South West Yorkshire Partnership **NHS**

NHS Foundation Trust

Trust Board (business and risk)
Tuesday 20 December 2016 at 13:00
Meeting rooms 49/50, Folly Hall, Huddersfield

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 25 October 2016** (attached)

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

5. **Update on Health & Wellbeing Strategies** (attached)

6. **Strategy refresh** (attached)

7. **Performance reports month 8 2016/17**
   7.1. Integrated performance report month 8 2016/17 including finance (attached)

8. **Exception reporting**
   8.1. 2015 Community Mental Health survey (attached)

9. **Governance matters**
   9.1. Compliance with NHS Constitution (attached)

   9.2. CQC well-led review update (attached)

   9.3. Agency staff self-certification (attached)

   9.4. Approval of the Operational Plan 2016/17 and 2017/18 (attached)

   9.5. Trust Board work programme 2017 (attached)

   9.6. Membership of Wakefield Multi-Speciality Community Provider Committee in Common (attached)

With **all of us** in mind.

10. Assurance from Trust Board Committees (attached)

- Remuneration and Terms of Service Committee 4 November 2016
- Clinical Governance and Clinical Safety Committee 8 November 2016
- Mental Health Act Committee 15 November 2016
- Estates Forum 15 November 2016

11. Use of Trust seal (attached)

12. Date of next meeting
The next meeting of Trust Board will be held on Tuesday 31 January 2017 at Fieldhead, Wakefield.

South West Yorkshire Partnership NHS

NHS Foundation Trust

Minutes of Trust Board meeting held on 25 October 2016

Present:	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Rachel Court	Non-Executive Director
	Julie Fox (Chair)	Deputy Chair
	Rob Webster	Chief Executive
	Dr Adrian Berry	Medical Director / Deputy Chief Executive
	Tim Breedon	Director of Nursing and Quality
	Mark Brooks	Director of Finance and Resources
	Alan Davis	Director of HR, OD and Estates
Apologies:	Ian Black	Chair
	Chris Jones	Non-Executive Director
	Jonathan Jones	Non-Executive Director
In attendance:	James Drury	Interim Director of Strategic Planning (item 7)
	Kate Henry	Director of Marketing, Communications and Engagement
	Dawn Stephenson	Director of Corporate Development (Company Secretary) (author)
Guests:	Bob Clayden	Publicly Elected Governor (Wakefield), Members' Council
	Bob Mortimer	Publicly Elected Governor (Kirklees), Members' Council

TB/16/69   Welcome, introduction and apologies (agenda item 1)

The Deputy Chair Julie Fox (JF) welcomed everyone to the meeting, in particular Bob Clayden and Bob Mortimer elected governors from the Members' Council. Apologies were noted as above.

TB/16/70   Declaration of interests (agenda item 2)

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

TB/16/71   Minutes and matters arising from previous Trust Board meeting held on 20 September 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 20 September 2016 as a true and accurate record of the meeting.

There was one matter arising. Alan Davis (AGD) updated on the newly launched Black Asian Minority Ethnic (BAME) staff network. The findings of the recently published 2015 Workforce Race Equality Standard (WRES) data analysis report for Trusts shows that there is still work to do to narrow the gap in experience and outcomes between white British and BAME NHS staff.

Acting as a collective voice articulating the experience of their members, staff networks can devise solutions to help close the gap between white British and BAME staff, offer support to members and create a safe space for discussions on issues of inequality and discrimination. The Trust's BAME staff network will be run by the staff; elections for key roles are currently underway. Themes from the network will be fed into the Executive Management Team (EMT) and the Equality and Inclusion Forum ensuring progression and monitoring of key issues.

TB/16/72   Chair and Chief Executives Remarks (agenda item 4)

JF began her remarks by noting the new requirements for submission of two year plans by December 2016 and agreement of centrally set control totals. She noted that a member of staff she had met recently had reflected that it has been a difficult year and so it is particularly important that we recognise the positive contribution and great work of our staff through our Excellence Awards being held on 7 November 2016. Charlotte Dyson (CD) commented positively on the judging process, the standard and variety of submissions from across the Trust.

JF provided feedback from the Yorkshire Chairs meeting she had attended on behalf of Ian Black (IB). Agenda items covered the need to address the gender gap at Board level to set the tone for the organisation, aiming for a 50/50 split by 2020. It was noted that the Trust was looking at the broader diversity of the Board through involvement in the Gatenby Sanderson Insight Programme. Dawn Stephenson (DS) stated she had been in contact with their identified candidate for a Trust placement who will attend Members Council, Board and relevant sub-committees as part of their development programme. Other opportunities to broaden the diversity of the Board through the development of individuals included unpaid associate Non-Executive Directors (NEDs) and the on-going development of trust governors. JF reported that the Shadow Board feedback was positive, individuals gaining confidence, knowledge and insight into what the Board does.

JF updated the Board on the Annual Members' meeting to be held on the 21st November 2016 at Barnsley Civic Theatre. She congratulated Dr Adrian Berry (ABe) on his appointment to the deputy Chief Executive role.

Rob Webster (RW) provided an update to his written report:

➢ Strong focus nationally on financial health and getting back into balance. Unlikely to be any new NHS funding in Autumn Statement, possibly additional social care funding, recognising systemic issues which are having a material impact on the wider system.

➢ British Medical Association (BMA) suspended strikes. Unfortunately Jeremy Hunt's message about becoming "self-sufficient" in medical staffing and a boost to the numbers of doctors in training has led to a row that this undermines our much valued overseas staff. The Trust's position had been clarified by RW through The View, his weekly communication with staff.

➢ Sustainability and Transformation Plans (STPs) have been submitted. NHS England and NHS Improvement (NHSI) have been requesting that plans are not published until quality assurance process completed. Plan for West Yorkshire is to publish w/c 31 October, to include a public facing easy read version, a summary of recent engagement activity and a short film that RW has made with Healthwatch. South Yorkshire are potentially going to publish in November.

➢ Planning guidance has significant impact for the Trust which sees elements of our autonomy as a Foundation Trust (FT) eroded.

➢ West Yorkshire has been designated as an "Acceleration Zone" for Urgent and Emergency Care and is the only one in England. This is a programme to ensure that the 95% target is met by February 2017 and that a 20% transfer of 111/999 calls to the "right service" is achieved by the end of March 2017. There may be additional resources available.

➢ Service reconfiguration plans for Calderdale and Huddersfield NHS Foundation Trust (CHFT) – both Calderdale and North Kirklees CCGs have agreed to move to the next phase, developing a full business case for changes to urgent and emergency care in Huddersfield and Halifax.

➢ Mid Yorkshire oversight and assurance executive meeting (of which we are a member) has been postponed until November, no further update available.

TB/16/73   Operational plan guidance and process (agenda item 5)

Mark Brooks (MB) introduced the report and raised the following:

➢ Our draft plan needs submitting by 24 November 2016 including agreement or not of control totals and the Trust's position around the nine "must do" priorities included in the planning guidance.

➢ STP / Trust finance and operational plans need to be aligned. There is a possible issue for our Trust re. CQUINS – 0.5% of our CQUIN income reliant on STP delivering on the collective control total.

➢ Settlement fixed for 2 years based on 2.1% uplift in tariff with a 2% efficiency deflator. Further pressures around out of area placements, commissioners retendering contracts and potential redundancy costs which means that it has been reported some Trusts will need to deliver a 4-6% efficiency requirement.

➢ Contracts need agreeing by 23 December 2016 at the same time as plan submissions. We have received commissioning intentions from Barnsley and meetings underway with WY Clinical Commissioning Groups (CCGs), formal responses required by 4 November. MB will update the Board through e-mail on a weekly basis.

➢ Laurence Campbell (LC) raised concerns that we will be submitting a plan with five months of the current year still to go, with further uncertainty around the underpinning baseline. MB stated we need to be very explicit about what our underpinning assumptions and risks are in the submission.

➢ JF asked how confident could we be in delivering the control total? MB stated the financial control total we have been set of £2.4m for 2017/18 is £1.9m above the 2016/17 control total, this added to required efficiencies and system unknowns around ACOs, will be very challenging.

➢ RW added commissioners and providers are having more open conversations now as part of the STP process re. money and as an EMT, we have been discussing our contract negotiation principles to ensure a robust approach on behalf of the people we support. Yorkshire and Humber CEO's network took place last week – Claire Murdoch, National Director for Delivery of 5 Year Forward View for Mental Health and Chris Hopson, CEO of NHS Providers, attended. Claire was fully appraised of our position regarding impact of the national focus on acute providers at the possible detriment of primary, community and mental health care and is keen to make sure it is understood nationally.

➢ CD noted that we also need to make sure we keep a focus on our day to day work, what we need to deliver this year and keeping staff engaged and informed.

➢ JF stated an additional private board meeting has been planned for 15 November 2016 to ensure the Board is fully involved in the submission of the draft plan and agreement of the control total.

It was RESOLVED to NOTE the summary of the planning guidance for 2017/18 and 2018/19, associated timescales and the further work required over the next two months.

TB/16/74   Single Oversight Framework (agenda item 6)

MB introduced the paper, key points to note:

➢ The Single Oversight Framework (SOF) introduced on 1 October 2016 replaces existing governance and financial risk frameworks. Trusts are segmented 1 – 4, based on performance. Segment 1 allows maximum autonomy, segment 4 applied to Trusts in special measures.

➢ An agency metric has been included that considers performance against the agency cap, which has implication on our use of resources score. Our current performance is well outside the cap. Noted that MB had corresponded with NHS Improvement on the inclusion of this metric with the need to balance efficiency and safety, whilst delivering complex packages of care.

➢ Given our CQC rating of "requires improvement" and our weak performance against the agency metric, we have been placed in segment 2 of "requiring targeted support". Clarity required on what exactly this might look like. Under the previous reporting arrangements the Trust was rated at 4 (highest rating).

➢ RW asked what the impact might be of not accepting our control total on our segmentation. MB stated this had not been made explicit, but felt likely to remain a 2.

➢ TB stated we have the opportunity to be re-rated by CQC, if the visit is before 23 December 2016 (six months from report publication). Beyond that, due to changes in the CQC regime, it is less clear how the rating would be changed.

➢ From October (November Board) reporting will be against the new Single Oversight Framework.

The Board RESOLVED to NOTE the introduction of the Single Oversight Framework and the initial segmentation of 2 – receiving targeted support.

TB/16/75   Strategic overview - business and associated risks (agenda item 7)

James Drury (JD) took the Board through the key items:

➢ Updated PESTLE and response re-revised SWOT analysis. The Trust is currently undertaking a strategy refresh through a process of listening and engaging with service users, staff and other key stakeholders. This will lead to the publication of a refreshed strategy in December 2016, subject to Board approval.

➢ A key element of our refreshed strategy will be our approach to place based planning and new models of care, possibly enacted through Accountable Care Organisations (ACOs). We need to agree a set of principles and answer a number of critical questions as set out in the paper. We will be focusing on service delivery, partnership approach, potential role in an ACO and what is our core business.

➢ Rachel Court (RC) queried the SWOT opportunities section. The first three are opportunities but the later ones are more our internal to do list and not necessarily opportunities. This was accepted and following a discussion, it was agreed JD to consider and amend, adding further opportunities.

Action: James Drury

➢ CD thought the report was a good piece of analysis. He would like more on how we differentiate ourselves, what our Unique Selling Points (USPs) are, what we want to be known for and how positioned in the marketplace. CD agreed to share her views with JD in the next 4 weeks.

Action: Charlotte Dyson / James Drury

➢ LC noted our segmentation of services, often depicted in a "triangle" of services from specialist at the top to locality based at the bottom, shows clearly what our different services are and we now need to understand alignment with STP priorities and financial contributions. JD agreed to bring updated information to the Board strategy session in November.

Action: James Drury

➢ CD agreed with the above and the need to understand pros and cons and our locality differences. This report provides a good context in which to have those conversations.
➢ RW noted that stakeholder research is underway at the moment to help inform this work. CD was very pleased this work is happening as a key piece of information to underpin our work.
➢ JF summarised the debate stating it was a good overview and helped contribute to a shared view of the Trust's strategic positioning.

It was RESOLVED to NOTE the progress to date and the further pieces of work to contribute to the board strategy session in November 2016.

TB/16/76   Strategies for approval (agenda item 8)
TB/16/76a Organisational development (OD) strategy (agenda item 8.1)
AGD provided an overview of the strategy, co-produced through staff engagement. The OD strategy uses a locally adapted version of the McKinsey 7S model, covering a period of 18 months, ensuring alignment with the Trust's strategy and financial plans currently under development.

➢ RC asked what would change and be different as a result. AGD stated we are doing a lot already, but staff feedback shows that sometimes we have lots of initiatives in train that aren't always aligned and there can be internal friction. The framework will help align our systems and processes and improve our use of resources. The changes that will be delivered as a result are show in the local descriptions of the "7S"
➢ LC asked how we would communicate the strategy effectively. AGD responded that it would connect to the engagement around our annual planning processes, linking to the communications and engagement agenda.
➢ RW thought it provided clarity about what we needed to do and how, with a consistent set of messages running through all we do.
➢ CD said she struggled with our local definition of strategy; the intent is right, but not fully articulated. CD to consider alternative and share with AGD.

Action: Charlotte Dyson

➢ IB comments (through JF) – the strategy is long, would like to see more on deliverables and measurable change. AGD stated this would be addressed through the outcome measures and the plan.

➢ CD asked what had happened to the work on system descriptors re. macro, meso, micro systems. AGD replied that we were still committed to the work on micro systems through the Jonkoping work, but staff felt that the language used could be a barrier within the organisation.

➢ JF asked if the cover sheet could be more diverse and include young people. AGD to work with Kate Henry (KH) to redesign.

Action: Alan Davis / Kate Henry

It was RESOLVED that the Board APPROVED the strategy subject to amending the strategy definition.

TB/16/76b Communications, engagement and involvement strategy (agenda item 8.2)
KH presented the paper which sets out the Trust's ambition over the next 3 years to effectively communicate, engage and involve people. The paper set out the four high level objectives which are relevant to all stakeholder groups. DS updated on membership strategy plans which will be co-produced through the Members Council, enabling local people to have a sense of ownership of the Trust and a greater say in how services are provided in the areas the Trust serves. As a Foundation Trust we are accountable to our members and need to ensure services take account of local need.

➢ RW noted that we now have a template being used for consistency across all strategies and the implementation of Equality Impact Assessments as standard.

➢ CD was pleased with consistent approach and linkages across strategies. Need to understand the context that this sits in and the strategy of the organisation, so that we can articulate the right messages in an engaging way.

➢ RC stated that we need to spend time on measurement and outcomes. RW agreed and that we need two to three high level measures / indicators for each of the strategic objectives to feed into the balanced scorecard.

It was RESOLVED to APPROVE the strategy subject to the comments above.

TB/16/77 Performance reports month 6 2016/17 (agenda item 9)
TB/16/77a Integrated performance report month 6 2016/17, including finance (agenda item 9.1)
MB introduced the new format which combines quality, workforce and finance. Following discussion with RC and Chris Jones (CJ), who had provided input into the new format, it was recommended that the format be adopted and reviewed in six months' time. Further work was required on outcomes and comparison of performance against strategy, this is being worked on.

➢ LC queried the tracking of the annual plan and transformation deliverables. MB stated these are being covered separately for now. Conversations with JD around how we do this in future are ongoing, to address how we reshape the report to align with our strategic objectives, after we've refreshed our strategy. It was noted that CD and RC have offered to help develop transformation metrics.

Tim Breedon (TB) updated on quality:

➢ Clarification was provided on the results of the Mental Health safety thermometer where the medicine omissions relate to refusal to take medication at any one time, more work is underway during quarter 2 to address this issue. ABe commented that we have improved

over the same quarter last year. More work is required as the CQUIN has been set at a more challenging level.

➢ Safer staffing, where the Board was asked to note that the detail of reporting has improved as requested, with provision of further detail around fill rates, challenged services and hotspots. It was noted that average staff fill rates were 108% in September. Yorkshire and Humber Nursing directors are looking at standardising reporting to enable benchmarking and sharing of best practice. Board confirmed they were satisfied with level of detail now about fill rates and exception reporting. RW noted the very high fill rates in specialised services are due to service users who require additional support over and above the planned levels. We have written to NHSI setting out our rationale for excluding this element in the calculation of expenditure contributing towards the agency cap.

➢ CQC meeting held on 22 September confirmed our action plan was approved. If action plans are completed by 23 December then there is an opportunity for re-rating. It was noted that CQC can come in at any time to do an unannounced visit.
  o The Board noted that we need to assess our position in relation to re-rating and that a recommendation is going to EMT on 3 November, prior to CQC meeting on 9 November. TB agreed to circulate decision to Board.

Action: Tim Breedon

  o Key issues in relation to delivery against the action plan are around a clinic room fridge system / temperature, work related to RiO, recording of consent and capacity assessments.
  o Updated action plan will go to Clinical Governance and Clinical Safety (CG&CS) Committee in November 2016. Internal visits scheduled over coming months – planned and unannounced.

➢ RC commented re. re-rating that it would be good if we have delivered against all of the actions and to make sure we've revisited the key points / issues raised by CQC and that our actions have fully addressed them. TB agreed and stated that the Governance Group is assessing this.

➢ CD asked about the Flu CQUIN and if staff understood the financial importance. TB reported uptake is currently at 30% of front line staff three weeks in to programme, need to reach 75% by end of December 2016. Main messaging based on our insight work is not about the money. It focuses on t myth busting, emphasising effective / evidence based, right thing to do re. protecting our service users, staff and family members. The financial consequences are understood, though this has caused some problems where some staff believe the driver is purely financial.

➢ JF asked if we would expect to see an improvement in the % of service users on CPA in employment as a consequence of the project in Barnsley. DS stated that because of the acuity levels of this group of service users it will take some time to see that figure changing. The operating plan guidance for 2017/18 and 2018/19 include a requirement to increase placement support for people with serious mental illness in secondary care by 25% by 2018 against a 2017/18 baseline. We are not currently funded for this and would need to work with the CCGs on how to take this forward. RW noted that we have had similar Board conversations in the past and need to recognise it is unlikely we will achieve the target this year. Next year we need to develop a credible plan that we can stick to and be held to account for delivery.

➢ RW asked if the Board were content with the level of detail regarding the nine incidents last month, resulting in severe harm and death. JF noted the detail was submitted and discussed at CG&CS Committee. TB noted the numbers were within similar levels to previous months and that the Board will be presented with more detail in future months in a new format. RW emphasised the need for "safety first" on the agenda and suggested that Board also looked at number of low / no harm incidents improving trajectories

through increased reporting. Where we have serious harm / death, the Board requires positive affirmation from TB/ABe that any immediate issues and lessons are being picked up. TB/ABe provided this, with reference to strong weekly risk scanning and action, weekly EMT discussions and the scrutiny of CG&CS Committee.

AGD introduced the workforce element of the report, key areas:

➢ Slight reduction in sickness this month to 4.8%. We are seeing positive improvements in specialist services and Barnsley BDU, with work on-going to support the other BDUs. KPMG (internal auditors) are under taking an internal audit report re. local management of sickness in BDUs and comparison with best practices.

➢ Caution required re. extrapolation of six month turnover rates due to recent TUPE transfers across to another provider for staff in Barnsley and Wakefield. Our underlying turnover rate stands at 9.8% excluding exceptional items.

➢ Audit of appraisal figures underway, current lag in updating system, focus on updating figures at end of month 6.

➢ Governance training group set up to look at risk based approach to mandatory training.

MB introduced the workforce element of the report key areas included:

➢ The Trust is marginally ahead of plan at month 6, and Sustainability and Transformation Fund monies are expected to be received for Quarter 2. The position remains challenging and requires action to focus on delivery of non-recurrent and amber rated cost improvement plans (CIPs) and improved delivery of CQUIN schemes.

➢ The "in month" financial performance deficit is £375k more than plan, due to a number of factors including redundancy payments arising from decommissioning of Health and Well Being services in Wakefield and those required to support the Trust's CIPs having a net impact of £600k. Also overspend of £400k in month on "out of area" spend for inpatient beds. On current projections, we won't qualify for our Q3 Sustainability and Transformation Funding, but will in Q4. Urgent work is underway with BDUs to improve our trajectory re. Q3 to ensure STF is received.

➢ We also need to ensure that our capital programme is funded and the consequences for our cash position are managed. We are currently looking at cash requirements and capital commitments over next two years.

➢ The Trust currently has a financial risk rating of 4 (good) under the Risk Framework in place as at Q2. From month 7 (October 2016) the Trust will be regulated under the new Single Oversight Framework. The impact of the breach of the Trusts agency cap by more than 50%, means that the Trust can only score a maximum of 3 overall on finances.

It was RESOLVED to RECEIVE the integrated performance report for September and Quarter 2.

TB/16/77b Customer services report Q2 2016/17 (agenda item 9.2)
DS presented the paper highlighting:

➢ New metrics around speed of response in handling complaints and focus on compliments will be going into the integrated performance report as part of the quality measures.

➢ There has been a positive Trust-wide increase in compliments and now capturing recording compliments between health professionals.

➢ No new Public and Health Service Ombudsman (PHSO) requests to review complaints during Quarter 2. Three complaints were upheld or partially upheld by the PHSO. The impact and consequences of these decisions are now shared with our Executive Management Team (EMT) re. action plan and lessons learnt.

➢ Key complaint themes this quarter include access for ASD / autism assessments. We are working with partners to address pathway issues and capacity.

➢ Newton Lodge involvement survey results were presented and it was noted that these are being taken through service user group, update to be provided in Quarter 3.

➢ CAMHS data is now broken down by district to highlight potential hot spots. RC queried having the right CAMHS action plans in place, given the number of complaints in certain districts and demand for services rising. JF outlined the reporting mechanisms into the Clinical Governance and Clinical Safety (CG&CS) Committee. TB stated metrics agreed with commissioners about where we want to get to, using those for our CG&CS Committee progress reports. Progress has been made in a number of areas, but need to look at speed of progress and can we better share learning across districts. RW stated good to have CAMHS data split by locality. Need to be clear with commissioners, particularly where retendering underway, what we are commissioned to deliver. The Board asked that we spread learning from Barnsley, where the picture was more positive.

Action: Tim Breedon

➢ Results of Mental Health Acute Inpatient survey results are included in the report. Key performance areas will be addressed through BDU and lead directors, as applicable. Working with Picker Institute to undertake benchmarking against other areas, learning from best practice.

It was RESOLVED to NOTE the feedback received through Customer Services for Quarter 2.

TB/16/78   Standing financial instructions (SFI) update (agenda item 10.1)
MB introduced the item. LC informed the board that the SFIs had been reviewed at Audit Committee and they were happy with the proposed updates.

➢ RW queried when we were due to review the scheme of delegation. DS responded that proposed revisions would be going through EMT December / January 2017, then into Audit Committee, Trust Board and Members Council.

It was RESOLVED that the Board APPROVED the updates to the Trusts Standing Financial Instructions.

TB/16/79   Assurance framework and risk register (agenda item 11)
DS presented the paper, key points to note:

➢ A revised approach to Red/Amber/Green RAG rating was included in the report which should ensure a greater consistency of internal reporting. The Board agreed to adopt the recommended approach subject to further refining the definition of red rating. There needs to be a distinction between being off track and being unable to deliver the target. EMT had reviewed the existing risks to ensure they reflected the Trust's current position and strategic objectives. They had also identified a number of possible new risks which will be reviewed in the next iteration of the organisational risk register.

➢ LC commented on the framework diagram re. strategic objectives and asked if these will be reviewed as part of the strategy refresh. RW responded that these would form be part of the refresh.

➢ RW asked if the BAF / risk register reflected the concerns of Board members, including "what keeps us up at night". The Board reflected that this was broadly right, with the BAF showing quality amber and green which feels accurate, but finance more amber and red which again feels accurate. The risks on the Organisational Risk Register and those outside of the Trust's risk tolerance felt like the right issues. RW suggested that the arrangements with sub group scrutiny of risks above risk tolerance would support better Board challenge of risk.

It was RESOLVED that the Board NOTED both the controls and assurances against the strategic objectives for Q2 and the key risks for the organisation.

TB/16/80   NHS Improvement Q2 returns and Board self-certification (agenda item 12)

DS noted that Quarter 2 was the last quarter under the old Risk Assessment Framework which is being replaced by the Single Oversight Framework. NHS Improvement have advised that due to the change in regimes they won't be requiring Quarter 2 governance returns. The Board in line with good governance was provided with an overview of the items that would normally have been included in the quarterly return.

It was RESOLVED that the Board NOTED the contents of the report and APPROVED delegated authority to the Chair/Deputy Chair and Chief Executive to APPROVE the submission and exception reporting to NHS I, should a return be required.

TB/16/81   Developing a Freedom to Speak Up Guardian Network (agenda item 13)

AGD presented the report which outlined the proposal to establish a network of freedom to speak up guardians as part of the staff governors' roles. This would reinforce the connection to staff membership and governance, enhancing their impact within the organisation.

The Board RESOLVED to SUPPORT the development of a pilot Freedom to Speak up Guardian network, with a six month review and APPROVED the reporting arrangements for a summary report of formal whistleblowing cases to go into CG&CS Committee every 6 months.

TB/16/82   Independent investigation report 2014/25273 (agenda item 14)

TB informed the Board that the report had not yet been published, therefore no further update available.

It was RESOLVED to NOTE the current position.

TB/16/83   Assurance from Trust Board committees (agenda item 15)

TB/16/83a Audit Committee 4 October 2016
LC noted the Cyber risk presentation from Deloitte and the actions being taken forward. He also highlighted that the level of materiality for audit has moved from £2.3m to £4.4m this year.

TB/16/83b Equality and Inclusion Forum 10 October 2016
CD reported that Equality Impact Assessments are on target to be completed / refreshed by the end of March for existing services. As reiterated that the BAME network had held their first meeting and work was underway to progress the Board equality work around encouraging more diversity at Board level.

TB/16/84   Date of next meeting
The next meeting of Trust Board will be held on Tuesday 20th December 2016, Rooms 49/50 Folly Hall, Huddersfield.

Signed ……………………………………………… Date …………………………

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 4

Title:	Chief Executive's Report
Paper prepared by:	**Chief Executive**
Purpose:	To provide the strategic context for the Board conversation
Mission/values:	The paper defines a context that will require us to focus on our mission and lead with due regard to our values.
Any background papers/ previously considered by:	This paper references several of the papers in the public and private parts of the meeting and also external papers and links.

Executive summary:	➢ *The Brief* for all staff has been shared with Board members. This sets out current contextual issues, delivery updates, risks and priorities
	➢ Since publication of *The Brief* we have seen:
	    o Greater focus nationally on a "crisis" in Social Care
	    o The CQC publication of a seminal report into the investigation of deaths in the NHS: Learning, candour and accountability
	    o Further developments on STPs and the availability of Transformation Funds and how to bid for them
	    o The appointment process for a Director of Strategy within the Trust
	    o The conclusion of a number of bids and tenders, with some success
	➢ The issues raised within this paper are largely contextual. They are adequately reflected in the assurance framework and risk register, with due consideration of the risk appetite, particularly on safety and finance.

Recommendation:	**Trust Board is asked to APPROVE that the Executive Director of Nursing and Quality is the lead Board director for learning candour and accountability, DISCUSS AND AGREE a Non-Executive lead, and NOTE that the Trust is working with Mazars to further test our own arrangements**.
Private session:	Not Applicable

With **all of us** in mind.

South West Yorkshire Partnership NHS Foundation Trust

Chief Executive's Report

Trust Board 20 December 2016

Introduction

1. This report sets the context for the Board debate, framing the discussion with local and national developments. The report builds on the contents of *The Brief,* which is used as the communications vehicle for cascading communications about the Trust to all staff. A copy of the Brief is attached as Annex A.

National Context

2. The health and care system continues to be a high profile issue politically, financially and operationally. There are three additional things to reflect since the publication of *The Brief* – the focus on **social care;** the CQC report into **reviewing deaths;** and the latest moves on **Sustainability and Transformation Plans***.*

3. **There continues to be significant and sustained requests from the NHS and the broader public sector to tackle issues in social care funding**, with social care providers at a "tipping point" in terms of sustainability. The Local Government Association, NHS Confederation, NHS England, Care England and senior politicians are united in the view that more funding must be found. The most recent speculation suggests that councils may be given greater powers to raise funds for social care through an increase in the "precept". This "precept" gives them an option for a 2% council tax levy to be applied. These moves would help reduce the gap in the Sustainability and Transformation Plans for West Yorkshire and Harrogate in relation to social care, helping to support Trust services and the wider system.

4. **CQC have published findings of their review into the way NHS organisations review and investigate the deaths of patients** in England. The review focused on five key areas: involvement of families and carers; identification and reporting; decision to review or investigate; reviews and investigations; governance and learning. The report, entitled Learning, candour and accountability, includes a series of recommendations which were addressed in a speech by the Secretary of State for Health, Jeremy Hunt. They include the creation of a new standardised national framework for identifying potentially avoidable deaths and guidance on reviewing and learning from the care provided to people who die, particularly those with a learning disability or mental health problem.

5. There will be several actions for Trusts to implement from April 2017, including publishing data on avoidable deaths and evidence of the learning and action taken, identifying a board-level leader as patient safety director to take responsibility for this agenda, and appointing a non-executive director to take oversight of progress. A briefing on the report from NHS Providers is attached as a useful reference at Annex B.

6. **The Board is asked to agree that Tim Breedon, the Executive Director of Quality & Nursing acts as the Executive lead and to discuss and confirm the Non Executive lead for this work.**

With **all of us** in mind.

7. The CQC report is essential reading and is clearly of significant interest to the Trust. **The Board should note that,** working collaboratively with partners across the north of England, we have commissioned Mazars to examine our processes around reviewing and investigating deaths. Mazars were involved in both the investigation into Southern Health and the CQC's review into the way NHS Trusts investigate deaths. A report is expected from Mazars in early 2017, when received it will be discussed at the Clinical Governance and Clinical Safety Committee as part of our continued review of our mortality review processes. The CQC's report and lessons for the Trust will be discussed in detail at the next Clinical Governance and Clinical Safety Committee.

8. **NHS England and NHS Improvement have formally written to all CEOs and STP leads setting out the next phase of development for STPs.** This includes two significant changes:

    a. The focus of STPs will shift from planning to engagement and implementation. This includes a suggestion that they should be seen as **"implementation partnerships"** with changes to governance that reflect this. There is no central prescription for a model but there is a suggestion that these partnerships could range from accountable care systems, with real decision making powers and budgets, to looser collaboratives. In South Yorkshire and West Yorkshire, the position varies, with more structured governance in the South Yorkshire STP, less complexity and a smaller number of organisations than West Yorkshire.
    b. The details of **Transformation Funding** arrangements have emerged. The positive news is that there are resources available for services we currently deliver – mental health, support for diabetes, for example. Accessing these funds is through a bidding process, linked to STPs. In West Yorkshire, we are looking to coordinate the bids through the STP. This bidding process is an additional burden on the system at a very busy time. Spreading the work across the STP will allow us to share the burden and our expertise.

9. Each of the developments described above are indicative of a system in transition and under pressure. They are issues that we will need to consider as we develop our plans and our strategy, as described in the later papers for this Board meeting.

Local Context
10. *The Brief* describes what is happening locally. It is worth noting that we are engaged in planning and contract discussions on Specialised Services in West Yorkshire, and a range of services in Calderdale, Kirklees, Wakefield, Barnsley as well as selling services as far as Sheffield, Rotherham, Doncaster and Bassetlaw. Each area has specific issues and is taking a specific approach. This is reflected in:
    - Commissioning intentions shared by some Local Government partners, NHS England and each CCG;
    - The current and developing Health and Wellbeing Strategies in each place. The strategies for our main areas are covered on the Board agenda;
    - The development of shadow and nascent accountable care systems. There are papers on the Board agenda about recent developments in Barnsley and Wakefield. The latter includes the development of a "Committee in Common" which will be brought to the Board for approval.
11. One of the tests of all of this work is whether it accurately reflects the assumptions in the STPs. At present, this is not always the case, with a disproportionate level of growth being invested in prevention, wellbeing, mental health and community based services seen in the STP not yet reflected in contracts and plans.

Update on Trust Context

12. On 15 December 2016, we are interviewing for the Director of Strategy role. We had 31 applicants and shortlisted a strong field of 5 people. I will provide an update to the Board on the process and whether we have made an appointment at the meeting.

13. The Director will be joining a team that is leading the Trust through a period of uncertainty and change. They do so with staff who are deeply committed to the NHS and to the organisation. This is apparent in everything from the response to the recent fire in Trinity 2, which caused the evacuation and relocation of very vulnerable people in our estate at short notice and at night; to the successful contracts, bids and tenders we have secured on smoking and wellbeing services; to the staff supporting vulnerable refugees in Barnsley and Wakefield; the carers and staff singing carols at Newton Lodge on the day the CQC were in for an inspection; and the innovators helping reassure people with chronic illness through tele-coaching. On each of my visits to spend time with front line teams – whether clinical or in the quality academy – I am always enthused by the potential that exists within our teams.

14. This potential will have to be realised if we are to be successful. The financial position for this year is tight and I have asked for the help of every team in every service to overcome the challenge we face.

Conclusion

15. This is a critical period for the Trust. This Board meeting will see us debate our planning, contracts and efficiency programmes for the next two years. It will see us discuss our strategy for the next five. We do this in a period of change and ambiguity, extra scrutiny and challenging finances. Our collective, values based leadership will be essential to see us through this period. As will good and constructive challenge of ourselves, our partners and the system

Rob Webster

CEO

South West Yorkshire Partnership NHS
NHS Foundation Trust

The Brief

1 December 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?

National news
The majority of sustainability and transformation plans (STPs) have now been published across the country. Media coverage has largely focused on them being 'secret plans' designed to 'close hospitals and A&Es'. Our chief exec Rob Webster was interviewed on TV and radio talking about the draft plans and the need for full engagement with local people.

While it was anticipated that there wouldn't be any new funding for the NHS announced in the Autumn Statement, there's widespread disappointment that social care funding didn't feature either. The NHS is already feeling the pressure from significant social care cuts.

On 26 Nov NHS England announced £40m funding for 20 areas across the country to focus on perinatal mental health – that's pregnant women and new mums. We're delighted to have been chosen – we'll receive £2.1m and are working on setting up the new service by 1 April 2017.

Local news
The two STPs covering our areas have both been published. Find out more on our website about the West Yorkshire and Harrogate STP and the South Yorkshire and Bassetlaw STP. Both have priority areas to focus on over the coming years, which fit well with our services.

We're working hard with our commissioning partners to finalise our contract negotiations by 23 Dec. These are two-year contracts and need to link closely with our two-year operational plans that we're currently developing. The plans also have to be submitted on 23 Dec.

What's happening internally?

Safety and quality
Following our Care Quality Commission (CQC) inspection earlier this year, the CQC will revisit our core services by January where we received 'must do' actions in relation to regulatory breaches. They will also undertake a well-led review in January 2017. We'll submit evidence to show the progress we've made and we expect to receive reports back on the services they visit within 50 days. We'll then need to check them for accuracy before they're published. This may result in changes to individual ratings - we'll keep you posted as we know more.

With all of us in mind.

We're currently focusing our attention on:

- Safer staffing – read about all the work underway on the intranet
- Waiting times – particularly in CAMHS and psychological therapies
- Mental Health Act / Mental Capacity Act training – now mandatory and will be reported on from next month.

Performance

We've introduced our own new indicators to measure our performance. This is in addition to the nationally identified indicators we have to report on. Our performance in Oct includes:

- **113%** safer staffing fill rate – against our target of 90%
- **95%** fill rate of registered nurses – against our target of 80%
- **992** incidents reported – including **6** serious incidents
- **18.7%** mental health safety thermometer medicine omissions
- **22%** of complaints with staff attitude as an issue – up from 6% in Sept
- **33** compliments received *(please always remember to log compliments with our customer services team)*
- **4** major information governance breaches this year reportable to the Information Commissioner's Office (ICO) – an ICO audit is now underway across the Trust

It's also important to keep an eye on our key organisational risks and to do everything we can to mitigate them. We have several on our organisational risk register, including:

1. **Risks around our finances** – e.g. if we lose income it could impact our sustainability
2. **Risks around pressures in the system** – e.g. public health / social care funding cuts could impact our services
3. **Risks around non-delivery of our plans** – e.g. if there's lack of progress on transformation, agency spend etc. it could impact our sustainability.

Staffing

- Our black, Asian and minority ethnic (BAME) staff network has now elected its steering group. Thanks to members of the network who expressed an interest and voted. Find out more on the intranet.
- Our information governance mandatory training is currently below our target of 95%. It was 86.5% at the end of Oct. If you haven't completed yours, please do.
- We've extended the bank incentives for our inpatient areas until the end of March 2017. This is so that we can fully evaluate the impact that it has had.
- Due to our high spend on agency costs we're now no longer able to use agency staff for non-clinical roles. We're also working hard to bring our agency spend down in clinical areas.
- Our sickness absence is currently at 4.8% – higher than our target of 4.4%. Thanks to all who are working hard to address this.
- Our appraisal rates are improving each month, but some staff still haven't had theirs. Band 5s and below should have had their appraisal by the end of Sept – so far only 76.8% have. Band 6s and above should have had theirs by the end of Jun – so far only 84.8% have. Our target for both is 95%. Please make sure you've had yours.

#ihadthejab

So far 56% of frontline staff have had their flu jab. We're edging closer to our 75% target which we need to meet by the end of Dec. There are more clinic dates coming up and all are listed on the intranet. If you're struggling to get to a clinic, a peer vaccinator can come to you email or phone occupational health. When you've had your jab, please make sure it's recorded on the flu list on the intranet. These stats will be submitted to the Department of Health and will be used to monitor achievement against our target. On the intranet you'll also find a breakdown of the number of staff vaccinated so far in each BDU.

With **all of us** in mind.

Month 7 finances (Oct 2016)

Our current financial position shows a surplus of £0.7m at the end of Oct. This excludes Sustainability and Transformation Funding and is in line with our plan. We have had much higher spend on out of area beds than planned - £1.5m so far this year. The rest of the year remains very challenging.

NHS Improvement recently published their Quarter 2 report on the NHS. It showed that we are the 8th highest spending Trust in the country in terms of our agency spend against our cap. We've spent £6m on agency costs so far this year, against our cap of £5.1m for the full year. Our agency spend in the month of Oct alone was £828k.

Our cost improvement programmes (CIPs), which add up to £10m this year, are currently £0.2m behind plan. In addition, £0.8m of our CIPs are rated as red.

Change

Thanks to everyone who gave their views on our future strategic direction. All this info has been collated and was discussed at our Trust Board meeting on 29 Nov. The draft strategy will be written in Dec and will set out our ambition for the years ahead – we'll share it in Jan.

We're also on with writing our operational plan for the next two years. We need to submit this to NHS Improvement by 23 Dec. Thanks to all the teams involved in this intensive work.

At the same time, we're working on several bids and tenders. Recent outcomes include:

- Our bid with Phoenix Futures to continue providing a substance misuse service in Barnsley was unsuccessful. Barnsley Council awarded the contract to DISC. Approx. 10 of our staff are affected and will be supported over the coming months.
- Our bid with Nova to provide a social wellbeing service in Wakefield was successful. This is a £420k contract over four years with Wakefield Council.

Infrastructure

Work on our infrastructure, including estates and IM&T, is progressing at pace:

- Staff are now working from Baghill House in Pontefract and Drury Lane in Wakefield. CAMHS will move into Drury Lane in December. There will be an official opening in the New Year – more details will be shared soon.
- After the fire on Trinity in Wakefield, Gaskell in Newton Lodge is now a PICU, there are 14 beds on Trinity 1, 22 on Priory 2 and the intensive home based treatment team has accommodation in the Horizon Centre – thanks to everyone involved.
- Workshops are taking place to help determine the future requirements of our mental health clinical system. Our contract with RiO runs out in Mar 2018. Make sure you feed in your views if you haven't already – dates are at the end of this Brief.
- It's been one year since we became a smoke-free Trust. From 5 Dec-13 Jan we'll be asking for views on how it's going – both from staff and from service users, carers and families. Please keep an eye out for details and take part.

Innovation

Well done to all involved in our Excellence 2016, long service and learning recognition awards celebration held on 7 Nov. Congrats to all the winners – read more on our website.

Some of our teams are doing pioneering work, including our Barnsley integrated community equipment service, recently featured on BBC's The One Show. The team were also shortlisted for an Excellence award for 'improving the use of resources'. Our telephonic health service is also saving the NHS money and supporting people to stay well at home, reducing GP and A&E visits and hospital admissions. Well done to all in both great services.

With **all of us** in mind.

Don't forget to join in discussions on i-hub – our platform for sharing ideas. There's a new challenge launched looking at how we can reduce bureaucracy – see 'how red is our tape?'

Dates for your diary

Future mental health clinical system workshops:
- Mon 5 Dec, 10-12 or 2-4   Robin Norbury room, Kendray
- Weds 7 Dec, 10-12 or 2-4   Rooms 5&6, Laura Mitchell
- Thurs 8 Dec, 1-2.30 or 3.30-5   Training room 2, Fieldhead
- Mon 12 Dec, 11-1 or 2-4   Robin Norbury room, Kendray
- Thurs 15 Dec, 10-12 or 2-4   Boardroom, CNDH

Other dates for your diary:
- Sun 4 Dec   SWYPFT cycling club ride, 10am from Folly Hall
- Weds 7 Dec   Fieldhead masterplan progress update, large conference room
- Thurs 8 Dec   Barnsley CAMHS open afternoon, New Street
- Thurs 15 Dec   Christmas carol concert and raffle, pastoral care, Fieldhead
- Tues 20 Dec   Trust Board meeting held in public, Folly Hall
- Tues 31 Jan   Trust Board meeting held in public, Fieldhead
- Flu clinics throughout Dec – details on intranet

Take home messages

1. Keep a focus on people - agency spend, appraisal, training and absence
2. Stay on top of your information governance training and stick to best practice
3. Manage our budgets this year, get ready for what we need to do next year
4. Share your ideas on i-hub to help find ways of saving money and reducing bureaucracy
5. Get your flu jab - clinic dates are on the intranet or book a peer vaccinator
6. Share your views on our future mental health clinical system – attend a workshop
7. Be aware of our key risks – finances, system pressures and non-delivery of our plans

We have 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

Thank you for your support during these challenging and changing times

Give feedback on The Brief to your line manager and/or the Communications team.

The next issue of The Brief will start on 5 January 2017.

With **all of us** in mind.

LEARNING, CANDOUR AND ACCOUNTABILITY: A REVIEW OF THE WAY NHS TRUSTS REVIEW AND INVESTIGATE THE DEATHS OF PATIENTS IN ENGLAND

INTRODUCTION AND SUMMARY

The Care Quality Commission has today published a review of how NHS acute, mental health and community trusts and foundation trusts review and investigate deaths of patients in care. The report provides helpful insight into the system-level and local challenges to effective investigations, greater candour and transparency, and learning from deaths across the NHS. Overall, the review found that:

- Families and carers often reported a poor experience of investigations and felt they were not always treated with kindness, respect and honesty, especially for people in mental health or learning disabilities services.
- There is no single framework for NHS trusts that sets out the approach to learning from deaths, which means there is wide variation in systems and processes in place locally. As a result, learning from deaths is not being considered appropriately in the NHS and opportunities to improve care for future patients are being missed.
- There are trusts that demonstrate elements of promising practice at individual steps in the investigation pathway, but none that could demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The CQC makes seven recommendations that require action across the health system. The Secretary of State responded today in Parliament to the recommendations, with a range of measures for all acute, mental health, community and learning disabilities providers that will require new regulations, to come into effect on 31 March 2017, including:

- New reporting requirements on a standardised set of information to be collected and published quarterly by providers on all deaths and serious incidents, including estimates of avoidable death at the trust and action plans setting out what action must be taken;
- A new single framework will be developed for identifying, reporting, investigating and learning from deaths in care that defines what families and carers can expect from providers during investigations, and addresses the specific challenges affecting persons with mental health or learning disabilities needs;
- Trusts must identify a board-level leader as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced, and appoint a non-executive director to take oversight of progress;
- Specific measures undertaken by providers and commissioners to address the identified shortcomings in governance, assurance, family and carer involvement, and learning at organisational level, to which boards will be expected to respond in due course and in alignment with the system-level response;
- A focus on the mortality of people with mental health and learning disabilities, especially in acute settings.

This briefing summarises the key findings main points from each of the thematic chapters in the report, the recommendations, the response from the Secretary of State, and NHS Providers media statement. We recommend that members review the full content of the report, particularly the sections examining board governance of the quality and outcome of mortality reviews and investigations. CQC will embed its review of this work into the 'well led' domain of its inspection framework for all acute, mental health, community and learning disabilities services providers going forward.

OVERVIEW OF REPORT

Introduction and methodology

In December 2015, as a response to the findings of the NHS England-commissioned review into the deaths of people receiving learning disability and mental health services from Southern Health NHS Foundation Trust, the Secretary of State commissioned the CQC to assess:

- how trusts identify, review, investigate and learn from deaths of people in receipt of their care;
- whether opportunities for improving care have been missed especially for people using mental health or learning disability services; and
- recommend changes in policy and process to drive improvements in learning, candour and quality of care

CQC's review examined the 'death in care' of any person receiving, or who had recently received, care from an acute, mental health or community NHS trust, whose death occurred within six months of the person's last contact with any service at a trust, or their last date of discharge from an inpatient setting. The methodology encompassed:

- site visits at 12 acute, community healthcare and mental health NHS trusts with in-depth reviews of processes, patient records, mortality review case notes, investigations and staff interviews;
- data analyses encompassing a survey completed by 212 NHS provider trusts and foundation trusts, national statistics datasets, and the NHS staff survey;
- analysis of board papers and minutes of 48 trusts covering meetings held December 2015 - February 2016;
- interviews and feedback from families, carers and charities;
- stakeholder engagement through monthly Expert Advisory Group meetings (which NHS Providers attended).

The review was guided by five 'key questions' around which the CQC's report is structured:

Theme	Key Question
Involvement of families and carers	How are families and carers treated, are they meaningfully involved and how do organisations learn from their experiences?
Identification and reporting	How are the deaths of people who use services identified and reported, including to other organisations involved in a patient's care, by NHS clinicians and staff, particularly when people die but are not an inpatient at the time of death?
Decision to review or investigate	Are there clear responsibilities and expectations to support the decision to review or investigate?
Reviews and investigations	Is there evidence that investigations are undertaken properly and in a way that is likely to identify missed opportunities for prevention of death and improving services?
Governance and learning	Do NHS trust boards have effective governance arrangements to drive quality and learning from the deaths of patients in receipt of care?

1. How families and carers are involved and treated

The first chapter reviews the family and carer involvement and experience of their engagement with the NHS including how they are informed of a death, their involvement in the investigation process, and their access to information, reporting and learning. It reports the feedback from CQC's family and carer engagement activities.

Key findings:

- Families are not routinely told what their rights are when a relative dies, what will happen or how they can access support or advocacy.
- The involvement of families and carers in reviews and investigations of their relative's death varies considerably and they are not always informed or kept up to date about investigations, which often causes further distress and undermines trust in investigations.
- Families and carers are often not listened to, their involvement is tokenistic and the views of families and carers are not given the same weight as that of clinical staff.
- The NHS underestimates the role that families and carers can play in helping to fully understand what happened because they see the whole pathway of care that their relative experienced.
- Trusts reported experiencing challenges balancing the requirement to keep families involved and informed and to complete investigations within the required 60-day timeframe
- NHS staff reported feeling inexperienced and lacking in necessary skill to involve families in investigations without adding to their distress. Involving lawyers early on tended to exacerbate the distrust felt by families.

2. How are the deaths of people receiving care identified and reported?

This chapter explores the processes by which trusts currently identify and report the deaths of people who are in their care, what systems are used and how deaths are categorised as warranting further review or investigation. It examines the way in which the system, as currently organised, prevents the effective sharing of information to ensure that deaths are notified to all relevant providers and that the assessment of care quality prior to a person's death considers care beyond the settings of the lead provider conducting the investigation.

Key findings:

- There is no clear and consistent picture of what constitutes good practice in identifying and reporting deaths, unless a person dies while they are receiving care in an inpatient setting.
- As a consequence, there is variation and inconsistency across the NHS in the way organisations become aware of the deaths of people in their care, with organisations being reliant on information shared by others to be notified when a death occurs outside their inpatient services.
- Many patients who die have received care from multiple NHS providers in the months before death. In such circumstances, there are no clear lines of responsibility or systems for the provider who identifies a death to inform other providers or commissioners.
- There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community. This includes the way trusts are able to record when people with mental health conditions or learning disabilities die in NHS hospitals or while receiving care from the community services of NHS trusts.
- Electronic systems do not support information being shared between NHS trusts or with others outside the service that have been involved in a patients' care before their death, and create confusion for staff about what should be recorded as an incident.
- Electronic systems do not support the effective identification of people with a mental health or learning disability who die while receiving care.

3. Making the decision to review of investigate

This chapter focuses on the way that staff and trusts decide when the death of a patient may be due to problems in care and refer the death for investigation or action. It reviews the tools and methodology for making decisions to investigate, the level of investigation needed, who is responsible for leading it, and whether there are clear responsibilities and expectations to support decision making.

Key findings:

- NHS staff understand the expectation to report patient safety incidents and are using the Serious Incident Framework to support decisions to review and/or investigate when deaths occur. However, this means that investigations will only happen if the care provided to the patient has led to a serious incident being reported.
- Criteria for deciding to report a death as an incident and application of the framework varied across trusts, particularly the range of information that needs to be considered by individual staff to identify any problems in care and escalate for further review or investigation.
- In the absence of a single national framework that specifically supports the review and decisions needed for deaths, which may warrant a different response to patient safety incidents, clinicians and staff are using different methods to record their decisions. This is leading to variation across NHS trusts, including within the same sectors, and limiting the ability to monitor, audit or regulate the decision-making process in relation to reviewing deaths across the NHS.
- There is confusion and inconsistency in the methods and definitions used to identify and report deaths, leading to decisions across trusts based on local procedures and reported in different ways to CCGs.
- Timely access to information by clinicians and staff is constrained by difficulties experienced in getting clinical information about the patient from others involved in delivering care, including from primary care services.

4. Reviews and investigations

This section of the report focuses on how reviews and investigations are carried out, the quality of the investigations, the training and support available to investigators, independence of investigations, involvement of coroners, timeliness of reporting and whether opportunities for preventing death and improving services have been missed.

Key findings:

- Most trusts follow the Serious Incident Framework when carrying out investigations. Despite this, the quality of investigations is variable and staff are applying the methods identified in the framework inconsistently. This acts as a barrier to identifying the opportunities for learning, with the focus being too closely on individual errors rather than system analysis.
- Specialised training and support is not universally provided to staff completing investigations; many staff completing reviews and investigations do not have protected time in which to carry out investigations. This reduces consistency in approach, even within the same services.
- There are significant issues with the timeliness of investigations and confusion about the standards and timelines stated in guidance that affect the robustness of investigations, including meaningful involvement of families.
- A multi-agency approach to investigating is restricted by a lack of clarity on identifying the responsible organisation for leading investigations or expectations to look across pathways of care. Organisations work in isolation, only reviewing the care individual trusts have provided prior to death. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with needs such as mental health or learning disability.

5. Do trust boards have effective governance arrangements to drive quality and learning from the deaths of patients in receipt of care?

This section focuses on whether NHS trust boards have effective governance arrangements to drive quality and learning from the deaths of patients in their care. It explores how boards monitor the deaths of patients in their care, support a culture of learning and share information about safety challenges.

Key findings:

- There are no consistent frameworks or guidance in place across the NHS that require boards to keep all deaths in care under review or effectively share learning with other organisations or individuals.
- Trust boards generally only receive limited information about the deaths of people using their services other than those that have been reported as serious incidents.
- When boards receive information about deaths, board members often do not interrogate or challenge the data effectively. Most board members have no specific training in this issue or time that is dedicated to focus on it.
- Where investigations have taken place, there are no consistent systems in place to make sure recommendations are acted on or learning is being shared with others who could support the improvements needed.
- Robust mechanisms to disseminate learning from investigations or benchmarking beyond a single trust do not exist. This means that mistakes may be repeated.

Conclusions, next steps and recommendations

The final section reviews the key findings and areas for improvement discussed in the previous sections, and sets out recommendations with coordinating organisations (mainly national bodies) to lead on the response:

Recommendation 1: to make learning from deaths a national priority the Department of Health, supported by the National Quality Board – in partnership with families and carers, professional bodies, Royal Colleges and third-sector organisations – to:

- Publish a full response to this review, setting out the timeframes for improvement work, identifying lead organisations, and noting how families will be actively involved in the developments (April 2017).
- Coordinate improvement work across multiple organisations and publish a full progress report annually.

Recommendation 2: Leaders of national oversight bodies (NHS Improvement, NHS England and CQC) and Royal Colleges, work together with families to develop a new single framework on learning from deaths. This should define good practice in relation to identifying, reporting, investigating and learning from deaths in care. The framework should consider cross-systems processes, leadership and oversight. For example:

- Describe arrangements between primary and secondary healthcare providers and between health and social care organisations and the role of clinical commissioning groups in coordinating investigations involving multiple organisations.
- Describe the additional scrutiny to be placed on deaths of individuals with learning disability or mental illness.
- Offer guidance on the role of boards to supporting improvements, how this will be resourced and how this will be regulated.
- Provide guidance on the expectation that the involvement of lawyers should be limited. Where lawyers are involved, there should be a focus on advising in the context of NHS values, the duty of candour, and the principles of patient partnership/involvement.

- Provide guidance for when an independent investigation may be appropriate.

Recommendation 3: NHS Improvement and NHS England, with support from CQC, should lead work to define what families and carers can expect from healthcare providers when they are involved in the investigation process. This guidance should be developed in partnership with families who have experienced the investigation process and should include how families can be offered access to timely independent advice and understand what resources are available to support them during the process. The guidance should set standards for local services on the information to be offered – for example, how and when families may be contacted about investigations, what local support is available, what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement, and how this will be communicated, nationally and locally. The guidance should ensure that:

- Families' views are proactively sought and inform decisions around whether a review or investigation is needed.
- When a decision is made that an investigation should be carried out, families and carers should be involved to the extent that they wish and treated as equal partners in this alongside NHS staff.
- Families and carers are involved in setting terms of reference, are kept fully informed of the progress of an investigation and offered an opportunity to shape the report, as well as updated on how this leads to improvements in care (if they wish).

Recommendation 4: NHS England and NHS Improvement should coordinate solutions to the range of issues identified for people with mental health conditions or a learning disability across national bodies. This should aim to improve consistency, definitions and practices that support the reduction of the increased risk of premature death.

Recommendation 5: NHS Digital and NHS Improvement assess how they can facilitate the development of:

- Reliable and timely systems, so information about a death is available to all providers who have recently been involved in that patient's care.
- A standard set of information to be collected on all patients who have died. In addition to demographic information, this should include information on whether the patient had a learning disability or mental health diagnosis and the outcome of screening for concerns in care. This should include concerns from the family as well as clinical staff.
- Processes to collate information about patient deaths that can be analysed by patient characteristics, such as diagnoses or services used. This information, combined with the findings from reviews and investigations should form the basis of audits to be presented to trust boards.

Recommendation 6: Health Education England should work with the Healthcare Safety Investigation Branch (HSIB) and providers to develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths and write good reports, with a focus on these leading to improvements in care. This work needs to be factored into job descriptions and work plans. Investigation teams must be comprised of staff who have mental health and learning disability expertise, where relevant, as well as the skills to apply the Duty of Candour compassionately, and the skills to support individuals at a time of complex bereavement. An accredited training programme for people undertaking hospital-led investigations needs to be considered.

Recommendation 7: Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers. Provider boards should ensure:

- Patients who have died under their care are properly identified.
- Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.
- Staff and families/carers are proactively supported to express concerns about care given to patients who died.
- Appropriately trained staff are employed to conduct investigations.
- Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.
- Investigations conducted in a timely fashion, recognising that complex cases may require longer than 60 days.
- Families and carers are involved in investigations to the extent that they wish.
- Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.
- Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.
- That particular attention is paid to patients with a learning disability or mental health condition.
- provider Boards should strongly consider nominating a non-executive director to lead on mortality and learning from deaths.

CQC will strengthen its assessment of learning from deaths to cover the process by which providers identify patients who have died and decide which reviews or investigations are needed, with particular emphasis on:
- patients with a learning disability or mental health problem
- quality of investigations carried out by trusts
- reports to trust boards on learning from death
- action taken in response to learning from death
- how trusts have involved families and carers in reviews and investigations

CQC will also review how learning from death is documented in impact reports and encourage inspection teams to report and identify good practice examples that emerge from local development work in response to this review.

RESPONSE BY THE SECRETARY OF STATE

The Secretary of State's statement to the House of Commons announced a range of measures to address the recommendations. For trusts, these will include:
- From March 31 2017 the boards of all NHS Trusts and Foundation Trusts will be required to:
  o Collect and report to NHS Improvement a range of specified information, to be published quarterly (this requirement will be confirmed in new regulations), on deaths that were potentially avoidable and serious incidents and consider what lessons need to be learned on a regular basis.
  o This will include estimates of how many deaths could have been prevented in their own organisation and an assessment of why this might vary positively or negatively from the national average, based on methodology adapted by the Royal College of Physicians from work by Professor Nick Black and Dr Helen Hogan.
  o Publish evidence of learning and action that is happening as a consequence of that information.
  o Identify a board-level leader (likely the medical director) as patient safety director to take responsibility for this agenda and ensure it is prioritised and resourced within their organisation.
  o Appoint a non-executive director to take oversight of progress.

- o Follow a new, standardised national framework to be developed for identifying potentially avoidable deaths, reviewing the care provided, and learning from mistakes.
- Government will ensure that investigations of any deaths that may be the result of problems in care are more thorough and genuinely involve families and carers.
- The NHS National Quality Board will draw up guidance on reviewing and learning from the care provided to people who die, in consultation with the new Chief Investigator of Healthcare Safety. These guidelines will be published before the end of March 2017, for implementation by all Trusts in the year starting April 2017.
- Health Education England will review the training for all doctors and nurses with respect both to engaging with patients and families after a tragedy and maintaining their own mental health and resilience in extremely challenging situations.

To address particular challenges for the investigations of deaths of people with learning disabilities:
- The Government will ensure that the NHS reviews and learns from all deaths of people with learning disabilities, in all settings.
- The Learning Disabilities Mortality Review Programme will provide support to both families and local NHS areas to enable reporting and independent, standardised review of all learning disability deaths between the ages of 4 to 74.
- There will be coverage in all regions by the end of 2017 and full national roll out by 2019.
- As the programme develops, all learnings will be transferred to the national avoidable mortality programme.
- The LeDeR programme has been asked to provide annual reports to the Department of Health on its findings and how best to take forward the learnings across the NHS.
- In acute trusts: particular priority will need to be given to identifying patients with a mental health problem or a learning disability to make sure their care responds to their needs; and that special effort is made during any mortality investigations to ensure wrong assumptions are not made about the inevitability of death for these patients.

The Secretary of State also emphasised that he will not be setting any target for reducing reported avoidable deaths, as does not believe it will be valid to compare numbers between hospitals because the data depends on clinical views which may change or vary. However, he expects to see an increase in the number of reported avoidable deaths as a likely result of hospitals getting "better at spotting and reporting them, than because care is deteriorating."

