ongoing review of the service. Monitoring arrangements	Deputy Director of CHS	On the completion of Children's Commissioning group's review of service	BDU Performance Meeting	

CHS – End of life services

SHOULD DO's	Actions	Outcomes How will we know when this action is complete	Evidence to show how outcomes have been met	Lead	Completion date	Key governance group	Progress report
The trust should ensure measurable improvements are demonstrated in relation to improving specialist support for patients with long term conditions at the end of life.	The Trust End of Life Clinical Lead will raise with CCG as part of the refresh of the EoL strategy for Barnsley and the development of specific KPIs Work with IT & P & I services to develop ways of monitoring improvements in relation to new strategy when published	The KPI's will have been set against the new strategy.	KPI targets around specialist support Outcome of discussions with IT & P & I.	Deputy Director of CHS	31st October 2016	BDU Performance Meeting	

Trust Board 20 September 2016
Agenda item 5.2

Title:	**Safer staffing report**
Paper prepared by:	Director of Nursing, Clinical Governance and Safety
Purpose:	This paper builds upon the previous six-monthly papers submitted since July 2014. It outlines the work being done to ensure ward areas provide staffing levels that are safe and effective.
Mission/values:	Honest, open and transparent, person first and in the centre and improve and be outstanding
Any background papers/ previously considered by:	Monthly safer staffing exception reports are submitted to the Trust Safer Staffing Group, Executive Management Team (EMT) and Deputy District Directors. Business case August 2015 and an updated paper May 2016 were presented to EMT.
Executive summary:	The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda and, despite the lead on Safer Staffing having changed to NHS Improvement, there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health/Learning Disability wards. The Trust currently meets its safer staffing requirement overall although the planned levels of qualified (registered) staff are not always met. This results in use of existing staff doing additional hours, bank and agency staff. Staff survey and Datix reports suggest concerns remain regarding safer staffing on wards and a more proactive, flexible and sustainable workforce is required to respond to fluctuations in need and demand. Despite this, the Trust endeavours to ensure its wards never operate at levels of unsafe staffing and has established escalation policies to increase capacity of the workforce where sudden staff shortages are experienced and/or manage the demand on the wards to ensure safety. Following its inspection of the Trust in March 2016, the Care Quality Commission (CQC) identified that, in working age adult and forensic mental health wards, the Trust does not always meet its planned 'minimum' staffing fill rates and the CQC raised concerns about the impact on the quality and safety of patient care. The Trust provided a full response and an action plan, and is scheduled to meet with the CQC again in September 2016 to discuss. In order to maintain progress, the Trust continues to: • build on and improve data in exception reports including triangulation of DATIX, exception reporting and HR information; • extend and maximise functionality within current e-rostering system including the centralisation of the Trust's staff bank; • provide effective and efficient support to meet establishment templates; • have in place a project manager to work closely with 'hotspot' wards where pressure on meeting staffing numbers; • have in place a safer staffing group, which includes staff side representatives; • review current establishment templates for inpatient areas;

	• support measures to reduce agency usage in line with NHS Improvement guidelines; • have in place a safer staffing lead to work with Practice Governance Coaches to review safer staffing in the community and improve understanding and monitoring of direct care contact time; • ensure the Safer Staffing lead is involved in the further development of the *Mental Health Safe Staffing Multiplier Tool* on a national level; • liaise with CQC to discuss understanding of optimum and minimum staffing levels; and • review and implement the outcomes from the recruitment and retention summit.
Recommendation:	**Trust Board is asked to RECEIVE the report as assurance that the organisation is meeting safer staffing requirements.**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Safer Staffing

Trust Board 20 September 2016

With **all of us** in mind.

Trust Board September 2016
Safer Staffing Board Report

1.0 INTRODUCTION

This paper builds upon the previous Safer Staffing board reports submitted bi-annually since July 2014. It outlines the continuing work being done to ensure ward areas provide staffing levels that are safe and effective and includes the recommended Board Checklist (appendix 1).

At a national level, there continues to be key changes around the delivery of this agenda. Despite the national lead on Safer Staffing having changed to NHS Improvement, there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health wards. However the Safer Staffing project lead within our Trust will be involved nationally in the further development of the Mental Health Safe Staffing Multiplier Tool.

Recent interest in safer staffing arose from concerns nationally regarding inpatient staffing levels. The Trust is expected to publicly declare staffing fill rates for inpatient settings only and the focus of much of the work to date has been on ensuring safer staffing levels on inpatient wards. However, some early work has begun to explore staffing levels in community teams and the community workforce has recently been reviewed in detail as part of the Trust's transformation programme. This has resulted in reconfiguration of services and job roles in many areas aimed at improving safety and effectiveness of services.

Given the lack of progress in the area of Safe Staffing guidance we continue to utilise the decision support tool adapted previously for our Trust, to look at establishments and rosters on our ward areas. There has been a review of this tool and the resulting establishment figures for our inpatient areas, the findings of which will be published in September. This will also cross reference levels and trends of acuity, fill rates and anomalies such as bespoke care packages.

We do, as per the Chief Nursing Officer's letter dated February 2015, continue to maintain accurate and up-to-date information of "composite indicators" on ESR in relation to the proposed Safer Staffing Indicators:

1. Staff sickness rate, taken from the ESR at the end of March 2016 (published by NHS Digital formerly HSCIC);

- Inpatient areas – 6.5% compared to the Trust 5.02% and England 4.15%

2. The proportion of mandatory training completed at the end March 2016, taken from the National staff survey measure;

- Inpatient areas: 86.5% compared to the Trust figure of 88.8%

3. Completion of a Performance Development Review (PDR) at the end of March 2016, taken from National staff survey measure;

- Inpatient areas – 94.7% compared to the Trust figure of 97.3% (target 95%)

4. Staff views on staffing, taken from the 2015 National staff survey measure;

- Key Finding 14. Staff satisfaction with resourcing and support shows a trust score of 3.42 from 5 (very satisfied), which is above the national average for trusts that are combined MH/LD and Community.

Based on these indicators, there are some positive findings but also some challenges facing inpatient services. Within SWYPFT, significant financial investments have already been made since 2014 to develop interventions around the Safer Staffing agenda including increasing some ward establishments after the presentation of a business case, establishing a peripatetic workforce and centralising the trust staff bank. The Trust has also set aside a recurrent Safer Staffing budget of £750,000 to support various projects influencing this agenda. This will aid the trust to meet demands arising from staffing shortfalls and support areas with increased clinical needs and risks.

The present breakdown of the use of the Safer Staffing budget is listed below. Provisional forecast as of 12th September 2016:

		APR-AUG 2016 YEAR TO DATE			FULL YEAR FORECAST		
Account	**Description**	Budget	Actual	Variance	Full Year Budget	Forecast	Variance
		£	£	£	£	£	£
	Pay						
6224	Nurse Band 8	22,505	22,505	0	54,012	54,012	0
6227	Nurse Band 5	117,325	0	-117,325	281,580	41,712	-239,868
6226	Nurse Band 4	0	0	0	0	155,094	155,094
6261	Nurse Band 3	172,670	0	-172,670	414,408	0	-414,408
6262	Nurse Band 2	0	7,857	7,857	0	196,821	196,821
6282	Bank Nurse Band 2	0	202	202	0	201	201
6648	A&C Band 3	0	4,058	4,058	0	10,574	10,574
6655	A&C Bank	0	3,459	3,459	0	34,641	34,641
	Total Pay	**312,500**	**38,080**	**-274,420**	**750,000**	**493,055**	**-256,945**
Non-Pay							
7253	Staff Recruitment Advertising	0	2,621	2,621	0	100,000	100,000
7270	Travel & Subsistence	0	637	637	0	10,000	10,000
7351	Office Equipment	0	0	0	0	10,000	10,000
Total Non-Pay		**0**	**3,258**	**3,258**	**0**	**120,000**	**120,000**
Grand Total		**312,500**	**41,338**	**-271,162**	**750,000**	**613,055**	**-136,945**

There is currently a projected underspend of over £136,945, largely due to the difficulty recruiting band 5 staff to the peripatetic workforce. However, cost pressures resulting from the establishment template review and ideas arising from the recruitment summit that will account for most if not all projected underspend.

2.0 SUMMARY OF PREVIOUS REPORT AND ACTIONS,

In the previous Board assurance reports we identified a need for the following.

1. **Continue monitoring safer staffing returns and where necessary identify remedial actions to ensure adequate staffing levels.**

Action

Monthly exception reports now highlight areas where staffing levels fall below 90% overall and below 80% for registered-qualified staff. Ward managers in areas that do not achieve targets are asked to provide updates to help improve our understanding of why we have shortfalls (see fill rates below). This “exception reporting” system continues to be developed to add more qualitative and quantitative data and now includes narrative from ward managers on why there were shortfalls, how they were managed and what action is being taken to prevent reoccurrence. Importantly we have also included the impact this may have had on the delivery of therapeutic activities.

Numbers of reported Datix incidents on staffing levels are included by BDU and highlight the previous six months so any trends and themes can be identified. This also includes supporting individual ward areas that have specific challenges and providing a review of actions taken and recommendations to support staffing levels

2. Review of the safer staffing tool in ward areas.

Action

To date the staffing tool which was devised specifically within SWYPFT was used in May 2015 and showed that the majority of inpatient ward areas were staffed beyond the "minimum" levels informed by the tool. Due to changes within the trends of ward acuity and the evolution of the nursing workforce within our Trust, this work has been revisited and a report will be presented to the Safer Staffing Group in October 2016.

3. Identify financial costs of current ward-based workforce across the Trust and calculate cost of meeting any staffing shortfall.

Action:

This was completed as part of the business case supporting the development of a peripatetic workforce. Since the approval of the business case in August 2016, the high level of staff vacancies on the wards has meant that recruitment to the supplementary peripatetic workforce has been delayed while vacancies are filled. However, the recruitment of apprentices and health care support workers onto the peripatetic workforce continues and the first deployment within the BDUs began with secondments in March 2016 and continues with the most recent peripatetic deployment from July and September this year. It continues to be analysed on a monthly basis.

4. Continued establishment of the safer staffing group that includes Nursing, HR, staff bank, finance and operational delivery staff to:

Action:

We are updating the safer staffing action plan to form part of the overall supplementary workforce agenda (see appendix 2). This will support the implementation of the Recruitment and Retention Summit action plan from 1st July 2016.

5. A systematic review of the staff bank

Action:

A systematic review has taken place and the process of re-centralising the Trust staff bank has begun with the launch date scheduled for 12th September 2016. This will support all areas in their temporary staffing needs with a particular focus, initially, on inpatient nursing, thus releasing time of senior clinicians into patient care, reducing any potential risks to Service Users, staff and the Trust as well as making a cost saving

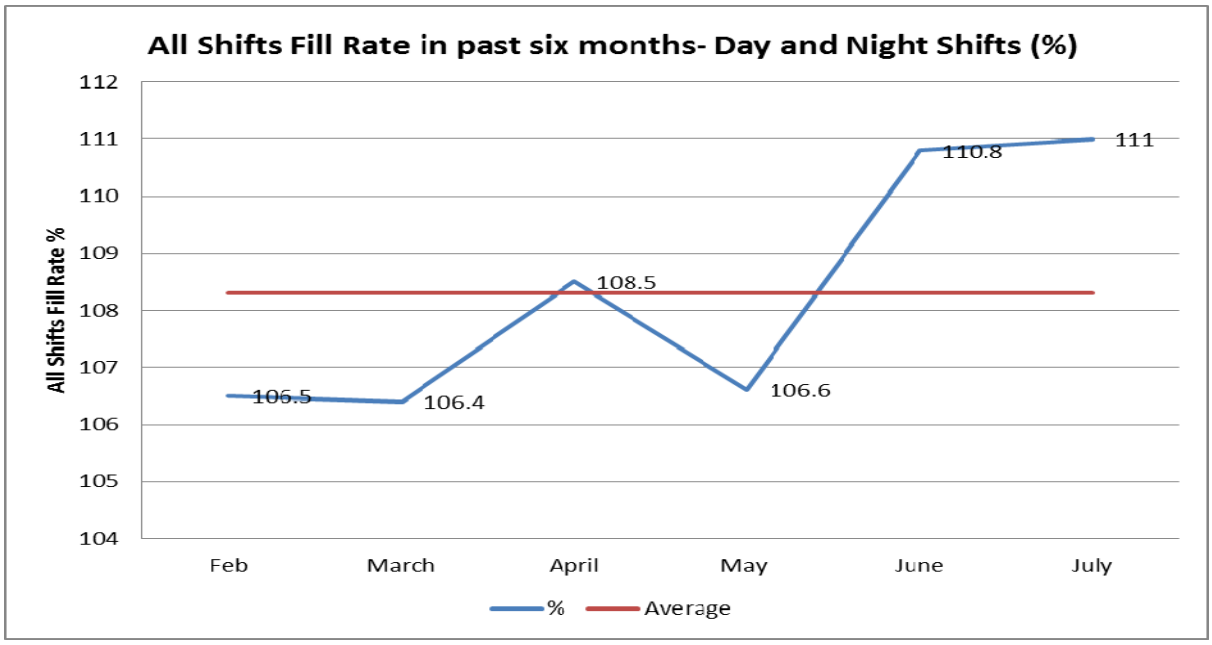
The staff bank has been centralised and there has been a focused recruitment drive for Registered and Non-Registered staff as part of the process of increasing the pool of supplementary staff available to services.

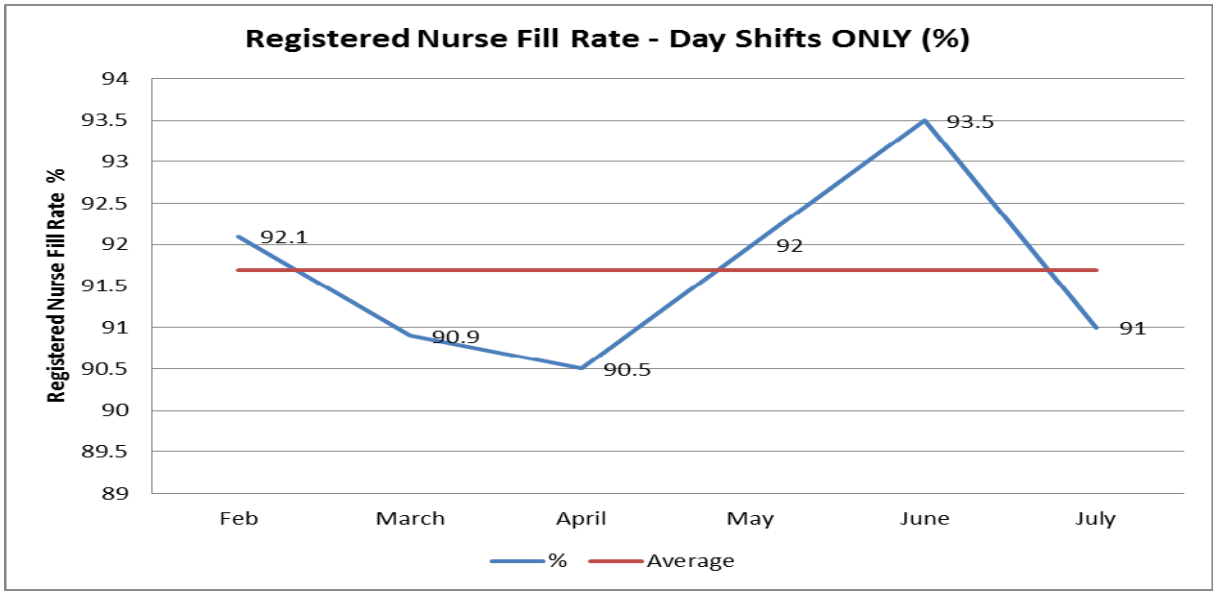
The peripatetic workforce is gradually being established with the aim by the end of October to have 18 non registered staff available across the trust.

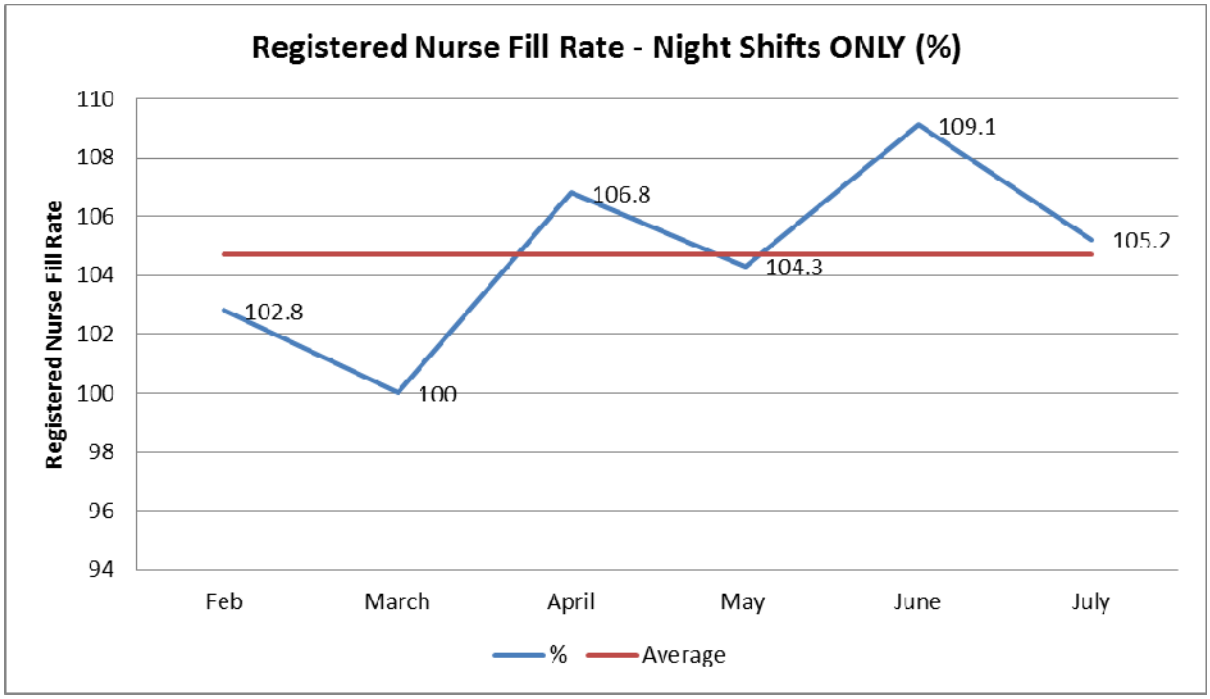
A new band 4 role is being established to develop the heath care support workers role into with enhanced knowledge and skills to support the registered nursing workforce. As a result of the Trust's recruitment summit a procurement process commenced to adopt a specialist recruitment agency for the Trust to update and improve our recruitment processes. This will support a range of initiatives aimed at increasing the capacity and capability of the workforce, including overseas recruitment. Developing a career structure to enhance staff's opportunities across all areas is in progress. This will include developing ways to respond positively to staff aspirations and for inter-area transfer of staff to maintain career development.

3.0 ANALYSIS OF FILL RATES FEBRUARY 2016 – JULY 2016

The Deputy District Directors and EMT receives monthly exception reports on fill rates within our inpatient areas with particular emphasis on areas where fill rate overall (registered nurses and nursing support) is below 90%, and where registered nurses on days or nights falls below 80%. Managers are asked to provide exception reports on why fill rate not achieved, how it was managed and actions to prevent recurrence.







Summary

Based on above graphs, overall fill rates remain above the 100% level. This trend shows an improvement in overall fill rate of 2% for Registered Nurses on nights and a slight fall of 0.4 % can be seen on days.

All BDUs continue to experience challenges in achieving the targeted fill rates for Registered Nurses in particular. In order to address this issue, there is a continued centralised recruitment drive, in addition to other measures being taken including the deployment of the peripatetic workforce and the process of identifying an agency to assist in a revitalised recruitment campaign.

The majority of wards are achieving the set targets in all three areas with Ashdale being the only inpatient area not to have achieved its overall fill rate target in the last six months. Additionally, they have experienced ongoing difficulties over the last three months on days with the Registered Nurse fill rate. This was identified by the BDU and resulted in the recruitment of Health Care Support Workers (HCSW's) which will positively influence the average fill rate. The Forensic BDU continues to improve its overall and qualified nurse fill rates.

Many of the areas continue to achieve the overall fill rate through the use of HCSW to cover temporary vacancies. Again a strategy for filling the vacancies is being developed and supported constantly. There is also a pattern of a higher fill rate of Registered Nurses on nights in comparison to days and this is explained in the exception reports as being reflective of a sustained increase in acuity on nights and the need for covering a time span out with the working patterns of other disciplines and senior clinical staff. Due to this sustained increase of acuity, the Safer Staffing Project Manager has revisited the ward establishments; acuity and ward fill rates, the findings of which will be reported into the Safer Staffing Group in October 2016.

4.0 ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING.

In the 12 months leading up to the 31st July 2016, there were 252 Datix incident reports highlighting staff shortages. Although this is a slight increase from the previous 12 months in the number of reported incidents, it continues to equate to less than one Datix incident per

100 shifts. However, it is important that the Trust triangulate Datix information with safer staffing fill rates and exception reporting to ensure safer staffing is maintained, this is considered within the Safer Staffing Group. There is also an ongoing piece of work around the classification of Datix reports pertaining to staffing issues to ensure an accurate reflection is reported into the group.

5.0 PERIPATETIC STAFFING BUSINESS CASE

Safer Staffing Project Manager commenced in post in January 2016. As part of the development of a supplementary workforce, a peripatetic workforce (PW) will be developed to enhance flexibility and sustainability of the workforce and giving more opportunities to cover the shortfalls as they arise. It will increase the wards staffing capacity in dealing with today's challenges. The deployment of this workforce has begun. However, since the original proposal it has become evident that nationally and locally there is a serious shortfall in registered nurses leading to significant vacancies in staffing establishments, especially on wards (> 20% in some areas). Therefore, recruiting registered nurses onto the PW will not be possible until substantive vacancies are filled. In the interim, non-registered staff are being recruited onto the PW provide much needed capacity. The plan is to recruit registered nurses as the vacancies within this group fall overall within the trust.

6.0 CQC INSPECTION AND REPORT ON SAFER STAFFING

The CQC published their report in June 2016 following a comprehensive inspection of SWYPT services in March 2016. In relation to safer staffing, the CQC identified that in working age adult and forensic mental health wards, we do not always meet our planned 'minimum' staffing fill rates and they raised concerns about the impact on the quality and safety of patient care. They also suggested that we had no 'plan' to address the staffing shortfalls. The CQC subsequently notified us that we had breached Health Regulation 18 HSCA (RA) Regulations 2014; Staffing, because;

'Staffing levels and staff skill mix did not meet the trust's minimum staffing levels at times on Ashdale and Elmdale wards at The Dales Hospital and Trinity 1 and Priory 2 at Fieldhead Hospital.' and

'There was not enough nursing staff to ensure that important nursing tasks were completed

- *Meaningful activity targets were not being met.*
- *There was a high level of bank and agency staff used who were unfamiliar with the wards.*
- *Data provided by the trust showed that the wards were regularly breaching their own targets on minimum staffing levels.*
- *Patients we spoke to told us there was not enough staff and too many agency workers.*
- *There was no long term plan to resolve the staffing problems.*

This meant that patient activities and leave entitlement were often cancelled due to the lack of staff.'

In our factual accuracy response, the Trust accepted that we faced significant staffing challenges while acknowledging the ongoing difficulties the Trust and healthcare providers are experiencing nationally in terms of staffing and recruitment. We also highlighted that our planned staffing levels are not defined as minimum or 'safe' staffing levels, but optimum staffing levels determined by the Trust based on many tears of experience and by using our evidence-based decision support tool. It is important to make clear that there is a difference between minimum staffing levels and optimum levels. Minimum numbers are the absolute minimum numbers required on a ward to maintain safety. Optimum staffing levels allow for

staff to engage fully with service users and accommodate their needs including leave and activities.

We emphasised that our wards would never operate at levels of unsafe staffing and that we have established escalation policies in place to increase capacity of the workforce where sudden staff shortages are experienced. In addition, we would also manage the demand to ensure safety and this could include reduction in beds available, temporary closure to admissions and more detailed risk assessment to prevent unmanageable and/or unsafe demand on staff.

In terms of a plan, we highlighted to the CQC that the Trust had taken significant steps to address staffing issues, and in August 2015 a formal piece of work was commenced by the Trust “The delivery of safer staffing,”, which has since led to several productive work streams aimed at ensuring safer staffing, including:

1. Planned over-recruitment of staff onto a supplementary-peripatetic workforce.
2. Appointment of a safer staffing Project Manager from the Forensic Service.
3. The establishment of a Safer Staffing Group and staffing exception reporting that includes staff-side reps.
4. Registered and unregistered nursing staff recruited and aligned to BDUs.
5. A pilot project where peripatetic workforce is rostered on to shifts within the BDUs to cover increases in acuity, staff sickness and activity levels.
6. Review of the staff bank.
7. Recruitment campaign running monthly since February 2016.
8. Recruitment and retention summit.

Neither the CQC report nor the judgments reached reflected this significant piece of work. However, the CQC report and response affords us an opportunity to respond positively and we have identified further remedial action aimed at improving staffing across the Trust (see action plan, appendix 2). We also plan to discuss our minimum-optimum reporting dilemma with the CQC at a time of significant recruitment challenges nationally and locally. Lowering our planned-expected staffing number would increase the chances of achieving the planned staffing level consistently, but in effect this would reduce the number of staff rostered onto the wards.

The trust has embarked on a centralised recruitment process for both Registered and Non-Registered nursing staff within inpatient areas. This has led to almost 50 acceptances of employment from registered staff and there will be 4 cohorts (each 15 strong) of band 2 Non-Registered staff onto the Apprentice scheme per year.

As a result of the Trust’s recruitment summit a process commenced to procure a specialist recruitment agency for the Trust to update and improve our recruitment processes. This will support a range of initiatives aimed at increasing the capacity and capability of the workforce, including overseas recruitment.

The peripatetic workforce is gradually being established with the aim by the end of October to have 18 non registered staff in place across the trust. A new band 4 role is being established to develop heath care support workers role in anticipation of the new nursing associate role. They will have enhanced knowledge and skills to support the registered nursing workforce.

Developing a career structure to enhance staff’s opportunities across all areas is in progress. This will include developing ways to respond positively to staff aspirations and for inter-area transfer of staff to maintain career development.

7.0 SUMMARY AND NEXT STEPS

The national commitment to safer staffing is ongoing and SWYPFT need to maintain the progress already made in delivering safer staffing as well as being engaged in the national development of the safer staffing tool. The Trust currently meets its safer staffing requirement overall, although there is regularly a shortfall in registered staff and in some areas difficulty in sustaining sufficient numbers in times of increased demands. This has resulted in use of existing, bank and agency staff and increases risks due to variable quality and competencies of staff and lack of familiarity with the Trust.

Planned inpatient staffing numbers rostered onto shifts meet or exceed the requirements for minimum staffing and measures are in place to manage demand and capacity to ensure our wards are safe. However, staff survey and Datix reports suggest concerns remain regarding safer staffing on wards and a more proactive, flexible and sustainable workforce is required to respond to fluctuations in need and demand. The peripatetic workforce supported by an enhanced centralised bank staff management system is likely to result in financial savings whilst providing higher quality staffing and safer care for service users.

Current plans will help the Trust prepare for new guidance from NHS England and increase capacity to meet demand. Current plans will also provide the platform from which to explore further workforce initiatives around the quality of care contact time, multi-professional approaches and use of non-registered staff. These plans include;

1. Continue to build upon and improve data in exception reports including
    - develop dashboards for Datix incidents
    - triangulation of DATIX, exception reporting and HR information
2. Extend and maximise functionality within current e-rostering system as part of the centralisation programme for the trust staff bank
3. Continue to provide effective and efficient support to meet establishment templates.
4. Project manager to work closely with ‘hotspot’ wards where there is pressure on meeting staffing numbers.
5. Involvement in the development of a National Safe Staffing tool for inpatient mental health areas.
6. Continue to develop, manage and deploy the peripatetic workforce
7. Continue the Safer Staffing group and monitor actin plan and new initiatives.
8. Safer Staffing Project Manager will work with Practice Governance Coaches to review safer staffing in the community and improve understanding and monitoring of direct care contact time.
9. Meet with CQC link officers in September to discuss our response to safer staffing concerns raised in the CQC report and explain our approach to determining planned staffing levels.