MEDIA STATEMENT

Vital to work with trusts to improve inconsistencies in investigating patient deaths

- CQC release report following review of investigation processes into patient deaths by NHS trusts
- Regulator expresses concerns that opportunities to learn from deaths are missed
- We welcome important report which exposes inconsistencies in practice. It's vital that circumstances around a patient's death are well understood, and if warranted, investigated to ensure lessons are learnt to improve quality of care

Today, the Care Quality Commission released its report following a national review about the quality of investigation processes led by NHS trusts into patient deaths.

The quality regulator has raised significant concerns about the processes undertaken by many trusts and the failure to prioritise learning from deaths so that action can be taken to improve care for future patients and their families.

The CQC's review was carried out at the request of the Secretary of State for Health following the findings of the NHS England commissioned report into the deaths of people with a learning disability or mental health problem who were being cared for by Southern Health NHS Foundation Trust.

Responding to the CQC's report on the way trusts review and investigate the deaths of patients, the chief executive of NHS Providers, Chris Hopson, said:

"When a person dies under NHS care, bereaved families and carers must be treated with honesty, respect and compassion. It is also vital that the circumstances surrounding the person's death are well understood and, if warranted, investigated to ensure that the NHS learns lessons that can improve the quality of care. Families need to know that the NHS will recognise and act on any failings in care to prevent them happening again.

"We welcome this important report from the Care Quality Commission. It exposes inconsistencies and variations in practice across the NHS and within trusts which mean opportunities to learn from deaths and improve care are being missed.

 "There are particular problems identifying and investigating the deaths of people who were being helped by a number of different services at the same time for a range of often-complex conditions, and who died out of hospital. This is frequently the case for those receiving NHS mental health or learning disability services, reinforcing health inequalities.

"We need significant change at local and national levels to resolve this.

"The CQC has identified some areas of good practice by trusts that can serve as examples for others to follow. The CQC has also recognised the commitment of NHS staff to making change happen.

"We look forward to supporting our members in working with the Department of Health and national bodies to develop the CQC's recommendations into clear improvement in care and to ensure families feel they have always been treated with kindness and candour."

NHS Providers
13 December 2016

Cassandra Cameron, Policy Advisor, cassandra.cameron@nhsproviders.org

Learning, candour and accountability

A review of the way NHS trusts review and investigate the deaths of patients in England

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation
Caring – treating everyone with dignity and respect
Integrity – doing the right thing
Teamwork – learning from each other to be the best we can

LEARNING, CANDOUR AND ACCOUNTABILITY

Contents

Foreword from CQC

The NHS is a universal healthcare system, caring for millions of people every year. As a result, it is not surprising that a large percentage of the nearly 500,000 people who die in England every year will have received care from an NHS trust in the days, weeks or months preceding their death.

Death is inevitable and a natural event for all of us, and not all deaths will represent a medical failing or problem in the way the person has been supported during their life. However, like any other human system, the NHS is fallible. It does not always respond when needed, its healthcare staff sometimes make mistakes and the component parts of the system do not always work together well.

This means that, when things go wrong, the cost can be a death that may have been prevented, and investigations need to be carried out to learn, explain to families and carers what went wrong or make sure accountability is clear when failure is found.

Two of the behaviours that underpin the vision and purpose of the NHS in England – openness and learning in order to improve – are never needed more than when a patient dies whose care may have been delivered differently and whose death might have been prevented.

All healthcare professionals have a duty, set out in their codes of conduct, to explain to those who are close to the patient what has happened and what will be done to reduce the likelihood of the same thing happening again, regardless of the emotions they may experience when someone dies. This includes being an active

participant in any reviews that follow, whether they are leading the investigations or asked to provide information.

As well as being a professional duty, this is what families and carers expect and have a right to expect. The NHS 'system' must enable this transparency and learning.

This report describes what CQC found when it reviewed how NHS trusts identify, investigate and learn from the deaths of people under their care. It concludes that many carers and families do not experience the NHS as being open and transparent and that opportunities are missed to learn across the system from deaths that may have been prevented. Many of the NHS staff we heard from shared this view, together with a commitment for this to change.

We found that the level of acceptance and sense of inevitability when people with a learning disability or mental illness die early is too common. This may often be due to unidentified or unsupported health needs that, in many cases, will offer even greater opportunity for learning. There can be no tolerance of their deaths being treated with any less importance than other patients.

There is a real opportunity for the NHS to become world leaders in the way learning and investigations are completed and changes are made when a person dies.

The report makes recommendations for the improvements that need to be made if the NHS, as a leader for the wider social and healthcare system, is to be more open about these events, and improves how it learns and acts on them. The recommendations consider the contribution made by the whole of the system. They address the culture of the NHS, national policy and guidance, information flows, the capability and capacity of staff to review deaths and how quality assurance and regulation can promote good practice.

We call on everyone working in and with the NHS to play their part in making the changes needed, with a focus on pace, transparency and consistency being achieved in 2017.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Dr Paul Lelliott
Deputy Chief Inspector of Hospitals
(Mental Health)

Professor Ted Baker
Deputy Chief Inspector of Hospitals
(Acute)

Foreword from CQC's Special Advisor on Family and Carer Experience

This review was carried out in response to the very low numbers of investigations or reviews of deaths at Southern Health NHS Foundation Trust. Over a four-year period, fewer than 1% of deaths in Southern Health's learning disability services and 0.3% of deaths in their mental health services for older people were investigated as a serious incident requiring investigation.

These figures and the lack of interest in patient safety and learning from deaths reflected the reality as described by families of patients at Southern Health. This review has set out to understand the picture across the rest of England, of how NHS trusts identify, investigate and learn from the deaths of people who are under their care.

We have known for decades that people with a learning disability and those with mental health problems are dying prematurely. Reports into failings at Ely Hospital, Mid Staffordshire, Morecambe Bay and Southern Health have all called for a change in culture, a focus on patient safety and the need to do better.

When a loved one dies in care, knowing how and why they died is the very least a family should be able to expect. Yet throughout this review process we have heard from families who had to go to great lengths themselves to get answers to these questions, who were subjected to poor treatment from across the healthcare system, and who had their experiences denied and their motives questioned.

Those working in health and social care have a moral responsibility, and a legal duty, to be open and honest with patients, and following their death, with their families and carers. Some families described incredibly kind and compassionate care by individual members of healthcare staff. Yet the same families also reported being ignored by others and feeling that their questions were left unanswered.

The work carried out by CQC, and this report, would not have been possible without the substantial contribution of bereaved families and relatives, who generously contributed their time and thoughts, in the hope that their experiences would be used to improve things for others.

We must learn from these families. Their trust, honesty and candour are an example to us all. We owe it to them, their loved ones, and to ourselves to stop talking about learning lessons, to move beyond writing action plans, and to actually make change happen.

Dr George Julian
Special Advisor on Family and Carer Experience

Summary

Last year 495,309 deaths were registered in England. Of these, 232,442 (47%) people died in hospital, with even more dying while receiving services provided by NHS trusts as an outpatient or from community services provided by the trust. In a small number of cases, NHS trusts will report these as needing a review of the care provided. Three key reasons why a trust may decide to investigate the care provided before a patient's death include:

- **Learning** to improve and change the way care is provided.
- **Candour** to support sharing information with others, including families.
- **Accountability** if failures are found.

However, in recent years it has become clear that there are problems with the way that trusts identify the need for investigation into the care provided and the way in which investigations are carried out. One of the most high profile examples of this is the death of 18-year-old Connor Sparrowhawk.

Connor, who had a learning disability and epilepsy, died in 2013 while receiving care at an assessment and treatment centre run by Southern Health NHS Trust. Initially the trust classified Connor's death as a result of natural causes, and his family had concerns about the way they planned to investigate Connor's death. Following campaigns by Connor's family, an independent investigation was commissioned by the trust that found his death was entirely preventable, and the coroner in 2015 concluded that there had been failures in his care and neglect had contributed to his death

In response to the concerns of Connor's family, NHS England commissioned a review of all mental health and learning disability deaths at Southern Health NHS Foundation Trust from April 2011 to March 2015. The report, published in December 2015, identified a number of failings in the way the trust recorded and investigated deaths and highlighted that certain groups of patients including people with a learning disability and older people receiving mental health care were far less likely to have their deaths investigated by the trust. This meant fewer than 1% of deaths reported in learning disability services and 0.3% of all deaths in mental health services for older people had been investigated.

Following its publication, the Secretary of State for Health asked CQC to look at how acute, community and mental health NHS trusts across the country investigate and learn from deaths to find out whether opportunities for prevention of death have been missed, and identify any improvements that are needed.

What we did

In order to understand what problems exist and what improvements are needed, we looked at the processes and systems NHS trusts (acute, mental health and community trusts) need to have in place to learn from problems in care before the death of a patient. As people with a mental health problem or learning disability are likely to experience a much earlier death than the general population, a key focus for the review was to look closely how trusts investigate the deaths of people in these population groups.

To gather the evidence for the review we:

- Carried out an information request with all NHS acute, community and mental health providers, and visited a sample of 12 acute, community health care and mental health NHS trusts.
- Involved more than 100 families through the public online questionnaire and social media, and held 1:1 interviews and listening events.
- Gathered evidence from charities, NHS professionals and other organisations.

What we found

Throughout our review, families and carers have told us that they often have a poor experience of investigations and are not always treated with kindness, respect and honesty. This was particularly the case for families and carers of people with a mental health problem or learning disability.

However, there is currently no single framework for NHS trusts that sets out what they need to do to maximise the learning from deaths that may be the result of problems in care. This means that there are a range of systems and processes in place, and that practice varies widely across providers. As a result, learning from deaths is not being given enough consideration in the NHS and opportunities to improve care for future patients are being missed.

Across our review, we were unable to identify any trust that could demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning is implemented. However, we have identified trusts that demonstrate elements of promising practice at individual steps in the investigation pathway. Specific findings from each of the key questions are outlined below.

1. Involvement of families and carers

- Families and carers told us they often have a poor experience of investigations and are not consistently treated with respect and sensitivity and honesty. This is despite many trusts stating that they value family

involvement and have policies and procedures in place to support it.

> "I was put in a room. I shall never forget what the nurse in the room told me. She said, 'You have got to accept that his time has come', bearing in mind my son was just 34 years old."
>
> **CQC family listening day, 2016**

- Families and carers are not routinely told what their rights are when a relative dies, what will happen or how they can access support or advocacy.
- The extent to which families and carers are involved in reviews and investigations of their relatives varies considerably. Families are not always informed or kept up to date about investigations – something that often caused further distress and undermined trust in investigations.
- Families and carers told us they are frequently not listened to. In some cases, family and carer involvement is tokenistic and the views of families and carers are not given the same weight as that of clinical staff.
- The NHS underestimates the role that families and carers can play in helping to fully understand what happened to a patient. They offer a vital perspective because they see the whole pathway of care that their relative experienced.

2. Identification and reporting

- There is variation and inconsistency in the way organisations become aware of the deaths of people in their care across the NHS. This was found to be an issue for acute, community and mental health trusts equally with organisations relying on information being shared by others to identify when a death occurs outside their inpatient services.
- Many patients who die have received care from multiple providers in the months before death, including GPs, acute hospitals, community health services, and mental health services. At present, there are no clear lines of responsibility or systems for the provider who

identifies a death to inform other providers or commissioners.

- There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community. This includes the way trusts are able to record when people with mental health conditions or a learning disability die in NHS hospitals or while receiving care from the community services of NHS trusts.

"As soon as we started asking questions it was like we were interfering and that they were the professionals, not us. They became antagonistic."

CQC family listening day

- Electronic systems do not support the sharing of information between NHS trusts or with others who have been involved in a patient's care before their death, for example primary care services or services run by independent health providers or adult social care.

3. Decision to review or investigate

- Healthcare staff understand the expectation to report patient safety incidents and are using the Serious Incident Framework as the process to support decisions to review and/or investigate when deaths occur. However, this means that investigations will only happen if the care provided to the patient has led to a serious incident being reported.

- Criteria for deciding to report as an incident and application of the framework varied across trusts, particularly the range of information that needs to be considered by individual clinicians and staff to identify any problems in care and escalate for further review or investigation. Decision making is inconsistently applied and recorded across the NHS trusts we visited.

- In the absence of a single national framework that specifically supports the review and decisions needed for deaths, recognising them as a significant event that may need a different response to patient safety

incidents, clinicians and staff are using different methods to record their decisions. This is leading to variation across NHS trusts, including within the same sectors, limiting the ability to monitor, audit or regulate decision making process in relation to reviewing deaths across the NHS.

- There is confusion and inconsistency in the methods and definitions used across the NHS to identify and report deaths leading to decisions being taken differently across NHS trusts.

- Decision making must be informed by timely access to information by clinicians and staff, but providers reported difficulties in getting clinical information about the patient from others involved in delivering care including from primary care services.

4. Reviews and investigations

- Most NHS trusts report that they follow the Serious Incident Framework when carrying out investigations. Despite this, the quality of investigations is variable and staff are applying the methods identified in the framework inconsistently. This acts as a barrier to identifying the opportunities for learning, with the focus being too closely on individual errors rather than system analysis.

- Specialised training and support is not universally provided to staff completing investigations. Many staff completing reviews and investigations do not have protected time in which to carry out investigations. This reduces consistency in approach, even within the same services.

- There are significant issues with the timeliness of investigations and confusion about the standards and timelines stated in guidance – this affects the robustness of investigations, including the ability to meaningfully involve families.

- A multi-agency approach to investigating is restricted by a lack of clarity on identifying the responsible agency for leading investigations or expectations to look across pathways of care. Organisations work in isolation, only reviewing the care individual

trusts have provided prior to death. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with specific needs such as mental health or learning disability.

5. Governance and learning

- There are no consistent frameworks or guidance in place across the NHS that require boards to keep all deaths in care under review or effectively share learning with other organisations or individuals.

- Trust boards only receive limited information about the deaths of people using their services other than those that have been reported as serious incidents.

- When boards receive information about deaths, board members often do not interrogate or challenge the data effectively. Most board members have no specific training in this issue or time that is dedicated to focus on it.

- Where investigations have taken place, there are no consistent systems in place to make sure recommendations are acted on or learning is being shared with others who could support the improvements needed.

- Robust mechanisms to disseminate learning from investigations or benchmarking beyond a single trust do not exist. This means that mistakes may be repeated.

Recommendations

Learning from deaths needs to be a much greater priority for all working within health and social care. Without significant change at local and national levels, opportunities to improve care for future patients will continue to be missed. Below we outline a summary of our recommendations for change. Detailed recommendations with coordinating organisations are on page 59.

- **Recommendation 1:** We urge the Secretary of State for Health, and all within the health and social care system, to make this a national priority. We suggest that the Department of Health, supported by the National Quality Board – in partnership with families and carers, professional bodies, Royal Colleges and the third-sector – work together to review the findings and recommendations from our report and publish a full response. Action should then be taken to begin coordinating improvement work across multiple organisations.

- **Recommendation 2:** The Department of Health and the National Quality Board working with Royal Colleges and families should develop a new single framework on learning from death. This should define good practice in relation to identifying, reporting, investigating and learning from deaths in care and provide guidance for when an independent investigation may be appropriate. This should complement the Serious Incident Framework and clearly define roles and responsibilities.

Specifically the framework should:

- **Recommendation 3:** Define what families and carers can expect from healthcare providers when they are involved in the investigation process following a death of a family member or somebody they care for. This should be developed in partnership with families and carers.

- **Recommendation 4:** Provide solutions to the range of issues we set out for people with mental health conditions or a learning disability across national bodies, including the Royal Colleges. This should aim to improve

consistency, definitions and practices that support the reduction of the increased risk of premature death.

- **Recommendation 5:** NHS Digital and NHS Improvement should assess how they can facilitate the development of reliable and timely systems, so that information about a death is available to all providers who have recently been involved in that patient's care. They should also provide guidance on a standard set of information to be collected by providers on all patients who have died.

- **Recommendation 6:** Health Education England should work with the Healthcare Safety Investigation Branch (HSIB) and providers to develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths and write good reports, with a focus on these leading to improvements in care.

- **Recommendation 7:** Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers.

What CQC will do

CQC will continue to be actively involved in translating these recommendations into actions through our involvement in the National Quality Board, and through the recommendations noted above. Specifically, we plan to:

- Strengthen CQC's assessment of learning from deaths to cover the process by which providers identify patients who have died and decide which reviews or investigations are needed, with particular emphasis on:
  - patients with a learning disability or mental health problem
  - quality of investigations carried out by trusts
  - reports to trust boards on learning from death
  - action taken in response to learning from death
  - how trusts have involved families and carers in reviews and investigations.

CQC will also review how learning from death is documented in inspection reports.

Introduction

Last year 495,309 deaths were registered in England. [a,1] Of these, 232,442 (47%) people died in hospital with even more dying while receiving services provided by NHS trusts as an outpatient or from community services provided by the trust.[2]

When a person dies, there is an action and decision that is then taken by someone working in the NHS, whether a doctor, nurse or paramedic. Actions are often routine, for example a doctor confirming the death of a patient.

However, a much smaller number of cases are reported by NHS trusts as needing a review of the care provided. From the information we received from trusts, we were told that in 2015/16 around 5,500 investigations into the deaths of patients receiving care were completed, with the intention of supporting learning and improvements through changes being made to the services provided for future patients.[b]

There are three, sometimes conflicting, reasons for NHS trusts to investigate a patient's death – identifying what care had been provided to offer **learning** to improve and change the way care is provided to others in future, supporting **candour** to share information with others including families, and making sure **accountability** is identified if failures are found.

The purpose of an investigation is to understand the care that was provided to the patient before they died and highlight any potential problems. The trust will carry out this investigation to make sure that both it and the patient's family understand what happened, and that staff can learn and changes can be made.

In a smaller number of cases, where there have been failings that could have been avoided, investigations can, if done well, help to identify issues that require holding organisations or individuals to account, through other systems such as disciplinary action, or regulatory action by CQC.

In recent years, it has become clear that there are problems with the way that deaths are identified as needing investigation and with the way in which they are investigated. One of the most high profile examples of this is the death of 18-year-old Connor Sparrowhawk. Connor, who had a learning disability and epilepsy, died in 2013 while receiving care at an assessment and treatment centre run by Southern Health NHS Foundation Trust.

Initially the trust classified Connor's death as a result of natural causes, and his family had concerns about the way they planned to investigate Connor's death. Following campaigns by Connor's family, an independent investigation was commissioned by the trust that found his

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a   495,309 is the total number of deaths registered in England in 2015. The 232,442 deaths in hospital is also for 2015 and based on the date the death was registered.

b   Response rate of approximately eight in 10 trusts across acute, community and mental health sectors and investigation types.

death was entirely preventable, and the coroner in 2015 concluded that there had been failures in his care and neglect had contributed to his death.

In response to the concerns of Connor's family, NHS England commissioned a review of all mental health and learning disability deaths at Southern Health NHS Foundation Trust from April 2011 to March 2015. The report, published in December 2015, identified a number of failings in the way the trust recorded and investigated deaths including a lack of leadership, poor quality investigations, a lack of family involvement in investigations, and opportunities for learning being missed.

The report also highlighted that certain groups of patients including people with a learning disability and older people receiving mental health care were far less likely to have their deaths investigated by the trust. This meant fewer than 1% of deaths reported in learning disability services and 0.3% of all deaths in mental health services for older people had been investigated.

Following its publication, the government asked CQC to look at how acute, community and mental health NHS trusts across the country investigate and learn from deaths to find out whether similar problems exist elsewhere.

The focus for our review

In order to understand what problems exist and what improvements are needed, we looked at five different aspects of the processes and systems that NHS trusts need to have in place in order to learn from the death of a patient.

- **Involvement of families and carers:** How are families and carers treated? Are they meaningfully involved and how do organisations learn from their experiences?
- **Identification and reporting:** How are the deaths of people who use services identified and reported, including to other organisations involved in a patient's care, by NHS clinicians and staff, particularly when people die but are not an inpatient at the time of death?
- **Decision to review or investigate:** Are there clear responsibilities and expectations to support the decision to review or investigate?
- **Reviews and investigations:** Is there evidence that investigations are carried out properly and in a way that is likely to identify missed opportunities for preventing death and improving services?
- **Governance and learning:** Do NHS trust boards have effective governance arrangements to drive quality and learning from the deaths of patients?

As part of our review, we placed a spotlight on the particular issues for people with mental health conditions or a learning disability, in order to consider the learning from the report on Southern Health for these patient groups and identify any additional challenges and barriers that exist elsewhere in NHS trusts.

SCOPE OF REVIEW

The Secretary of State asked CQC to look only at **NHS trusts providing acute, community or mental health services**. This means that this review identified the way these providers investigate and learn from deaths. Other organisations, including ambulance trusts, GP practices, independent healthcare providers and adult social care services, will also carry out their own reviews when someone in their care dies.

Our review has identified the importance of reviews and investigations in providing both health and social care providers with an understanding of circumstances leading to deaths from a variety of perspectives. We expect commissioners of all NHS-funded care, and other services and organisations, to use this report to review their own practices and individual professional responsibilities, and identify the improvements needed against our findings.

WHAT DO WE MEAN BY A DEATH IN CARE?

We use this term throughout the report to refer to any person who is currently receiving, or has recently received, care from an acute, mental health or community NHS trust.

Where the person is an inpatient at the time of death they are clearly 'receiving treatment'. However, when someone dies outside hospital there are no national guidelines that define how long ago someone was 'recently in receipt of services'.

We wanted to understand the system for all deaths – inpatients, people receiving community services, and outpatients – so we looked at any deaths that occurred within six months of the person's last contact with any service at the trust or their last date of discharge from an inpatient setting.

WHAT DO WE MEAN BY TRUSTS?

Throughout this report we refer to NHS trusts. By this, we mean all NHS acute, mental health and community trusts, including both inpatient services in hospitals and community services. We did not review ambulance trusts or other NHS-funded care settings such as independent healthcare providers, primary care services or nursing homes.

The terms used by the NHS and in this report can be found at: **www.nhs.uk/NHSEngland/ thenhs/about/Pages/authoritiesandtrusts. aspx**

WHAT DO WE MEAN BY SYSTEM?

We use the term system throughout the report, but this has two different applications:

- The healthcare processes and systems that exist within NHS trusts, for example policies, procedures and electronic systems.
- The wider health and social care landscape, including national agencies responsible for regulation, guidance or oversight, local health and social care providers or commissioners, and other agencies and organisations that work to support or advise patients, carers and professionals.

WHAT DO WE MEAN BY FAMILIES AND CARERS?

We use this term in the report to refer to a relative or carer (paid and unpaid) of a person who has died following the care from an acute, mental health or community NHS trust. While, in most cases, family members will have the greatest knowledge of the person who has died, we recognise that where there is no family present, friends or advocates may know the person best and should therefore be considered in the review and/or investigation process.

Methodology

Our approach

Throughout the review, we sought the help and advice of experts, individuals and organisations to make sure we heard from everyone affected by the current approach following a death in care. This includes families with experience of reviews and investigations by the NHS, people working in the NHS, and national stakeholders from all sectors.

In particular, we have worked closely with our expert advisory group (EAG) to understand what evidence would be the most useful to inform a review in this area. Members of the EAG included representatives from family and patient groups, national organisations, NHS trusts and voluntary sector organisations. Appendix C shows a full list of member organisations.

Families and carers

Listening to the experiences, concerns and ideas for change has been a core focus of our review. Over the course of the review, we heard from more than 100 families with direct experience of an NHS review or investigation. Engagement activity included:

- **Online questionnaire** – in July 2016, we asked families and carers to tell us, through an online form, about their experiences of NHS investigations following the death of a relative. The questionnaire was hosted on our website and was promoted via different social media channels. This was delivered as an open consultation and respondents were self-selecting volunteers. Given the challenges of identifying a robust sample of individuals who have experienced NHS death investigations, this method was more appropriate than

using surveying or sampling tools within the available timeframe. In total, we had 66 responses to the questionnaire.

- **1:1 conversations with families** – we followed up the online questionnaire by inviting eight families to attend a family listening day (below) and contacted an additional four people, who could not attend the event, to ask them directly about the information they had provided about their experience.

- **Family listening day** – we commissioned the voluntary organisation INQUEST, working with our Special Advisor on Family and Carer Experience, to host an event to listen to the experiences of families and ask for their views on what needs to change. The event was attended by 30 family members, and a full report from the day will be available on the INQUEST website.

- **Making Families Count** – we held a separate engagement event with Making Families Count, a group of experts by experience who work with NHS trusts to promote the status of families during investigations.

People working in the NHS and system reviews

To understand the current system and processes in place, we carried out a number of activities with NHS providers and staff:

- **Provider information request** – in June 2016, we sent all 228 NHS acute, community and mental health trusts an information request. This asked trusts about the systems and processes for recording, reporting and investigating deaths (see annexes 3 to 9). We received responses from 212 trusts (93%).

This consisted of 143 (93%) acute trusts, 53 (96%) mental health trusts and 16 (84%) community trusts.

- **Site visits** – in July and August 2016, we visited a sample of 12 NHS trusts, comprising four acute, four mental health and four community trusts. We interviewed staff at different levels, including members of the board, operational leads and governance leads. Overall, we spoke with 137 different staff members: 44 in acute, 47 in community and 46 in mental health trusts. Appendix B shows a list of the trusts we visited.

- **Records review** – on the site visits, we reviewed 146 records of investigations, mortality reviews and notifications of death, and various supporting policy or procedural documents. This included reports on serious incidents , statutory notifications to CQC about patients detained under the Mental Health Act 1983, and complaints relating to the death of a person in their care. In addition to the serious incidents we reviewed on site, we conducted an in-depth review of 27 investigation reports from 10 of the trusts.

- **Review of board papers** – we analysed trust board papers and minutes from a sample of 48 NHS acute and community trusts covering the period December 2015 to March 2016.

We also reviewed findings of a separate analysis of 56 mental health trust board papers, carried out by our Special Advisor on Family and Carer Experience, Dr George Julian, covering the period December 2015 to February 2016. We carried out this activity to understand what information was provided to, and discussed by, boards in relation to deaths.

- **Analysis of national data** – we analysed national datasets, including Office for National Statistics (ONS), NHS Digital's Hospital Episode Statistics (HES), Strategic Executive Information System (STEIS), National Reporting and Learning System (NRLS), NHS staff surveys and Dr Fosters Intelligence.

- **Live Twitter chat** – as part of our spotlight on mental health and learning disability, we held a live Twitter chat with mental health and learning disability nurses on the #WeCommunity platform. In total, 170 people took part in the conversation.

We are grateful to everyone who has supported us in undertaking this review. We are especially grateful to those individuals who told us what it is like to lose a relative when the NHS was involved in their care and their experiences of the responses and processes that followed.

1. How are families and carers involved and treated?

KEY FINDINGS

- Families and carers told us that they have a poor experience of investigations and are not consistently treated with respect, sensitivity and honesty. This is despite many trusts stating that they value family involvement and have policies and procedures in place to support it.

- Families are not routinely told what their rights are when a relative dies, what will happen or how they can access support or advocacy.

- The extent to which families and carers told us they are involved in reviews and investigations of their relative's death varies considerably. Families are not always informed or kept up to date about investigations – something that often causes further distress and undermines trust in investigations.

- Families and carers are often not listened to, their involvement is tokenistic and the views of families and carers are not given the same weight as that of clinical staff.

- The NHS underestimates the role that families and carers can play in helping to fully understand what happened to a patient. They offer a vital perspective because they see the whole pathway of care that their relative experienced.

This section of the report focuses on how NHS trusts involve families and carers. It looks at how families and carers are treated, whether they are meaningfully involved and how organisations learn from their experiences.

Listening to, and understanding, the experience of families and carers has been a crucial part of this review. We have reviewed the publicly available evidence from healthcare inquiries, including Mid-Staffordshire, Winterbourne View and Morecambe Bay. We have also analysed information from other reports, such as the Public Health Service Ombudsman report on their review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged; and heard directly from a range of bereaved relatives and carers to understand what is working well, and what needs to change.[3]

Families told us that what they want most from an investigation is to know what has happened, why their relative has died, and to help prevent this from happening to anyone else. One family member summed it up. "All I want is the truth – the worst has already happened."

Some trusts report struggling to balance completing investigations to the standards they should within required timetables and involving families. This is despite many saying that they valued family involvement in investigations and that they had policies and procedures to make this happen. Having a policy in place does not guarantee the effective involvement of families.

Finally, staff working in NHS trusts do not feel confident enough to effectively involve families in investigations, with too few having the skills, expertise and experience needed to do this well.

Initial contact and notification of death

The way in which families and carers are treated, including from the very beginning when they are told about the death of a relative and the initial discussions that take place, is extremely important. It will often set the tone for their experience of the investigation process.

> "The most toxic, damaging, compounding, devastating thing that happens is they drip feed you information, they give you a tiny closed off answer. Letters are sent Friday so they arrive Saturday morning, you've nowhere to go, nothing to do with it. Every single time a piece of information came through it raised another question, and another question, and another question."
>
> **CQC interview, 2016**

NHS clinicians and staff should treat all bereaved relatives and carers with great sensitivity and compassion. Feedback from our share your experience questionnaire showed that when this is done well, NHS staff are helping individuals to understand what has happened, and to grieve.

> "They invited us (my sister and I) to meet with them, including the surgeon who operated on mum. The face-to-face meeting was extremely difficult but very valuable to us in understanding what happened and hearing things direct from a human being."
>
> **Family experience, online questionnaire**

However, families and carers told us that this opportunity is often missed and, in the case of people with a mental health problem or learning disability, that trusts seem ambivalent to the death of their relative.

> "I was put in a room. I shall never forget what the nurse in the room told me. She said, 'You have got to accept that his time has come.' Bearing in mind my son was just 34 years old."
>
> **CQC interview, 2016**

Families also described how trusts did not provide basic information around the death of their relatives, and how they were not routinely asked whether they had any questions or concerns. Families also reported that they had to apply to access information and care records. This can lead to mistrust and the feeling that trusts are hiding behind patient confidentiality to prevent information being disclosed.

> "The trust wouldn't release records without going through the access to information process; my daughter didn't make a will so I had to get letters of administration, that felt unnecessary... Once I got it, I felt hopeful that 40 days on I should get all of the records but how naïve can you be. We waited 40 days and nothing arrived, I pursued it and was told it was a longer job than they thought."
>
> **CQC interview, 2016**

In addition, we heard a number of accounts of NHS lawyers being present, even in the first meeting that relatives had with trusts after their relative died. Relatives described this as being intimidating and at odds with wanting to create a sense of openness and trust, which they themselves tried to protect.

"All the way through people said that we should get solicitors, I thought if we got a solicitor involved the hospital would stop talking to us, I didn't want a solicitor."

CQC interview, 2016

Lack of information about the forthcoming investigation process was also a concern, with only eight out of 42 respondents (19%) to our questionnaire saying they were clear about what would happen. Families also described feeling left out of decisions, including the initial decision about whether or not to investigate a death.

"There is no formal process. No one comes to you and says, 'This is what is going to happen'."

Making Families Count meeting, 2016

Involvement in the investigation process

Relatives and carers offer a vital perspective in helping to fully understand what happened to a patient as, unlike most clinicians and staff, they see the whole pathway of care that their relative experienced. Family involvement is particularly important when investigating the death of a person with complex needs, including people with a mental health problem or a learning disability. Without the meaningful involvement of families, it is likely that investigations will not identify what happened, the learning needed or the changes that need to be put into place.

"When the investigation happened, we were invited up to the hospital, it was one of the most uncomfortable experiences we've ever had as a family."

They said he wasn't given pain relief, I know he was, but they never recorded it. As a family it was awful, we didn't feel anybody took us seriously."

CQC interview, 2016

Just four out of 42 respondents to our questionnaire (10%) said they were treated with as much care and respect as they would have liked during investigations. Others commonly described insensitive actions by staff, which added to their distress. Families also described being poorly informed about what is going on.

"[We] were only told an investigation was happening when they responded to our complaint. However, it seems that an investigation was started, or considered at least, pretty much as soon as the consultant heard about mum's death. We think we should have been contacted sooner, although they did say they waited so that they had something meaningful to say to us rather than 'holding' responses."

Family experience, online questionnaire

Some trusts reported feeling nervous about involving families, in some cases deciding not to involve families in an attempt to avoid adding to their distress. This is at odds with the duty of candour that legally requires health and care providers to be open and transparent with family and carers in these situations.[c] Other trusts referred to the difficulty of balancing starting the investigation quickly while following best practice around involving families.

A number of trusts said that they felt uncomfortable contacting families at the point of an investigation starting, which could be before or very soon after their relative's funeral. Yet only

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c   The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate, truthful information from health providers.

one mental health trust said they had received feedback from relatives to say they had been contacted too soon in terms of informing them of an investigation.

DUTY OF CANDOUR

The duty of candour requires all health and social care providers, including NHS trusts, to be open and transparent with the people who use their services when there are notifiable safety incidents. This means incidents that are categorised as death, moderate harm, severe harm or prolonged psychological harm. This is a statutory requirement under regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In order to meet the duty of candour, the person representing the provider is required to tell the relevant person face-to-face as soon as possible, give an account of the known facts and offer appropriate support to them. They must also notify the Care Quality Commission.

Where the incident has led to the death of a patient, the duty of candour applies to the patient's family member(s) or carer(s).

The person representing the provider must advise family members or carers about any more enquiries that are planned and must apologise on behalf of the provider. This means that the provider is admitting fault and expressing regret for harm caused is not the same as admitting liability. This means the risk of legal action should never prevent an apology.

If the provider is not sure if a notifiable safety incident has occurred, CQC urges providers to err on the side of caution and exercise the duty of candour.

Failure to comply with regulation 20 can lead to CQC issuing requirement notices or taking enforcement action.

Families told us that the decision about whether to be involved, and to what extent, should lie with them. People will be ready to get involved at entirely different stages, so trusts need to take a person-centred approach to engagement.

> "You should be able to have the level of involvement you want…families don't always know at the beginning how much they want…you need time to breathe."
>
> **CQC family listening day**

When families were involved, they told us that they were not happy with the level of involvement. Only three out of 42 (7%) respondents to our questionnaire said that they had had the right level of involvement. In these cases, positive examples included families being offered a family liaison officer or a named point of contact, and being invited to comment on or check the factual accuracy of the report.

Others, however, told us that their involvement felt tokenistic, that trusts seemed unwilling or reluctant to listen to them, and that their views were not given the same weight as that of clinical staff.

> "As soon as we started asking questions it was like we were interfering and that they were the professionals, not us. They became antagonistic."
>
> **CQC family listening day**

There was a sense that trusts were immediately on the defensive, with families describing an attitude of 'trust before patient', and seeing trusts as more interested in self-preservation.

> "You are viewed, I have a feeling that you're viewed as a pain in the neck really, it's a bit like if you keep complaining about the washing machine but the machine is out of warranty. I've had more courtesy at the supermarket checkout than I've had at the trust."
>
> **CQC interview, 2016**

This is another example of the tensions that exist and the lack of confidence in using the investigation process to support learning and candour, rather than an exercise in accountability from the outset. The tensions will be heightened when NHS trusts involve lawyers, which families found to be intimidating and counter-productive.

Both families and trusts described concerns around the skills and suitability of those conducting the investigation, including whether staff were experienced enough or too close to the incident.

> "The person who did the investigation did not have any experience or qualification. The main people who were in charge of my son's care were not interviewed, they sent us minutes with great chunks missing or selectively minuted what we said to improve their side of the discussion. They promised to update us but never did."
>
> **CQC interview, 2016**

Some families had dealt with individual investigators who were unable or unwilling to involve families, leading them to believe that trusts do not want to learn lessons. This reflected trusts' concerns that some staff lack the skills to involve families effectively in investigations and need specific training around this.

> "In a recent investigation, listening to the family gave the investigators vital clues about what had gone wrong and these included actions of other providers. We may not have picked up on some of the additional problems without speaking to the family, which has helped us provide a more joined-up level of care across the health economy."
>
> **Provider information request – mental health trust**

CASE STUDY: FAMILY INVOLVEMENT IN TRAINING VIDEOS

During our visits, we viewed a video made for a trust that featured the husband of a patient who had died while in the trust's care. The video was one of several featuring families of people who use services who had died and was being used for training purposes. The trust felt that there was great value for their staff in watching these videos, and that for people involved in making the experience could be cathartic.

Trusts told us that they value family involvement in investigations and have policies and procedures in place to support it. Examples included inviting family members to help draw up the terms of reference, asking them to sit on investigation panels, and offering them the opportunity to make a video sharing their experiences to be used in staff training. They also described ensuring that family members had the opportunity to comment on draft investigation reports, and sharing the final versions with them.

However, these practices were inconsistent across the NHS and the extent to which families were involved varied between trusts. In addition, despite the existence of such policies, families were not consistently treated with respect, sensitivity and honesty.

> "The report reads as though it's an investigation into us as parents, rather than an investigation into his care."
>
> **CQC interview, 2016**

There are trusts who are trying to address the poor involvement of families in investigations, but national support, for example an accredited training programme for investigators, would help reduce the problems we found.

Reporting and learning

Families expressed concern that their experiences of the investigation process, and the quality of reporting, gave them no confidence that lessons are being learned from investigations. In our online questionnaire, 73% of respondents said it was not clear what had been learned from the investigation and 83% felt that the investigation had not made a positive difference.

Families who completed our online questionnaire reported long delays to investigations being concluded, or delays to them being informed of the findings, sometimes with no explanation of why the delay had occurred:

> "The trust said it would be completed before Christmas, but it wasn't finished until the end of January. We were not shown the report until NHS England released it in May 2015. The trust said the reason for delay was that NHS England had it – no further explanation. NHS did not communicate with us at all regarding the report".
>
> **CQC family listening day**

While some trusts said they believed they were responsive to families' needs and preferences, they felt that this sometimes created a tension in terms of them meeting their reporting deadlines.

> "It is important that we are able to 'leave the door open' for families to contact us when they feel able to; however this does not sit easily with the timeframes for concluding serious incidents."
>
> **Provider information request – mental health trust**

As with the investigation itself, most families felt that either they were not involved or consulted on the writing of the report, or they were partially consulted and then ignored.

> "We were promised involvement and were invited to a meeting. We were very knowledgeable and were asking very pertinent questions, asking for copies of minutes, etc. We wrote a narrative version of what happened, which was a very long document. The author of the report did not read it, they totally ignored all the points we had raised. They ignored us, lied to us and refused to send us minutes. During that stage independent advocates or an organisation like INQUEST would have been very beneficial."
>
> **CQC family listening day**

There was a frustration that their comments were not included in the findings, and some families questioned how the reports can contribute to learning when vital information is missing or ignored.

> "Reading the report, they do accept these things happened, presumably from doctor's notes not what we said. Everything we told them was completely ignored or completely glossed over with statements like 'yes suboptimal care, but also good care'. Anything the hospital said they accepted as true, without any challenge."
>
> **CQC interview, 2016**

Some trusts told us that they offered families the opportunity to read and comment on the final report, but our review of the quality of investigations showed that there was a lack of clarity or recording of whether this had been done in several of the final reports reviewed.

"We trusted her, she said she'd make our changes to the report in May. In October we finally got our redacted copy and our changes hadn't been made."

CQC family listening day

When reports were published, families and carers told us that they contained factual inaccuracies, missing information, spelling and grammatical mistakes.

There was also feedback that the reports were full of jargon. This was supported by findings from our site visits, where inspectors felt that reports were not always written clearly enough, with some containing medical terminology that families might not understand. Following analysis of 27 investigation reports, we found that only two (7%) of the reports contained responses that we felt provided a satisfactory response to the family or carers of the person who died. Furthermore, 16 (59%) of reports clearly left important questions that had not been identified and/or explored.

On our site visits, we did find some examples of how, with the active involvement of families, trusts were learning from investigations and putting recommendations into place, but this is an area that needs significant improvement.

2. How are the deaths of people receiving care identified and reported?

KEY FINDINGS

- There is variation and inconsistency in the way organisations become aware of the deaths of people in their care across the NHS. This was found to be an issue for acute, community and mental health trusts equally with organisations relying on information being shared by others to identify when a death occurs outside their inpatient services.

- Many patients who die have received care from multiple providers in the months before death. These include GPs, acute hospitals, community health services, mental health services, ambulance services, NHS 111 services, out-of-hours doctors services, and urgent care centres. At present there are no clear lines of responsibility or systems for the provider who identifies a death to inform other providers or commissioners.

- There is no consistent process or method for NHS trusts to record when recent patients die after they have been discharged from the care of the service, either from an inpatient service or from receiving services in the community. This includes the way trusts are able to record when people with mental health conditions or a learning disability die in NHS hospitals or while receiving care from the community services of NHS trusts.

- Electronic systems do not support the sharing of information between NHS trusts or with others outside the service who have been involved in a patient's care before their death, for example primary care services or services run by independent health providers or adult social care.

This section of the report looks at how the deaths of people who use services are identified and reported by NHS trusts – in other words, how the death becomes 'known' or identified by clinicians and staff working in services, and how this may be captured or reported to others, or reported on electronic systems.

This is a key aspect of the process: any errors or omissions will have a critical and detrimental effect on the decisions, reviews and learning that may follow. Without being able to clearly identify deaths in care or after care has been provided, it will be impossible for NHS trusts to make decisions about whether or not the care they provided needs to be reviewed or investigated to support learning and make sure action takes place.

Overall, we found that there is not a clear or consistent picture of what good looks like for

identifying and reporting deaths, unless the person dies while receiving care on a hospital ward. This was particularly the case for people who use mental health services and those with a learning disability.

It is well known that people with a learning disability or mental health condition will, on average, experience much earlier death than the general population[d]. Capturing information about the deaths of these patients is critical to informing improvements and reducing the health inequalities, routine discrimination and

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d   For example: Confidential Inquiry into premature deaths of people with learning disabilities (2012), Death by Indifference. Mencap (2007). Rethink Mental Illness (2013) Lethal discrimination. Why people with mental illness are dying needlessly and what needs to change. London: Rethink Mental Illness. Thornicroft G (2011) Physical health disparities and mental illness: the scandal of premature mortality. The British Journal of Psychiatry 199: 441-2.

premature mortality of this group of people. However, we found particular issues in the way NHS trusts identify and recognise when people with learning disabilities and people with mental health conditions have died in both community and hospital settings. This is not being captured in local reporting systems in a systematic way.

There are programmes in place to try and address this. For example, the NHS England learning disability mortality review and National Confidential Inquiry into Suicide and Homicide are learning programmes that review and analyse deaths at a national level to improve overall learning and improvements. However, they rely on services reporting accurate and timely information to support the use of the national databases to identify relevant deaths.

Many people who die will have received care from several different providers of NHS-funded care and social care. These may include primary care services, an acute general hospital, a mental health trust, a community health trust or a tertiary centre providing complex surgery or other treatments, for example for cancer or heart disease. Through our provider information request and on our site visits, we found that information about a person's death is not being passed between providers consistently and that this leads to problems in the way services identify a death has occurred.

We were told there are a number of reasons for this, including no national standard guidance available that would require people to share information, electronic systems not automatically sharing information between providers, difficulties over information governance (knowing what can be shared and how), and a lack of clarity about responsibilities for making sure that information is shared. This means that there is either a delay in finding out a patient has died or no knowledge of their death. As a result, there may be no review of care, no liaison or late liaison with families, and a limited understanding of the number and rate of post-care deaths.

Another barrier to identifying and sharing information highlighted during our review is the definitions that are used to capture if the death is 'unexpected', 'avoidable' or 'preventable'.

We explore this in more detail in chapter 3, but if a GP or NHS trust do not decide that there have been problems in the care received before death, by their service or other care providers, it is unlikely they will take additional steps to identify which other organisations need to be informed. This means that any review is limited to an individual provider's episode of care, and that there may not be a holistic review of the care by the NHS, which is what the patient and their family will have experienced.

Without a clear or consistent picture of 'what good looks like' for identifying and reporting deaths across organisations, it is not possible for there to be consistent practice across all parts of the NHS. There is a significant opportunity to improve how hospitals, and the wider system, share information about deaths.

Sharing information between organisations when a death occurs

Through our review we found that staff do not know what to do when a person dies while receiving care from more than one organisation. For example, if a person receiving care from a community mental health team dies on the ward of an acute hospital, how does the mental health trust come to hear of this death? If a person attending an outpatient clinic managed by an acute trust dies at home under the care of their GP, what role should staff in the acute trust play in any subsequent investigation?

Our site visits and provider information request highlighted that, unless a death is defined as a serious incident by a trust, there are no clear national guidelines on what to do when multiple organisations are involved.[e] This means, for example, that when a patient dies in the community and the death is identified by the GP, it is not clear whether they need to report or inform the other organisations providing additional care. There is also no single perspective on the length of time after a patient has been

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e   If the death is defined as a serious incident, the Serious Incident Framework provides guidance on the processes and protocols to follow.

discharged from a service or services, that any providers should be informed of their death.

The 'need to know' will vary for different patients, services and causes of death. For example, it may be less relevant if a patient had been treated for a minor injury in an acute hospital but later dies from an unrelated cause in another hospital setting. However, it may be more relevant for a patient admitted to hospital and who dies from an undiagnosed illness related to their previous care.

There needs to be a standard expectation and guidance available so that hospitals and primary care services are clear on when to identify and share information about deaths that may need to be reviewed by other services. It should also be expected that information is routinely shared with families and carers.

Recording of deaths following discharge

As there is no standard or agreed length of time for what is meant by 'recently' discharged from a service, for the purpose of our review we agreed to look at all deaths occurring within six months of the patient's last contact with the provider[f]. Our provider information request and site visits showed that trusts' ability to identify when someone receiving care or treatment from one of their services, or who has recently (within the last six months) received care from their services, has died is variable.

While, on the whole, trusts were able to give us a number of deaths of people who they believed were receiving care from their service when they died, this was not consistent. Trusts, particularly

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f   This is in line with the time period guidelines for homicide reviews, as stated in the NHS Serious Incident Framework. This included anyone who had had an inpatient spell (up to the date of discharge), attended outpatient appointment, A&E attendance, care given by the provider in a patient's own home, care home or any other location, any face-to-face contact between provider and patient, telephone appointment and contact with any of the providers of mental health support teams (including crisis support, substance misuse, mother and baby services, assertive outreach teams). This did not include telephone calls to discuss appointments only.

acute trusts, may know when people have died within 30 days of discharge from inpatient admissions, but a significant number of trusts told us they did not know how many patients died within six months of their last contact with them.

- All acute trusts who responded to our provider information request (143) could provide the number of people recorded in their systems who had died while an inpatient or an A&E patient in their trusts. However, 31% (45) told us they did not know how many of their patients had died within six months of their last point of contact with the service.

- All community trusts that responded (16) could report their total deaths of patients currently receiving care, but 25% (4) said they did not know the number of people who had died within six months of last receiving care from the trust.

- All but one mental health trust who responded (53) told us how many people in inpatient care had died. Twenty-one per cent (11) reported not knowing how many patients died post-discharge from both inpatient and community services.

- Across all the different types of trusts, a small proportion – 2% acute, 6% mental health and 19% community – reported that no deaths had occurred in the six months post-discharge.

Reporting on electronic systems

Effective reporting is important at a local level to support cross-organisational working, drive improvements in commissioning services based on learning from deaths, and improve the ability of providers to compare themselves against other, similar services. At a national level, it improves understanding about the number of deaths and informs policy changes.

Difficulties with reporting deaths, and which organisations should be involved, are made worse by the different electronic systems in use across the NHS. These all collect different pieces of data about a person and their care, and have different purposes for capturing information.

Many of the current electronic record systems do not readily support information sharing

between services within a trust, or with other organisations involved in the care provided to a person before their death. In the trusts we visited, there are a number of different systems in place including, for example, a patient record system for recording clinical information about patients, and a separate local risk management system used to record incidents in the service including those relating to individual patients. Risk management systems record patient safety data that should be used to inform service improvement or report incidents to the National Reporting and Learning System (NRLS).

Across trusts, we found different systems in use. For example, on our site visits three out of four of the mental health trusts we visited used different patient record and incident management systems, which were local to the trust and not linked to

other organisations. There is no requirement for trust systems to be linked to national databases such as the 'NHS Spine', a collection of national databases that hold key information about patients' health and care. This includes a 'Personal Demographics Service', which records mortality information about the deaths of people who use services.[g] This will be updated by NHS trusts and GPs at the time of death and then by the registrar for deaths who will confirm the record. Any NHS organisation with access to the NHS Spine will have a way of updating their own records although we heard of examples where this was being done 'automatically' or manually by staff.

g   NHS Spine connects clinicians, patients and local service providers throughout England to a number of essential national services, including the Electronic Prescription Service, Summary Care Record, e-Referral Service and Demographics.

USING ELECTRONIC SYSTEMS TO IMPROVE OUR UNDERSTANDING OF PATIENT MORTALITY

Understanding the patterns of mortality within a trust can inform clinicians, patients and carers in ways that are helpful to improving care. Automatically updating electronic systems can make sure clinicians, staff and organisations have an accurate understanding of mortality rates in their patient populations and develop approaches to collecting data to identify themes and areas for potential improvement. The following example from the Royal College of Psychiatrists describes the way information could be collected, updated and shared within an organisation.

Step 1: Identifying and reporting the death
– Notification entered onto the NHS spine
– Patient records system updated and care team alerted
– Risk management systems sends notification to mortality leads and adds details to trust mortality database
– Team share information with GP, coroner and pathology department
– Notification shared with CQC as required

(within 1-2 days)

Step 2: Decision to review and investigate
– Mortality leads and weekly mortality panel review notification and manually record their initial decision on local systems

(within a week)

Step 3: Reviewing later information
– Updated information requested automatically from coroner, GP and Pathology
– Patient record system, and incident management system, populated with this information when received

(60 days)

Step 4: Governance and shared learning
– Trust quality group and trust board receive quarterly reports summarising mortality data from patient record systems and incident management systems (combined reports)
– Clinical commissioning groups and multi-agency groups receive information and comparative all-provider data

(quarterly)

Once known to clinicians and staff, many of the deaths in care will be recorded on the patient management system, so the services know the patient has died. However, unless there is a serious incident identified or problems with the care are flagged, these deaths will not be entered on to the incident management system. Some systems are linked across organisations, meaning that information can be shared, but our site visits and provider information request showed that systems are not consistently linked within a trust or between trusts.

In addition, staff reporting deaths did not always understand the coding system for reporting deaths. We were told this was because their managers had not given them clear guidance or training. As a result, there is inconsistency between trusts, and between staff within trusts.

As well as different local incident reporting systems, trusts have a number of different national databases that they are required to report to depending on the incident being reported. For example, all serious incidents must be recorded on the incident management system – STEIS (the STrategic Executive Information System) – as well as the National Reporting and Learning System (NRLS), a system used by the NHS to capture learning and information about patient safety incidents.

The NRLS is a voluntary system for all incidents except for serious incidents, including those that result in death and never events[h] that NHS providers are required to report via NRLS as part of their CQC registration. The criteria for what needs to be recorded on these systems is open to interpretation, and the guidance that does exist differs because they were set up with different purposes in mind. However, figures obtained for this review from March 2015 to April 2016 show that only 4,134 incidents resulting in death were reported to the NRLS, compared with 4,832 reported to STEIS during the same period.

The requirement to report deaths that are considered to be an incident on a number of different local and national systems makes it difficult for staff to know what to report and where. This results in them reporting some deaths multiple times and others not at all. Together with a lack of support and guidance for the staff making the decisions about whether they consider a death should be recorded as an incident, this shows the pitfalls of not sharing information and suggests that opportunities to learn from incidents are being missed.

This has been recognised and NHS Improvement had begun commissioning of a new Patient Safety Incident Management System in 2014.[4] The development of this system is urgently needed and our review findings, including the additional detail of the specific challenges for provider types and staff, should be used to inform the development and support the pace at which this work needs to progress.

Spotlight on mental health and learning disabilities

We found that staff in acute and community trusts often do not know or record whether people had a mental health problem or a learning disability. This meant that they could not report which of the people who died while under their care had a mental health problem or a learning disability.

These groups of patients will often be receiving care from multiple organisations, who would need to be aware of their death to be in a position to consider whether the care they had provided may need a review to identify problems. However, if services are not aware of the person's diagnosis then it is unlikely that information will be shared and the ability to identify problems in care that may have led to a premature death will be missed.

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h   Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers

"We have no reliable way of identifying those with mental health team involvement at present, although this is to be added to our definition of 'vulnerable patient' shortly. In addition, the information we have regarding those with a learning disability substantially depends on the personal knowledge of our LD coordinator (Matron). The recognition of deaths in the NRLS upload depends on the coding within our local risk management system."

CQC provider information request – acute trust return

We asked all acute, mental health and community providers to tell us which of the patients who had died under their care had been in receipt of care from secondary mental health services or had a learning disability diagnosis. Acute trusts told us that they do not always record this information or know whether they are receiving care from other trusts. Similarly, the community trusts we visited did not always have a robust and reliable method to identify patients with mental health conditions or a learning disability. The incident recording systems we looked at on our site visits did not have a function that enabled trusts to flag patients with mental health problems or a learning disability.

Mental health trusts by their very nature record the mental health diagnosis of their patients, but struggled to identify deaths relating to people using their services who had a learning disability. In terms of specifically identifying whether a person had a learning disability, of the providers that responded to our provider information request:

- 25% (36) of acute trusts reported that they did not know how many of their inpatient/ A&E deaths related to patients with a learning disability. A further 13% (18) reported they did not have any deaths of patients with any learning disability recorded.
- 19% (3) of community trusts reported that they did not know how many of the deaths

of patients in their service had a learning disability. A further 50% (8) reported they did not have any deaths of patients with any learning disability recorded.

- 19% (10) of mental health trusts reported that they did not know how many of their inpatient deaths related to people with a learning disability diagnosis. Additionally 21% (11) reported that they did not know how many patients with a learning disability had died while receiving care in the community. A further 62% (33) and 8% (4) reported that they did not have any deaths of patients with any learning disability recorded for inpatient and community services respectively.
- The majority of acute trusts (69%) and a large proportion of community trusts (38%) reported that they did not know how many patients currently receiving care in their service were accessing secondary mental health services. A further 20% of acute trusts and 38% of community trusts reported that they did not have any deaths of people using secondary mental health services recorded.

In our provider information request, we asked NHS trusts to report on the data held in local systems only. It should be noted that the report on Southern Health described difficulties in identifying a clear picture of the total number of patients who had died while receiving services from the trust over the four-year period reviewed. The audit team looked at local databases and compared local system data to other local and national datasets, including the Office for National Statistics, coroner information, NRLS and information held by CQC relating to deaths.

3. Making the decision to review or investigate

KEY FINDINGS

- Healthcare staff understand the expectation to report patient safety incidents and are using the Serious Incident Framework as the process to support decisions to review and/or investigate when deaths occur. However, this means that investigations will only happen if the care provided to the patient has led to a serious incident being reported.

- Criteria for deciding to report as an incident and application of the framework varied across trusts, particularly the range of information that needs to be considered by individual staff to identify any problems in care and escalate for further review or investigation. Decision making is inconsistently applied and recorded across the NHS trusts we visited.

- In the absence of a single national framework that specifically supports the review and decisions needed for deaths, recognising them as a significant event that may need a different response to patient safety incidents, clinicians and staff are using different methods to record their decisions. This is leading to variation across NHS trusts, including within the same sectors, and limiting the ability to monitor, audit or regulate the decision-making process in relation to reviewing deaths across the NHS.

- There is confusion and inconsistency in the methods and definitions we use across the NHS to identify and report deaths leading to decisions being taken differently across NHS trusts.

- Decision making must be informed by timely access to information by clinicians and staff, but we found difficulties in getting clinical information about the patient from others involved in delivering care including from primary care services.

This section of the report focuses on the way that staff and trusts decide when the death of a patient may be due to problems in care and refer the death for investigation or action. Decisions at this stage will include the level of investigation needed, who is responsible for leading it, and whether there are clear responsibilities and expectations to support decision making.

Overall, we found that staff across the NHS understand that they are expected to report patient safety incidents, and we are seeing incident reporting increasing across the NHS. This includes the expectation for deciding if a serious incident may have occurred.

Serious incidents are defined in the Serious Incident Framework as "adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified".[5]

However, the decision to review or investigate relies on clinicians and staff seeing potential problems in the care provided to the patient before their death as an opportunity for learning, and deciding that this needs to be reported as an incident, using the Serious Incident Framework.

The Serious Incident Framework provides guidance and standards for all providers of NHS-funded care (including NHS trusts, GPs and independent health care) on the process for reporting the death of a patient when it is clear that there has been a serious incident. The Serious Incident Framework also sets out a number of standards and expectations for clinical commissioning groups, who have an important role in the local management, oversight and assurance of learning when serious incidents are reported by providers. However, the framework is not designed to support decision making and the potential for wider learning when a death occurs. Many deaths will not be associated initially with problems in care; the care given in the days, weeks or months before the death may have been of a high standard. Where there are no immediately obvious or potential problems in care, and without an incident being recorded, there is no other clear and consistent process for screening, reviewing or investigating deaths.

Because there is no single national framework for reporting and reviewing deaths, staff take different approaches. This results in differences in practice between trusts and between clinicians and staff in the same trust. It makes it difficult for the NHS as a whole to monitor, audit or regulate how the decision-making process is completed.

For example, if the decision is not recorded and no action has been taken to refer the case for an investigation, then there is no way for regulators such as CQC to question who made the decision, what information was captured, or whether families were involved. It also limits the extent to which the NHS learns or identifies themes from the investigations of deaths.

Tools and methodology for making decisions to investigate

Healthcare staff providing care to the patient will often be responsible for the initial decision to report and escalate a death for further review. This means that the system relies on individual clinicians and staff feeling confident in highlighting potential failures to more senior

staff, and not fearing any possible retribution from doing this.

The Serious Incident Framework provides guidance and support for a just culture that helps clinicians and staff to report and learn from problems in care and, if failure is found, for this to be clearly identified and appropriate mechanisms used to take action. How effectively this works depends on how well leaders and managers support good local cultures of patient safety reporting, openness and learning.

The Department of Health's consultation on providing 'safe spaces' aims to reduce the likelihood of people fearing retribution or blame for speaking out when they are part of particular types of safety investigations, with the focus being on learning and not blaming individuals. This proposes introducing new legal protection so that any details shared by individuals will not be able to be disclosed without a court order or an overriding public interest.[6] This is intended to help create greater openness when mistakes occur, making sure families get the truth faster and clinicians are supported in speaking out. Although the final details of how this will work will not be known until the consultation response has been completed, protection for individuals will only exist where no malicious or criminal activity has occurred. Individual details shared with investigations will not be shared beyond the investigation team, although the findings, learning and actions for change as a result of the investigation would still be public.

Across trusts, there are considerable differences in how the decision is made as to whether or not to investigate a death, and who makes it. There will also be barriers and difficulties if the service caring for the person when they die needs to understand earlier contacts with other services, to identify whether there may have been problems in care. For example, a person with a learning disability may die of a heart attack while receiving care in an acute hospital. This may not require investigation of the acute care provided, but a review of the whole care pathway may identify issues and highlight problems at an earlier point in the patient's care from other

services, including opportunities to reduce the risk of heart attack.

In addition, information sharing about the deaths of people receiving services outside of hospitals is often lacking. The processes for investigating these deaths are far less clearly defined than those in inpatient settings. There is inconsistency in the definitions used across the NHS to identify and report deaths, with no nationally agreed terminology. We found that there were multiple definitions in use for deciding whether a death needed to be reported, including 'preventable', 'avoidable', 'expected', 'unexpected', 'natural' and 'unnatural'.

National bodies, such as CQC, use the terms 'unexpected' and 'avoidable' for reporting purposes, but we found that staff understanding of these terms varied both within and between trusts.

The lack of clarity around terminology makes it very difficult for providers, families and regulators to be clear on what should happen in the period after the person dies. Usually, the decision to review or investigate relies on the early assessment by members of staff as to whether the death may be 'unexpected' or 'avoidable', based on their knowledge of the patient's illness and care, and whether there needs to be further investigation to establish this.

Many people we spoke to during the review felt that the terms 'unexpected' and 'avoidable', which are used throughout national guidance, regulation and data collection, can be misleading and unscientific. It was suggested that improving the standard definitions should be a key part of the work programmes that follow this review. Families and carers should be involved in these discussions, to ensure that there is a holistic view of the person's care. This is even more important for people with a learning disability whose death, because of personal or collective prejudices or discrimination, may be considered 'expected' or inevitable, even if it would be a cause for concern in other patients.

In many cases, the decision about whether a death was 'unexpected' or 'avoidable' can only

be made after a review or investigation has been completed. In our provider information request, some smaller trusts told us that they screened all the deaths for people in their care to decide whether an investigation was needed, regardless of whether a death had been identified as 'unexpected' or 'avoidable', or whether an incident had been reported. This included patients receiving end of life care – to assess whether there had been any problems in the delivery of care, for example highlighting a late diagnosis of a physical health condition for people with mental health needs or a learning disability. We highlighted this issue in our thematic review on end of life care *A different ending*, which we published in 2016.[7]

However, in larger trusts where there could be more than 3,500 deaths a year, only 'unexpected' deaths (and perhaps a sample of other deaths) were routinely being screened. This highlights the importance of achieving greater consistency in the definitions and factors to consider when carrying out an initial assessment. There is a need for a system that clearly sets out expectations for screening all deaths, capturing the decision as to whether or not to refer the death for further review, and documenting the factors that must be considered in that decision-making process, for example:

a) the person being in ongoing and regular receipt of care in the period before death, including any open referrals to services.

b) clear or obvious (to staff, families or others) factors that indicate service failure.

c) the vulnerability of the patient – for example the death of a child or person with a learning disability should make it more likely that an investigation takes place.

d) the legal status of the patient, for example detained under the Mental Health Act.

e) certain types of death, for example suicide, unexplained, sudden or illness as a result of medical treatment.

Supporting protocols would help to create consistency in decision making. These should outline clear expectations for clinical staff,

such as asking families and carers if they had concerns.

In some trusts, we found that standard definitions or 'trigger lists' were available to support decision making, but this was not consistent across the sites we visited. There was also a common misperception that there are 'mandatory' types of deaths in the NHS. For example, we were told that all suicides in mental health settings must be investigated or maternity deaths in acute settings. However, there is no requirement for any specific types of death or group of patients to be investigated by the NHS in the Serious Incident Framework or elsewhere in guidance. There is a risk that this misperception could lead to organisations failing to explore other causes of death in depth while focusing on the 'must do's'. This means that potentially valuable quality improvement and opportunities to improve future care in other areas may be lost.

Recording of the decision to report or not was also inconsistently applied in the trusts we visited, and there is no expectation that NHS staff should record this initial decision in either the patient records or local risk management systems.

We were told of local processes being put in place that reported all known deaths in care as either an 'incident' or a 'significant event', with local guidance to support the decision, recording and reporting. However, these are not common or expected practices across NHS trusts, so national guidance does not exist to support or monitor their use.

Once an incident has been reported, it is likely that a more senior member of staff, who may be independent of the care provided¸ will make the decision about whether further review or investigation is needed. This is typically a decision made by a director. The information they have to help them assess and understand any potential problems in care will be critical, but there is currently no standard approach to the level of detail or factors to consider at this stage in decision making.

CASE EXAMPLE

One NHS trust has introduced a triage system for all deaths known to their mental health and community services (around 1,200 a year). It is led by a Mortality Surveillance panel. All deaths are reported and considered weekly by divisional teams.

A death will be reviewed if any of the following criteria are involved:

- anti-psychotic medication
- drug and alcohol related
- unexpected death
- stepped-up care engaged
- inpatient at the time of death and within two weeks of discharge
- self-harming behaviour involved.

Once the panel has reviewed the death, they will identify if mental health care could have contributed and report it as an incident with further investigation to be completed.

The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. The appropriate level of investigation should be proposed by the provider as informed by the initial review. The investigations team and, where applicable, other stakeholders will use the information obtained through the initial review to inform the level of investigation. The level of investigation may need to be reviewed and changed as new information or evidence emerges as part of the investigation process.

Serious Incident Framework guidance – agreeing the level/type of investigation (page 39)

Clinical commissioning groups (CCGs)[i] will offer a level of independence from the trust once the decision is made to report a serious incident relating to a death in care. The Serious Incident Framework requires CCGs to be notified whenever a death has occurred and the trust has made the decision that problems in care may have led to the death.

The expectations and standards of reporting of deaths to CCGs is variable. It is even more variable in trusts whose services are commissioned by a number of different CCGs. These trusts often have to work with a number of different protocols and systems for deciding to investigate a death. This leaves staff unsure about which policies and procedures they should be following, and as a result means that some decisions and discussions with CCGs may not be taking place.

However, the Serious Incident Framework says that trusts should be clear on their 'lead commissioner' for investigations into serious incidents. This would mean a single commissioner should be identified for providers who will set the expectations for serious incidents in individual cases or taking a lead on the processes in place overall. Therefore, this should not be a barrier to trust leadership teams identifying when problems or inconsistencies are occurring and raising this with their CCGs to identify a solution and agree a single lead.

The process for deciding whether to carry out a review or investigation is even more complicated and variable for patients who die in the community. This is because the GP will typically be seen as the 'lead NHS provider' for the patient, and so may complete their own review of care. For example, a desk-based examination of the clinical records may not lead to a GP to report the death to a trust, if a problem is not identified. GPs have access to the Serious Incident Framework, but it is not used as standard guidance in the same way as it is by NHS trusts (who are expected to follow

the Serious Incident Framework as part of NHS standard contracts).

This difference in approach, and expectations of information sharing, may be a key factor why investigations are less likely to be carried out for patients who die out of a hospital setting – see **FIGURE 1**, which shows the number of deaths and rates of incidents, reviews and investigations in different settings. But this should not be a barrier or reason for hospital providers to not carry out their own reviews for learning from the care they provided. Other factors identified in both our provider information request and on our site visits included a lack of coordination and information sharing within and between trusts.

Medical examiners

There are plans already in place to implement the medical examiner role across England.[8] This is expected to be implemented nationally from April 2018; the date will be confirmed after the Department of Health has reviewed responses to its recent consultation on the role.

Once in place, an independent clinical review of all deaths that occur in England (that are not being investigated by a coroner) will be required before the death can be registered. Medical examiners will be senior doctors who report to local authorities. They will be independent of the NHS, and have access to medical records, clinicians and staff and at least one of the relatives or carers of the person who has died. This will introduce a new system and additional role, to the NHS, for making decisions and identifying or defining the causes of deaths in England, and examiners will be well placed to identify non-malicious problems with the quality of health care, including problems that did not necessarily contribute to a death but which should still lead to change or action from services. The medical examiner will seek to identify cases that should be referred to the coroner, and pilots have also shown that they can identify cases that are likely to be informative if NHS organisations carry out more detailed reviews.

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i   Clinical commissioning groups are responsible for commissioning (purchasing) most health and care services for people in a local area.

There have been some delays in implementing the medical examiner role since identifying the value and need for it. Our review shows the importance of all parts of the system working together to ensure it is introduced without further delay.

The medical examiner pilots to date have not been fully operational and have not included all community patients. However, they have shown that the independent 'check' with families and carers, including a clinical explanation of the cause of death and events preceding death, can help to support people during the grieving process, while enabling the experience and views of families to be captured and any concerns identified quickly.

The medical examiner role has the potential to offer a new important safeguard in England. However, it should be seen as an additional check for the NHS and not something to replace the important role of individual clinicians and staff and services being interested in identifying problems in care, and speaking directly with families and carers to offer explanations or invite concerns to be raised.

Learning Disabilities Mortality Review

Another important initiative is the Learning Disabilities Mortality Review (LeDeR) programme. All deaths of people with a learning disability are expected to be notified to the programme as it rolls out across England in 2017. All deaths of people with a learning disability, that meet the programme criteria, will receive an initial review by a trained reviewer. Where it is felt that further learning about a death could contribute to improved service provision, that death will receive a full multi-agency review.

The main purpose of the LeDeR reviews is to identify any potentially avoidable factors that may have contributed to the person's death, and to then develop action plans that, either individually or in combination, will guide changes needed in health and social care services to reduce premature deaths of people with a learning disability.[j]

National Mortality Case Record Review Programme
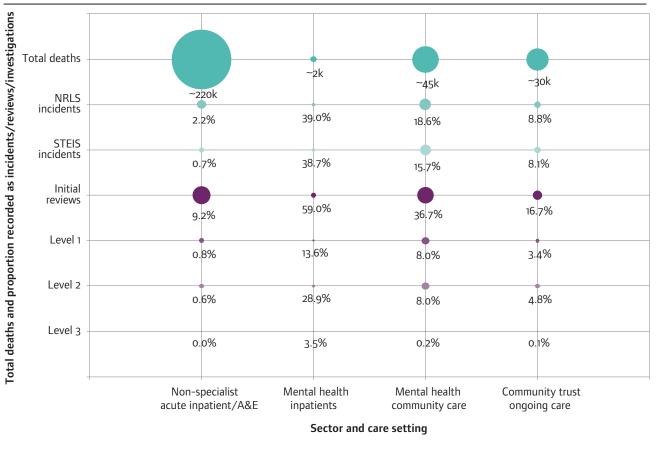
Another programme, the Royal College of Physicians' National Mortality Case Record Review Programme, aims to develop and implement a standardised way of reviewing the case records of adults who have died in acute hospitals across England and Scotland, thereby improving understanding and learning about problems and processes in health care associated with mortality, and to share best practice.

The standardised approach referred to as a Structured Judgement Review assesses separate phases of care including:

- admission and initial care – first 24 hours
- ongoing care
- care during a procedure
- perioperative/procedure care
- end of life care or discharge care
- assessment of care overall.

A judgement is made on each relevant phase of care, which are also scored from excellent (score 5) to poor (score 1). This approach has also been adapted for use by some mental health trusts although it is recognised that further national work will be needed to make sure mental health services are supported in implementing this approach, with particular focus on how problems with physical healthcare needs can be confidently identified by mental health staff.

j   Further information about the programme can be found at: **www.bristol.ac.uk/sps/leder**.

A REVIEW OF THE WAY NHS TRUSTS REVIEW AND INVESTIGATE THE DEATHS OF PATIENTS IN ENGLAND   **33**

FIGURE 1: AVERAGE REVIEW AND INVESTIGATION RATE BY SECTOR AND CARE SETTING

Source: CQC provider information request

The graph should be read vertically. Each column represents a sector and care setting. The top row shows the total deaths recorded, extrapolated to reflect the approximate total deaths we would have seen had all trusts responded to our information request. The rows below represent the different levels of incident reporting, reviews and investigations. The percentage given is the mean of the responses we received; the number represented by the size of the bubble is derived from that mean being applied to the extrapolated total deaths. While the overall response rate was 93%, not all trusts responded to every question, and therefore some of the average levels of investigation are based on responses from a smaller number of trusts. It should also be noted that there was considerable variation reported to CQC from trusts, even from within the same care setting regarding the proportion of deaths that were reviewed or investigated. For example, while nearly six in 10 acute trusts told us that they had carried out initial reviews on under 1% of inpatient deaths, approximately one in 10 acute trusts said that they had carried out initial reviews on more than half of their inpatient deaths. This variation does not relate to the number of deaths happening in trusts, the size of trusts or their location. Full details are available at annexes 5 and 9.

LEVEL OF REVIEW OR INVESTIGATION – SERIOUS INCIDENT FRAMEWORK DEFINITIONS

Once a decision to review or investigate is made, NHS trusts use the Serious Incident Framework to decide which level of review or investigation to carry out, with input and agreement from the lead CCG. Current definitions for the different levels and what they mean are outlined below. They will include individual reviews of patient safety incidents that result in death, and multi-incident reviews where multiple deaths may have occurred that need reviewing to identify cross-cutting issues. For example, three suicides of people receiving care from a hospital service may lead to a collective review of the care provided.

INITIAL MANAGEMENT REVIEW

A review, carried out by the identifying NHS trust and commissioner in the first 72 hours following the reported incident, to make the decision to investigate or not investigate. The information submitted as part of the initial review should be reviewed by the appropriate stakeholders and the investigation team (once in operation), to inform the subsequent investigation.

CONCISE INTERNAL INVESTIGATION (LEVEL 1)

A concise or compact investigation, which includes the essentials of a credible investigation. This is suited to less complex incidents that can be managed by individuals or a small group at a local level. A level 1 investigation must be completed within 60 working days of the incident being reported to the relevant commissioner.

COMPREHENSIVE INTERNAL INVESTIGATION (LEVEL 2)

A comprehensive investigation used to review complex issues. It should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable. The standard for completing a level 2 investigation is within 60 working days of the incident being reported to the relevant commissioner.

INDEPENDENT INVESTIGATION (LEVEL 3)

Required where the integrity of the investigation is likely to be challenged, or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/capability of the individuals available, and/or the number of organisations involved. The investigator and all members of the investigation team must be independent of the provider. The investigation must be commissioned and carried out entirely independently of the organisation whose actions and processes are being investigated. Level 3 investigations should be completed within six months of the date that the investigation is commissioned.

Multi-agency information to support decision making

Timely sharing of information between trusts and other organisations is key to good decision making, but we found that there are difficulties in routinely getting clinical information about the patient from others involved in delivering care. As each trust has their own patient record and incident management system (see chapter 1),

trusts often told us that that information was not readily shared, or not shared in timely way.

This was highlighted in our provider information request, where on average 28% of all types of trust did not know how many people had died within six months of being discharged from their service. Patient confidentiality was cited by NHS staff during our review as one reason why the medical records of patients who had died were

not exchanged. Yet families reported feeling that the system was not keen on sharing information.

> "It would help if trusts worked on the premise that they would have to release notes to someone in the family. There might be extenuating circumstances, but they work on the basis that they release nothing unless forced to legally."
>
> **CQC interview, 2016**

There is a consensus among national bodies, including the Department of Health, the General Medical Council and the British Medical Association, that patient confidentiality should continue after the death of a patient. However, Department of Health guidance permits the sharing of patient information if this is necessary, proportionate and justified in the public interest.[9] There is a clear public interest to be served by sharing clinical information to support learning and improvement following a death in care. Investigation leads should seek the advice of their Caldicott Guardian, information governance leads and legal team on a case by case basis, and follow guidance on making public interest disclosures.[10]

When patients who die in the community are identified by trusts, but multiple providers are involved, there is guidance in the Serious Incident Framework about who is responsible for leading a review of any problems in care that may have led to their death. If there are any disagreements, the CCG or NHS England can be asked to identify a single provider, or they may carry out the investigation themselves in some complex cases. Local protocols should support the identification of the lead provider, or escalation to the CCG where this cannot be determined, but we heard examples of where both providers and families had been left confused about who should be accountable for coordinating the review or investigation.

> "It is not clear, nor is there a multi-agency agreement in place, as to who then takes the lead in declaring a death [using electronic reporting systems to commissioners] or completing an investigation, and ultimately then sharing the learning."
>
> **Mental health trust – provider information request**

> "I was told, 'He was not in hospital so there will not be an investigation.' I stumbled over the fact that my son was in their 'care' and so there should have been an investigation. I asked again but they would not agree."
>
> **Family member – share your experience questionnaire**

Without timely access to information, trusts may be making decisions on whether to review or investigate a death without all of the relevant information available. This is particularly crucial for the initial management review stage. Key information could be held by another organisation, which would affect the decision to review or investigate. Without this an investigation may not take place, when there is a clear need for one if all the facts are taken into account.

Spotlight on mental health and learning disabilities

As noted in chapter 2, acute and community trusts often do not record whether a patient also has a mental health problem or a learning disability. Mental health trusts are similarly poor at identifying people with a learning disability.

Without reliable and effective recording of whether people receiving care have a mental health problem or a learning disability, it is impossible to know with any degree of certainty how many investigations are taking place into the deaths of patients in these groups.

Mental health trusts are reporting significantly larger proportions of total deaths as incidents, compared with acute or community trusts. However, how staff in mental health trusts decide whether to review or investigate a death varies widely between different trusts. While a third of mental health trusts told us that they report all deaths of inpatients as an incident and carry out at an 'initial management review', some trusts are reporting far fewer deaths as incidents and carrying 'initial reviews' on only a small proportion of their total deaths. This variation does not relate to the number of deaths happening in these trusts.

The proportion of initial management reviews and investigations carried out by trusts for patients with a mental health or learning disability diagnosis also varies. **FIGURE 2** shows the number of initial management reviews and investigations conducted by trusts in relation to patients with a mental health or learning disability diagnosis who have died whilst receiving services. Of the 1,070 deaths of patients with a learning disability diagnosis who die as inpatients or in A&E settings in an acute trust, 8.7% had an initial management review, in comparison to 17.9% of initial reviews carried out by mental health trusts for patients with a learning disability who died whilst receiving services as an inpatient.

FIGURE 2: TOTAL COUNT AND MEAN RATE OF INITIAL MANAGEMENT REVIEWS AND INVESTIGATIONS INTO DEATHS OF PATIENTS WITH A MENTAL HEALTH AND LEARNING DISABILITY DIAGNOSIS RECEIVING SERVICES AT TIME OF DEATH

		Acute non-specialist inpatient/A&E		MH trust inpatient		Mental health community care		Community trust ongoing care	
		Mental health	Learning disability	Mental health	Learning disability	Mental health	Learning disability	Mental health	Learning disability
Total deaths	Total count	2,946	1,070	704	25	25,600	823	534	42
	Response count	45	107	50	43	50	42	10	13
Initial management reviews	Total count	64	90	364	19	5,162	174	17	0
	Response count	63	91	52	42	51	42	10	11
	Mean rate	4.8%	8.7%	61.6%	17.9%	36.1%	25.0%	0.8%	0.0%
Level 1 investigations	Total count	32	28	75	3	770	29	17	1
	Response count	93	107	52	48	52	47	12	12
	Mean rate	1.6%	1.9%	14.1%	4.3%	7.6%	8.0%	0.7%	2.3%
Level 2 investigations	Total count	9	10	152	1	1,137	10	33	2
	Response count	78	99	52	43	51	44	15	15
	Mean rate	0.6%	0.7%	31.2%	2.3%	8.9%	3.6%	1.7%	1.4%
Level 3 investigations	Total count	5	1	9	1	7	3	0	0
	Response count	122	126	51	50	51	51	13	13
	Mean rate	0.0%	0.3%	3.8%	1.0%	0.1%	0.5%	0.0%	0.0%

There is less variation between sectors in the proportion of investigation carried out by trusts for patients with a learning disability diagnosis. **FIGURE 2** shows the mean proportion of investigations between the different sectors for patients with either a mental health or learning disability diagnosis. Further information can be found in annexes 6 to 8.

For mental health trusts, the legal status of a patient, and whether or not the patient is subject to the Mental Health Act 1983 (MHA) at the time of their death, will be relevant when making a decision to review or investigate. There were 266 deaths of people detained under the MHA reported in 2015/16, including those in independent healthcare settings. The Serious Incident Framework requires trusts to consider whether an independent review would

be appropriate when someone who is subject to the MHA dies, and when the cause of death is unknown or where their "death may have been avoidable or unexpected".[11]

However, we found there was a lack of understanding about what is expected when someone who is detained under the MHA dies. We also found examples of where internal notifications and procedures were unclear or relied on the knowledge of experienced staff to make sure additional actions are completed – for example reporting the death directly to CQC[12] and the coroner, or reviewing care against national best practice in human rights such as the Equality and Human Rights Commission's Human Rights Framework.[13]

4. Reviews and investigations

KEY FINDINGS

- Most NHS trusts follow the Serious Incident Framework when carrying out investigations. Despite this, the quality of investigations is variable and staff are applying the methods identified in the framework inconsistently. This acts as a barrier to identifying the opportunities for learning, with the focus being too closely on individual errors rather than system analysis.

- Specialised training and support is not universally provided to staff completing investigations; many staff completing reviews and investigations do not have protected time in which to carry out investigations. This reduces consistency in approach, even within the same services.

- There are significant issues with the timeliness of investigations and confusion about the standards and timelines stated in guidance – this affects the robustness of investigations, including the ability to meaningfully involve families.

- A multi-agency approach to investigating is restricted by a lack of clarity on identifying the responsible organisation for leading investigations or expectations to look across pathways of care. Organisations work in isolation, only reviewing the care individual trusts have provided prior to death. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with mental health or learning disability needs.

This section of the report focuses on how reviews and investigations are carried out, the quality of the investigations, and whether opportunities for preventing death and improving services have been missed.

Overall, we found that trusts have systems in place, based on the current national guidance, for carrying out investigations once a death is identified as a serious incident, but the methods are not well understood at a local level. People told us that the lack of understanding and consistency in application creates confusion, for staff, families and others, about the purpose of the reviews and investigations and they are not focused on learning but used as management tools or reports to coroners. This is wrong, and limits the quality of the reviews and investigations being carried out and the learning that can take place across the NHS.

If a death is investigated under the Serious Incident Framework, there should be a consistent approach to the process of investigation. However, our findings indicate that there is a lack of understanding and skilful application of the guidance available in the Serious Incident Framework about the Root Cause Analysis methodology that is used for investigations. We found that analysis was often superficial, focusing on the acts or omissions of staff with little evidence of systems analysis.

Barriers to learning are most notable where care is provided outside of hospital settings and where multiple providers are involved. A greater level of resource in time, training and expertise would give a platform for increasing the quality and output of investigations.

Context and approach

To understand the context in which reviews and investigations are carried out, in our provider information request we asked trusts to tell us about the total number of deaths for their services from April 2015 to March 2016, and how many initial management reviews, and level 1, 2 and 3 investigations they had completed using the criteria set out in the Serious Incident Framework (**FIGURE 3**). These figures obviously rely on trusts accurately identifying deaths. A more detailed summary of the provider information request are in annexes 6 to 8.

FIGURE 3: TOTAL NUMBER OF DEATHS BY TRUST SETTING AND SECTOR COMPARED WITH THE NUMBER OF INITIAL REVIEWS AND LEVEL 1, 2 AND 3 INVESTIGATIONS

		Acute non-specialist		Mental health			Community	
		Inpatient /A&E	Six-months post-discharge	Inpatient	Community	Six-months post-discharge	Ongoing care	Six-months post-discharge
Total deaths	Total*	207,633 (128 trusts)	233,942 (85 trusts)	1,987 (51 trusts)	40,635 (51 trusts)	19,343 (39 trusts)	25,842 (16 trusts)	8,517 (9 trusts)
Initial reviews	Total**	15,539 (120 trusts)	2,104 (62 trusts)	466 (53 trusts)	6,069 (53 trusts)	768 (41 trusts)	383 (15 trusts)	8 (10 trusts)
	Mean	9.2%	6.1%	59.0%	36.7%	30.4%	16.7%	11.1%
	Median	0.8%	0.0%	62.5%	16.3%	6.1%	2.2%	0.0%
Level 1 investigations	Total**	1,498 (118 trusts)	75 (64 trusts)	87 (53 trusts)	860 (53 trusts)	151 (42 trusts)	105 (16 trusts)	5 (10 trust)
	Mean	0.8%	3.5%	13.6%	8.0%	10.1%	3.4%	0.0%
	Median	0.1%	0.0%	0.0%	1.0%	0.1%	0.6%	0.0%
Level 2 investigations	Total**	1,163 (125 trusts)	111 (66 trusts)	175 (53 trusts)	1,204 (52 trusts)	232 (41 trusts)	109 (16 trusts)	14 (11 trusts)
	Mean	0.6%	0.2%	28.9%	8.0%	14.4%	4.8%	7.4%
	Median	0.5%	0.0%	24.6%	2.6%	0.8%	0.0%	0.0%
Level 3 investigations	Total**	23 (117 trusts)	5 (77 trusts)	14 (52 trusts)	10 (51 trusts)	4 (46 trusts)	17 (15 trusts)	1 (10 trusts)
	Mean	0.0%	0.0%	3.5%	0.2%	0.0%	0.1%	3.3%
	Median	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

* Excludes 0 and 'not known' responses   ** Excludes 'not known' responses
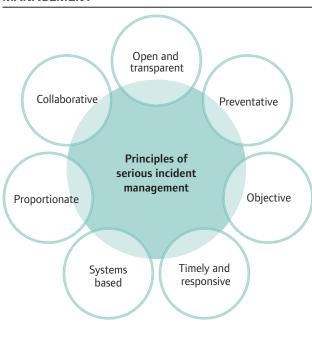
Source: CQC provider information request

On our site visits we found that, once the decision to carry out a review or investigation has been made, most trusts have processes to support the minimum expectations of the Serious Incident Framework. This includes guidance and expectations for:

- setting up an investigation team
- involving stakeholders, including families and carers
- the appropriate level of investigation
- action planning
- submitting the report to commissioners.

It also outlines the seven underlying principles for managing serious incidents, which we expect should be applied to all reviews and investigations (**FIGURE 4**).[14] However, on our site visits we found that staff do not always fully understand the guidance or know how to apply it, and that they have not always had training on how to do so. In addition, we were frequently told that staff do not have dedicated time to be able to conduct investigations. This reduces the consistency of approach, even within the same services.

FIGURE 4: PRINCIPLES OF SERIOUS INCIDENT MANAGEMENT

Quality of investigations

To assess the quality of investigations, we looked at 27 investigation reports from 10 different trusts. Of these, 26 were level 2 investigations. There was little evidence in the reports that the depth of investigation and analysis met the requirements of a level 2 investigation.

The reports we reviewed highlighted that there was no consistent approach to involving staff and families, or how investigators seek to establish facts (what happened) or offer opinions (cause of death and standard of care). In one case, only one member of staff was interviewed when the information provided in the report suggested that more than one person would have needed to give facts and offer opinions to give a full picture. Of the 27 reports, only three evidenced consideration of the family's perspective. Many reports included information about the family, but did not show that they had invited the family to contribute to the investigation.

The initial terms of reference should be a key factor in ensuring a quality investigation is completed. The Serious Incident Framework expects terms of references to be developed for all investigations and the objectives agreed with commissioners, and this is an opportunity for the involvement of families and carers.[15] It is particularly important to ask families and carers, who will often want to know what happened up to the time of death, rather than up to the last contact with the service investigating the death.

By addressing this at an early stage in the investigation, there will be a common origin to start from and a greater likelihood of the final report being satisfactory from a family perspective. Some families and carers may not want to engage at the start, and in these instances the Serious Incident Framework expects that the terms of reference will be provided to them and their views invited.

However, most of the investigations that we reviewed used the standard example terms of reference that are set out in the Serious Incident Framework. Only one report showed any evidence that questions from the family were included in the terms of reference.

The development of clear, effective terms of reference is directly within the control of providers and commissioners, and should be used to make sure there is clarity for any investigation team on the areas that should be reviewed. Strengthening this would also identify where the input of other organisations would be critical to meeting the review's objectives. Including families from the start could improve the transparency, relevance and accuracy of the investigation, and is highly likely to lead to a more open and credible investigation for families.

> "I don't apportion any blame for his death at all, it's one of those things that happened. But we're still not quite sure whether he did fall or not. So many different stories there, some of them just didn't make sense. There was no blame involved but the way it was handled was dreadful, it was quite embarrassing to be a nurse at that period of time."
>
> **CQC interview, 2016**

Training and support for investigators

Evidence from our site visits and provider information request showed that staff do not always receive specialised training and support in conducting an investigation. Previous reports, including the Parliamentary and Health Service Ombudsman's review of the quality of NHS complaints investigations, have equally highlighted the lack of a national, accredited training programme to support local investigators in the NHS.[16] This means that, even within the same services, there is not a consistent approach.

The Serious Incident Framework requires all investigations to use a recognised systems-based methodology that identifies:

- what the problems were
- how the various factors, including environmental and human factors, led to the incident

- why it happened and the fundamental issues that need to be addressed.

It identifies the Root Cause Analysis (RCA) approach as the most common methodology to use. Although we found that all the trusts included in our site visits were using the RCA methodology, not all of them were providing RCA training to people undertaking investigations, nor were they clear on which members of staff needed training or how they could make sure this was completed.

> "There needs to be some standard framework for investigators. They keep saying they've done the Root Cause Analysis course. So what is wrong with that course, if this is the quality of what's being written?"
>
> **CQC interview, 2016**
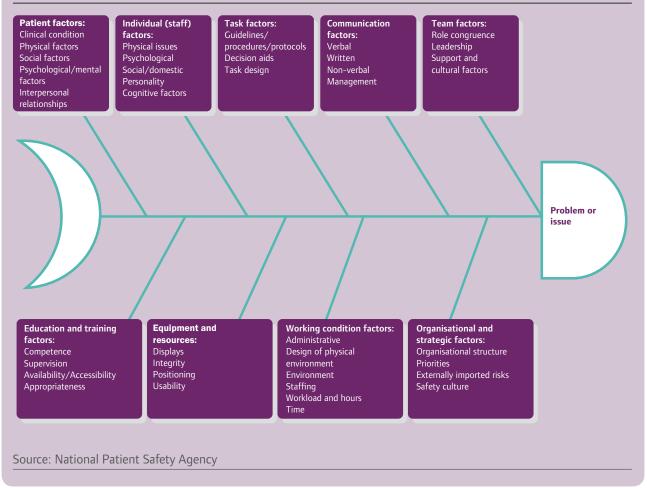
We found examples of misinterpretation of the RCA approach, with some trusts not understanding how it can be implemented in a variety of settings. Some mental health trusts told us they felt the methodology is better suited to acute trusts where there may be a greater likelihood of a single failure or 'root cause' – for example, a missed diagnosis or wrong site surgery. However, this showed a lack of understanding of the techniques, which rarely conclude with a single failure or root cause and which can be applied to most incidents in any setting. This supports the view that investigators need to be trained in how to apply the methods effectively to different scenarios.

EXAMPLE: ROOT CAUSE ANALYSIS INVESTIGATIONS

The following diagram is taken from the guidance for NHS staff on how to analyse contributory factors and root causes when reviewing patient safety.[17] This tool is called a 'fishbone diagram' and prompts investigation teams to look at a range of different information about the issue, event or incident they are investigating.

ROOT CAUSE ANALYSIS INVESTIGATION FISHBONE DIAGRAM – TOOL

Patient factors:
Clinical condition
Physical factors
Social factors
Psychological/mental factors
Interpersonal relationships

Individual (staff) factors:
Physical issues
Psychological
Social/domestic
Personality
Cognitive factors

Task factors:
Guidelines/procedures/protocols
Decision aids
Task design

Communication factors:
Verbal
Written
Non-verbal
Management

Team factors:
Role congruence
Leadership
Support and cultural factors

Problem or issue

Education and training factors:
Competence
Supervision
Availability/Accessibility
Appropriateness

Equipment and resources:
Displays
Integrity
Positioning
Usability

Working condition factors:
Administrative
Design of physical environment
Environment
Staffing
Workload and hours
Time

Organisational and strategic factors:
Organisational structure
Priorities
Externally imported risks
Safety culture

Source: National Patient Safety Agency

"The Root Cause Analysis process may not be the most appropriate methodology for investigating some incidents. It is very difficult for a single RCA investigation report to satisfy the needs of all stakeholders, that is the trust (so that it learns), the family, commissioners, coroner, CQC, other involved organisations, and so on."

Provider information request, mental health trust

Lack of support was also identified as an issue, with staff telling us that the quality of reviews and investigations are often compromised by a lack of time and dedicated resources.

When clinicians and staff have to lead on the investigation and report writing, this is often not factored into their job plans, meaning that they have to fit investigations alongside other responsibilities. As a result, investigations can be rushed, with families not being meaningfully involved, or not completed on time, which affects the quality of reports.

Some trusts have specialist teams that are designated to carry out or oversee investigations.

In our provider information request, trusts told us that specialist investigators drew on clinical expertise as needed to carry out an investigation. In some trusts, we were told of concerns that having a team of specialist investigators removed from clinical settings would not allow the investigators to stay in touch with the context and pressures under which clinicians and staff work. Although this may not be necessary to identify the facts in investigations, trusts believed this clinical knowledge can often support identification of changes needed and help embed the learning in different clinical services.

It is important to recognise the need for support networks to be in place for staff following incidents, as being closely involved can have a significant emotional impact on the staff involved. This may be a negative or positive experience for staff but should be appropriately acknowledged and support offered by all care providers.

Independence of investigations

Many families and organisations external to the NHS raised concerns with us about the independence of investigations carried out within the NHS. The definition and understanding of 'independent' can mean multiple things in relation to the investigation of deaths in care, but the three main definitions are:

- Independence from the care team – this means trusts may identify investigators who work for the trust but who have not been involved in the care provided to the patient.

- The Serious Incident Framework sets out criteria for a level 3 Independent Investigation as "both commissioned and undertaken independently of those directly responsible for and directly involved in the delivery of the elements that the investigation is considering".[18] This will mean the investigation team is external to any organisation that has been responsible for care and treatment. This may look at specific provider level issues or more widely at commissioning systems or service configurations.

- Article 2 of the Human Rights Act – this requires an investigation to be completed that is independent of those implicated by the events under investigations, including NHS trusts as a public body or the NHS overall. Case law established that the role of the coroners and their inquiry into how the person died will satisfy the requirement for independence.[19] For example, in the case of a suicide of a patient subject to the MHA, the need for Article 2 would be triggered as the person is 'detained by the state' and a referral to the coroner will always be required.

The Serious Incident Framework requires that all investigations be completed by "teams that are sufficiently removed from the incident to be able to provide an objective view". We were told during the site visits and in our provider information request that it was quite common for some acute trusts to use people working in the same clinical area or team, where understanding of the specialty involved in the incident would be seen as preferable to someone from a different service type leading the investigation.

There is not currently a way to capture the number of level 1 and 2 investigations that are being completed independently of the clinical team in the different settings, but we did ask how many level 3 investigations occur (independent of the trust). Providers who responded reported 74 completed in 2015/16, out of about 5,500 investigations that they told us about. Trusts, working with commissioners, will typically be responsible for commissioning and covering the costs of any independent investigations, unless they are carried out on behalf of other organisations. For example NHS England may decide, as they did at Southern Health, to commission a specific separate investigation into a single death or multiple problems.

Coroners

Coroners have a statutory duty to investigate all deaths, including those in state detention, if the cause is unknown. However, there are no statutory or other clear criteria for medical practitioners reporting deaths to coroners. It has

been noted that this creates uncertainty and inconsistency in reporting deaths to coroners.[20] The Chief Coroner has urgently called for there to be clear statutory guidance for doctors, providing a clear framework and the basis for better education and training.

Of the 495,309 deaths registered in England in 2015, 222,174 (45%) were reported to the coroner, and there were 31,036 inquests.[21] Where reports are made, the coroner will be responsible for establishing the 'why and when' of death. However, they are not required to review a broad range of issues relating to the whole care and treatment provided to the person, so investigations would not be a substitute for the reviews for learning in the NHS.

Coroners also have the power to issue 'Reports Preventing Future Deaths', which highlight concerns and require action from organisations such as the NHS, other care providers or national bodies if they find problems in the care provided to the person or failings from services. In 2015, coroners in England and Wales issued 571 reports, which are all publicly available but will include deaths that are not related to NHS care delivery. These reports can be used to encourage local, regional or national learning in the NHS. For example, NHS England (London Region) has used this resource to identify learning from the deaths of vulnerable adults and children in healthcare settings across London.[22]

People who die while subject to the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards are considered to be 'in state detention', so will always need to be referred to a Coroner, even if the cause of death is known and the person's death had been expected by the services delivering care and the family or carers. Last year, there were around 6,500 inquests for people subject to the Deprivation of Liberty Safeguards, but changes planned to the Coroners and Justice Act 2009 in 2017 will amend the meaning of state detention in the Act and only require an inquest for a person subject to the Deprivation of Liberty Safeguards if there are any unusual circumstances.

The requirement for all people who die when they are subject to the Mental Health Act to receive an inquest will continue. This involves between 200 and 300 cases a year.[23] A court judgment found that there is no obligation to have a separate independent investigation if an inquest is taking place.[24]

Other independent investigations

It should be noted that other independent investigations may take place when someone dies, including Child Death Overview Panels, police investigations, homicide investigations or local safeguarding board investigations.[25] This can be particularly challenging for bereaved relatives and carers.

> "In an ideal world I'd like just one to two people to coordinate things. From the death to when you go to see bereavement officer to get paperwork, that bit worked quite well. They told you to go to the registrar and register death, but there was no real link between ward, bereavement office, coroner and investigatory team. Actually someone explaining this is the investigation, this is what happened, so you weren't having to ring six different places to find out what's going on, that would be good."
>
> **CQC interview, 2016**

Although there will always be a need for different investigations to work together, it is likely that each will have a different purpose and scope. The existence of a separate investigation should not act as a barrier or reason for NHS trusts not to consider whether they should conduct a local investigation or review (depending on the circumstances of the individual case) to identify learning for their services.

The variation in the way independent investigations are identified as being needed (unless required by statute) was a significant problem for stakeholders during the review.

A consistent national approach is needed, acknowledging the different degrees of independence that will come with different problems, and identifying lead organisations to offer professional expertise when required.

Any new models should improve the capacity and capability of services to see independent investigations not as only for the 'most complex', but the potential to maximise opportunities for greater reflection and shared learning. During the review, it was suggested that this may include local trusts establishing joint investigation approaches – for example, where they have particular specialisms so that investigators are independent from the service but still clinically knowledgeable.

Another option that should be explored is for the Royal Colleges to consider offering clinical leadership and guidance for investigators to support local services. This would potentially reduce the high costs associated with external investigation teams (approximately £100,000 per investigation) or the likelihood of large independent public inquiries (around £22 million spent in the NHS over 10 years[k]) being required.

Timeliness of reporting

There are significant issues with the timeliness of investigations, and confusion about the standards and timeframes outlined in the Serious Incident Framework.

The Framework states that, once a death is categorised as requiring investigation, the trust has 60 days in which to produce a report and action plan.[l] NHS Improvement advises that this is a guideline only and can be changed in negotiation between providers and clinical commissioning groups. However, at a local level we were told that timelines for completing investigations can be interpreted as targets and used as a measure of quality and performance by some trusts or commissioners.

This can compromise the effectiveness of an investigation, especially in complex cases, with staff more focused on timescales than producing a quality review with involvement from others including family members. In some cases, the tight timelines for conducting the investigation were used as an example of why families were not involved.

In our provider information request, we asked trusts to tell us how long, on average, they were taking to complete their investigations and reports. Overall, the length of an investigation reported by trusts ranged from 0 (or same day) to 264 days, with 57 (27%) reporting that their average length of investigation is exactly 60 days (**FIGURE 5**).

It is unlikely that so many are completing investigations on the 60-day target. It is more likely that trusts are not recording this data. One trust confirmed this in their feedback to our provider information request, telling us the average length of time recorded "is an estimate only".

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k   Cost and averages based on the information shared by Department of Health teams establishing the Healthcare Safety Investigation Branch (HSIB).
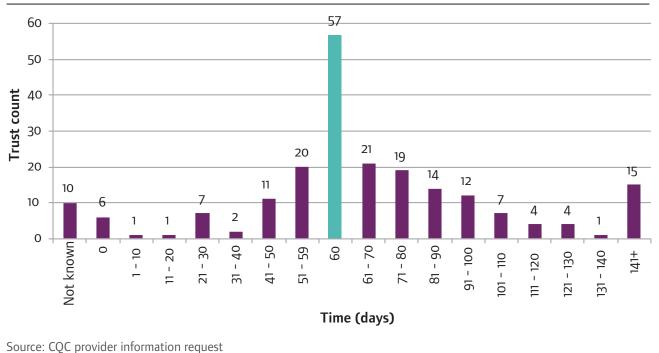
l   The Serious Incident Framework states that serious incident reports and action plans must be submitted to the relevant commissioner within 60 working days of the incident being reported to the relevant commissioner, unless an independent investigation is needed, in which case the deadline is six months from the date the investigation began. However, there is a recognition that circumstances will not always allow for the timely submission of reports and permits for alternative timeframes to be agreed between the commissioner and investigation team.

FIGURE 5: AVERAGE LENGTH OF TIME FOR COMPLETING LEVEL 1 AND LEVEL 2 INVESTIGATIONS

Source: CQC provider information request

Some trusts told us that balancing completing investigations to the standard they should within the required timescales, and treating families with sensitivity, can be a challenge. Families told us that there were long delays to investigations being concluded, or delays to being informed of the findings, sometimes with no explanation from the trust of why the delay had occurred.

"They were supposed to send us monthly updates, they also told us they'd come back to us for clarification if people raised things where they wanted to hear our side of the story, but basically we waited and waited. After about seven weeks we didn't have an update, a pattern that we wouldn't hear, I'd think I don't want to chase them and look difficult."

One-to-one conversation with family and carers

A multi-agency approach to investigations

As identified throughout this report, there will often be more than one organisation involved when investigations take place. The organisation that first identifies a problem in care will be responsible for informing other providers, commissioners or partner organisations to begin discussions about further review or action.

The Serious Incident Framework is clear that organisations must work collaboratively and there should be a multi-agency approach to conducting investigations, supported by jointly agreed policies or procedures for multi-agency working. This includes requirements for providers and commissioners to liaise with other organisations, such as primary care or local authority safeguarding leads, and to work in partnership to support learning and avoid duplication or confusion in the investigation and how they work, and share information, with families.

However, during our site visits we found that trusts and other organisations are not routinely working together to at the point of identifying problems in care, or when conducting

investigations. This was a view reinforced by families.

> "I was phoning the location inspector. CQC put the care home under special measures after my brother died, but I had been contacting them when he was alive and telling them how bad it was there but no one was taking any notice. If a relative rings and reports serious concern, what happens? When you ring and they don't act, they don't visit the place? And someone dies, then what?"
>
> **CQC family listening day**

The Serious Incident Framework is clear that needing to involve multiple providers or commissioners should not be a barrier to completing a single investigation. However, local implementation of the guidance means that organisations tend to work separately, and if reviews are carried out this only looks at individual care they have provided before the person has died, rather than the totality of the care the person received before death. Coordination is particularly poor when an investigation involves two or more providers, and there is a lack of clarity about which organisation should or is taking the lead. This is a missed opportunity for identifying improvements in services and commissioning, particularly for patients with specific needs such as those with mental health problems or a learning disability.

Although some trusts make the effort to work with other providers and organisations as part of the investigation process, the local frameworks to support how this should be done are lacking. This is particularly the case for services outside of hospital settings, where processes are often unclear and much less well developed than for inpatients. Commissioners should be working collaboratively to agree how best to manage serious incidents for their services and make sure local protocols for reporting and escalating any complex or multi-agency issues exist.

Spotlight on mental health and learning disabilities

We have already highlighted in the report that many people with a mental health problem or a learning disability are not being correctly identified within NHS systems.

While this is sometimes the result of the policies and processes, or the configuration of IT systems, staff and organisational attitudes are also an important factor. Many trusts we visited did not consider people in these groups as needing specific attention, while others felt their normal systems covered everyone well. This means that many people are being 'lost in the system' and their deaths may not be investigated when they should be.

5. Do trust boards have effective governance arrangements to drive quality and learning from the deaths of patients in receipt of care?

KEY FINDINGS

- There are no consistent frameworks or guidance in place across the NHS that require boards to keep all deaths in care under review or effectively share learning with other organisations or individuals.
- Trust boards generally only receive limited information about the deaths of people using their services other than those that have been reported as serious incidents.
- When boards receive information about deaths, board members often do not interrogate or challenge the data effectively. Most board members have no specific training in this issue or time that is dedicated to focus on it.
- Where investigations have taken place, there are no consistent systems in place to make sure recommendations are acted on or learning is being shared with others who could support the improvements needed.
- Robust mechanisms to disseminate learning from investigations or benchmarking beyond a single trust do not exist. This means that mistakes may be repeated.

This section of the report focuses on whether NHS trust boards have effective governance arrangements to drive quality and learning from the deaths of patients in their care.

Overall, although we found governance systems in place, there is too little focus on the specific responses following the death of patients. The current approach across NHS trusts is not comprehensive enough to provide timely or detailed learning and improvements.

Based on the current guidance available, there are clinical and corporate governance systems in place for NHS trusts to monitor, review and improve systems following patient safety reviews and investigations. However, we found overall information about the deaths of patients is not routinely asked for or reviewed by trust boards, especially in the case of people receiving care outside hospitals.

There are opportunities to improve information and enhance the system's ability to learn and improve. This will need all parts of the system to recognise the importance of such information – regulators, commissioners, supervisors and boards.

Monitoring the deaths of patients

NHS trust boards are responsible for overseeing the quality and safety of their services, and for creating strong safety cultures that support learning. Across the NHS, trusts should have clear systems for sharing information and learning from patient outcomes to prevent harm to others.

As the regulator, CQC is responsible for checking that trusts' leadership teams are supporting a culture of learning. This includes the ability to identify learning, be open to challenge, and share information about safety issues to improve care. CQC also look at the systems in place to

make sure learning is shared across services and with external organisations, families, carers and patients. There are many improvements to be made to the way that CQC will regulate this in future, based on the learning from this review.

Guidance from NHS England and NHS Improvement requires trusts to have clinical and corporate governance systems in place to monitor, report, review and improve systems following patient safety reviews and investigations.[m] However, there is no guidance that specifically requires boards to keep all deaths in their care under review, corroborate information from a mix of data relevant to mortality (for example, looking at information from complaints, coroners or near-misses to get a complete picture), or effectively share any learning with other organisations or individuals.

We found that the governance of, and learning from, deaths of patients varied widely between trusts, meaning that trusts are not able to respond appropriately and in turn protect future patients.

> "If trusts spent more time on dealing with recommendations rather than on cover ups, we would not be here. They should put more effort in saving people's lives. It is always people at the bottom, nurses, agency staff etc., people at the bottom get all the blame, it is never the people at the top, the managers, the decision makers."
>
> **CQC family listening day**

From our review of board papers it was clear that most trust boards are provided with information about the deaths of people using their services. However, this is not always the case and the information provided is often limited, especially in the case of people receiving care outside of hospital. This particularly affects people with a mental health problem or a learning disability,

as they use community services and multiple providers. The level of detail that boards received again varied from trust to trust, ranging from boards being provided with information about overall mortality rates to those who held discussions about individual cases. This variability could result in valuable learning opportunities being missed and for relevant actions not being developed or shared within and across the NHS.

Board members did not always challenge trusts' assertions that there were strong systems and processes in place for identifying and reporting deaths, or monitoring whether reviews and investigations were completed fully. For example, at one trust we visited, the board were assured that the systems in place accurately captured the deaths of all patients. However, following a request by NHS England to carry out a retrospective case record review, the trust uncovered that they had missed a significant number of patient deaths in the previous year.

Evidence from board meeting minutes showed that some boards actively reviewed their policies in the light of national issues or findings from national publications, such as the *Report of the Morecambe Bay investigation* and the report on Southern Health. One acute trust told us that they had used the report into Southern Health to make sure they had appropriate mortality review processes in place, and the staff we spoke with at the trust appeared to understand its implications.

Most boards believed that their policies were appropriate and that the trusts were not making the same mistakes as those found at Southern Health. While some trusts did go on to recommend further actions to ensure that policies were appropriate and practice reflected the policies, others did not think that they needed to make changes. In trusts that did make changes, there was no shared framework for them to follow and ensure that their improvements were robust. In addition, while some of these boards set clear targets, objectives and measures to achieve improvement in their death review processes, this was not always evident in other trusts.

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m   For example, the standard NHS contracts for hospitals requires services to have systems in place to report deaths to CQC or any other body and to have measures in place for the prevention of serious incidents

Reviewing mortality and investigations

The ability of boards to seek and review or interrogate the information they are given on mortality reviews and investigations can be limited because of the issues with current recording practices. Because patient management systems and incident management systems are not linked, some trusts told us that they find it difficult to identify deaths and related investigations.

This needs to be addressed locally and prioritised by services. Without being able to accurately identify when a patient in their care dies, boards will not have a full picture of the circumstances and will be unable to sufficiently challenge or interrogate the information they are presented with. This means that the potential for learning will be limited both within trusts and between trusts.

Where information is presented to boards, again data is not always sufficiently challenged or interrogated by board members. Reasons for this may include a lack of dedicated time to focus on deaths, and a lack of training for board members. In addition, there is considerable variability in reviewing the quality of investigations that take place, or making sure that recommendations are acted on and learning is shared with others who could support improvements and prevent it happening again.

Even where difficulties in running reports from electronic systems exist, additional information from the experience of families and carers, views from advocates or local support services can also be used by boards who want to understand how their staff are responding following a death in care. We identified some trusts who used examples and case studies from investigations and complaints. This type of user story and focus on individual experiences method should be considered on a wider scale, and in addition to the plans for developing mortality data, locally and nationally.

Focus on quality and learning

Across our inspections of NHS trusts, we often find concerns around safety culture. Problems include support for reporting and learning from incidents, insufficient record keeping, poor data sharing and systems that are not fit for purpose.[26] This review has found the same issues when we place a spotlight on deaths.

In trusts rated as good and outstanding, we have seen how boards prioritise quality and safety issues. During the review, a number of trusts also told us that they were trying to cultivate a culture of learning. We saw this on some of our site visits, where trusts were trying to embed a just staff culture, in which learning, transparency and openness are valued, encouraged and supported. However, trusts said that trying to change organisational culture was challenging, particularly engaging staff and being able to spend enough time on learning when resources are already stretched.

Over the last decade we have seen a change in attitude towards patient safety culture, and in turn positive changes in practice, but there has not been a clear approach that looks specifically at deaths and what happens when the patient can no longer be involved. For example, although CQC will always look at whether services are safe and people are being protected from harm, our inspection handbook for mental health providers does not include any specific reference to mortality or death.

This will be changed in our next phase of inspections for all services, with a new specific reference to learning from mortality reviews and deaths in the key lines of enquiry that we use when we look at how 'well-led' an organisation is.[n] However, the current lack of oversight and support means that the systems currently in place are not identifying failings or learning, and trusts are not communicating with bereaved families in effective or meaningful ways.

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n   We are consulting on our next phase of inspection approach in December 2016. Key lines of enquiry refer to the questions we ask of providers during an inspection or informing the information we collect during our monitoring of services.

Findings from our provider information request suggest that learning is not always comprehensively embedded. Trusts often rely on written communication, such as newsletters and reports posted on the intranet, as the primary way to share learning with staff. However, staff felt that the pressures of clinical responsibilities mean they are not always fully considering information when shared in this way. Another challenge when sharing across the trust and between providers is making the content accessible and relevant to all staff from all specialisms.

Our site visits and provider information requests highlighted a variety of approaches that trust boards are taking to improve the way learning is shared with staff, to overcome these challenges. In some trusts, little follow-up, assigned time or support to embed learning was evident. In others, learning was more embedded with specific communication and learning strategies, where messages were tailored to suit specific audiences using a variety of channels. These trusts tended to make sure that staff had dedicated time (for example, monthly learning sessions) and designated roles to do with learning (such as learning groups).

"We have used staff reflective groups to promote a culture of reflection and compassionate practice. These groups emphasise learning from each other in the here and now, in a completely confidential space. Specific workshops using a 'forum theatre' approach have focused on particular themes from external feedback complaints and serious incidents."

Provider information request – mental health trust

The Serious Incident Framework promotes information sharing and encourages providers to share lessons learned at local and national levels to prevent incidents from happening again. However, our provider information request and site visits showed little evidence that learning was effectively shared within and between trusts, even though they recognised how valuable this would be.

PUBLISHING INFORMATION ON LEARNING FROM DEATHS

During the review, we asked providers what type of information they believed could be shared publicly, for example in their Quality Accounts or board reports, to support transparency and improve consistency in the information available to the public. A proposed summary was developed by NHS trusts through our NHS Co-production group and included:

- A summary description of the governance framework that guides how deaths are reported, reviewed and investigated within organisations.

- An explanation of how leadership teams seek assurance that processes after a person dies result in appropriate action and involve families and carers. This should include an outline of what recent changes (if any) have been made to improve local processes and take into account the findings and recommendations made by this review.

- An overview of how leadership teams make sure the views of families and carers are included in investigations and reviews, including any actions taken to improve and support meaningful family involvement in the reporting period.

- A summary of the themes identified from across the reviews and investigations completed in the organisation. This should include a statement of how the themes have been used to inform the selection of any quality priorities for the year ahead and plans for improvements.

This has been shared with the Department of Health to inform future development of the NHS Quality Account.

A key reason for this is the lack of robust local mechanisms to disseminate learning from investigations between trusts and within the wider health economy. These need to be developed so that mistakes are not repeated within trusts, and so that other providers do not have to make the same errors in order to learn from them. While we heard examples of clinical commissioning groups holding mortality review events for trusts to share learning from incidents, this is not common practice.

The National Reporting and Learning System (NRLS) should support national learning. Following the review of individual patient safety incidents that result in severe harm or death, it issues patient safety alerts, which offers the opportunity for cross-organisational learning.

SHARING LEARNING FROM PATIENT SAFETY INCIDENTS: THE NATIONAL REPORTING AND LEARNING SYSTEM (NRLS)

When an error occurs, even if no harm comes from it, any member of NHS staff should use their local reporting system to capture the information so that changes can be made to reduce the risk of it happening again. Local reporting systems also feed into the NHS National Reporting and Learning System (NRLS). This contains around 15 million records of patient safety incidents, including errors that have led to severe harm or the death of a patient.

The National Patient Safety team at NHS Improvement analyse each incident reported as leading to severe harm or death, to identify wider patient safety issues. When a new or under-recognised risk is identified, the team also review incidents reported as no, low or moderate harm, to better understand how to reduce the risks. The team then provides advice and guidance about how to take action by issuing a Patient Safety Alert. Healthcare providers are required to share the alert with the relevant teams in their organisation and put any relevant actions into practice.

There are three types of alerts, all of which are published online:[27]

- **Warning alerts**: typically used to quickly raise awareness of a risk that may be under-recognised and where healthcare providers could take action to reduce the risk of harm. Warning alerts ask healthcare providers to agree and coordinate an action plan, rather than simply distributing the alerts to frontline staff.

- **Resource alerts:** used to ensure healthcare providers are aware of any substantial new resources – typically guidance or toolkits – that will help to improve patient safety, and to ask healthcare providers to plan implementation in a way that ensures sustainable improvement.

- **Directive alerts**: typically issued because a specific, defined action to reduce harm has been developed and tested to the point where it can be universally adopted, or when an improvement to patient safety relies on standardisation (all healthcare providers changing practice or equipment to be consistent with each other) by a set date.

Providers told us that there was a greater emphasis on conducting investigations and completing investigation reports within a set timeframe, over ensuring that the learning from investigations was disseminated and embedded into practice. This was reflected in our provider information request, where one trust said they felt the focus was on getting through the "numbers" rather than learning and improvement. This was echoed by other trusts, suggesting that there needs to be a change with learning and understanding the improvements made or needed. This should be the priority for provider boards, rather than a focus on the numerical measures that will only give part of the picture and can limit the learning achieved about what is and is not working well across services.

"There is a risk in creating an investigative culture with the right balance between enough investigations to ensure good responsive learning culture, and an overbearing culture where the investigation itself takes precedence over the needs of the family and the patient."

Provider information request – mental health trust

Costs and benefits of reviewing and investigating deaths

To help us to understand the current costs of reviews and investigations and how these may vary, we worked with two mental health trusts, one acute trust and one community trust to estimate the costs of the activities they carry out for reviews and investigation when someone in their care dies. We looked at their activities in 2015/16 (**FIGURE 6**).

FIGURE 6: ESTIMATED ANNUAL COSTS TO TRUSTS OF UNDERTAKING DEATH REVIEWS AND INVESTIGATIONS IN 2015/16

		Mental health trust 1*	Mental health trust 2	Community health trust	Acute trust
Estimated total cost		£240,000–£280,000	£640,000	£62,000	£484,000
Total cost as a percentage of trust income		0.16%	0.18%	0.06%	0.05%
Total number of	Deaths recorded of people who had contact with the trust	948	948	225	2744
	Provider initial management reviews	218	137	3	100
	Level 1 investigations	32	68	3	100
	Level 2 investigations	10	56	3	7

*Mental health trust 1 also provides community services

FIGURE 7 provides a breakdown of the costs for each trust by the key activities they carry out when reviewing and investigating deaths. The activities that each trust described for the different activities varied. For example, involving family and carers included:

- Going out to visit the family and carers to discuss the incident and to explain that the trust is planning to carry out an investigation.

- Speaking with the family and carers to describe what the investigations will cover and to get their views on the terms of reference for investigation.

- Sharing the findings and recommendations of the report with the family and carers and asking for their comments before publication.

In addition to staff costs on the activities above, it included other costs such as translating the report into different languages for the family and carers, and staff travel costs. The costs are mainly the cost of staff time spent on the different activities carried out during reviews and investigations. Some trusts described the non-staff costs, such as IT software licenses, but these were small in comparison to staffing. The variation in costs, particularly for full investigations, reflects the different methods and levels of staff that trusts use when carrying out an investigation. For example, while mental health trust 1 uses a central team of trained incident investigators to carry out investigations, mental health trust 2 uses senior clinical staff. In contrast to these approaches, the acute provider has a dedicated team of four medical examiners that review the deaths in their trust.

It should be noted that the costs apply to the resources for the current systems in place. Any future developments to improving and strengthening the effectiveness of the reviews and investigations will need to be factored into changes. However, common themes cited by all four trusts around the benefits of carrying out investigations included providing closure and reassurance to those close to the deceased, and learning from incidents to ensure care is improved.

FIGURE 7: ANNUAL COST TO TRUSTS OF CARRYING OUT ACTIVITIES IN REVIEWING AND INVESTIGATING DEATHS (TO NEAREST £000)

	Mental health trust 1*	Mental health trust 2	Community health trust	Acute trust
Identifying and recording deaths	£9,000	£26,000	£24,000	£176,000
Decision making	£32,000	£204,000	£2,000	£43,000
Review and investigation	£51,000	£292,000	£12,000	£237,000
Governance and assurance	£107,000	£32,000	<£1,000	£1,000
Involving family and carers	£63,000	£19,000	£1,000	£10,000
IT costs	Not known	£67,000	£21,000	£16,000

*Mental health trust also provides community services

The cost of litigation

While some trusts may find the costs of conducting an investigation prohibitive, the costs of legal claims to the NHS overall can be even higher. Information from the NHS Litigation Authority (NHS LA) shows that, in the period from 2013/14 to 2015/16, they received 4,110 claims involving the death of a patient. Over the same period, £317 million was paid out on successful clinical claims where someone had died.[o] Many of these claims would have been received in previous years because of the time it takes to settle claims.