Appendix 1

Board Checklist

1. Do Boards fully understand the specific characteristics of Mental Health that will have an impact on the approach to capacity and capability? Do they have a clear vision and values around quality and safety and how it is defined differently in a Mental Health setting?

   Board receives regular presentations on staffing (e.g. monthly exception reports, regular assurance visits from Board members to the wards/departments in order to learn about and understand the services better (e.g. CQC mock visits)

2. Are their processes for escalating issues identified by staff, patients or relatives or responsive to the quickly changing acuity and unpredictability of Mental Health services?

   Acuity is regularly and routinely monitored on wards including need for 1:1 observations. On call arrangements mean staffing issues can be escalated quickly and senior managerial support sought. Staffing issues are captured via Datix system.

3. Is there a clear methodology for the planning and deployment of staffing that is firmly rooted in an evidence based approach? How can the calculator tools be best deployed in delivering this?

   The Trust has developed a bespoke decision support tool. The tool has been developed in collaboration with ward managers as a decision support tool, to enable staff to match bed numbers with other variables, such as acuity, and calculate the numbers of staff and skill mix required to run both a day and night shift given these circumstances. E-rostering extrapolates where fill rates fall below optimum levels and managers are asked for exception reports on why, mitigation and actions to prevent recurrence.

4. What practical steps are being taken to develop sound skills in professional judgement because of the less predictable nature of Mental Health services?

   Managers are empowered to use a range of interventions (e.g. use of bank/agency etc.) to ensure safer staffing where unexpected demand is encountered. Widespread roll out of dashboards and benchmarking across the organisation continues to improve data fields available to support professional judgement.

5. How are the needs of Mental Health service users incorporated in staffing?

   Services are planned and designed in consultation with service users and carers. Transformation of care pathways ensures that they are contemporary and relevant.

6. What evidence is there that a multi-professional approach to staffing is being deployed across the organisations? How is the need to spend time simply engaging with and talking to the patients built into workload calculation?

   The transformation programme currently underway considers how care pathways can be enhanced by all professional groups. Service user and carer engagement and satisfaction tools assure us that service users and carers are largely satisfied with the care and treatment they receive.

7. As well as staffing measures outlined by the NQB are there measures of improvement or performance that reflect some of the unique characteristics of Mental Health services and specific clinical drivers?

Complex benchmarking and performance data is widely available throughout the organisation and drills down to team level. Clinical metrics in relation to incidents such as violence and aggression are also available and reviewed regularly.

8. How this ward staffing information might be presented differently within a Mental Health setting where the ward based team is not the only important resource available?

   Wards display boards which demonstrate staffing fill rates. More work to support better information to the public about the wider MDT may be required.

9. How are the challenges of filling specific Mental Health roles handled? E.g. recruitment training etc.?

   We have extremely good relationships with providers of undergraduate education and have recently invested in improvements to the Practice Placement Quality Team to ensure we remain the local employer of choice. Training Needs are reviewed across the organisation each year and training programmes commissioned to support. Supervision and appraisal also support identification of training/learning needs.

10. How is the commissioner kept informed about best practice in Mental Health such that informed commissioning decisions are made?

    Local CCG Quality Boards receive updates on how the organisation is performing in relation to safer staffing.

Appendix 2

Safer Staffing Action Plan
August 2016

Safer Staffing Action plan [DRAFT]
Source documents: Safer Staffing Business Case August 2015 and EMT Update Paper May 2016

RAG rating
Red – deadline missed by more than a month
Amber – missed deadline by less than a month
Green – on track or completed
Blue - complete

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
1. Bank Centralisation	• Centralised office space	Diane Traynor/ Colin Hill	Sally Ironfield (Estates Senior Manager)	July 2016	- Proposed office space identified - office refurbishment estimate requested	
	• Establish bank office staff	Diane Traynor/ Colin Hill	- Negotiations to take place in relation to staff, currently undertaking the role to some degree, to be seconded to bank office for 6 months - Advertise bank secondment post - Recruitment + communications Team	July 2016	- staffing agreed as per updated paper - discussions with GM of current staff scheduled - secondment advert to be published by 11/07/16	

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
	• Communicate changes to staff through communication brief	Colin Hill	Communications Team Discussion with staff side	July 2016 Update: to continue until end of September	- Met with staff side - Engagement events held throughout the trust	
	• Reset ESR system to reflect how bank/agency will be accessed	Colin Hill	- Electronic Staff Rotas Team - Communications Team	July 2016 Update: End of September	- Initial discussion with the ESR team	
	• Agree office times	Diane Traynor/Colin Hill	- HR Department - Bank Staff	June 2016 Completed	- as per updated paper May 2016	
2. Bank Workers Changes	• Increase number of shifts required to remain on bank workforce (1 in 6 months to 4 in 6 months)	Diane Traynor/Colin Hill	- Communications Team - Engagement events - Bank Staff	July 2016 Update: end of September	- as per updated paper May 2016 - discussed and accepted at EMT May 2016	
	• Introduce enhanced bank payments for limited period	Mike Doyle	Alan Davis	June 2016 Completed	- as per updated paper May 2016 - discussed and accepted at EMT May 2016	

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
	• Extend enrolment on to the bank to include 2nd and 3rd year Nursing students	Colin Hill	- Communications Team - ESR team - Practice Learning Facilitator team - Bank Office	June 2016 Completed and ongoing	- Information in the Communications brief - ESR users informed - Practice Learning Facilitators informed - bank office staff informed	
	• Finalise Staff Bank Policy	Diane Traynor/Colin Hill	- HR department - Safer Staffing Group - Clinical Governance Group - EMT	October 2016	- Policy is in draft - ensure changes to staff bank are incorporated	
	• Explore partnership working with local providers to look at bank and agency working	Colin Hill	- Mike Doyle - Workforce planning -Tony Cooper	October 2016	- Meeting with Tony Cooper and providers around cloud bank	
3. Workforce planning	• Centralised inpatient Band 5 Recruitment	Sue Hastewell-Gibbs	- Recruitment Group - Safer Staffing - Recruitment/HR teams -BDUs	July 2016 Completed and ongoing	- Process established and ongoing from Feb 2016 - engagement event established for new recruits	
	• Centralise inpatient Band 2 recruitment	Claire Hartland	- Colin Hill - Recruitment - Care Certificate co-ordinators	October 2016	- Courses planned - Partnership with Barnsley College	
	• Review and enhance preceptorship Programme	George Smith		September 2016 and ongoing	- meeting with various parties established	

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
	• Review of establishment templates	Colin Hill	- BDU Trios - Ward Managers	September 2016	- Meetings arranged - Data review	
	• Consider introduction £1200 annual recruitment and retention premium to ward band 5 staff and to review annually	Mike Doyle	- Alan Davis	September 2016	- On hold while implications being fully considered	
	• Set up a steering group to develop a recruitment and retention strategy	Ashley Hambling	- Colin Hill - Kate Henry - Diane Traynor - Recruitment - Richard Butterfield - Nursing Directorate	October 2016	Nursing/HR directorate recruitment summit meeting in July to look at safer staffing	
	• Review cost pressures on Safer Staffing including bank, agency and Peripatetic working	Mike Doyle	- Colin Hill - Dawn Eastwood - Andrew Prince - HR/ Safer Staffing group	August 2016 and ongoing		
	• Explore an Overseas recruitment strategy	Recruitment summit	- Sue Hastewell-Gibbs - Colin Hill - Diane Townend - Andrea Horton - Mike Doyle	October 2016		
	• Identify recruitment issues within other disciplines	Recruitment summit	-			

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
4. New ways of working	• Set up a steering group to review band 6 – 8a Nurse Practitioner roles	Kathryn Padgett	- Richard Butterfield - Claire Hartland - Kathryn Hemming - Mike Doyle - Colin Hill	July 2016	- Practitioners Meeting already established	
	• Development of band 4 strategy	Richard Butterfield	- Colin Hill - Kate Henry - Diane Traynor - Recruitment - Richard Butterfield - Nursing Directorate - Jackie Davis/Lynne Nightingale - BDUs	Ongoing	- evolvement of the band 2 strategy group - explore potential cohort with local partnership organisations	
	• Trust wide inter area transfer procedure	Richard Butterfield	- HR Directorate - Colin Hill - Sue Hastewell-Gibbs - Richard Butterfield	September 2016		
	• Utilising the Peripatetic Workforce as a recruitment stream for the organisation	Colin Hill	- Claire Hartland - Sue Hastewell-Gibbs - Diane Traynor	October 2016		

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
5. Communication	• Launch bank plan and communicate strategy for working with staff and external partners	Colin Hill	- Think stakeholder and develop plan for each - Develop a Safer Staffing page on Trust website - Updates of measurable differences - Engagement events to raise awareness - Link with communications Team	October 2016		

Trust Board 20 September 2016
Agenda item 6

Title:	**Transformation programme**
Paper prepared by:	Interim Director of Strategic Planning and Contracting
Purpose:	The purpose of this report is to provide assurance to Trust Board on the delivery of the Transformation Programme. Trust Board is asked to note the progress and the next steps in each project. There are no new risks arising from this programme which currently require escalation to Trust Board.
Mission/values:	The Transformation Programme is one way in which we ensure that we improve and aim to be outstanding so that our services are ready for tomorrow. In delivering the Transformation Programme it is essential that we keep our focus on putting people first and in the centre. At the present time several of the transformation projects are at the stage of consulting with colleagues about new roles and ways of working. This reminds us of the importance of our value to be respectful, honest, open and transparent.
Any background papers/ previously considered by:	Trust Board receives quarterly updates regarding the delivery of the Transformation Programme. The most recent updates prior to this one was received by Trust Board in June 2016
Executive summary:	The main areas of note from the Mental Health transformation work stream are as follows. • The acute and community project has now completed staff consultation about the change of roles resulting from the new model of care. The transition into the new ways of working (e.g. Core and Enhanced pathways) will now take place and will be implemented by April 2017. • There remains an outstanding issue with regard to the medical staffing model. This will be resolved through further conversations in September, and may result in a reduction in the level of efficiency gains made across the Business Delivery Unit. • The rehab and recovery project has successfully trialled the community support model, and discussions are ongoing with the CCG to enable this to be strengthened and embedded. Castle Lodge has not been required for over a year now, and out of area beds for equivalent placements have not been required. However: • In Kirklees and Calderdale the Rehab project is moving at a slower pace, and will be reviewed with commissioners imminently. In relation to the Learning Disabilities work stream, strong progress has been made in relation to both inpatient provision and implementation of community teams. • All colleagues in LD services have now transitioned to their new teams and roles. The focus is now on team-based Organisational

	Development to adopt the new ways of working required to help people remain as independent as possible • Work with commissioners to agree pricing and risk/ reward in relation to inpatient provision has concluded, • This project is on track to conclude implementation in Q3 and move into post-project benefits realisation tracking in Q4. The general community transformation work increasingly reflects the movement towards the creation of an accountable-care system in Barnsley. • Key tests in the next two Quarters will relate to the integrated care pathways for diabetes and respiratory, and also around local collaboration on intermediate tier services.
Recommendation:	**Trust Board is asked to NOTE the progress and the next steps in each project.**
Public session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Transformation Update

Agenda Item 5 Trust Board (public session) 20th September 2016

James Drury – Interim Director of Strategic Planning and Contracting

James.drury@swyt.nhs.uk 07768120982

Table of Contents

1. Acute and Community Mental Health 5
1.1 The purpose of this project is to: 5
1.2 Staff Consultation Process 5
1.3 Implementation Phase 5
1.4 Lead Director Commentary (Karen Taylor) 7
2. Rehabilitation and Recovery 7
2.1 The purpose of this project is to: 7
2.2 Progress to Date: 8
2.3 Lead Director Commentary (Karen Taylor) 9
3. Older People's Mental Health 9
3.1 The purpose of this project is to: 9
3.2 Progress to Date: 9
3.3 Lead Director Commentary (Karen Taylor) 10
4. Early Intervention in Psychosis 10
4.1 The purpose of this project is to: 10
4.2 Progress to date 10
5. Barnsley Administrative Services 12
5.1 The purpose of this project is to: 12
5.3 Next Steps: 12
6. Barnsley Therapy Services Review 13
6.1 The Purpose of this project: 13
6.2 Progress so far: 13
6.3 Next Steps: 13
7. Barnsley Community Nursing Transformation 13
7.1 The Purpose of this project: 13
7.2 Progress so Far: 14
7.3 Next Steps: 14
8. Integrated Pathways for Diabetes Services and for Respiratory Services 14
8.1 The Purpose of this project: 14
8.2 Progress so Far: 15
8.3 Next Steps: 16
9. Barnsley Intermediate Care Services 16
10. Barnsley 0-19 Service Transition 16
10.1 Lead Directors Comments: 17
11. Specialist Adult Learning Disability Services 18
11.1 The purpose of this project is to: 18
11.2 Progress to Date: 18
11.3 Next Steps: 19
11.4 Lead Directors Comments: 19
12. Appendices 20
12.1 General Community Summary Highlight Report 20
12.2 Learning Disability Summary Highlight Report 25
12.3 Mental Health Summary Highlight Report 28

1. Acute and Community Mental Health

1.1 The purpose of this project is to:

- Ensure care is delivered in the least restrictive and most empowering way possible, with more people being supported at home.
- Reduce the need for admission to hospital or the need for Intensive Home Based Treatment as an alternative to admission.
- Minimise the potential of people being subjected to multiple assessments and reduce the number of hand offs between teams.
- Provide effective, evidence-based treatments to reduce and shorten distress and disability.
- Promote recovery based approaches.
- Support people to stay well in primary care through collaborative working and shared care arrangements.

1.2 Staff Consultation Process

- Staff consultation process has concluded and the formal response has been provided to all staff
- There remains an outstanding issue with regard to the medical staffing model. This will be resolved through further conversations in September, and may result in a reduction in the level of efficiency gains made across the Business Delivery Unit.
- A further meeting is to be held between the BMA, HR and the project clinical lead to ensure all their concerns have been addressed following recent correspondence from the BMA.

1.3 Implementation Phase

- The implementation phase has now commenced. BDU Implementation Teams have been established to lead the transformation at a local level
- With leadership and oversight provided by the Transformation Implementation Group, work will be undertaken within BDUs to support the behaviour change that will be necessary for effective mobilisation and planned reduction in overall caseload. This involves:
    - Supporting staff to develop new ways of working (i.e. transition of people back to primary care or co care

with primary care, when it is appropriate)
    - Working with Consultants to develop caseloads of about 100, with caseload support from other disciplines
    - Establishing multidisciplinary working within teams as routine practice
    - Ensuring focus on promoting recovery

- In addition the following work will be required during implementation:
    - Carry out the caseload review to ensure only those patients needing a secondary care intervention are retained on caseloads
    - Work with local GPs to ensure patients can be safely discharged back into the community and provide assurance there's a rapid route back into treatment, if needed
- The phasing of activity within the implementation stage is as follows:
    - June to September
        - Completed communications with individual colleagues regarding the personal impact of the new model on their role
        - Agreement of redeployment moves between teams
    - September to April - Create new teams and commence mobilisation
    - By 1st April 2017 – Fully live with new model across the Trust and budgets reduced by Finance
- Reviews of benefits realisation and of clinical risks identified through the Quality Impact Assessment process will take place throughout implementation and thereafter at 3, 6 and 12 months post-implementation to ensure project objectives have been met and to identify any further efficiencies which can be delivered once the teams are embedded in new cultural practices
- Beyond the implementation of the proposed model, it has been identified through the consultation period that there are additional opportunities to create a richer skill mix in some services through the development of new clinical roles. This work is being picked up through the workforce planning cycle

- Benefits that will be tracked include:
  - Tracking release of efficiencies by 1st April 2017.
  - Improved service user experience – with work now underway to review historical sample of complaints and compliments against the NICE Quality Standard for Service User Experience in Mental Health, against a sample taken post-transformation of services
  - reduced waiting times, reduced waiting times for psychology
  - Improved staff satisfaction, including staff retention rates, staff sickness rates, more consistent clinical caseloads
  - Complaints will also be reviewed with the aim of ensuring that these do not increase whilst going through transformation
  - Improved quality – reduced Serious incidents, reducing the amount of time a patient spends on complex pathway), Reduced MHA assessments and admissions, fewer ward admissions

1.4 Lead Director Commentary (Karen Taylor)

Good progress continues to be made with one key issue remaining in relation to Barnsley medics, and how many should be included in the future established model (which includes medics within the BDU but outside the scope of the transformation). A meeting is to be scheduled for September with key people to find a way forward.

2. Rehabilitation and Recovery

2.1 The purpose of this project is to:

- Ensure that the Trust's mental health rehabilitation and recovery services support people needing longer term rehabilitation support as part of their recovery to live in their own community.
- Ensure that where specialist in-patient facilities are required these services are clearly focused on recovery and as close to home as can be achieved within efficiency and quality parameters.
- Achieve greater clarity of purpose for in-patient rehab units.

Currently inpatient units meet a wide range of needs, ranging from respite through to acute step down and long term care.

- Support more people who are currently in placements 'out of area' to move back to their local area and into the community.
- 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 Progress to Date:

- Intensive Community Rehab Support Services now exist in Wakefield and in Barnsley as part of the new community mental health model integrated within existing community teams in the Enhanced Pathway.
- Castle Lodge has now been closed to admissions for approximately a year with no requirement for any alternative in-patient admission within this client group.
- Work is underway in Kirklees and in Calderdale with Commissioners and other providers of accommodation and support to develop appropriate solutions for local populations.
- Profiling work has been undertaken in Calderdale and Kirklees to establish options for the current cohort of people in Lyndhurst and Enfield Down with an expectation of implementation of new models of care over the coming year.
- Clinical discussions have been ongoing with commissioners about the need for beds in the future service model. Kirklees commissioners have a current preference for eight rehab beds within the SWYPFT footprint, with an additional level of security (i.e. locked rehab). Calderdale commissioners continue to have a preference for local services to operate without NHS beds. Related issues that are being explored include appropriate care for people subject to the Mental Health Act and in relation to the use of Community Treatment Orders. The quarterly partnership board is meeting on 23 September and will focus on future requirements for a local rehab unit.
- There have been underlying differences of views on the future level of need for NHS rehab beds across the SWYPFT footprint. These have led to some delay in overall progress. However, with clarity on the number of future beds and level of need they will support, faster progress should be made

over the coming months.

- All commissioners support the need for enhancing community rehab services to reduce the ongoing need for beds.

2.3 Lead Director Commentary (Karen Taylor)

The local authority in Kirklees has changed its position on the future of Enfield Down and there is now no longer a short term requirement to return the building for Local Authority use. In the coming period a stock-take will take place to review progress and achievements to date, clarify current scope and changes from original brief, along with establishing appropriate actions to take the work forward.

3. Older People's Mental Health

3.1 The purpose of this project is to:

- Ensure that older people's mental health services are as effective and efficient as possible, with an optimal mix of community and inpatient provision; and the right capacity and capabilities to meet the needs of service users including both dementia and functional mental health need; with clear links to physical healthcare provision to support holistic care.
- Opportunities have been identified for productivity gains in community services, and for more care to be provided in the community, which in turn will support efficiency and quality enhancement in inpatient settings.
- Ensure that models of care can cope with future demographic pressures
- Build on opportunities for integrated and holistic care e.g. through Vanguard projects and the Kirklees Care Closer to Home contract.

3.2 Progress to Date:

- The discovery phase has been completed including identification and quantification of the opportunity for productivity gain, though work with Meridian Productivity.
- Co-design workshops have been well attended by colleagues and stakeholders representing a range of perspectives. Information from the workshops is now being used to inform design activity.
- Memory and community mental health pathways formed the first phase of design work up to the end of July 2016. Further

workshops have now been held that have focused on the intensive support model, the inpatient pathways and outcomes, through August and September 2016.

- Conversations are being held through September with commissioners to establish their current position and consider how this might impact on the transformation.
- Views and information gathered will then be fed into a SWYPFT event on 28 September, which will consider preferred options.
- Work through October to December will include the detailed design of preferred options, establishing standard operating procedures and a business case.
- Jayne Gilmour, who had previously worked on the LD Transformation Project, has now taken a project lead role, with John Keaveny being the lead Deputy Director.

3.3 Lead Director Commentary (Karen Taylor)

Progress is being made on designing suitable options and conversations with commissioners are planned to establish a better understanding of differences in commissioner arrangements across the patch. This will then inform the scope and options for the changes.

4. Early Intervention in Psychosis

4.1 The purpose of this project is to:

- To performance manage rapid admission to Early Intervention in Psychosis services (EIP) through a new waiting times target (50% in 14 days),
- To ensure our EIP teams meet the new NICE based standard ((Centre for Creative Quality Improvement (CCQI) audit).
- To re-develop their EIP services to the new standard and report performance to Monitor by April 2016 (in line with new national policy)
- The new standard is accompanied by new recurrent national funding for EIP. The Trust is entitled to a share of £40M of new investment in 2016/17. A further £70M of new funding for EIP has been announced as part of the 5yr Forward Implementation Plan (17-21).

4.2 Progress to date

- National funding was made available in April 2016 to all CCGs but some of this was initially utilised for other priorities.
- Overall, good progress has been made to secure funds required

to deliver the new model but some funding gaps still remain. The trust has agreed to fund the gap in 16/17

- The Trust has good EIP services in all of its localities but the new standard represents a considerable development challenge for all of our teams.
- NHS Improvement (Monitor), NHS England and the Trust Development Agency (Tripartite) are now monitoring Trust and CCG preparedness, planning and implementation.
- A Trust-wide project group is meeting regularly - design phase project plan completed.
- A detailed workforce plan and risk analysis, including proposed interim plans and the financial risk where funding isn't fully established was re-presented to EMT and approved:
  'Recognising the high profile of the EIP model and the potential impact on the Trust if new standards are not achieved, it is recommended that recruitment commences across all BDUs to staff to the proposed delivery model'.
- In the next period we will:
  - Continue to work on 17/18 funding plans where it is not yet confirmed
  - Continue recruitment, training and workforce development activity
  - Review of referral pathways and protocols in relation to Mental Health Minimum Data Set (MHMDS) reported performance
  - Review and implement a realisation plan for mandated outcome measures and local outcome measures/benefits.
  - Detailed delivery planning work with locality teams and attendance at key meetings (2 days per week from September)
  - Review of operational policies and development of Trust-wide Standard Operating Procedures
  - Preparation for Accreditation: CCQI Self-Assessment return required by end of September.
  - Further work on information system development including MHSDS reporting, Patient Tracking Lists, Outcomes and Benefits Realisation.

5. Barnsley Administrative Services

5.1 The purpose of this project is to:

- This project is remodeling the inpatient and reception administration functions across Barnsley BDU's main sites (Kendray and Mount Vernon Hospital) to reduce inefficiencies and duplication.
- This will provide an administrative service that is flexible and responsive with provision from 8.30am to 7pm at each location.
- It will also create clearer career development pathways and apprenticeship opportunities.

5.2 Progress so Far:

- Briefing meetings with the staff groups affected and consultants/staff grades regarding secretary posts and staff affected took place in June/July, and this helped to clarify the options which were subsequently presented to the General Community Transformation Work Stream Board. Staff communication has been added to the intranet and via weekly bulletin.
- An updated options paper was submitted to the General Community Transformation Board in July and approval was given for the project to continue.
- Formal staff consultation was undertaken in August 2016. The changes proposed do not require any redundancies, and are achieved through integration of several functions at each location. This will enable administrative support to be provided over a longer period of each day to improve customer service and match service user needs. In addition operational efficiencies have been achieved in the management of postal communications across the Barnsley BDU.

5.3 Next Steps:

- Implement the changes to staff roles and locations following successful completion of consultation. All changes to be complete by.
- Work with finance to verify the contribution that this project will make to Cost Improvement Plans.
- Progress a further review of senior admin posts including

managerial support and business managers. This will be concluded by the end of Q3

- Undertake an analysis of utilisation and staff roles at the large number of community buildings across the Barnsley estate to identify further efficiencies. This work is scheduled for Q4.

6. Barnsley Therapy Services Review

6.1 The Purpose of this project:

- The purpose of this project is to establish Therapy clinical centres with appropriate satellite clinical provision.

6.2 Progress so far:

- Three mini administration hubs (New Street, Mount Vernon and Physiotherapy Outpatients) are now in place.
- Demand and capacity modelling of current service provision has been undertaken aligned to the work of the CCG review of MSK pathway.
- Work progresses for SystmOne clinical recording system to provide full clinical functionality across all therapy services. This has a dependency on other priorities within the IM&T programme

6.3 Next Steps:

- This project is in effect complete, within the current terms of reference. There are however ongoing improvements and learning in preparation for an end-to-end pathway review of the Musculoskeletal (MSK) speciality and a new integrated service specification by Barnsley Clinical Commissioning Group (CCG) which is expected in the next few months with the new service to be delivered from April 2017.

7. Barnsley Community Nursing Transformation

7.1 The Purpose of this project:

- The purpose of this project is to ensure the right person, right contact, and right time; and to equip more patients to self-care
- Better integrate community nursing and care navigation teams.
- Establish a clear operating framework working in defined

localities which align with primary and social care.

- This is being developed in conjunction with local commissioners in response to a new community nursing service specification which aligns community nursing with primary care and place based collaborative working.

7.2 Progress so Far:

- Transformation workshop events were held in June where ideas for the new neighbourhood model were discussed with staff, partners and service users.
- The Neighbourhood Delivery Model was finalised and has since been agreed with the Commissioner in July. This will allow for teams wrapped around local groups of GP practices, which promotes visibility, and enables more people to remain in their own home
- The project has progressed with roll-out of core assessment across Community Nursing Services (CNS). This allows for a more flexible use of MDT resources and supports care closer to home and enables services users to tell their story once with single assessments and single care plans.
- Developed an approach to workforce modelling and demand and capacity analysis that can be used by managers to flex deployment of resources – supporting a more responsive service.
- Agreed a competency framework following CCG recommendations, and staff engagement.

7.3 Next Steps:

- Agree and finalise the Community Nursing workforce modelling prior to formal staff consultation on change of roles in support of the Neighbourhood Delivery Model
- Carry out Organisational Development work to support the implementation of the Community Nursing specification

8. Integrated Pathways for Diabetes Services and for Respiratory Services

8.1 The Purpose of this project:

- New integrated pathways are being developed with local partners Barnsley Hospital NHS Foundation Trust and Barnsley Healthcare Federation.

- The new pathways will support revised contracts to incentivise providers to collaborate to help people with long term conditions to stay well, and to reduce hospitalisation.
- This is part of the movement towards an accountable-care system for Barnsley. It will improve outcomes for people with long term conditions through;
    - More help for self-care, and condition specific management education and peer support
    - Faster access to the right help, closer to home, through an integrated MDT wrapped around primary care, a single point of access for GP and other professionals to refer into
    - Less hospitalisation – through admission avoidance with an on-sire respiratory hub, telehealth monitoring and a step up option through a flexible expert team working with local MDTs. Shorter lengths of stay also supported with early supported discharge initiatives

8.2 Progress so Far:

- Provider Partnership steering group established
- SWYPFT and Barnsley Hospital NHS Foundation Trust have agreed to jointly provide project management support to both projects to aide progression and governance.
- Key clinical work streams associated with the delivery of both service specifications have been established and all subgroups are making progress with implementation plans and actions assigned
- Demand and Capacity modelling is being refreshed and mapping of current and future pathways is in progress.
- Submission of a joint bid to the Pioneer Programme to support both programmes of work
- Established joint communications and engagement group
- Commenced options appraisal for a Single Point of Access for Diabetes Service
- Ashville Medical Practice identified as pilot practice to undertake analysis of Diabetes practice lists.
- Commenced drafting of business case for type 1 Diabetes education provision

- Insulin Pump Peer review has been undertaken and feedback incorporated into implementation plan

8.3 Next Steps:

- Benchmark current services for diabetes and for respiratory against NICE (National Institute for Health and Care Excellence) guidelines
- Type 1 Diabetes Education - Prepare business case to present at Provider partnership group
- Diabetes update to GPs at forthcoming BEST event in September and Respiratory (COPD) update in November.
- Complete Demand and capacity modelling in Barnsley Hospital NHS Foundation Trust and SWYPFT for all services
- Complete future pathway design in Q3, and then implement quick wins by Q4 such as early discharge arrangements, and revised approach to long term home oxygen provision.
- Financial modelling and associated contractual arrangements will be addressed in Q4, with aim of implementing full future pathways from Q1 2017

9. Barnsley Intermediate Care Services

- The CCG has welcomed SWYPFT's suggestion to work with them and other local healthcare providers to co-produce an intermediate Care services specification
- Memorandum of Understanding has been drafted and submitted
- The internal intermediate care project team have commenced preparatory activities and scoping work in preparation for co-production specification design

10. Barnsley 0-19 Service Transition

- The current contracts with Barnsley Metropolitan Borough Council for the provision of School Nursing and 0-5 Health Visitor services in Barnsley by SWYPFT are to expire on 30 September 2016.
- The Barnsley BDU Senior Management Team holds weekly internal transition team meetings and fortnightly transition board meetings with Barnsley Metropolitan Borough Council (BMBC) colleagues to support the transfer.