Of this £317 million, £164 million was paid to the bereaved in terms of damages, £118 million was paid to cover their legal expenses and £35 million was the cost of legal defence for the NHS.[p] The lower total cost of legal expenses to the NHS may be the result of different factors, for example only 2% of claims will be subject to a court case and require legal representation from the NHS LA, but people making a claim may have had legal representation from the start.[28]

The NHS LA always encourages trusts to say sorry to those who have suffered harm when things go wrong. Saying sorry is not an admission of legal liability; it is the right thing to do. This supports the findings throughout this review, from families, clinicians and staff, that when trusts support a culture that starts with a meaningful apology for any harm or the loss of life, it promotes open communication between services and families and is less likely to lead to families feeling they need to escalate or make legal claims to get the answers they need.

The NHS LA expects local policies to be in place that set out the process of communication and raise awareness of expectations to support openness during the investigation process. There was consensus among Expert Advisory Group members that if trusts are more open and honest about what has happened and apologise for the death of their relative, the bereaved may not feel they need to make a legal claim.

o   Claims can also be settled on many factors, and we are unable to distinguish what percentage of the damages related purely to the fatality aspect of the claim.

p   Please note that the NHS Litigation Authority database was designed primarily as a claims management tool rather than for research purposes. A claim may be multi-factorial and/or settled on a number of bases. The fatality figures provided here reflect the total numbers of all claims received annually and the cost to the NHS annually as the claims are closed with damages paid or not. They are not directly related to each other due to the timelines of receipt and investigation. They should not be relied on as a basis for audit or research.

Conclusion, next steps and recommendations

This review set out to discover how NHS trusts in England identify, investigate and learn from the deaths of people who are receiving their care. We conclude that opportunities to improve care for future patients are being missed, because learning from deaths is not currently being given enough consideration in the NHS.

Throughout our review, families and carers have told us they often have a poor experience of investigations and are not consistently treated as equals with kindness, respect and honesty, even though many trusts state that they value family involvement. This was particularly the case for families and carers of people with a mental health problem or learning disability.

We have found a lack of consistency in the way the NHS responds when deaths do occur and how problems in care may have contributed to premature deaths for people. There is currently no single mortality framework that recognises deaths as significant events, and outlines what NHS trusts need to do to maximise learning from these events.

There are a wide range of systems and processes in place, meaning that the way NHS trusts identify, share information and report the deaths of patients varies. This particularly applies to people with a learning disability or mental health problem, who often receive care from multiple organisations, as well as those who die in the community. If trusts are not made aware of a patient's death soon after the death has occurred, opportunities for learning, and opportunities to take action to improve care for future patients, are lost.

Where problems in care will require deaths to be subjected to further reviews or investigations, there needs to be training, support and education on the process for everyone working in the NHS, informed and developed by families and carers. This needs to highlight the importance of getting conversations right, from the first point of contact following the death of a patient and through all ongoing involvement.

Our evidence clearly shows that the quality of investigations varies both between trusts and within trusts. A lack of specialised training and support for staff means that the methods in the Serious Incident Framework are applied inconsistently, and a lack of protected time for staff to complete the review or investigation can affect the timeliness and robustness of the investigation. Trust boards have a major role in ensuring that there is a just learning culture within their organisations, and that opportunities to learn are maximised with improvements in care clearly evidenced. In addition, they need to make sure they keep all deaths in care under review, share learning and act on recommendations both within and beyond their trust.

Across our review we were unable to identify any trust that was able to demonstrate good practice across all aspects of identifying, reviewing and investigating deaths and ensuring that learning is implemented – although we did identify trusts that demonstrated good practice at individual steps in the investigation pathway.

Change is needed to make sure there is learning from the deaths of patients, and that this quickly translates into improved care for other patients. Although the remit of our review was limited to NHS trusts only, our findings and recommendations are applicable to all commissioning or providing NHS-funded care, and should be used to inform changes in the mortality processes and learning from death across local health and care economies. For this to happen there needs to be a change in culture across health care, and a change in approach from all parts of the system.

There is a real opportunity for the NHS to become world leaders in the way learning and investigations are completed and changes are made when a person dies.

We recommend that the Department of Health, supported by the National Quality Board – in partnership with families, clinicians, staff, professional bodies, colleges and the third-sector – do the following:

- Review CQC's findings and recommendations.
- Publish a full response to the review, setting out any progress already made that is starting to address the problems identified and stating how clarity will be provided for families and everyone working in the NHS on 'what good must look like'. This will state timeframes for improvement work and lead organisations, and note how families will be actively involved in developments (April 2017).
- Coordinate improvement work across multiple organisations and publish a full progress report on at least a six-monthly basis.

Next steps

Change is needed to make sure there is learning from the deaths of patients, and that this quickly translates into improved care for other patients. For this to happen health professionals need support from local boards and the wider system to reflect and improve the way they provide care; trust boards, leadership teams and commissioners need to be able to quickly respond to identified needs; and relatives and carers need to be actively involved and to always be treated equally, with honesty, compassion and respect. This will take a change in culture across health care, and a change in approach from all parts of the system.

This report sets out the problems found, the challenges and barriers that exist across healthcare and how – in some areas – families and organisations that support them are trying to overcome these. To support the change that is needed we make specific recommendations below However, these need to be considered, challenged and refined by all, developing and agreeing the best solutions, together.

Accountable bodies must be identified to ensure progress is made and clearly communicated. Importantly, this work must set the tone for how we expect cultures to truly involve families – at all levels of the system. In particular, we need to see honest, open conversations with families when things go wrong, as part of a genuine commitment to reflect, learn and make sure that things are different in the future.

Recommendations

Learning from deaths needs to be a much greater priority for all working within health and social care. Without significant change at local and national levels, opportunities to improve care for future patients will continue to be missed.

Clinicians and healthcare professionals will need to make changes to their practice to improve learning from deaths. They will need to be supported by trust boards and clinical commissioning groups.

National organisations must support local changes, including those for families, carers and others. To do this, national oversight bodies should develop specific guidance related to learning from death. These include the Department of Health, CQC, NHS England, NHS Improvement and Health Education England. Work will need to focus on agreeing definitions of what good looks like in relation to the areas highlighted in this report. For this work to be effective, it must be carried out in partnership with families and carers, and with clinical leadership from the Royal Colleges.

Below we outline the areas that need to improve, with our recommendations for changes to support this.

Learning from deaths needs much greater priority across the health and social care system. Without this, opportunities to improve care for future patients will continue to be missed.

Recommendation 1:

We urge the Secretary of State for Health and all within the health and social care system, to make this a national priority. We suggest that the Department of Health, supported by the National Quality Board – in partnership with families and carers, professional bodies, Royal Colleges and third-sector organisations – undertake the following:

- Review CQC's findings and recommendations.
- Publish a full response to this review, setting out the timeframes for improvement work, identifying lead organisations, and noting how families will be actively involved in the developments (April 2017).
- Coordinate improvement work across multiple organisations and publish a full progress report annually.

Coordinating organisations: Department of Health, CQC, NHS England and NHS Improvement and Royal Colleges.

Healthcare providers should have a consistent approach to identifying and reporting, investigating and learning from the deaths of people using their services, and when appropriate, sharing this information with other services involved in a patient's care before their death.

Recommendation 2:

Leaders of national oversight bodies (NHS Improvement, NHS England and CQC) and Royal Colleges, work together with families to develop a new single framework on learning from deaths. This should define good practice in relation to identifying, reporting, investigating and learning from deaths in care and should complement the Serious Incident Framework. Roles and responsibilities should be clearly defined.

The framework should consider cross-systems processes, leadership and oversight. For example:

- Describe arrangements between primary and secondary healthcare providers and between health and social care organisations and the role of clinical commissioning groups in coordinating investigations involving multiple organisations.

- Describe the roles of regional patient safety teams and Quality Surveillance Groups working in NHS England and NHS Improvement.

- Describe the additional scrutiny to be placed on deaths of individuals with learning disability or mental illness.

- Offer guidance on the role of boards to supporting improvements, how this will be resourced and how this will be regulated.

- Provide guidance on the expectation that the involvement of lawyers should be limited. Where lawyers are involved, there should be a focus on advising in the context of NHS values, the duty of candour, and the principles of patient partnership/involvement.

- Provide guidance for when an independent investigation may be appropriate.

To support the development of the single framework, we also recommend that a single lead for deaths in care in each national organisation is identified so there is a clear and accountable person for escalated issues and consistent involvement in the improvement work we have proposed.

Coordinating organisation: NHS Improvement, NHS England and CQC

Bereaved relatives and carers must always be treated as equal partners and receive an honest and caring response from health and social care providers. Families and carers should be supported to the extent that they wish to be involved, with particular importance and priority given to the first discussion and explanation of the processes that will follow, offering a full and accurate explanation of the reasons the person died and a response to all concerns they have raised about care provided.

Recommendation 3:

NHS Improvement and NHS England, with support from CQC, should lead work to define what families and carers can expect from healthcare providers when they are involved in the investigation process.

This guidance should be developed in partnership with families who have experienced the investigation process and should include how families can be offered access to timely independent advice and understand what resources are available to support them during the process. The guidance should set standards for local services on the information to be offered – for example, how and when families may be contacted about investigations, what local support is available, what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement, and how this will be communicated, nationally and locally.

The guidance should ensure that:

- Families' views are proactively sought and used to inform decisions around whether a review or investigation is needed.

- When a decision is made that an investigation should be carried out, families and carers should be involved to the extent that they wish and treated as equal partners in this alongside NHS staff.

- Families and carers are involved in setting terms of reference, are kept fully informed of the progress of an investigation and offered an opportunity to shape the report, as well as updated on how this leads to improvements in care (if they wish).

Coordinating organisations: NHS Improvement and NHS England supported by CQC

The deaths of people with a learning disability or severe mental illness are not consistently receiving the attention they need – both from healthcare professionals locally and at national level. NHS England's work to review the deaths of individuals with a learning disability is a significant step forward, but more is needed

Recommendation 4:

NHS England and NHS Improvement should coordinate solutions to the range of issues we set out for people with mental health conditions or a learning disability across national bodies, including the Royal Colleges. This should aim to improve consistency, definitions and practices that support the reduction of the increased risk of premature death.

Coordinating organisations: NHS England and NHS Improvement

Systems and processes need to be developed and implemented to ensure that all relevant providers are aware when a patient dies and that information from reviews and investigations is collected in a standardised way

Recommendation 5:

NHS Digital and NHS Improvement assess how they can facilitate the development of:

- Reliable and timely systems, so information about a death is available to all providers who have recently been involved in that patient's care.

- A standard set of information to be collected on all patients who have died. In addition to demographic information, this should include information on whether the patient had a learning disability or mental health diagnosis and the outcome of screening for concerns in care. This should include concerns from the family as well as clinical staff.

- Processes to collate information about patient deaths that can be analysed by patient characteristics, such as diagnoses or services used. This information, combined with the findings from reviews and investigations should form the basis of audits to be presented to trust boards.

Coordinating organisations: NHS Digital and NHS Improvement

Reviews and investigations need to be carried out to a high quality, with a focus on system analysis rather than individual errors. Staff require specialist training and protected time to carry out investigations to help ensure that these identify missed opportunities for prevention of death and to improve care.

Recommendation 6:

Health Education England should work with the Healthcare Safety Investigation Branch (HSIB) and providers to develop approaches to ensuring that staff have the capability and capacity to carry out good investigations of deaths and write good reports, with a focus on these leading to improvements in care. This work needs to be factored into job descriptions and work plans. Investigation teams must be comprised of staff who have mental health and learning disability expertise, where relevant, as well as the skills to apply the Duty of Candour compassionately, and the skills to support individuals at a time of complex bereavement. Within this, we propose that an accredited training programme for people undertaking hospital-led investigations needs to be considered.

Coordinating organisation: Health Education England.

To ensure that learning from deaths is given sufficient priority at a local level, provider boards and clinical commissioning groups must take action without delay on this report and implement national guidance when this becomes available.

Recommendation 7:

Provider organisations and commissioners must work together to review and improve their local approach following the death of people receiving care from their services. Provider boards should ensure that national guidance is implemented at a local level, so that deaths are identified, screened and investigated, when appropriate and that learning from deaths is shared and acted on. Emphasis must be given to engaging families and carers.

Provider boards should ensure:

- Patients who have died under their care are properly identified.
- Case records of all patients who have died are screened to identify concerns and possible areas for improvement and the outcome documented.
- Staff and families/carers are proactively supported to express concerns about the care given to patients who have died.
- Appropriately trained staff are employed to conduct investigations.
- Where serious concerns about a death are expressed, a low threshold should be set for commissioning an external investigation.
- Investigations are conducted in a timely fashion, recognising that complex cases may require longer than 60 days.
- Families and carers are involved in investigations to the extent that they wish.
- Learning from reviews and investigations is effectively disseminated across their organisation, and with other organisations where appropriate.

- Information on deaths, investigations and learning is regularly reviewed at board level, acted upon and reported in annual Quality Accounts.
- That particular attention is paid to patients with a learning disability or mental health condition.

We also recommend that provider Boards strongly consider nominating a non-executive director to lead on mortality and learning from deaths.

Lead organisations: Boards in NHS trusts and other healthcare organisations.

What CQC will do:

CQC will continue to be actively involved in translating these recommendations into actions through our involvement in the National Quality Board, and through the recommendations noted above. Specifically we plan to:

1. Strengthen CQC's assessment of learning from deaths to cover the process by which providers identify patients who have died and decide which reviews or investigations are needed, with particular emphasis on:

- patients with a learning disability or mental health problem
- quality of investigations carried out by trusts
- reports to trust boards on learning from death
- action taken in response to learning from death
- how trusts have involved families and carers in reviews and investigations

CQC will also review how learning from death is documented in impact reports.

2. In addition to our involvement in the wider changes needed, we will use our independent voice to:

- Share our findings and insight about the quality of systems and processes in place across health and social care, including for people with mental health conditions or a learning disability, to encourage improvement at a local and national level.
- Encourage our inspection teams to report and identify good practice examples that emerge from the local development work that is taking place across the country, sharing examples in our national reports or in other communications as needed.

Appendix A: Deaths of NHS patients – roles and responsibilities

In this section we describe some of the main organisations that have direct or indirect roles or responsibilities in relation to incidents resulting in the death of an NHS patient. Almost all of the organisations listed have other roles and responsibilities too.

Organisation	Roles and responsibilities
Academy of Medical Royal Colleges	• Coordinates sharing of information between its 23 member colleges and faculties to help ensure consistent learning from deaths (and other sources) across all specialities.
Care Quality Commission (CQC)	• Receives National Reporting and Learning System (NRLS) data on deaths for NHS trusts, and uses this and other intelligence to prioritise and focus inspections. • Lead health and safety enforcement body when patients die/are harmed in registered health and social care services. • Receives direct notifications of all deaths of people detained under the Mental Health Act. Shares this information with national oversight systems including the Ministerial Board on Deaths in Custody. • Investigates complaints from/on behalf of people subject to the Mental Health Act, including in relation to deaths in detention (no powers to investigate other complaints).
Clinical commissioning groups (CCGs)	• Coordinate and disseminate learning from local deaths and near misses. • May commission or participate in some reviews or investigations.
Crown Prosecution Service (CPS)	• Decides which cases of death should result in prosecution. • Determines the charges in serious or complex cases. • Prepares cases and presents them at court. • Provides information, assistance and support to victims and prosecution witnesses.
Department of Health	• Leads on creation of national policies and legislation, which may be influenced by learning from deaths. • Accountable to UK Parliament for the performance of the NHS.
Fire and Rescue Service	• Investigates deaths that may have resulted from fire, gas, chemical or radiation incidents. • Has power to prosecute.

Organisation	Roles and responsibilities
Healthcare providers	• Verify death (or arranges for verification).
	• Notify family/carers.
	• Notify coroner if criteria met.
	• Notify police/fire service/other organisations if criteria met.
	• Comply with internal reporting requirements.
	• Comply with national reporting requirements.
	• Liaise with other relevant providers involved in the patient's care.
	• Decide whether review or investigation criteria are met.
	• Liaise with family/carers.
	• Conduct review or investigation if criteria met.
	• Involve and support family/carers if they wish.
	• Report on review or investigation.
	• Disseminate any learning internally.
	• Liaise with CCG/other relevant bodies to disseminate learning externally.
	• Prepare and implement action plan if required.
	• Monitor and review action plan progress.
	• Respond to any complaints arising from the death.
Healthcare Safety Investigation Branch (HSIB)	• Carries out independent safety investigations led by experts. • Identifies causes of harm and publishes reports with recommendations.
Health Education England (HEE)	• Ensures the health workforce has the right number of staff with the right skills, values and behaviours, so embeds learning from deaths (and other sources) in education and training outcomes.
Local authorities	• Register deaths.
	• Arrange public health funerals and disposal of assets if no next of kin.
	• Are involved in safeguarding investigations.
	• Have public health duties if death attributable to public health incident.
Local coroner	• Statutory duty to investigate all unnatural deaths, including those in state detention. Limited role in investigating unknown causes of death which turn out to be natural. Highlights concerns to prevent future deaths.
Local independent advocacy services	• May represent a deceased patient during review or investigation using a non-instructed rights-based approach if the patient's human rights or rights under the Equality Act 2010 may have been infringed.
	• Involvement post-death will depend on local commissioning arrangements.

Organisation	Roles and responsibilities

Local Safeguarding Boards – adults and children	• Safeguarding Children Boards have a statutory duty to undertake reviews if abuse or neglect of a child is known or suspected; and the child has died.
	• Safeguarding Adults Boards will become involved in investigations if the deceased patient had support needs, to
	  – help coordinate a response
	  – ensure agencies and individuals respond appropriately when abuse or neglect have occurred
	  – use lessons learned to improve support to other adults who may be vulnerable.

Medicines and Healthcare products Regulatory Agency (MHRA)	• Investigates medicines and medical devices if they are implicated in a death and a manufacturing defect is suspected; issues alerts and recalls when appropriate. • Operates a system for clinicians to report adverse incidents (including deaths) involving medicines, medical devices, blood and counterfeit products.
NHS Digital	• The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care, including production of national data sets such as Hospital Episode Statistics (HES) and the Mental Health Services Data Set (MHSDS), and the publication of statistics including the Summary Hospital-level Mortality Indicator (SHMI).
NHS England (NHSE)	• Investigates homicides committed by patients being treated for mental illness.
NHS Improvement (NHSI)	In 2016, NHSI took over the statutory functions of the National Patient Safety Agency including: • operation of the National Reporting and Learning System (NRLS) • the Strategic Executive Information System (STEIS) • development of advice and guidance for the NHS on reducing risks to patients.
NHS Litigation Authority	• Offers indemnity cover to NHS providers (and independent providers of NHS-funded care) and manages claims against them. • Shares lessons from claims and other legal and professional cases. • Resolves concerns about professional practice through the National Clinical Assessment Service (NCAS).
National Institute for Health Research	• Manages Patient Safety Translational Research Centres which conduct and support research to improve safety, quality and effectiveness of services within the NHS.
National Quality Board	• Ensures the alignment of the systems for managing and improving quality to prevent avoidable deaths and other adverse incidents.

Organisation	Roles and responsibilities
Office for National Statistics	• Produces an annual report on deaths in England and Wales broken down by age, sex, area and cause of death. • Produces annual reports on specific types of death, for example, infants aged under one year or suicides.
Parliamentary and Health Service Ombudsman	• Makes final decisions on complaints in relation to deaths and other matters that have not been resolved by the NHS (and some other organisations); this includes NHS-funded care and treatment that takes place in independent healthcare settings.
Police	• Investigate deaths when criminal activity is suspected.
Professional regulatory bodies	Includes the General Medical Council, the General Pharmaceutical Council, the Health and Care Professions Council and the Nursing and Midwifery Council. • Maintain professional standards of conduct. • Resolve complaints against their registered practitioners.
Public Health England (PHE)	• Supports the management of deaths and other serious incidents within health services when there is potential for the wider population to be adversely affected.

Appendix B: Trusts visited

Trust type	Trust name
Acute	● Homerton University Hospital NHS Foundation Trust
	● Norfolk and Norwich University Hospitals NHS Foundation Trust
	● Royal Devon and Exeter NHS Foundation Trust
	● Sheffield Teaching Hospitals NHS Foundation Trust
Community	● Gloucestershire Care Services NHS Trust
	● Hounslow and Richmond Community Healthcare NHS Trust
	● Leeds Community Healthcare NHS Trust
	● Staffordshire and Stoke on Trent Partnership NHS Trust
Mental Health	● Cumbria Partnership NHS Foundation Trust
	● Dorset Healthcare University NHS Foundation Trust
	● North Essex Partnership NHS Foundation Trust
	● West London Mental Health NHS Trust

Appendix C: Expert advisory group membership

We worked with an expert advisory group (EAG) who provided advice and guidance throughout the review. The EAG was made up of representatives from family and patient groups, national agencies, NHS trusts and voluntary sector organisations.

- Action Against Medical Accidents
- Action on Elder Abuse
- Bindmans LLP Civil Liberties & Social Welfare
- Challenging Behaviour Foundation
- Consequence UK
- Coroners' Society
- Council For Disabled Children
- Department of Health
- Disability Rights UK
- Equality and Human Rights Commission
- Foundation of People with Learning Disabilities
- Generate (Opportunities Ltd)
- Healthwatch England
- HundredFamilies
- INQUEST
- Mazars
- Mental Health Foundation
- Mental Health Network
- Mental Welfare Commission for Scotland
- National Children's Bureau
- National Development Team for Inclusion
- NHS Confederation
- NHS Commissioners Confederation
- NHS Digital
- NHS England
- NHS Improvement
- NHS Litigation Authority
- NHS Providers
- Parliamentary and Health Service Ombudsman
- Prison Probation Ombudsman
- Race Equality Foundation
- Regulation and Quality Improvement Authority
- Rethink Mental Illness
- Scope
- Solent NHS Trust
- Southerns Law
- Sussex Partnership Foundation Trust
- The Royal College of Pathologists
- University of Bristol (Learning Disabilities Mortality Review Programme)
- Yorkshire and Humber Academic Health Science Network

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South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 5

Title:	**Update on Health and Wellbeing Strategies**
Paper prepared by:	District Directors
Purpose:	1.0 To update the Trust Board regarding Health and Wellbeing Board Strategies and Membership. 2.0 To approve the revised Barnsley Health and Wellbeing Strategy (2016-2020).
Mission/values:	The paper helps set the context for our strategy and shows the Trust Board how our strategic objectives link to improve people's health and wellbeing, to improve the quality and experience of all that we do and improve our use of resources. The paper highlights the joint working across the health and social care community.
Any background papers/ previously considered by:	Background papers are attached as appendices 1-4, one for each geographical locality. They have not previously been to Trust Board.
Executive summary:	**Introduction** The attached documents aim to inform board members as to the status of health and wellbeing strategies across the four geographical areas. Additionally, the Trusts attendees at each Health and Wellbeing Board, and their status at the meeting, are set out in the following table: Attendance at Health and Wellbeing Boards *(table below)* **Current Health and Wellbeing Strategies by locality** 1.1 Barnsley – Appendix 1 1.2 Wakefield – Appendix 2 (note currently being updated for January 2017) 1.3 Kirklees – Appendix 3

	Attendees	Organisation Status
Barnsley Health and Wellbeing Board	Rob Webster Deputy Sean Rayner	Voting Member
Wakefield Health and Wellbeing Board	Rob Webster Deputy Sean Rayner	Voting Member
Calderdale Health and Wellbeing Board	Dr Adrian Berry Deputy Karen Taylor	Non-voting Member
Kirklees Health and Wellbeing Board	Rob Webster Deputy Karen Taylor	Invited Observer

With **all of us** in mind.

	1.4 Calderdale – Appendix 4
	Risk appetite
	The Health and Wellbeing Strategies align with and support the delivery of our overarching strategic objectives, will improve the quality of services we provide and the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the revised Barnsley Health and Wellbeing Strategy (2016-20).**
	Trust Board is asked to ACCEPT the other attached Health and Wellbeing Strategies for information only.
Private session:	Not applicable.

South West Yorkshire Partnership NHS

NHS Foundation Trust

Trust Board 20 December 2016

BARNSLEY DRAFT HEALTH AND WELLBEING STRATEGY (2016-20)

1.0   Purpose of the Report

1.1   The purpose of this Report is to present for approval and adoption the revised Health and Wellbeing Strategy (2016-20) for Barnsley.

1.2   This Report is presented in a standard format issued by Barnsley MBC for Partners to take to their respective Boards.

2.0   Recommendation

2.1   That the Trust Board approves the revised Barnsley Health and Wellbeing Strategy (2016-20) for adoption.

3.0   Introduction

3.1   <u>Role of the Barnsley Health and Wellbeing Board</u>

3.2   The Barnsley Health and Wellbeing Board was originally established, in shadow form, in January 2012 and following implementation of the Health and Social Care Act (2012) formally assumed its responsibilities in April 2013.

3.3   The purpose of the Board is to enable the local health and social care sectors to work together to improve the health and wellbeing of local people and communities and to reduce inequalities in health within the Borough, and in comparison to other areas of the country.

3.4   <u>The Statutory Duty to Produce a Health and Wellbeing Strategy</u>

3.5   One of the responsibilities of the Health and Wellbeing Board is to produce a Health and Wellbeing Strategy which sets out how the Board will meet the health and wellbeing needs of local people and communities. These are identified, in particular, through the local Joint Strategic Needs Assessment (JSNA) together with other assessments such as child and family poverty as well as other sources of evidence, including the Director of Public Health's Annual Report.

3.6   Barnsley's first Health and Wellbeing Strategy was produced in June 2014. A mid term review of the current Strategy has recently been undertaken with a view to refreshing the document and

With **all of us** in mind.

ensuring its approval and adoption by the Boards of each Partner on the Health and Wellbeing Board.

3.7   Barnsley Draft Health and Wellbeing Strategy (2016-20)

3.8   The refreshed, draft, Barnsley Health and Wellbeing Strategy is attached as Appendix 1 to the report. Its 'Vision' is to ensure:

"That the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live."

3.9   The draft Strategy recognises the NHS 5 Year Forward View, the Regional Sustainability and Transformation Plan (STP) and the local Integrated Place Based Plan. It is formulated on the basis of four guiding principles, summarised below:

1.   A focus on doing things more efficiently, particularly in terms of promoting the prevention of debilitating conditions, through the life course approach.

2.   To inspire and empower individuals and communities to take the lead in improving their health and wellbeing, and in planning and delivering health and social care services of relevance to them.

3.   To connect, collaborate and co-produce solutions which will lead to improvements in the health and wellbeing of individuals and communities.

4.   To go further, faster, through targeting resources and prioritising actions aimed at helping those vulnerable individuals and communities most in need of help.

3.10   Key Objectives and Strategic Priorities of the Draft Strategy

3.11   The key objectives of the draft Strategy will be to ensure:

- Children start life being healthy and staying healthy.
- People live happier, healthier and longer lives.
- People enjoy improved mental health and wellbeing.
- People live in stronger, more resilient families and communities.
- People are enabled to contribute to a strong and prosperous local economy.

3.12   A number of strategic priorities have been identified where, if the principles outlined in Paragraph 3.9 are practically applied, thereby leading to the improvements sought, will at the same time, demonstrate that the Health and Wellbeing Board is well on the way to achieving its strategic purpose. Successful implementation of the Strategy will,

therefore, demonstrate that the Board is helping in:

- Reducing the incidence of smoking.
- Improving early help for those suffering from mental ill health.
- Joining up services for supporting older people (focusing on dementia and falls).

The Trust is the main Provider of NHS/Public Health commissioned services in Barnsley in these strategic priority areas. There is therefore a close alignment and strategic fit between the Health and Wellbeing Strategy priorities and the Trust's Strategy and ambition for these services.

3.13 Achieving these key objectives and strategic priorities will place an onus on the Board and its partners in undertaking the following:

- Focusing on the areas in greatest need of improvement, as identified in assessments, notably the JSNA.
- Helping build the components for stronger, resilient communities, including good housing; improving education outcomes and access to skills and jobs.
- Making the prevention of ill health everybody's business, including workforces via improved engagement.
- Delivering the Borough's 'Digital Road Map', to continually improve health and social care provision.

3.14 The recently published South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP) has also highlighted priorities that represent a strategic alignment with both this Strategy and the Trust's Strategy and ambition:

"Preventable mortality rates from such things as cancer and heart disease are higher in South Yorkshire and Bassetlaw than the national average. We will therefore target smoking, inactivity and obesity in our population to prevent future illnesses developing and empower people to take control of their own lifestyles and wider health needs.

Mental health will be integral to our ambitions around improving population wellbeing. We will put services in place to support individual needs and in the most appropriate settings by transforming services and focusing on early education and prevention."

4.0 Consideration of Alternative Approaches

4.1 The development of a refreshed Health and Wellbeing Strategy which addresses the health and social care needs of local individuals and communities, aimed at improving the overall health and wellbeing of the Borough and which closes the gap in health inequality, during the period 2016-20, remains a statutory responsibility for the Health and Wellbeing Board and its constituent partners, including SWYPFT.

With **all of us** in mind.

5.0   Proposal and Justification

5.1   In view of this prevailing statutory duty, it is essential that the key objectives and strategic priorities of the draft Strategy are considered by the Boards of partner organisations within the Health and Wellbeing Board, with a view to approval and adoption. This should be as part of an integrated and place based approach to improving systems for health and social care in the Borough.

6.0   Implications for Local People and Service Users

6.1   The draft Barnsley Health and Wellbeing Strategy (2016-20) will, with due regard to needs assessments, including the current and forthcoming JSNA and other documents, including the Director of Public Health's Annual Report, lead to the planning and commissioning of services which will bring improvements to the health and wellbeing of individuals and communities, throughout Barnsley and close any gap(s) in health inequality between areas of the Borough.

6.2   The 2016, the JSNA is currently in progress and will be published via the Council's Website at the end of December 2016. From then onwards, regular updates will be made to the JSNA through the 'State of the Borough' Portal to assist with service planning and improvement, including within localities.

7.0   Financial Implications

7.1   There are no specific financial implications for SWYPFT arising from the report and draft strategy. It is envisaged that the strategic priorities of the draft Strategy that apply to SWYPFT will be reflected in relevant Business Plans, and therefore allowed for within agreed budgetary provision.

8.0   Employee Implications

8.1   There are no specific employee implications for SWYPFT emerging through consideration of the report and draft Strategy. Again, particularly in the context of the strategic alignments highlighted above (in section 3), the SWYPFT workforce should be considered as an important stakeholder in the Strategy.

9.0   Communications Implications

9.1   Following approval and adoption by partner organisations on the Health and Wellbeing Board, steps will be taken, to promote an interactive version of the Strategy, including encouraging stakeholders such as GP practitioners and schools, to ensure it is signposted on their Websites.

With **all of us** in mind.

10.0   Consultations

10.1   All partner organisations within the Health and Wellbeing Board, including Barnsley Healthwatch, have been consulted on the development of the refreshed, draft Strategy, together with the SWYPFT Executive Team.

10.2   The Board, also, gratefully acknowledges the contribution made to the formulation of the Strategy by participants at the Health and Wellbeing consultation event, held on 21st June 2016, together with those participants who attended the Health and Equality event, organised by Barnsley 'Reach' on 15th October.

11.0   Promoting Equality, Diversity and Inclusion

11.1   A full Equality Impact Assessment (EIA) has been carried out to support the development of the Strategy. The EIA will continue to be updated as further evidence becomes available (including through community engagement, analysis of health outcome data, particularly via the JSNA and performance data) about the health inequalities faced by people from diverse groups in Barnsley as part of informing and developing the Strategy.

12.0   Tackling the Impact of Poverty

12.1   The key objectives and strategic priorities of the refreshed, draft Strategy aim to improve the health and wellbeing of individuals and communities in Barnsley, in recognition that poor health and wellbeing is a determinant of deprivation.

12.2   In striving for these improvements, the benefits of improved health and wellbeing, such as a good early start in life for children, together with the independence and choice which personalised services can bring, will enable people to become more active in thriving communities and to play a fuller role in the economic and social prosperity of the Borough.

13.0   Tackling Health Inequalities

13.1   One of the primary objectives of the refreshed, draft Strategy will be to close the gap in any health inequality which has been identified in assessments such as the JSNA, together with other sources, including the Director of Public Health's annual report.

14.0   Reduction of Crime and Disorder

14.1   As part of evaluating the impact of the refreshed, draft Strategy on a range of outcomes, including community safety, there should be no implications for tackling crime, disorder or anti-social behaviour, arising through its approval and adoption.

With **all of us** in mind.

15.0   Risk Management Issues

15.1   In response to the findings and recommendations of a recent Internal Audit review of the governance of the Health and Wellbeing Board, a Board risk register has been formulated which will enable the Board, as part of its revised Terms of Reference, to be kept aware of any risks that could impact on the progress of key objectives and strategic priorities of the draft Strategy, leading to effective, remedial action.

16.0   Health, Safety and Emergency Resilience Issues

16.1   There should be no implications for the safety of the public or employees, emerging through this report.

17.0   Compatibility with the European Convention on Human Rights

17.1   There are no implications for the Articles and Protocols of the Convention arising through approval and adoption of the refreshed, draft Strategy.

18.0   Conservation of Biodiversity

18.1   There are no implications for the local environment or the conservation of biodiversity emerging through this report.

19.0   Glossary of Terms and Abbreviations

19.1   None, applicable.

20.0   List of Appendices

20.1   Appendix 1:   'Feel Good Barnsley: Barnsley's Health and Wellbeing Strategy (2016-20)'

Sean Rayner

District Director

December 2016

With **all of us** in mind.

FEEL GOOD BARNSLEY

Barnsley's Health & Wellbeing Strategy

2016 - 2020

CONTENTS

01

INTRODUCTION

04. Introduction

INTRODUCTION

The Health and Wellbeing Board is a formal committee of the local authority, established under the Health & Social Care Act 2012, and has a legal duty to produce a joint strategic needs assessment and a joint health and wellbeing strategy.

The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.
LOCAL GOVERNMENT ASSOCIATION

The purpose of this strategy is to set out how the Health and Wellbeing Board will drive integration in order to improve services, join up care and support people in Barnsley to better help themselves in order to help realise our collective vision:

That the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live.

This new strategy comes at a particularly important and challenging time for health and care services. As NHS England's Five Year Forward View recognises, to achieve consistently high quality care for everyone, respond to demographic change and achieve long-term financial sustainability across the health and care system, we must do things differently; we must rise to the challenge of what NHS England calls 'a radical upgrade' in prevention and integration (NHS Five Year Forward View).

Barnsley faces some significant challenges over the next few years. People are living longer but with this comes an expected rise in the number of people with one or more long term conditions. This will place extra demands on an already stretched health and care system. Health outcomes are improving within the borough but compare relatively poorly to the rest of the country, with marked life expectancy variations within the borough itself.

The Board brings together clinical, political, professional and community leaders and is therefore well placed to respond to these challenges. Our strength lies in working together to increase prevention and early help, and make sure the right system of help will be there for people when they need it most.

The Health and Wellbeing Board is accountable for making the best decisions for the whole health & care system. The Board will hold steady through the inevitable periods of change ahead. It will also ensure the system has the ability to mount a robust response to unforeseen, unpredicted, and unexpected demands so that services can continue normal operations.

02

OUR APPROACH

OUR APPROACH

Vision: That the people of Barnsley are enabled to take control of their health and wellbeing and enjoy happy, healthy and longer lives, in safer and stronger communities, whoever they are and wherever they live.

The principles that will guide us:

Focus on efficiencies and outcomes
We know that we need to do things differently and we need to be more radical in favour of prevention.

Inspire & Empower
We know that we cannot do this alone or in isolation. We must engage as many people as possible to make the greatest difference.

Connect, Collaborate & Co-produce
We know that the solutions will involve working together with the public, patients, carers and our partners and communities. We will broaden our reach to those who we have not connected to in the past.

Go further, faster
We know that time and resources are precious and therefore we must target our resources and prioritise those actions that will take us further, faster.

OUR APPROACH

What we need to achieve:

Improved health and wellbeing:
Health and wellbeing is determined by a complex interaction between individual characteristics, lifestyle and the physical, social and economic environment. These 'broader determinants of health' are more important than health care services in ensuring a healthy population, and therefore this is where the Board will focus its efforts.

Reduced health inequalities:
There are marked inequalities in health which exist between Barnsley and England as a whole and within Barnsley itself, which is not acceptable. A gap also exists between people with severe mental illness, learning disabilities and autism, and the general population. Our approach will therefore be to target our resources to achieve equality of outcomes for all.

What this will mean for individuals:

1. Children start life healthy and stay healthy
2. People live happy, healthier and longer lives
3. People have improved mental health and wellbeing
4. People live in strong and resilient families and communities
5. People contribute to a strong and prosperous economy

How will the system need to change to achieve this?

- **By strengthening** and broadening partnership working to make the health and care system stronger and more responsive

- **By creating** joined up approaches that make sense to us all by putting public, patients and carers at the heart of what we do.

Appendix 2 provides an overview of the health & care system in Barnsley.

Appendix 3 provides some examples of the progress made against key actions from the previous strategy (2014 – 2016)

03

EXAMPLES OF AREAS WE NEED TO IMPROVE

09. Improve for outcomes for children and young people
09. Reducing smoking
09. Improve early help for mental health
09. Join up services for older people

Transforming access to the right support, at the right time for strengthening the health and wellbeing of children and young people

We recognise that in order to address the health and wellbeing gap in the Borough in the longer term we must strive to improve outcomes for our children and young people. To this end we will work through the Children and Young People's Trust to ensure local services are integrated in a way which eases access for all children, young people and families in our communities in line with the ambitions set out in the Children and Young People's Plan (2016-19)

Other examples of areas we need to improve over the course of this strategy include:

Reduce smoking

Smoking is the primary cause of preventable illness and premature death, accounting for 1355 deaths in Barnsley between 2012 – 2014. This equates to 7 double decker buses full of people dying in Barnsley as a direct result of smoking every year. Smoking is a leading cause of health inequalities and is responsible for half the difference in life expectancy between rich and poor.
Interventions having the greatest, quickest and most sustainable impact on smoking prevalence are those aimed at changing social norms and de-normalising smoking. We will therefore target our resources to tackle the availability and acceptability of smoking.

Improve early help for mental health

At least one in four of us will experience a mental health problem at some point in our life and around half of the people with lifetime mental illness experience their first symptoms by the age of fourteen. People with a diagnosed severe mental illness die up to twenty years younger than their peers in the UK, predominantly due to higher rates of poor physical health.
Mental health is everyone's business - individuals, families, employers, educators and communities all need to play their part to improve the mental health and wellbeing of the people in Barnsley. By promoting good mental health and intervening early we can help prevent mental illness from developing and support the mitigation of its effects when it does.

Join up services for older people

Multi-morbidity, dementia and frailty are increasing, yet services are traditionally focused around single diseases and organisations. The government requires all local areas to integrate health and care services by 2020.
To do this, we need greater co-ordination between specialisms within the NHS and between primary care, secondary care and mental health services and outside the NHS with social care and the voluntary and community sector. This will enable care to become more personalised and integrated with patients having more control and choice.

The focus includes:

Dementia
In line with the current Mayor's focus on Dementia and 'the best of Barnsley', deliver an integrated pathway for dementia ensuring high quality care throughout the pathway that reflects the Prime Minister's challenge on dementia 2020.

Falls
Aligned to the work on Early Help and Prevention, develop comprehensive pathways to help to prevent, identify and minimise the impact of frailty and falls.

If we can impact these areas significantly over the next 3 years, we will have gone a long way to establishing integrated, joined up approaches as the new norm in Barnsley. Healthy life chances for generations to come will improve as a result.

04

WHOLE SYSTEM ACTIONS
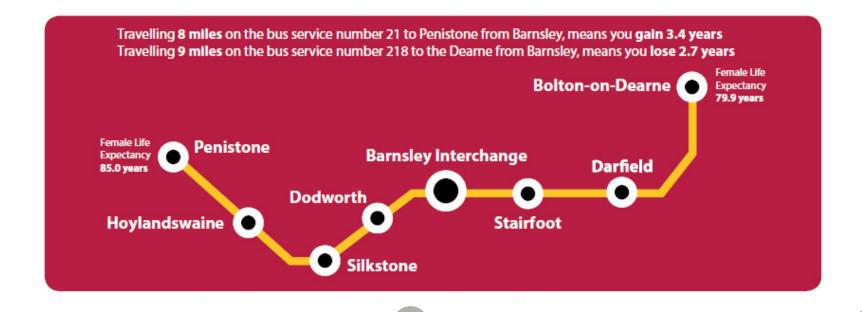
11. Focus on the areas of greatest need
12. Build strong and resilient communities
13. Make prevention everybody's business
14. Deliver our digital road map to improve services
15. Develop a communication and engagement plan

WHOLE SYSTEM CHANGE PRIORITIES

1. Focus on the areas of greatest need

There are marked differences in life expectancy and healthy life expectancy across Barnsley and therefore to make the greatest difference we need to focus our resources on the areas of greatest need.

The diagram below is one example that shows how life expectancy differs from one of the most affluent parts to one of the least affluent parts of the borough, where residents live on average six years less. For more information and data on life expectancy and healthy life expectancy across the borough, please see the Joint Strategic Needs Assessment.

We will make the joint strategic needs assessment accessible and easy to understand so everyone can have a shared understanding of the health inequalities in the borough and develop a greater understanding into the areas which have the poorest health outcomes.

We will review our resources at a neighbourhood level and ensure that we have multi-agency teams that are responsive to local need. We will also collectively agree what additional resources are needed where and how this can be achieved, to make the greatest impact on health & wellbeing.

Travelling **8 miles** on the bus service number 21 to Penistone from Barnsley, means you **gain 3.4 years**
Travelling **9 miles** on the bus service number 218 to the Dearne from Barnsley, means you **lose 2.7 years**

Bolton-on-Dearne — Female Life Expectancy 79.9 years

Female Life Expectancy 85.0 years — Penistone

Barnsley Interchange

Darfield

Dodworth

Hoylandswaine

Stairfoot

Silkstone

2. Build strong and resilient communities

Building strong and resilient communities means that people live in good houses, in vibrant communities, and have access to a good education and jobs. People are engaged in positive activities, able to access early help and support services when they need them which enable them to live a comfortable and healthy life.

The evidence shows that:

- Good housing can have a positive impact on people's physical and mental health and wellbeing.

- A good education is strongly associated with better health outcomes including life expectancy

- There is a strong association between unemployment and poor mental health

- Poverty is a key determinant of poor outcomes in health and wellbeing and is linked to numerous health problems and unhealthy life styles.

We will continue to explore prevention opportunities to get the greatest return on investment by developing new ways of working with our partners. We will work with our partners in housing to improve standards, particularly in the private rented sector; improve children's health & wellbeing by working with our family centres and the education system; increase employment opportunities, particularly for the hardest to reach groups (those with mental health, learning disabilities and care leavers) by connecting to the Local Enterprise Partnership.

In addition, our local area arrangements provide further opportunities to create healthy communities through localised commissioning. We will continue to support our 6 Area Councils to target resources based on the priorities identified by those who live there.

3. Make prevention everybody's business

The Health and Wellbeing Board will radically upgrade its focus on prevention, empowering residents, communities and patients to improve their own health and wellbeing. We will build a broad coalition that helps all of us take healthier decisions, working with individuals and families, retailers and employers to help make the healthy choice, the easy choice.

As well as taking actions on the broader determinants of health and wellbeing, we will strengthen our advocacy role and use our local democratic and enforcement powers where appropriate to help better the health and wellbeing of Barnsley residents.

Staff from across our organisations such as fire, police, NHS and the council support thousands of people in our local community each and every day. This gives us an unparalleled opportunity to 'make every contact count' providing support to people to make positive changes to their physical and mental health and wellbeing.

The Health and Wellbeing Board is committed to giving our workforce the skills, knowledge and confidence to support people to make lifestyle behaviour changes, access early help and take control of their health and wellbeing.

We will embed the culture of behaviour change in all our workforce development, education and training plans so that providing brief advice and early help becomes the norm for all staff. Mobilising our workforce in this way will help achieve large scale change and increase the capacity to deliver improved health and wellbeing services.

4. Deliver our 'Digital Road Map' to improve services

People are having increasingly positive experiences of digital technology in everyday life. Whether it is through Internet banking or shopping or learning online, the use of digital technology is becoming the norm for a growing number of people

The health and care sector is way behind the commercial sector when it comes to maximising the benefits of digital technology. In Barnsley, we know from a range of engagement activities over the past few years that our communities are frustrated when communication between services and patients fails. This means that not only time and effort is wasted but this also leads to poor experiences.

We recognise that:

● 'IT systems are a barrier to people working together'

● 'Communication between health and care teams needs to improve'
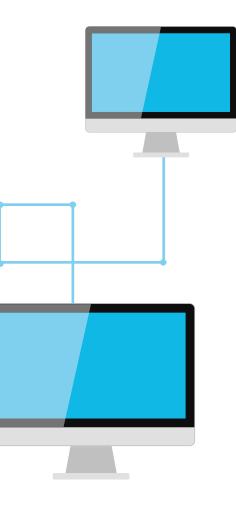
● 'We need to take a holistic view of the patient and see them as a whole'

We have therefore developed a *'Digital Road Map'* to transform our approaches, develop systems that 'talk' to each other and deliver a better experience for patients and service users.

Our vision in Barnsley is to:

● Increase technology enabled care to support people to stay in their homes for longer and help them maintain their independence and wellbeing.

● Transform the way in which we engage with residents; empowering them to maintain their own health and wellbeing through digital solutions.

● Transform the way in which health and care providers and our voluntary and charitable sector organisations engage with patients and their communities.

● Accelerate mechanisms that promote record sharing and support access to data for those working within health and care services.

● Enable clinicians to provide the best care in all settings by the use of mobile technology.

5. Develop a communication and engagement plan

Having a strategic framework for communication will allow the Board to make greater use of networks, target specific issues and share information through a mixture of channels. This approach will also enable us to pull resources and networks across organisations to allow better joined up working and less duplication.

The Health and Wellbeing Board is committed to putting the voice of Barnsley people at the heart of decisions. In Barnsley we have a strong tradition of service user, carer and patient involvement through groups such as Carers and Friends Group, Learning Disabilities Forum, Older People's Forum, Patient Forums, Equality Forums and Healthwatch Barnsley. These and other forums play a key role in bringing together people's experience of health and social care in Barnsley to influence and shape local services:

We intend to develop the mechanisms to hear the voice of our communities in the Joint Strategic Needs Assessment and use the community voice to assess our progress against our priorities.

We are proud to have such an extensive reach in to our communities, where we can have ongoing conversations about what is and what isn't working, and how ,together, we can improve outcomes for our people. Openness and transparency will help bring about continuous improvement. We will ensure that the joint strategic needs assessment will be publicly available and in a user friendly format. Likewise we will report regularly on performance at local and borough wide level, in partnership with CCGs and other key stakeholders. This information can then be used by the Area Councils, individuals and voluntary and community groups to achieve creative solutions to improve and shape the health and wellbeing of their communities.

We intend to develop the mechanisms to hear the voice of our communities in the Joint Strategic Needs Assessment and use the community voice to assess our progress against our priorities.

05

TURNING STRATEGY INTO ACTION

17. Turning strategy into action

TURNING STRATEGY INTO ACTION

This is the Health and Wellbeing strategy for Barnsley, developed by the Health and Wellbeing Board.

All partners on the Health and Wellbeing Board have agreed the strategy and will reflect it within their organisational plans and work.

Similarly, all organisations represented agree to shape their own future organisational strategies and plans in order to underpin and help deliver this joint Health and Wellbeing Strategy.

All relevant future plans will be formulated with regard to the joint strategic needs assessment (JSNA).

To outline progress in delivery, Barnsley's Health and Wellbeing Board will invite all partners to contribute to a joint annual report each year. The joint annual report will be made publicly available.

Appendix 4 provides summary information about the health and wellbeing challenges in Barnsley.

More detailed information about the health and wellbeing of the Barnsley population can be found in the following documents:

Public Health England's Health Profile provides a picture of health in Barnsley in 2015.

The Joint Strategic Needs Assessment (JSNA) assesses the current and future health and social care needs of the local community. (Available December 2016)

HEALTH & WELLBEING STRATEGY

06

APPENDICES

Appendix 1 - People's Stories

It's 2015

Mrs Brown is 75 and lives alone at home in Barnsley. She doesn't know many people. She has had high blood pressure and early onset dementia for some time. She is losing her eyesight and is becoming increasingly unsteady on her feet.
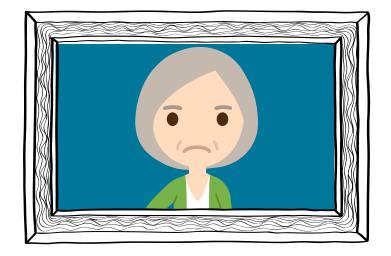
Mrs Brown receives some care from the council, and a few services from the local NHS which help to give her some independence. These include some home care and telecare from the council. She also sees the specialist nurses at the memory assessment service, the outpatients department for her vision and the district nurse is currently visiting daily to treat an injury from a fall. She has been to hospital three times in the past two months because of a fall or her conditions meaning an ambulance had to be called.
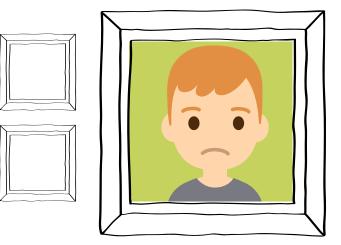
She has had to have a number of assessments, is often referred on from the people she has told her story to, has to do a lot of travelling to different services which are changed at the last minute.

Jack, Mrs Brown's son, who lives on the next street cares for Mrs Brown for about 20 hours per week. He is struggling to pay his bills as he is unable to work and the carers' benefit does not cover these outgoings. He may have to give up caring and try to go back to work. Consequently Jack is suffering with anxiety and mild depression.

Mrs Brown is worried that she will have to go into a home if Jack is unable to continue caring and her health and wellbeing deteriorates further.

This is an expensive situation for two reasons:

- Duplication of resources
- The likelihood that Mrs Brown's situation will escalate and lead to more intensive, more expensive care.
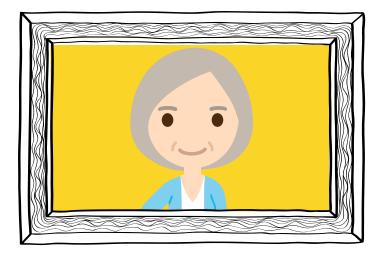
It's 2020
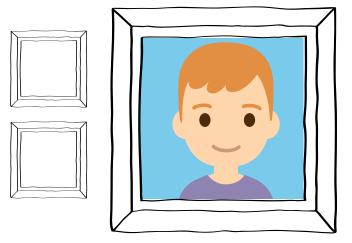
Mrs Brown is now 80. She is still at home despite her fears. Following a discussion with Mrs Brown and Jack, Mrs Brown was given an integrated personal budget to help her manage her health and care needs. As part of this, a single integrated care plan was developed jointly with Mrs Brown and her son Jack. Her care plan involves planned integrated health and care services, the use of assistive technology and the support from local neighbours and the local VCS. For the services Mrs Brown has chosen to buy with her personal budget, there is consistent information about quality that has been provided from regulator's report that helps them make informed choices about who provides the care.

Having a single integrated care plan is a much more cost effective approach as resources are planned more effectively across the system, leading to less emergency visits, and avoiding the need for Mrs Brown to go into a care home.

This has taken some pressure off Jack who is now able to find time to do some training to help him when he is ready to go back to work. Because the system has been integrated and devolved, it is now much clearer how the system works and patients and carers are partners in making decisions. As a result Jack wants to be a part of helping design future services. He has agreed to join a sub group of the Health and Wellbeing Board to help design e-health services for the future so individuals can remain in control of their own health and wellbeing.

Staff in the local health and care economy work together in local multi-disciplinary teams. This helps them to respond more readily to Mrs Brown's needs without having to have multiple appointments and assessments every time something happens. Staff focus on working proactively with Mrs Brown to help her manage her conditions better and therefore avoid a hospital visit due to escalation. Staff have also had training in the use of mobile technology. They can now share and access information to provide the best care for their patients.
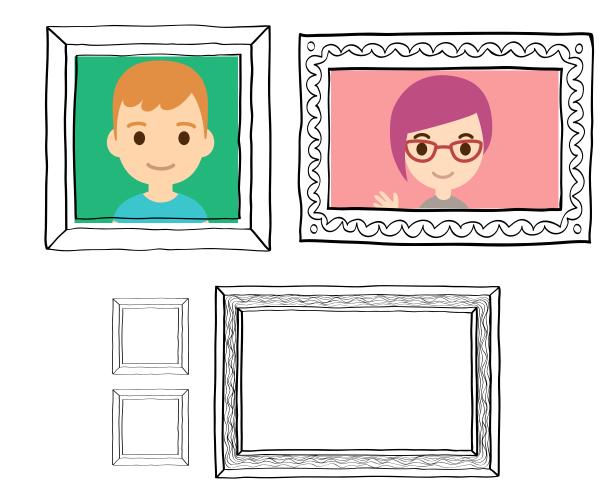
It's 2030

Mrs Brown passed away at the age of 90, at home supported by an integrated end of life plan. Her granddaughter Yasmin was born in 2015 in the same part of Barnsley. Thankfully, partners from the council, NHS, housing and education worked with the local community to develop a range of services that support Jack, Yasmin and other families to be healthy and get involved in lots of community activities – they all understand it's important to stay healthy!

When Yasmin turned 15, she joined a local community group that organises activity clubs, helps people use technology to stay connected and remain independent, and provides support to local carers. Jack has told Yasmin how important these were for her grandmother.
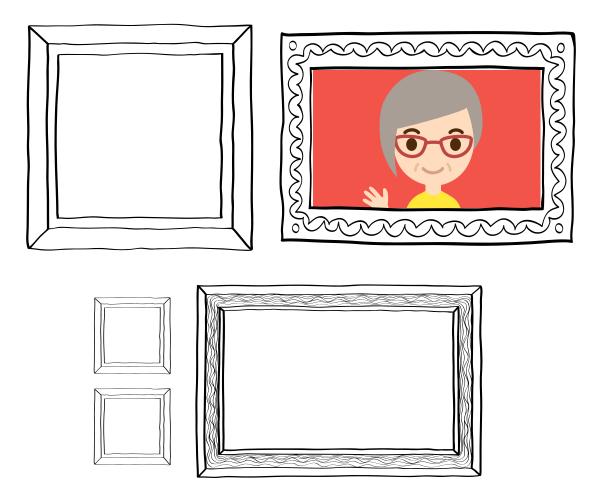
Jack now works in social care and supports people with dementia. In his spare time Jack volunteers as an e-health community champion helping people to make use of assistive technology to support their independence.

It's 2100

Healthcare now uses predictive analytics to forecast future conditions so that proactive and preventative action can be taken to stay healthy. Thanks to Yasmin being active and having a healthy lifestyle, she has remained free from long-term conditions throughout her life. She rarely goes to the doctor; she uses the pharmacist for support in a lot of things. She has only had to go to hospital once when she broke her arm.

When she reached 85, Yasmin did become frail and needed some support at home. Due to a better balanced system, the local integrated health and care system was able to provide support despite the growth in demand. Yasmin remained supported at home, with people who are close to her, and lives well at home into old age.

APPENDICES

Appendix 2: The System
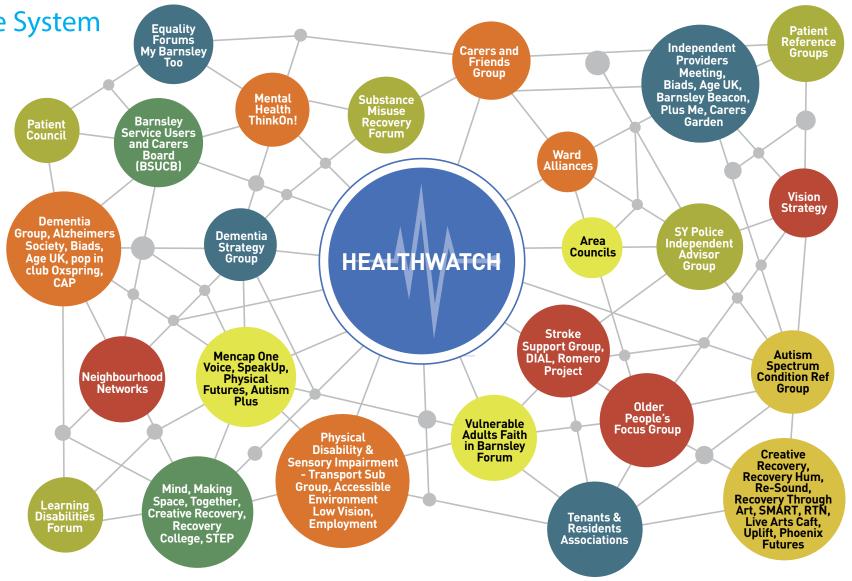
Networks

In Barnsley we have many organisations, individuals, community groups and partnerships that make up the 'Health & Wellbeing Network' in Barnsley.

The responsibility to improve our health lies with us all – government, local communities and with ourselves as individuals.

PUBLIC HEALTH OUTCOMES FRAMEWORK

HEALTHWATCH

- Equality Forums My Barnsley Too
- Carers and Friends Group
- Independent Providers Meeting, Biads, Age UK, Barnsley Beacon, Plus Me, Carers Garden
- Patient Reference Groups
- Mental Health ThinkOn!
- Substance Misuse Recovery Forum
- Patient Council
- Barnsley Service Users and Carers Board (BSUCB)
- Ward Alliances
- Vision Strategy
- Dementia Group, Alzheimers Society, Biads, Age UK, pop in club Oxspring, CAP
- Dementia Strategy Group
- Area Councils
- SY Police Independent Advisor Group
- Neighbourhood Networks
- Mencap One Voice, SpeakUp, Physical Futures, Autism Plus
- Stroke Support Group, DIAL, Romero Project
- Older People's Focus Group
- Autism Spectrum Condition Ref Group
- Physical Disability & Sensory Impairment - Transport Sub Group, Accessible Environment Low Vision, Employment
- Vulnerable Adults Faith in Barnsley Forum
- Learning Disabilities Forum
- Mind, Making Space, Together, Creative Recovery, Recovery College, STEP
- Tenants & Residents Associations
- Creative Recovery, Recovery Hum, Re-Sound, Recovery Through Art, SMART, RTN, Live Arts Caft, Uplift, Phoenix Futures

PARTNERSHIP NETWORK

Strategies & Plans

These networks work together to shape and deliver a number of strategies which collectively spell out our approach to improving Health and Wellbeing in Barnsley:
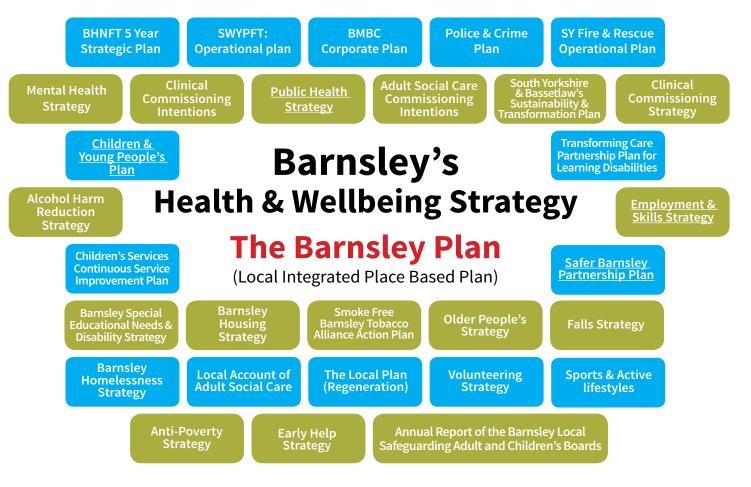
There are many linkages between and across the different boards and groups; strategies and plans and collectively they are responsible for contributing to making this strategy a reality.