- Various work streams such as Estates, IT, Service, Finance and Human Resources, are progressing to ensure that the services are transferred in a safe and effective manner. The Trust's PMO is providing project management and governance support to the service transfer via the General Community Transformation Board. A summary update report on the 0-19 service transition has recently been submitted to EMT.
- SWYPFT are working with BMBC to formally consult with staff and transfer staff contracts to BMBC under the TUPE transfer of undertakings Regulations.
- The Community Service Manager for 0 – 19 services is having weekly service meetings and spending time with BMBC to discuss service requirements. A few spin off TAGs have been established such as CHIS, Data and Information, Customer Services, Health & Safety, Risk and Incident reporting to progress clinical work streams.
- Contingencies are being put in place to alleviate the level of risk in relation to clinical governance and patient safety during the transition, for example, associated with staff leaving the services, and the Trust has supported the requirement and development of an urgent risk share agreement.

10.1 Lead Directors Comments:

In the context of the general Community Services Contract for 2016/17, the majority of Community Services are subject to Commissioner-led Review as part of the Service Development and Improvement Plan (SDIP). This is in addition to internal Trust-led projects.

11. Specialist Adult Learning Disability Services

11.1 The purpose of this project is to:

- Provide timely and effective specialist health services for people with learning disabilities who need extra help to live safely
- Improve the 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

11.2 Progress to Date:

- The Learning Disabilities Transformation project has now implemented the new teams in every locality, and this represents a significant element of the implementation of the project
- Provision is now being made for the tracking of benefits realisation to be incorporated into service performance management, and ongoing oversight of clinical and operational matters identified through the Quality Impact Assessment process.
- Community health team hubs have been established in each locality and are working on specific locality action plans to finalise the transition. These local plans represent the implementation of new ways of working, plus team development activities to embed the new service model in practice
- Following the completion of a third round of service user and carer engagement events over the summer a full report of service user engagement is being produced and will be used to help teams focus their local plans.
- Agreements have been reached with existing commissioners for the planned and pre-booked purchasing of bed capacity within the Horizon Centre assessment and treatment facility. It has been agreed with commissioners that the new inpatient service specification can commence following the end of the bespoke individual placement at the Horizon Centre.
- Barnsley CCG has agreed to commission one bed within the Horizon Centre assessment and treatment facility. This is a

new development which creates more equitable access for service users and supports a sustainable funding model for the Horizon Centre.

- There are ongoing discussions with commissioners regarding community specifications and pricing schedules, and the setting of KPIs to enable a comparable service delivery model to be in place across all localities.
- Final adjustments are being made to internal management arrangements such as data migration and new cost centre recoding onto the RiO clinical system in preparation for shadow reporting to CCGs in quarter 4 of 2016/17.

11.3 Next Steps:

- Finalise contract negotiations with Commissioners and setting of KPIs in relation to the new community model
- Continue to implementation transition plans in each community health team hub
- Finalise data management activity in preparation for commencement of “shadow period” of data capture
- Make final adjustments to mechanisms for tracking benefits realisation and continue monitoring of the clinical and operational KPIs identified through the Quality Impact Assessment process.

11.4 Lead Directors Comments:

The programme is nearing formal transition from implementation into business as usual service delivery and benefits realisation. In the next Quarter it is expected that a formal request will be made to the Programme Board (EMT) to transition from project implementation into benefits tracking.

However the variation in offer across the districts remains a challenge and will require careful negotiation to minimise clinical variation. The associated challenge of improving the quality of the data is also essential to completion of the longer term benefits realisation ambition.

The team can be proud of the achievements to date, particularly considering the recent CQC results for LD services.

12. Appendices

12.1 General Community Summary Highlight Report

General Community Work stream			
Report Date:	29 July 2016	**Period Covered:**	July 2016

Progress Against Plan	Costs and Benefits	Engagement/ Communication	Key Risks
Amber	*Amber*	*Green*	*Amber*

1. Update

General Update
In response to the future possibilities created through the application of ideas such as multi-specialty community provider and accountable care systems, this work stream has adapted to reflect changing priorities.

2. Progress Against Plan

Administrative Services:

Activities Completed this Period

- Submission of revised options paper went to GCTB in June 2016 and circulated for comments.
- Briefing meetings with both consultants/staff grades regarding secretary posts and staff affected in phase 1 and directly with staff affected in phase 1 of the project. Staff communication has been added to the intranet and via weekly bulletin.
- Sought a solution with estate for management of postal services in Barnsley BDU
- GCTB, meeting held on 27/07/16, discussed options paper and agreed that consultation with staff affected by Phase 1 could commence on 1 August 2016.

Activities or Milestones Scheduled for Next Period

- Rotas developed to ensure cover up to 7.00 pm at Mount Vernon Hospital.
- Estates solution to accommodation issues, e.g. reception areas
- Staff within phase 1 consultation to commence on 1st August
- Management of post services in Barnsley BDU to be transferred to estates on 1st August
- Communications and engagement strategy moving forward
- Finance to clarify position regarding project savings and review CIP
- Progress Phase 2 (Senior Mgt) and Phase 3 (Community) in line with Community Nursing Review / Integrated Pathway developments (MCPs)
- Stock take in community buildings to commence.
- Work with IT and telecommunications to resolve issues such as Fax provision, record storage and scanning.

Therapy Services:

Activities Completed this Period

- The Children's Therapy service has relocated from rented Acorn Centre in Grimethorpe to Mount Vernon Hospital.

- Agile kit has been provided to Children's therapy staff.
- Three mini administration hubs (New Street, Mount Vernon and Physiotherapy Outpatients) are now in place

Activities or Milestones Scheduled for Next Period

- An end-to-end pathway review of the Musculoskeletal (MSK) speciality and a new integrated service specification by Barnsley CCG is expected in the next few months with the new service to be delivered from April 2017. A Therapy Services project team will be established to undertake a discovery review of current service provision aligning to the work of the CCG.
- Measuring benefit realisation ongoing
- Ongoing demand and capacity modelling
- Work progresses for SystmOne full clinical functionality across all therapy services.

Community Nursing Services: Community Nursing Specification

Activities Completed this Period

- Progressed with roll-out of core assessment across Community Nursing
- Held a CNR Transformation event for staff and partners
- Agreed the Neighbourhood Delivery Model
- Undertook appraisal of District Nursing workforce modelling management tools including visit to Stockport
- Final sign off of competency framework following CCG recommendations
- Work has been undertaken on the staff engagement plans to support Organisational Design work.
- CCG approval of progress being made in establishing outcomes for the Community Nursing Review CQUIN

Activities or Milestones Scheduled for Next Period

- Agree and finalise the Community Nursing workforce modelling and JD/PS to support the Neighbourhood Delivery Model
- Finalise the bespoke staff engagement plan
- Carry out OD work including courses to support the implementation of the CN specification
- Finalise the strategic communications plan
- Formulate system processes to support data flow of Outcomes 1-3 to CCG
- Agree the specification for a bespoke workforce modelling management tool

Community Nursing Services: Integrated Pathways (MCPs) for Diabetes Services and for Respiratory (COPD) Services

Activities Completed this Period

- New integrated pathways are being developed with local partners Barnsley Hospital NHS Foundation Trust and Barnsley Healthcare Federation – TOR and MOU now signed off by all providers and Provider Partnership steering group established.
- SWYPFT and BHNFT agreed to jointly provide project management support to both projects to aide progression and governance.
- Established key clinical work streams associated with the delivery of both service specifications – all 11 subgroups are making progress, implementation plans and actions assigned.
- Refreshed Strategic Mobilisation Plan for both service specifications
- Submission of a joint bid to the Pioneer Programme to support both programmes of work
- Established joint communications and engagement group
- Commenced drafting of options appraisal for a Single Point of Access for Diabetes Service

- Ashville Med Practice identified as pilot practice to undertake analysis of Diabetes practice lists.
- Commenced drafting of business case for type 1 Diabetes education provision
- Demand and Capacity modelling refreshed and gaps identified for both services
- Commenced mapping of pathways for Service Specifications

Activities or Milestones Scheduled for Next Period

- Diabetes SPA – Prepare business case to present at Provider partnership group
- Undertake Insulin Pump Peer review and incorporate feedback into implementation plan
- Benchmark current services for diabetes and for respiratory against NICE guidelines
- Type 1 Diabetes Education - Prepare business case to present at Provider partnership group
- Diabetes - Prepare update for presenting to GPs at forthcoming BEST event in September
- Complete Demand and capacity modelling in BHNFT and SWYPFT for all services
- Complete mapping of current pathways
- Commence mapping of future pathways
- Seek ways of Engagement with GPs from within and/or outside GP Federation

Intermediate Care Services

Activities Completed this Period

- The CCG has welcomed SWYPFT's suggestion to work with them and other local healthcare providers to co-produce a specification.
- MOU drafted and submitted
- The internal intermediate care project team held an initial meeting on 29 July to commence preparatory activities

Activities or Milestones Scheduled for Next Period

- Attend stakeholder event scheduled for August
- Continue preparatory and scoping work in preparation for coproduction specification design

0 -19 Services

- The current contracts with BMBC for the provision of School Nursing and 0-5 Health Visitor services in Barnsley by SWYPFT are set to expire on 30/09/16.
- The Barnsley BDU Senior Management Team holds weekly internal transition team meetings and fortnightly transition board meetings with BMBC colleagues to support the transfer.
- Various work streams such as Estates, IT, Service, Finance and HR, are progressing to ensure that the services are transferred in a safe and effective manner.
- SWYPFT have commenced consultation to formally transfer staff contracts to BMBC under the TUPE Regulations.
- Staff engagement sessions have been held and 1:1 meetings have been offered. A FAQ section has been added to intranet page and regular staff updates are being provided.

3. Variations from Achieving Outputs or Target

Admin Project:

The project has been split into a phased approach to enable the limited resources to focus on progressing the Inpatient & Reception merger as phase 1.

Therapy Services:
Wider Transformation project on hold until an accommodation solution can be sought – ongoing discussions with Estates team continue.

4. Engagement/Communication Activities

Included in section 1: Project updates

5. Current Issues/Decisions Required

0-19 services:
Safe delivery of services during transition as staffing numbers have reduced owing to vacancies and staff leaving the service. BMBC have agreed to temporary recruitment to certain posts. Weekly monitoring of the situation is being undertaken.

Therapy Services:
The requirement for full clinical functionality across all services on SystmOne has been escalated to BDU agile working group and IM&T for inclusion as a priority into roll out plan for 2016.
Estates solution required.

Admin Services:
Sufficient estate provision to accommodate staff relocating to Kendray as part of GC/ MH reception has been raised and discussions with estates team continue.

Community Nursing Services:
Business continuity linked to recruitment and workforce changes – associated work streams will not in the interim address this issue.

- Remodelling of integrated pathways is not representative owing to lack of Primary Care involvement
- Extremely tight timeframes have been set by CCG, placing significant pressure on clinicians and workloads to implement the new specifications and create the new services required
- Integrated pathways require the creation of a framework for sharing data/patient info and system interoperability
- Integrated pathways require the creation of a framework for sharing financial and contractual information and system interoperability
- No additional funding has been provided via the CCG to support any of the new ways of working.

6. Work Stream Resourcing

	Therapies Services	Children's services	Admin and Clerical	Health and Wellbeing	Community Nursing
Lead Director	Sean Rayner	Sean Rayner	Sean Rayner	Sean Rayner	Sean Rayner
Deputy Director Lead	Sue Wing	Sue Wing	Sue Wing	Sue Wing	Sue Wing
Clinical Lead	Keith Sands	Kathryn Padgett	Keith Sands	Keith Sands	Keith Sands
Project Manager	Bob Senior	Michele Tudor	Pat Hunter	Gill Stansfield	Andrea Dauris

Lead Director Comments

12.2 Learning Disability Summary Highlight Report

Learning Disabilities Work stream

Report Date:	29 July 2016	Period Covered:	Jun - July 2016

Progress Against Plan	Costs and Benefits	Engagement/ Communication	Key Risks
Amber	*Amber*	*Green*	*Amber*

7. Update

The Learning Disabilities Transformation project is now nearing a key transition point between implementation of changes to services and the realisation of benefits arising from those changes.
Provision is now being made for the tracking of benefits realisation, and ongoing oversight of clinical and operational matters identified through the Quality Impact Assessment process.

8. Progress Against Plan

Activities Completed this Period:

- Final stages of 3rd round of engagement events took place in Calderdale and Barnsley
- The specification for Inpatient is now agreed with current commissioners in Wakefield and Kirklees. Kirklees and Wakefield CCG's have reduced their block contract in total from 8 to 5 beds (2 Wakefield and 3 Kirklees).
- Barnsley agreed to block purchase one bed and have signed up to the Inpatient pricing schedule.
- The community specification has been signed up to by Wakefield and Kirklees.
- Wakefield and Kirklees CCGs have agreed to a protocol for use between CCG's who block contract when they wish to use each other's vacant beds.
- Commissioners have agreed to activity reporting commencing in Quarter 4.
- A date for implementation of the new service offer has been agreed with Kirklees and Wakefield. New structures in Calderdale and Barnsley are ready subject to agreed dates for implementation.
- Nursing resources in Wakefield LA have transitioned back into community services.
- The Trust has served notice on the current contract with Caring for You. From 1st December 2016, the contract will terminate and the Trust will have no further responsibility for this service. No funding will be withdrawn from SWYPFT in 16/17.
- Continued roll out of integrated pathways across Calderdale and Kirklees.
- Community Health Team Hubs have been established in Calderdale and Kirklees, clinical staff are now working with agile kit.

Activities or Milestones Scheduled for Next Period

- PMO to update the engagement report and submit to the August meeting of LDTB
- It has been agreed with Kirklees CCG that the inpatient contract will be varied to reduce to 3 beds as soon as occupancy reduces to 3 beds, at which point the contract with Barnsley can commence. It has been agreed with Wakefield CCG that the contract cannot be varied until the current inpatient (who is blocking 4 beds) moves to a new placement.
- Contract meeting with Kirklees CCGs, including setting of KPIs, has been scheduled for 23/08/16
- Continue to seek agreement with Calderdale CCG and Barnsley CCG on the community service specification and pricing schedule.
- Continue to seek agreement with Barnsley CCG to a protocol for use between CCG's who block contract

when they wish to use each other's vacant beds.
- Make final adjustments to internal management arrangements for spot purchasing of inpatient beds.
- Support transition of transport contract to Kirklees
- Set up timescales for using new cost centres across associated Finance, P&I, RIO, and ESR systems and resources required to support case load and clinic data migration.
- Continue to work on roll out of integrated pathways across the Trust
- Manage the transition of health care assistants back into community services from Wakefield LA.
- The Trust to serve notice on the continence product contract with Kirklees and support service transition to new provider.
- Manage transition to Wakefield Community Hub and implementation of agile working.
- Resolve location issues regarding Barnsley Community Hub with BMBC.
- Finalise recruitment for all vacant posts, including the new investment from Kirklees.
- Finalise benefits realisation framework and incorporate into service performance management

9. Variations from Achieving Outputs or Target

- Engagement & Consultation – there has been one complaint – it has been evidenced that there has been no engagement going back to 2013 for this individual. An apology has been provided to the family of the SU and to date he has not been back since he was sent the last communication.
  Communications team is to work with the LD service to produce a communications plan to ensure that there is regular engagement with SU/Carers and other Stakeholders as the service moves into business as usual.
- The LD transformation project was scheduled to move into business as usual by July 2016. At the June meeting of the LDTB it was considered that the issues yet unresolved are still part of transformation and therefore the LDTB should not be stood down as yet. The next LDTB meeting is scheduled for 24th August at which consideration will be given as to whether a recommendation to EMT for when the Transformation Board should cease operations will be made.
- The ongoing negotiations with commissioners and delays to service implementation have meant the project continuing beyond the LD Project Manager's tenure. To minimise impact, the management of the project was handed over to the General Service Manager on 1st July, with support of a LD locality project manager.

10. Engagement/Communication Activities

See progress in section 2.

11. Current Issues/Decisions Required

- The new model highlights disparities in funding and service provision between each CCG area. The senior level finance team are continuing to seek agreement to a service model and pricing schedule with Calderdale and Barnsley to enable comparable service delivery model to be in place across all localities.
- Proactive operational planning required to mitigate risk relating to reduction in block purchase and management of spot purchase inpatient service offer.
- Ongoing arrangements are in place to effectively support an individual placement via a bespoke package at the Horizon Centre. Additionally, learning from this situation is being shared with commissioners via the Transforming Care Partnership.
- The model is not resourced to provide Continuing Health Care Assessments (Decision Support Tool (DSTs)), yet it appears that Wakefield LA want SWYPFT to complete DSTs, with the added issue of a waiting list for the DST assessments even though it appears that they are not included in the service specification. The service requires the resource currently utilised for this function to implement the new service structure, and will fail to meet some elements within the new community specification if the DST work has to continue. The

service is working with colleagues to assess clinical and financial risks associated with this and determine a way ahead with Wakefield CCG.

- Owing to the delay in service implementation, the expected "shadow year", crucial in allowing time to capture data on caseload activity and mitigating the risk of loss of income and reduction in service quality, has currently been reduced to a quarter, with expected data capturing commencing in quarter 4 of 2016/17. This may require renegotiating with the Commissioners for an extension to the period of shadowing to enable more meaningful data reporting to be undertaken.

12. Work Stream Resourcing

	Specialist Adult Learning Disabilities
Lead Director	Tim Breedon
Deputy Director Lead	Vacant – currently supported by Carol Harris, Director
General Manager	Jane Smith
Clinical Lead	Tom Jackson
Project Lead	Jane Smith
PMO Programme Manager	Sharon Carter

Lead Director Comments

The programme is nearing formal transition into implementation through the BDU delivery system. Benefits realisation work is progressing well and is planned for the next, and possibly final, programme board in August.
The variation in offer across the districts remains a challenge and will require careful negotiation to minimise clinical variation. The associated challenge of improving the quality of the data is also essential to completion of the longer term benefits realisation ambition.
The team can be proud of the achievements to date, particularly considering the recent regulatory visit and operational challenges.

12.3 Mental Health Summary Highlight Report

Mental Health Work stream

Report Date:	8 Jul 2016	Period Covered:	June 2016

Progress Against Plan	Costs and Benefits	Engagement/ Communication	Key Risks
Amber	*Amber*	*Amber*	*Amber*

13. Update

General Update:

- Rehab and Recovery – Conversations remain ongoing about the future use of the Enfield Down site in Kirklees and we are seeking confirmation in writing from the council in relation to their future intentions for the building. Consideration will then be given to closing Enfield Down to new referrals, depending on future intentions. Conversations are now required to establish what a future bed base might look like and where it might be as Kirklees Commissioner have indicated a preference for commissioning 8 'locked' NHS beds in a future model. Positive feedback at the Wakefield Clinical Cabinet Meetings to proposals to reinvest in enhanced community services.
- Older People – Task and finish groups are ongoing. The memory pathway has been agreed and process mapping of the functional / community pathway has taken place. Work is ongoing to establish where current contracts / commissioning intentions dictate that services operate in a certain way and where there is scope to agree best practice approaches. The meridian follow up visit has been held and found some positive developments but also areas for improvement.
- Acute and Community: Provisional sign off of A&C consultation by EMT (sign off now received following information provided to Dr Berry)
- EIP: No issues in hitting the 14 day target. 50% new funds agreed for Calderdale and Kirklees CCGs for 15/16. Wakefield CCG has provided some new funding but a shortfall remains.

14. Progress Against Plan

Acute and Community

Activities Completed this Period

- Meeting (8th June) with Kirklees and Calderdale medics to discuss the issues raised during formal consultation period.
- Pre-EMT meeting with Dr Berry, Tim Breedon, Kate Henry and Alan Davis to discuss and final issues from A&C consultation
- Meeting with BMA (22nd June) to discuss consultation outcome.
- All evidence of issues and queries have been gathered in one place and the response to the consultation has been drafted.

Activities or Milestones Scheduled for Next Period

- Formal consultation response to be sent to all staff
- Staff affected by consultation to receive letter from HR detailing the next steps for them
- Allocating staff into teams based on preference forms.

- Where required, arranging competitive interviews for medic posts
- Reshape steering group to become lead on implementation
- Creation of meetings/ groups to support implementation at steering level and in BDUs

Rehab and Recovery:

Activities Completed this Period

- In Wakefield, a presentation was agreed with the commissioner and given to the clinical cabinet group, with the proposal for enhanced community services agreed in principle.
- Kirklees BDU has updated the audit of service users in Enfield Down and mapped options for each service user.
- Planning for further workshops in Calderdale is taking place.

Activities or Milestones Scheduled for Next Period

- Meetings to be held in Calderdale to further develop project plans.
- Wakefield BDU to work with the commissioner to co-produce service specification.
- Clarity to be sought in Kirklees on likely timescale to move people from Enfield Down to appropriate alternative accommodation.
- Communication with staff and service users planned for 8 July, with follow-ups to be held when there is new information.
- Time out planned for 13 July at Enfield Down to consider grouping existing service users, out of area placements, process mapping, managing gradual closure of beds and planning implementation of enhanced community resource, process mapping and putting a plan in place for the changes over time.
- Task and finish group to be set up to start considering a locked rehab option on the SWYPFT footprint (if agreed by the board).

Older People:

Activities Completed this Period

- Memory pathway now agreed.
- Further workshops held focussing on community / functional pathway.
- Project team attended meetings to support Wakefield pre memory tender process, including request for P&I data on memory pathway which could hopefully be replicated for other parts of the trust.
- Meridian follow on visit held and actions required have now been considered.

Activities or Milestones Scheduled for Next Period

- IHBT pathway modelling planned for 6 July
- Outcomes workshop to be held to define expected benefits and outcomes from activity.
- Investigation into contracts, what's fixed and what the project can focus on.
- Review of project team to ensure appropriate clinical, project management and leadership is available.

EIP

Activities Completed this Period

- Design phase project plan completed
- Tripartite Review of Preparedness: Calderdale and Kirklees CCGs are still 'Partially Assured' and Barnsley and Wakefield are now 'Fully Assured'. Barnsley has been highlighted as an example of good practice.
- Strong performance in relation to the waiting times target (Unify):

- We continue to develop the system for reporting data via the more stringent MHSDS method.
- Workforce: Training and development sub-group meeting regularly.
- Some recruitment commenced but this needs accelerating
- Kirklees update and review meeting rearranged. Meetings held Calderdale and Barnsley CCGs in May. Wakefield planned for 05/07/16.
- 2016/17 project delivery plan drafted.

Activities or Milestones Scheduled for Next Period

- Detailed workforce plan and risk analysis, including proposed interim financial support for Calderdale and Huddersfield/N Kirklees, will be re-presented to EMT.
- Confirm 16/17 funding plans for Wakefield
- Recruitment, training and workforce development
- Review of referral pathways and protocols in relation to MHSDS reported performance
- Outcomes: Mandated outcome measures and local outcome measures/benefits realisation plan to be reviewed and implemented
- Clinical Lead to commence detailed delivery planning work with locality teams and attendance at key meetings
- Review of operational policies and development of a Trust-wide SOP
- Preparation for Accreditation
- Further work on information system development including MHSDS AWT reporting, Patient Tracking Lists, Outcomes and Benefits Realisation.
- Finalise 2016/17 project delivery plan

15. Variations from Achieving Outputs or Target

Acute and Community
Some slight delay due to need to provide further evidence following EMT sign-off, but the project now has agreement to move on into implementation.

Rehab and Recovery:
Plan for Kirklees to be developed in July – Calderdale might be August due to difficulties in bringing providers together.

Older People
None

16. Engagement/Communication Activities

Acute and Community:
Response to staff consultation and ongoing individual activity to support staff through planned changes.

Older People:
In the next period the project will start planning communications and external engagement with stakeholders for late summer / autumn.

Rehab and Recovery
Initial meetings with staff at Enfield Down planned for 8 July. Service users and carers will be

updated on the same day via their dialogue group. Plans are being made to keep these groups updated over the coming periods.

17. Current Issues and Risks

Acute and Community

Reducing risks around operationally holding posts and using agency staff as steps are now being taken to recruit into vacancies in the new system.

Rehab and Recovery

Future Bed Base in Kirklees – we are awaiting confirmation in writing from the council about future intentions for the Enfield Down site and consideration will then be given to emerging risks.

Whether we can provide a comprehensive, safe and efficient rehab service based upon a standalone locality model or whether a more corporate solution needs to be found across the three localities.

Older People

Risk of key services going out to tender in Wakefield could be reducing as commissioner is considering a provider alliance approach and this might now be delayed until December, whilst in Barnsley, this has also reduced following the memory services pilot and agreement.

However, this risk needs to be considered with the risk around local specifications tying BDUs into particular processes.

Resources to support the transformation through 2016/2017 – with limited funds in the next financial year the PMO is currently working with clinical lead to take activities forward.

BDU's service improvements continue working to different timescales, local specifications, and governance meaning that different models are delivered in each BDU.

Risk that future model doesn't deliver financial savings.

EIP

Two key uncertainties remain: (1) Funding for Wakefield is unresolved and Calderdale and Kirklees funding is not confirmed beyond the end of this year, and (2) How NHS Improvement will performance manage NICE concordance.

18. Work Stream Resourcing

	Acute and Community	Older People	Rehab and Recovery
Lead Director	Karen Taylor	Karen Taylor	Karen Taylor
Deputy Director Lead	John Keaveny	Andrea Wilson	Andrea Wilson
Clinical Lead	Arasu Kuppuswamy	Subha Thiyagesh	N/A
Project Manager	Cheryl Thorne	Vacant (cover by Ryan Hunter)	Vacant (unlikely to be recruited centrally)

19. Lead director comments

Acute & Community – we are moving on and establishing detailed plans for implementation.

Rehab and Recovery – risk in relation to Enfield Down and the council's future intentions for the building. We are still awaiting confirmation from the council in writing about this.

Older People – new team structures are being put in place and the project will soon focus on further staff and stakeholder engagement.

Trust Board 20 September 2016
Agenda item 7.2

Title:	**Finance Report – Month 5 2016/17**
Paper prepared by:	Director of Finance
Purpose:	To inform the Board of the financial position of the Trust as at month 5 2016/17. To raise any specific financial risks and issues with the Board and enable a discussion to take place regarding any actions that need to be taken to address these risks and issues.
Mission/values/objectives	Improve our use of resources
Any background papers/ previously considered by:	Not applicable
Executive summary:	• Net surplus of £0.2 million in August, which was marginally ahead of plan. Year-to-date surplus including Sustainability and Transformation Fund (STF) of £1.6 million, which is also ahead of plan. • Cumulative surplus excluding STF is £1 million which is £0.4 million ahead of plan. • Full year forecast remains at £0.5 million pre-STF and £1.85 million post-STF. • Risks relate to under achievement of cost improvement programme (CIPs), agency expenditure and achievement of Commissioning for Quality and Innovation (CQUIN). • Agency expenditure continues to be above both plan and forecast. August agency spend was highest in the year at close to £1 million. Total pay costs remain under plan. • Cost improvements delivery to date of £3.9 million, which net of contingency is £0.3 million lower than plan. Specific issues relate to use of out of area bed placements and a range of other Trust-wide schemes. • Cash remains relatively healthy at £28.6 million. • Capital expenditure of £3.8 million year-to-date. Most significant expenditure on Pontefract Hub (£1.8 million) and Fieldhead non-secure (£0.8 million). • 2017/18 financial plan to be produced by December 2016. It will be a two-year plan. Trust Board updates will be provided in October and November, with sign off at the December 2016 meeting.
Recommendation:	**Trust Board is asked to REVIEW the finance report and DISCUSS any issues arising from it.**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 5 (2016/2017)

www.southwestyorkshire.nhs.uk

With **all of us** in mind.

Contents

1.0	Strategic Overview	1.0	Key Performance Indicators	3
		1.1	Financial - Continuity of Service Risk Rating (COSRR)	4
		1.2	Benchmarking Information	5
2.0	Statement of Comprehensive Income	2.0	Summary Statement of Income & Expenditure Position	6
		2.1	Cost Improvement Programme	8
3.0	Statement of Financial Position	3.0	Balance Sheet	9
		3.1	Capital Programme	10
		3.2	Cash and Working Capital	11
		3.3	Reconciliation of Cash Flow to Plan	12
4.0	Additional Information	4.0	Better Payment Practice Code	13
		4.1	Transparency Disclosure	14
		4.2	Annual Plan 2017 / 2018	15
		4.3	Glossary of Terms & Definitions	16

1.0 Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative
1	NHS Improvement Risk Rating	4	4	The Trust has planned for and delivered a risk rating of 4 in August 2016. It is currently forecast that a rating of 4 will be maintained throughout the year.
2	Surplus	£1.6m	£1.9m	Surplus to date is £1.0m pre Sustainability and Transformation Funding (STF) and £1.6m post STF. Delivery of the pre STF surplus (£0.4m better than plan) ensures continued recovery of the STF which equates to £0.6m to date. The forecast remains challenging and actions continue to ensure that this is secured.
3	Agency Cap	£4.3m	£7.3m	Agency spend in August was close to £1m, some £260k above forecast. Reasons currently under investigation. All BDUs advese to forecast.
4	Cash	£28.6m	£22.3m	The Trust cash position is £1.7m less than plan at month 5 due to invoice timing and associated cash receipt assumptions. Forecast remains in line with plan. Overall the cash position remains strong.
5	Capital	£3.8m	£12.1m	Capital expenditure is marginally ahead of plan as at August 2016. The forecast remains that the capital programme will spend in line with plan for the full year.
6	Delivery of CIP	£3.9m	£9.2m	Year to date CIP delivery is £0.3m behind plan. Overall the forecast position includes £0.83m of red rated schemes which is a further reduction from the previous month.
7	Better Payment	97%		This performance is based upon a combined NHS / Non NHS value.

Red	Variance from plan greater than 15%
Amber	Variance from plan ranging from 5% to 15%
Green	In line, or greater than plan

1.1 NHS Improvement Risk Rating

The Trust currently completes a detailed return demonstrating current and future financial performance to NHS Improvement on a monthly basis. This is summarised, as per the Risk Assessment Framework, into a Financial Risk Rating and scored on a range of 0 to 4 (with 4 being the best rating possible).

As highlighted below current performance is either in line with or better than plan for all metrics. The forecast also illustrates the Trust expects to achieve a rating of 4 for the remainder of the year. Successful achievement of this rating is dependant upon delivery of the overall financial plan and therefore mitigation of current risks identified.

				Actual Performance		Plan - Month 5	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	25%	Capital Service Capacity	4.9	4	3.7	4
	Liquidity	25%	Liquidity (Days)	17.6	4	14.9	4
Financial Efficiency	Underlying Performance	25%	I & E Margin	1.7%	4	1.3%	4
	Variance from Plan	25%	Variance in I & E Margin as a % of income	0.4%	4	-0.4%	3
Weighted Average - Financial Sustainability Risk Rating					4		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.

1.2 NHS Improvement Benchmarking

All Foundation Trusts

		Governance Rating			
		No Evident Concerns	Issues Identified	Enforcement Action	Total
Continuity	4	30	1	1	32
	3	24	1	4	29
	2	35	12	24	71
	1	4	1	14	19
	Total	93	15	43	151

Mental Health Foundation Trusts

		Governance Rating			
		No Evident Concerns	Issues Identified	Enforcement Action	Total
Continuity	4	20	0	1	21
	3	13	0	0	13
	2	5	1	2	8
	1				0
	Total	38	1	3	42

As at 17th August 2016 there are 156 licenced Foundation Trusts monitored by NHS Improvement (5 Trusts pending ratings and excluded from this analysis). This includes 42 Trusts classified as Mental Health Trusts by NHSI. This classification includes Mental Health and Community 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.

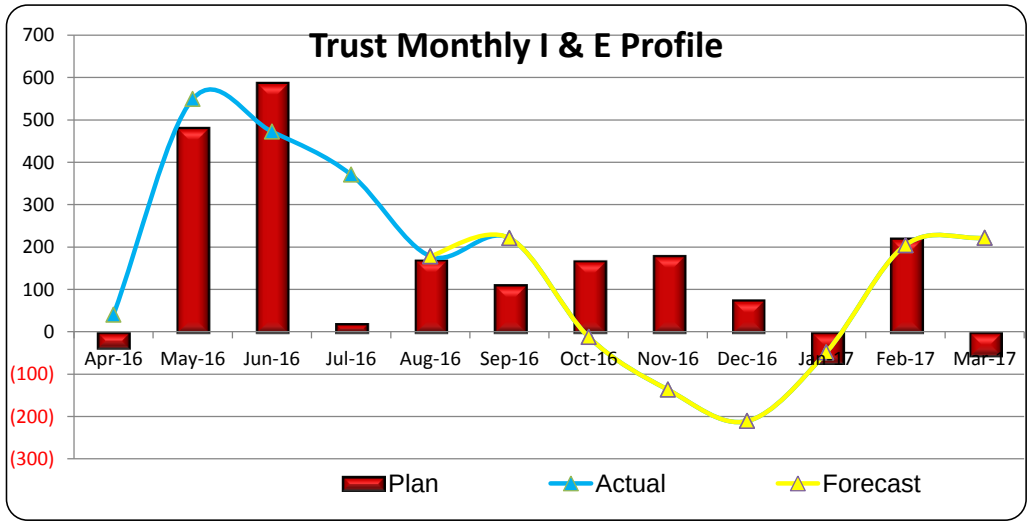
Performance reporting from NHS Improvement incorporates the 156 FTs and 82 NHS Trusts giving a total of 238 provider organisations.

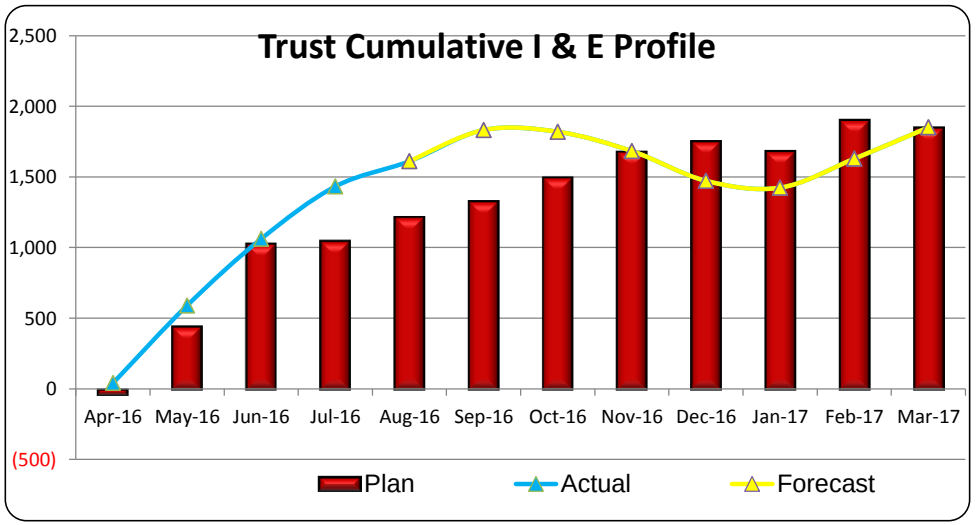
* By early July 2016 214 out of 238 Trusts accepted individual control totals. 185 met Q1 targets and received Q1 STF payments.
* Q1 deficit £461m (£5m better than planned) 153 providers reporting deficit (190 at Q1 15/16)
* Progress on pay bill - £9.8m better than plan. On course to reduce agency costs by £1bn
* Non-pay pressures - drugs and clinical supplies (£44m overspend) driven by both cost and volume
* CIP - £45m short of plan

It is important to note, as NHS Improvement do, that whilst Q1 demonstrates financial progress the provider plan profile has a challenging trajectory for the remainder of the year.

2.0 Income & Expenditure Position 2016 / 2017

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**
				17,884	17,729	(155)	Clinical Revenue	89,873	89,750	(123)	211,865	211,687	(179)
				17,884	**17,729**	**(155)**	**Total Clinical Revenue**	**89,873**	**89,750**	**(123)**	**211,865**	**211,687**	**(179)**
				1,502	1,553	50	Other Operating Revenue	6,244	6,325	81	13,689	13,821	133
				19,387	**19,282**	**(105)**	**Total Revenue**	**96,117**	**96,075**	**(41)**	**225,554**	**225,508**	**(46)**
4,471	4,113	(358)	8.0%	(14,767)	(14,585)	183	Pay Costs	(73,926)	(72,603)	1,323	(172,760)	(172,474)	287
				(3,647)	(3,424)	223	Non Pay Costs	(18,325)	(18,206)	119	(42,700)	(44,027)	(1,327)
				(43)	(410)	(367)	Provisions	1,536	973	(563)	1,795	2,885	1,090
4,471	**4,113**	**(358)**	**8.0%**	**(18,457)**	**(18,419)**	**38**	**Total Operating Expenses**	**(90,715)**	**(89,835)**	**879**	**(213,666)**	**(213,615)**	**50**
4,471	**4,113**	**(358)**	**8.0%**	**929**	**862**	**(67)**	**EBITDA**	**5,402**	**6,240**	**838**	**11,888**	**11,893**	**4**
				(509)	(433)	76	Depreciation	(2,930)	(3,382)	(452)	(7,034)	(7,037)	(3)
				(257)	(257)	0	PDC Paid	(1,283)	(1,283)	0	(3,080)	(3,080)	(0)
				6	5	(1)	Interest Received	31	36	4	75	74	(1)
				0	0	0	Revaluation of Assets	0	0	0	0	0	0
4,471	**4,113**	**(358)**	**8.0%**	**170**	**178**	**8**	**Surplus / (Deficit)**	**1,220**	**1,611**	**391**	**1,850**	**1,850**	**0**





Income & Expenditure Position 2016 / 2017

Trust Surplus Position (Pre and Post Sustainability and Transformation Funding)

The Trust year to date and forecast finance position including and excluding STF funding is highlighted below.

	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k
Surplus (Excluding STF)	658	1,048	391	500	500	0
STF	563	563	0	1,350	1,350	0
Surplus - Total	**1,220**	**1,611**	**391**	**1,850**	**1,850**	**0**

Month 5

It should be noted that the Trust plan for 2016 / 2017 did allow for some non-recurrent measures. To date £0.7m of non-recurrent provision release has favourably impacted the year to date financial performance.

Income - This year to date position includes £180k CQUIN shortfall for Quarters 1 and 2. Quarter 1 is currently in the process of being agreed within Commissioners and Quarter 2 will be confirmed during October 2016. Actions continue to mitigate against this loss of Healthcare income remain broadly in line with plan.

Pay - Despite increased agency costs pay expenditure continues to be less than plan in month (£0.2m). This is due to savings arising from vacancies continuing to exceed the cost of providing backfill such as bank, overtime and agency.

Non Pay - Expenditure has reduced for the second month running and for month 5 is less than plan. This has been driven by reductions in drugs expenditure (when compared to both plan and to that previously forecast) and reductions in travel expenditure.

Other non pay areas to note include that the purchase of additional bed capacity (£0.4m over plan for the year to date) was in line with plan in August 2016.

Forecast

The Trust forecast position is noted above and the focus remains in delivery of the pre STF surplus value (£0.5m) in order to secure STF monies. Forecasts are developed at a detail level with consideration given to other risks and opportunities not explicitly contained within these positions.

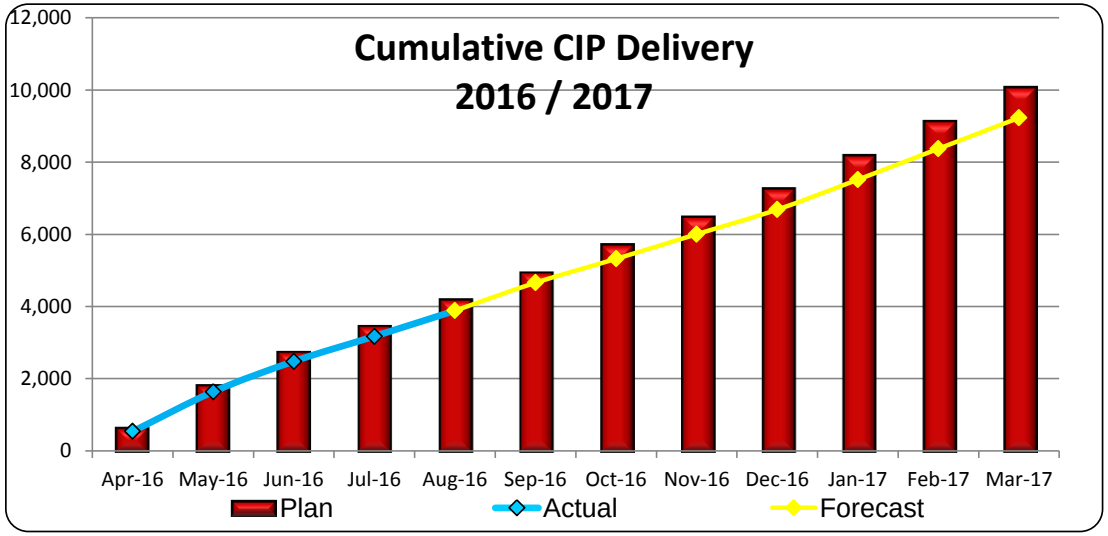
Examples of additional risks and opportunities identified included:

* Risk associated with delivery of CQUIN income
* Additional redundancy cost implications arising from decommissioning of services

Taking both elements into account the Trust is confident that, although very challening, measures will be taken to safeguard the plan surplus of £0.5m.

2.1 Cost Improvement Programme 2016 / 2017

	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	661	662	662	665	679	695	717	723	728	863	891	891	3,330	8,837
Target - Non Recurrent	9	509	259	49	49	49	49	49	49	49	49	49	877	1,223
Target - Monitor Submission	670	1,172	922	715	729	744	766	772	777	912	940	940	4,207	10,059
Target - Cumulative	670	1,842	2,764	3,479	4,207	4,952	5,718	6,490	7,267	8,179	9,119	10,059	4,207	10,059
Delivery as planned	452	1,446	2,147	2,686	3,236	3,868	4,441	5,026	5,612	6,416	7,247	8,079	3,236	8,079
Mitigations - Recurrent	0	6	9	14	18	22	26	30	34	38	42	46	18	46
Mitigations - Non Recurrent	84	185	323	473	630	768	854	947	1,040	1,061	1,083	1,105	630	1,105
Total Delivery	**536**	**1,637**	**2,479**	**3,172**	**3,883**	**4,659**	**5,320**	**6,003**	**6,686**	**7,515**	**8,373**	**9,230**	**3,883**	**9,230**
Shortfall / Unidentified	135	205	285	306	324	293	398	487	581	664	747	830	324	830



The Trust identified a CIP programme for 2016 / 2017 which totals £10.1m. This was subject to an external review.

As per previous months progress continues to secure in year delivery of CIPs. Red rated schemes have reduced from £1.3m to £0.8m and the impact of this has been included within the Trust forecast I & E position.

In year delivery includes non recurrent elements and as such the recurrent impact of the Trust CIP delivery for 2017 / 2018 has been shared internally within the Trust and mitigations and actions are being developed to support the Trust annual planning process.

3.0 Balance Sheet 2016 / 2017

	2015 / 2016 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	114,134	115,577	114,805	1
Current Assets				
Inventories & Work in Progress	190	190	190	
NHS Trade Receivables (Debtors)	2,623	2,723	1,052	2
Other Receivables (Debtors)	7,541	5,467	8,182	3
Cash and Cash Equivalents	27,107	30,287	28,632	4
Total Current Assets	**37,461**	**38,667**	**38,057**	
Current Liabilities				
Trade Payables (Creditors)	(6,430)	(7,130)	(5,455)	5
Other Payables (Creditors)	(3,481)	(4,764)	(4,361)	5
Capital Payables (Creditors)	(785)	(785)	(1,441)	5
Accruals	(8,576)	(10,276)	(9,406)	6
Deferred Income	(789)	(789)	(714)	
Total Current Liabilities	**(20,060)**	**(23,743)**	**(21,377)**	
Net Current Assets/Liabilities	**17,401**	**14,923**	**16,680**	
Total Assets less Current Liabilities	**131,535**	**130,500**	**131,484**	
Provisions for Liabilities	(10,017)	(8,327)	(8,355)	
Total Net Assets/(Liabilities)	**121,518**	**122,173**	**123,129**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	19,446	19,446	19,446	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,361	54,016	54,971	7
Total Taxpayers' Equity	**121,518**	**122,173**	**123,129**	

The Balance Sheet analysis compares the current month end position to that within the annual plan. The previous year end position is included for information.

1. The capital programme is ahead of plan however the current balance sheet fixed asset value is behind plan due to the level of depreciation charges for the year to date.
2. NHS Debtors remain very low and any issues continue to be proactively chased in preparation for the month 6 agreement of balances exercise. £128k, covering a number of debtors, is older than 90 days and focus remains on collection.

3. Other debtors on the balance sheet consists of £3.6m accrued income, £2.2m prepayments and non NHS debtors £2.2m. Non NHS debtors is in line with plan for August 2016 and accrued income continues to be reviewed.

4. The reconciliation of actual cash flow to plan compares the current month end position to the annual plan position for the same period. This is shown on page 13.

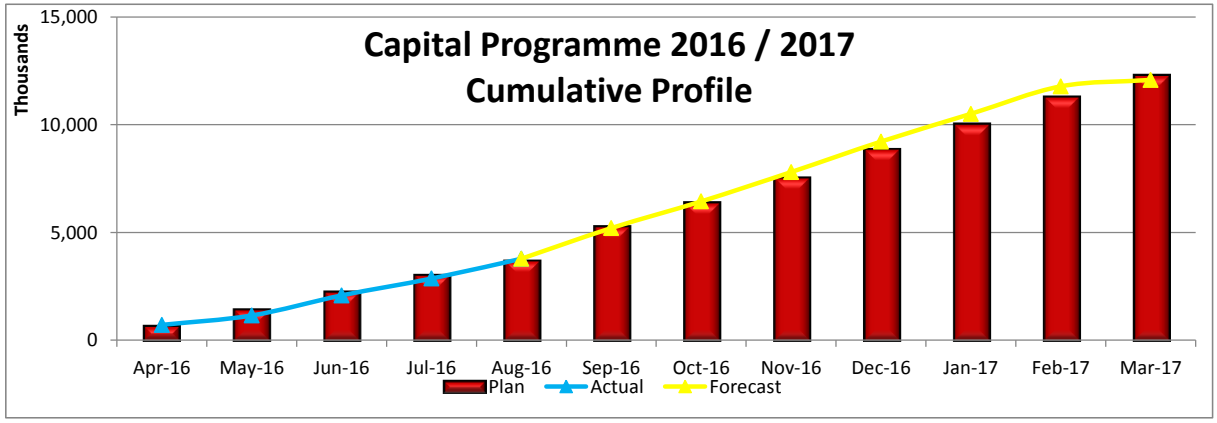
5. Creditors remain lower than planned. A number of NHS invoices have not yet been received and as such are included within the accruals value.

6. Accruals are lower than planned.

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

3.1 Capital Programme 2016 / 2017

	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	2,050	625	539	(86)	2,185	135	
IM&T	1,210	446	114	(332)	1,187	(23)	3
Total Minor Capital & IM &T	**3,260**	**1,071**	**653**	**(418)**	**3,372**	**111**	
Major Capital Schemes							
Pontefract Hub	1,795	1,611	1,794	183	1,889	94	4
Wakefield Hub	735	375	378	3	715	(20)	4
Fieldhead Non Secure	4,725	253	847	595	4,725	0	5
Fieldhead Development	1,300	67	6	(61)	1,099	(201)	
Other	498	348	414	67	587	89	
Total Major Schemes	**9,053**	**2,653**	**3,439**	**786**	**9,016**	**(37)**	
VAT Refunds	0	0	(312)	(312)	(312)	(312)	2
TOTALS	**12,313**	**3,724**	**3,780**	**56**	**12,076**	**(237)**	



Capital Expenditure 2016 / 2017

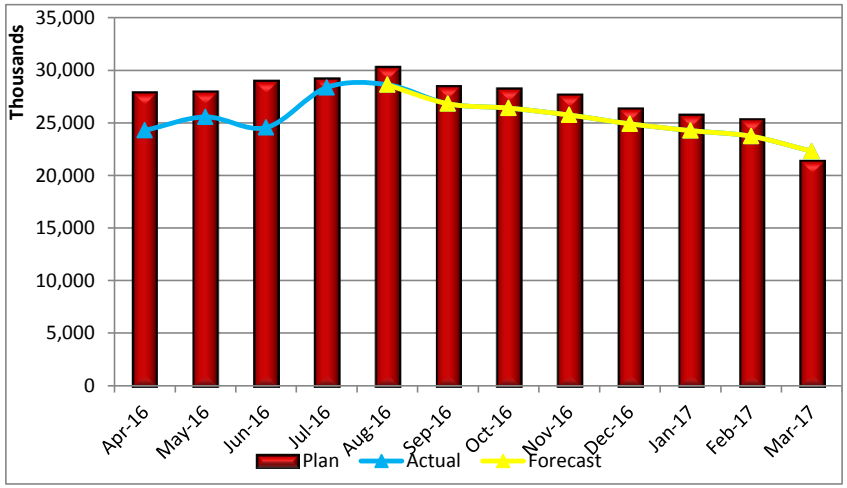
1. The Trust capital programme for 2016 / 2017 is £12.3m and schemes are guided by the Trust Estates Strategy.
2. The year to date position is £0.1m ahead of plan (2%). Excluding the benefit arising from successful VAT recovery agreed with HRMC this would be £0.4m ahead of plan (10%).
The main areas relate to expenditure ahead of profile for the Fieldhead non secure and Pontefract hub developments. Both schemes are forecast broadly in line with plan and therefore this is currently a timing issue.

3. IM & T plans continue to be developed to ensure that suitable value for money solutions are procured. All schemes remain forecast to be delivered in year.

4. Pontefract and Wakefield Hub will complete in Quarter 3 and overall will be in line with total business case approved expenditure.

5. A Guaranteed Maximum Price has now been agreed for the Fieldhead Non Secure development and work has commenced on site. This is programmed to complete in Q3 2018 / 2019.

3.2 Cash Flow & Cash Flow Forecast 2016 / 2017



	Plan	Actual	Variance
	£k	£k	£k
Opening Balance	27,107	27,107	
Closing Balance	30,287	28,632	(1,654)

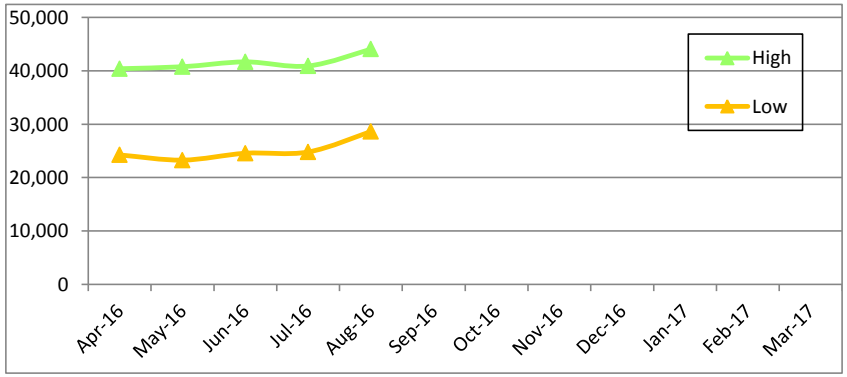
The cash position provides a key element of the Continuity of Service and Financial Efficiency Risk Rating. As such this is monitored and reviewed on a daily basis.

Weekly review of actions ensures that the cash position for the Trust is maximised.

The key cash variance to plan remains higher than planned levels of accrued income. Q1 CQUIN is close to final agreement and work is ongoing with regard to the Q2 position.

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

Interest rates received on cash balances within the GBS account have reduced from 0.25% to 0.14% with effect from 5th August 2016. This will mean a reduced value of interest receivable and this has been reflected in the current forecast position.



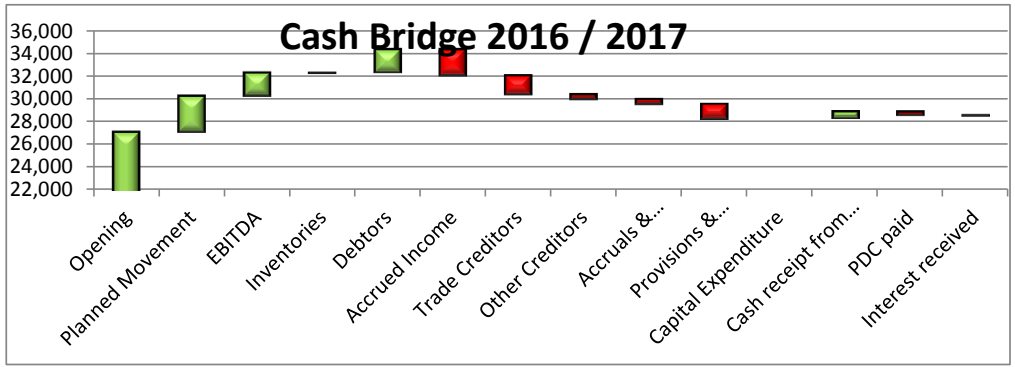
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is:	£44m
The lowest balance is:	£28.6m

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

3.3 Reconciliation of Cashflow to Cashflow Plan

	Plan £k	Actual £k	Variance £k	Note
Opening Balances	**27,107**	**27,107**		
Surplus (Exc. non-cash items & revaluation)	4,189	6,267	2,079	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	2,175	4,221	2,046	2
Accrued Income	0	(2,286)	(2,286)	3
Trade Payables (Creditors)	700	(975)	(1,675)	4
Other Payables (Creditors)	0	(403)	(403)	
Accruals & Deferred income	1,200	756	(444)	5
Provisions & Liabilities	(1,690)	(2,966)	(1,276)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(3,724)	(3,124)	600	
Cash receipts from asset sales	299	0	(299)	
PDC Dividends paid	0	0	0	
Interest (paid)/ received	31	36	4	
Closing Balances	**30,287**	**28,632**	**(1,654)**	



The plan value reflects the April 2016 submission to Monitor.

Factors which increase the cash positon against plan:

1. The overall surplus position at month 4 is ahead of plan. Additionally the non cash element, specifically higher than profiled depreciation charges, is favourable from a cash perspective.

2. Debtors are lower than plan with strong focus on cash collection. Action continues to minimise and supports the cash position.

Factors which decrease the cash position against plan:

3. Accrued income remains higher than planned. Key elements are £0.8m CQUIN, £0.2m STP funding. Teams have been reminded to ensure that invoices are raised in a timely manner and this is reviewed weekly.

4. The value of creditors continue to be lower than planned. The plan had included an assumed impact arising from changes in the Trust financial ledger system which have not materialised.

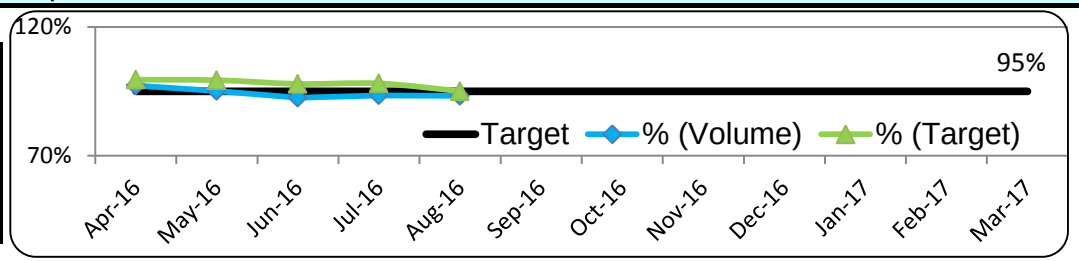
5. Accruals, and assumptions around expenditure commitments remain lower than plan.