For more information on each of these strategies and plans, please click on to the relevant link.

From across all of these plans and strategies, the Health and Wellbeing Board has agreed to focus on a number of priority programmes that will make the biggest impact on health and wellbeing. Details of these priorities may be found in the Barnsley Local Integrated Place Based Plan. This Plan complements and reflects the commitments set out in the Health and Wellbeing Strategy..

The **Barnsley Plan** complements and reflects the commitments set out in this strategy.

Enabling Strategies & Plans

| BHNFT 5 Year Strategic Plan | SWYPFT: Operational plan | BMBC Corporate Plan | Police & Crime Plan | SY Fire & Rescue Operational Plan |

Mental Health Strategy | Clinical Commissioning Intentions | Public Health Strategy | Adult Social Care Commissioning Intentions | South Yorkshire & Bassetlaw's Sustainability & Transformation Plan | Clinical Commissioning Strategy

Children & Young People's Plan

Transforming Care Partnership Plan for Learning Disabilities

Barnsley's Health & Wellbeing Strategy

Alcohol Harm Reduction Strategy

Employment & Skills Strategy

The Barnsley Plan
(Local Integrated Place Based Plan)

Children's Services Continuous Service Improvement Plan

Safer Barnsley Partnership Plan

Barnsley Special Educational Needs & Disability Strategy | Barnsley Housing Strategy | Smoke Free Barnsley Tobacco Alliance Action Plan | Older People's Strategy | Falls Strategy

Barnsley Homelessness Strategy | Local Account of Adult Social Care | The Local Plan (Regeneration) | Volunteering Strategy | Sports & Active lifestyles

Anti-Poverty Strategy | Early Help Strategy | Annual Report of the Barnsley Local Safeguarding Adult and Children's Boards

APPENDICES

Appendix 3: Progress to Date

Communities:

The Stronger Communities Partnership is now established as a system wide partnership working to develop strong and resilient communities. The partnership is focussed on improving early help and prevention and tackling areas such as poverty. Our Area Councils and Ward Alliances have worked hard at developing community based solutions to wellbeing and create a strong foundation for the future.

Children & Young People:

A Local Transformation Plan (LTP) for children and young people's mental health and wellbeing has been developed and funding received from NHS England for 5 years, ending in March 2020. 'Improving Social and Emotional Mental Health and Resilience in Young People' is part of the work programme where primary school staff are trained in the 'Thrive Approach'. This is an evidence based whole school approach to enhance teachers' awareness of the social and emotional wellbeing among young people.

Adult Social Care:

A new operating model in adult social care services has now been implemented. The model has fundamentally changed how the service responds to its customers and the services it offers. Evidence shows that these changes have had a positive impact with more customers taking control over their care and support and an increased uptake of reablement with sustained outcomes. The service has been recognised nationally as 1 of 8 shortlisted finalists for the Local Government Chronicle Awards, under the business transformation category.

RightCare Barnsley:

A telephone based care coordination centre providing a brokerage service for Healthcare Professionals seeking a care solution. The aim of RightCare Barnsley is to facilitate the provision of the right care, at the right time, in the right setting, for the benefit of the public and patients. This service has been recognised nationally and has recently won a Health Service Journal Award.
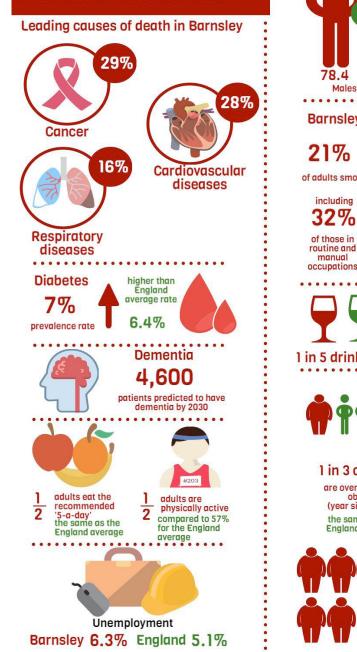
APPENDICES

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(Available December 2016)

Barnsley Health Needs Assessment 2016

Leading causes of death in Barnsley

Cancer 29%

Cardiovascular diseases 28%

Respiratory diseases 16%

Diabetes
7% prevalence rate — higher than England average rate 6.4%

Dementia
4,600 patients predicted to have dementia by 2030

½ adults eat the recommended '5-a-day' the same as the England average

½ adults are physically active compared to 57% for the England average

Unemployment
Barnsley 6.3%   England 5.1%

Life Expectancy Years / Healthy Life Expectancy Years

78.4   57.5   Males
81.8   56.3   Females

Barnsley
21% of adults smoke
including 32% of those in routine and manual occupations

England
17% of adults smoke
including 27% of those in routine and manual occupations

1 in 5 drinkers drink at 'increasing risk' levels

1 in 5 young children are overweight or obese (reception pupils) the same as the England average

1 in 3 children are overweight or obese (year six pupils) the same as the England average

7 in 10 adults are overweight or obese
Compared to 6 in 10 for England

APPENDICES
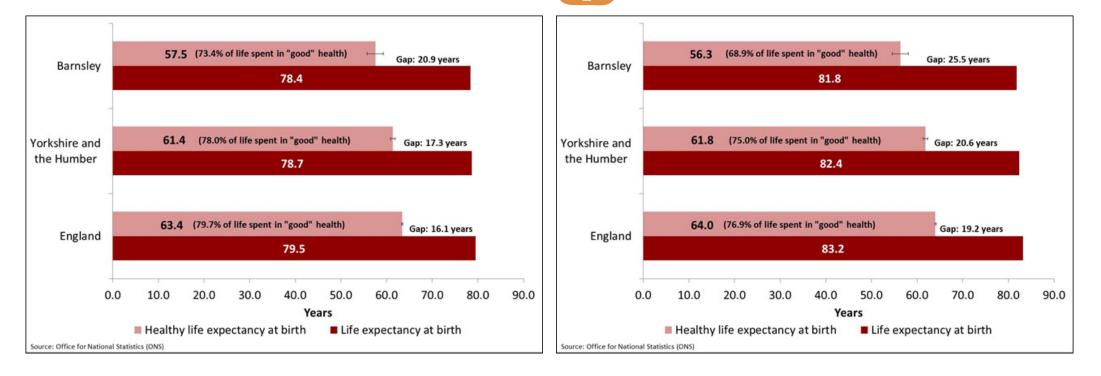
Life Expectancy and Healthy Life Expectancy

Life expectancy at birth, healthy life expectancy at birth and the proportion of life spent in "good" health for men in Barnsley, compared with Yorkshire and the Humber and England (2012-2014)

Life expectancy at birth, healthy life expectancy at birth and the proportion of life spent in "good" health for women in Barnsley, compared with Yorkshire and the Humber and England (2012-2014

Men:
- Barnsley: 57.5 (73.4% of life spent in "good" health), 78.4, Gap: 20.9 years
- Yorkshire and the Humber: 61.4 (78.0% of life spent in "good" health), 78.7, Gap: 17.3 years
- England: 63.4 (79.7% of life spent in "good" health), 79.5, Gap: 16.1 years

Healthy life expectancy at birth ■ Life expectancy at birth
Source: Office for National Statistics (ONS)

Women:
- Barnsley: 56.3 (68.9% of life spent in "good" health), 81.8, Gap: 25.5 years
- Yorkshire and the Humber: 61.8 (75.0% of life spent in "good" health), 82.4, Gap: 20.6 years
- England: 64.0 (76.9% of life spent in "good" health), 83.2, Gap: 19.2 years

Healthy life expectancy at birth ■ Life expectancy at birth
Source: Office for National Statistics (ONS)

Health and Wellbeing Strategy for Wakefield

2013-2016

contents

Good health and wellbeing means that wherever possible people are free of illness or disability and they have a positive physical, social and mental state. We want people in Wakefield to have healthier, happier and longer lives with less inequality. Health and Wellbeing has been a priority for a number of years to the partners in Wakefield district. Our Local Services Board prioritised improving the health of our community in our first Community Strategy in 2003, and we have been working hard since that time to do so.

The Health and Social Care Act 2011 brings fundamental changes to the way we plan and deliver health improvements within the district. The Act has seen the end of the Primary Care Trust and the development of the Wakefield Clinical Commissioning Group, responsibility for public health has moved into the Local Authority and HealthWatch has become the voice of the public on health matters. These organisations are tasked with working together through a Health and Wellbeing Board to ensure that there are local plans in place to protect and improve health outcomes and where necessary to provide the best available Health and Social Care.

The board must develop a Joint Health and Wellbeing Strategy that gives an overview of the key challenges and how the partners are going to agree to work on these together, which must be based on the findings of the district Joint Strategic Needs Assessment. It should provide the framework for the individual agencies to develop commissioning and delivery plans which will together meet the needs of the district. It must encapsulate some joint principles by which all partners agree to operate. Other strategies exist within the district which will contribute to better health and wellbeing, such as the Community Safety Strategy and the Jobs and Growth Plan. The Health and Wellbeing Board will work with partners to ensure these strategies are implemented in a way which maximises health and wellbeing.

Our Health and Wellbeing board has been in shadow form since March 2011 and is committed to working together. We have reviewed the process by which we developed and refreshed our Joint Strategic Needs Assessment. We have produced a web based JSNA tool, which allows us to have access to the most up to date information in a ready useable form. We have collated the knowledge of our commissioners and of our communities in one place giving a better picture of the health needs of the district. We have attempted to move beyond communicating need and have looked at what else do we need to do and what assets exist within our communities that will assist in tackling some of

the issues identified. We hope our JSNA becomes a "living document" where new assets and needs can be quickly integrated into what people can access.

As part of this review we have engaged with key commissioners, key delivery partners and the voluntary sector to sense check the information we have provided and to agree to a way forward for review and use of the JSNA. The JSNA can be viewed at **www.wakefieldjsna.co.uk**. This first Health and Wellbeing strategy for the district outlines our priorities and the way forward we believe we need to take to effect the changes our residents deserve.

Outcome: The Health and Wellbeing board working in partnership to tackle the underlying causes of poor health and wellbeing in the District

Objectives:

- All members of the Board will ensure that their commissioning plans reflect the agreed priorities and the methodologies for working set out within this strategy, and embed these within their organisations

- All members will also, when appropriate, influence other partner organisations to do the same

- Ensure that existing partnership strategies and plans are implemented in a way which maximises health and wellbeing

- Ensure effective stakeholder engagement through the development of an engagement and communication strategy and action plan

Councillor Pat Garbutt

1

Background & Process

The Wakefield Health and Wellbeing Board have a duty to develop a Joint Strategic Needs Assessment (JSNA) and a Joint Health and Wellbeing Strategy (JHWS) to address the identified needs. This is a three year strategy, however an annual review will be undertaken.

The Health and Wellbeing board has:

- Engaged with key commissioners, key delivery partners and the voluntary sector to review the process for developing, refreshing and using the Joint Strategic Needs Assessment

- Produced a web based JSNA tool, which allows us to have access to the most up to date information in a ready useable form

- Collated the knowledge of our commissioners and of our communities in one place giving a better picture of the health needs of the district

- Looked at what else needs to be done and what assets exist within our communities that will assist in tackling some of the issues identified

- Agreed to the six priorities that emerged from the Joint Strategic Needs Assessment (see page 5) and focussed board discussions around the key issues, challenges and solutions to these priorities

- Engaged with Major Providers with regards to the strategy

- Engaged with wider statutory and voluntary and community sector providers in relation to delivery of the strategy

- Engaged community members about the strategy and received a number of suggestions around what else needs to be done or could be done differently.

An Annual Engagement Plan has been developed to ensure that key commissioners, providers, the voluntary and community sector and community members are involved in the development of the Health and Wellbeing Strategy. This aims to:

- Raise awareness and understanding of the Health and Wellbeing Strategy

- Give people the opportunity to contribute to and comment on the draft Strategy

- Identify organisations' existing and potential contribution towards delivery of the strategy

- Ensure that local services and decisions are based on up-to-date information by creating ongoing opportunities for commissioners, providers and community members to feed information into the Joint Strategic Needs Assessment

We want our engagement to be ongoing, so if you have any comments or views on this Health and Wellbeing Strategy or any health and wellbeing data you would like to feed into the Joint Strategic Needs Assessment please contact us **jphu@wakefield.gov.uk** or visit our online survey at **www.wakefield.gov.uk/hwb**

Particularly we would be interested to hear your thoughts on the questions below:

1. What do you think of the priorities and objectives?

2. Is there anything else that needs to be done to improve health and wellbeing across the six priorities or do you have any ideas of how we could do things differently?

3. How could the services and activities your organisation is already delivering be adapted so that they better relate to the six priorities?

4. How could your organisation contribute to activities delivered by other organisations so that they better relate to the six priorities?

This strategy gives a common framework and set of approaches for those commissioning or providing services that contribute to the health and wellbeing priorities. It gives all those working to improve health and wellbeing and reduce inequalities the same focus to achieve the outcomes.

The strategy will enable:

- All partners to be clear about the key health and wellbeing issues in the district and the approaches that are required to address these issues

- All members of the Board to embed the priorities from the JSNA within their own organisations and ensure that their commissioning and delivery plans reflect the priorities and the approaches for working agreed within this strategy

- Individual agencies to develop commissioning and delivery plans which will together meet the needs of the district

- Joined-up/integrated commissioning and delivery plans to be developed

- The Health and Wellbeing Board to assess local plans and working of its member organisations

- The Health and Wellbeing Board to hold member organisations to account for their actions towards achieving the outcomes within the strategy

- Members of the board to work with and influence partner organisations to contribute to the priorities and the approaches for working agreed within this strategy
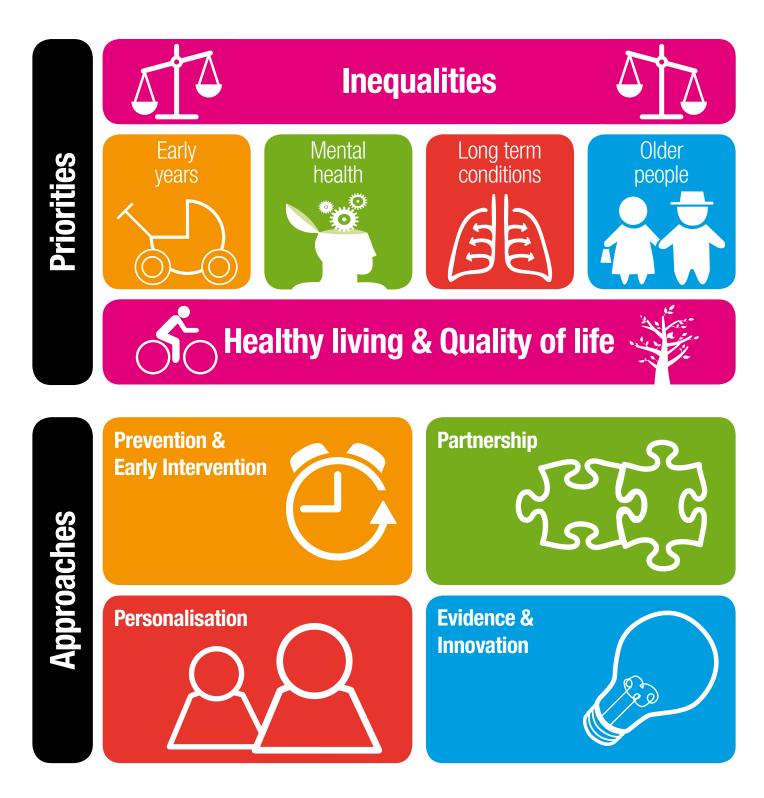
How will we measure our success?

- The inclusion of the priorities and approaches in the commissioning and delivery plans of board members and wider partners

- Monitoring the impact of our commissioned work

- Monitoring of the key Outcomes Frameworks

- Engagement with stakeholders and the community

This diagram outlines the common priorities and approaches that the Health and wellbeing Board, its member organisations and key partners will adopt to move the agenda forward.

Priorities

Inequalities

Early years

Mental health

Long term conditions

Older people

Healthy living & Quality of life

Approaches

Prevention & Early Intervention

Partnership

Personalisation

Evidence & Innovation

Our Joint Strategic Needs Assessment showed six main health and wellbeing priorities. The Health and Wellbeing Board, its member organisations and key partners will focus on delivering improved health and well-being outcomes across these six priorities. Each partner will identify the specific actions they can take in relation to each of these priorities which should be detailed in their own commissioning and delivery strategies.

Inequalities

Whilst health for most of our residents is improving and we are narrowing the gap between health outcomes for Wakefield and other parts of the country we are noticing a worrying trend of health outcomes deteriorating for those living in our most deprived areas (particularly women). We want to see improvements for all residents, with those with greatest needs and disadvantage improving fastest.

Inequalities can occur due to vulnerability (e.g. equality groups), location (e.g. deprived neighbourhoods) or in relation to access to and quality of services. We know that groups that experience inequality are more likely to have poor experiences or outcomes for other issues that affect health and wellbeing. We also know that inequalities are intergenerational, with children from such families tending to experience poorer outcomes as a result. Therefore, inequality cuts across the five other priorities within this strategy.

The economic climate and Welfare Reform will have an effect on individuals' health outcomes, aspirations and inequality. It will also impact on organisations' ability to meet increasing health needs with limited resources. It is clear that a lack of available finance can have a huge impact on our health and wellbeing and the choices we make in relation to our lifestyle. Direct lack of finance can lead to poor mental health outcomes, poor lifestyle, lack of opportunities and loss of personal care.

Evidence suggests that work is good for health and wellbeing, however in some areas of the district we have worryingly high levels of unemployment, particularly in the younger population. Many of these areas match the areas with poor outcomes for other health and wellbeing issues (e.g. mental health and long term conditions). Lack of employment opportunities, lack of skills and lack of

aspiration or poor health may be impacting on the financial situation of some residents in Wakefield. However it is less clear whether these inequalities are the cause or effect of poor health and wellbeing. The Welfare Reforms could also create further impacts on inequality within the district. It is difficult to predict how much impact this will have on health outcomes for the district, but it is important that we give some clear priority to helping people deal with this.

Limited levels of public spending will add to the overall challenges faced within our district on improving the health of our citizens. Organisations are already preparing themselves for different models of delivery and commissioning for services. For example, the council is becoming a "catalyst council" which means that it may not directly deliver all the existing services that it currently does. In addition, the Adult Services commissioning strategy for transformation brings together the council's proposals to forge a viable and sustainable adult social care system within the context of significantly limited resources and significantly increasing demands.

Outcome: More equal experiences of health and wellbeing between different communities and areas within the Wakefield District

Objectives:

- Improve the wider factors that affect inequalities in health and wellbeing e.g. developing links with the Jobs and Growth Plan

- Reduce inequalities in health outcomes (e.g. healthy living, mental health, long term conditions and life expectancy)

- Reduce inequalities in access (e.g. to services, employment) and quality of services

Healthy Living & Quality of Life

It is widely accepted that many of the health effects we experience in Wakefield can be contributed to the way in which people live their lives. This refers to personal lifestyles and the environment in which people live, which affects their quality of life, health and well-being. The evidence tells us that unhealthy risk-taking behaviours by young people and adults are often a consequence of wider issues such as deprivation, inequalities and social exclusion. They can also be linked to lower educational attainment and involvement in either the care or criminal justice system.

As the way in which people live their lives is interdependent and complex it is less clear exactly which lifestyle choices need to be targeted to see clear improvements in health outcomes. It is important that we continue to promote and encourage healthy lifestyles to all. We can do this in a number of ways but we need to ensure that we do not promote a 'blame' culture; rather we can ensure that people have access to sufficient information around their lifestyle choices to make an informed choice. We need to make sure that people are supported and encouraged where appropriate to make those choices, for example through creating health promoting environments which support and encourage people to make the healthy choice. We also need to support people with the consequences of unhealthy living, including support for the individual and their families who may be affected by it.

Quality of life acknowledges that individuals may be physically and mentally healthy, however wider factors may have a negative impact on their wellbeing. This could include the local environment, circumstances at work or money issues. There is also the need to promote positive quality of life for people who have established health issues.

Healthy living and quality of life can have a positive impact on health and wellbeing throughout the lifespan and as mentioned it can also be influenced by wider issues, which means that this has a bearing on the five other priorities within this strategy.

Outcome: People making healthier choices and having a good quality of life

Objectives:

- Increase awareness of healthy living

- Support people to make healthy choices

- Improve the wider factors that make healthy living easier and improve quality of life (e.g. working with partners to deal with the causes of the causes - environment, housing, workplaces, Local Development Framework)

- Increase the proportion of people who lead healthy lifestyles

Early Years

The more action that can be taken in the first three years of a child's life, the better the outcome for the child. Taking better care of our children's early health and development is crucial. The evidence tells us that giving every child the best start in life lays down the foundation for the whole of their life and reduces inequalities across the life course. Therefore, action towards this priority will have an impact on the other priorities within this strategy. Children's physical, social and cognitive development during the early years strongly influences their school readiness, educational attainment, economic participation and health.

Parents and the wider community play a major role in a child's health and development, through positive parenting and creation of an environment that is safe, healthy and encourages active learning. However issues such as parents' health and lifestyle, social networks, financial resources and knowledge about parenting impact on whether they are able to nurture the health and development of their child. Expectant parents, existing parents, communities and services will need to work together to ensure they have the support and skills to give children the best start in life. Clearly, action towards some of the other priorities within this strategy and throughout the life course will have an impact on parents, families and communities and their ability to provide a positive environment for children in the district.

Outcome: Every child has the best start in life

Objectives:

- Children are developing well and are healthy

- Parenting enables development and health of children

- The parenting context enables good parenting

[Objectives adapted from: UCL Institute of Health Equity. 2012. An Equal Start]

Mental health

We are recognising an increasing problem around mental health issues. The effect of the recession and money worries will add to the risk factors associated with poor mental health. Traditionally we have focussed on severe mental health issues, where we have successfully moved away from hospitalised treatments to community services. We now need to consider lower level mental health issues and also the impact that these can have on our physical ill health. We need to better understand how some people are able to build resilience so that we can share this more widely.

At any one time about 10% of our young people experience mental health problems which places demands on social services, schools and the youth justice system as well as the health service. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, with problems often continuing into adult life and then affecting the next generation. We also know that there are associations with criminal behaviour and some mental health problems such as those that are undiagnosed or 'hidden impairments'.

Early diagnosis of mental health conditions will be key to offering appropriate support or treatment that will improve long-term outcomes for individuals with mental health problems and their families. Evidence suggests that mental health patients are not always accessing or receiving the most appropriate care, for example many mental health patients are accessing Emergency Departments. Therefore we need to ensure that the mental health care pathways are clear, seamless and patient centred to ensure that people get the support they need in the most suitable environment.

Outcome: Wakefield District is a place where mental health and wellbeing is everyone's concern and everyone contributes to enable the whole population to flourish

Objectives:

- Improving the mental wellbeing of individuals, families and the population addressing the social determinants and consequences of mental health (Healthy Living & Quality of Life)

- Reducing the impact of mental ill-health through promotion of positive mental health ('living well') and prevention of mental disorder across the life course

- Raising awareness and reducing stigma around mental health

- Improve quality, efficiency and equality of access to services

- Early identification and intervention so that fewer people of all ages and backgrounds develop mental health problems

- Improving participation and quality of life for people with a mental health problem

Long term conditions

Within the district we have a heavy burden of illness and disease. There will inevitably be those for whom prevention interventions come too late or not at all. Our care and treatment services must deal with the demands of these high levels of ill health. Our aim is to provide this in a timely fashion, with the best care possible, with the aim of continually improving the quality of care and promoting individual's choice (e.g. personalisation).

We must endeavour to ensure that our new split commissioning responsibilities do not provide a "postcode lottery" for care and treatment in the district. Services should be available to those who are identified as in need and meet the criteria for service provision. We must use the best available information to predict the treatment and care that will be necessary. At the same time we need to identify the factors that have led to the prevalence of the illness/disease and introduce prevention services based on our local knowledge of cause and effect.

The proportion of people living with a long term condition is set to get worse as people are living longer. These conditions however are no longer associated just with old age, people are starting to suffer from such conditions from a much younger age. This will put an additional burden on our care services and budgets, as well as lowering the quality of life for individuals. Identifying symptoms at an early stage or identifying those at risk can lead to a much better outcome. We need to recognise early symptoms and set up systems to offer interventions at an early stage.

Correct management of long term conditions is essential to reduce the health risks of the individual suffering from secondary ill-health, unwanted side effects and preventable hospital admissions. For example, it is estimated that 75% of hospital admissions for people with asthma are preventable. Treatment and care also supports people to manage their illness in such a way that they are able to enjoy their lives. Integration and transition planning is important if we want to provide seamless services.

With good condition management, many people are able maintain a good quality of life and participation. Some people are able, with a small amount of intensive support to get back to a reasonable quality of independent living. We need to continue to support and encourage this so that wherever possible the long term outcome for an individual should is considered rather than the short term input. Difficult decisions will need to be made about individuals which may affect the options of care and treatment that are offered on an individual basis. Focussing care and treatment on those who will be able to return to independent living should be a focus of each organisations move to prevention and each commissioning organisation should make it clear within their commissioning plans how they will do this.

Outcome: People 'at risk' of or diagnosed with long term conditions feel supported to reduce further harm:

Objectives:

- Preventing future harm to those 'at risk' of having a long term condition e.g. people with poor lifestyles, high blood pressure etc

- Improving quality and equality of access to services

- Early detection and identification of long term conditions

- Ensure that people with long term conditions are supported to take responsibility for self-care

- Improving quality of life and participation for people with a long term condition e.g. employment, independence

Older people

Life expectancy is increasing year on year, and by 2031, the number of older people is expected to have grown by over 50%. Whilst this is an asset to the district and many of our older population have very healthy lives, a growing percentage are experiencing poor health issues. The expectation is that many of our existing population of young people will demonstrate poorer health outcomes as they get older (due in part to lifestyles/unhealthy living). It is also important that with the ageing population that we prepare for the predicted rise in dementia and work towards having a 'Dementia Friendly Wakefield'.

As the population ages the requirements for services also changes. This will cause a huge demand on social care and on primary and secondary health care providers. There are already pressure points in our care systems around hospital attendances and available beds and the growing number of residents that need full or part time social care provision once they are discharged from hospital. Wakefield already has a strategy for an ageing population.

It is widely acknowledged by all partners that to tackle some of these potential pressures we need to invest more in prevention services. Disinvestment in existing services or releasing new money to fund prevention initiatives is often difficult because we are not always able to prove the value for money of prevention services. Partners need to plan what the impact will be on their own services of an aging population, and finances may need to be moved accordingly. We need to work together to enable people to live as independently as possible as they reach old age. There needs to be a shift of culture towards people self managing through the personalisation agenda, knowing that when it is necessary good quality care and support will be available. It is important that we start to understand the key triggers to ill health in older people rather than seeing illness as inevitable stage in ageing. Transition between family home, hospital and care needs to be properly supported allowing proper re-ablement of those who are able to go back to independent living.

Outcome: Our ageing population feel supported and have a good quality of life

Objectives:

- Maintenance of behaviours that promote positive health and wellbeing

- Ensuring that our district is age-friendly

- Older people being independent and living in their own homes for longer

- Uphold the National Pensioners Convention Dignity Code to uphold the rights and maintain the dignity of older people

This section outlines a common framework and set of approaches for the Health and Wellbeing Board, its member organisations and key partners that will be necessary to move the agenda forward.

Prevention & Early Intervention

It is well known that prevention and early intervention results in better health and wellbeing outcomes. Prevention and early intervention may occur at any point in the life course. This means that there is a need to consider how we will build prevention and early intervention into our plans for all of the priorities within this strategy.

There is a need for a shift to an approach that moves towards preventing the causes of poor health and wellbeing rather than dealing with the consequences. This includes reducing the risk factors that may lead to poor health and wellbeing and promoting the protective factors that increase peoples' resilience to risk.

It is also essential that we intervene as early as possible to tackle health and wellbeing problems that are emerging.

Once health and wellbeing problems are established we need to prevent people from slipping into crisis and ensure that we promote positive quality of life so that people can live a full a life as possible.

How?	Prevent health and wellbeing problems from happening promoting Healthy Living and Quality of Life	Early intervention to prevent further harm to health / wellbeing	Help people with problems, promoting self management & preventing crisis
Who?	'At risk' or 'in need' Whole population(s) Universal	Early signs of wider determinants of health/wellbeing or early signs of ill health	People with identified health / wellbeing problems to promote healthy life expectancy

Partnership

Improving health and wellbeing will involve everyone in the District; it is not the sole responsibility of any one agency. We will ensure that everyone living and working within Wakefield has an opportunity to contribute to the Health and Wellbeing Strategy.

How will this work?:

- Joint priorities are agreed by the board, as are actions that will address them

- Priorities and actions are influenced by on-going stakeholder and community engagement

- All partners are clear about the key health and wellbeing issues

- Partners can see how they contribute to tackling the priorities and are identifying potential areas and actions for improvement/development

- Members of staff at all levels play a role in improving health and wellbeing outcomes (distributed leadership), building on the 'health is everyone's business' and Every Contact Counts approaches

- Partners are aware of the services or support that is available in relation to the priorities

- The Health and Wellbeing Board will work with partners to ensure that other partnership strategies are implemented in a way which maximises health and wellbeing

- Partners are developing co-production models for service delivery, that acknowledge the role that voluntary and community sector organisations and citizens play in improving and delivering services and support

- Partners work together to improve the outcomes (effectiveness) and to make best use of budgets and resources (efficiency)

- Commissioning of wider health and wellbeing services are more closely integrated with commissioning of health and social care services

Behaviour Change & Health Protection

Public Health & Partners
- primary prevention
- health protection (targeted)
- health promotion

Vulnerable Children and Adults

Family Services/GPs/Partners
- prevention (primary & secondary)
- protection (safeguarding)
- personalisation (choice, control & empowerment)

Wider determinants - "causes of the causes"

Other Council Directorates & Partners
- environment
- economy
- social/community

Personalisation

It is well known that people's needs are best met when local people and communities are put at the centre of commissioning and delivery of services. In order to have a greater impact on the health and wellbeing priorities we will further embed personalisation into our planning and encourage partner organisations to do the same.

How will this work?

- Targeting resources proportionate to level of need, inequality or vulnerability rather than demand

- Making the most of identifying and addressing health and wellbeing issues and reducing inequality at key stages during the life course (e.g. pregnancy, starting school, retiring)

- Using social marketing which is an approach that ensures that services, actions and communications are tailored to change the behaviour of different target groups. This includes designing actions that consider enablers or barriers to behaviour change. We know that general publicity campaigns and providing information is not enough to change unhealthy behaviours

- Identifying community assets and strengths that positively impact on the health and wellbeing priorities and strengthening these to develop community capacity to further improve outcomes

- Enabling communities and individuals to come up with or 'coproduce' their own solutions alongside the voluntary sector, wider partners and businesses

- Supporting people and developing their confidence and motivation to take responsibility for their own health and wellbeing and be independent e.g. through development of Technology, Telecare and Telehealthcare; prevention; personalised budgets; self-care; community based services; re-ablement

- Working with individuals and families in a co-ordinated and holistic way ensuring that issues and impacts on the wider family are not considered in isolation

Evidence and Innovation

This strategy is based on evidence of the key health and wellbeing priorities within the District and evidence of what is effective in making improvements to health and wellbeing. Moving forward the board and wider partners will demonstrate the impact that our work is having on health and wellbeing outcomes.

How will this work?:

- Where evidence exists that certain methods work and are cost effective, we will ensure that these become our chosen ways of working, equally we need to use evidence of things not working to inform our commissioning and delivery

- Balancing needs information with evidence from frontline workers and community engagement information around perceptions of key issues, community assets and potential solutions

- Impact assessment to ensure that plans have a positive impact on health and wellbeing and that any potential negative impacts are reduced

- Monitoring whether commissioning and delivery plans address the priorities and approaches in this strategy

- Monitoring the key Outcomes Frameworks and evaluating the impact of our commissioned work or actions on health and wellbeing outcomes

- Engagement with stakeholders and the community to further inform the development and delivery of the strategy.

Where there is no evidence of best practice, we will be innovative and prepared to try new approaches in order to make progress towards improving health and wellbeing outcomes. This will be reliant on staff identifying new ways to work with individuals or population groups and evaluating the impact of this. This evidence will then feed into the Joint Strategic Needs Assessment and Health and Wellbeing Strategy process. Ongoing engagement with stakeholders will be a key conduit for sharing such information.

your

health and wellbeing

Kirklees Joint Health and Wellbeing Strategy
2014-2020

Version 2

Contents

1. Prologue

Two things will be pivotal to making Kirklees a better place in the future - healthy people enjoying a great quality of life for longer via a strong and growing economy.

Those goals are not only crucial, but intimately bound together. A successful economy that offers good jobs and incomes for all of our communities makes a huge contribution to prosperity, health and wellbeing of all age groups. Likewise, confident, healthy, resilient people are better able to secure a job and are more productive in the workplace. Both strategies focus on building resilience in business, communities and people in order to increase independence.

Because of the importance of these issues and the connections between them, Kirklees Council and its partners are focusing on two complementary strategies that will set our future priorities and guide action:

> The Kirklees Joint Health and Wellbeing Strategy

> The Kirklees Economic Strategy

These two strategies respond to the challenges and opportunities that apply to them individually and set their own priorities and actions accordingly. They cover different ground and do different things, yet are fundamentally connected. Two way discussion, shared analysis and a rounded understanding of how health and the economy are mutually supportive have been central to the development of both strategies. At the heart of both is commitment to achieve a **shared aim.** That is:

Kirklees is a District combining great quality of life and a strong and sustainable economy – leading to thriving communities, growing businesses, high prosperity and low inequality and where people enjoy better health throughout their lives.

A coordinated governance framework will oversee the implementation of the Economic Strategy and the Joint Health and Wellbeing Strategy. This will ensure that they continue to support one another through their delivery. Both strategies will also use a similar 'strategic thinking framework' to help to develop initiatives and make decisions.

There are specific, practical ways in which work on economic development and health and wellbeing will deliver the stated shared aim for Kirklees.

Examples are shown in the tables opposite.

> " Thriving communities, growing businesses, high prosperity and low inequality - where people enjoy better health throughout their lives "

Economic development will support health and wellbeing by:

Resilient businesses creating good, fulfilling and long term employment opportunities.

Supporting higher incomes and reducing poverty.

Building skills that aid employability, career progression and life chances, thereby reducing inequalities and ensuring there is the workforce necessary to deliver effective health and social care in the future.

Business support offer to promote healthy, safe, diverse workforces and workplaces.

Having a spatial planning policy that increases connectivity whilst improving health and wellbeing, air quality and reducing accidents.

Open spaces and green infrastructure that encourage physical activity and support positive emotional wellbeing.

Good quality housing and high energy efficiency/standards supporting affordable warmth, good health and reduce living costs.

Access to suitable, good quality homes and neighbourhoods providing a secure place for families to thrive and promote good health, wellbeing and independent living.

A quality residential and neighbourhood offer impacting on quality of life and attracting people and businesses to locate there.

Encourage sustainable business practices, e.g. those which cut waste and enhance air and water quality.

Development that respects and creates attractive places, thriving communities and supports health and wellbeing.

Health and wellbeing will support economic development by:

Resilient people powering business success.

Enhancing the pool of confident, ambitious, healthy people able and willing to work.

Better health for longer meaning more productive employees and volunteers able to work for longer.

People being increasingly independent and resourceful thereby developing a supportive, positive, self-sufficient culture.

Ensuring people have the best possible start in life and are therefore enabled to fulfil their potential and become productive members of society.

Creating opportunities for community economic development that reduce the cost to the public sector.

Improved perceptions of places and communities helping to support enterprise and investment.

Ensuring the local health and social care sector considers the impact of the decisions it makes on the local economy.

Growth in the health and social care sectors provides major opportunities for new business activity, innovation and employment.

2. Introduction and Purpose

2.1 The Kirklees Joint Health and Wellbeing Strategy (JHWS)

The purpose of the JHWS is to:

- Provide a context, vision and overall focus for improving the health and wellbeing of local people and reduce inequalities at every stage of people's lives by 2020.

- Identify shared priorities and clear outcomes for improving local wellbeing and health inequalities.

- Support effective partnership working that delivers health improvements.

- Provide a framework to support the innovative approaches required to enable change, given the changing needs of local people and the current economic climate.

It recognises the need to understand where single agency action may have significant impact for other partners and focuses on wider issues of transformation, including the system changes required, and not just the population outcomes identified in the JHWS.

For organisations it provides direction and a framework for them to review their commissioning and service planning. With its focus on tackling inequality, the JHWS also enables organisations to fulfil their statutory equality duties.

2.2 Making this a reality

The Kirklees JHWS has two broad components:

- The **Policy** which includes:

  - The **JHWS Vision and Outcomes** - designed to describe our aspirations of the future.

  - **System Change Priorities** - provide the foundation for change across organisations in order to enhance systems, have shared expectations for behaviour in planning and delivering change and build more productive relationships.

- The **Implementation Plan** which includes the overall approach to making change happen during 2014 - 16 across partnership organisations, with a focus on the system change priorities and Joint Strategy Needs Assessment (JSNA) issues. This work is supported by the:

  - **Strategic Thinking Framework** - designed to ensure plans and actions use an approach designed to ensure the achievement of the JHWS outcomes.

All these have been reviewed and refined for 2014 - 2016 in light of experience, changes to policy and funding and the 2013 refresh of the JSNA.

The Implementation Plan continues to evolve as we all become more familiar with 'working in a JHWS way' and as new challenges and opportunities emerge. The Kirklees Economic Strategy (KES) also includes a Strategic Thinking Framework, and a coordinated governance framework for that strategy and the Kirklees JHWS will ensure joined up delivery.

> " The Joint Health & Wellbeing Strategy focuses on improving health and wellbeing and tackling inequalities. "

3. The Policy: Vision and Outcomes

3.1 The Joint Health and Wellbeing Strategy Vision

Our vision is that by 2020:

> No matter **where** they live, **people in Kirklees** live their lives **confidently**, in **better health**, for **longer** and experience **less inequality**.

This is ambitious especially given the number of very significant factors affecting local health and wellbeing. These include the economic challenges facing the country and thus those who are more vulnerable; the increasing numbers of older people and their needs for care and support; and taking advantages of opportunities, for example, the Care Act (2014).

3.2 The future state of Kirklees people and their communities by 2020

What difference are we trying to make for whom?

1. People in Kirklees are as well as possible, for as long as possible, both physically and psychologically, through:

   - Having the **best possible start in life** through every child and young person being safe, loved, healthy, happy, supported to be free from harm; and have the chance to make the most of their talents, skills and qualities to fulfil their potential and become productive members of society.

   - Encouraging the **development of positive health and social behaviours**.

   - Identifying issues **as soon as possible** that affect health and wellbeing.

   - Enhancing **self-care**: people being increasingly independent, self-sufficient and resourceful so able to confidently manage their needs and maximise their potential.

2. Local people can **control and manage life challenges** through:

   - Being **resilient**: having a sense of purpose, self-esteem, confidence, adaptability; be emotionally aware; taking responsibility for their own physical and emotional needs; being supportive and compassionate; being **connected to others**. So resilience is developed in individuals, families, communities and organisations.

   - Feeling **safe** and positively **included**.

   - Being **able to navigate through life**: being able to participate and contribute to society by being able to:

     - **Understand** and **communicate**;

     - Take advantage of opportunities and **achieve goals**;

     - **Increase** their **potential**, including for work;

     - **Constantly learning and adapting**.

3. People have a **safe, warm, affordable home** in a **decent physical environment** within a **supportive community** through:

   - Continuing to work in partnership to deliver an appropriate supply of homes and jobs to meet the needs of a growing and ageing population.

   - Working with communities and individuals to enable and support independent living and an environment which promotes good physical and emotional health and wellbeing.

   - Improving homes and neighbourhoods through encouraging greater involvement and joint action.

4. **People take up opportunities that have a positive impact** on their health and wellbeing through:

- People experience **seamless health and social care** appropriate to their needs

- Strong communities;

- Healthy schools;

- Taking up opportunities for wider learning;

- Active and safe travel;

- Access to green and open spaces and leisure services;

- Improved regulation of factors that affect health and wellbeing e.g. takeaways, air pollution;

- Spatial planning supporting a place-based approach to improving health and wellbeing encouraging health promoting environments.

3.3 How do the JHWS and the KES complement each other

Achieving the KES outcomes of a stronger business base, more and better jobs, enhanced skills and resilience, quality green infrastructure and reduced inequalities will also help in delivering health and wellbeing outcomes.

This focus on people is complimented by the KES focus on sustainable economic growth which supports business competitiveness and benefits people through jobs, housing, skills and incomes. To achieve this, the KES has 5 priorities:

- **Precision engineering and innovative manufacturing**: strength in depth and excellence;

- **Innovation and enterprising businesses**: championing creativity, entrepreneurship and resilience;

- **Workforce, skills and employment**: extending opportunities and powering business success;

- **Infrastructure**: making it easier for businesses to succeed and for people to access work;

- **Quality places**: locations of choice for people, business and investment.
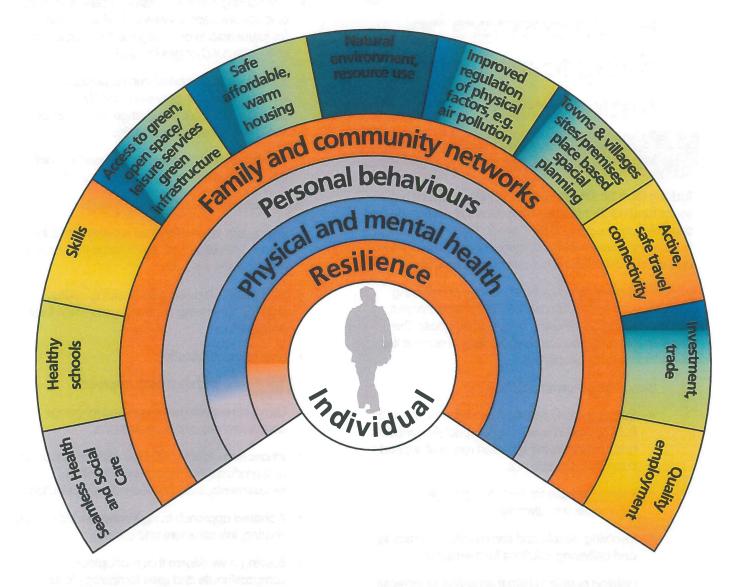
A particular challenge will be ensuring we have a health and social care workforce with the skills and capacity to deliver the JHWS.

Its focus on these factors reflects and complements the JHWS, whilst both strategies place focus on resilience - be that of individuals, communities or businesses.

This is shown by the rainbow for Health and Wellbeing on page nine, opposite.

> " The focus on people is complimented by the Kirklees Economic Strategy "

Connecting Kirklees People and Places for Health and Wellbeing

Outer ring (clockwise from top left):
- Access to green, open space/ leisure services green infrastructure
- Safe affordable, warm housing
- Natural environment, resource use
- Improved regulation of physical factors, e.g. air pollution
- Towns & villages sites/premises place based spacial planning
- Active, safe travel connectivity
- Investment, trade
- Quality employment
- Seamless Health and Social Care
- Healthy schools
- Skills

Rings (outer to inner):
- Family and community networks
- Personal behaviours
- Physical and mental health
- Resilience
- Individual

People being as well as possible for long as possible.
- Best possible start in life
- Positive health/social behaviours
- Identify issues asap
- Enhance self care

Take up opportunities that enhance health and wellbeing

Live in a decent physical environment

Control and manage life challenges
- Resilient
- Connect to others
- Feel safe and included
- Navigate through life

4. What should the Health and Wellbeing Board partners be doing to realise this future state?

System Change Priorities – Thinking the Joint Health and Wellbeing Strategy way

Tackling local health and wellbeing inequalities as public sector funding decreases is a significant challenge. To best support local people and their needs, this challenge needs to be owned across the partnership and include agreed and shared behaviour in achievement of outcomes.

All partners recognise that this challenge of delivering services in the future can only be met by fundamental system change, i.e. different, better and cheaper. The key changes and areas for development to achieve the outcomes for local people are:

1. Being **Person-centred** through:

   - Taking an early **holistic view** of the individual in their context in order to appropriately signpost and /or access the broadest range of support to improve their resilience.

   - **Valuing people** for their strengths, gifts, differences and diversity.

   - **Involving** people and communities in creating and delivering solutions for themselves.

   - Helping people to help themselves to increase their sense of **control, independence and resilience**.

   - Creating a **clear way** for individuals **to navigate** through services and systems.

   - Having consistent and appropriate **quality information**.

2. **Changing the relationship** between citizens and the public sector to shared responsibility:

   - Making best use of the strengths/assets existing in all **communities**.

3. Improving the **quality of, and access to**, services and reducing variation across them through:

   - Use of the Joint Strategic Needs Assessment (JSNA) to **identify needs and priorities**.

   - Being **evidence based** in outcomes and what works. Learn from evaluation and perceptions of users/communities.

   - Considering current provision of service vs need and effectiveness, as well as horizon scanning for future risks to achieving the JHWS outcomes and potential changes in need.

   - **Minimising unintended consequences** of changes in service provision. Identify the potential impact of any change, e.g. on other services, increasing inequalities.

   - **Prioritisation according to need and impact**, e.g. risk stratification, soft intelligence, etc.

4. True **collaboration** and thinking through:

   - Being clear what difference is being made for whom, i.e. **outcomes**; and how do they address any issues in the JSNA?

   - **Prevention** - focussing on stopping issues starting, minimising consequences when they happen.

   - Eradicating **duplication**.

   - **'Do it once and do it right' approach**.

   - **Using consistent messages** and language across services and organisations.

   - **Innovation** - Identify effective systems, processes and products that meet new or existing requirements, including technological solutions.

   - A **shared** approach to **digitisation** including data sharing, infrastructure and culture.

   - Building a **workforce** that is adaptable, compassionate and uses technology to its maximum extent (linked to delivery of skills and ICT elements of the KES).

   - Considering **all resources**: Private, Public, Voluntary, Individual, Community.

5. Additionally, for health and social care:

   - **Integration** of systems, resources, capacity and finances.

   - People receiving **coordinated care** at home as appropriate for their needs.

   - A **workforce that can span health and social needs** and support a 24/7 service.

   - Recognising and supporting the **contribution of informal carers**.

5. The Implementation Plan: Implementing the Joint Health and Wellbeing Strategy

5.1 The role of the Kirklees Health and Wellbeing Board (HWB)

The Kirklees Health and Wellbeing Board bring together senior local Councillors, Directors of Children's Services, Adults Services and Public Health from Kirklees Council, Clinical Commissioning Groups and Healthwatch. The Council Chief Executive and a representative from NHS England, along with invited observers from the local NHS Trusts and Locala Community Partnerships are also actively involved in the Board.

The purpose of the HWB is through collaboration to understand the needs of the local community and to plan how to best meet those needs.

The JHWS enables the Health and Wellbeing Board to:

- Assess local plans and ways of working of its member organisations to ensure the vision and outcomes are being achieved by and making changes to systems and tackling key local health and wellbeing issues.

- Influence partner organisations thinking and subsequently hold those organisations to account for their actions against the JHWS.

- Share responsibility and ownership of tackling all the health challenges for Kirklees.

- Make effective decisions in a clear and transparent framework.

Health and Wellbeing Board - leaders of change

The HWB has a critical leadership role to ensure the achievement of the JHWS vision and outcomes. The Board members have an individual and collective responsibility to champion the changes required to achieve the system change priorities, and ensure appropriate focus on key JSNA issues. Given the scale of the challenge, leadership will be required at all levels across a wide range of partners and understood by the public.

The leadership challenge is:

- Committing **to energetic and sustained leadership**, starting with the Health and Wellbeing Board but supported by a wide range of leaders at all levels, spreading **clear and consistent messages** about what we want to achieve with leaders continually articulating the vision and outcomes and reinforcing their commitment to it through their day-to-day transactions with colleagues.

- Investing in training, organisational and leadership development and bringing together capacity across partners to **drive the vision and fully embed the integration message in our organisations**.

- Making space for **creative thinking** and **taking risks**.

- Forming **constructive relationships** and **breaking down barriers**, such as culture and language, across the system.

- Building **collective responsibility** across the most significant planning systems for achieving the Vision.

- Enabling the leaders to **hold each other to account** for the delivery of this Strategy.

Coordination of governance structures for the JHWS and the KES will help to implement both in a joined up manner.

5.2 Strategic Thinking Framework – a tool for robust planning and review

The Strategic Thinking Framework is a set of questions developed from the JHWS system change priorities. It is a tool to use in developing robust plans that meet the health and wellbeing needs of local people and identifying gaps in current plans. It enables insight into current practices and signposts areas to be considered in future planning.

This framework should be used:

- To embed the system change priorities into significant local plans;

- To plan action for key health and wellbeing issues;

- By the Board to identify gaps, pull out interdependencies and to ensure that the key local plans / systems contribute to the achievement of the JHWS vision and outcomes;

- By commissioners and service planners to inform the development or review of key strategies and plans.

> ❝ Supporting people to have more control and independence, and increased resilience ❞

JHWS Strategic Thinking Framework

Outcomes

Q1. What difference are you trying to make for whom?
Q2. Why does change need to happen?
Q3 What are the main factors affecting these outcomes?
Q4. How will you know what difference you have made?

Actions

Q5. What does evidence tell you about the actions that will be effective in achieving the outcomes?
Q6. How will your actions address key health and wellbeing issues from the JSNA?
Q7. What could be changed by local action?

Impact

Q8. What impact have your actions had on the desired outcomes?
Q9. How will your actions reduce variability of quality between providers?
Q10. How will you plug any gaps in your understanding of the outcomes and the impact you are having on them?
Q11. What are unintended consequences and what have you done to mitigate against them?

Involvement

Q12. Who else should be involved in order to achieve the outcomes?
Q13. Think individual (including carers/family), the community, voluntary, private and public organisations.
Q14. What community strengths or assets are there, and how can they be used and developed to build community resilience?

Resources

Q15. How can you use resources to reflect differing levels of need between groups/communities?
Q16. How can you change the use of resources?
Q17. How can you use resources to support prevention – to stop something happening in the first place and earlier intervention when issues do occur?
Q18. What are the implications of your actions for the workforce?

Increasing independence and resilience

Q19. How do your actions support people to have more control and independence, and increased resilience?
Q20. How do your actions support a holistic view of the individual and their life?
Q21. How do your actions enable people to access appropriate information and enable them to navigate through services?
Q22. How do your actions build community and organisational resilience?

Collaboration

Q23. How do your actions promote collaboration, shared responsibility; integration of systems, technology, resources, capacity and finances where appropriate?
Q24. How will your actions impact on other services and possible duplication of provision?
Q25. How do your actions help people to help themselves?

Using this framework will also contribute to ensuring organisations fulfil their statutory equality duties.

5.3 What are the main health and wellbeing factors affecting the outcomes?

Focusing on improving significant issues

The Kirklees Joint Strategic Needs Assessment (JSNA) describes a wide range of health and wellbeing issues affecting people across Kirklees and identifies key themes that impact locally.

The JSNA identifies issues where:

- There is a significant local **impact** in terms of size and severity.

- The issue itself or its consequences are **comparatively worse**, either compared with other areas or between different areas/groups within Kirklees.

- Impact of the issue is **not improving or is worsening** compared with other areas or over time.

For example, the key issues identified by the JSNA:

Wider factors	Networks	Behaviours	Biological issues
Income and debt	Family	Food	Infant Deaths
Learning	Social Connectedness	Physical Activity	Cancers
Work and skills	Dependency	Alcohol	Long Term Conditions, esp.: Cardiovascular Obesity
Housing	Community Capacity	Tobacco	Depression/Anxiety
Being/feeling safe		Sexual health	Dementia
Obesogenic Environment			Chronic Lung Disease
			Asthma
			Diabetes
			Pain/Musculo-Skeletal

Individual, Community, Organisational RESILIENCE

Vulnerable groups	
Families with complex needs	People with mental health issues
Women of child bearing age	Adults with physical disabilities or sensory impairments
Dependent disabled children	Adults with learning disabilities
Looked after children/care leavers	Carers
Offenders	Older people
People on low incomes	

The JSNA should be used:

a) As a starting point for planning;

b) As part of the Strategic Thinking Framework;

c) To consider how resilience is built into planning.

The JSNA is available online at www.kirklees.gov.uk/jsna

5.4 Tools to enable people to implement the Joint Health and Wellbeing Strategy (JHWS)

The following areas of work are crucial to support the implementation of the JHWS:

- Developing a **coherent and co-ordinated approach to creating and using intelligence** about health and wellbeing needs and assets, effective action and local impact. High quality, easily accessible intelligence is essential in tackling both the system changes and key health and wellbeing issues.

- Developing a **coherent and co-ordinated approach to commissioning** through increasing awareness of the commissioning discipline, the local skills and capacity to undertake it effectively for health and wellbeing.

- Developing a consistent approach across partners **identifying, involving, engaging with communities and building community assets**. This is a shared area of work with the Safer Stronger Partnership.

- Identifying what **type of action** is necessary:

  - **Evolutionary** improvement: work will continue to be undertaken and improvement will be on a steady, continuous trajectory;

  - **Revitalisation**: focussed action should achieve significant improvement;

  - **Transformation**: a complete review and potential redesign.

  Action should be prioritised where:

  - There is local **capacity to change** and the potential **return on investment**.

  - **Quality of local action** is compromised because there is considerable scope for reducing inequality in appropriate access or quality of local service provided; care pathways or specific service redesign is required.

  - **Change is feasible** in the shorter term.

  - It is **timely** to take action now.

  - Action on this issue will improve the overall **JHWS vision and outcomes**.

5.5 How will we know what impact our actions have had on the outcomes?

Assessing the success of the implementation approach of the JHWS includes:

- Achievement towards the overall vision and outcomes are assessed by the outcome indicators.

- To assess the implementation of the system change priorities, the key plans will be prioritised for importance and assessed using the strategic thinking framework and evidence provided to support this. A briefing paper will then go regularly to the Health and Wellbeing Board outlining the changes resulting from using the framework and any outstanding action which may need partnership solution, i.e. what are they doing differently as a result, and is this achieving the desired outcomes.

> " Involving, engaging with communities and building community assets "

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CALDERDALE'S JOINT WELLBEING STRATEGY

2012-2022

CALDERDALE HEALTH AND WELLBEING BOARD

March 2013

Contents

Foreword:

Wellbeing is a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment.

This is Calderdale's first Joint Wellbeing Strategy (JWS). It sets out our vision for improving the wellbeing of local people and reducing inequalities in Calderdale. It goes beyond taking simply a physical view of wellbeing to also include good mental health, spirituality and the broader environment in which we live. It sets out the priorities that partners across Calderdale will focus on in order to deliver our vision.

"Our vision is for Calderdale to be an attractive place where people are prosperous, healthy and safe, supported by excellent services and a place where we value everyone being different and through our actions demonstrate that everyone matters"

This broad vision was agreed by all partners in the Local Strategic Partnership in 2009/10 and was set out in Calderdale's Sustainable Community Strategy. Behind the vision and strategy there lay an ambition to address wide economic, environmental and social issues. That ambition is carried forward into the Wellbeing Strategy, with a focus on those issues that impact on health inequalities and the wellbeing of local people.

Calderdale is facing some key challenges including: an increase in population – which is greatest in the over 65s and the 0 to 15 year-old age group; constraints on local economic growth due to a lack of viable land for development and a highway network close to capacity; high dependence on the manufacturing, public and financial services sectors; an estimated one in five children living in poverty; a growing health gap, with those living in Calderdale's most disadvantaged communities experiencing greater ill-health than elsewhere in the district; and, a similar gap in educational attainment between the most and least deprived areas .

National policy changes and financial constraints on the public sector mean that in developing this Strategy a practical and focused approach to tackling the main issues has been adopted.

This Wellbeing Strategy provides a framework for addressing the District's key issues and identifies a number of outcomes which have been widely agreed as being those that will most effectively improve wellbeing in the District. As in previous years it is recognised that Calderdale's economy is the foundation for driving improvements in quality of life in the District.

This joint strategy serves two functions - it is both an overarching strategy to guide broad decision-making and it provides a high-level framework for improving service provision to meet the needs of local people.

The JWS has been produced by the Health and Wellbeing Board, a new forum involving a number of key partners in the area of health and social care. The Health and Wellbeing Board was established in 'Shadow' form in 2011 but, from April 2013, functions as a statutory committee of the Council. The Board will operate with major contributions by the local authority and the Calderdale Clinical Commissioning Group (CCG), representing the group of GPs that, from April 2013, is responsible for the designing and commissioning of health services in the District. At the time the JWS was produced, the Board was reviewing its role and membership with a view to broadening both of these in time for April 2013.

The JWS will be reviewed periodically and updated when wellbeing issues and system changes make it appropriate. Each review of the strategy will be consulted upon and published.

It is recognised that a number of issues, which people feel are very important, do not feature in the JWS. However these issues will not be forgotten and partners will still continue to take these forward and include them in their strategies and plans.

Whilst this Strategy has been developed and produced by the Health and Wellbeing Board, it is very clear that the broad set of issues it covers cannot be successfully addressed without the support of many organisations, both within and outside Calderdale, and without the support of residents in local communities.

The aim now is to seek broad support for the outcomes in this strategy and to harness commitment and resources from a wide range sources to achieve measurable improvements in the wellbeing of local people.

Signed on behalf of the Shadow Health and Wellbeing Board

Chair of the HWB   Chair of the CCG

1. What is a Joint Wellbeing Strategy?

The 2012 Health and Social Care Act sets out a duty for the local authority and the Clinical Commissioning Group to prepare a Joint Strategic Needs Assessment (JSNA) and to use the findings on needs to develop a Joint Health and Wellbeing Strategy.

The starting point for the development of the joint strategy is the Joint Strategic Needs Assessment, or the JSNA. The JSNA is a process that takes and analyses data and information from a wide range of issues and services which affect our health, independence, care and wellbeing. From this emerges an objective view of the priorities for action in Calderdale.

The role of the Joint Wellbeing Strategy is to translate Calderdale's JSNA into a high-level 'summary' of existing and planned activity, which partners on the Health and Wellbeing Board agree to support in the ways most appropriate for their organisations. It follows that these priorities then become a focal point for discussion, tracking of outcomes, integrated commissioning and service delivery at the Health and Wellbeing Board. In Calderdale the JSNA has been incorporated into a broader analysis of need (see Section 3) which goes beyond health and social care. A key task of the Board is to encourage other key partners who are not on the Board to support and contribute to the delivery of the Strategy's objectives.

In July 2011, Calderdale's Shadow Health and Wellbeing Board agreed that, the Calderdale Wellbeing Strategy should be broad in its scope addressing a wide set of issues, many of which lay outside the remit of health and social care but which nevertheless impacted on health and health inequalities .

To be successful, the Board agreed the strategy needs to:

- Focus on a small number of high level outcomes which require the co-operation of a range of partners to deliver.
- Address the economic, environmental, social, medical and behavioural determinants of wellbeing and health.
- Be based on the best evidence available.
- Focus on life stages – e.g. prenatal, preschool, school, training, employment and retirement.
- Prioritise activities which have a positive impact on the poorest populations and communities.
- Be sensitive to differences according to for example , age, sex, culture etc.
- Be sensitive to the balance between individual responsibility and the responsibility of society.
- Inform the commissioning strategies of the NHS, local authority, schools and other partners to deliver the actions necessary to achieve the outcomes
- Include evaluation and monitoring of progress as essential components.
- Have a 10 year timeframe.
- **Not** attempt to summarise all the activity that should be going on in Calderdale.

2.   The approach in Calderdale

Process

It was agreed the Wellbeing Strategy needed to focus on a small number of high level outcomes and that to arrive at these a prioritisation process was required. The chosen outcomes were required to meet certain criteria. It was required that the outcomes selected should:

- produce measurable results over time
- address inequalities
- require actions of a number of partner agencies
- be based on evidence
- focus on preventive or early intervention activity
- build on existing strategies

In November 2011 the first Calderdale Assembly considered the evidence of need (from the Calderdale Needs assessment) across a wide range of issues – economic, health, housing, environment, community safety, children and older people - and put forward three priority outcomes for each "life stage" of the local population.

The prioritisation process took place during December 2011 and January 2012. A long list of 15 priorities, drawn from the Assembly meeting in November was widely circulated within the public, private and voluntary and community sector. Around 100 responses were received. The conference report provides a full analysis of the event and prioritisation process.

Following much discussion, on the 31st January 2012, the Health & Wellbeing Board endorsed the top six outcomes that received the most support from the prioritisation process. There was some concern at the Board that the prioritisation process had not supported an environmental outcome amongst the top six. Rather than add a seventh outcome to the list, the Board felt it was more appropriate that environmental sustainability become a principle to which all 6 outcomes should be required to adhere.

The Calderdale Assembly met for a second time in March 2012 to agree the priorities and the approach for moving them forward.

3.   Calderdale Needs Assessment

The Wellbeing Strategy is informed by the strategic needs assessment.   This highlights "the big picture" in terms of the needs of Calderdale. The needs assessment is to enable local priorities to be agreed and services commissioned to meet those needs. It identifies groups where needs are not being met and are experiencing poor outcomes. The needs assessment draws data from a number of data sources, including the JSNA, local economic assessments and emerging work on child poverty, to provide a broader view of needs and determinants of wellbeing.

The key issues identified, by pulling a range of assessments together, are set out below. The evidence behind the key issues was presented at the first Calderdale Assembly in November 2011.

Profile	Key Issues				
Economy	Resilience	Inequality	Retail & Tourism	Innovation	Location & Connectivity
Health	Children and young people	Cancer and cardiovascular disease	Lifestyle choices	Health inequalities	Ageing population
Safer & Stronger	Confidence	Tackle antisocial behaviour and create stronger and more cohesive communities	Reduce Risk to the public and vulnerable groups	Reduce Re-offending	Support strong communities with a thriving voluntary sector
Environment	Climate Change & Calderdale's Energy Future	Biodiversity & Green Infrastructure	Waste Management	Sustainable Travel	Pollution
Child Poverty	Achievement	Poor Health	Household Income & Financial Support	Worklessness	High risk groups
Housing	Providing affordable housing	Preventing homelessness	Supporting vulnerable groups	Addressing fuel poverty	Sustaining housing and neighbourhoods

4.   Priority Outcomes

The outcomes identified as those that should be priorities within the Wellbeing Strategy see Calderdale as a place …

- **Where people have good health**

- **With a balanced and dynamic local economy**

- **Where children and young people are ready for learning and ready for life**

- **Where fewer children under the age of 5 live in, and are born into, poverty**

- **Where older people live fulfilling and independent lives**

- **Where everyone has a sense of pride and belonging based on mutual respect**

Developing the 6 outcomes

The Outcomes Based Accountability (OBA) approach has been used to develop and flesh out the 6 outcomes. This approach concentrates on finding the root causes of issues and problems and finding ways to improve things for local residents. The focus in the OBA approach is not on services.

A key technique in the OBA approach is the completion of "turning the curve" report cards against the key issues.   The aim of completing the report cards is that an examination of each issue will identify:
- the factors and causes at work;
- how the problem or issue might be measured;
- what actions might help to improve things or "turn the curve"; and,
- the partners that need to be involved in improving outcomes

Each of the 6 priority outcomes were broken down into 2 or 3 constituent parts and turning the curve report cards were developed by small groups for, what were considered to be, the significant barriers to achieving the main outcomes. This resulted in the identification of a number of success measures and ideas for actions to achieve success.

Confirming our Commitment

Some of the ideas for action are longer-term proposals requiring further development, including sign-up from a range of partners to ensure the transition from proposal to action. These are identified in the following pages as "calls to action".

Where there is an existing commitment to deliver these ideas, these actions have been classified as "commitments to action".

5. Vision and Outcomes

"Our vision is for Calderdale to be an attractive place where people are prosperous, healthy and safe, supported by excellent services and a place where we value everyone being different and through our actions demonstrate that everyone matters"

Further detail on the 6 priority outcomes that would impact most on wellbeing in Calderdale were developed using the outcomes based accountability framework and methodology. This approach resulted in:

- further clarification of the 6 outcomes

- the outcomes expressed as a series of success measures, and

- ideas for improving these outcomes.

These details are set out for each outcome in the following pages.

CALDERDALE IS A PLACE WHERE PEOPLE HAVE GOOD HEALTH

Why this is a priority for Calderdale

In Calderdale where you live can have an impact on your health. If you live in poorer neighbourhoods you will, on average, spend more of your life with a disability and die 9 years earlier than people living in the richest neighbourhoods.

What success will look like?

It is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors. As we start to choose healthier lifestyles we will reduce the rate of early deaths and illness. Fewer people will smoke, drink too much alcohol and more people will eat healthily. When we do this there will be less risk of developing cancer, diabetes or cardiovascular diseases, fewer heart attacks and less people going to hospital for alcohol related issues.

As a result of changing lifestyles and tackling housing, income levels and other factors, people in the poorest neighbourhoods will live longer without disabilities and live longer overall, bringer them more in line with the richest neighbourhoods.

We will know that we are achieving our outcome if:

- People in the poorest neighbourhoods in Calderdale live for longer
- People in the poorest neighbourhoods in Calderdale live healthily for longer
- The life expectancy gap between the people in the poorest neighbourhoods and those in the richest neighbourhoods is narrowed

Our measures of success

- Life expectancy by electoral ward or Age Standardised Mortality Rate by electoral ward.
- Healthy life expectancy by electoral ward
- Slope index of Inequality.

Our approach to tackling this outcome

We believe the choices we make as individuals affect our health and these are influenced by: the day-to-day pressures we face; the behaviours, aspirations and peer pressure of those around us; the neighbourhood and environment we live in; and, the messages we receive from the news and media.

The approach we are taking to improve people's health in Calderdale is to focus on encouraging and supporting individuals and their families to make healthy choices and to adopt healthy lifestyles. We are also encouraging and supporting communities to take responsibility for the healthy lifestyles of those living there. We are seeking to develop an environment conducive to good health, and ensure appropriate and accessible health and social care services.

Therefore the actions we have committed to taking now focus on working with people in their home and communities to encourage them to think of their own and their family's health, to change their lifestyle particularly in relation to healthy weight, smoking and alcohol, and to signpost them to further specialised help and support where appropriate.

However, more needs to be done in order to have the greatest impact over the next decade on the health of people in the poorest neighbourhoods. This will involve the commitment of organisations and communities to work together over a number of years. It has been recognised that to achieve real health improvements over the long term: organisations need to be more joined up in persuading people to adopt a more active lifestyle; the efforts of several organisations need to come together to provide a seamless package of support for people experiencing housing problems; the staff in all organisations need to be involved in efforts to encourage and support people in their homes and communities to live healthier; and, young people and adults in schools and in local areas should be encouraged to help and support their families, friends and neighbours to live healthier lives.

Commitments to action:

- The "Making Every Contact Count" Programme, through which staff working with people in their homes or in a front line position, encourage healthier lifestyles and signpost to the right intervention or organisation.
  <u>Delivery Partners</u>: NHS, Council, Voluntary and Community Sector, Fire Service, Police, Housing providers

- Make homes smoke free in Calderdale to protect children and young people from second hand smoke
  <u>Delivery Partners</u>: NHS, Council, Voluntary and Community Sector, Housing Providers, Fire Service

- Ensure all 40-74 year olds are invited for a health check over the next 5 years
  <u>Delivery Partners</u>: NHS (including GPs)

- Expansion of the weight management programmes in Calderdale
  <u>Delivery Partners</u>: NHS, Council, Voluntary and Community Sector

- Increase the number of health champions working in priority neighbourhoods
  <u>Delivery Partners</u>: Council, NHS Voluntary and Community Sector

- Improved pathways for people with alcohol problems
  <u>Delivery Partners</u>: NHS, Council, Voluntary and Community Sector

Calls to action:

- A major integrated programme to improve healthy lifestyles and make Calderdale a place where more people enjoy being active, based on the format of "Active Calderdale", developing a brand and profile, which encourages people of all ages to develop a more active lifestyle.

- An integrated "wrap-around" programme for people with a range of problems related to their housing situation (such as possibly losing their home), which addresses issues such as debt, worklessness, redundancy and subsequent mental health issues.

- To extend "Making Every Contact Count" to include all organisations in Calderdale

- Develop a cohort of mentors, role models and champions, including young people as peer mentors, to work in schools to encourage young people and their parents to live healthier lives. The project would recruit local people leading healthy lives as mentors and champions to promote the "if I can you can" ethos.

CALDERDALE IS A PLACE WITH A BALANCED AND DYNAMIC LOCAL ECONOMY

Why this is a priority for Calderdale

For its income and employment, Calderdale relies on businesses in manufacturing and financial services, although the public sector too is a major contributor. Action is needed to support existing businesses to stay in Calderdale, and to attract and develop new business and employers from a range of sectors, particularly those with the potential for good growth in the future.

The increase in youth unemployment over the last few years is a major concern and unemployment in general remains high in certain areas of Calderdale.

What success will look like?

With more business, local people will have more job opportunities requiring a range of different skills. A greater variety of jobs will lead to reduced unemployment in both younger people and in those areas of Calderdale where it has been high.

Increased confidence about the future will continue to attract new investment into Calderdale, resulting in a more sustainable economy.

We will know that we are achieving our outcome if:

- Existing businesses stay in Calderdale
- New businesses and employers, especially high growth businesses are developed and sustained
- Unemployment amongst young people and all people living in areas of high unemployment is reduced

Our measures of success

- Gap between births of enterprises and enterprise deaths (Source: ONS Business Demography)
- Survival rate of businesses beyond 2 years(Source: ONS Business Demography)
- Youth unemployment rate (JSA Claimants 18-24 – Source ONS/NOMIS)

Our approach to tackling this outcome

The approach we are taking reflects the fact that only in the longer term can our actions have any impact on the structure and size of the Calderdale economy. During these challenging and fluctuating economic times, there is little that can be done by the public sector to directly create businesses and jobs. We believe that the public, private and not for profit sectors working together should focus on developing a supportive environment and enabling an infrastructure both physical, digital and environmental that is conducive to attracting sustainable business growth and employment. Similarly, in order to develop an appropriate local skills base to meet future business needs a long term approach involving all sectors of the economy is

required. Crucial to our long term prosperity is being very clear about, and promoting, what makes Calderdale a good place to invest, work, live and visit.

The actions that we are committed to now reflect this long term approach. Clarifying future land and infrastructural options over the next fifteen years is central to providing for the future needs of business and jobs. Supporting local businesses, social enterprises and helping young people to get training and job opportunities during the current recession is a crucial part of preparing for future growth. Making the most of local producers and services and linking them up to create local supply chains supports the retention of profits, income and jobs in the District and helps to make us more economically resilient. Working with education and training providers, businesses and not for profit organisations to plan skills training will ensure we are meeting future business and skills needs.

A number of proposals have been identified to develop the economy in the longer term and to ensure it remains dynamic - creating jobs and income into the future. These actions will require further discussion, clarification and commitment from many organisations across the business, public and not for profit sectors. One stop shops for businesses and skills have been identified to reduce confusion and simplify access to support business creation and growth.

Additionally, attracting new business and investment from outside the District is seen as equally important to our economic health and establishing a private sector-led agency to achieve this is also a key proposal. Promoting local business success and encouraging a 'buy local' approach amongst business and consumers builds on current actions and helps create economic resilience in the longer term as well as potentially helping to diversify our business structures through the establishment of social enterprises. Directly tackling unemployment through a funding programme and supporting businesses to train apprenticeships will provide help, particularly for young people, to gain useful experience and skills, crucial to support economic growth in the future.

Commitments to action:

- The production of a Local Plan setting out the priorities and policies for sustainable development for the period to 2029 – setting out for consultation the Council's preferred spatial options for housing and economic growth in Calderdale.
  Delivery Partners: Council, Utility companies, Infrastructure providers, local residents

- Support through the Council's Economic Fighting Fund of £2.8m to assist business start-ups and improvement, social enterprises, a youth employment programme and a Creative Calderdale network.
  Delivery Partners: Council, Mid- Yorkshire Chamber of Commerce, Halifax Opportunities Trust, Calderdale College, Job Centre Plus, Training providers, Halifax Courier

- A Totally Locally marketing and branding campaign to support local growers, producers and services.
  <u>Delivery Partners</u>: Council, Totally Locally.

- A review of Post 16 provision - to ensure appropriate capacity and choice to support the future workforce.
  <u>Delivery Partners</u>: Council, Calderdale College, Secondary and Higher Education Providers

- Implement the 'Raising Participation Strategy' - to ensure young people are appropriately skilled and work ready.
  <u>Delivery Partners</u>: Council, Calderdale College, Training Providers, Voluntary and Community Sector Providers

Calls to action:

- Create a Calderdale One-Stop Business Offer.

- Establish an Inward Investment Agency – private sector-led.

- Encourage businesses and people to buy locally- seek to develop local supply chains.

- Develop a "made in Halifax campaign" using business success stories.

- Review and refresh the Council's economic strategy to take account of changing local, regional and national developments.

- One Stop Skills Agency (Apprenticeships) - a one stop skills point for employers to find their apprentice.

- A 'Future Jobs Fund' type programme to combat unemployment.

- Apprenticeship Training Agency – sector-based model for small and medium sized enterprises (SMEs).

CALDERDALE IS A PLACE WHERE FEWER CHILDREN UNDER THE AGE OF 5 LIVE IN, AND ARE BORN INTO, POVERTY.

Why this is a priority for Calderdale

Children who are born into a family in Calderdale living in poverty are more likely to end up living in poverty as an adult. In Calderdale, 21% of children are living in poverty which equates to 9,660 children, of which approaching 5,000 are estimated to be below 5 years of age.

Living in poverty means that children will not do as well at school, get a job or go into training for a job. There is a greater risk of ill health, substance misuse, domestic violence and becoming a teenage parent.

What success will look like?

Reducing the numbers of children living in, and born into, poverty means there will be fewer babies born with low birth weight and fewer infant deaths under the age of one. It will also mean that children have better physical and mental health, making them ready for school.

Families will have more income and claim less welfare benefits.

We will know that we are achieving our outcome if:

- Numbers of children under 5 living in or born into poverty are reduced

- Families with children in poverty become more financially independent

Our measures of success

- Children aged 0-4 in families in receipt of Child Tax Credit (<60% median income) or Income Support/Job Seekers Allowance
- Children in families in receipt of Child Tax Credit (<60% median income) or Income Support/Job Seekers Allowance
- A reduction in the under 18 conception rate

Our approach to tackling this outcome

Success in achieving a reduction in child poverty relies mainly on providing employment opportunities in order to raise income levels. Additional jobs can only be provided in the longer term and will be located primarily in the private sector. Our challenge is to support sustainable growth in the local economy, in order to increase local jobs and provide opportunities for parents in low income families to enter employment and receive a living wage.

Our approach is to create the conditions in which businesses will thrive and more jobs might be generated over the medium and longer term.   Recognising that tackling child poverty requires considerable focus on families and that many

organisations and services can have an impact on the family situation, a strategic approach to child poverty to clarify objectives and identify where actions are taken is being developed. Securing a public and private sector commitment to a living wage policy could impact positively upon the income levels of poor families thus raising them out of poverty. Other support is currently being provided, mainly in partnership with the voluntary sector to help and support families with debt problems and benefits. Actions that directly address infant mortality, which is often a result of family poverty, are also being taken.

The actions we have already committed to therefore reflect our desire to target and support those most at risk of being born into or living in poverty. There is however much more to do over the next decade if we are to understand and change the nature of poverty, and support the most vulnerable groups. Future activities involve training front line staff to recognise and support those families and children most in need and to assess the appropriateness of current service provision. More knowledge is needed in order to assess the extent and depth of child poverty within the private rented housing sector in order to better understand the problem and devise responses. Support to help those in need to develop skills to deal with home and family demands, to manage finance and to enter the employment market is also proposed. Increasing the aspirations of children, along with other interventions, could in the long term reduce the numbers of children born into poverty who end up in poverty as adults.

Commitments to action:

- The development of a strategy for tackling child poverty based on the needs identified in the 2011 Child Poverty Needs Assessment and taking account of the impact of Welfare Reform on child poverty.
  Delivery Partners: Council, Clinical Commissioning Group, Schools, Police, Voluntary and Community Sector (including Calderdale Citizens Advice Service)

- To secure a commitment to a living wage policy for Calderdale, the success of which will be measured by its inclusion in future procurement rules and the commitment of a leadership group of private and public sector employers.
  Delivery Partners: Council and Public and Private Sector Employers

- Amelioration of the effects of the recession – support for advice services, including giving people access to information and advice on benefits services, financial inclusion and other issues affecting their health and wellbeing.
  Delivery Partners: Council, Voluntary and Community Services

- A Demonstration Project in Park Ward set up to explore ways of reducing infant mortality - Targeted work with pregnant women and young mothers to encourage them to choose healthy lifestyle choices, to improve health outcomes for them and their babies.
  Delivery Partners: Public Health, Council, Midwives, Health Visitors, Children's Centres, Calderdale Safeguarding Board, The Park Initiative, Halifax Opportunities Trust

Calls to action:

- Review training for front line staff, set against criteria of what needs to be delivered differently, encouraging increased understanding of the spectrum of current provision and how this can be used more effectively to target those most in need.

- Improve knowledge on levels and nature of poverty in private rented accommodation.

- Further develop a 'Resilience Programme' to help the most vulnerable groups, and those who could fall into that category, to manage personal finances, keep their home, and access life and vocational skills.

- Develop a programme to raise aspiration amongst children and young people.

CALDERDALE IS A PLACE WHERE CHILDREN AND YOUNG PEOPLE ARE READY FOR LEARNING AND READY FOR LIFE

Why this is a priority for Calderdale

Some children and young people from low income families living in areas considered deprived may not have the same opportunities or experiences as other children in Calderdale. This affects their early development, ability to learn and can have a serious impact on the opportunities available to them later in life.

What success will look like?

Education improves life chances. If children across Calderdale are able to make expected progress and achieve learning outcomes, in line with or greater than the national average, this will increase their long term participation in education and training and support their successful transition to working life.

Young people will successfully enter the labour market and, as a result, will be healthier, safer, more likely to contribute to their community and less likely to raise their own children in poverty.

Children and young people will share their experiences about their own heath and well being and this will help to improve and target service provision.

We will know we are achieving our outcome if:

- More children in deprived areas are school ready by the age of 4.

- More young people at the age of 18 will achieve education outcomes in line with or above the national average.

- More children, young people and families will feel safe at home, in school and in their community.

- There are increased numbers of young people accessing apprenticeship places.

- There is a decrease in the number of unemployed young adults aged 16-24.

Our measures of success

- Narrow the gap between lowest achieving 20% in the Early Years Foundation Stage Profile and the rest to national levels
- Reduce the inequality gap - KS2 & KS4 gap between pupils eligible for Free School Meals and peers to national levels
- An increase in the number of young people reporting that that they never feel unsafe at home, school and community through the Electronic Health Needs Assessment (e-HNA)
- Maintaining a low level of 16 – 18 year olds who are 'Not in Education, Employment or Training' (NEET)

Our approach to tackling this outcome

The approach we are taking to tackle this outcome focuses on ensuring high quality education, skills and training, to equip children and young people with the tools they need to be ready for learning and for life. Our aim is to ensure the best possible start for all our children by working with and supporting families. We will encourage and value the contribution of young people to society and their communities, engaging them as active participants in the shaping of Calderdale.

The actions we have committed to, demonstrate a determination to tackle this outcome from a multitude of different angles. They include actions aimed at: improving the outcomes for looked after children, early year's settings, educational attainment, and preparing and supporting young people for their progression into work.

Commitments to action:

- To undertake e-HNA survey with all year 10 students and a pilot with year 6 pupils - Present the outcomes from the survey to head teachers and governors and develop an action plan in response to the outcomes.
  <u>Delivery Partners</u>: Public Health, Council, Secondary and Primary Education providers, School Governors

- To deliver the actions in the Single Integrated Improvement Plan to secure systemic and sustainable change in children's social care services.

- To engage with Early Years settings to support quality improvement through a challenge and support model.
  <u>Delivery Partners</u>: Council, Child Care providers, Voluntary & Community groups, Parents and Carers

- To review Child Care provision across Calderdale and ensure resources are targeted at those most in need.
  <u>Delivery Partners</u>: Council, Child Care providers

- To determine the specification for Children's Centre delivery in Calderdale, with resources target at those most in need and clear ready to learn outcomes established to monitor performance.
  <u>Delivery Partners</u>: Council, service providers - including the VCS, NHS, Schools

- To support and challenge schools, through the self improving school system, to ensure children and young people achieve expected levels of progress and learning outcomes in all phases of education.
  <u>Delivery partners</u>: School clusters, School Governors, Council

- To implement an information sharing agreement between schools and produce a data booklet, shared with school governors, which will ensure transparency and improve outcomes.
  Delivery Partners: School clusters, School Governors, Council

- To create an Early Intervention delivery model in localities with partners targeting resources on those most in need as early as possible.
  Delivery Partners: Council, NHS, schools, VCS

- To agree Calderdale's Partnership Strategy to Raise Participation in line with statutory requirements.
  Delivery Partners: Council, Calderdale College, Voluntary & Community groups, Local Employers, Secondary Education Providers, Parents, Carers, Young People, Calderdale & Kirklees IAG provider, National Apprentice Service

- Develop a coherent vocational offer with providers to achieve progression from learning into work, including foundation learning pathways.
  Delivery Partners: Council, Calderdale College, Secondary and Higher education Providers, Voluntary & Community groups, Calderdale & Kirklees IAG provider, employers

- Development of sector skills academies for key sectors with skill shortages, built in paid work experience, progressing into pre- apprenticeships / apprenticeships.
  Delivery Partners: Council, College, Voluntary & Community groups; Workwise, Job Centre Plus, Training providers, Princes Trust

- A Youth Employment campaign.
  Delivery Partners: Council, Return to Work Group, National Apprenticeship Service, Training providers, Job Centre Plus, Skills Funding agency, Calderdale College, Halifax Courier

Calls to action:

- To roll out the new Early Years Foundation stage, review child care provision and commission the delivery of Children's Centres to target resources and drive up standards.

- To engage all partners in the delivery of the Early Intervention Strategy

- To fully implement the self improving school model in partnership with schools and governors.

- To agree key actions arising from the e-HNA survey in discussion with schools and learning providers.

- To implement the Raising Participation Strategy and outcomes from the Post 16 review.

- To develop a coherent vocational offer in Calderdale.

CALDERDALE IS A PLACE WHERE OLDER PEOPLE LIVE FULFILLING AND INDEPENDENT LIVES

Why this is a priority for Calderdale

The age structure of the Calderdale population is projected to change in the coming years, with a notable increase in the number of people aged over 65.

This will have a significant impact on the health and social care needs of the population, including:
- an increased burden of chronic diseases associated with old age
- an associated increase in demand on health services
- an increase in the demand for adult social care services across all client groups.
- Specifically, an ageing population will also have an impact on neurological, rheumatologic and orthopaedic conditions, dementia and falls, and social and physical isolation.

What success will look like?

Older people will be supported to remain in control of their lives and stay comfortable in their own homes for as long as they want.

Older people will be safer, warmer and more physically and socially active and will manage their own long term conditions, which will lead to fewer emergency admissions to hospital and less demand for traditional health and social care services.

The partners and carers of older people will get appropriate advice and support when they need it.

We will know we are achieving our outcome if:

- More older people feel they have control of their lives and are comfortable in their own homes.

- More older people with chronic long-term conditions manage their condition from home

- Fewer emergency admissions to hospital by older people and less demand for traditional health and social care services.

How we will measure success

- Fewer emergency admissions for patients aged 65 or over/ Care home placements
- Fewer Care home placements
- Survey of how much control older people (social care users) feel they have over their daily life.
- Smaller proportion of older people receiving formal community care assessments

Our approach to tackling this outcome

The approach we are taking to achieve fulfilling and independent lives for Calderdale's older people focuses on supporting people to find their own solutions within their own communities. We aim to improve the health and wellbeing of older people through early and preventative interventions, supporting them to be less dependent on statutory services. We will also support older people to remain active participants in their communities. Our approach over the longer term will include helping people to plan for their older age, with the aim of ensuring their own good economic wellbeing.

Therefore the actions we have committed to taking now focus on providing services and support to enable older people to take control of their lives and feel supported within their homes and neighbourhoods, whilst also ensuring that those who are vulnerable are kept safe.

However, to better meet the challenges of an ageing population and also achieve positive outcomes for Calderdale's older people over the term of this strategy, we need to come together with partners to concentrate our efforts on providing integrated, personalised and innovative ways of increasing choice and control, aimed at early intervention and centred around the future needs of individuals.

Commitments to action:

- To offer services and support that aim to promote personal resilience and inclusion within communities.
  <u>Delivery Partners</u>: Council, NHS, Voluntary and Community Services, Social landlords; Police; Neighbourhood schemes

- To help people remain connected to their communities wherever possible.
  <u>Delivery Partners</u>: Council, NHS, Voluntary and Community Services, Social landlords; Neighbourhood Schemes, Care Providers

- To safeguard adults at risk of abuse.
  <u>Delivery Partners</u>: Council, NHS, Police, Care Providers

- To expand the support available for people to adapt their homes or make positive choices over their housing options.
  <u>Delivery Partners</u>: Council, Social and Private Landlords, NHS, Voluntary and Community Services

- To adopt a positive attitude and approach to older people.
  <u>Delivery Partners</u>: Council, NHS, Voluntary and Community Services, Social landlords; Police

Calls to action:

- Training for all front line staff in valuing and respecting older people, to promote dignity and to reduce assumptions and stereotyping.

- Personalised planning - professionals working with individuals to enable them to develop their own personal care plans.

- Housing research to find the best ways to develop improved housing facilitates to help keep older people comfortable at home for as long as possible,(this will include short, medium and longer term solutions and the necessary financial options to fund).

- Health Information Hub - including health promotion, prevention activities, housing and carer support (broadening out the current "Connect to Support" service).

- Expansion of the "Making Every Contact Count" service to ensure all staff who have contact with older people are able to refer, offer early intervention or signpost in a positive way that focuses on individual need.

- Development of a system of shared intelligence across all organisations that come into contact with Older People (including research, data and analysis of evidence from the NHS, Adult Social care, Age UK, Older People Forums, other Third Sector Bodies).

- Use customer insight to develop a range of preventative activities to improve the quality of people's lives.

- Introduce telehealth and expand telecare, e.g. develop a care navigation model, where phone contact is made with individuals and visits made if a person's position changes.

- Adapt the recent partnership approach taken to supporting people with dementia, (initiated by an in-depth scrutiny exercise), to support the development of plans for other long-term conditions, with the inclusion of preventative measures.

CALDERDALE IS A PLACE WHERE EVERYONE HAS A SENSE OF PRIDE AND BELONGING BASED ON MUTUAL RESPECT

Why this is a priority for Calderdale

Compared to other areas in West Yorkshire, fewer people in Calderdale say they feel that people from different backgrounds get on well together.

Improving relationships within and between different communities so they get on well together and mix easily will help to increase people's sense of belonging to their neighbourhood and to Calderdale as a whole. Understanding that we are all different and accepting and respecting differences is a key sign that people within our communities are becoming more confident.

What success will look like?

People feel part of their community and feel they can influence decisions in their local area and play a part in shaping its future. This may happen in many ways including; by doing voluntary work for local communities or charities, being school governors, magistrates or councillors.

Trust in local statutory agencies like the police and the council will improve and local communities will have an increased understanding of their rights and responsibilities.

Where people from different backgrounds have similar life opportunities they will develop strong and positive relationships with each other in the workplace, in schools and within neighbourhoods.

We will know we are achieving our outcome if:

- More people living in Calderdale feel a sense of belonging to their neighbourhood and to Calderdale as a whole

- More people have confidence in local statutory agencies

- More people feel that they can influence local decisions

How we will measure success

Currently the West Yorkshire Police Authority Survey is the main source of data. This provides data on:
- The number of people who strongly agree or agree that their local area is a place where people from different backgrounds and communities live together harmoniously
- The number of people who report that they are satisfied with how the police and council are dealing with ASB/crime

We are working with our partner authorities at a Regional level to agree a basket of indicators to improve the measurement and tracking of this indicator.

Our approach to tackling this outcome

Our aim is to work locally with our communities to help them develop a sense of pride and place. We will also engage local communities to ensure they have influence over the things that affect their lives.

There are a number of key issues in the immediate future that will impact significantly on this outcome such as the forthcoming Welfare Reform programme, the establishments of Police and Crime Commissioners, public sector reform and the continued economic recession. The actions we have committed to taking are therefore aimed at managing the impact of these challenges and building on the successes we have already achieved to maintain and increase the confidence and resilience within our communities.

Although significant work has been undertaken to support communities to become more cohesive and resilient, there is still more to do. We will continue to build better relationships and trust between Calderdale's different communities, through meaningful community involvement and engagement, to shape neighbourhoods and services.

Commitments to action:

- Produce a Partnership Confidence Strategy, which links individual to individual or locality confidence plans.

- Increased partnership work and visibility to offset reduction in budgets within individual services.

- Effective Multi-agency problem solving around safer cleaner greener issues raised as local priorities.

- Collaboration around services delivered through locally shared contact points.

- Continued commitment to Neighbourhood Teams and Neighbourhood Policing.

- Increase resilience in communities, the ability to respond to challenge driven by local or national agendas.

- Manage the impact of the Welfare Reform and Universal credit on the residents of Calderdale.

- Implement the Troubled Families Strategy in partnership through the appointment of key workers.

    The Delivery Partners for all the above actions are the partners on Calderdale's Community Safety Partnership, as follows: Police, Council, NHS, Together

Housing, West Yorkshire Fire Service, Voluntary and Community Sector, West Yorkshire Probation Service.

Calls to action:

- As negative reporting is cited as a key issue, there needs to be a review of communication strategies and plans across partner bodies. Consider how to improve use of the partner website and find ways to engage using social media.

- Develop a strong Calderdale profile and identity that people can be proud of and that generates a sense of pride of place. This needs to be a celebration of place and draw together the rich tapestry of the range of communities.

- Increase community engagement and involvement by all partners and build relationships between and within communities at every opportunity, building trust and promoting a sense of fairness and transparency.

- Build on the existing "Make Every Contact Count" initiative to gain greater insight and local intelligence and using this as a form of customer insight to change or reprioritise services.

6.   Implementing the Strategy

Whilst a number of actions are set out under each outcome in this document, the Health and Wellbeing Board will not be producing a detailed action plan for this Strategy. Instead it will be looking to organisations/partners to support the strategy and deliver through their individual and joint plans/strategies. A list of those partners that are committed to delivering the strategy's priority outcomes is published on the Calderdale Forward website. Where gaps are identified in terms of the actions required to deliver the outcomes, the Health and Wellbeing Board and its members will engage with partners and exert influence to ensure these gaps are filled. Where partners commit to the delivery of an action in the Strategy they will be asked to ensure it is then embedded in their own strategy/business plan.

It is important to note that in many cases the actions identified to deliver a specific outcome will contribute positively to other key outcomes. For example, actions taken to improve people's health will not only have a positive impact on older people feeling more in control of their own lives, but will also minimise the effects of sickness on the workplace.

The Health and Wellbeing Board will discuss and reach agreement with other key partnerships in Calderdale, which of the six priority outcomes individual partnerships might take the lead on and which they might contribute to.

Board members will all work to ensure that their own organisations' plans and strategies support the Joint Wellbeing Strategy and, through their leadership role within their organisation and with partners, will press for the use of evidence to support service provision to meet the Strategy's outcomes.

7.   Assessing the Strategy's performance

The Strategy will be assessed in two ways.

a) Through its progress towards delivering the priority outcomes

The Health and Wellbeing Board has overall responsibility for ensuring progress against the measures of success for the 6 priorities agreed through this strategy. The Board will use current trends in the measures of success to identify the changes achieved.   A report on progress against the measures of success will be published annually although it should be borne in mind that the strategy is a long term one and change on some issues is not expected in the short term, and may not be achieved in the medium term.

The Board will rely on a range of partners to deliver actions against the priorities and report on their performance in delivering these actions. The partners will be expected to provide details of the actions they have taken, give evidence of the

impact on the outcomes in the Strategy. The precise details and timing of these reports will be decided following discussions between the Health and Wellbeing Board and partners.

In addition, a senior group working to the Health and Wellbeing Board will be charged with ensuring performance issues are effectively dealt with and promoting a culture of performance improvement.

b)   As a framework for commissioning

The Health & Wellbeing Board will also use the strategy to ensure that the commissioning plans of key partners, especially the Council and the Clinical Commissioning Group (CCG) reflect the Strategy's priorities. The Local Authority and the CCG will share their commissioning plans with the Health and Wellbeing Board for this purpose.

Detailed assessment of the effectiveness of these commissioning plans is undertaken through the performance systems of the commissioning organisations. Overview reports are presented regularly through arrangement with the Health and Wellbeing Board.

In addition partners will be encouraged to follow an outcome based accountability (OBA) approach to assess their individual and joint contributions to the strategy's outcomes.

South West Yorkshire Partnership NHS

NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 6

Title:	**Strategy Refresh**
Paper prepared by:	Interim Director of Strategic Planning and Contracting
Purpose:	To provide the Trust Board with an update on the development of the Trust Strategy Refresh following the recent Trust Board workshop. To provide the Trust Board with clarity of the intended process to complete the Strategy Refresh.
Mission/values:	Our Trust Strategy provides clear aims and objectives that implement our mission in accordance with our values
Any background papers/ previously considered by:	Trust Board has received regular updates on the strategy refresh process and has contributed to the formulation of the strategy via workshops, including those with the Members Council
Executive summary:	The Strategy Refresh document is a work in progress and is shared with Trust Board at this point to note the progress to date, and the intended process for completion • The Strategy Refresh document brings together the learning gained from the recent engagement and insight exercises with stakeholders. This has included discussion sessions, online surveys, social media, and workshops with Members Council, Trust Board, and the Extended Executive Management Team. **The document sets out the following content:** • Our mission and Values • A summary of the population we serve and the key demographic and health need factors. • A summary of the Services that we provide (to be developed) • A description of the changing context in which we are formulating our strategy (policy, regional and place based collaborations, trends in contracts and income, and the regulatory environment) • A description of the engagement process and the key messages arising. • Our ambition for the future including the key choices we make in relation to strategic issues. • Objectives and measures for the implementation of the strategy • Implementation Plan (to be added) **The plan for completion of the strategy refresh document is to;** • complete writing and cross reference with all enabler strategies in December. • Develop a detailed implementation plan in January • Develop an integrated business plan for 2017/18 that incorporates

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	the actions required to implement the strategy, and those necessary to implement our 2017/18 Operational Plan. This to be completed with service line level plans by March 2017.
Recommendation:	**Trust Board is asked to NOTE the progress made with the strategy refresh, and the suggested process and timescale for completion.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS

NHS Foundation Trust

SWYPFT

Strategy Refresh

December 2016

Interim Director of Strategic Planning and Contracting

Version 0.1

With **all of us** in mind.

Table of Contents

With **all of us** in mind.

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Foreword

to be added – CEO and Chair comments and pictures

1. Our Mission and Values

South West Yorkshire Partnership NHS Foundation Trust is a values led organisation. Our Mission and Values are well established and are recognised and endorsed by the people we work with and the people who work in the Trust.

Throughout this refresh of our organisational strategy our Mission and Values remain consistent. In the face of considerable change to the ways in which the health and care sector works together the needs and desires of the people we serve remain consistent. Therefore so does the purpose of the organisation, and the values which we will embody to achieve our shared goals.

Our Mission

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

Our Values

- 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.

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2. Our Population

We primarily serve the 1.2m people who live across South West Yorkshire in the local authorities of Barnsley, Calderdale, Kirklees and Wakefield. Most of the care we provide is delivered in local communities. This means we work in all the villages, towns and cities from Todmorden and Hebden Bridge in the west, to Castleford and Pontefract in the east and to Hoyland and the Dearne Valley to the south of Barnsley – and all points in between.

For some of our services we work across a wider area, often in partnership with others. For example we provide help for people to stop smoking across South Yorkshire and in many parts of West Yorkshire too. We provide low and medium secure forensic mental health care that serves people across the whole of Yorkshire and the Humber.

We also provide telehealth coaching to help people stay in control of their long term health conditions in Bassetlaw, and we provide specialist mental health support into Wetherby Young Offender Institution.

Our population lives in a mix of rural and urban areas. Population density varies considerably between 573 people per km2 in Calderdale to 1063 people per km2 in Kirklees.

Population Projections

The population of our area is changing in much the same way as the rest of the UK population. The 2015-based population projections estimate that by 2035 there will be 1.34 million living in the area, an increase of 11 per cent on 2015. However, the older population is projected to increase at a much higher rate. The 65+ population is projected to rise by 41% from 2015 to 2035, and the 85+ population by 75% (from 4,700 in 2015 to 8,100 in 2035).

Ethnicity

In March 2011, White British people made up 87% of the region's population, more than the England average of 81 per cent. Black or Black British people comprised 1%, less than the England average of 3%, while Asian or Asian British people comprised 8%, the same as the England average (2011 census). The local authorities with the largest proportions of Asian people were Kirklees (16%) and Calderdale (8%). This profile is likely to change significantly over the next 20 years with BME groups accounting for almost 80% of the

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UK's population growth (Policy Exchange, 2014). While the UK population is generally ageing, among BME communities specifically, this patterned is reversed. The major ethnic minority communities are generally weighted towards the younger generation, with most ethnic minority groups having more than half of their population under the age of 30. In 2016, the estimated median age for the BME population was between 11 and 13 as compared to 40 for the white population'.

Deprivation and Unemployment

Figure 1 shows that the area has almost 4 times as many Lower Layer Super Output Areas (LSOA) in the most deprived quintile (20%) as in the least deprived, with Barnsley having 37% of its population living in the most deprived 20% of the country compared with 25% in Calderdale. The long-term unemployment rate for residents aged 16 in the area was 6.4% in 2015, higher than the England rate of 4.6%. The highest rates of long-term unemployment in the area are Barnsley (7.5%) and Calderdale (6.8%).
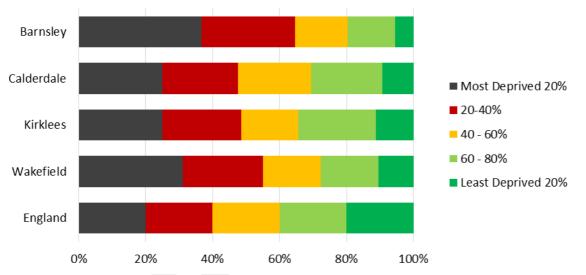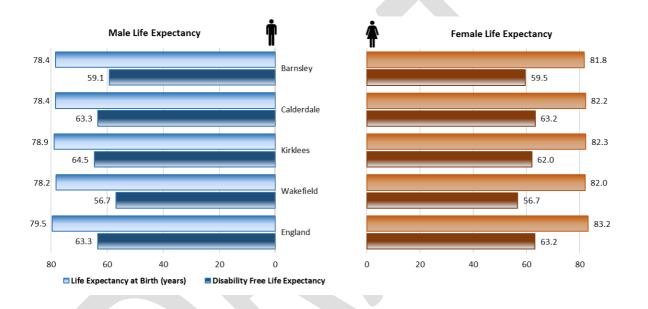
Figure 1. Distribution of lower super-output area rankings for Index of Deprivation (IMD, 2015) South West Yorkshire Partnership Trust Local Authorities

Health

While the local population is living longer, they are not necessarily healthier. Life Expectancy and Disability Free Life Expectancy (DFLE) are extremely important summary measures of mortality and morbidity. They are indicators of the general health of the local

population and will be influenced by socio-economic, environmental and lifestyle factors.

Female life expectancy in the area was 82.1 years for 2012 to 2014, compared with 83.1 years for England. For males, life expectancy was 78.5 years in the area compared with 79.5 years for England. Life expectancy in Yorkshire and Humber is the third lowest of the English regions. Life expectancy is 8.3 years lower for men and 7.8 years lower for women in the most deprived areas of the region than in the least deprived areas.

Male Life Expectancy

Area	Life Expectancy at Birth (years)	Disability Free Life Expectancy
Barnsley	78.4	59.1
Calderdale	78.4	63.3
Kirklees	78.9	64.5
Wakefield	78.2	56.7
England	79.5	63.3

Female Life Expectancy

Area	Life Expectancy at Birth (years)	Disability Free Life Expectancy
Barnsley	81.8	59.5
Calderdale	82.2	63.2
Kirklees	82.3	62.0
Wakefield	82.0	56.7
England	83.2	63.2

☐ Life Expectancy at Birth (years)   ■ Disability Free Life Expectancy

The needs of our population

The health of people in our local communities is generally worse than the England average, and worse than the Yorkshire and Humber average.

Child Health. In 2015, 18.5% (2319) of children in Year 6 were classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 42* (range 30.3 to 54.2) worse than the average for England. This represents 321 stays per year. Levels of GCSE attainment is lower than the England average, particularly in Barnsley. Smoking status at the time of delivery and breastfeeding initiation are also worse than the England average, particularly in Barnsley and Wakefield.

Adult Health. In 2015, 68.5%% of adults were classified as overweight or obese compared with 65% England average. The figure for Barnsley and Wakefield is over 70%.

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The rate of alcohol related and self-harm related hospital stays is worse than the average for England. The rate of smoking related deaths is worse than the average for England. This represents over 6100 deaths per year. Estimated levels of adult smoking (19.6%) and physical activity (55.8%) are worse than the England average. The rates of teenage pregnancy (26.4 per 100,000 females aged 15-17) are worse than the England average (22.8) and particularly in Barnsley where the rate is 36.3.

The percentage of people with a long-term condition or disability is 20.4%, which is higher than the England average (17.6%), with the figure for Barnsley and Wakefield being significantly worse at 22 and 24% respectively. This is also reflected in the health related quality of life figures for adults over 65, with an average EQ-5D score of 0.7 compared with 0.73 for England and Barnsley scoring 0.67.

The rate of cancer diagnosis at an early stage, and premature death from all causes including under 75 mortality from cancer and cardiovascular disease is worse than the England average.

The percentage of persons with a Learning Disability (QoF prevalence, and Adults with a learning disability receiving long-term support from their local council) are higher than the England average. The number of children with a Moderate Learning Disability known to schools (37.7 per 1000 pupils) is also higher than the England average (28.5), particularly in Barnsley and Calderdale where the figure is around 50.

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3. Our Services

Our service model is to provide integrated care to people in their community. Many of our services will be part of joined up neighbourhood teams working hand in hand with primary care and social care. Other services will be provided by specialist teams working across a whole town or district. We also provide some very specialist services which will work across a wider footprint to provide high quality specialist support for needs which are less common.

Insert diagram here

All our services are focused on principles of **recovery** and **co-production**, working with the **strengths** of each person and those of their carers and wider community.

- Recovery is about a person living a satisfying and hopeful life, with or without limitations caused by illness.

- Co-production is the way we work - through equal and reciprocal relationships between people using services and professionals; recognising that both partners have vital contributions to make.

- Working with Strengths means providing opportunities to recognise and grow people's capabilities and actively support them to put them to use at an individual and community level.

We currently deliver services across a wide range of needs and specialisms. In the future it is our intention to continue delivering services for people of all ages across the full spectrum of need.

Prevention and Wellbeing

Add text

Integrated Community Services

Add text

Inpatient Care

Add text

Specialist Services

Add text

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4. Our Context

We are already a successful well-established Foundation Trust which means we are refreshing our strategy from a position of having achieved relative financial stability, and delivered many high quality services. However the context in which we operate is changing so we must adapt with it to continue to meet the needs of our population in the future.

Policy

The legislative framework for the NHS has not changed since the 2012 Health and Social Care Act which established Clinical Commissioning Groups and reinforced the use of competition as a driver of improvement.

However in the intervening years there has been a major shift in the emphasis of policy towards increased collaboration and a continued drive to empower and support people to take charge of their own health and wellbeing. This direction fits well with the ethos of the Trust to enable and work in partnership, and with the service portfolio of the Trust which is community based and focused on recovery and prevention. **We are well positioned to make a strong contribution to the future of health and care.**

The Five Year Forward View signaled an intent to focus on prevention, engage communities, and where necessary to change organisational and contractual approaches to achieve the 'triple aim' of better health outcomes, better quality of care, and better use of resources. Since April 2016 the triple aim has informed our Trust strategy.

Our Strategic Goals

- Improve people's health and wellbeing
- Improve the quality and experience of all that we do
- Improve our use of resources

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Regional and local change

We work together with partners across health and care to make the triple aim a reality. One of the significant ways we do this is through active participation in the shaping of Sustainability and Transformation Plans for both South Yorkshire and West Yorkshire, and through the development of ambitious shared plans for each of the places we work; Barnsley, Calderdale, Kirklees, and Wakefield.

Our strategy is informed by and informs the STPs. There are opportunities for us to contribute in all our service areas as both STPs work through a mix of place based delivery plans, and STP-wide thematic plans where scale and consistency is important. For example working together to optimise the stroke pathway for South Yorkshire, or collaborating on low and medium secure forensic services to help more people receive care closer to where they live.

In addition to greater collaboration between providers of care, commissioners are also collaborating to share expertise, operate efficiently and to improve quality. This means that we will work with providers to offer a joined up service response where required – e.g. if mental health beds are commissioned once for West Yorkshire by a commissioning collaborative.

In all of the places we work there are plans to develop new models of care delivery and new ways of contracting and commissioning care. The purpose of this is to support the achievement of the triple aim – better care, better quality, and better use of resources. This may also require new partnerships and new organisational forms if existing structures are blocks to progress.

It is not intended to dwell on detailed considerations of the specific models of integrated care such as 'Multi Speciality Community Provider' or whole system approaches to integrated commissioning and provision through 'Accountable Care Organisations'. However it is noted that a significant element of the context in which we are refreshing our strategy is **an increased freedom to collaborate to redefine local health and care systems**. This will require us to build upon our partnership working strengths, apply our values to constantly improve and aim to be outstanding; so we can be relevant today, and ready for tomorrow.

A summary of some of the opportunities available to us through these contextual changes are set out at figure ___ below.

- **STPs**
- Liaison in general hospitals & with police
- Suicide prevention
- Reduce out of area placements
- Low and Medium Secure Forensic
- CAMHS – alternatives to admission

- **5 Year Forward View**
- IAPT
- EIP
- Perinatal
- Future in Mind (CAMHS)
- Primary care

- **Business Development**
- Health in Justice e.g. Liaison & Diversion
- ADHD and ASD – consolidate income
- Transforming Care
- Telehealth coaching and care navigation
- Individual Placement and Support

- **Partnerships and Joint Ventures**
- Back office collaboration
- Consolidate community service provision
- Health and wellbeing
- Care Integrators
- Care Homes/ Home Care

Contracts and income

The majority of the Trust's income comes from the contracts we hold with local CCGs, local Councils and NHS England's specialised commissioning function. In 2016/17 we anticipate receiving £X income. Of this Y% is contingent on achieving specific quality targets and Z% is contingent on delivery of particular activities and outcomes. For example the number of people who we support to stop smoking.

Each year many of our contracts are subject to competitive tendering. This gives us opportunities to gain services where this helps us to better achieve our mission, but it also means that some services may be transferred to other providers, or decommissioned altogether. The consequences of tendering are felt by the people who use services and who work in them. This can be positive, where quality improvements are enabled. Tendering also has financial implications for the Trust and our ability to operate effectively.

The general trend over recent years has been for the value of contracts to decline each time they are tendered, which reflects the wider context of austerity. This has been particularly the case in respect of public health services which are commissioned by local authorities.

With **all of us** in mind.

Consequently the annual income of the Trust has declined by X% between 2013/14 and 2016/17. In 2017/18 there are X services with Y staff and Z income (XX% of the anticipated total income) that will be subject to re-procurement or incorporation into alliances or new models of care.

The contracting and income context will remain challenging. This has several implications for our strategy.

- We must work effectively with both competition and collaboration

- We must remain focused on quality improvement, and on communicating the great things we do

- We must continue to strive for efficiency, which we will increasingly find through innovation

- We must proactively pursue growth in the service areas that best enable us to deliver our mission

Regulation

The regulation of health and care continues to be reformed. There is now closer collaboration between the regulation of systems, governance and finance; and regulation of quality. There is also a shift towards system-wide regulation, which reflects the collaborative ethos of STPs and the Five Year Forward View.

The regulatory environment has also become tighter, with closer scrutiny and fewer freedoms to act. In that context **it is critical that we maintain our high standards in delivery every day, and take fast, effective action to rectify issues where they arise**.

It will be challenging to do this while working within an increasingly tight budget; and to focus on system wide working while we also focus on service delivery, but we recognise the importance of doing so. A failure to do this will undermine our ambitions to be a leader in place based care.

Our regulators the Care Quality Commission and NHS Improvement have highlighted some important areas where we need to change;

- The CQC (Care Quality Commission) inspected our services in 2016 and rated our Trust *Requires Improvement*. While noting that this overall rating masks the many

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Good and several *Outstanding* ratings contained within our assessment, we welcome the learning opportunity. We have embraced the challenge to demonstrate the improvement we have made when the CQC revisits in 2017.

- NHS Improvement introduced a new approach to evaluating the financial and governance performance of NHS trusts during 2016. The Single Oversight Framework has recognised the deteriorating trend in our finances and in particular has highlighted control of spending on agency staff as a significant cause to be addressed.

It is a strategic priority for us to address these issues highlighted by regulators, not because of the potential regulatory consequences, but because they indicate **opportunities to better meet the needs of our service users as effectively and efficiently as possible**.

With all of us in mind.

5. Refreshing our strategy

In the context set out above we have engaged with our stakeholders to help refresh the Trust's strategy to ensure we remain relevant today and ready for tomorrow.

We have done this by speaking with people individually and in workshops, asking their views digitally using surveys and social media, and through our formal governance structures such as the Members Council and Trust Board. Through these approaches we have been able to hear the views of people who use our services, people who work in the Trust, and others who take an interest in our work.

We have also asked an independent research company to specifically talk with key stakeholders in the organisations we need to work with to test their perceptions of us and our ambitions for the future.

This has provided a rich picture that has informed our future strategic direction. In summary the key messages that people have shared with us are;

Working with our communities

The people we talked to endorsed the idea that we should continue to focus on working with communities to support people to stay well and to intervene at the earliest opportunity if people become unwell.

People highlighted many areas of existing good practice in working with communities and suggested that we should continue and make this a bigger part of our work, as it is effective and fits our mission and values.

This would mean doing more with Recovery Colleges, Creative Minds, Care Navigation, and working with partners like Altogether Better. Many opportunities were highlighted to us for closer working with schools and community groups. The importance of supporting volunteers was a clear message.

It was also noted that there are many types of community - based on shared interests and backgrounds as well as on geography or diagnosis. Some communities asked us to do more to work with them to ensure help is accessible in ways that are sensitive to the needs of all cultures. We will do this by working and learning together with existing community groups.

With **all of us** in mind.

Joined up services

People told us that they agree with our ambition to treat the physical and mental health needs of individuals holistically and in a joined up way. They also recognised that it is important to take a wide view of the social factors that impact on health.

Many people highlighted the importance of working well with the voluntary and community sector as part of a joined up approach. It was suggested that there are many good examples of such partnerships across that Trust, as well as opportunities to do more.

It was also noted that there are positive examples of 'multi-disciplinary team' working, and of integrated locality or neighbourhood teams. People suggested that we can learn from these examples as we continue to develop joined up, holistic care.

Several people told us about their experiences of moving between different services. It is clear that this does not always work as smoothly as it should, and it is a cause of worry for people and their families. We agreed we would work together to make the experience as smooth and easy as possible. This includes transitions between young people's services and those designed for adults; making it easier to move between hospital and community based services; and between secondary care and primary care.

Relationships and positioning

People told us that they see SWYPFT as ambitious, dynamic and well-led. People identify with our mission and values, and agree that we generally act in accordance with them. However they also note that as a large organisation we can sometimes appear to value consistency over localism, and they would like to see us be more flexible. The survey also highlighted opportunities to empower our service delivery teams to innovate.

Our survey confirmed that we are primarily known as a mental health provider by many stakeholders. This means we need to do more to engage with people and help them understand the full range of our activities. This is particularly important in view of our ambition for the future, which is focused on holistic, place-based care.

In particular it is important that we focus on our relationships with GPs, in terms of day to day delivery through key link contacts, and also in the development of strategic alliances.

System leaders told us that they see SWYPFT as central to the formation of local place-based accountable care systems. They endorse the idea of SWYPFT acting as an integrator of care, and would like to see us working in partnership to achieve this.

With **all of us** in mind.

6. Our Ambition

Our Mission and Values (Section 1) will remain consistent throughout the delivery of this strategy. Our Mission is **to help people reach their potential and live well in their community**. Our Values are;

- To put **people first and in the centre** and recognise that **families and carers matter**

- To be **respectful** and **honest, open and transparent** in our dealings, to build trust and act with integrity

- To constantly **improve and aim to be outstanding** so we can be **relevant today, and ready for tomorrow**

Equally we will remain committed to the achievement of the consistent strategic goals (Section 4) which are in effect to deliver the 'triple aim' of

- Improving people's health and wellbeing

- Improving the quality and experience of all that we do

- Improving our use of resources

Strategic Choices

The process of refreshing our strategy requires us to make choices. Through the conversations and analysis described above we have clarified the following choices;

- We will take a **place-based approach** to the delivery of care. Except where a service based approach over a wider area is more appropriate e.g. forensic mental health.

- We will continue to be a **combined provider of care** with expertise in prevention, physical healthcare, learning disabilities and mental health.

- We will act as a **system integrator**, and in some places we may host accountable care partnerships. We will do this alongside our service delivery activities.

- We will become an **exemplar of co-production**, valuing both the service user and clinical perspectives.

With **all of us** in mind.

In order to make a marked difference in delivery of our mission and strategy, we have set the following ambition for the next five years;

Our Ambition

Become the leading operator of accountable care systems in West and South Yorkshire, by co-producing with people a holistic and recovery focused approach to improving health outcomes for everyone

With **all of us** in mind.

7. Our Strategic Objectives

In order to implement this strategy and to measure its achievement it is important that we break down the overall goal and ambition into specific objectives that help us clarify the actions to take.

This section sets out our strategic objectives.

Objectives	Measures of Success
Deliver financially sustainable and high quality services across the full range of Trust activities from 2017/18 onwards	• Single Oversight Framework 'Segment 1' • CQC rating of at least 'Good' • All BDUs in financial balance individually as well as collectively
Co-produce holistic, integrated models of care that improve outcomes. Implement new models by 2018/19	• Key Outcomes (from user perspective) baselined by Q2 2017/18 • Holistic and integrated models of prevention, physical and mental health piloted in at least two 'places' by Q4 2017/18 • Learning from pilots assimilated and 'target operating model' for each place agreed by Q3 2018/19 • Implementation by Q4 2018/19
By 2019/20 become a leading integrator of place based systems of care	• Skills and competencies understood and baselined by Q2 2017/18 • SWYPFT model of systems integration developed by Q3 2017/18 • Due diligence undertaken on two most likely place based systems of care by Q4 2017/18

This section is for illustrative purposes – requires collaborative development

With **all of us** in mind.

8. Implementation

This Strategy Refresh document provides a summary of the recent work to help establish the future direction for the Trust. In order to implement the Strategy a more detailed implementation plan will be required.

It is proposed that this is developed in conjunction with the 2017/18 and 2018/19 Operational Plan so that there is one Implementation Plan that addresses both requirements. This will be developed at both 'business unit' and trust-wide levels during Quarter 4 2016/17. This will provide a golden thread by the start of 2017/18 whereby every team will understand their contribution to the achievement of the operational plan and longer term strategy. This will enable individual objectives to be aligned as part of the 2017/18 appraisal process.

With **all of us** in mind.

South West Yorkshire Partnership NHS

NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 7.1

Title:	**Integrated Performance Report Month 8 2016/17**
Paper prepared by:	Director of Finance
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for November, 2016.
Mission/values/objectives	All Trust objectives.
Any background papers/ previously considered by:	Not applicable.
Executive summary:	**Quality** • Medicine omissions (refusals) position has deteriorated. Actions in place to repeat previous success • First year of 'sign up to safety' plan shows positive outcomes. • CQC revisit plan progressing as anticipated • CQC action plan on schedule • The most significant CQUIN risk relates to the level of flu vaccinations. At the time of writing 62% of front line staff have received a vaccination. In order to retain CQUIN monies 75% of front line staff need to have the vaccination. • Number of reported incidents of 1,146 in November remained in line with recent average • Average staff fill rates were 113% in October. November position will be updated verbally at the Trust Board **NHSI Indicators** • For NHSI indicators the Trust is meeting all established metric targets • IAPT – proportion of people completing treatment who move to recovery was below target in October. Plans are being put in place to improve performance against this target • Reporting is now in place against priority metrics covering employment status and accommodation. Currently there is under-performance and significant progress will need to be made in order to achieve the year-end target. **Finance** • Net deficit of £566k in the month driven by a continued increase in out of area bed placements, CQUIN achievement and timing of ADHD income • Finance Risk metrics have deteriorated in month due to the deficit and variation from plan • Year-to-date pre STF surplus of £0.1m which is £0.7m behind plan • Full year pre STF surplus forecast remains at £0.5m, but with very significant risk attached. Actions being taken to reduce discretionary spend and agency usage. Specific group established to focus on options to reduce out of area bed usage.

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	• Whilst agency spend reduced by £0.1m in the month it remains well above both ceiling and forecast. Cumulatively agency spend is now £6.7m, which is in breach of our full year ceiling of £5.1m. Total pay costs marginally higher than plan in November although £1.5m below plan year-to-date. • £4.2m of asset impairments recognised in month which do not impact on normalised financial position. Impairment relates to independent valuation of specialist buildings and recognition of Keresforth, Fieldhead, CNDH and Baghill House impairments. • Cost improvements delivery to date of £6.1m, which net of contingency is £0.4m lower than plan. Specific issues relate to the use of out of area bed placements and a range of other trust wide schemes. • Cash reduced to £26.2m in the month, which is £1.5m lower than plan **Workforce** • Sickness levels remain at 4.8% • Increased focus required on Information Governance training. Currently at 85.9%. • Best practice training developed for Mental Health Act and Mental Capacity Act. Now mandatory in the Trust.
Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable.