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

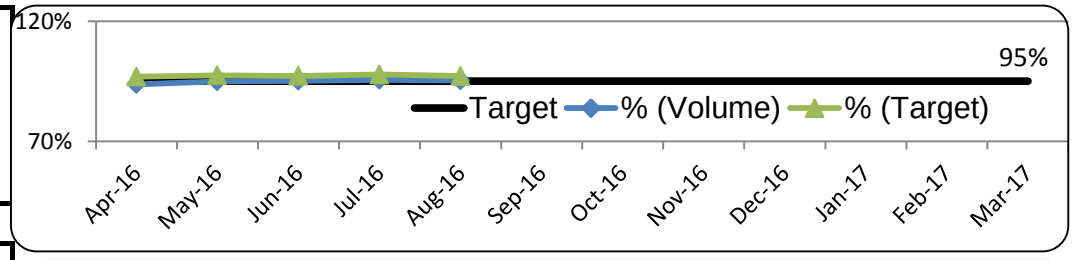
4.0 Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.
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 delivery of the 95% target and identify solutions to problems and bottlenecks in the process. Overall year to date progress remains positive.

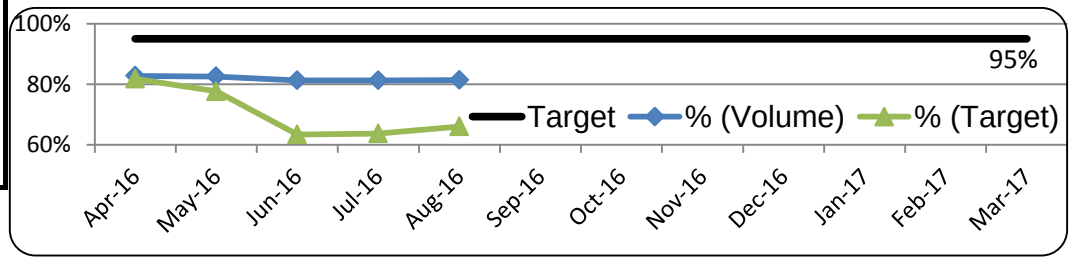
NHS	Number %	Value %
Year to July 2016	93%	98%
Year to August 2016	93%	95%



Non NHS	Number %	Value %
Year to July 2016	96%	98%
Year to August 2016	95%	97%



Local Suppliers (10 days)	Number %	Value %
Year to July 2016	81%	64%
Year to August 2016	81%	66%



4.1 Transparency Disclosure

As part of the Government's commitment to greater transparency on how public funds are used the Trust makes a monthly Transparency Disclosure highlighting expenditure greater than £25,000.

This is for non-pay expenditure; however, organisations can exclude any information that would not be disclosed under a Freedom of Information request as being Commercial in Confidence or information which is personally sensitive.

At the current time NHS Improvement has not mandated that Foundation Trusts disclose this information but the Trust has decided to comply with the request.
The transparency information for the current month is shown in the table below.

Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
23/08/2016	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3006624	208,398
27/07/2016	Drugs	Wakefield	Mid Yorkshire Hospitals NHS Trust	3003615	127,849
20/07/2016	Lease Rents	Wakefield	Mid Yorkshire Hospitals NHS Trust	3002944	120,263
21/06/2016	Drugs	Wakefield	Mid Yorkshire Hospitals NHS Trust	3000132	117,913
20/07/2016	Domestic SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	3002944	88,017
25/07/2016	Drugs	Calderdale	NHS Calderdale CCG	3003415	85,964
29/07/2016	Audit Fees : Statutory	Trustwide	Deloitte LLP	3004194	64,406
25/08/2016	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3007090	56,655
20/07/2016	Utilities SLA	Trustwide	Mid Yorkshire Hospitals NHS Trust	3002944	47,302
14/07/2016	Drugs	Trustwide	Lloyds Pharmacy Ltd	3002303	45,453
02/08/2016	Specialty Registrar (CT1-3)	Trustwide	Leeds and York Partnership NHS FT	3004398	44,707
14/07/2016	Drugs	Trustwide	Lloyds Pharmacy Ltd	3002303	43,625
12/08/2016	CNST contributions	Trustwide	NHS Litigation Authority	3005732	33,986
29/07/2016	Pharmacy SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	3004125	27,035
22/07/2016	Radiology SLA	Wakefield	Mid Yorkshire Hospitals NHS Trust	3003250	26,920

4.2 Annual Plan 2017 / 2018

NHS Improvement have confirmed that by December 2016 Trusts will be required to submit plans covering 2017 / 2018 and 2018 / 2019. The full process and timetable is expected to be confirmed in September / October 2016. This deadline is approximately 3 months earlier than prior years.

Working on the assumption that the deadline is at the end of December 2016 it is planned to bring the Annual Plan to Board for final approval on December 20th 2016.

Working from this assumption other key dates from a financial perspective are:

Trust Board	Confirm national requirements	October 2016
	Update paper - including financial challenge, agreement of assumptions and contract negotiation parameters	October 25th
	Agree updated strategy	November 29th
	Final approval	December 20th
Delivery EMT	Regular monthly updates	Ongoing
	Final approval	December 8th / 15th

Following conformation of national requirements and timetables the finance team, in conjunction with the planning team, will be updating Trust budget setting guidance. This update will include consideration of recommendations provided by Internal audit and will include benchmarking against the processes applied by other NHS Trusts.

4.3 Glossary

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

* Non-Recurrent - an action or decision that has a one off or time limited effect

* Full Year Effect (FYE) - quantification of the effect of an action, decision, or event for a full financial year.

* Part Year Effect (PYE) - quantification of the effect of an action, decision, or event for the financial year concerned. So if a CIP were to be implemented half way through a financial year, the Trust would only see six months benefit from that action in that financial year

* 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. For 2016 / 2017 the Trust were set a control total surplus.

* In Year Cost Savings - These are non-recurrent actions which will yield non-recurrent savings in year. So are part of the Forecast Surplus, but not part of the Recurrent Underlying Surplus.

* Cost Improvement Programme (CIP) - is the identification of schemes to increase efficiency or reduce expenditure.

* Non-Recurrent CIP - A CIP which is identified in advance, but which only has a one off financial benefit. These differ from In Year Cost Savings in that the action is identified in advance of the financial year, whereas In Year Cost Savings are a target which budget holders are expected to deliver, but where they may not have identified the actions yielding the savings in advance.

* EBITDA - earnings before Interest, Tax, Depreciation and amortisation. This strips out the expenditure items relating to the provision of assets from the Trust's financial position to indicate the financial performance of it's services.

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

Trust Board 20 September 2016
Agenda item 7.3(i)

Title:	**Sustainability update**
Paper prepared by:	Director of Corporate Development
Purpose:	To note the activity underway and planned to support the organisation to evidence it operates within the Good Corporate Citizen framework and delivers against Trust strategy.
Mission/values:	The Trust's mission is to enable people to reach their potential and live well in their community. The Trust will not achieve this unless it ensures it operates sustainably in the use of resources and in how it works with local communities. Sustainability in the organisation is defined in its broadest terms as being a good corporate citizen. Sustainable operations support all the Trust's values and delivery of strategic objectives through improving people's health and wellbeing, improving people's experience of services and the efficient and effective use of resources.
Any background papers/ previously considered by:	Sustainability Strategy 2015/16 – 2019/20
Executive summary:	The purpose of this paper is to update the Board on work to integrate sustainability into Trust operations, as defined in the Trust's Sustainability Strategy which runs to 2020. The strategy covers the three national goals: • a healthier environment, including reducing pollution and carbon emissions; • resilience for changing times and climates multi-agency working on local plans and assurance mechanisms; • prevent ill-health, health inequalities and unnecessary treatment taking every opportunity to support people to be independent and manage their own health. And each of the Good Corporate Citizen assessment headings: • energy and carbon management; • procurement; • transport, travel and access; • water; • waste; • designing the built environment and adaptation • organisational and workforce development • partnerships and networks. The Trust is delivering on the agreed Sustainability Strategy and will continue to monitor the actions identified to ensure continued progress against plan. Self–assessment against the Good Corporate Citizen tool will be repeated as soon as green travel plans are in place and delivery of agreed actions underway. The target for improvement will be 5% (a score of 83% against a current score of 78%).
Recommendation:	**Trust Board is asked to NOTE the progress made to date against the areas identified in the Trust's sustainability strategy and to note areas**

	of work being taken forward.
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

Sustainability

Summary report

Trust Board - 20 September 2016

sustainability
Be part of our solution

Director of Corporate Development

September 2016

With **all of us** in mind.

Sustainability Summary Report – September 2016

Introduction

The Trust's mission is to enable people to reach their potential and live well in their community. The Trust will not achieve this unless it ensures it operates sustainably in the use of resources and in the way it works with local communities. The Trust defines sustainability in its broadest terms as being a good corporate citizen.

Community engagement and workforce involvement are the cornerstones to this work and we know we will only succeed if we continue to harness the commitment and support of our staff and volunteers to behave and work in a sustainable way.

Sustainability Strategy

The national strategy for sustainable development for the health and social care system includes 3 goals to aim for by 2020:

- A healthier environment – including reducing pollution and carbon emissions
- Resilience – for changing times and climates – multi-agency working on local plans and assurance mechanisms
- Prevent ill-health, health inequalities and unnecessary treatment – taking every opportunity to support people to be independent and manage their own health, including the use of digital technologies.

The Trust Board approved a five year Sustainability Strategy in June 2015, covering the period 2015/16 – 2019/20. The strategy provides a vision and framework for how the Trust will drive integration of sustainability into its operations and in its engagement with staff, service users and the communities it serves.

The strategy covers the three national goals and each of the Good Corporate Citizen assessment headings. Areas covered include energy and carbon management, procurement, transport, travel and access, water, waste, designing the built environment and adaptation, organisational and workforce development and partnerships and networks.

An implementation plan, developed to support the delivery of the strategy is monitored by the Partnerships Team and evaluated by the Sustainability Project Group, made up of information owners and colleagues with an interest who champion the agenda. The Group adopts a virtual and face to face meeting style as appropriate.

There is much work to do to re-energise staff connection to the agenda in the coming year. A plan is being developed to promote sustainable initiatives, maximising the use of digital technology, particularly i-hub, the Trust's crowdsourcing approach to innovation and through yammer. The Trust's established communications channels will also be used to engage staff and interested stakeholders.

Energy and Carbon Management

The requirement to monitor the Trust's utilities forms part of the Sustainable Development and Carbon Management Plan. This alongside the need to invest in energy efficient improvements and the contribution made through the implementation of the Trust's Estates Strategy (through rationalisation of the property portfolio) indicated an anticipated saving of 26.2% CO2 (Tonnes). An actual saving of 28.76% CO2 (Tonnes) has been achieved.

NHS Carbon Management Plan - 2015-16 Update **(Final Year)**
(source: ERIC return 2015/16 Carbon Trust assessment tool)

	5 yr plan (baseline)	Year 1	Year 2	Year 3	Year 4	Year 5 (final year)	
	CO2 (tonnes) 2010/11	CO2 (tonnes) 2011/12	CO2 (tonnes) 2012/13	CO2 (tonnes) 2013/14	CO2 (tonnes) 2014/15	CO2 (tonnes) 2015/16	Variation on baseline
Stationary	11,515	8,949	9,739	9,511	9,503	8,336	-27.61%
Transport	1,404	1,496	1,460	1,274	1,167	1,127	-19.73%
Further sources	452	427	77	102	90	64	-85.84%
	13,373	**10,873**	**11,277**	**10,887**	**10,761**	**9,527**	**-28.76%**

All the measured emissions have reduced when compared to the base year, with the majority of the reduction taking place on the stationary emissions, which include electricity, gas and water. The 'further sources' emission measurement covers waste.

The actual stationary emission in 2015 -16 reduced by over 1,100 Tonnes CO2 on the previous year. This significant reduction was achieved through a combination of improved heating controls, more efficient lighting and lighting controls and the closure of a number of properties. This included Dean Clough, reduced occupation on the Castleford and Normanton District Hospital and Keresforth sites and the closure of a number of smaller properties as part of the clinical transformation, estates strategy and property rationalisation plan.

The overall position at the end of the 5 year cycle is extremely positive, confirming that with a combination of planning, improved monitoring, deployment of energy efficient improvements, improved waste management and recycling, the Trust has been able to meet national targets and realise the goals set in the Carbon Management Programme.

Procurement

We continue to procure our services using the whole life costing model. We monitor the use of local SME (Small, Medium Enterprises) suppliers and work proactively to maintain and increase engagement with these organisations. Any contracts which are tendered for are conducted via the Trust's e-Tendering portal and are advertised on *"Contracts Finder",* the recommended website for advertising public sector contract opportunities to local community suppliers. In addition, all tenders include a

section on sustainability which requests the submission of a statement from the bidder on their organisations position linked to the Good Corporate Citizen concept.

The main procurement challenges for the coming months include:

- To monitor environmental and sustainability in all goods and service tenders
- To work with suppliers who are environmentally aware and hold the relevant accreditations
- To undertake large contracting exercises
- To identify purchasing Cost Improvement Plans
- To develop skills in the procurement team to enable positive change
- To update the Sustainable Procurement Strategy.

Sustainable Travel & Agile Working

The Trust recognises its responsibilities to contribute to a cleaner environment and is committed to sustainable transport. We are working to reduce the need for staff to bring their personal vehicle to work, to reduce the need to use their vehicle for business purposes and to promote awareness of the benefits of sustainable travel choices and reducing reliance on car travel.

One in five journeys in the UK is linked to the NHS and 17% of the NHS carbon footprint is from travel (3.57 million Tonnes of CO2)l.

Transport emissions have decreased by 19.73% from 1404 to 1127 Tonnes CO2, with 3,735,911 business miles being undertaken in 2015/16, compared to 4,594,983 miles in 2010/11. This represents a decrease of 859,072 miles (the equivalent of travelling to Australia and back over 40 times!). The reduction in business mileage is as a result of improvements in agile working, increases in the use of technology (e.g. video and tele-conferencing, Lync and PC desktop communications alongside other green travel initiatives that offer alternatives to car travel. As well as saving the planet this allows re-investment in front line services.

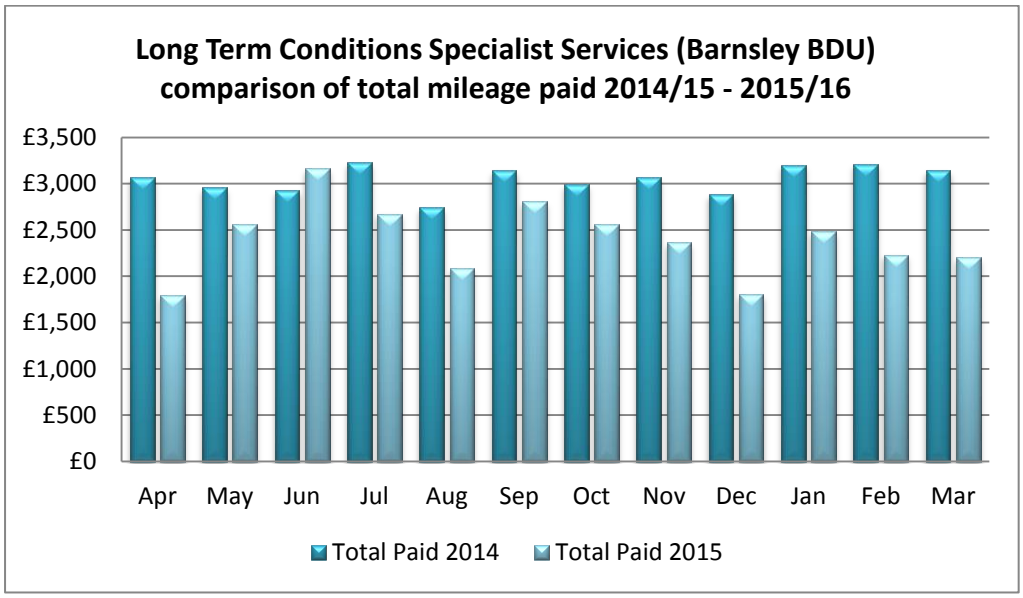
Examples of positive practice in agile working and use of technology:

The agile working mobilisation group implemented the use of Lync / Skype for Business to reduce travel costs. An average month shows nearly 900 business miles avoided, a saving on expenses at public transport rate of over £500 and significant time saved in not travelling to meetings.

Not all clinical services who now work on an agile basis will see a reduction in mileage as clinicians will see more people. Unnecessary mileage has, however, been reduced.

A clinical service in Barnsley has covered the cost of VPN remote access for 15 people through a reduction in travel costs.

The Trust has fitted vehicle tracking devices into a number of Facilities department vehicles. These support reduced fuel and running costs, improved productivity, enhanced customer service, improved health and safety and loan worker protection. The tracking system can record driver behaviour and performance analysis to ensure optimum fuel efficiencies and running costs.



The Trust is developing further green travel plans to minimise the impact of travel on the environment within the context of running an efficient business, which will be presented to the Executive Management Team in the near future. If effective, this will bring environmental, social and health benefits to both staff and to our communities.

The travel plan will ensure:

- A positive corporate social responsibility message, demonstrating good environmental and transport practice
- A reduction in greenhouse gas emissions, contributing to environmental targets both corporately, locally and nationally
- Healthier and more motivated staff
- Improved access to sites for staff, visitors and patients
- Economic and environmental sustainability over time
- Cost/energy savings.

For staff, an effective travel plan should offer:

- Increased travel choices
- Contribute to improved health and reduced stress
- Travel cost savings through cheaper alternatives and car-sharing
- Reduce parking pressure
- Support staff who, out of necessity or choice, do not use a car
- Slow down the growth in car use, especially drivers travelling alone.

For local communities, green travel can enhance the local environment through:

- Reduced congestion and pollution
- Reduced greenhouse gas emissions that contribute to climate change
- A healthier, more attractive environment in which to live and work
- Support for the use of public transport and the development of safe cycling and walking routes will enhance opportunities for all.

The plan will also aim to improve the accessibility of Trust estate, improve road safety on or near sites, preserve valuable land and avoid the costs of providing too much parking.

The objective is to further reduce the number of personal and business miles and increase the use of public transport by 5% by 2020. The plan will include targets and baseline measurement and evaluation.

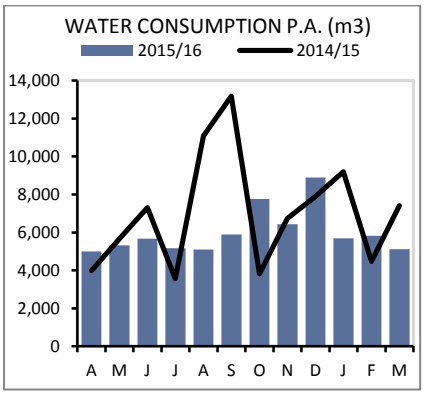
As the Trust's use of buildings and estate changes, site specific plans are developed and the Trust's vehicle fleet reviewed.

Other initiatives include:

- Providing public transport information on the intranet and the Trust's website
- Bike to Work and staff cycle incentive schemes
- Staff invited to join task and finish groups for specific pieces of work, providing a forum to consult staff on the implementation of the Travel Plan and to develop ideas for further improvement.
- Extension to car sharing schemes with Liftshare
- Smarter Driving lessons for staff to reduce fuel and carbon emissions
- Work with local bus companies to provide better public transport links, for example to community hubs.

Water

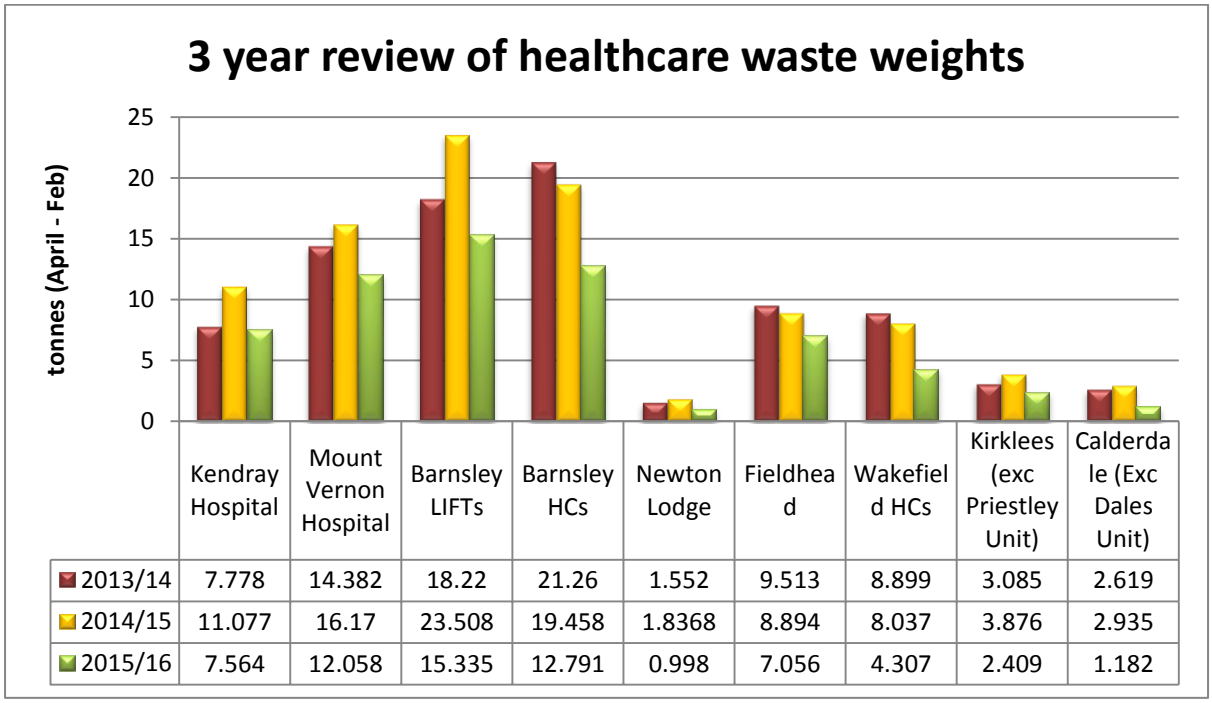
The Trust continued to reduce water consumption using water efficient technologies and continued metering, monitoring and leak detection. Water efficiency is considered in all maintenance, refurbishment and new build projects. Smart meters are installed as standard into building and refurbishment projects.



Waste management

As an organisation we are committed to reducing the amount of waste we produce and how much waste we send to landfill. We are successful in managing our waste

through efficient recycling and waste disposal methods, including energy recovery and conversion to building material schemes.



	Kendray Hospital	Mount Vernon Hospital	Barnsley LIFTs	Barnsley HCs	Newton Lodge	Fieldhead	Wakefield HCs	Kirklees (exc Priestley Unit)	Calderdale (Exc Dales Unit)
2013/14	7.778	14.382	18.22	21.26	1.552	9.513	8.899	3.085	2.619
2014/15	11.077	16.17	23.508	19.458	1.8368	8.894	8.037	3.876	2.935
2015/16	7.564	12.058	15.335	12.791	0.998	7.056	4.307	2.409	1.182

A new commercial waste contract, bringing waste streams under the same contractor is supporting better reporting and monitoring of waste. The contract includes the following work streams:

- Building & general rubble waste
- WEEE waste (Electrical and Electronic Equipment)
- Chemical waste
- Furniture waste
- Garden waste
- General commercial waste
- Recycled waste
- Metal waste
- Confidential waste

The aim is to ensure maximum reduction in waste to landfill, segregation of all waste and efficient disposal.

The Trust's Waste Policy and Waste Procedures are due to be updated to incoporate the significant developments in environmental and waste legislation which have increased the complexity of waste mangement. The Trust complies with all statutory environmental, waste and health and safety legislation.

The waste management team is also introducing a new campaign to raise awareness of the significant changes brought about by the new waste contract and to promote recycling and the need to segregate waste streams correctly. The GRASP campaign has evaluated well in other health settings and raises awareness across 5 areas:

G-Green
R-Recycle
A-Aware
S-Sustainable
P-patients

Food waste

The Department of Health has developed a toolkit containing an overview of the hospital food standards and supporting the development of a food and drink strategy to improve service user experience and ensure value for money. The Trust is using the toolkit to support improved practice in food management, including sustainable procurement of food and catering services. The Trust is also about to pilot a scheme where waste food is used in an energy stream rather than being taken to landfill or down the drains through macerators. This initiative will reduce food wastage further whilst ensuring reuse rather than landfill disposal.

The Trust monitors food waste on a ward by ward basis. Waste monitoring information was recently shared with Birch as part of the review, commissioned by the Trust, into all aspects of facilities management, including catering services.

A snapshot of food waste, collected over a period of one week during the review is shown below.

	Main Meals	Vegetables	Desserts
Fieldhead	30%	42%	20%
Kendray	15%	45%	25%

A number of factors have been identified as contributing towards food waste. Action plans are being developed to address these, which will be subject to ongoing monitoring. These factors include:

- Current food ordering systems and link to assessed requirements
- Current low accountability at ward level for food management / food waste

- Need for improved links between catering services and ward teams
- Impact of service users missing meals (for example where they remain in bed and miss a meal time or go off site at short notice)
- Managers uphold different rules with regard to food wastage. For example, some wards will offer service users second helpings but other wards will not.
- The practice of ordering in takeaway food when food already ordered from catering services (this also results in waste packaging)

Through improved links between catering services and ward teams a number of initiates are supporting a reduction in food waste:

- Snack teas (sandwiches) are produced on takeaway nights for Bretton Centre service users
- Newton Lodge service users prefer a reduced food order on takeaways nights on Fridays and Saturdays
- Work is ongoing to reduce overproduction on teas, without limiting choice for service users
- A more consistent approach to measuring food waste and benchmarking with comparable services.

Designing the Built Environment and Adaptation

The Trust's estates strategy, approved by Trust Board and monitored through the Estates Trust Action Group, is to move from smaller properties, which do not offer a functional space, to purpose built Hubs which offer an optimal environment from which to deliver healthcare. This includes improving high quality green space and biodiversity on our estate, promoting physical health & wellbeing.

Integrating health and sustainable development considerations in our built environment is part of all new build projects and adaptations, with continued investment in energy reduction technologies, renewable energy and future proofing. We work closely with our local strategic partnerships and stakeholders to promote the delivery of health and sustainability outcomes when planning the built environment. We share our strategy with partner organisations and work with local Health and Wellbeing Boards and other partners to ensure that adaptation (the ability to respond in extreme circumstances) is a key part of local planning processes.

The Trust works to the Climate Change Mitigation and Adaptation Plan and BDUs are supported to embed resilience activity into their operations. The Trust aims to be a leading exemplar in the management of major and extreme events and has incorporated the impacts of climate change into the scenarios utilised for testing our plans.

Organisational and workforce development

- The Sustainability Strategy encourages all staff to become 'sustainable aware', to act responsibly in their roles and to understand the actions the Trust is pursuing

to reduce its impact on the environment. This links to the Trust's strategic objective 16/17 to improve our use of resources.

- All communications channels were employed to publicise the strategy, including a film, information sharing and training offers.
- Efforts continue to promote initiatives and schemes which support staff to contribute to a sustainable environment, including Bikes for the NHS, cycle to work schemes, recycling information and best practice updates.
- Staff will be invited to join task and finish groups to scope green travel plans to reduce the use of personal vehicles and the use of vehicles for business purposes, particularly single occupancy.
- All staff are encouraged to be efficient and effective in their use of Trust resources and to adopt agile principles into working practices wherever possible.
- Further staff engagement is planned through the use of digital platforms to promote good practice and invites suggestions for innovative practice in this area.

A range of initiatives have been implemented in support of enabling an agile workforce:

- 58 clinical teams have been supported in becoming agile across Barnsley, Calderdale & Kirklees, Wakefield and Specialist Services BDUs. Typically this involves workshops tailored for individual teams covering the key themes related to Agile Working. Equipment deployment and training is managed alongside this by the Agile Mobilisation Team.
- Additional support has been offered to support services on request, for example the Executive Management Team move to shared working space.
- The Trust currently has 1527 Lync/Skype for Business users able to conduct video and audio calls and conferences, instant messaging and screen sharing.
- The Trust is federated with Wakefield Council, Locala and Kirklees Council which means we can Skype/Lync them by typing a user's email address into Lync to initiate contact
- 1000+ devices have been deployed to agile workers
- Equipment is set up at Priestly Unit to enable clinicians from community teams to join ward rounds and Multi-disciplinary Team Meetings via video conference, saving time and avoiding travel.
- The Trust has provided a range of hot desk / agile working spaces across Trust facilities and provision is subject to continual review.
- Staff drop in sessions were offered prior to the opening of the Laura Mitchell Health and Wellbeing Centre and the CNDH Agile Suite. Further sessions are planned to support the transition of staff to the Wakefield Hub.
- Staff can access training on IT skills to support agile working practices. To date over 100 staff have been supported at bookable sessions across Trust sites.