South West Yorkshire Partnership

NHS

NHS Foundation Trust

Integrated Performance Report

Strategic Overview

November 2016

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report for November 2016. This report is as comprehensive as possible at the time of preparation, where information is not yet available the report will be updated and re-circulated to all Trust Board members by December 23rd. The recent developments on the report now ensure that an owner has been identified for each key metric, and the alignment of the metrics with Trust objectives and CQC domains. This ensures there is appropriate accountability for the delivery of all our performance metrics and helps identify how achievement of our objectives is being measured. The report is now more in line with the vision of having a single report that plots a clear line between our objectives, priorities and activities. The intention is continue to develop the report such that it can showcase the breadth of the organisation and its achievements as well as meeting the requirements of our regulators and providing an early indication of any potential hotspots and how these can be mitigated.
It is recognised that for future development stronger focus on outcomes is required and a clearer approach to monitoring progress against Trust objectives would be beneficial.

The integrated performance strategic overview report is a key tool to provide assurance to the Board that the strategic objectives are being delivered and to direct the Board's attention to significant risks, issues and exceptions and will contribute towards streamlining the number of different reports that the board receives.

The Trust's three strategic objectives are:
• Improve people's health and reduce health inequalities
• Improve the quality and experience of care
• Improve our use of resources

Performance is reported through a number of key performance indicators (KPIs). KPIs provide a high level view of actual performance against target. The report has been categorised into the following areas to enable performance to be discussed and assessed with respect to:
• Strategic Summary
• Quality
• NHS Improvement (formerly Monitor)
• Locality
• Transformation
• Finance
• Contracts
• Workforce

Performance reports are available as electronic documents on the Trust's intranet and allow the reader to look at performance from different perspectives and at different levels within the organisation. Our integrated performance strategic overview report is publicly available on the internet.

| Summary | Quality | NHS Improvement | Locality | Transformation | Finance/Contracts | Workforce |

Section	KPI	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Year End Forecast
NHS Improvement Compliance	NHS Improvement Governance Risk Rating (FT)	Green	Green	Green	Green	Green	Green	Green	Not applicable after 30th Sept 16						N/A
	NHS Improvement Finance Risk Rating (FT)	4	4	4	4	4	4	4	Not applicable after 30th Sept 16						N/A
	Single Oversight Framework metric		Not Applicable prior 1st Oct 16						2	2					2
CQC	CQC Quality Regulations (compliance breach)	Green	Green	Green	Green	Green	Green	Green	Green	Green					Green

From 1st October 2016, the following ratings apply:
1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

Lead Director:
The performance information above shows the previous ratings for governance and finance to September. From October onwards the performance rating metrics have changed to be in line with the new Single Oversight Framework which captures Trust performance against quality, finance, operational metrics, strategy and leadership under one single overall rating. The most significant reasons for the Trust to be rated as 2 are the CQC rating of 'requires improvement' and the level of spend above our agency staff expenditure ceiling.

Areas to Note:
• A number of specific risks relating to CQUIN achievement have been identified and focussed action plans are in place to improve our ability to deliver. Financially this risk equates to £0.7m of lost income if not achieved.
• Medicine omissions (refusals) position has deteriorated, action in place to repeat previous success
• First year of 'sign up to safety' plan shows positive outcomes.
• CQC revisit plan progressing as anticipated
• CQC action plan on schedule
• Number of reported incidents of 1146 in November remained in line with recent average
• Four serious incidents reported in November; 1 of which was an apparent suicide, 2 of which were deaths by other causes and the remaining 1 related to a fire incident
• NHS Improvement metrics - risk identified relates to some of the newly included metrics including IAPT moving to recovery, Mental Health Services Data Set priority metrics, Cardio-metabolic assessment for patient with severe mental illness.
• Achieving Better Access to Mental Health Services by 2020 - Access Targets for Early Intervention for Psychosis and Improving Access to Psychological Therapies - The Trust continues to achieve against all the national thresholds.
• The Trust continues to perform well against the national standards for 18 weeks referral to treatment for applicable services. Detail of performance can be seen in the NHSI section of the report.
• Net deficit of £566k in the month driven by a continued increase in out of area bed placements, CQUIN achievement and timing of ADHD income
• Finance Risk metrics have deteriorated in month due to the deficit and variation from plan
• Year-to-date pre STF surplus of £0.1m which is £0.7m behind plan
• Full year pre STF surplus forecast remains at £0.5m, but with very significant risk attached. Actions being taken to reduce discretionary spend and agency usage. Specific group established to focus on options to reduce out of area bed usage.
• Whilst agency spend reduced by £0.1m in the month it remains well above both ceiling and forecast. Cumulatively agency spend is now £6.7m, which is in breach of our full year ceiling of £5.1m. Total pay costs marginally higher than plan in November although £1.5m below plan year-to-date.
• £4.2m of asset impairments recognised in month which do not impact on normalised financial position. Impairment relates to independent valuation of specialist buildings and recognition of Keresforth, Fieldhead, CNDH and Baghill House impairments.
• Cost improvements delivery to date of £6.1m, which net of contingency is £0.4m lower than plan. Specific issues relate to the use of out of area bed placements and a range of other trust wide schemes.
• Cash reduced to £26.2m in the month, which is £1.5m lower than plan
• Sickness levels remain at 4.8%
• Increased focus required on Information Governance training. Currently at 85.9%.
• Best practice training developed for Mental Health Act and Mental Capacity Act which are now mandatory in the Trust

South West Yorkshire Partnership NHS — NHS Foundation Trust

Quality Headlines (& CQUINS performance on a quarterly basis)

As identified in previous months, work has been undertaken to identify additional quality metrics. These have now been included and are reported against from September 16 onwards - where historic data is available, this has been included. Where targets have not yet been agreed, a proposal will be taken to EMT regarding what they should be in January.

Section	KPI	Objective	CQC Domain	Owner	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Year End Forecast Position *
Infection Prevention	Infection Prevention (MRSA & C.Diff) All Cases	Quality & Experience	Safe	TB	6	0	3	0	0	0	0	0	0	0	0	0	0	4
C-Diff	C Diff avoidable cases	Quality & Experience	Safe	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Outcomes	% SU on CPA in Employment	Health & Wellbeing	Responsive	DS	10%	7.2%	7.6%	7.4%	7.3%	6.9%	7.0%	7.2%	7.0%	6.7%	6.9%	6.5%		1
	% SU on CPA in Settled Accommodation	Health & Wellbeing	Responsive	DS	60%	64.4%	62.8%	64.1%	62.3%	60.0%	67.9%	64.6%	65.8%	67.0%	64.4%	64.4%		4
Complaints	% Complaints with Staff Attitude as an Issue	Quality & Experience	Caring	DS	< 25%	14% 23/179	13% 20/156	14% 20/140	15% 31/211	8% 4/53	23% 12/53	11% 7/62	8% 4/52	9% 4/45	6% 4/65	22% 12/54	18% 8/44	4
Service User Experience	Friends and Family Test - Mental Health	Quality & Experience	Caring	DS	80%	77%	83%	79%	78%	74%	72%	70%	70%	77%	64%	67%	76%	2
	Friends and Family Test - Community	Quality & Experience	Caring	DS	95%	98%	99%	97%	98%	99%	98%	99%	98%	98%	97%	97%	98%	4
Quality	Total number of reported incidents	Quality and Experience	Safety Domain	TB	N/A					1082	1195	1229	1166	1129	1106	992	1147	N/A
	Total number of incidents resulting in severe harm and death	Quality and Experience	Safety Domain	TB	N/A					1	3	0	2	6	5	6	5	N/A
	Total number of incidents resulting in moderate or severe harm and death	Quality and Experience	Safety Domain	TB	N/A					15	32	20	19	26	30	31	28	N/A
	MH Safety thermometer - Medicine Omissions	Quality and Experience	Safety Domain	TB	17.7%					11.8%	20.7%	17.7%	17.4%	19.6%	16.0%	18.7%	22.9%	3
	Safer staff fill rates	Quality and Experience	Safety Domain	TB	90%					108%	107%	111%	111%	109%	109%	113%	Data not avail	4
	Safer Staffing % Fill Rate Registered Nurses	Quality and Experience	Safety Domain	TB	80%					98%	98%	101%	98%	93%	91%	95%	Data not avail	4
	Number of pressure ulcers (attributable) a	Quality and Experience	Safety Domain	TB	N/A					24	40	34	23	38	34	21	23	N/A
	Number of pressure ulcers (avoidable) b	Quality and Experience	Safety Domain	TB	0					0	0	1	1	1	2	0	2	3
	Complaints closed within 40 days	Health & Wellbeing	Responsive	DS	TBC	Reporting established from Sept 16									8	8	14	
	Complaints closed over 40 days	Health & Wellbeing	Responsive	DS	TBC	Reporting established from Sept 16									13	14	14	
	Referral to treatment times	Health & Wellbeing	Responsive	KT/SR/CH	TBC	KPI under development												
	Un-outcomed appointments	Quality and Experience	Effective	KT/SR/CH	TBC	To be included from October									2.2%	3.2%	3.5%	
	Data completeness	Quality and Experience	Effective	KT/SR/CH	TBC	KPI under development												
	Number of Information Governance breaches	Quality and Experience	Effective	MB	TBC	Reporting from April 16				16	8	12	8	10	7	10	Data not avail	
	Staff FFT survey - % staff recommending the Trust as a place to receive care and treatment	Quality and Experience	Caring	AD	80%	To be included from October								79.26%	Avail end of Q4		N/A
	Staff FFT survey - % staff recommending the Trust as a place to work	Quality and Experience	Caring	AD	N/A	To be included from October								65.19%	Avail end of Q4		N/A
	Number of compliments received	Quality and Experience	Caring	DS	TBC	To be included from October								26	33	79	

* See key included in glossary

a - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. There is evidence in care records of all interventions put in place to prevent patients developing pressure ulcers, including risk assessment, skin inspection, an equipment assessment and ordering if required, advice given and consequences of not following advice, repositioning if the patient cannot do this independently off-loading if necessary

b - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of SWYFT staff. Evidence is not available as above, one component may be missing, e.g.: failure to perform a risk assessment or not ordering appropriate equipment to prevent pressure damage

Work has been undertaken to identify the key quality measures to report both monthly and quarterly to EMT and Trust Board. These metrics are now available in the report in the table above and reporting commenced from April 16 onwards where data is available (please note, historic data has been provided where available). There are a few areas that require additional development; these relate to:
• Referral to Treatment waiting times - we are awaiting some national guidance on this - this was anticipated to be received during November but remains outstanding. This will relate to CAMHS services. We will align our reporting to this once the report criteria is published.
• Data completeness - this indicator is being developed and will focus on the completeness of the clinical record.
• Some of these KPIs are new, work is now taking place to identify appropriate threshold and forecast trajectories.
Historically we have not reached the target in achieving 10% of CPA service users in employment and the current trajectory does not suggest this will be achieved at the year end. The indicator parameters only include clients on CPA within the age range 18-69 years old. The Trust is currently undertaking a pilot project in Barnsley covering all mental health service users (regardless of CPA status or age) which is focusing on employment, volunteering and training. Focus will also be placed on the collection of this data for all adults to align to the NHSI Single Oversight Framework; the baseline for this is currently being identified.
NHS Safety Thermometer - Medicines Omissions – this is an indicator within the CQUINs for the west and has been identified as at risk of achievement. Detail of the issues behind this can be seen in the CQUIN section below.

| Summary | Quality | NHS Improvement | Locality | Transformation | Finance/Contracts | Workforce |

Quality Headlines (& CQUINS performance on a quarterly basis)

Commissioning for Quality and Innovation (CQUIN)

The Trust submitted its quarter 2 returns at the end of October and 90% achievement for the quarter has been agreed with commissioners - this equated to a financial loss of £98,506. Areas of under-performance related to:
• Mental Health Currencies adherence to red rules in Calderdale
• Cluster review (clusters 4-17) all BDUs
• Medicine omissions Calderdale, Kirklees and Wakefield
• Partial achievement for quality of care plans in Calderdale and Kirklees
Mitigating action for the underperforming areas can be seen in the table below which identifies all areas of risk for Q3 and Q4.
The Trust forecast out turn based on Q2 actual performance is 84% achievement. Q3 is due to be submitted at the end of January 2017. Focus is on improving this position.

Assessment of Risk for 16/17

Indicator	Ref	KPI	RAG Rating	Reason for Loss	Actions in place
Improve the health and wellbeing of NHS Staff (National CQUIN)	1c	Improving the uptake of flu vaccinations for frontline clinical staff		Q3: Uptake in Vaccinations. SWYPFT need to get between 65%-74% of front line staff vaccinated to receive half of the income associated with this indicator.	• Weekly updates are being put in place to both monitor the RAG rating position and identify any potential hot spot areas for targeted works. • 69 peer vaccinators have been recruited and trained • Significant communications exercise undertaken • BDU Practice Governance Coaches and leads have been identified and take part in fortnightly meetings to ensure that the campaign is heavily promoted and details reach all staff members within BDUs.
Improving physical healthcare to reduce premature mortality in people with severe mental illness (National CQUIN)	2a	Cardio Metabolic Assessment and treatment for patient with psychosis		Q4 Outcome of Audit Partial Achievement to be expected across all BDUs	• Continuing to share learning across the Trust from areas that have established clinics. • Continuing to promote the physical health checks to the 'target group' initially but then roll out to wider population. • Literature being shared with teams to share with SU. • Training up of workforce in undertaking checks.
	2b	Communication with General Practitioners		Q2 Local Audit A realistic achievement of between 50-65% has been placed in this indicator across the BDUs	• Continuing to share learning across the Trust • PGCs and CQUIN leads working with team leaders embedding standards in practice – focus on hospital discharge / medical care planning. • Easily accessible and usable literature / practice guidance. • Regular BDU tracker meetings and team structures, supervision and audit. • Scrupulous preparation for Q2 audit.
Recovery & Progress (Local CQUIN across all BDUs)	3a	MH Clustering - Adherence to Red Rules		Q2 and Q3 Predicted that all BDUs will not meet target.	• Barnsley: Trust wide coordinator meeting with the experts within the teams to identify training and who is requiring the update by the Trust lead. Sending the new monthly dashboard • Calderdale/Kirklees: Practice Governance Coaches supporting and targeting teams/HCP that are underperforming. Trust wide coordinator being present within teams and targeting HCPs.
	3b b	Review of Service Users and Clusters (4-17)		Q2 and Q3 Predicted that all BDUs will not meet the target.	
Care Plans (Local CQUIN West)	4	Care Planning - Quality of Care Plans		Q2 and Q4 Local Audits Targets of 80% & 85% respectively to be achieved. Partial achievement expected across all BDUs.	• Continuing to share learning across the Trust • Practice Governance Coaches and CQUIN leads working with team leaders embedding standards in practice. • Easily accessible and usable literature/practice guidance. • Regular BDU tracker meetings and team structures, supervision and audit. • Scrupulous preparation for Q2 audit.
NHS Safety Thermometer (Local CQUIN West)	5b	Reduction in Medicine Omissions for inpatients		Q3 and Q4 Predicted that BDUs will not meet required reduction.	• Internal support by Trust wide coordinator and pharmacy across the organisation. • The majority of omissions relate to refusals – procedures are being reviewed to ensure that progress achieved in September is repeated for the future months.

Quality Headlines (& CQUINS performance on a quarterly basis)

Safety First

Summary of Q1, Q2 incidents compared to October, November 16/17

Summary of Incidents	Q1	Q2	Oct-16	Nov-16
Green No Harm	2145	2039	590	644
Green	979	963	291	366
Yellow	293	312	96	99
Amber	80	73	20	29
Red	9	15	7	9
Total	3506	3402	1004	1147

• All serious incidents are investigated using Root Cause and Systems Analysis techniques. Further analysis of trends and themes are available in the quarterly incident reports, available on the patient safety support team intranet pages.
• Incident reporting levels remain within the normal range.
• Risk panel remains in operation and scans for themes that require further investigation.

No never events reported in November.

Summary of SIs reported in Q1 and Q2 compared with October and November 16/17

	Q1	Q2	Oct-16	Nov-16
Apparent Suicide	5	8	3	1
Information disclose in error	2	0	0	0
Death - other cause	1	1	1	2
Formal patient absent without leave	0	1	0	0
Inappropriate Sexual Behaviour (including assault)	0	1	0	0
Physical violence (contact made) against other by patient	1	0	0	0
Physical violence (contact made) against staff by patient	1	0	0	0
Physical violence (contact made) against patient by patient	0	1	0	0
Slip, trip or fall - patient	1	0	1	0
Pressure Ulcer grade 3	1	1	0	0
Fire / Fire alarm related incidents	0	0	0	1
Self harm (actual harm) with suicidal intent	1	0	1	0
Total	13	13	6	4

Mortality Review Training – Mortality Reviews – Work continues with Mazars to improve reporting and review arrangements. Mortality Review training took place on 2/12/16. 26 members of staff were trained. A Trust process for mortality reviews is being developed.
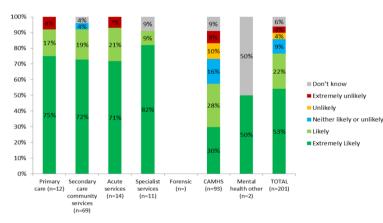
Patient Experience
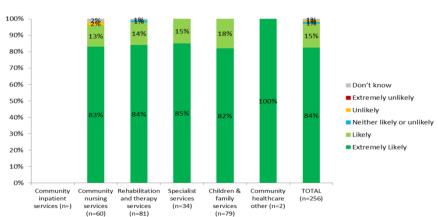
Friends and family test shows
• Community Services – 99% would recommend community services.
• All service lines achieved 82% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
• Mental Health Services – 75% would recommend mental health services.
• Significant variance across the services in the numbers extremely likely to recommend the Trust– between 30% (CAMHS) and 82% (Mental Health Other)
• Small numbers stating they were extremely unlikely to recommend.

Mental Health Services

Community Services

South West Yorkshire Partnership NHS Foundation Trust

Quality Headlines (& CQUINS performance on a quarterly basis)
Safer Staffing

Safer staff fill rates 90%   November =

November data is not available at the time of report preparation. A verbal update will be provided at the meeting.

Average Fill Rate by BDU

Average Fill Rate				
	Jul-16	Aug-16	Sep-16	Oct-16
Barnsley	109%	105%	111%	110%
C & K	107%	104%	109%	114%
Forensic	105%	107%	107%	109%
Wakefield	113%	110%	104%	110%
Specialist Services	261%	275%	243%	224%
Grand Total	111%	109%	108%	113%

Career and Competency Framework for Neighbourhood Nursing

A quality impact assessment was conducted using the Trust's new QIA standard operating procedure to review the Barnsley Community Nursing Service Career and Competency Framework. The proposals were viewed as very positive by the challenge panel with only minor amendments required and all felt the collaborative QIA process was very useful.

CQC inspection update

The CQC have re-visited our core services that required improvement or have a regulatory breach. The inspectors have revisited the teams within the community mental health services for older people, long stay rehabilitation and recovery, inpatient wards for older people, Forensic services, LD community services and CAMHS. We await feedback from the CQC as to the findings of the visits. No immediate concerns have been raised.

In January we are expecting a re-inspection of our acute and PICU wards and latterly a well led review.

Revisit draft reports are expected within approximately 40 days of the visit date for factual accuracy checking.
A new process for factual accuracy has been implemented by the CQC, which in essence means the person who has wrote the report no longer responds to the factual accuracy queries. We anticipate a short turn- around time for factual accuracy as the timescale for the report publication is 50 days from the day of visit.

The tables below demonstrate progress against the CQC action plan, as at end of November 2016. October's table has also been added as a comparison and demonstrates progress that is being made.

November 2016	MUST (n=33)	SHOULD (n=60)
Blue	13 (39%)	35 (58%)
Green	11 (33%)	10 (16%)
Amber/Green	7 (21%)	10 (16%)
Amber / Red	1 (3%)	4 (7%)
Red	1 (3%)	1 (2%)

October 2016	MUST (n=33)	SHOULD (n=60)
Blue	9 (27%)	31 (52%)
Green	11 (33%)	13 (22%)
Amber/Green	4 (12%)	8 (13%)
Amber / Red	8 (24%)	7 (12%)
Red	1 (3%)	1 (2%)

The red actions all have action plans in place to address the must or should do actions. These actions are red as we have missed the original deadline date, these actions can only now turn blue upon completion now initial deadline has been missed.

CQC report on learning from deaths - Learning, candour and accountability

A national review by the Care Quality Commission (CQC) has found that the NHS is missing opportunities to learn from patient deaths and that too many families are not being included or listened to when an investigation happens. The report was published December 13th. Any implications for the Trust will be considered and will be subject to a separate board report in the new year.
The full report can be found at:
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

South West Yorkshire Partnership NHS
NHS Foundation Trust

Quality Headlines (& CQUINS performance on a quarterly basis)

Sign up to safety

The first year of the Trust's sign up to safety plan has recently been reviewed and a number of positive outcomes identified. Inpatient falls, pressure ulcers, harm from MAV incidents, prone restraint and medication omissions are currently on track to reduce by over 30% by 2018. Reducing the duration of prone restraint shows that 80% of incidents were for three minutes or less and the target is to increase this further to 90%.

More detailed report will be presented early in the new year when full year outcome data available.

Quality Impact Assessments

The Trust has reviewed its Quality Impact Assessment Process and developed a Standard Operating Procedure to guide staff in implementation. The updated process is being used to assess the cost improvement proposals that have been put forward as part of the annual planning process for 2017-18.

Fitness to Practice

New guidance has been published which is intended to support managers who have concerns over the Fitness to Practice of practitioners (other than doctors) who work in regulated areas of health and social care. It outlines some of the reasons why Fitness to Practice may be called into question and provides guidance on how to get support.

National Reporting and Learning System (NRLS)

National Reporting and Learning System (NRLS) is a system that enables the Trust to submit patient safety incident reports to a national database. The data submitted by the Trust is then analysed to identify hazards, risks and opportunities to improve the safety of patient care. Information from reported incidents helps the Trust and the wider NHS understand why things go wrong and how to stop them happening again.
The National Reporting and Learning System published a report on 30th September 2016 that relates to patient safety incidents submitted by the Trust during the period 01 October 2015 to 31 March 2016. The report is available here: NRLS Summary Report 01.10.16- 31.07.2016.pdf.
The data in the NRLS report illustrates an increase in patient safety incidents, which is reflected in the overall Trust incident reporting figures for 15/16 which showed a 13% increase in incident reporting overall, compared with the previous year. An increasing patient safety incident reporting rate, where there is no or low harm, is nationally recognised as an indication of a good safety culture, where staff feel able to report incidents. The Trust continues to encourage the reporting of incidents and indications for the next six month period is that the Trust will have an increase number of incidents being reported when compared to this period (01 October 2015 to 31 March 2016).

South West Yorkshire Partnership NHS Foundation Trust

NHS providers must strive to meet key national access standards, including those in the NHS Constitution. From the 1st October, NHS Improvement have introduced a new framework for monitoring providers performance. One element of the framework relates to operational performance and this will be measured using a range of existing nationally collected and evaluated datasets, where possible. The following table lists the metrics that will be monitored and identifies baseline data where available and identifies performance against threshold. The frequency of the monitoring against these KPIs will be monthly and quarterly depending on the measure. The Trust will continue to monitor performance against all KPIs on a monthly basis where possible and will flag up any areas of risk to the board.

KPI	Objective	CQC Domain	Owner	Target	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Q1 16/17	Q2 16/17	Year End Forecast Position *	Trend
Max time of 18 weeks from point of referral to treatment - incomplete pathway	Health & Wellbeing	Responsive	SR	92%	98.4%	98.8%	98.8%	98.1%	97.8%	98.0%	99.1%	98.4%	95.9%	96.51%	96.24%	98.87%	98.2%	97.0%	4	
Maximum 6-week wait for diagnostic procedures	Health & Wellbeing	Responsive	SR	99%	100%	100%	100%	100%	100%	100%	98.80%	100%	100%	100%	100%	100%	99.6%	100%	4	
% Admissions Gatekept by CRS Teams	Health & Wellbeing	Responsive	SR/KT	95%	95.5%	97.3%	95.7%	98.3%	96.8%	96.8%	97.1%	95.7%	100.0%	100%	98.7%	99.1%	96.9%	99.3%	4	
% SU on CPA Followed up Within 7 Days of Discharge	Health & Wellbeing	Safe	SR/KT	95%	98.7%	98.0%	95.5%	97.4%	95.1%	96.6%	98.6%	96.2%	100.0%	97.1%	97.6%		96.7%	97.8%	4	
Data completeness: Identifiers (mental health)	Health & Wellbeing	Responsive	SR/KT	95%	99.6%	99.5%	99.5%	98.5%	98.8%	98.4%	98.1%	98.8%	99.8%	99.7%	99.8%	99.7%	98.1%	99.7%	4	
Data completeness: Priority Metrics (mental health)	Health & Wellbeing	Responsive	SR/KT	85% (by end March 17)	Reporting developed from Oct 16										42.1%	44.0%	Data not avail		2 **	
IAPT - proportion of people completing treatment who move to recovery	Health & Wellbeing	Responsive	SR/KT	50%	Reporting from 1st Oct 16				50.2%	61.4%	42.1%	55.2%	52.8%	49.1%	44.9%	48.1%	50.1%	52.5%	3	
IAPT - Treatment within 6 Weeks of referral	Health & Wellbeing	Responsive	SR/KT	75%	77.8%	75.9%	71.6%	70.5%	74.0%	74.2%	80.0%	83.8%	81.3%	86.2%	86.51%	85.29%	76.1%	83.6%	4	
IAPT - Treatment within 18 weeks of referral	Health & Wellbeing	Responsive	SR/KT	95%	99.1%	99.1%	99.4%	98.1%	98.6%	98.4%	99.2%	99.6%	99.0%	99.2%	99.21%	100%	98.9%	99.3%	4	
Early Intervention in Psychosis - 2 weeks (NICE approved care package) Clock Stops	Health & Wellbeing	Responsive	SR/KT	50%	N/A	N/A	85.2%	86.0%	73.9%	78.3%	80.0%	83.3%	93.8%	73.1%	81.0%	93.1%	77.5%	82.0%	4	
% clients in settled accommodation	Health & Wellbeing	Responsive	DS	60%	Reporting developed from Sept 16									82.7%	83.4%	82.7%	Data not avail		4	
% clients in employment	Health & Wellbeing	Responsive	DS	10%	Reporting developed from Sept 16									9.0%	8.9%	8.8%	Data not avail		1	
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards / b) early intervention in psychosis services / c) community mental health services (people on Care Programme Approach)	Health & Wellbeing	Responsive	SR/KT		Reporting being developed - due quarter 4														2	

* See key included in glossary.

Areas of concern/to note:

• Data completeness: Priority Metrics (mental health) ** – this is a new metric and the reporting has been developed in line with currently available guidance. The indicator is required to be achieved by 2016/17 year-end. Comprising: ethnicity, employment status (for adults only), school attendance (for CYP only), accommodation status (for adults only), ICD10 coding. Note: ICD10 for Children and Young People (CYP) may be supplanted by capture of a problem descriptor, rather than a formal medical diagnosis. Some risk associated with recording of employment and accommodation status for all adults (previously reported for CPA only) and school attendance and ICD10 coding for non CYP as this has not routinely been collected for all records. Performance from the November primary MHSDS submission shows this indicator to be an area of risk. The data will be reviewed and an action plan for improvement will be developed to target hotspot areas.

• IAPT – Proportion of people completing treatment who move to recovery: Trust wide performance for the last 3 months shows to be under threshold. The QTD position for this KPI is 46.6% and therefore there is risk associated with achievement – at quarter end. Underperformance is attributed to the Kirklees (QTD 48.8%) and Barnsley (QTD 43.7%) services. Work is taking place within both services to review the current data – Kirklees are focusing on data quality and Barnsley are undertaking a review of the referrals to identify whether there are issue with referral appropriateness.

• Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely for inpatient wards; early intervention in psychosis services; community mental health services (people on Care Programme Approach) - this aligns to the 2016/17 CQUIN and some risk has been identified in achievement of this. Barnsley BDU achieved this partially in 2015/16, a robust programme of work has been put in place during 16/17 to improve performance. Results will be available during Quarter 4.

• The technical guidance regarding the reporting criteria for these indicators is not detailed at this stage, this may lead to some discrepancy in interpretation of requirements or reporting criteria.

This section of the report is to be developed during 2016/17 and populated with key performance issues or highlights as reported by each BDU.

Barnsley BDU:

• IAPT Moving to recovery – improvement on last month but still under performance against threshold. Action plan in place and agreed with commissioner – service to undertake a review of the referrals to look at source and the number of inappropriate referrals being received that may be impacting.
• Community Nursing and Intermediate Care services are continuing to experience significant pressures in the system due to increasing demand for the service and pressures in acute sector.
• Two patients in Mount Vernon have been identified as a delayed transfer of care (DTOC, the reason for this relates to awaiting appropriate nursing home placement). This links to pressures in the system overall as such delays are usually minimal.

Calderdale & Kirklees BDU:

• Improved performance of assessments within 14 days in Kirklees, now above 80%.
• Delayed transfers of care (DTOC) in Calderdale Older Peoples services (Beechdale) remains above target. Continuing main reason, is the lack of suitable nursing home placements in Calderdale, although in month the number of patients DTOC on the ward reduced to one however as more patients recovered they were declared as DTOCs. This has been escalated to senior management in the council. Positive progress has been sustained with Calderdale council to resolve social work engagement and speed of assessments.
• Significant pressure on adult beds which has led to Bronze status in BDU with twice daily teleconferences with all teams to look at flow and capacity. Average length of stay is up in month at 36 days reflecting acuity and level of acute need.
• Sickness absence positively improved again this month due to management and HR focus.

Forensics BDU:

• CQC re visit 6th and 7th December. There were 4 inspectors (the lead inspector was lead inspector at the last visit). Verbal feedback was overall very positive with improvement being noted in the areas covered by the action plan earlier this year.
• Unprecedented clinical acuity in medium secure with two main incidents generating 5 AMBER incidents. Both these will be subject to investigation to determine what lessons can be learned.
• Work continues to identify CIP's for 17/18 and ensure we can predict income from CQUIN's.
• All attempts are being made to encourage/persuade staff to have a 'flu' jab by a more targeted approach with individuals who have not taken up the opportunity at this point.

Specialist BDU:

• LD service transformation – including a strengthening of operational management – has enabled a sharper focus on access standards. Introduction of SPA arrangements across LD services will also underpin achievement of the agreed standards.
• Introduction of CAMHS Single Point of Access arrangements in Calderdale/Kirklees has reduced the number of referrals and contributed to a sustained reduction in the numbers waiting for treatment (and waiting times). NHSE funding has recently been released to support CAMHS waiting time initiatives and the detail of local investment plans (and trajectories for end March 2017) has been agreed with CCG's.
• Waiting lists in CAMHS, diagnostic for autistic spectrum disorder assessment remain a key priority for the service. The Clinical Governance Clinical Safety Committee receives routine detailed reports to monitor progress.
• Flu vaccination rates remain significantly below target in CAMHS. More general communications in this regard have been complemented by service specific vaccination sessions and initiatives (e.g. a development day vaccination clinic). Service managers are ensuring all staff identified as not having/refusing the vaccine receive a one-to-one discussion regarding the importance of the vaccination and any access concerns/issues they may have.
• Although performance against target for appraisals and specific areas of mandatory training are currently below target action in this regard has been prioritised by specialist services Trios. Improvement is expected to be evidenced in future reports.
• The action plan to improve ethnicity recording across CAMHS is underway to support the achievement of the Trust target by the end of November 2016 (Note: this was the plan but have not seen the end Nov data).

Wakefield BDU:

• Delivery of routine access targets has been sustained in both Older People and Working Age adult services
• Delayed Transfers of Care remain well below target across the BDU
• Reported incidents of violence against staff by patients is above the expected range for the third consecutive month.

South West Yorkshire Partnership **NHS**
NHS Foundation Trust

This section of the report reports the Trust's progress against the identified transformation projects.

Acute & Community Mental Health Transformation Project

Currently implementing the 'core and enhanced' community pathways which have been devised through this project. This is due to be completed in Q4 of 2016/2017.	Delivery against plan	🟩
Main issue was the impact of the proposed model on the Barnsley BDU medical workforce – but a recent resolution has been found and the project is progressing toward implementation. The main risk now is the potential impact of changes in Barnsley as a result of Older People's transformation proposals.	Management of risk	🟩
Benefits arising from this project will be: more flexible and responsive deployment of resources; simpler and faster core pathway, supporting sustainable recovery; savings are being realised in Q4 16/17, already counted in BDU CIP delivery for the year.	Benefits Realisation	🟨
QIA has been sent to the Quality Team in August 2016. A benefits framework has been established to track the delivery of the quality improvements and these will be tracked in the year post implementation.	Quality impact	🟨

Core and enhanced fully implemented — Financial savings realised and handover to business — Post Implementation Review Commences

March 2017 | April 2017 | May 2017 | June 2017 | July 2017 | August 2017 | September 2017

Older Peoples Mental Health Transformation Project

A proposed community model developed and feedback from BDUs is now being considered. Business case in development for completion by March 2017 with formal consultation to commence in Spring 2017.	Delivery against plan	🟧
A cost pressure of £60k in 2017/18 is anticipated to enable dedicated clinical leadership and change management resource to deliver the project. Risk that some financial benefits identified can't be fully realised if parts of the community workforce require enhancing.	Management of risk	🟨
Financial benefits are targeted for realisation in 18/19 via a reduction in the number of older peoples mental health beds, enabled by provision of dedicated intensive support as a community alternative to admission. This will be modelled up and considered in the business case.	Benefits Realisation	🟨
Extensive engagement around clinical model provides assurance of positive quality impact.	Quality impact	🟩

Business Case Established — Staff Consultation Commences — Staff Consultation Complete — Implementation Phase Commences

March 2017 | April 2017 | May 2017 | June 2017 | July 2017 | August 2017 | September 2017

| Summary | Quality | NHS Improvement | Locality | **Transformation** | Finance/Contracts | Workforce |

Rehab and Recovery Transformation Project

Community model agreed in principle with local CCGs. Implemented in Wakefield with financial savings of £457K attached. Implementation in Calderdale expected in 2017/2018. Next step re Kirklees is a business case re feasibility of High Dependency Unit and impact of this on community model and Enfield Down.	Delivery against plan	🟧
Challenges remain to develop capacity required in Kirklees to establish new ways of working. A paper is in development to seek clarity on the future rehab services model and required resources to support the transition. Resourcing of delivery remains a block to progress – this is being addressed within the	Management of risk	🟥
Financial benefits have already been realised in Wakefield (£457k) and further financial savings have been put forward for a CIP in Calderdale on closure of Lyndhurst (£106K). This is anticipated to be realised in 2017/18.	Benefits Realisation	🟨
This project had a QIA conducted in the business case phase - it indicated a positive impact on quality.	Quality impact	🟩

Agreement of proposed model for Kirklees — January 2017
Implementation Phase Commences — February 2017
Pathway Mapping Complete — March 2017
Transition to Community Model Commences — April 2017
Lyndhurst closure and reprovision into community model — Oct 2017

January 2017 | February 2017 | March 2017 | April 2017 | May 2017 | June 2017 | July 2017 | August 2017 | Sept 2017 | Oct 2017

Barnsley Administrative Services Review

Staff consultation has now closed and appropriate HR processes are being completed. Estimated relocation date to Kendray is December 2016 – January 2017. Plans are in place for key functions, such the cashiering process, to operate from one site. Mail and franking services have been consolidated to one site at Kendray and are now managed as part of estates and facilities. This project is nearing completion. A project closure request will be made detailing how benefits will be tracked through 2017/18.	Delivery against plan	🟨
	Management of risk	🟩
Benefits of this project are: remodelling the inpatient and reception admin functions; provide a 0830-1900 admin service; create clear development pathways/apprenticeship opportunities. Savings of £58k included in BDU CIP delivery for 2016/17. Work is ongoing to schedule the realisation of these benefits for the next update.	Benefits Realisation	🟩
This project had a QIA conducted in the business case phase – it indicated a positive impact on quality through extended hours of reception, improving customer experience, and extended availability of administrative support to services.	Quality impact	🟩

Workforce job roles aligned with workforce model — November 2016
Relocation Complete — January 2017
Restructuring of reception and Administrative functions completed — March 2017
Savings of £58k CIP Realised — March 2017

November 2016 | December 2016 | January 2017 | February 2017 | March 2017

South West Yorkshire Partnership NHS — NHS Foundation Trust

Barnsley Therapy Services Review

Therapy clinical centres are established and operational. Changes to service model have been completed but significantly over the planned time scale – hence amber rating on delivery against plan. A project closure request is being made and will detail how benefits will be tracked through 2017/18.	Delivery against plan	
Impact of re-specification of Intermediate Care services need to be taken into cnsideration. MSK services are also under review with expected re-specification and tender in 2017/18.	Management of risk	
The purpose of this project was to establish Therapy clinical centres with appropriate satellite clinical provision. The impact of this for service users and staff will be monitored throughout 2017/18	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated a positive impact on quality through co-location and creation of centres of excellence, but also noted that consolidation of services moves some provision further from communities	Quality impact	

Implementation of therapy leadership structure — Single Point of access for MSK — Full clinical functionality plan across all therapy services on SystmOne — Benefits of SPA begin to be realised

December 2016 | January 2017 | February 2017 | March 2017 | April 2017

Barnsley Community Nursing Transformation

Project currently mobilising workforce changes required to move the service to a six neighbourhood model and supporting new ways of working. Implementation commenced 1st October 2016. Rebranding of the service to 'Neighbourhood Nursing Service' has taken place and communications held with primary care practices.	Delivery against plan	
There are key elements of service to mobilise in January 2017, which require significant collaboration between partner agencies. Engagement is good and associated risks are being managed – level of risk considered high hence amber rating	Management of risk	
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 integrated teams in localities which align with primary and social care. Planning phase successfully completed, implementation now critical. Benefits realisation tracking now required.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated positive impact on quality. To be repeated when implemented.	Quality impact	

Establish generic competencies — Establish Neighbourhood MDTs — Commence behaviour change and development work — Commence use of live capacity modelling tool

December 2016 | January 2017 | February 2017 | March 2017

South West Yorkshire Partnership **NHS**

NHS Foundation Trust

Specialist Adult Learning Disability Services Transformation Project

Description	Area	RAG
This project has moved to a benefits realisation phase. A project closure report is being prepared for submission to EMT in January 2017 which will focus on benefits identification, measurement, timetabling and tracking and on post implementation quality impact assessment.	Delivery against plan	🟩
Project risks have been closed. Operational risks and issues related to the new model remain. Notably income risk related to assessment and treatment beds, and need for ongoing OD work with new teams. Plans are in place to manage operational risks.	Management of risk	🟩
Work is currently taking place within the LD trio on identifying benefits in the areas of: outcomes for service users; system; partnerships; business intelligence and cost efficiencies for completion by end of December 2016. These benefits will be summarised in the project closure report, for presentation to EMT in January 2017, with realisation of benefits tracked through to end of Quarter 1 of 2017/2108	Benefits Realisation	🟨
The implementation of the new service model was assessed in the QIA against the original business case as excellent or good for all quality areas. QIA required to be repeated now implemented, prior to project close down.	Quality impact	🟩

Establishment of Benefits

Finalisation of project closure Report

Presentation of project closure report to EMT

Realisation of Benefits

December 2016 | January 2017 | February 2017 | March 2017 | April 2017 | May 2017 | June 2017 | July 2017

Key for Transformation:

Implementation deliverables		RAG Ratings	
🟢	On Target to deliver within agreed timescales	🟩	On Target to deliver within agreed timescales/project tolerances
🟡	On Trajectory but concerns on ability/confident to deliver within agreed timescales	🟨	On Trajectory but concerns on ability/confident to deliver actions within agreed timescales/project tolerances
🟠	Off Trajectory and concerns on ability/capacity to deliver within agreed timescales	🟧	Off Trajectory and concerns on ability/capacity to deliver actions within agreed timescales/project tolerances
🔴	Action will not be delivered within agreed timescales	🟥	Actions will not be delivered within agreed timescales/project tolerances
🔵	Action Complete	🟦	Action Complete

South West Yorkshire Partnership NHS Foundation Trust

Overall Financial Performance 2016 / 2017

Executive Summary / Key Performance Indicators

	Performance Indicator	Year to Date	Forecast	Narrative
1	NHS Improvement Risk Rating	3	3	The NHS Improvement risk rating remains capped at level 3 due to the agency metric rating of 4. Given the in-month deficit position ratings associated with underlying financial performance (and performance against plan) have deteriorated from 1 to 2.
2	Normalised Surplus	£1m	£1.9m	November 2016 financial performance is a normalised deficit position of £566k compared to planned surplus of £181k, cumulative surplus of £964k is £718k below plan. The main factors being continued and increased cost pressures on Out of Area beds and CQUIN income. Action is being taken to reduce expenditure and whilst forecast remains in line with plan there is a real risk this will not be achieved.
3	Agency Cap	£6.7m	£9.1m	Agency expenditure in November 2016 is £0.7m which represents a £0.1m reduction compared to October. Spend has reduced across nursing and non clinical staff but has increased for medical staff. Year to date this position is 85% over the NHSI cap.
4	Cash	£26.2m	£20.8m	The Trust cash position is £1.5m less than plan at month 8 due to the level of accrued income and higher creditor payments. Actions are being identified to ensure cash is in line with plan by March 2017.
5	Capital	£6.2m	£12.2m	Capital expenditure is behind plan at October by £1m excluding VAT reclaims. The forecast is being assessed to identify if any projects will not be on track at the year-end.
6	Delivery of CIP	£6.1m	£9.2m	Year to date CIP delivery is £0.4m behind plan. Overall the forecast position includes £0.8m of red rated schemes. There has been no movement on this position in month.
7	Better Payment	96%		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

Contracting

Contracting Issues - 2017-18 Negotiations

Contract negotiations are ongoing. Offers largely in line with expectations but still some issues to resolve before signatures. Memorandums are being inserted into contract financial schedules to ensure that there is ongoing dialogue and negotiation as appropriate in relation to FYFV investment.

CQUIN

Full CQUIN achievement remains challenging. Q2 performance remains below planned trajectory but there has been an improvement on a number of schemes. The major programme of social marketing to increase the uptake of Flu Vaccination continues into Q3 and negotiation of the Q3 and Q4 trajectories for the NHS Safety Thermometer CQUIN will support CQUIN delivery. There continues to be intense Trust wide scrutiny and support in order to assist with CQUIN delivery.

QIPP

Specific QIPP schemes have been agreed with Wakefield CCG and are on track to deliver. These cover circa half of the target. Negotiation stances for 17/18 with regard to QIPP have been clarified and recognise the Trust's broad contribution to system sustainability.

Key Contract Issues – Barnsley

Contracting negotiations have been constructive and will reduce the significant current pressures for continence products and MH Out of Area Locked Rehabilitation Placements quite considerably. £13.6m of services will transfer from the main contract into new Alliance Contracts during 17/18. On track for contract signature by 23rd December. Overall the agreed contract value has reduced by 0.3% which is predominantly due to the transfer of LIFT premises to BMBC. Other key movements include funding of cost pressures associated with continence and locked rehab, commissioning of a Learning Disability bed.

Key Contract Issues – Calderdale

Recurrent funding in EIP addressed. Two issues remain for resolution. Relating to IHBT and CAMHs.

Key Contract Issues – Kirklees

Final contract offer required, but no issues expected. EIP investment in full being made recurrent for 17/18 onwards.

Key Contract Issues- Wakefield

Final contract offer required, but no issues expected. Surplus LD beds will now be sold to other Trusts. Overall the agreed contract value has reduced by 2.3% which is predominantly due to the changes in commissioning of LD beds and the transfer of IAPT.

Contracting Issues - Forensics

Contract negotiations are progressing well.

Key Contract Issues – Other

Contract negotiations are concluding in finalising the terms of two Smoke Free services contract extensions for 17/18 in Rotherham and Doncaster and Sheffield. Commissioning Intentions are awaited from Kirklees Council in relation to Smoke Free services.

Summary	Quality	NHS Improvement	Locality	Transformation	Finance/Contracts	**Workforce**
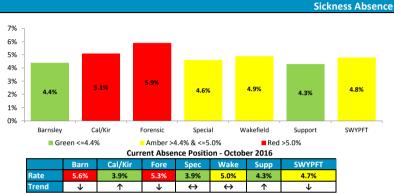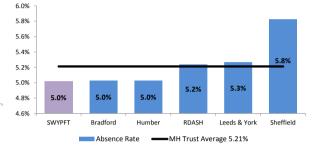
Workforce

Human Resources Performance Dashboard - November 2016

Sickness Absence

Green <=4.4%   Amber >4.4% & <=5.0%   Red >5.0%

Current Absence Position - October 2016

	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.6%	3.9%	5.3%	3.9%	5.0%	4.3%	4.7%
Trend	↓	↑	↓	↔	↔	↑	↓
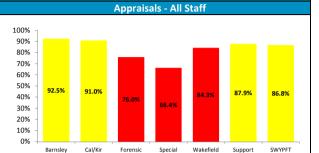
The Trust YTD absence levels in October 2016 (chart above) were above the 4.4% target at 4.8%.

Absence Rate   MH Trust Average 5.21%
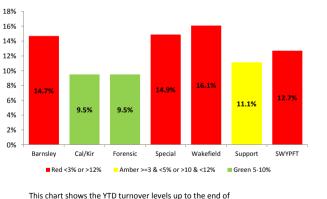
The above chart shows the YTD absence levels in MH/LD Trusts in our region for the 12 months to the end of March 2016. During this time the Trust's absence rate was 5.02% which is below the regional average of 5.21%.

Appraisals - All Staff
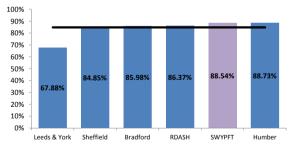
Red <85%   Amber >=85% & <95%   Green >=95%

The above chart shows the appraisal rates for all staff for the Trust to the end of November 2016. The figures are calculated over the financial year from April 2016 to March 2017. The total percentages have decreased slightly since the inclusion of Band 1-5 but all staff groups continue to show improvement over the course of the financial year.

Turnover and Stability Rate Benchmark

Red <3% or >12%   Amber >=3 & <5% or >10 & <12%   Green 5-10%

This chart shows the YTD turnover levels up to the end of November 2016.
Family Nurse Partnership and 0-19 staff have been excluded from the above data.

Stability Index   MH Trust Average 84.78%

This chart shows stability levels in MH Trusts in the region for the 12 months ending in April 2016. The stability rate shows the percentage of staff employed with over a year's service. The Trust's rate is better than the average compared with other MH/LD Trusts in our region.

Fire Lecture Attendance

Red <70%   Amber >=70% & <80%   Green >=80%

The chart shows the YTD fire lecture figures to the end of Nov 2016. The Trust continues to achieve its 80% target for fire lecture training; Specialist Services have improved their performance slightly but are still just below the target.

| Summary | Quality | NHS Improvement | Locality | Transformation | Finance/Contracts | **Workforce** |

Workforce - Performance Wall

Trust Performance Wall													
Month	Objective	CQC Domain	Owner	Threshold	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.0%	4.7%	4.5%	4.6%	4.7%	4.7%	4.8%	4.8%	
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.8%	4.7%	4.4%	4.8%	5.0%	4.9%	4.8%	4.7%	
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	1.3%	20.1%	43.1%	56.7%	71.0%	81.4%	84.8%	89.8%	
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	0.1%	6.3%	14.1%	26.8%	44.3%	68.5%	76.8%	84.9%	
Aggression Management	Quality & Experience	Well Led	AD	>=80%	83.3%	82.6%	81.7%	80.8%	81.0%	82.4%	80.0%	78.8%	
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%				62.0%	60.6%	63.2%	65.0%	66.9%	
Clinical Risk	Quality & Experience	Well Led	AD	>=80%				28.2%	39.0%	41.0%	39.9%	45.1%	
Equality and Diversity	Resources	Well Led	AD	>=80%	91.8%	92.0%	91.5%	91.9%	91.7%	90.9%	90.3%	89.4%	
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	85.2%	83.2%	82.8%	84.5%	85.1%	84.6%	83.7%	82.9%	
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	78.4%	79.1%	80.0%	80.8%	82.2%	81.8%	82.6%	82.9%	
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.6%	83.4%	84.5%	84.8%	83.4%	82.5%	81.3%	81.9%	
Information Governance	Resources	Well Led	AD	>=95%	93.6%	90.0%	89.9%	90.2%	89.2%	88.2%	86.5%	85.9%	
Moving and Handling	Resources	Well Led	AD	>=80%	85.0%	84.4%	82.2%	82.2%	79.4%	78.2%	77.0%	78.1%	
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.3%	89.0%	90.0%	90.1%	89.7%	89.2%	89.0%	88.6%	
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.4%	87.1%	88.0%	88.3%	88.2%	88.0%	86.7%	87.0%	
Bank Cost	Resources	Well Led	AD		£463k	£370k	£434k	£434k	£512k	£605k	£486k	£458k	
Agency Cost	Resources	Effective	AD		£805k	£842k	£925k	£791k	£989k	£833k	£833k	£753k	
Overtime Costs	Resources	Effective	AD		£31k	£33k	£35k	£23k	£17k	£9k	£16k	£14k	
Additional Hours Costs	Resources	Effective	AD		£87k	£60k	£68k	£78k	£52k	£48k	£40k	£41k	
Sickness Cost (Monthly)	Resources	Effective	AD		£497k	£469k	£456k	£481k	£504k	£501k	£462k	£457k	
Business Miles	Resources	Effective	AD		345k	321k	267k	286k	300k	273k	328k	330k	

Workforce - Performance Wall cont…

Notes:

Sickness
• The trust remains amber at 4.8%
• Calderdale & Kirklees (5.1%) and Forensic (5.9%) BDUs report the highest levels of sickness. Both have improved compared to October.
• Although year to date still above the target level Specialist Services BDU sickness rates have continued to fall month on month from 5.7% in May to 4.6% in November. Barnsley BDU continues to remain within the 4.4% threshold but have had a spike in sickness during November 16. Support Services sickness rate remains below target.

Mandatory Training
• The Trust is achieving above threshold for all areas with the exception of Information Governance (85.9%); Moving & Handling (78.1%) and Mental Health Act (MHA) training - compliance against MHA training will flow from Q3. Cardiopulmonary resuscitation and clinical risk training are new measures and whilst these are currently showing as red, they are on a planned trajectory.
• Continued focus being placed on IG across the trust given recent ICO reportable incidents.
• Mental Health Act Training - The Trust has developed best practice training regarding the use of the Mental Health Act and Mental Capacity Act (including Deprivation of Liberty safeguards). This training has become mandatory in our Trust following national recommendations, and also recent Care Quality Commission recommendations. The MCA/MHA Specialist Leads, with support from L&D have identified the MHA training requirements of all staff and we are currently in a consultation period with services to ensure the data collected is accurate. Reporting will be available from January 2017 onwards.
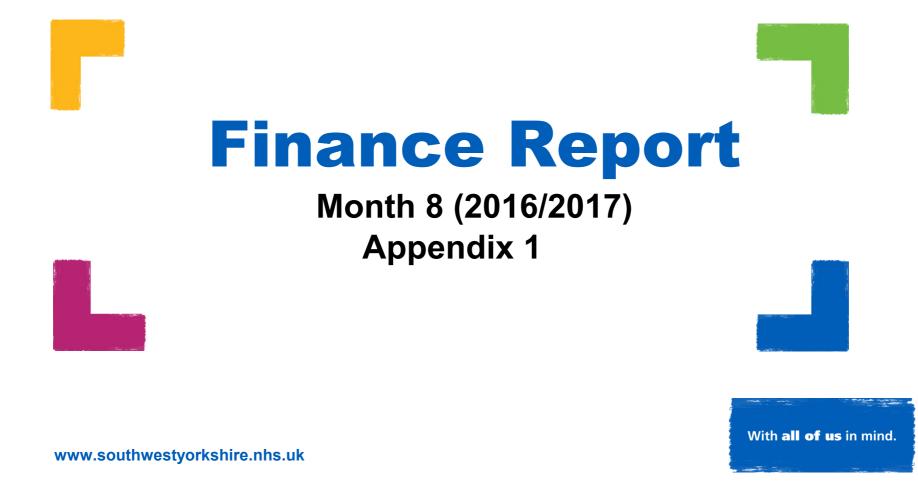
Publication Summary

The following section of the report identifies publications that may be of interest to the Trust and it's members.

Quarterly monitoring report: November 2016 (The Kings Fund)

Children and young people's mental health: time to deliver (Commission on Children and Young People's Mental Health)

Best practice for perinatal mental health care: the economic case (Personal Social Services Research Unit (PSSRU))

2016 community mental health survey: statistical release (Care Quality Commission)

Overall patient experience scores: 2016 community mental health survey update

Mixed-sex accommodation breaches, October 2016

NHS Improvement provider bulletin, 16 November 2016

Seasonal flu vaccine uptake in healthcare workers: 1 September 2016 to 31 October 2016

Winter health watch summary: 17 November 2016

Mental health services monthly statistics: final August, provisional September 2016

Improving Access to Psychological Therapies report, August 2016 final, September 2016 primary and most recent quarterly data (Q1 2016/17)

NHS sickness absence rates - July 2016

NHS workforce statistics - August 2016, provisional statistics

Diagnostic imaging dataset, November 2016

Bed availability and occupancy: quarter ending September 2016

NHS Improvement provider bulletin: 23 November 2016

Monitoring the Mental Health Act in 2015/16 (Care Quality Commission)

Inpatients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment: 2015/16, annual figures

Mental health bulletin: 2015-16 annual report

Hospital outpatient activity, 2015-16

NHS Provider bulletin: 30 November 2016

Out of area placements in mental health services, October 2016

Suicides in the UK, 2015 registrations

Winter health watch summary, 1 December 2016

Female genital mutilation - July 2016 to September 2016, experimental statistics, report

Children and young people's health services monthly statistics - April to June 2016

Combined monthly performance (NHS England)

The mental health of children and young people in England (Public Health England)

NHS Improvement provider bulletin: 7 December 2016

South West Yorkshire Partnership **NHS**

NHS Foundation Trust

Finance Report
Month 8 (2016/2017)
Appendix 1

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With **all of us** in mind.

Contents

1.0	Executive Summary / Key Performance Indicators			
	Performance Indicator	**Year to Date**	**Forecast**	**Narrative**
1	**NHS Improvement Risk Rating**	3	3	The NHS Improvement risk rating remains capped at level 3 due to the agency metric rating of 4. Given the in-month deficit position ratings associated with underlying financial performance (and performance against plan) have deteriorated from 1 to 2.
2	**Normalised Surplus**	£1m	£1.9m	November 2016 financial performance is a normalised deficit position of £566k compared to planned surplus of £181k, cumulative surplus of £964k is £718k below plan. The main factors being continued and increased cost pressures on Out of Area beds and CQUIN income. Action is being taken to reduce expenditure and whilst forecast remains in line with plan there is a real risk this will not be achieved.
3	**Agency Cap**	£6.7m	£9.1m	Agency expenditure in November 2016 is £0.7m which represents a £0.1m reduction compared to October. Spend has reduced across nursing and non clinical staff but has increased for medical staff. Year to date this position is 85% over the NHSI cap.
4	**Cash**	£26.2m	£20.8m	The Trust cash position is £1.5m less than plan at month 8 due to the level of accrued income and higher creditor payments. Actions are being identified to ensure cash is in line with plan by March 2017.
5	**Capital**	£6.2m	£12.2m	Capital expenditure is behind plan at October by £1m excluding VAT reclaims. The forecast is being assessed to identify if any projects will not be on track at the year-end.
6	**Delivery of CIP**	£6.1m	£9.2m	Year to date CIP delivery is £0.4m behind plan. Overall the forecast position includes £0.8m of red rated schemes. There has been no movement on this position in month.
7	**Better Payment**	96%		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

With effect from month 7 (October 2016) the way that NHS Improvement assess financial performance and efficiency has changed. This is now regulated under the Single Oversight Framework and the financial metric is on the Use of Resources.

This retains the 4 previous metrics but adds a 5th to compare agency expenditure against the Trust agency ceiling (set for the Trust as £5.1m for the full year).

Additionally the Use of Resources metric changes the scoring regime. This is now rated from 1 to 4 with 1 being the best possible weighted average score. NHS Improvement will use this score to inform which segmentation the Trust falls under and if and when any support is required.

	Financial Criteria	Weight	Metric	Actual Performance		Plan - Month 8	
				Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	20%	Capital Service Capacity	4.4	1	3.6	1
	Liquidity	20%	Liquidity (Days)	16.7	1	11.6	1
Financial Efficiency	Underlying Performance	20%	I & E Margin	0.8%	2	1.1%	1
	Variance from Plan	20%	Variance in I & E Margin as a % of income	-0.4%	2	-0.4%	2
Agency Cap	Variance from Plan	20%	Agency Margin	85%	4	#N/A	#N/A
Weighted Average - Financial Sustainability Risk Rating					**3**		**1**

Impact
The impact of the breach of the agency cap by more than 50% means that this metric scores 4. As a result any trust scoring 4 on a particular metric can only score a maximum of 3 overall.

The weak financial performance in November has resulted in a deterioration in financial efficiency scores from 1 to 2.