Partnerships and Networks

The Trust continues to review specialist advice and source best practice in relation to this agenda. The Trust has used the Good Corporate Citizen self-assessment tool to

review performance, with a current assessment of 78%. Further progress against the tool will require the adoption of a green travel plan, which is currently under development by Estates and Facilities for approval by the Executive Management Team. As soon as the plan is in place and delivering on agreed actions, re-assessment will be undertaken. The target for improvement will be 5% - a score of 83%.

Creative Minds

The Trust continues to work to embed creative approaches across the organisation and with our partners to enhance the service offer.

.

Since its launch, Creative Minds has supported more than 250 creative projects in partnership with over 120 voluntary, third sector, not-for-profits organisations and other community groups. It has delivered creative arts, spiritual, sporting and environmentally based group activities to more than 20,000 people. Creative Minds has brought together funding streams from statutory and community sources to deliver these partnership approaches. Being underpinned by the Trust's governance arrangements has given funders the confidence to invest in Creative Minds community projects. These projects have added substantial value to the Trust's overall service offer, by exploring service delivery areas beyond the existing provision and co-creating new and innovative solutions to the issues faced by individuals and communities. All projects are subject to evaluation using outcome and quality indicators and service user reported outcomes measures such as the Recovery Star, the Warwick and Edinburgh Wellbeing Scale and self-reported satisfaction measures. The results are consistently very positive.

Two projects have carried out a social return on investment, which identified that for every £100 invested, a £700 social return on investment was indicated.

Current challenges include the general sustainability of creative partners due to austerity and that they struggle to find matched funding for new projects. Operating as part of the Trust charity presents challenges in attracting funding, and work is ongoing with the Charities Commission to move to linked charitable status.

Spirit in Mind

The Spirit in Mind project will support and add a further dimension to the work already being implemented in the Trust through the Creative Minds Strategy. Building on the success of that model, Spirit in Mind will enable the Trust to significantly extend its partnership working and community outreach and involvement.

The project is still in its initial stages with partnerships being developed between the Trust and a small number of partners as part of a pilot. This follows an event with Huddersfield University and four locality workshops which generated lots of interest.

The pilots will represent the cultural and religious diversity of the areas served by the Trust.

Volunteering

The Trust developed a vision for volunteering to enhance the services we offer to local people. Over the last 12 months the number of volunteers has steadily grown and the Trust currently benefits from 200 people who between them volunteer over 2400 hours a week to support the Trust in a variety of roles, including in Recovery Colleges and in the Expert Patient Programme.

The Trust achieved accreditation against the national Investing in Volunteers standard in March 2016 and we continue to work proactively with NHS England and the national association NAVCO to embed best practice to ensure we offer a positive volunteering experience.

We are innovative in our approach to creating volunteer opportunities. We have recently introduced a pilot, working with forensic services, to enable 2 female service users, detailed under the Mental Health Act, to volunteer in Trust catering services at Fieldhead. In another initiative, young people have also been recruited as volunteers to support staff recruitment activity in our CAMHS services.

Volunteer services are working with BDUs to continue to explore opportunities for volunteer roles and are linking with communities and partners to promote volunteering. This includes both general promotion and targeted activated, for example working with the Women's Action Group in Calderdale to promote links to the BAME community and joint working with NOVA Wakefield.
Challenges in respect of volunteering in the coming months include:

- Continuing to raise the profile of the volunteering function and create new opportunities
- Working with services to identify volunteer opportunities
- Recruitment of volunteers to undertake identified roles
- Improving the ease with which people can volunteer and the support offered with the application process
- Engagement with community groups to promote volunteering
- Explore opportunities to increase use of the volunteer lounge space, including the potential for re-siting same.

Summary / Next Steps

Much work is on-going to deliver on the Trust's Sustainability Strategy and to improve performance against the Good Corporate Citizen framework. Actions will continue to be monitored by the Sustainability Project Group and an update provided to Trust Board on an annual basis.

.

Trust Board 20 September 2016
Agenda item 7.3(ii)

Title:	**Appraisal/revalidation annual board report 2015/16**
Paper prepared by:	Medical Director
Purpose:	The purpose of this paper is to inform Trust Board of progress in achieving satisfactory medical appraisal and revalidation and to support the signing of the Statement of Compliance as required by NHS England.
Mission/values:	Ensuring that all medical staff are fit to practice and up to date supports the Trust's mission to enable people to reach their potential and live well in the community.
Any background papers/ previously considered by:	Not applicable
Executive summary:	132 doctors had a prescribed connection with the Trust as at 31 March 2016. - 94% successfully completed the appraisal process during 2015/16. - The remaining 6% had an agreed postponement in line with the medical appraisal policy. These were approved by either the Associate Medical Director for Revalidation or Responsible Officer as appropriate. 42 revalidation recommendations were required from 1 April 2015 to 31 March 2016. - 41 doctors had positive recommendations made. - One doctor had a recommendation of deferral. The deferral was recommended after the Responsible Officer had consulted with the General Medical Council (GMC) Liaison Employment Advisor. - All recommendations made were upheld by the GMC. One doctor was subject to GMC Conditions of Practice during this period. This was investigated and the case was closed by the GMC with no further action in February 2016. The Trust continues to strengthen its appraisal and revalidation processes. The implementation of the appraisal and revalidation system has been at a cost to the Trust and there are continuing requirements from NHS England to further strengthen a Trust system and ensure the quality assurance of their processes. With the approach of the end of the first five-year cycle, it is anticipated that further pressures, including financial, may become apparent. The Trust currently relies on doctors who are willing to undertake the appraisal role as part of their existing job plans. If the impact of transformation impacts on the doctor's willingness and/or ability to undertake the role of medical appraiser, the Trust would need to consider additional remuneration to support the activity, as occurs in some other organisations. Over the course of recent years, the Trust has provided Responsible Officer functions to Barnsley Hospice. This is an area of ongoing development in order to ensure a robust governance framework and the agreed Service Level Agreement is adhered to. The Trust's statutory duties relating to equality and diversity have been met and an Equality Impact Assessment has been undertaken on the Medical Appraisal Policy which underpins the appraisal and revalidation process.

Recommendation:	**Trust Board is asked to NOTE the report and APPROVE the statement of compliance confirming that the organisation is a designated body as in compliance with the regulations**
Private session:	Not applicable

South West Yorkshire Partnership NHS
NHS Foundation Trust

MEDICAL APPRAISAL / REVALIDATION ANNUAL BOARD REPORT 2015-16

1. Executive Summary

- 132 doctors had a prescribed connection with the Trust as at 31st March 2016.
  - 94% successfully completed the appraisal process during 2015/16.
  - The remaining 6% had an agreed postponement in line with the medical appraisal policy. These were approved by either the AMD for Revalidation or Responsible Officer as appropriate.
- 42 revalidation recommendations were required from 1st April 2015 to 31st March 2016.
  - 41 doctors had positive recommendations made
  - 1 doctor had a recommendation of deferral. The deferral was recommended after the Responsible Officer had consulted with the GMC Liaison Employment Advisor.
  - All recommendations made were up held by the GMC.
- 1 doctor was subject to GMC Conditions of Practice during this period. This this was investigated and the case was closed by the GMC with no further action in February 2016.
- The Trust continues to strengthen its appraisal and revalidation processes.

2. Purpose of Paper

This report is presented to the Board:

2.1. For assurance that the statutory functions of the Responsible Officer role are being appropriately and adequately discharged

2.2. To inform of progress in medical appraisal and revalidation during 2015/16

2.3. To support the signing of the Statement of Compliance (see appendix 6)

3. Background

3.1. 2015/16 was the fourth year of medical revalidation. Launched in 2012 to strengthen the way that doctors are regulated, the aim is to improve the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical profession.

3.2. Each doctor much have a Responsible Officer who must oversee a range of processes including annual appraisal, and who will at five yearly intervals make a recommendation to the GMC in respect of the doctor's revalidation.

3.3. The Responsible Officer is appointed by the Board of the organisation, termed a Designated Body, to which the doctor is linked by a Prescribed Connection.

3.4. Provider organisations have a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards / executive teams will oversee compliance by:

3.4.1. Monitoring the frequency and quality of medical appraisals in their organisation

3.4.2. Checking there are effective systems in place for monitoring the conduct and performance of their doctors

3.4.3. Confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors

3.4.4. Ensuring that appropriate pre-employment background checks (including pre-employment for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3.5. Compliance with the Responsible Officer Regulations forms part of the CQC inspection.

4. Governance

4.1. Trust's Revalidation Team

- Responsible Officer – Dr Adrian Berry
- Associate Medical Director (AMD) for Revalidation – Dr Gerard Roney
- Business Manager, Medical Directorate – Julie Hickling
- Medical Directorate Administrator – Debbie Hellowell
- Revalidation HR Representative – David Batty/Andrea Horton

4.2. Policy and Guidance Update

- Medical Appraisal Policy was reviewed in 2015/16 and approved in February 2016.
- Case Based Discussion guidance developed February 2016
- Indemnity/Insurance guidance developed March 2016

4.3. Designated Body List

The Business Manager and Administrator ensure that the designated body list of doctors is accurate. The formal list of the Trust's prescribed connections is recorded on the GMC Connect portal. As individual doctors are able to add themselves to this list, it is regularly checked to ensure that all the prescribed connections are appropriate. To facilitate this, a regular starters and leavers report is run from Electronic Staff Record.

4.4. External Oversight

The Trust is subject to the oversight of the NHS England Revalidation Team, and is required to complete a quarterly report and an Annual Organisational Audit to provide assurance to them. These were all completed satisfactorily during 2015/16.

4.5. Internal Oversight

4.5.1. The AMD and Business Manager meet fortnightly to oversee the day-to-day running of the appraisal and revalidation processes

4.5.2. The RO, AMD and Business Manager meet monthly to ensure that there is regular communication with the RO and that any issues are highlighted and acted upon in a timely manner

4.5.3. The Revalidation Team have a monthly Revalidation Review meeting to formally consider those doctors with a revalidation recommendation required within the following 3 months.

4.6. Independent Verification

During 2012/13, KPMG undertook an audit of the Trusts appraisal and revalidation processes, as part of the Trusts internal audit programme. The resulting report in March 2013 provided an overall rating of substantial assurance. Independent verification is required to be undertaken every 5 years.

5. Medical Appraisal

5.1. Appraisal and Revalidation Data

	Consultant		**SAS & Trust Grade**	
Number of doctors as at 31st March 2015 who have a prescribed connection to the Trust	83 (4 of which are fixed term)		49 (5 of which are fixed term)	
Number of completed appraisals during 2015/16:	79	95%	45	92%
Number of missed/ incomplete appraisals during 2015/16:	4	5%	4	8%
Number of doctors in remediation:	0	0%	0	0%
Number of doctors in disciplinary processes	0	0%	0	0%

See Appendix 1; Audit of missed/incomplete appraisals

5.2. Appraisers as at 31st March 2015

5.2.1. Number of appraisers – 26

5.2.2. Support activities undertaken:

5.2.2.1. 2 full day appraiser training days were provided on 19.10.15 and 21.3.16, with 11 appraisers attending the courses in total (excluding the facilitators). Both sessions where facilitated by at least 2 of the experienced Trust appraisers – Dr Mark Radcliffe, Dr Ruth Stockill and Dr Isaura Gairin.

5.2.2.2. Appraisers Forums were held 29.4.15, 10.7.15 and 18.11.15. These continue to provide an opportunity for

appraisers to share good practice and discuss areas of concern/difficulty. Continuous improvement of the appraisal process in the Trust is also an important topic for discussion the in the Forums.

5.3. Quality Assurance Processes

5.3.1. There is a portfolio minimum data set required for appraisal and the appraisers are required to check that this is uploaded or an adequate reason provided for non-inclusion.

5.3.2. The Revalidation Team check that an up-to-date patient feedback and 360 colleague feedback is the included in the doctors portfolio as appropriate (required to be undertaken every 3 years, unless new to the trust then required within first year) and has the required number of responses. If this is not the case, it is flagged with the AMD.

5.3.3. The Revalidation Team inform the doctor if they are required to change their appraiser for their next appraisal (required to change after every 3rd consecutive appraisal with same appraiser).

5.3.4. The AMD reviews all submitted appraisals (excluding those where he was the appraiser) Checks are made on appraisal inputs (appraisal portfolio), appraisal outputs (PDP, appraisal summary and sign-off) and where appropriate, will request further work be undertaken prior to AMD recommending to Responsible Officer that annual appraisal is satisfactory. Those appraisals where the AMD was appraiser, the RO reads and checks inputs and outputs.

5.3.5. The RO also reviews the appraisals on receiving the AMD's recommendation and either concurs or requests further clarification.

5.3.6. Appraisers undertake an annual 360° appraisal in their role as appraisers and this is considered by the AMD and RO.

5.3.7. There is on-going feedback to the doctors being appraised and appraisers, at the time that appraisal submissions are being reviewed. This takes the form of email correspondence or telephone conferences with the relevant doctors. The aim of this is to improve the quality of the appraisal submissions and to ensure there is satisfactory engagement.

5.3.8. The appraisers receive further group feedback during Appraiser Forum meetings.

5.4. Access, security and confidentiality

5.4.1. The e-appraisal system (MyL2P) is required to be used by all doctors. No breaches to the system or individual portfolios were recorded during 2015/16.

5.4.2. Access to individual appraisals on MyL2P is restricted by login, to the doctor, their appraiser, RO, AMD and the Revalidation Team and any other person the doctor provides access to (via their own login).

5.4.3. Doctors are made aware via the MyL2P system, that patient identifiable information should not be included in their appraisals. This is also stated in the Trust Medical Appraisal Policy.

5.5. Clinical Governance

5.5.1. All doctors are provided with a PDF record (including a nil response if appropriate) of their Incidents, Complaints and Sickness for their appraisal year from the Revalidation Team. This data is directly uploaded to the doctors appraisal record on MyL2P. Doctors are required to reflect on their involvement in incidents and complaints, both those included in the reports and any others that they are aware of but may not have been linked to them via Datix.

5.5.2. The minimum requirement for their appraisal portfolio is provided in a Portfolio Minimum Data Set.

6. Revalidation Recommendations (1.4.15 to 31.3.16)

Number of recommendations	42
Recommendations completed on time	41
Positive recommendations	41
Deferral requests	1
Non engagement notifications	0

6.1. The Revalidation Review Group meet monthly and consider those revalidation recommendations due to be made in the following 3 months, this allows time for any further requirements to be actioned to enable a positive revalidation recommendation to be made.

6.2. As an outcome of this process, 98% of recommendations due in 2015/16 were submitted on time.

6.3. Of these, all but 1 were positive recommendations, the remaining one was for deferral.

6.4. All recommendations were approved by the GMC and the doctor was subsequently revalidated. In the case of the deferral, the proposed new recommendation date was accepted by the GMC.

6.5. 1 recommendation was made late (within GMC category of late 7 days and under). This was due to a misunderstanding regarding the requirement to make a revalidation recommendation even though the doctor had requested voluntary erasure from the medical register prior to them leaving the Trust and retiring from clinical practice. On being informed by the GMC of the required need for the recommendation, this was actioned immediately.

See Appendix 3; Audit of revalidation recommendations

7. Recruitment and engagement background checks

7.1. Substantive & Fixed Term appointments

7.1.1. During the application and interview process, doctors are assessed to ensure they have the qualifications and experience in order to fulfil the duties of the post.

7.1.2. For consultants, an assessment centre is usually held.

7.1.3. Where appropriate, Medical HR check the national database for AC and Section 12 status. GMC registration is also checked.

7.1.4. Reference checks from the previous 3 years of employment are undertaken by Medical HR and the Appointing Officer confirms that they are satisfied with the references before a final offer is made. The references will be checked for the correct dates and that the person giving them is the relevant person to provide.

7.1.5. Medical HR will meet with the doctor to verify their ID using the acceptable documents list. They request the original documents which are copied and used to process the DBS check.

7.1.6. The Medical Directorate request information from the doctor's current/last Responsible Officer. This includes information about the doctors last appraisal date, whether there are any concerns about the doctors practice, conduct or health and if there are any outstanding investigations.

7.1.7. If a doctor is recruited with GMC conditions, further information from the GMC is requested.

7.2. Agency Locum appointments

7.2.1. During 2015/16 the Trust had a sole supplier agreement with Athona Recruitment.

7.2.2. The Medical Clinical Lead/Medical Manager usually leads on the securing of locum doctors for their areas.

7.2.3. Athona provides suitable CVs and references through an online portal.

7.2.4. If a booking is taken forward, a checklist is sent via email confirming the doctor has a DBS, OH clearance, Right To Work etc.

7.2.5. In line with the Trust guidance on booking locum doctors, the internal lead is then required to undertake a telephone interview prior to commencement.

7.2.6. In line with Trust guidance on booking locum doctors, on their first day a locum doctors ID should be verified through the checking of their passport or photo-card driving licence.

See Appendix 5; Audit of recruitment and engagement background checks

8. Monitoring Performance

8.1. Doctors are generally monitored through their team management structures.

8.2. In addition a doctor's performance is monitored via the appraisal system which includes a requirement for feedback from service users and 360° feedback from colleagues on a three yearly basis.

8.3. Information in relation to whether a doctor is involved in serious untoward incidents or subject to complaint is also included in the appraisal system.

8.4. Serious untoward incidents are investigated using the Trust investigation procedures carried out by the trained investigators.

8.5. In the event that any concerns are raised, these are referred to the Medical Director who can instigate various levels of investigation and take to the Responding to Concerns Advisory Group as appropriate.

9. Responding to Concerns and Remediation

9.1. The Trust has a Responding to Concerns and Remediation Policy which was approved January 2015.

9.2. The Trust currently has 2 trained Case Managers and 4 trained Case Investigators, all of whom are medical consultants.

9.3. A Responding to Concerns Advisory Group meets monthly. It is chaired by the Responsible Officer/Medical Director and is also attended by the Director of Human Resources and Workforce Development, the Associate Medical Director for Revalidation, Director of Nursing, Clinical Governance and Safety, Medical Directorate Business Manager and HR Business Partner responsible for medical staffing. Relevant general management representatives attend as and when required. This approach ensures there is a consistent and open approach taken across the Trust in the investigation of concerns in relation to doctors.

9.4. Remediation, when identified, is carried out on an individual basis, being tailored to the individuals' needs.

10. Risk and Issues

The following are areas of potential difficulty for the Trust:

10.1. Over the course of recent years the Trust has provided Responsible Officer functions to Barnsley Hospice. This was reviewed during 2015/16 and from 1st April 2016 a more detailed and robust Service Level Agreement for ongoing provision was agreed by both parties. This needs to be monitored to ensure it is adhered to by both parties.

10.2. The appraiser role is a responsible role which is undertaken on a voluntary basis and is reliant on doctors having sufficient time in their job plan to carry out. Informal feedback from some doctors suggests that the impact of transformation could influence the doctors' willingness and/or ability to undertake the role of medical appraiser. If this proved to be the case, the Trust would need to consider the current stance of the medical appraiser role and the fact that it is not remunerated.

10.3. There is an expectation that appraisal/revalidation requirements will increase as we approach the end of the first cycle (5 years). This could impact on the amount of resource required to ensure the Trust maintains it current position of having robust systems and processes in place.

11. Actions, Improvements and Next Steps

11.1. 2014-15 Actions

11.1.1. Review the non-participation in appraisal procedure to extend it scope from its current focus on timescales to take account of the content of the appraisal.
Update: Non participation is an on-going area of debate within the Responsible Officer network because of the potentially subjective nature of its definition. It remains the subject of discussion at the appraiser's forum within the Trust.

Engagement in appraisal in the Trust runs at 100%, this is in contrast to the appraisal rate as stated in the UMbRELLA survey as reported by the GMC, which found that 90% of doctors had had an appraisal in their career. The Trust has had a small number of doctors who have submitted their appraisal late but lateness is covered by our existing non-participation procedure which has successfully managed these instances

11.1.2. The standard of appraisal will be continued to be developed in the appraisers forum.
Update: This is on-going.

11.1.3. Review the need to establish a formal process for sharing of information for a doctor undertaking licensed additional medical practitioners work outside the Trust.
Update: A process has been established whereby the responsibility rests with the doctor to provide supporting information from other organisations, as part of their declaration of whole scope of practice. This is subject to the quality assurance process and templates have been provided to assist doctors in requesting this information.

11.1.4. As referenced in the body of this report, there are increasing demands arising out of the quality assurance requirements which may require additional administrative support. Consideration will be given to the development of a business case which will be presented at a later date.

11.2. Additional Improvements

11.2.1. The MyL2P appraisal system was enhanced during the latter half of 2015/16 and now has an embedded feedback form that every doctor is requested to complete on submission of their appraisal. This timely feedback covers the performance of their appraiser and the overall appraisal system. From 2016/17 this will provide the revalidation team with enhanced data about the appraisers and the appraisal system thus enabling timely developments/actions as appropriate.

Therefore from 2016/17 the requirement for an appraiser to undertake an annual 360 feedback exercise in the role of appraiser will cease.

11.2.2. From 1st April 2016 the MyL2P system will require each doctor to complete a checklist around their appraisal portfolio prior to submitting it to their appraiser. It is anticipated that this will reduce the referred back requirements for incomplete portfolios.

11.3. **Next Steps (2015-16 Actions)**

11.3.1. To further strengthen the appraiser development process, an annual desk-top exercise to review individual appraiser performance will be developed for 2016/17. The exercise would cover areas such as number of appraisals undertaken, number of late submission, number referred back for additional work and attendance at training and forums. This together with the knowledge gathered from the individual review by the AMD for Revalidation of every appraisal undertaken, will assist in identifying potential development needs.

11.3.2. Consideration to be given to undertaking a peer review with a neighbouring Trust to comply with the requirement for independent verification every 5 years.

11.3.3. Undertake an audit to check the appraisal status of agency locum doctors appointed to work in the Trust.

11.3.4. Ensuring that appraiser time is reflected in the job plans of appraisers.

12. Recommendations

12.1. The Board is asked to receive this report noting that it will be shared, along with the Annual Organisational Audit, with the Tier 2 Responsible Officer at NHS England.

12.2. The Board is further asked to recognise that the resource implications of medical revalidation are likely to continue to increase year on year.

12.3. The Board is finally asked to approve the Statement of Compliance attached as Appendix 1 of this report confirming that the Trust, as a Designated Body, is in compliance with the regulations.

APPENDIX 1

AUDIT OF MISSED / INCOMPLETE APPRAISALS DURING 2015/16

DOCTOR FACTORS	**CONSULTANT**	**SAS/TRUST GRADE**
Maternity Leave during the majority of the appraisal period	0	0
Sickness Absence during the majority of the appraisal period	1	1
Prolonged Leave during the majority of the appraisal period	0	0
Suspension during the majority of the appraisal period	0	0
New starter	3	3
Postponed due to incomplete portfolio / insufficient supporting information	0	0
Lack of time of doctor	0	0
Lack of engagement of doctor	0	0
Other doctor factor (describe)	0	0
APPRAISER FACTORS	**NUMBER**	
Unplanned absence of appraiser	0	0
Lack of time of appraiser	0	0
Other appraiser factor (describe)	0	0
ORGANISATION FACTORS	**NUMBER**	
Administration or management factors	0	0
Failure of electronic information systems	0	0
Insufficient numbers of trained appraisers	0	0
Other organisational factors (describe)	0	0

APPENDIX 2

QUALITY ASSURANCE AUDIT OF APPRAISAL INPUTS AND OUTPUTS

TOTAL NUMBER OF APPRAISALS COMPLETED - 124		
	NUMBER OF APPRAISAL PORTFOLIOS AUDITED (1.4.15-31.3.16)	**NUMBER OF APPRAISAL PORTFOLIOS DEEMED TO BE ACCEPTABLE AGAINST THE STANDARDS**
APPRAISAL INPUTS		
Scope of work	124	124
Is continuing professional development compliant with GMC requirements?	124	122
Is quality improvement activity compliant with GMC requirements?	124	124
Has a patient feedback exercise been completed?	124	120
Has a colleague feedback exercise been completed?	124	121
Have all complaints been included?	124	124
Have all significant events been included?	124	121
Is there sufficient supporting information from all the doctor's roles and places of work?	124	116
Is the portfolio sufficiently complete for the stage of the revalidation cycle?	124	124
APPRAISAL OUTPUTS		
Appraisal summary	124	124
Appraiser statement	124	124
PDP	124	124

All deficits were either addressed satisfactorily after the appraisal had been referred back, or agreement given that it would be addressed in the doctors next appraisal. Some appraisals were referred back for multiple reasons.

APPENDIX 3
AUDIT OF REVALIDATION RECOMMENDATIONS (1st April 2015 to 31 March 2016)

Recommendations completed on time (within GMC recommendation window)	41
Late recommendations (completed, but after the GMC recommendation window closed)	1
Missed recommendations (not completed)	0
TOTAL	42
PRIMARY REASON FOR LATE/MISSED RECOMMENDATIONS	
No Responsible Officer in post	0
New starter / new prescribed connection established within 2 weeks of revalidation due date	0
New starter / new prescribed connection established more than 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	1
Responsible Officer error	0
Inadequate resources or support for the Responsible Officer role	0
Other (describe)	0
TOTAL (sum of late and missed)	1

APPENDIX 4

AUDIT OF CONCERNS ABOUT A DOCTOR'S PRACTICE

CONCERNS	HIGH LEVEL	MEDIUM LEVEL	LOW LEVEL	TOTAL
NUMBER OF DOCTORS WITH CONCERNS ABOUT THEIR PRACTICE IN THE LAST 12 MONTHS				
Capability concerns (as primary category)	0	0	1	1
Conduct concerns (as primary category)	0	0	1	1
Health concerns (as primary category)	0	0	0	0
REMEDIATION/RESKILLING/RETRAINING/REHABILITATION				
Number of doctors who have undergone formal remediation				0
Consultants (permanent, employed staff)				1
Staff grade, associate specialist, specialty doctor (permanent, employed staff)				0
Temporary or short term contract holders				0
OTHER ACTIONS / INTERVENTIONS				
LOCAL ACTIONS				
Number of doctors who were suspended/ excluded (commenced or completed between 1.4.15 and 31.3.16)				0
Number of doctors who have had local restrictions placed on their practice in the last 12 months				0
GMC ACTIONS				
Number of doctors referred to the GMC between 1.4.15 and 31.3.16				0
Number of doctors who underwent or undergoing GMC Fitness to Practice procedures between 1.4.15 and 31.3.16				1
Number of doctors who had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1.4.15 and 31.3.16				0
Number of doctors who had their registration / licence suspended by the GMC between 1.4.15 and 31.3.16				0
Number of doctors who were erased from the GMC register between 1.4.15 and 31.3.16				0
NATIONAL CLINICAL ASSESSMENT SERVICES ACTIONS				
Number of doctors about whom NCAS has been contacted between 1.4.15 and 31.3.16				0
Reason for contacts:				
For advice				
For investigation				
For assessment				
Number of NCAS investigations performed				
Number of NCAS assessments performed				

APPENDIX 5

AUDIT OF RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

NEW DOCTORS COMMENCING BETWEEN 1.4.15 and 31.3.16	NUMBER
Permanent employed doctors	7*
Temporary employed doctors	7
Locums brought in to the Trust through a locum agency	22
Locums brought in to the Trust through a 'Staff Bank' arrangements	0
Other (provide explanatory note)	0
TOTAL	**36**

*3 of these were internal appointments

For how many of these doctors was the following information available within 1 month of the doctor's starting date

	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC / NCAS investigations	DBS	References from last 3 yrs of employment (minimum 2)	Name of last RO[1]	Reference from last RO[1]	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs[2]	Unresolved performance concerns
Permanent employed	7	7	7	7	7	7	4 (3 N/A)	3 (3 N/A)	7	3 (3 N/A)	7	4 (3 N/A)	4 (3 N/A)	2 (3 N/A)	N/A
Temporary employed	7	7	7	7	7	7	7	3	7	3	7	7	7	1	N/A
Locums via locum agency	**	**	**	**	**	**	**	**	**	**	**	**	**	**	**
TOTAL	14	14	14	14	14	14	11	6	14	6	14	11	11	3	

[1]Not available for those doctors joining the Trust from overseas

[2] Not available for those doctors joining the Trust from a training post or joining the Trust from overseas

** The pre employment checks for agency locums are undertaken by the agency as their employment is with them

APPENDIX 6

South West Yorkshire Partnership NHS Foundation Trust

Designated Body statement of Compliance

The board of South West Yorkshire Partnership NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Yes, this being the Medical Director Dr Adrian Berry

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Yes, this is maintained by the Trust's Medical Revalidation Team utilising GMC Connect and MyL2P

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Yes, as of 31st March 2016 there are 26 appraisers for 132 doctors with a prescribed connection to the Trust. The Medical Appraisal Policy requires appraisers to undertake between 3 and 7 appraisals per year.

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Yes, this is achieved by attendance at appraisal training every 2 years, appraisers forum (3 during 2015-16), undertaking 360° feedback for the role and receiving direct feedback from the AMD for Revalidation on quality issues.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Yes, see annual report

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

Yes, see annual report

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Yes, as specified within the Trust's Responding to Concerns and Remediation Policy

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Yes, there is a requirement through the appraisal process that supporting information regarding a doctors full scope of practice is incorporated and reviewed.

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[1] have qualifications and experience appropriate to the work performed; and

Yes, the Trust's HR procedures are followed

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Yes, a regularly reviewed action plan is in place to continue to development the quality and management of the appraisal and revalidation processes.

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Signed: _

[chief executive or chairman]

Date: _ _ _ _ _ _ _ _ _ _

Trust Board 20 September 2016
Agenda item 7.3(iii)

Title:	**Nurse Revalidation**
Paper prepared by:	Director of Nursing Clinical Governance and Safety
Purpose:	To assure the Board of progress relating to nurse revalidation
Mission/values:	A high quality nursing workforce skilled in enabling people to reach their potential and live well in the community are required to be reflective in their practise, well trained and be able to demonstrate compliance with a professional code of practise.
Any background papers/ previously considered by:	Trust Board and the Clinical Governance and Clinical Safety Committee have been updated on progress.
Executive summary:	Following work undertaken by the Department of Health (DOH) and the English Revalidation Board (ERB), the Nursing and Midwifery Council (NMC) made a decision to introduce three-yearly revalidation for nurses and midwives (October 2015). The Chief Nurse for England communicated that this should commence April 2016 with a robust monitoring processes to be enforced from point of introduction, revision of guidance and impact to ensure delivery had intended benefits without any negative impact on the front line. The NMC has provided significant support to the nursing and midwifery workforce in enabling the process of nurse revalidation to take place from a national perspective, ensuring consistency of standards. At local level, Trusts have developed systems and processes to ensure a consistently high standard of compliance. In the national revalidation pilot it was estimated that 5% of all nurses failed to revalidate. If 5% of existing registered nurses within the Trust failed to revalidate then this would have a significant impact on the capacity and capability of our nursing workforce at a time of significant recruitment and retention challenges. The Trust has, therefore, developed a comprehensive system to ensure individual nurses and their managers are equipped with the necessary information and support leading to the successful revalidation of all registered nurses or deferral where appropriate. Since 1 April 2016, all registered nurses in the Trust have been successfully revalidated. At local level, the appointment of a Revalidation Co-ordinator responsible for training, advising and supporting staff in partnership with the Trust's HR/workforce team has been tested and deemed to be of value to nurses and managers. It should be noted that, in September 2016, there are a higher number of nurses requiring revalidation than average (which is 84). This compares to 25 for October 2016. There are 280 in total for September 2016 to March 2017. The re-appointment of a Revalidation Co-ordinator for a further six months confirms the Trust's commitment to prioritising this objective.
Recommendation:	**Trust Board is asked to NOTE the update on the implementation of the revalidation programme and to NOTE that the processes in place have achieved expected outcomes.**
Private session:	Not applicable

Trust Board 20 September 2016
Agenda item 7.3(iv)

Title:	**Workforce Race Equality Standard (WRES) summary report and action plan**
Paper prepared by:	Director of Human Resources and Workforce Development
Purpose:	The WRES summary report requires Trust Board sign off prior to submission and publication
Mission/values:	The Trust serves a diverse population across a large geographical area and it is important we strive for a workforce that reflects the local population. Equality and Diversity is core to the Trust's values and is an important part of its service and workforce objectives.
Any background papers/ previously considered by:	The WRES action plan has been agreed by the Executive Management Team (EMT). The issues within the action plan have been central to a number of discussions at the Equality and Inclusion Forum. Key background papers are the Trust Equality Workforce Monitoring Annual Report 2015 and 'The snowy white peaks of the NHS' – Roger Kline 2014
Executive summary:	Trust Board is committed to ensuring the Trust delivers culturally sensitive services that meet the needs of the communities it serves and recognises that a diverse workforce is critical to achieving this aim. The WRES, which is a requirement for Trusts and has been included in the NHS standard contract from 2015/16, provides a framework which will assist with embedding workforce equality. The main purpose of the WRES is to help local and national NHS organisations to review their workforce data against nine indicators. This review should then enable organisations to produce action plans to close any gaps in workplace experience between White and Black and Ethnic minority (BME) staff and to improve BME representation at a senior level of the organisation. The Equality and Diversity Council (EDC) prioritised the WRES as the best means of helping the NHS as a whole to improve its workforce race equality performance. There is considerable evidence across the NHS that suggests BME staff experience is less favourable, which then has a significant impact on the efficient and effective running of services. It is important that, in addition to considering the business case for equality and a diverse workforce, the Trust's mission and values demonstrate the Trust's commitment to create a workplace where people feel valued and are treated with dignity and respect. Trust Board has a key leadership role to play in shaping a collective and inclusive culture and recognises that discussion at this level is essential in ensuring the development of an ethos where everyone takes responsibility for ensuring equality is at the centre of everything the Trust does. The Trust's WRES action plan integrates with the Equality Delivery System 2 (EDS2) to ensure a consistent approach and reflects the commitment to moving this agenda forward. The action plan also recognises that the key objective around senior appointments will require the Trust to work in partnership with other NHS and public sector organisations. The Trust's Wellbeing and Engagement Survey results are important in helping to develop an understanding of the targeted actions required.

	There are three key initiatives within the action plan: • to establish a BAME (Black, Asian and Minority Ethnic) Staff Equality Network; • to establish a clinical network to look into and propose action on harassment and bullying by service users; and • to engage with local communities on career development and opportunities. Approval by Trust Board is required to comply with the requirements of the WRES. Three documents are attached: • the WRES summary report, which is a template provided by WRES for publication; • appendix 1, which relates to indicator 1 of summary report; • an integrated EDS2 and WRES workforce action plan to meet the requirement to publish a separate action plan to accompany the summary report. This enables the commonalities between EDS2 and WRES to be easily identified as well as highlighting differences.
Recommendation:	**Trust Board is asked to APPROVE the WRES action plan and ongoing monitoring through the Equality and Inclusion Forum.**
Private session:	Not applicable

Workforce Race Equality Standard
REPORTING TEMPLATE
Template for completion

Name of provider organisation	**Date of report; month/year**	
South West Yorkshire Partnership NHS Foundation Trust	Month: August	Year: 2016
Name and title of Board Lead for the Workforce Race Equality Standard		
Alan Davis, Director of HR and Workforce Development		
Name and contact details of lead manager compiling this report		
Claire Hartland, HR business manager, claire.hartland@swyt.nhs.uk 01977 605303		
Names of commissioners this report has been sent to		
Wakefield CCG, Barnsley CCG, North Kirklees CCG, Greater Huddersfield CCG, Calderdale CCG., NHS North of England SCT		
Names and contact details of co-ordinating commissioner this report has been sent to		
Paul Harding	Contract Manager	NHS Barnsley Clinical Commissioning Group	paulharding@nhs.net Karen Pollard	Senior Contract Manager	NHS Calderdale & NHS Greater Huddersfield CCG	karen.pollard@greaterhuddersfieldccg.nhs.uk Jonathan Hepworth |Senior Supplier Manager, Mental Health	NHS England, North of England Specialised Commissioning Team (Yorkshire & Humber Hub)	jonathan.hepworth@nhs.net		
Unique URL link on which this report will be found (to be added after submission)		
http://www.southwestyorkshire.nhs.uk/about-us/corporate-information/equality-and-diversity/equality-information/		

This report has been signed off by on behalf of the Board on (insert name and date)
Alan Davis, Director of HR and Workforce Development – insert date

Report on the WRES indicators

1. Background narrative

a. Any issues of completeness of data
There are issues with the data relating to Indicator 2. 1) The introduction of NHS Jobs 2 resulted in data not being transferred for year 2013/14. 2) An updated link between NHS Jobs 2 and the Electronic Staff Record (ESR) resulted in data being lost in May 2015. The required data for this indicator is therefore only available from June 2015 onwards.

b. Any matters relating to reliability of comparisons with previous years
No issues except for point 1a above

2. Total numbers of staff

a. Employed within this organisation at the date of the report
There were 4608 staff employed by South West Yorkshire Partnership NHS FT as at 31st March 2016

b. Proportion of BME staff employed within this organisation at the date of the report
7.77% BME staff in the workforce as at 31st March 2016

3. Self reporting

a. The proportion of total staff who have self-reported their ethnicity
99.44% of staff have self-reported their ethnicity

b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
The Trust uses ESR employee self-service so staff can self-report and check their own data

c. Are any steps planned during the current reporting period to improve the level of self reporting by ethnicity
Please see 3b above

4. Workforce data

a. What period does the organisation's workforce data refer to?
Years ending 2014/15 and 2015/16

5. Workforce Race Equality Indicators

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

	Indicator	**Data for reporting year**	**Data for previous year**	**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	For each of these four workforce indicators, the Standard compares the metrics for White & BME staff.				
1	Percentage of BME staff in each for the AfC bands 1-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and clinical staff.	Please see Appendix 1	Please see Appendix 1	The % of BME staff in the workforce has increased by 0.84% in the current year. The Trust has reviewed demographic workforce data for Trusts in Yorkshire and Humber. This has identified there is a lack of available candidates from across the region. The Trust is having conversations with HEE regarding the potential for a regional scheme to support BME managers	~ Pilot Trust breakthrough programme ~ Discussion on regional breakthrough programme ~Leadership & Management strategy supports encouraging BME staff development by means of coaching & mentoring, succession planning and talent management. ~Workforce report includes AfC band data by ethnicity, monthly reports showing this data are also produced.
2.	Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts	2.01	0.87	Due to data issues highlighted in the background narrative provided at 1a, this indicator has been calculated on information from May 15 to date, therefore the accuracy of the data provided for 'previous year' remains unreliable.	~Undertake audit of reason BME staff not shortlisted and develop appropriate support programme ~ Engaging with BME communities in North Kirklees through 'New Horizons' pilot with the local college and 2 schools to encourage consideration of the Trust and the NHS as an employer of choice
3.	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation*	2.08	0.78	The average figure required by the Indicator shows that BME staff are 2.08 times more likely to enter a formal disciplinary process than White staff. Data for previous year may be unreliable due to incomplete recording.	~ Analysis of disciplinary cases involving BME staff for the 2 year reference period ~ Consult with BME staff network regarding understanding data and any common themes in disciplinary cases involving BME staff. ~ HR Operational meeting agenda to include BME case review

	*Note: this indicator will be based on data from a two year rolling average of the current year and the previous year				
4	Relative likelihood of BME staff accessing non-mandatory training and CPD as compared to White staff	0.88	0.94	The data show that BME staff are more likely to access non-mandatory training and CPD than White staff. The data includes medical staff.	~ Maintain robust process for training data collection and collation, including focus on break down by staff group ~ In line with Values Based Appraisal policy will continue to monitor uptake and will undertake random sample on qualitative data. ~Look at breakdown of medical and non-medical staff accessing training.

	Indicator	**Data for reporting year**		**Data for previous year**		**Narrative – the implications of the data and any additional background explanatory narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	For each of these four staff survey indicators, the Standard compares the metrics for each survey question response for White and BME staff						
5.	KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	27.66	White	27.49	The 2015 staff survey was sent to a sample of 850 staff. The response rate was good at 50%, an improvement on the previous year (43.65% in 2014) and above the national average of 41%. The Trust works with wellbeing specialist Robertson Cooper, and undertakes an annual wellbeing survey for staff which now captures WRES issues. Data from survey completed June 2016 currently being analysed, some initial findings included in action plan please see attached/link 2015 staff survey indicates that the BME staff who responded indicated they were more likely to experience harassment and bullying from service users and carers than white staff	~ Continue to work to maintain the return rate of the staff survey by supporting managers to understand the importance of regular staff feedback ~ Engage with BME staff network to improve understanding of the survey issues, actions that can be taken, support that can be given ~Clinical network to be established to review support and actions required regarding harassment and bullying from service users and carers
		BME	52.17	BME	33.33		

6.	KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	19.73	White	17.27	2015 staff survey indicates that the BME staff who responded indicated they were less likely to experience harassment and bullying from staff than white staff	~ Continue to work to maintain the return rate of the staff survey by supporting managers to understand the importance of regular staff feedback ~ Engage with BME staff network to improve understanding of the survey issues, actions that can be taken, support that can be given
		BME	13.04	BME	36.36		
7	KF21. Percentage believing that the Trust provides equal opportunities for career progression or promotion	White	91.01	White	91.87	2015 staff survey indicates that the BME staff who responded indicated they were more positive regarding believing the Trust provides equal opportunities for career progression or promotion than white staff.	~ Leadership & Management strategy supports encouraging BME staff development by means of coaching & mentoring, succession planning and talent management. ~Continue to network and benchmark with other Trusts, for example, through the regional E&D network and look at examples of good practice nationally
		BME	94.12	BME	69.57		
8	Q17b. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	White	5.07	White	3.32	2015 staff survey indicates that the BME staff who responded indicated they were less likely to experience discrimination at work from their Manager/team leader or other colleagues than white staff	~ Continue to work to maintain the return rate of the staff survey by supporting managers to understand the importance of regular staff feedback. ~Engage with BME staff network to improve understanding of the survey issues ~ The Bullying and Harassment policy is currently being refreshed and will be shared with the BME staff network for their views prior to submission to the policy group.
		BME	4.17	BME	21.21		
	Board representation indicator. For this indicator, compare the difference for white and BME staff						
9	Percentage difference between the organisations Board voting membership and its overall workforce	-7.77		-7.32		There is currently no BME representation on the organisations Board voting membership Barnsley 2.13% BME population Calderdale 10.32% BME population	E&I forum to take action including establishing links to the Insight Programme with Gatenby Sanderson which works with Trusts to improve the quality and diversity of NHS Boards

				Kirklees 20.87% BME population Wakefield 4.57% BME population	

Note 1: All provider organisations to whom the NHS Standard Contract applies are required to conduct staff surveys though those surveys for organisations that are not NHS Trusts may not follow the format of the NHS Staff Survey.
Note 2: Please refer to the Technical Guidance for clarification on the precise means of each indicator

Report on the WRES indicators, continued

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

The Trust also publishes a detailed Equality Workforce Monitoring Annual Report on our website. Progress regarding the Equality agenda is monitored by the Trust Board at the Equality and Inclusion Forum.

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

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

The Trust has developed an integrated EDS2 and WRES workforce action plan, please see attached/link

WRES 2016 Appendix 1
Indicator 1

	2014/2015				2015/2016			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Band 1	140	7	2		130	6	3	
Band 2	154	6	243	7	152	5	243	9
Band 3	385	7	668	57	370	12	600	51
Band 4	224	6	104	2	210	9	101	1
Band 5	123	5	685	71	115	6	641	65
Band 6	72	5	815	52	62	8	794	57
Band 7	45		372	14	43		364	17
Band 8a	34		139	8	39		131	8
Band 8b	18		63	1	13		59	1
Band 8c	3		23		4		23	
Band 8d	8		8	1	5		8	1
Medical & Dental Consultants			41	49			37	49
Medical & Dental Non-consultant career grade			15	36			15	32
Medical & Dental Trainee grades			13	18			9	20
Medical & Dental Other			2				2	
VSM	21		7	1	31		10	1
Grand Total	**1227**	**36**	**3200**	**317**	**1174**	**46**	**3040**	**312**
Not Started	**26**				**25**			
Total Staff Number	**4806**				**4597**			

	2014/2015				2015/2016			
	Non Clinical		Clinical		Non Clinical		Clinical	
Grade	**White**	**BME**	**White**	**BME**	**White**	**BME**	**White**	**BME**
Band 1	2.91%	0.15%	0.04%	0.00%	2.83%	0.13%	0.07%	
Band 2	3.20%	0.12%	5.06%	0.15%	3.31%	0.11%	5.29%	0.20%
Band 3	8.01%	0.15%	13.90%	1.19%	8.05%	0.26%	13.05%	1.11%
Band 4	4.66%	0.12%	2.16%	0.04%	4.57%	0.20%	2.20%	0.02%
Band 5	2.56%	0.10%	14.25%	1.48%	2.50%	0.13%	13.94%	1.41%
Band 6	1.50%	0.10%	16.96%	1.08%	1.35%	0.17%	17.27%	1.24%
Band 7	0.94%		7.74%	0.29%	0.94%		7.92%	0.37%
Band 8a	0.71%		2.89%	0.17%	0.85%		2.85%	0.17%
Band 8b	0.37%		1.31%	0.02%	0.28%		1.28%	0.02%
Band 8c	0.06%		0.48%		0.09%		0.50%	
Band 8d	0.17%		0.17%	0.02%	0.11%		0.17%	0.02%
Medical & Dental Consultants			0.85%	1.02%			0.80%	1.07%
Medical & Dental Non-consultant career grade			0.31%	0.75%			0.33%	0.70%
Medical & Dental Trainee grades			0.27%	0.37%			0.20%	0.44%
Medical & Dental Other			0.04%				0.04%	
VSM	0.44%		0.15%	0.02%	0.67%		0.22%	0.02%
Grand Total	**25.53%**	**0.75%**	**66.58%**	**6.60%**	**25.54%**	**1.00%**	**66.13%**	**6.79%**
Not Started	**0.54%**				**0.54%**			
Annual Total	**100.00%**				**100.00%**			

Integrated EDS2 and WRES workforce action plan 2016

EDS2 Goal 3 outcomes		WRES indicators		Objective area	Mapping		Evidence and Actions
					EDS2	WRES	
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	1 2 9	% of staff in each of the AfC bands 1-9 and VSM(inc Executive Board members) compared with the % of staff in the overall workforce Relative likelihood of staff being appointed from shortlisting across all posts % difference between the organisations' Board voting membership and it's overall workforce	Fair recruitment and impact on workforce profile	3.1	1, 2, 9	Evidence • ESR • Equality workforce monitoring annual report • Values based recruitment and induction Actions • Introduce centralised exit interviews for all staff • Insight programme being considered to support increased Trust Board BME representation • Developing 'New Horizons' pilot project, working with schools and colleges in North Kirklees. Project includes engaging with the local BME community on the areas of mental health awareness, employability skills and promoting the Trust and wider NHS as an employer of choice. • E&I Forum key priority "Improve the representation of South Asian people in the workforce to better reflect the communities we serve and to increase the number of people from a BME background at managerial grades 8 & 9, where they are currently under represented" • Update recruitment information to include use of social media • To ensure progress the Staff Wellbeing survey will include questions for both EDS2 and WRES
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations			Equal pay (and gender pay gap)	3.2	-	Evidence • AfC • ESR • Equality workforce monitoring annual report Actions • Awaiting guidance on audit framework from government equalities office. Mandatory gender pay gap reporting regulations (expected Autumn 2016) – carry out gender pay gap audit (mandatory April 2018)

3.3	Training and development opportunities are taken up and positively evaluated by all staff	4	Relative likelihood of staff accessing non-mandatory training and CPD	Training opportunities accessed	3.3	4	Evidence • ESR • Equality workforce monitoring annual report • Staff survey – staff pledge 2 Actions • To ensure progress the Staff Wellbeing survey will include questions for both EDS2 and WRES • Ensure all training is recorded/study leave forms completed across the Trust.
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	5 6	KF25 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months KF26 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Staff are free from abuse, harassment, bullying and violence from a)*any source b)patients, relatives, public c)staff*	3.4	5, 6	Evidence • Wellbeing survey Q6 - reports that risk of physical violence is felt to be high by BME staff • Staff survey for KF25 - 2015 results show that BME staff are **more** likely to experience B&H from SU's, relatives, public than white staff. • **However**, Staff survey for KF26 – 2015 results show that BME staff are **less** likely to experience B&H from staff than white staff. Actions • Work with BME Staff network regarding WRES metric 5 results • Work with Nursing directorate regarding establishing clinical network re results from staff survey and wellbeing survey. • To ensure progress the Staff Wellbeing survey will include questions for both EDS2 and WRES
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives			Flexible working options available to staff	3.5		Evidence • Staff survey staff pledge 3, staff satisfied with opportunities for flexible working patterns Actions • Review flexible working arrangement and 12 hour shifts • To ensure progress the Staff Wellbeing survey will include questions for both EDS2 and WRES

3.6	Staff report positive experiences of their membership of the workforce			Staff report positive experiences of their membership of the workforce	3.6		Evidence • Staff survey - Staff pledge 1 – providing staff with clear roles, responsibilities and rewarding jobs • Wellbeing survey – questions around perceived commitment of organisation to the individual Actions • Development of internal Communications programme • Development of OD strategy • Development of Workforce strategy • Refresh of Staff Engagement and Leadership and Management strategies • Friends and Family test
		3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	BME entering formal disciplinary investigation		3	Evidence • ESR • Equality workforce monitoring annual report Actions • Work with BME Staff network to consider analysis of disciplinary data
		7	KF21 - % believing the Trust provides equal opportunities for career progression or promotion	Equal opportunities for career progression		7	Evidence • Staff survey KF21 - results show that BME staff are more positive regarding this than white staff • Wellbeing survey Q7 – the majority of BME staff agree that the Trust provides equal opportunities for career progression. BME staff are generally more positive regarding this than white staff. Actions • Development of talent management plan linked to key strategic roles within the Trust
		8	Q17 b – In the last 12 months have you personally experienced discrimination at work from manager/ team leader or other colleagues	Staff experiencing discrimination at work from manager/ team leader or other colleagues		8	Evidence • Staff survey Q17b – results indicates that BME staff are less likely to experience discrimination at work from their manager or colleagues than white staff

							• Wellbeing survey Q7 - Both white and BME staff are generally positive in this area and agree that they do not experience discrimination from their manager or colleagues. Actions • Continue to monitor and take action as appropriate

Trust Board 20 September 2016
Agenda item 8.1

Title:	**Well-led governance review**
Paper prepared by:	Director of Corporate Development
Purpose:	To update Trust Board of progress against the recommendations arising from the independent review of the Trust's governance arrangements.
Mission/values:	Ensuring the Trust has good and appropriate governance arrangements in place provides the framework for the Trust to meet its mission and adhere to its values.
Any background papers/ previously considered by:	Regular updates provided to Trust Board.
Executive summary:	Following a robust and thorough review and scrutiny of the Trust's governance arrangements by Deloitte against Monitor's well-led framework for governance reviews, the report and action plan were formally presented to Trust Board in September 2015. There were no 'material governance concerns' arising from the review. Out of the ten areas assessed, two areas were rated as green (in relation to Board engagement with patients, staff, governors and other stakeholders, and the Board having the skills and capability to lead the organisation) and eight as amber/green. A number of developmental areas were identified where Deloitte has recommended further work; these form the basis of the action plan. An update on the Trust's progress is attached for information. The majority of the recommendations are now complete or will be after September 2016. There are a small number of actions of a longer-term nature, which are noted below with the process for ensuring completion and delivery. ➢ Recommendation 3: Phase II to further develop strengthened outcome measures and reporting through integrated performance report. o Included in Chief Executive's objectives for 2016/17 and reported through Remuneration and Terms of Service Committee. ➢ Recommendation 4: Team briefing and staff communications arrangements reviewed and strengthened co-produced with staff and informed by staff feedback. o Evaluation of implementation will be undertaken through the wellbeing survey in May 2017. ➢ Recommendation 6: Discussion papers presented to Executive Management Team to improve monitoring and governance processes around the Transformation Programme to provide assurance to Trust Board quarterly and Executive Management team monthly. o Reports highlight progress, identify risks and issues with mitigating action, and resources. Work begun to strengthen benefits realisation, monitored through Executive Management

	Team. ➢ Recommendation 11: Review of internal governance arrangements and Trust Action Groups undertaken, arrangements clarified in terms of governance, assurance and delivery. Paper to Executive Management Team for discussion 8 September 2016. o Implementation of revised arrangements by end of October 2016 monitored through Executive Management Team. The key risks of failing to deliver against the recommendations arising out of the well led review are: ➢ limited opinion from planned internal audit review impacting on reputation with the regulator. Assessed as moderate risk (4-6) on the basis of level of completed actions and processes in place to complete the remainder. This is in line with the Trust's Risk Appetite Statement of cautious/moderate. ➢ monitoring compliance with national and local performance targets, assessed as minimal/low risk (1-3) on the basis of existing performance management arrangements in place as outcome measures and reporting are further developed. This is in line with the Trust's Risk Appetite Statement of cautious/moderate.
Recommendation:	**Trust Board is asked to NOTE, the update on progress against the recommendations arising out of the independent review of the Trust's governance arrangements and confirm that the mechanisms outlined above, provide sufficient governance to allow the action plan to be signed-off by Trust Board.**
Private session:	Not applicable

Independent review of governance arrangements – recommendations
30 July 2015
V7 Trust Board 20 September 2016

designed
implemented

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
1	**1A**	Ensure that the five year plan clearly articulates the strategic priorities for the Trust along with outline goals over the short, medium and longer term.	H	RW	Agreed – articulation of strategic priorities to be clearer in five-year plan with associated goals. <u>Timescales</u> - Review transformation programme Extended EMT August 2015 - Revised structure for EMT meetings to provide focus for transformation - Stocktake of strategic plan and transformation Trust Board September 2015 - EMT time out October 2015 - Trust Board strategy November 2015 and February 2016 - Trust Board in March 2016 sign-off	Original actions complete and operational/annual plan submitted to Monitor 18 April 2016 (approved by Trust Board 29 March 2016). A summary version of the plan was developed and cascaded to staff through briefing arrangements. Further work undertaken to develop clear strategic objectives with seven underpinning priorities led by the Chief Executive and informed by a series of staff engagement events. Further work to develop clear delivery and governance mechanisms, including ongoing reporting to Trust Board. This will include review of performance against the operational plan by the Operational Management Group and by the Executive Management Team.	Actions completed. Action completed September 2016

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
2	1A	Consider further strengthening the annual planning cycle by providing an opportunity to increase the levels of engagement between the board and senior leaders in order to increase oversight of the key aspects of the BDU plans and to provide a further opportunity for debate.	M		Agreed – annual planning cycle to be reviewed and strengthened to increase engagement. Timescales - Review transformation programme Extended EMT August 2015 - Revised structure for EMT meetings to provide stronger focus on transformation - Stocktake of strategic plan and transformation Trust Board September 2015 - Review EMT time out October 2015 - Trust Board strategy November 2015 and February 2016 - Trust Board in March 2016 sign-off	Strategic planning team will support planning events in each BDU for 2016/17. Process begun – EMT September 2015 Completed – revised structure implemented from August 2015 Completed – stocktake presented to Trust Board 22 September 2015. EMT time out 15 October 2015 Trust Board strategy sessions 24 November 2015 and 1 March 2016 First draft of annual plan submitted to Monitor 8 February 2016 (approved by Trust Board 29 January 2016). Final version of annual plan submitted to Monitor 18 April 2016 (approved by Trust Board 29 March 2016).	**Completed**
3	**1A**	Further develop the process for monitoring progress against the strategic plan including strengthening outcome measures and collating progress into a single dashboard which is presented to the strategy board at regular intervals throughout the year.	H	MB	Agreed - How – September 2015 Trust Board through stocktake of strategic plan and transformation - What – November 2015 strategy Trust Board. - Close links with new Non-Executive Directors ('fresh pair of eyes') and utilising skills and experience.	<u>Update</u> Phase I to develop a single dashboard. Phase II to further develop strengthened outcome measures and reporting through integrated performance report. Included in Chief Executive's objectives for 2016/17 *Examples of best practice reviewed.* *Stocktake of 2015/16 plan at Trust Board January 2016.* *Agree format for review of plan for 2016/17 in March/April 2016.* *EMT approval of approach to development*	September 2016 March 2017

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
						of business intelligence January 2016. Group established involving Non-Executive Directors to review dashboard reporting (stocktake and follow up meetings held November 2015 and February 2016). Timescales revised to reflect development of strategic objectives (EMT time out 21 April 2016 and Trust Board 28 April 2016). Meetings of sub-group established to finalise.	
4	**1A**	Strengthen the processes for the dissemination and monitoring of the strategy both to ensure that there is greater awareness of the key objectives for the Trust, as well as increased engagement in this process. This should include: • Localised activities, such as the BDU leadership undertaking engagement events in their service areas; • greater dissemination of the message to staff using a varied of media sources; and • alignment of BDU, service and individual objectives with the strategic intentions.	H	BDU Dirs KH/AGD EMT	Agreed. - Review transformation programme Extended EMT August 2015. - Revised EMT focus and strengthened communications and engagement with report into Trust Board September 2015. - Link to staff wellbeing survey to agree metrics to review. - EMT time out October 2015. Implementation December 2015 with review of progress in February 2016.	<u>Update</u> Team briefing and staff communications arrangements reviewed and strengthened, co-produced with staff and informed by staff feedback. Evaluation of implementation will be undertaken through the wellbeing survey in May 2017. *See 1 and 2. Regular stocktake of transformation programme, and strengthened communications and engagement at EMT and Trust Board.* *Revised methodology for dissemination to staff developed with detailed plan and timescales.* *Following approval of Trust operational plan for 2016/17, EMT time out 21 April 2016 to determine priorities for strategic objectives with paper to Trust Board 28 April 2016.*	From 28 July 2016 May 2017
5	**1B**	As part of the planned review of the AF, the Trust should amend this to more clearly align to the strategic objectives; to align risks to Board Committees as well as	H	DS	Agreed. Revised version of assurance framework to Trust Board October 2015 (with quarterly reporting from December 2015 – see below).	Examples of best practice reviewed and assurance framework revised for presentation to October 2015 Trust Board. Q3 presented to Trust Board January 2016. Internal audit February 2016 (with	**Completed**

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
		an ED; and for the format to be in line with best practice taking into account the points outlined in 1B.				finding of significant assurance).	
6	**1B**	The Trust needs to be clear how assurance over the delivery of the Transformation programme will be undertaken, especially given the risks to the Trust in this area. In particular, the Trust should consider: • implementing a Transformation forum or a Finance Committee (which could also amalgamate the work of the IM&T and Estates forums); and • strengthening the content of reports presented to the Board.	H	JD/ workstream leads	Trust Board has considered establishment of a finance Committee on a number of occasions (most recently at the Deloitte feedback workshop on 21 July 2015) and agreed that the Trust's financial position is a matter for Trust Board and should receive full Trust Board attention (see also recommendation 7). Reporting of transformation will be strengthened from September 2015. - Re-alignment of EMT meetings from August 2015 to provide stronger scrutiny of transformation progress. - Discussion at Extended EMT regarding clarity of visions and governance for transformation August 2015. - Reviewed also at EMT to inform report to Trust Board in September 2015. - Ongoing quarterly reporting to Trust Board (at business and risk meetings) with exception and risk reporting as required.	<u>Update</u> Two discussion papers presented to Executive Management Team to improve monitoring and governance processes and to provide assurance to Trust Board quarterly and Executive Management team monthly. Reports highlight progress, identify risks and issues with mitigating action, and resources. Work begun to strengthen benefits realisation. *Completed – revised structure implemented from August 2015* *Process begun – EMT September 2015 and EMT time out 15 October 2015* *Completed – stocktake presented to Trust Board 22 September 2015* *Project Management Office developed highlight report for transformation programme for ongoing quarterly reporting to Trust Board.* *Review of governance arrangements and reporting at different levels moving from planning to implementation.* *Group established involving Non-Executive Directors to review dashboard reporting (stocktake and follow up meetings held November 2015 and February 2016). Timescales revised to reflect development of strategic objectives (EMT time out 21 April 2016 and Trust*	Embedded by December 2016 December 2016

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
						Board 28 April 2016). Meetings of sub-group established to finalise.	
7	**2A**	Revisit the name and content of the business and risk board and the public board to clarify the distinction and to set agendas in the context of the key risks facing the Trust. Retain a separate focus on strategy through the strategic board.	M	IB	Agreed – establish clearer distinction between business and risk, and 'public' Trust Board meetings. Attendance at Trust Board reviewed and agreed by Chair and Chief Executive from September 2015. Formal terms of reference to be established for Trust Board in support. Implementation of revised Trust Board quarterly meeting cycle from October 2015 with paper to September 2015 Trust Board and Audit Committee October 2015. - Month 1 business and risk – purpose to ensure strategy and, in particular, transformation, feature more prominently, including the Trust's plans for investment, to provide a link to the Trust's financial position and sustainability (i.e. change job). Will include quarterly reporting to Monitor. - Month 2 maintain strategic sessions as protected time. - Month 3 performance and monitoring – focus on delivery, finance and performance (i.e. the day job), including the assurance framework and risk register, compliance and regulation.	Review of quarterly cycle of Trust Board meetings: - Business and risk - Strategy - Performance and monitoring Attendance at Trust Board reviewed and agreed.	**Completed**
8	**2B**	Implement a range of engagement mechanisms to supplement the Trust newsletter. Consider especially how any additional	M	KH/AGD	Agreed – commission full review of all internal communication approaches, including newsletter, intranet, social media and other digital approaches. - Initial presentation to EMT August	<u>Update</u> As recommendation 4. Arrangements in place including: - Chief Executive's weekly Huddle; - The View and The Brief;	

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
		communications can be meaningful to staff in diverse roles and locations.			2015 with view to agree a definitive approach. - Include in presentation to Trust Board in September 2015 with implementation by December 2015.	- revised team brief arrangements from July 2016; - ongoing staff insight events; Wellbeing survey will demonstrate the impact of revised arrangements. - *Implementation of staff engagement strategy through action plan owned at EMT level. Will form key part of Director Q4 reviews with CE.* - *Review of marketing, communications and engagement function and channels – completed by KH and revised structure in place from January 2016.* - *Clinical advisory role established.* - *Develop new approach to how the Trust engages with people using digital technology – role established within Communications Team to take the Trust's approach forward.* - *Revisit transformation programme visions, and communications and engagement plans.* - *Survey of staff for views on communication and engagement with outcome reported to EMT September 2015.* - *Paper presented to Trust Board in September setting out plans for a refocused marketing, communications and engagement function – implemented and in place from January 2016.* - *Plan in place to engage and communicate with staff on the Trust's strategic objectives – to follow April's EMT time out and Trust Board.*	
9	**3A**	Update Committee terms of reference to clarify their	L	DS	Agreed – to be included in Committee annual reports February 2016	Terms of reference reviewed as part of annual reporting process and	**Completed**

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
		expected interaction with other groups and forums and to incorporate the additional aspects of good practice.				amendments will be presented to Trust Board on 29 March 2016.	
10	**3A**	Consider further enhancing the Committee reporting to the Board through the use of a standard format for the Chair's action log. Revisit the frequency of Committee reporting to the Board, ensuring that there is a clear process to escalate issues as required, and ensure that Board forums are included within this process also.	M	DS	Agreed – Committee minutes to be presented to the most appropriate and timely Trust Board meeting (business and risk or performance and monitoring). From October 2015.	Completed – Committee minutes taken at each Board meeting as appropriate.	**Completed**
11	**3A**	Clearly define the required reporting and escalation arrangements from TAGs which outlines when (and to where) TAGs should report along with the frequency and nature of reports required.	M	EMT TB/DS	Agreed. - Scope TAG reporting and report to EMT in September 2015 (performance, delivery and assurance), with clear links to Trust Board Committees and sub-committees in terms of assurance. - Update to Trust Board in October 2015.	<u>Update</u> Review undertaken August 2016 by new Chief Executive to support Director portfolio review. Arrangements clarified in terms of governance, assurance and delivery. Paper to Executive Management Team for discussion 8 September 2016. Implementation of revised arrangements by end of October 2016. *TAGs mapped as part of description of Trust governance arrangements for Care Quality Commission inspection visit.*	September 2016 October 2016
12	**3B**	Further refine the content and purpose of BDU performance meetings by improving the structure of items to be considered across all BDUs and through the inclusion of a specific focus on the	M	BDU Dirs	Agreed – clarify arrangements at EMT September/October 2015. Extend to include BDU governance meetings and transformation boards.	<u>Update</u> Role and remit of Operational Requirement Group reviewed and revised terms of reference and approach approved by Executive Management Team in August 2016. Operational Management Group	September 2016

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
		development of and progress against strategic objectives.				established from September 2016, which is BDU-led and operationally focused to provide assurance to the Executive Management Team and Trust Board. Part of remit is to monitor progress against operational plan and strategic objectives. *To be reviewed by EMT following receipt of CQC final report and linked to planned audit of BDU Governance Groups to be undertaken by Practice Governance Coaches (due date September 2016).* *NB annual BDU governance groups report presented to Clinical Governance and Clinical Safety Committee in April each year.*	
13	**3B**	Clarify the role and purpose of ORG. Consider amending its remit to include a focus on broader performance issues on an exceptions basis where it impacts on operational delivery.	M	AF	Agreed. - Purpose for ORG reviewed early August 2015. - Clarity to be confirmed in development of ToR for ORG and EMT October/November 2015.	Purpose of operational requirement group clarified by Chief Executive August 2015 and in February 2016. *(To review, discuss and agree action in relation to operational issues and pressures, and to focus on delivery of the plan, in particular, the delivery of the cost improvement programme. It is not a replication of EMT meetings or of its role.)*	**Completed**
14	**3B**	Introduce an Assurance and Escalation Framework that clearly describes when and how key issues and risks should be escalated.	M	DS	Agreed.	Examples of best practice reviewed and paper presented to Trust Board and approved January 2016.	**Completed**
15	**4A**	The IPR should be updated to include: • an executive summary in order to highlight key exceptions and outline actions in place to	M	MB	Agreed. Recommendations 3 and 12 inform 15 and 16. Longer timescales to allow for development of reporting and to ensure involvement of NEDs,	<u>Update</u> Performance report now contains executive summary and report makes better use of graphical analysis. Integrated performance reporting now in place and fully embedded by	

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
		improve performance in these areas; • greater use of graphical analysis to present data in order to aid interpretation and understanding; and • a more rounded overview of performance at BDU level against key metrics covering all aspects of the business (to include quality, performance, finance and workforce).			particularly new appointments.	December 2016 *Examples of best practice reviewed. Presentation and engagement to Extended EMT September 2015.* *Group established involving Non-Executive Directors to review dashboard reporting (stocktake and follow up meetings held November 2015 and February 2016). Timescales revised to reflect development of strategic objectives (EMT time out 21 April 2016 and Trust Board 28 April 2016). Meetings of sub-group established to finalise.*	December 2016
16	**4A**	The Board would benefit from the inclusion of clear alignment between the metrics included in the Strategic Overview Dashboard and the key strategic priorities. This should be accompanied by the inclusion of locally determined metrics aligned to the priorities.	M	MB	Agreed. Recommendations 3 and 12 inform 15 and 16.	See recommendation 15.	**Completed (link to 15)**
17	**4A**	Review the aspects of the finance report which are currently received by the Board in private with a view to merging non-commercially sensitive elements into the main IPR finance report received in public.	M	AF	Agreed. Finance report to be discussed at agenda setting and challenged at callover, supported by review at end of each Board meeting. From September 2015.	All agenda items for Trust Board are reviewed and discussed at agenda setting and callover with Chair and Chief Executive to ensure appropriate items are reported in public and private with a clear rationale for items scheduled for both public and private meetings.	**Completed**
18	**4A**	Introduce a more granular BDU level view of quality performance as part of the quality metrics received by	M	TB	Agreed.	To be included in the scope of work address recommendation 15.	**Completed (link to 15)**

Rec	Ref	Recommendation	Priority/ risk rating	Dir. Lead	Management response/action	Update	Timescales
		the CG&CS Committee. This could take the form of a heat map or performance wall.					
19	**4B**	Introduce routine assurance reporting on data quality with clear alignment to a Board Committee. This should include periodic updates on progress in delivering the data quality action plans.	M	TB	Agreed. Routine reporting for assurance on process to Audit Committee. Routine reporting for clinical assurance to Clinical Governance and Clinical Safety Committee. Continued reporting in terms of IM&T Strategy at IM&T Forum. From October 2015.	Report to Audit Committee October 2015 with ongoing reporting as appropriate. Standing item on the agenda for the Clinical Governance and Clinical Safety Committee. Issues escalated to Trust Board as appropriate (for example, IT virus and RiO V7 implementation).	**Completed**
20	**4B**	Introduce data quality kite marks to Board performance reporting to enabling BMs to have a clear line of sight of the underlying data quality in each of the indicators being presented.	M	MB	Agreed.	<u>Update</u> Key performance indicators audited as part of internal audit work programme and Quality Accounts. 'RAG' rating of data quality against targets and key performance indicators to be introduced as part of work to develop integrated performance report. Forms part of wider improving clinical record keeping work (facilitated through Improving Clinical Record Keeping Group) to develop a Trust-wide overarching action plan. *To be included in the scope of work address recommendation 15.* *Further action to be aligned to the recommendations arising from the internal audit report (April 2016).*	Links to recommendation 3 March 2017.

Trust Board 20 September 2016
Agenda item 9 – assurance from Trust Board Committees

Clinical Governance and Clinical Safety Committee

Date	13 September 2016
Presented by	Julie Fox/Charlotte Dyson
Key items to raise at Trust Board	➢ Implementation of the patient safety strategy and development of co-ordinated reporting. ➢ Child and adolescent mental health services, local procurement and Autism Spectrum Disorder waiting times. ➢ Quality impact assessments of the cost improvement programme. ➢ Care Quality Commission inspection action plan.

Mental Health Act Committee

Date	2 August 2016
Presented by	Chris Jones
Key items to raise at Trust Board	➢ Delays by Ministry of Justice (as raised in the presentation from forensic services) ➢ Audits undertaken in relation to Section 132 patients' rights and place of safety, and BDU responses to consent to treatment and Section 17 leave. ➢ Legislative changes potentially affecting Section 136 arrangements. ➢ Food (as raised during Mental Health Act visits by the Care Quality Commission). ➢ The importance of access to and interoperability of IT.

Information Management and Technology Forum

Date	12 September 2016
Presented by	Ian Black
Key items to raise at Trust Board	The Forum received a demonstration of the clinical portal. Other key items considered were: ➢ an update on the upgrade to RiO V7 and a Freedom of Information request made in relation to the upgrade; ➢ options for procurement of the Trust's clinical information system (mental health); ➢ an update on the IT strategy milestones and IM&T funding.

Minutes of the Mental Health Act Committee Meeting held on 2 August 2016

Present:	Julie Fox	Deputy Chair of the Trust
	Chris Jones	Non-Executive Director (Chair)
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
Apologies:	**Members**	
	Jonathan Jones	Non-Executive Director
	Attendees	
	Shirley Atkinson	Professional Development Support Manager (Barnsley) – local authority representative
	Anne Howgate	AMHP Team Leader (Kirklees) – local authority representative
	Gill Pepper	Safeguarding Adults Named Nurse, Barnsley Hospital NHS Foundation Trust – acute trust representative
In attendance:	Jo Barber	Ward Manager, Johnson Ward (women's service), Newton Lodge (item 2.1)
	Andy Brammer	Mental Health Act Professional Lead (Wakefield) – local authority representative
	Laurence Campbell	Non-Executive Director
	Julie Carr	Clinical Legislation Manager
	Bernie Cherriman-Sykes	Board Secretary (author)
	Charlotte Dyson	Non-Executive Director
	Yvonne French	Assistant Director, Legal Services
	Mike Garnham	Health Intelligence Analyst (item 10.1)
	Clare Hughes	Outreach Liaison, Newhaven (item 2.1)
	David Longstaff	Independent Associate Hospital Manager
	Mary McSharry	Practice Governance Coach, Forensic Service
	Ian Priddey	Professional Lead and Development Co-ordinator (Mental Health) (Calderdale) – local authority representative
	Adrian Wilson	Ward Manager, Priestley Ward (men's service), Newton Lodge (item 2.1)

MHAC/16/27 Welcome, introduction and apologies (agenda item 1)

Chris Jones (CJ) welcomed everyone to the meeting. He advised that he has taken over as Chair of the Committee from this meeting and thanked Julie Fox (JF) for her time as Chair. JF will remain on the Committee for the time being. The apologies, as above, were noted.

MHAC/16/28 The Act in practice (agenda item 2)

Transformation and Mental Health Act/Mental Capacity Act implications – forensic and child and adolescent mental health services (agenda item 2.1)

Presentation from Mary McSharry, Clare Hughes, Jo Barber and Adrian Wilson.

MHAC/16/29 Legal update/horizon scanning (agenda item 3)

Judicial Review – Staffordshire hospitals vs. hospital managers (agenda item 3.1)

Julie Carr (JC) explained the background to the case and outlined the findings. A review has begun of decision-making recording processes and other documents relating to Hospital Managers to ensure recording of decisions is robust and clear. David Longstaff (DL) commented that Hospital Managers within the Trust are independent and do feel able to

make independent decisions. He would be happy to discuss how and why any decision is reached with the Trust. Laurence Campbell (LC) commented that the matter appears to be one of inadequacy of documentation rather than the processes in place.

Law Commission interim report for the Mental Capacity Act/Deprivation of Liberty Standards review (agenda item 3.2)
JC highlighted the following as of importance for the Trust:

- the shift in responsibility for establishing the case for Deprivation of Liberty (DoLs) from care providers to commissioners (local authority or clinical commissioning group);
- the dropping of the original proposal for a separate scheme for authorising DoLs in hospitals; and
- the dropping of a proposal to create a new mechanism in the Mental Health Act to cater for people lacking capacity who are compliant with their treatment.

A draft Bill will be submitted to Parliament later this year; however, a sense of disappointment with the proposals remains.

Parliamentary and Health Service Ombudsman – unlawful detention (agenda item 3.3)
JC explained that this has implications for the Trust's liaison services and services at Mount Vernon. Guidance for staff on how to act lawfully in relation to any detention if any individual lacks capacity or is perceived to lack capacity has been prepared. Tim Breedon (TB) confirmed that the Trust will ensure acute trust colleagues are also in receipt of the briefing/advice and guidance.

Action: Julie Carr

York City Council – S117 audit concerns (agenda item 3.4)
The Committee noted that a Section 117 policy has been agreed in Calderdale and Kirklees but remains to be agreed in Wakefield.

MHAC/16/30 Minutes from the previous meeting held on 17 May 2016 (agenda item 4)

It was RESOLVED to APPROVE the minutes from the meeting held on 17 May 2016.

MHAC/16/31 Matters arising from previous meeting (agenda item 5)

Action points from the meeting held on 17 May 2016 (agenda item 5.1)
The action points were noted and three items raised.

MHAC/15/51 – the outcome of patient-led assessments of the care environment (PLACE) will be reported to the Committee at its November meeting.

Action: Tim Breedon (Alan Davis)

MHAC/16/21 – risk assessment of findings from audit reports are included in the revised audit report format.
MHAC/16/23 – in relation to access to RiO for local authority colleagues, this will be taken forward by the Systems Development Board in terms of interoperability and access. The Committee asked for a further explanation of the issues from the IT team and how this can be resolved. It was agreed that TB would follow this up.

Action: Tim Breedon

Oversight and escalation process for Mental Health Act (agenda item 5.2)
TB explained that, if the Committee was supportive of the proposed approach, future reporting would be by exception with any areas of concern escalated to either this Committee or the Clinical Governance and Clinical Safety Committee. Any urgent issues would be considered by the Executive Management Team (EMT) given the timing of Committee meetings. JF asked that an expectation that issues are addressed within three months is also added to the paper.

Subject to these two caveats, the proposal was supported.

MHAC/16/32 Annual report (agenda item 6)
To be received in February 2017.

MHAC/16/33 Transformation update (agenda item 7)
Transformation highlights June 2016 and update for Mental Health Act Committee for relevance, information and action if required (agenda item 7.1)
TB advised that there were no issues to raise with the Committee. The report was noted. TB alerted the Committee to the reference to the preference in Kirklees to commission locked rehab beds.

MHAC/16/34 Audit and compliance reports (agenda item 8)
BDU audit actions (agenda item 8.1)
The report contains BDU responses to the consent to treatment, and Section 17 leave audits. CJ asked how this relates to the escalation process considered under item 5.2. TB responded that this would preclude detailed reporting, which would be by exception only. The annual review of BDU governance groups would provide assurance that action has been completed or is in progress. Yvonne French (YF) added that actions will still be monitored by the Mental Health Act administration office and exceptions reported to the Committee if there is a cause for concern. Timescales would be contingent on the type of recommendation and action required to address.

LC asked if the Care Quality Commission (CQC) inspection had changed the focus of the audit programme. TB responded that it had not for those in train or planned; however, there will be some additional items for the audit programme as a result. There will also be a further review in terms of objectivity, which was raised in the inspection report.

Section 132 patients' rights (agenda item 8.2)
Three recommendations were supported:

- for the audit to be shared with BDU Directors;
- for BDUs to review the audit findings and provide the Committee with an action plan to support the implementation of the Patients' Rights Policy; and
- for a re-launch of the revised Policy with supporting guidance notes.

The Committee asked that referral to advisory services if the patient does not understand their rights is also included in the policy.

TB commented that it might be useful to bring the action plan from BDUs at the same time as the audit report to support the outcome of the audit. The main issue appears to be where compliance is recorded not necessarily that it is not happening. The conclusion should, therefore, note this. YF commented that the target should be 100% and the audit would

identify the reasons why an individual was not given their rights. It was agreed to receive the action plan at the next meeting and the Committee asked that the action plan minimises any unnecessary clinical variation.

Action: Julie Carr

The general view was that the conclusion and recommendations from the audit should be clearer with clear timescales.

Action: Julie Carr

Place of safety report (agenda item 8.3)
TB commented that the report/data presented will include analysis for future presentations. Adrian Berry (ABe) commented that there are no apparent trends although the report does highlight variations between Wakefield and other districts in terms of use of Section 136 and outcomes. The Committee asked for further analysis to understand this. It was agreed YF would take forward with Mike Doyle (MD) through the Section 136 Group and provide an update to the next meeting.

Action: Yvonne French

Ian Priddey (IP) advised that the Police and Crime Bill will propose some changes to the use of Section 136, particularly in terms of the length of time before admission, which will result in greater demand for suites raising commissioning issues. YF responded that this issue is on the Section 136 Group agenda for an assessment of the implications for the Trust.

MHAC/16/35 Care Quality Commission visits (agenda item 9)

Recent visits (agenda item 9.1)
The three monitoring visits to Gaskell, Newton Lodge, Fieldhead, Wakefield (26 April 2016), Newhaven, Fieldhead, Wakefield (20 May 2016) and Ward 18, Priestley Unit, Dewsbury (27 May 2016) were noted.

TB commented that the Committee is clear on its role in receiving reports on actions arising from CQC Mental Health Act visit reports through the oversight and escalation process discussed under agenda item 5.2; however, it also needs to be clear about its role in receiving full reports. The Committee agreed that the reports should continue to come to the Committee for information and only discussed where relevant areas require further clarification or information.

Charlotte Dyson (CD) commented that she was disappointed that food continues to be an issue. Mary McSharry (MMc) responded that services work hard to provide good food. This is an area of real concern; however, it is a difficult issue for the Trust to address. ABe advised that quality assurance mechanisms to ensure dietary requirements are met are included in contracts and monitored. CD asked that Trust Board tries the food offered to patients.

Action: Dawn Stephenson

YF commented that the Mental Health Act Code of Practice is currently showing 'green' in this area. She will, therefore, ask for a rationale for this rating from the strategic lead given the findings by the CQC. Dawn Stephenson (DS) commented that food does not feature regularly in complaints; it is mainly raised when discussed face-to-face. TB suggested bringing an update to the Clinical Governance and Clinical Safety Committee in terms of the Trust's food strategy.

Action: Tim Breedon (with Alan Davis)

Compliance inspection (agenda item 9.2)
The Trust is required to return its action plan to the CQC by 8 August 2016, which will link to information included in item 9.4.

Outstanding actions/progress report (agenda item 9.3)
An example of a BDU report was presented. The Committee will receive information on 'red' areas. Concern was expressed that some areas currently rated 'amber' may be seen by the Committee as 'red'. CJ asked that the Committee continues to see assurance around 'amber' actions as well as 'red'.

Action: Yvonne French

In relation to service user access to IT, DS will provide an update to the next meeting following her meeting with Kate Henry and Bronwyn Gill to discuss the Trust's approach.

Action: Dawn Stephenson

Mental Health Act Code of Practice action plan (agenda item 9.4)
YF confirmed that progress updates will be retained as an item on the Committee's agenda. CJ commented that he was slightly concerned that the action plan was developed in February 2015 and some actions remain as 'amber'. They should, therefore, automatically default to 'red'. TB commented that more complex/complicated pieces of work require a reference group to be established or technical advice, which would also look at the ratings given.

It was suggested that the Code of Practice for the Mental Capacity Act should also come into the Committee. Any new work would go into the clinical group and reported, if necessary, to the Committee.

Action: Yvonne French

MHAC/16/36 Monitoring information (agenda item 10)

Monitoring information Trust-wide January to March 2016 and new form of report for comment (agenda item 10.1)
Mike Garnham (MG) provided a demonstration of the revised reporting format. For reporting to the next meeting, it was hoped that all information would come from RiO and, therefore, information would be comprehensive and complete. Analysis will be enhanced, including a clinical view of the data. CD commented that she took assurance from the analysis and, therefore, this is where she would like the focus of reporting to be to aid the Committee's understanding. The Committee was supportive of the new format for presentation.

JF commented that she remained concerned about the 'not knowns' recorded, particularly in relation to ethnicity. MG agreed to re-visit the original data as it was understood that 'not known' was no longer an option for completion and making a choice is mandatory.

Action: Mike Garnham

It was agreed that there should be an in-depth analysis of 'not known', 'not disclosed' and 'other' as work to improve recording does not seem to have produced an improvement.

Action: Tim Breedon/Yvonne French

ABe commented that it may be that, if an existing service user (that is one already on the system) is recorded as 'not known' when it was an option, then it would remain so.

Local authority information (agenda item 10.2)
IP observed that there appear to be far more assessments in Kirklees even allowing for a larger population size and a large proportion of these results in no further action and delays. CJ commented that this is interesting data but it requires analysis. JC responded that the

intention is to incorporate into Mental Health Act monitoring; however, there are issues with recording and consistency. MG is working with local authority colleagues to make recording and collation of information easier.

The Committee was concerned that information for Barnsley and Wakefield was missing. TB appreciated the concern. He commented that this was, however, over and above what most trusts would receive and the Committee should not underestimate the willingness of local authority partners to share information with the Trust.

Hospital Managers' Forum 27 May 2016 (agenda item 10.3)
The Forum notes from the May meeting were noted.

Compliments/complaints/concerns in relation to the Mental Health Act April to June 2016 (agenda item 10.4)
The Committee agreed the report was useful and helpful. JF asked whether the outcome of complaints under investigation could come back to the Committee. YF commented that the Mental Health Act administration office also reviews each complaint in relation to the Mental Health Act and she suggested that this information is also included.

Action: Dawn Stephenson/Yvonne French

Hospital Managers' concerns (agenda item 10.5)
The two issues were noted. TB was asked to provide information to CJ and JF on the first issue (in relation to the lack of permanent, qualified staff on duty) to consider whether this should be referred to the Clinical Governance and Clinical Safety Committee for review in terms of safer staffing and to understand the issue in more detail.

Action: Tim Breedon

MHAC/16/37 Partner agency update (agenda item 11)

Local authority (agenda item 11.1)
IP reported on the shortage of Approved Mental Health Professionals (AMHP) over the next couple of months in Calderdale; however, arrangements are in place for cover. Five AMHPs are in training with two waiting to start. He also advised that he is leaving the Council. Following a review of arrangements, Terry Hevicon-Nixon will assume an Operations Manager role and will cover Committee meetings.

Acute health care (agenda item 11.2)
This item was not taken.

MHAC/16/38 Key messages for Trust Board (agenda item 12)

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

- delays by Ministry of Justice (as raised in the presentation under agenda item 2.1);
- audits undertaken and the outcomes;
- legislative changes affecting Section 136 arrangements;
- food; and
- the importance of access to IT.

MHAC/16/39 Date of next meeting (agenda item 13)

The next meeting will be held on Tuesday 15 November 2016 at 14:00 in the small conference room, Learning and Development Centre, Fieldhead, Wakefield.

Trust Board 20 September 2016
Agenda item 10

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.
Mission/values:	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 once since the report to Trust Board in June 2016 in respect of the following. - Contract for sale of freehold land at Pomfret Lodge, Pontefract between the Trust and Kip McGrath Education Centre.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in June 2016.**
Private session:	Not applicable