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.
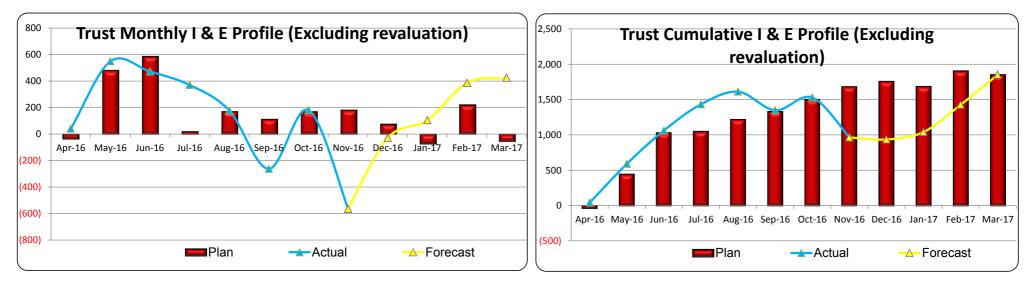
Income & Expenditure Position 2016 / 2017

Budget Staff in Post WTE	Actual Staff in Post WTE	Variance WTE	Variance %	This Month Budget £k	This Month Actual £k	This Month Variance £k	Description	Year to Date Budget £k	Year to Date Actual £k	Year to Date Variance £k	Annual Budget £k	Forecast Outturn £k	Forecast Variance £k
				17,230	17,155	(75)	Clinical Revenue	142,078	141,946	(132)	211,480	211,325	(154)
				17,230	**17,155**	**(75)**	**Total Clinical Revenue**	**142,078**	**141,946**	**(132)**	**211,480**	**211,325**	**(154)**
				1,446	1,350	(96)	Other Operating Revenue	10,506	10,383	(123)	15,341	15,430	89
				18,676	**18,504**	**(172)**	**Total Revenue**	**152,585**	**152,329**	**(255)**	**226,821**	**226,755**	**(65)**
4,325	4,046	(279)	6.4%	(13,981)	(14,032)	(50)	Pay Costs	(116,536)	(115,085)	1,451	(173,148)	(171,828)	1,320
				(3,797)	(4,331)	(535)	Non Pay Costs	(29,746)	(30,481)	(735)	(43,895)	(45,827)	(1,933)
				128	96	(32)	Provisions	2,229	1,406	(824)	2,309	3,067	758
4,325	**4,046**	**(279)**	**6.4%**	**(17,650)**	**(18,267)**	**(617)**	**Total Operating Expenses**	**(144,053)**	**(144,161)**	**(108)**	**(214,733)**	**(214,587)**	**146**
4,325	**4,046**	**(279)**	**6.4%**	**1,027**	**238**	**(789)**	**EBITDA**	**8,532**	**8,169**	**(363)**	**12,087**	**12,168**	**80**
				(595)	(550)	45	Depreciation	(4,848)	(5,201)	(354)	(7,233)	(7,301)	(69)
				(257)	(257)	0	PDC Paid	(2,053)	(2,053)	0	(3,080)	(3,080)	(0)
				6	4	(3)	Interest Received	50	49	(1)	75	63	(12)
4,325	**4,046**	**(279)**	**6.4%**	**181**	**(566)**	**(747)**	**Normalised Surplus / (Deficit)**	**1,681**	**964**	**(718)**	**1,850**	**1,850**	**0**
				0	(4,189)	(4,189)	Revaluation of Assets	0	(4,189)	(4,189)	0	(4,189)	(4,189)
4,325	**4,046**	**(279)**	**6.4%**	**181**	**(4,755)**	**(4,936)**	**Surplus / (Deficit)**	**1,681**	**(3,226)**	**(4,907)**	**1,850**	**(2,339)**	**(4,189)**

Trust Monthly I & E Profile (Excluding revaluation)

Trust Cumulative I & E Profile (Excluding revaluation)

Income & Expenditure Position 2016 / 2017

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

The Trust year to date and forecast finance position including and excluding STF funding are highlighted below. This is calculated, by NHS Improvement, upon the normalised surplus value. This therefore excludes exceptional items such as the revaluation of Trust Estate. The current forecast is that the pre STF financial performance will remain in line with plan. If this does not prove to be the case the Trust will lose STF funding of £590k in the last two quarters.

	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k
Surplus (Excluding STF)	781	64	(718)	500	500	0
STF	900	900	0	1,350	1,350	0
Surplus - Total	**1,681**	**964**	**(718)**	**1,850**	**1,850**	**0**

Two key components need to be achieved in order to receive STF monies.

	Plan	Actual	Variance	Plan	Actual	Variance
Financial Performance	788	788	0	1,181	1,181	0
Referral to Treatment	113	113	0	169	169	0
STF - Total	**900**	**900**	**0**	**1,350**	**1,350**	**0**

Month 8

In month there have been adverse movements in the financial position resulting in a deficit position for month 8 / November 2016 of £566k. The main headlines are:

Income - The current year to date position includes £405k shortfall in CQUIN income. Additionally an adjustment has been made to reflect agreed changes to ADHD income profile.

Pay - Pay costs exceeded plan by £50k in month 8. Agency expenditure, although reduced in month, continues to be a significant financial pressure.

Non Pay - In month expenditure is £535k higher than planned. This includes the purchase of external healthcare and out of area beds (£482k higher than plan Trustwide) and represents a continued increase in usage.

Other areas of overspend such as on clinical supplies have been offset by underspends in non-clinical areas such as travel and training costs.

The Trust has also recognised the impact arising from the annual revaluation exercise of assets. This includes a review of future estate requirements (Modern Equivalent Asset basis) following hub developments. This amounts to £4.2m and covers the Pontefract Hub (£0.9m), CNDH (£0.2m), Keresforth (£1.7m) along with district valuer assessment of current building valuations. All valuations have been independently assessed.

Forecast

Acknowledging the year to date financial performance outlined above the Trust remains committed to achieving the planned £0.5m surplus pre STF. This presents a significant challenge based on recent run rates. Weekly operations meetings have been re-instated and all non-essential expenditure is being stopped. Further communication and engagement has taken place with respect to increasing uptake of the flu jab and strong focus remains on reducing agency usage and out of area bed placements.
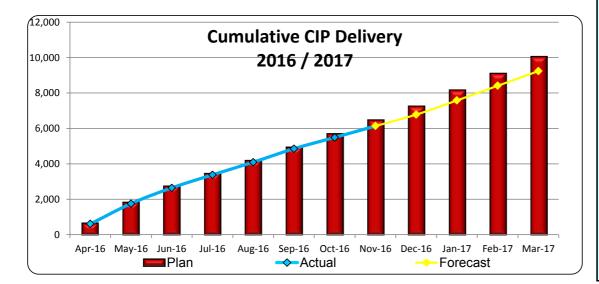
The impact of the out of area bed activity has resulted in an increase of £416k month on month which will need to be reduced very quickly in order to improve our financial position.

If the financial position is not back in line with plan this risks achievement of the STF funding and cash. This would total £590k for Quarter 3 and 4. The Q3 STF is very much at risk.

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	5,465	8,837
Target - Non Recurrent	9	509	259	49	49	49	49	49	49	49	49	49	1,025	1,223
Target - Monitor Submission	670	1,172	922	715	729	744	766	772	777	912	940	940	6,490	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	6,490	10,059
Delivery as planned	452	1,446	2,147	2,686	3,232	3,826	4,338	4,859	5,379	6,056	6,761	7,465	4,859	7,465
Mitigations - Recurrent	0	6	9	14	18	22	26	30	34	38	42	46	30	46
Mitigations - Non Recurrent	146	299	485	678	841	1,005	1,125	1,245	1,365	1,485	1,606	1,726	1,245	1,726
Total Delivery	**598**	**1,751**	**2,641**	**3,377**	**4,091**	**4,853**	**5,489**	**6,134**	**6,779**	**7,580**	**8,409**	**9,237**	**6,134**	**9,237**
Shortfall / Unidentified	72	92	123	101	116	99	229	356	488	599	711	822	356	822

Cumulative CIP Delivery 2016 / 2017

Legend: Plan, Actual, Forecast

The Trust identified a CIP programme for 2016 / 2017 which totals £10.1m. (£11.0m recurrent full year effect) This was subject to an external review.

There has been no movement in the programme in month. As such the forecast shortfall remains at £822k. This remains a number of key schemes with the majority of schemes now rated as green and delivering.

For example schemes currently rated as red include:

Procurement / Non pay savings which are delayed compared to original milestones
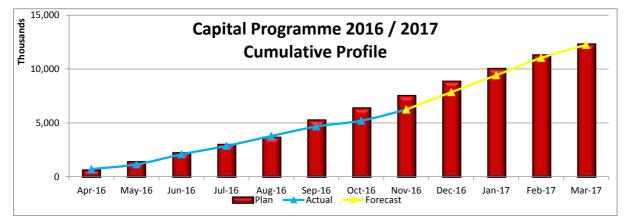
Drugs expenditure reductions which are unlikely to materialise in the short term.

3.0 Balance Sheet 2016 / 2017

	2015 / 2016 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	114,134	118,054	110,423	1
Current Assets				
Inventories & Work in Progress	190	190	190	
NHS Trade Receivables (Debtors)	2,623	2,273	2,188	2
Other Receivables (Debtors)	7,541	5,092	7,338	3
Cash and Cash Equivalents	27,107	27,689	26,180	4
Total Current Assets	**37,461**	**35,244**	**35,896**	
Current Liabilities				
Trade Payables (Creditors)	(6,430)	(6,230)	(6,544)	5
Other Payables (Creditors)	(3,481)	(3,994)	(3,605)	5
Capital Payables (Creditors)	(785)	(785)	(888)	5
Accruals	(8,576)	(10,876)	(8,080)	6
Deferred Income	(789)	(789)	(1,159)	
Total Current Liabilities	**(20,060)**	**(22,674)**	**(20,275)**	
Net Current Assets/Liabilities	**17,401**	**12,571**	**15,621**	
Total Assets less Current Liabilities	**131,535**	**130,624**	**126,044**	
Provisions for Liabilities	(10,017)	(8,327)	(7,886)	
Total Net Assets/(Liabilities)	**121,518**	**122,297**	**118,158**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,492	
Revaluation Reserve	19,446	19,446	19,311	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,361	54,140	50,135	7
Total Taxpayers' Equity	**121,518**	**122,297**	**118,158**	

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 value of fixed assets is below plan. This is due to the current capital programme (less than plan) and the accelerated depreciation charges. This also includes the impact of the revaluation exercise, and recent asset impairments.

2. NHS debtors are currently slightly below plan. Actions continue to ensure the timely recovery of all outstanding income.

3. As per previous months other debtors are higher than plan with the main reason being accrued income. Invoices are being raised during December to further reduce this value.

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 12.

5. Creditors are marginally higher than plan and are in line with historical levels. Payments continue to be made to support the Trust Better Payment Practice Code and ensure that no issues remain outstanding.

6. Accruals are lower than planned. This is mainly due to invoices being received from other NHS bodies which had been planned, based upon previous experience, to be received later in the year.

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

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	1,291	862	(430)	2,147	97	3
IM&T	1,210	791	199	(592)	1,182	(28)	
Total Minor Capital & IM &T	**3,260**	**2,082**	**1,060**	**(1,022)**	**3,329**	**69**	
Major Capital Schemes							
Pontefract Hub	1,795	1,795	1,873	78	1,939	144	4
Wakefield Hub	735	735	707	(28)	790	55	4
Fieldhead Non Secure	4,725	1,992	2,347	354	4,829	104	
Fieldhead Development	1,300	567	127	(440)	1,089	(211)	
Other	498	398	442	45	585	87	
Total Major Schemes	**9,053**	**5,487**	**5,496**	**9**	**9,230**	**177**	
VAT Refunds	0	0	(324)	(324)	(324)	(324)	2
TOTALS	**12,313**	**7,570**	**6,232**	**(1,337)**	**12,235**	**(78)**	

Capital Programme 2016 / 2017 Cumulative Profile

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 £1.3m behind plan (18%). Excluding the benefit arising from successful VAT recovery agreed with HRMC this would be £0.9m behind plan (14%).

3. Non committed schemes continue to be reviewed to ensure they are fit for purpose and offer value for money.
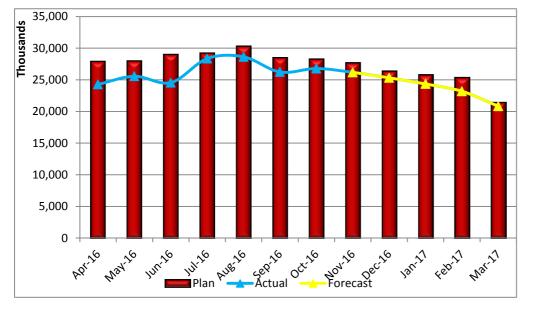
Other minor works are being reviewed against organisational requirements. The current forecast assumes that they will be completed. However options for deferring some spend are being considered so as to preserve the cash position.

4. In November the Trust has disposed of 2 properties which has been made possible by the hub developments. These have realised total receipts of £581k. Other disposals identified in the business cases are progressing.

In line with Trust policy a review of asset valuation has been conducted by the independent District Valuer. The financial impact of this has been reflected within the November financial position. This is made up of:

Impact of MEA assessement	£1,741k
Revaluation of Estate	£1,520k
Impairment	£929k
	£4,190k
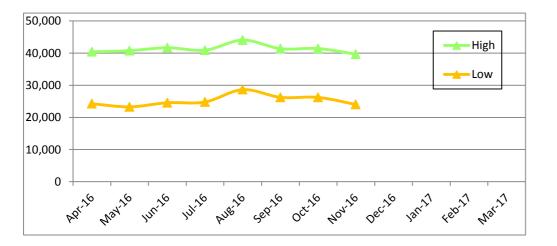
	Plan £k	Actual £k	Variance £k
Opening Balance	27,107	27,107	
Closing Balance	27,689	26,180	(1,509)

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 and lower than planned levels of accruals (meaning that the Trust has received invoices earlier than planned and paid those)

A detailed reconciliation of working capital compared to plan is presented on page 11.

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: £39.6m
The lowest balance is: £24m
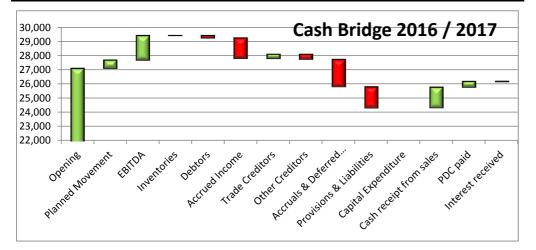
This reflects cash balances built up from historical surpluses that are available to finance capital expenditure in the future.

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)	6,432	8,165	1,733	1
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	2,625	2,448	(177)	
Accrued Income	0	(1,448)	(1,448)	4
Trade Payables (Creditors)	(200)	113	313	
Other Payables (Creditors)	0	(369)	(369)	
Accruals & Deferred income	1,800	(126)	(1,926)	5
Provisions & Liabilities	(1,315)	(2,791)	(1,477)	6
Movement in LT Receivables:				
Capital expenditure & capital creditors	(7,570)	(6,129)	1,440	2
Cash receipts from asset sales	299	720	422	3
PDC Dividends paid	(1,540)	(1,560)	(20)	
Interest (paid)/ received	50	49	(1)	
Closing Balances	**27,689**	**26,181**	**(1,508)**	

Cash Bridge 2016 / 2017

The plan value reflects the April 2016 submission to Monitor.

Factors which increase the cash positon against plan:

1. The normalised surplus position at month 8 is behind plan although year to date remains in a surplus position. As this position includes depreciation charges which are higher than originally planned, and these are non cash, there is still a cash benefit from the surplus position.

2. Capital expenditure, including capital creditors, is less than plan as noted within the capital expenditure report.

3. In disposing of a number of Trust properties in November 2016, the cash receipt (£580k) from sales is now higher than planned.

Factors which decrease the cash position against plan:

4. Accrued income continues to be higher than planned. Quarter 3 recharges will be made, where ever possible, during December 2016.

5. Accruals remain at a low level. Issues with receiving invoices from NHS bodies, and reflected in the plan, have not been experienced to date in 2016 / 2017.

6. Provisions released are higher than planned.
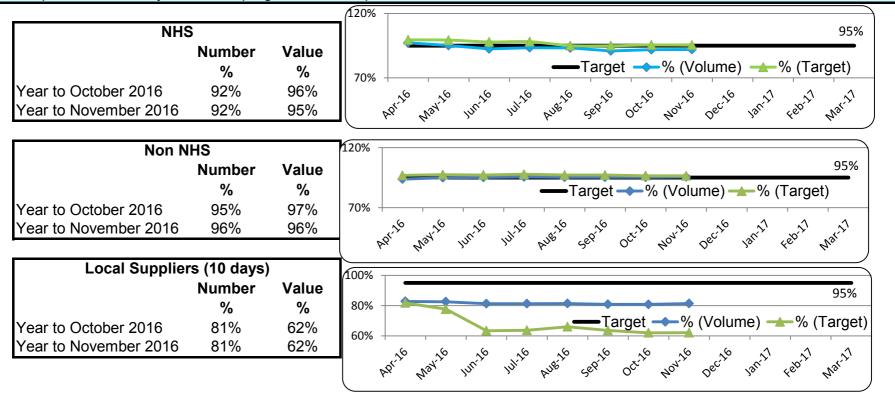
The cash bridge to the left depicts, by heading, the positive and negative impacts on the cash position as compared to plan.

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 October 2016	92%	96%
Year to November 2016	92%	95%

Non NHS	Number %	Value %
Year to October 2016	95%	97%
Year to November 2016	96%	96%

Local Suppliers (10 days)	Number %	Value %
Year to October 2016	81%	62%
Year to November 2016	81%	62%

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.
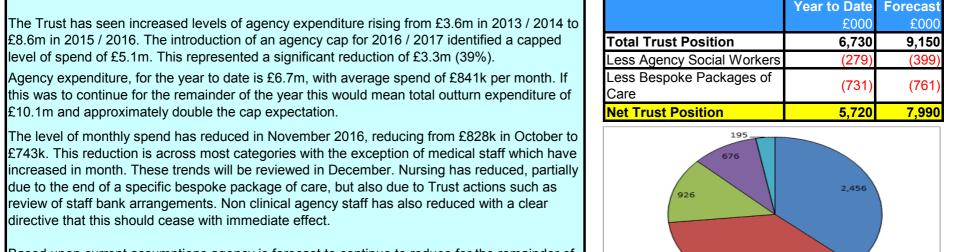
Date	Expense Type	Expense Area	Supplier	Transaction Number	Amount (£)
03/11/2016	Property Rental	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3014544	209,476
07/11/2016	Property Rental	Wakefield	Quest (Wakefield) Ltd	3015113	125,000
03/10/2016	Local Authority Social Work	Wakefield	Wakefield MDC	3010766	61,514
19/10/2016	Drugs	Trustwide	Lloyds Pharmacy Ltd	3012977	48,397
19/10/2016	Drugs	Trustwide	Lloyds Pharmacy Ltd	3012977	46,882
11/10/2016	Radiology SLA	Barnsley	Barnsley Hospital NHS Foundation Trust	3011823	45,238
24/10/2016	Drugs FP10´s	Trustwide	NHSBSA Prescription Pricing Division	3013439	43,432
02/11/2016	Property Rental	Barnsley	Community Health Partnerships	3014378	43,333
02/11/2016	Property Rental	Barnsley	Community Health Partnerships	3014380	43,333
02/11/2016	Property Rental	Barnsley	Community Health Partnerships	3014379	43,333
16/11/2016	CNST contributions	Trustwide	NHS Litigation Authority	3016139	33,986
01/11/2016	Staff Recharge	Trustwide	Leeds and York Partnership NHS FT	3014241	33,055
25/11/2016	Staff Recharge	Kirklees	Kirklees Council	3017308	29,713

Agency costs continue to remain a focus for the NHS nationally including publication by NHS Improvement performance against maximum levels of spend. The most recent publication was based upon performance at Quarter 2; for the first 6 months of 2016 / 2017.
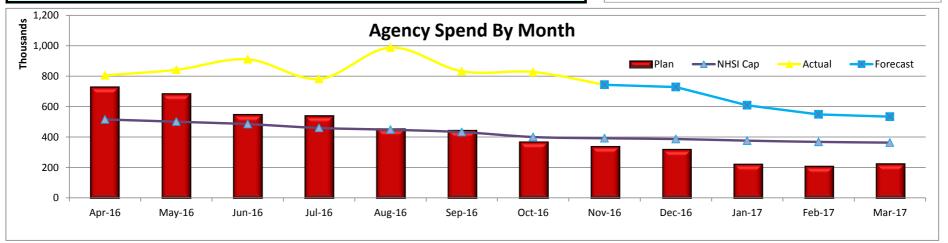
The financial pressure, alongside clinical and other considerations, continues to be a high priority area for the Trust. We acknowledge that agency and other temporary staff have an important role to play within our overall workforce strategy but this must fit within the overall context of ensuring the best possible use of resources and providing a cost effective strategy.

The Trust has seen increased levels of agency expenditure rising from £3.6m in 2013 / 2014 to £8.6m in 2015 / 2016. The introduction of an agency cap for 2016 / 2017 identified a capped level of spend of £5.1m. This represented a significant reduction of £3.3m (39%).

Agency expenditure, for the year to date is £6.7m, with average spend of £841k per month. If this was to continue for the remainder of the year this would mean total outturn expenditure of £10.1m and approximately double the cap expectation.

The level of monthly spend has reduced in November 2016, reducing from £828k in October to £743k. This reduction is across most categories with the exception of medical staff which have increased in month. These trends will be reviewed in December. Nursing has reduced, partially due to the end of a specific bespoke package of care, but also due to Trust actions such as review of staff bank arrangements. Non clinical agency staff has also reduced with a clear directive that this should cease with immediate effect.

Based upon current assumptions agency is forecast to continue to reduce for the remainder of the year. As a minimum these need to be delivered and further cost reductions need to be identified and actioned.

	Year to Date £000	Forecast £000
Total Trust Position	6,730	9,150
Less Agency Social Workers	(279)	(399)
Less Bespoke Packages of Care	(731)	(761)
Net Trust Position	**5,720**	**7,990**

Pie chart (£000): Medical 2,456; Nursing 2,478; Other Clinical 926; A & C 676; Other 195

Agency Spend By Month

In this context the term Out of Area expenditure refers to spend incurred in order to provide clinical care to Service Users in non-Trust facilities. The reasons for taking this course of action can often be numerous and complex but some key trends are highlighted below.

 - Specialist health care requirements of the Service User not available directly from the Trust or not specifically commissioned.
 - No current bed capacity to provide appropriate care
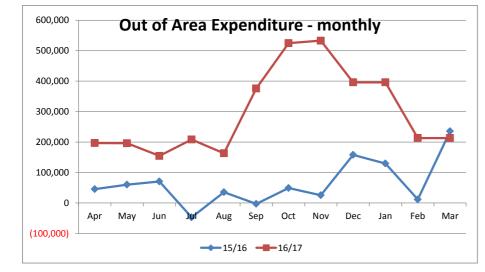
On such occasions a clinical decision is made that the best possible care option is to utilise non-Trust resources. Where ever possible service users are placed within the Trust footprint.

This analysis excludes activity relating to Barnsley, specifically that relating to Locked Rehab. This is directed commissioned and is subject to ongoing negotiations.

Out of Area Expenditure 2015 / 2016 & 2016 / 2017

	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
15/16	46	60	71	(47)	36	(3)	49	25	158	130	12	236	772
16/17	197	196	155	209	163	376	525	533	396	396	213	213	3,572

Bed Day Information 2015 / 2016 & 2016 / 2017

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
15/16	104	152	192	190	246	42	92	119	180	338	439	504	2,598
16/17	294	272	343	310	216	495	755	726					3,411

Bed Day Information 2016 / 2017 (by category)

PICU	138	167	196	144	70	211	367	377					1,670
Acute	96	43	100	89	62	154	288	309					1,141
Gender	60	62	47	77	84	130	100	40					600

Out of Area Expenditure - monthly

This shows that expenditure has increased from £0.8m in 15/16 to forecast spend of £3.6m in 16/17. (362% increase). This has seen a further increased step in September 2016 which has increased into October and November 2016.Factors which have influenced this increase have been:
- Reduced bed capacity arising from bed closures (staffing shortages)
- Reduced bed capacity (12) due to fire on the Fieldhead site
- Increased demand meaning that demand exceeds full operational capacity

Actions being undertaken include:
- OOA bed project focussing on pathways and patient flow
- Trustwide bed management team approach
- ensure that wards are appropriately staffed to allow full bed capacity to be used
- options appraisal of Trust estate with a view to safeguarding additional capacity

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.

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	3.9%	4.0%	4.1%	4.3%	4.3%	4.4%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	3.6%	4.1%	4.6%	4.7%	4.6%	5.6%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	58.6%	69.9%	82.1%	91.5%	92.1%	94.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	23.8%	41.7%	60.4%	77.5%	83.2%	91.4%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	88.0%	86.7%	83.9%	88.0%	84.5%	83.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%		75.5%	75.7%	76.8%	79.0%	80.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		47.5%	55.3%	58.5%	64.3%	66.5%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.4%	92.7%	92.6%	92.6%	92.1%	90.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	86.6%	87.5%	88.4%	88.5%	87.5%	86.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	76.6%	76.9%	79.9%	79.0%	80.7%	81.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	89.8%	89.7%	89.3%	88.5%	87.3%	87.7%
Information Governance	Resources	Well Led	AD	>=95%	90.9%	90.8%	89.9%	89.0%	89.1%	88.8%
Moving and Handling	Resources	Well Led	AD	>=80%	83.7%	83.7%	80.6%	80.3%	79.6%	80.5%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	91.7%	91.7%	90.9%	91.2%	91.2%	91.4%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	89.0%	89.5%	89.3%	89.5%	89.3%	90.1%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%		98.9%	97.4%	97.4%	96.3%	95.7%
Bank Cost	Resources	Well Led	AD		£55k	£66k	£90k	£105k	£79k	£85k
Agency Cost	Resources	Effective	AD		£157k	£127k	£169k	£180k	£152k	£143k
Overtime Costs	Resources	Effective	AD		£12k	£6k	£6k	£4k	£6k	£5k
Additional Hours Costs	Resources	Effective	AD		£35k	£44k	£25k	£24k	£22k	£26k
Sickness Cost (Monthly)	Resources	Effective	AD		£135k	£153k	£177k	£182k	£158k	£171k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		138.43	154.87	156.73	173.89	97.45	116.31
Business Miles	Resources	Effective	AD		113k	114k	123k	116k	130k	115k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.0%	5.3%	5.4%	5.4%	5.3%	5.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.4%	5.7%	5.9%	5.5%	4.9%	3.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	42.9%	56.5%	67.5%	82.4%	85.0%	95.1%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	11.1%	23.1%	35.6%	63.5%	72.3%	87.9%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.9%	83.3%	83.5%	84.3%	80.8%	79.7%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%		47.3%	47.6%	53.7%	57.9%	61.0%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		19.1%	34.6%	35.6%	41.9%	50.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.9%	92.5%	92.3%	89.3%	88.1%	88.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.2%	84.4%	84.5%	83.0%	83.1%	82.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	77.6%	77.4%	77.4%	79.9%	79.8%	79.9%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	84.8%	84.1%	80.0%	77.9%	74.8%	78.0%
Information Governance	Resources	Well Led	AD	>=95%	91.3%	91.7%	89.7%	88.7%	84.0%	83.8%
Moving and Handling	Resources	Well Led	AD	>=80%	81.2%	80.2%	76.5%	73.5%	72.7%	73.4%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.0%	91.2%	90.8%	90.0%	89.4%	89.5%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.9%	86.9%	86.4%	85.3%	84.1%	85.5%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%		98.3%	97.5%	96.4%	95.4%	95.9%
Bank Cost	Resources	Well Led	AD		£134k	£134k	£140k	£150k	£121k	£117k
Agency Cost	Resources	Effective	AD		£143k	£162k	£179k	£165k	£165k	£195k
Overtime Costs	Resources	Effective	AD		£5k	£2k	£2k	£2k	£5k	£2k
Additional Hours Costs	Resources	Effective	AD		£4k	£6k	£1k	£2k	£3k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£123k	£126k	£125k	£119k	£101k	£79k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		71.46	73.49	78.74	69.49	61.86	55.8
Business Miles	Resources	Effective	AD		51k	57k	56k	50k	64k	71k

South West Yorkshire Partnership **NHS**

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.0%	5.7%	5.9%	6.1%	6.00%	5.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.4%	7.1%	6.7%	6.7%	5.80%	5.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	41.9%	55.6%	67.6%	80.9%	87.30%	90.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	5.8%	13.6%	26.5%	49.2%	62.20%	71.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	75.7%	77.6%	78.9%	80.7%	80.30%	82.9%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%		70.0%	62.6%	60.8%	51.60%	49.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		0.0%	0.0%	0.0%	0.00%	0.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	94.0%	93.1%	92.2%	91.9%	90.50%	89.2%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	80.9%	83.5%	84.0%	84.6%	85.10%	84.8%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	89.7%	89.6%	90.0%	88.5%	86.60%	88.3%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	86.8%	87.7%	84.1%	83.0%	81.10%	81.9%
Information Governance	Resources	Well Led	AD	>=95%	89.7%	88.6%	85.5%	84.6%	83.90%	84.6%
Moving and Handling	Resources	Well Led	AD	>=80%	85.9%	86.3%	85.2%	83.6%	83.40%	84.1%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.8%	88.9%	88.8%	88.1%	86.60%	85.3%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.9%	89.3%	88.2%	88.4%	89.00%	85.5%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%		0.0%	12.5%	80.0%	82.40%	77.8%
Bank Cost	Resources	Well Led	AD		£115k	£116k	£134k	£179k	£148k	£125k
Agency Cost	Resources	Effective	AD		£174k	£130k	£163k	£62k	£117k	£80k
Overtime Costs	Resources	Effective	AD		£1k		£0k	£0k	£0k	£125k
Additional Hours Costs	Resources	Effective	AD		£1k		£0k	£0k	£0k	£80k
Sickness Cost (Monthly)	Resources	Effective	AD		£47k	£60k	£60k	£62k	£49k	£0k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		61.1	61.91	56.93	49.49	41.34	£51k
Business Miles	Resources	Effective	AD		10k	14k	6k	9k	8k	33.25

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.3%	5.2%	5.1%	4.9%	4.8%	4.6%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.0%	4.8%	4.8%	4.2%	4.1%	3.9%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	13.3%	31.4%	48.5%	58.9%	63.8%	69.3%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	10.3%	22.9%	35.6%	50.4%	55.6%	61.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	70.1%	69.9%	75.8%	78.2%	77.0%	73.5%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%		49.5%	38.9%	52.0%	61.2%	65.9%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		13.6%	0.0%		9.6%	15.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.5%	93.2%	92.4%	92.3%	89.5%	89.3%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.9%	83.2%	80.8%	82.0%	75.6%	75.7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	68.0%	68.1%	54.2%	60.0%	57.7%	53.8%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	82.6%	83.6%	86.5%	85.1%	84.2%	84.5%
Information Governance	Resources	Well Led	AD	>=95%	88.7%	87.7%	85.9%	85.0%	81.0%	82.7%
Moving and Handling	Resources	Well Led	AD	>=80%	83.2%	81.4%	80.1%	79.0%	77.3%	79.5%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	87.7%	87.3%	86.9%	86.5%	84.8%	84.1%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.1%	86.9%	87.1%	86.7%	84.4%	86.7%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%		90.9%	72.7%		83.6%	87.4%
Bank Cost	Resources	Well Led	AD		£20k	£20k	£20k	£25k	£18k	£22k
Agency Cost	Resources	Effective	AD		£303k	£172k	£269k	£227k	£266k	£197k
Overtime Costs	Resources	Effective	AD		£1k	£3k	£2k	£1k	£2k	£2k
Additional Hours Costs	Resources	Effective	AD		£5k	£6k	£12k	£10k	£3k	£2k
Sickness Cost (Monthly)	Resources	Effective	AD		£45k	£44k	£46k	£40k	£38k	£39k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		76.07	76.05	81.08	76.83	86.37	77.57
Business Miles	Resources	Effective	AD		29k	32k	33k	20k	43k	47k

Workforce - Performance Wall cont…

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.2%	4.0%	4.1%	4.1%	4.2%	4.3%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	3.8%	3.7%	4.2%	4.3%	4.4%	4.3%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	36.4%	52.4%	71.2%	79.3%	83.7%	89.7%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	6.8%	13.7%	34.2%	76.9%	84.3%	87.2%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.4%	75.2%	70.8%	70.3%	70.1%	66.8%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%		66.7%	62.5%	66.7%	65.6%	64.7%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		0.0%	0.0%	0.0%	100.0%	50.0%
Equality and Diversity	Resources	Well Led	AD	>=80%	85.7%	86.7%	87.0%	87.2%	87.8%	87.1%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	77.1%	82.2%	82.5%	81.4%	82.3%	82.0%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	91.7%	93.7%	96.3%	92.2%	95.9%	95.0%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	76.1%	77.0%	74.6%	75.4%	76.9%	76.3%
Information Governance	Resources	Well Led	AD	>=95%	84.2%	86.7%	88.7%	88.3%	86.2%	86.1%
Moving and Handling	Resources	Well Led	AD	>=80%	81.4%	83.4%	82.3%	81.3%	77.6%	80.0%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.1%	87.3%	87.2%	86.2%	88.1%	87.2%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	89.3%	90.0%	90.7%	89.9%	87.5%	88.0%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%		0.0%	0.0%	0.0%	50.0%	50.0%
Bank Cost	Resources	Well Led	AD		£30k	£29k	£40k	£35k	£42k	£26k
Agency Cost	Resources	Effective	AD		£53k	£57k	£39k	£48k	£34k	£42k
Overtime Costs	Resources	Effective	AD		£1k	£0k	£6k	£0k	£4k	£3k
Additional Hours Costs	Resources	Effective	AD		£17k	£16k	£10k	£9k	£10k	£10k
Sickness Cost (Monthly)	Resources	Effective	AD		£53k	£47k	£54k	£57k	£56k	£60k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		82.14	80.4	71.62	73.63	66.29	57.40
Business Miles	Resources	Effective	AD		33k	37k	39k	39k	44k	50k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.1%	5.0%	4.9%	4.8%	4.8%	4.9%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.6%	4.9%	4.3%	4.5%	5.1%	5.0%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	37.0%	50.3%	69.1%	80.6%	88.5%	91.5%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	10.4%	23.1%	43.8%	58.8%	74.8%	78.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.0%	85.9%	86.3%	86.9%	83.9%	83.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%		47.4%	45.1%	50.8%	52.8%	55.2%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		30.4%	34.2%	36.6%	40.2%	41.8%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.7%	94.5%	94.1%	93.0%	93.3%	92.8%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.6%	80.8%	83.7%	82.6%	81.2%	81.2%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	70.3%	73.9%	76.0%	75.2%	77.8%	76.5%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	78.8%	80.8%	81.4%	81.6%	80.1%	79.0%
Information Governance	Resources	Well Led	AD	>=95%	94.5%	94.9%	92.4%	90.8%	90.9%	85.2%
Moving and Handling	Resources	Well Led	AD	>=80%	76.1%	76.1%	70.4%	70.6%	70.8%	69.7%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.3%	89.9%	89.7%	89.3%	89.0%	87.6%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	84.1%	84.2%	84.5%	86.1%	83.1%	80.1%
Sainsbury's Tool	Quality & Experience	Well Led	AD	>=80%		99.3%	98.8%	97.6%	95.0%	94.1%
Bank Cost	Resources	Well Led	AD		£79k	£69k	£87k	£111k	£78k	£83k
Agency Cost	Resources	Effective	AD		£95k	£143k	£170k	£152k	£97k	£96k
Overtime Costs	Resources	Effective	AD		£15k	£12k	£1k	£1k		£3k
Additional Hours Costs	Resources	Effective	AD		£6k	£5k	£3k	£2k	£3k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£52k	£53k	£50k	£57k	£57k	£57k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		61.17	66.14	64.72	67.1	73.43	75.95
Business Miles	Resources	Effective	AD		31k	32k	43k	37k	38k	40k

Glossary

ADHD	Attention deficit hyperactivity disorder	**FOT**	Forecast Outturn	**NICE**	National Institute for Clinical Excellence
AQP	Any Qualified Provider	**FT**	Foundation Trust	**NK**	North Kirklees
ASD	Autism spectrum disorder	**HEE**	Health Education England	**OOA**	Out of Area
AWA	Adults of Working Age	**HONOS**	Health of the Nation Outcome Scales	**OPS**	Older People's Services
AWOL	Absent Without Leave	**HR**	Human Resources	**PbR**	Payment by Results
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield	**HSJ**	Health Service Journal	**PCT**	Primary Care Trust
BDU	Business Delivery Unit	**HSCIC**	Health and Social Care Information Centre	**PICU**	Psychiatric Intensive Care Unit
C&K	Calderdale & Kirklees	**HV**	Health Visiting	**PREM**	Patient Reported Experience Measures
C. Diff	Clostridium difficile	**IAPT**	Improving Access to Psychological Therapies	**PROM**	Patient Reported Outcome Measures
CAMHS	Child and Adolescent Mental Health Services	**ICD10**	International Statistical Classification of Diseases and Related Health Problems	**PSA**	Public Service Agreement
CAPA	Choice and Partnership Approach	**IG**	Information Governance	**PTS**	Post Traumatic Stress
CCG	Clinical Commissioning Group	**IHBT**	Intensive Home Based Treatment	**QIA**	Quality Impact Assessment
CGCSC	Clinical Governance Clinical Safety Committee	**IM&T**	Information Management & Technology	**QIPP**	Quality, Innovation, Productivity and Prevention
CIP	Cost Improvement Programme	**Inf Prevent**	Infection Prevention	**QTD**	Quarter to Date
CPA	Care Programme Approach	**IWMS**	Integrated Weight Management Service	**RAG**	Red, Amber, Green
CPPP	Care Packages and Pathways Project	**KPIs**	Key Performance Indicators	**RiO**	Trusts Mental Health Clinical Information System
CQC	Care Quality Commission	**LD**	Learning Disability	**SIs**	Serious Incidents
CQUIN	Commissioning for Quality and Innovation	**Mgt**	Management	**S BDU**	Specialist Services Business Delivery Unit
CROM	Clinician Rated Outcome Measure	**MAV**	Management of Aggression and Violence	**SK**	South Kirklees
CRS	Crisis Resolution Service	**MBC**	Metropolitan Borough Council	**SMU**	Substance Misuse Unit
CTLD	Community Team Learning Disability	**MH**	Mental Health	**STP**	Sustainability and Transformation Plans
DoC	Duty of Candour	**MHCT**	Mental Health Clustering Tool	**SU**	Service Users
DoV	Deed of Variation	**MRSA**	Methicillin-resistant Staphylococcus aureus	**SWYFT**	South West Yorkshire Foundation Trust
DQ	Data Quality	**MSK**	Musculoskeletal	**SYBAT**	South Yorkshire and Bassetlaw local area team
DTOC	Delayed Transfers of Care	**MT**	Mandatory Training	**TBD**	To Be Decided/Determined
EIA	Equality Impact Assessment	**NCI**	National Confidential Inquiries	**WTE**	Whole Time Equivalent
EIP/EIS	Early Intervention in Psychosis Service	**NHS TDA**	National Health Service Trust Development Authority	**Y&H**	Yorkshire & Humber
EMT	Executive Management Team	**NHSE**	National Health Service England	**YTD**	Year to Date
FOI	Freedom of Information	**NHSI**	NHS Improvement		

KEY for dashboard Year End Forecast Position / RAG Ratings	
4	On-target to deliver actions within agreed timeframes.
3	Off trajectory but ability/confident can deliver actions within agreed time frames.
2	Off trajectory and concerns on ability/capacity to deliver actions within agreed time frame
1	Actions/targets will not be delivered
	Action Complete

NB: The Trusts RAG rating system was reviewed by EMT during October 16 and some amendments were made to the wording and colour scheme.

NHSI Key - 1 – Maximum Autonomy, 2 – Targeted Support, 3 – Support, 4 – Special Measures

Trust Board 20 December 2016
Agenda item 8.1

Title:	Community Mental Health (CMH) Service user Survey
Paper prepared by:	Director of Corporate Development
Purpose:	The Board is asked note the survey results and support the proposed actions
Mission/values:	The paper supports both the Trust's mission to help people reach their potential, live well in their communities and the Trusts strategic objectives to improve people's health and wellbeing, to improve the quality and experience of all that we do, and improve our use of resources. This is achieved through the benchmarking of the services we provide and formulating an action plan to improve the services building on the Trust's values of putting the service user first and in the centre. .
Any background papers/ previously considered by:	Builds upon the previous CMH service user surveys commissioned by the Trust. The paper has previously been considered by the Executive Management Team.
Executive summary:	The CMH survey is an annual survey conducted by the CQC, covering the experiences of over 13,000 people who received specialist care or treatment for a mental health condition in 55 Trusts in England between September and November 2015.

We commissioned The Picker Institute to conduct the survey on behalf of the Trust. Questionnaires were sent to people aged 18 years or over between February/March 2016. 260 responses were received out of 819 questionnaires, a response rate of 32% (national response rate 29%).

The CQC's key findings for England are: *Around two thirds of respondents reported a positive experience of their overall care: when asked to evaluate their overall experience on a scale of 0 to 10, 65% rated this with a score of seven or above. Concerns remain about the quality of care some people using community mental health services receive. There has been no notable improvement in survey results in the last year. The survey results suggest scope for further improvements in a number of areas including: involvement in care, crisis care, care planning and reviews"*

Of the 32 questions asked, SWYPFT improved on 8 questions, stayed the same on 4 questions and deteriorated on 18 questions (since 2015). 2 new questions were added to the questionnaire in 2016. The full list of questions and results are appended to the report. The key points have also been set out in the attached pictorial diagram.

Areas of improvement (>5%)
- 7% increase in the number of people reporting that in the last 12 months a mental health worker checked how they were getting on with their medicines (75% in 2015, 82% in 2016)
- 6% increase in the number of people reporting that in the last 12 months, mental health services gave help or advice with finding support for physical health needs (51% in 2015, 57% in 2016)
- 5% increase in the number of people reporting they knew who was in charge of organising their care and services (72% in 2015, 77% in 2016)
- 5% increase in the number of people reporting NHS mental health services help with what is important to them (62% in 2015, 67% in 2016)

Areas of decline (>5%)
- 7% decrease in the number of people that stated the change in the person they saw did not have a positive impact on their care (75% in 2015, 68% in 2016)
- 6% decrease in the number of people that felt decisions were made together with the person seen (79% in 2015, 73% in 2016) |

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- 6% decrease in number of people reporting their care agreement took their personal circumstances into account (80% in 2015, 74% in 2016)
- 5% decrease in the number of people being involved as much as they wanted to be in discussing how their care is working (80% in 2015, 75% in 2016).
- 5% decrease in the number of people reporting that in the last 12 months they received help or advice from NHS mental health services about finding support for financial advice or benefits (46% in 2015, 41% in 2016)
- 5% decrease in the number of people reporting they were involved as much as they wanted to be in decisions about which medicines they receive (72% in 2015, 67% in 2016)

Nationally, SWYPFT scored 'about the same as most other Trusts' on all 32 questions. With the exception of the following:
- 73% said they had a very good experience overall (National: 61%-75%)
- 85% said the people they saw listened to them carefully (Nationally: 73%-86%).
- 86% said they were treated with dignity and respect (Nationally: 77%-89%).
- 86% said therapies were explained in a way they could understand (Nationally: 75%-90%)

Problem Scores

The problem score shows the percentage of service users for each question who, by their response, indicated that a particular aspect of their care could have been improved. The Picker Institute recognise this to be the simplest summary measure that focuses on quality improvement.

As the name suggests, problem scores indicate where there may be a problem within the Trust, and may need further investigation. We have identified below problem scores over 50%:

Other areas of life: not given information about getting support from people with similar mental health problems	78%
Other areas of life: did not receive support in taking part in a local activity	70%
Day to day living: not given enough support in getting financial advice/benefits	70%
Day to day living: not given enough support with finding/keeping work	68%
Change in people you see: has impacted on care	65%
Day to day living: not given enough support with physical health needs	59%
Crisis care: did not get all the help wanted	56%
Planning care: did not agree what care would be received	55%
Treatments: did not receive treatments or therapies that did not involve medicines	55%
Treatments: was not involved in decisions about medicines	55%
Other areas of life: people in NHS mental health services do not help with what is important	52%
Care or treatment: not seen often enough/seen on time	52%

NOTE: the problem scores are calculated by creating a fraction based upon the total number of responses (this number is placed in the denominator) and the total number of responses that constitute a problem response (this number is placed in the numerator). By dividing the total number of responses into the total number of problem responses a percentage is determined that reflects the Problem/Positive Score. Missing values are excluded from this calculation.

Risk Appetite

The key risks are around service user, carer and public perception of the quality of services we provide, although 73% said they had a very good experience overall (National: 61%-75%), we still have some way to go. The proposed actions will improve the quality of the service we provide and the Trust's reputation in line with the Trust's risk appetite statement.

Conclusion

Overall we are mid table, a position we can and should improve on. Unfortunately because of the timing of the surveys, we may not see a significant improvement in the 2017 survey, as the cohort of people will be selected from people currently in service: September to November 2016.

	Next steps
	Following presentation of the paper at EMT, it was agreed to focus on those areas where we are showing both a decline in performance and where we are at the lower end of the national scores. We have grouped together a number of the questions that meet these two criteria and identified the following themes:
	• Service users being involved in decisions about their own care
	• Service users being provided with information around peer support
	• Service users being provided with information around finding support for financial advice or benefits
	The survey results will be shared with the Community Practice Governance Coaches to look at best practice in the above 3 areas, both within and external to the Trust.
	Through this shared learning, the "Trios" will develop relevant action plans to support the delivery of a person centred and holistic approach to care in line with our mission and values. Where possible, the action plans will be integrated into the existing Quality Plans we have in place re CQC and Customer Service Excellence, rather than being stand alone. The monitoring of the implementation of the plans will be undertaken through the BDU Governance Groups.
Recommendation:	**Trust Board is asked to NOTE the contents of the report and support the actions set out above.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust
2016 NHS Community Mental Health Service User Survey Results

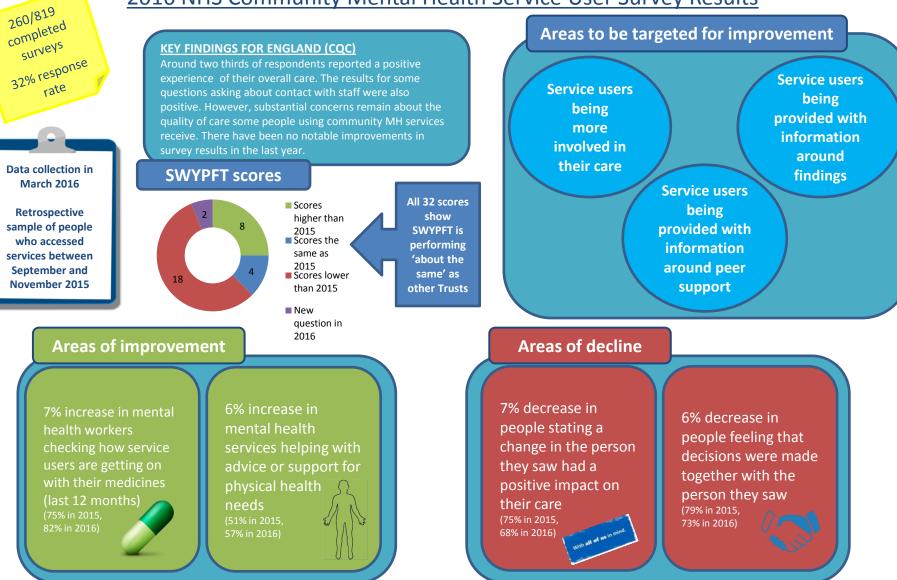| Question	2015	2016	National low/high		Difference
			Low	Hi	
In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?	75%	82%	67%	89%	+7%
In the last 12 months, did NHS mental health services give you any help or advice with finding support for physical health needs?	51%	57%	37%	66%	+6%
Have you been told who is in charge of organising your care and services?	72%	77%	65%	84%	+5%
Do the people you see through NHS mental health services help you with what is important to you?	62%	67%	53%	72%	+5%
In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	41%	45%	28%	56%	+4%
Do you know who to contact out of office hours if you have a crisis?	64%	67%	52%	88%	+3%
Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	65%	67%	55%	75%	+2%
Do you know how to contact this person if you have a concern about your care?	97%	98%	91%	100%	+1%
Overall… [I had a very poor experience – I had a very good experience]	73%	73%	61%	75%	---
Have you agreed with someone from NHS mental health services what care you will receive?	63%	63%	52%	69%	---
Were you involved as much as you wanted to be in decisions about what treatments or therapies to use?	76%	76%	64%	82%	---
Did the person or people you saw listen carefully to you?	85%	85%	73%	86%	---
[Changes in who people see] Were the reasons for this change explained to you at the time? (New Q for 2016)	-	64%	50%	75	---
Were these treatments of therapies explained to you in a way you could understand? (New Q for 2016)	-	86%	75%	90%	---
In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?	74%	73%	58%	82%	-1%
[Changes in who people see] Did you know who was in charge of organising your care while this change was taking place?	56%	55%	38%	73%	-1%
Were you given enough time to discuss your needs and treatment?	78%	77%	68%	82%	-1%
Were you given information about new medicine(s) in a way that you were able to understand?	70%	69%	60%	79%	-1%
[Crisis care] When you tried to contact them, did you get the help you needed?	61%	60%	43%	73%	-1%
Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	87%	86%	77%	89%	-1%

Question	2015	2016	National high/low		Difference
			Low	Hi	
Has someone from NHS mental health services supported you in taking part in an activity locally?	49%	47%	33%	57%	-2%
Have NHS mental health services given you information about getting support from people with experience of the same mental health needs?	37%	35%	28%	49%	-2%
Were you involved as much as you wanted to be in agreeing what care you will receive?	76%	73%	66%	82%	-3%
Did the person or people you saw understand how your mental health needs affect other areas of your life?	75%	72%	62%	78%	-3%
How well does this person organise the care and services you need?	87%	83%	73%	89%	-4%
In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	67%	63%	49%	70%	-4%
Were you involved as much as you wanted to be in decisions about which medicines you receive?	72%	67%	63%	77%	-5%
In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	46%	41%	31%	59%	-5%
Were you involved as much as you wanted to be in discussing how your care is working?	80%	75%	68%	85%	-5%
Does this agreement on what care you will receive take your personal circumstances into account?	80%	74%	71%	83%	-6%
Did you feel that decisions were made together by you and the person you saw during this discussion?	79%	73%	66%	83%	-6%
[Changes in who people see] What impact has this had on the care you receive?	75%	68%	55%	82%	-7%

South West Yorkshire Partnership NHS

NHS Foundation Trust

2016 NHS Community Mental Health Service User Survey Results

260/819 completed surveys

32% response rate

Data collection in March 2016

Retrospective sample of people who accessed services between September and November 2015

KEY FINDINGS FOR ENGLAND (CQC)
Around two thirds of respondents reported a positive experience of their overall care. The results for some questions asking about contact with staff were also positive. However, substantial concerns remain about the quality of care some people using community MH services receive. There have been no notable improvements in survey results in the last year.

SWYPFT scores

- 2
- 8
- 4
- 18

- Scores higher than 2015
- Scores the same as 2015
- Scores lower than 2015
- New question in 2016

All 32 scores show SWYPFT is performing 'about the same' as other Trusts

Areas to be targeted for improvement

Service users being more involved in their care

Service users being provided with information around findings

Service users being provided with information around peer support

Areas of improvement

7% increase in mental health workers checking how service users are getting on with their medicines (last 12 months)
(75% in 2015, 82% in 2016)

6% increase in mental health services helping with advice or support for physical health needs
(51% in 2015, 57% in 2016)

Areas of decline

7% decrease in people stating a change in the person they saw had a positive impact on their care
(75% in 2015, 68% in 2016)

6% decrease in people feeling that decisions were made together with the person they saw
(79% in 2015, 73% in 2016)

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Trust Board 20 December 2016
Agenda item 9.1

Title:	**NHS Constitution**
Paper prepared by:	Director of Corporate Development
Purpose:	To provide assurance to Trust Board that the Trust meets the rights and pledges set out in the NHS Constitution in relation to patients and staff, and that it is mindful of the commitments in the NHS Constitution in delivering, planning and developing its services.
Mission/values:	Meeting the rights and pledges in the NHS Constitution supports the Trust to adhere to its mission and values.
Any background papers/ previously considered by:	NHS Constitution January 2009 and papers to Trust Board in March 2010, September 2011, September 2012, June 2013, September 2014 and September 2015. A full copy of the NHS Constitution can be found on the Department of Health website at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england. The attached assurance document was reviewed and updated as appropriate by the Executive Management Team.
Executive summary:	The NHS Constitution was published in January 2009, following an extensive public consultation during 2008. It established the principles and values for the NHS in England and set out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieving, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required, by law, to take account of the NHS Constitution in their decisions and actions. The NHS Constitution also applies to public health services, which are now the responsibility of local authorities. The Government has committed to renewing the NHS Constitution every ten years with the full involvement of patients who use the NHS, the public who fund it and the staff who work in it. The first review took place in early 2012 and a further review was undertaken following the publication of the second Francis Report, which was published in March 2013. In July 2015, the Constitution was updated to reflect a limited package of changes. These included: ➢ reflecting recommendations made by Sir Robert Francis QC in his Inquiry Report on Mid- Staffordshire NHS Foundation Trust; ➢ incorporating a series of fundamental standards, below which standards of care should never fall; ➢ highlighting the importance of transparency and accountability within the NHS; ➢ giving greater prominence to mental health, through reflecting a parity of

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	esteem between mental and physical health problems; and
	➢ making reference to the Armed Forces Covenant.
	The Trust meets the rights and pledges of the NHS Constitution. There are elements of the Constitution that refer to consultation and involvement with service users. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness makes this inappropriate.
	Risk appetite The delivery of the NHS Constitution rights and pledges supports the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to APPROVE the paper, which demonstrates how the Trust is meeting the requirements of the Constitution.**
Private session:	Not applicable.

The NHS Constitution – patients and the public
How the Trust meets its obligations
Trust Board 20 December 2016

Heading	Compliance	Evidence	Lead
Access to health services – rights			
➤ R1 You have the right to receive NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.	Yes	Core services are commissioned by clinical commissioning groups covering the areas the Trust covers in Barnsley, Calderdale, Kirklees and Wakefield local authority areas, and NHS England (via the Specialist Commissioning Team). Annual contracts and service specifications are evidenced through annual contract negotiations.	Director of finance and resources
➤ R2 You have the right to access NHS services. You will not be refused access on unreasonable grounds.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right.	Director of finance and resources
➤ R3 You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.	Yes	The Trust has contracts in place for its services with commissioners and endeavours to provide access to services within its available resources. The Trust's complaints and contracting processes would identify any instances where the Trust has not met or is perceived not to have met this right.	Director of finance and resources
➤ R4 You have the right to expect your local NHS to assess the health requirements of your community and to commission and put in place the services to meet those needs as considered necessary and, in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.	Yes	The Trust does assesses the health needs of the local community in the development of its operational and strategic plans and, as part of the development of its transformation programme, is working with commissioners, stakeholders, service users and carers, and local people to transform its services and develop new models and pathways of care that meet people's needs. The Trust has also embarked on a major health intelligence project, which will include further assessment of local health needs in relation to modelling future service provision. The Trust is a member of the local Health and Wellbeing Boards who have a statutory duty to do this.	
➤ R5 You have the right, in certain circumstances, to go to other European Economic Area countries or Switzerland for treatment which would be available	N/A		

With **all of us** in mind.

Heading	Compliance	Evidence	Lead
to you through your NHS commissioner.			
➤ R6 You have the right not to be unlawfully discriminated against in the provision of NHS services including on the grounds of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.	Yes	The Trust complies with appropriate legislation relating to discrimination and has an Equality First Strategy in place with the prime aims of respecting and valuing difference and promoting a fairer organisation. The Trust has committed to implementing the NHS Workforce Race Equality Standards (WRES) in accordance with the NHS Standard Contract. The Trust Board established an Equality and Inclusion Forum, which has identified four priorities for 2016/17, including supporting staff and supporting service users into employment. The Trust established a Black, Asian, and minority ethnic (BAME) staff network in 2016/17. The Trust uses an Equality Impact Assessment to evaluate the effect of its strategies and policies on its service users and the communities it serves and publishes these on its website. The Trust is implementing the Equality Delivery System 2 (EDS2) and Trust Board has recently agreed for each of the four EDS2 goals to focus on one key outcome in each area as assessed by service users and staff.	Director of corporate development
➤ R7 You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the Handbook to the NHS Constitution.	N/A	The Trust does not provide services subject to waiting times as outlined in the Handbook to the NHS Constitution; however, the Trust does comply with targets related to services provided in Barnsley (also see P1).	
Access to health services – pledges			
➤ P1 The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the Constitution.	N/A	As part of its contracts with commissioners, the Trust is required to report on local waiting times in relation to improving access to psychological therapies (IAPT) and psychological therapies, referral and treatment times in relation to the Barnsley BDU musculoskeletal service. The Trust meets the required timescale. Access is one of the Trust's quality priorities set out in its Quality Accounts and performance is monitored and reported on a quarterly basis. The Trust has local Commissioning for Quality and Innovation (CQUIN) targets in relation to waiting times for mental health services, which are monitored and reported on a monthly basis.	
➤ P2 The NHS commits to make	Yes	The papers and minutes for public Trust Board meetings are published on	Director of

Heading	Compliance	Evidence	Lead
decisions in a clear and transparent way so that patients and the public can understand how services are planned and delivered.		the Trust's website. The Trust holds an annual members' meeting and regular public events throughout the year. The Trust has a Members' Council in place comprising elected public and staff governors and stakeholder representatives. Meetings are held in public and papers and minutes are published on the Trust's website. The Trust's Communication, Engagement and Involvement Strategy outlines its approach to involvement and engagement. Service users and carers are involved in planning and designing Trust services, including the transformational service change programme. The Trust's services have individual service user groups. A description of the Trust's service offer is available on its website.	corporate development
➢ P3 The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them.	Yes	The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness may make this inappropriate. Care planning is a priority area for the Trust 2016/17. The Trust has improved systems and processes to ensure that all service users have a care plan in place and that they know who is responsible for their care. The Care Programme Approach (CPA) and standard care standards demonstrate the Trust's commitment to put service users at the centre of care planning. Service user and their carers perceptions of the Trust are regularly reviewed through national and local surveys. The Trust is committed to system wide improvement of services and interagency protocols through the Sustainability and Transformation Plans (STPs) and local partnership arrangements.	District Directors / Director of nursing and quality
Quality of care and environment – rights			
➢ R8 You have the right to be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.	Yes	The Trust has in place strong and robust processes for the employment, appraisal and re-validation of medical staff. The Trust ensures all appropriate staff are registered with the Health and Care Professions Council (HCPC). The Trust endeavours to use bank staff where appropriate. In circumstances, where it has to use agency staff, these are from approved suppliers to ensure the quality, skills and experience of staffing is maintained. The Trust has an e-rostering system for all inpatient areas with agreed	Director of nursing and quality / Director HR, OD and estates / Medical director

Heading	Compliance	Evidence	Lead
		establishment levels for qualified and unregistered staff. The Trust is registered with no conditions with the Care Quality Commission. The Trust is licensed by Monitor with no conditions and continues to comply with licencing requirements. The Trust is compliant with relevant National Institute for Health and Care Excellence (NICE) guidelines. The Trust has a robust system in place to undertake appropriate employment checks for all its staff. The Trust has an ongoing Continuous Professional Development approach. A Human Resources and Workforce Development Strategy, including mandatory training plan, is in place. The Trust's Patient Safety Strategy brings all aspects of patient safety together in one document. The Trust has an unannounced visits programme in place supported by the 15-Steps Challenge programme involving staff, service user and carer volunteers.	
➤ R9 You have the right to be cared for in a clean, safe, secure and suitable environment.	Yes	The Trust has established a Board-level Estates Forum to drive implementation of the Estates Strategy to support and meet the needs of services. Development of the Estates Strategy included a detailed six-facet survey of Trust estate. The Trust is compliant with Fire and OHS legislation. The latest round of Patient-led assessments of the care environment (PLACE) visits of the Trust continue to result in a positive outcome. Infection prevention and control advisers and specialist advisers in place with regular programme of audits in place.	Director HR, OD and estates / District Directors
➤ R10 You have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing.	Yes	The Trust's approach is based on the key areas included in the Department of Health Food Standards in relation to nutritional care, healthier eating for the whole hospital community and sustainable procurement of food and catering services. In all areas, the Trust works with its dieticians to create a balanced nutritional and healthy menu to cover the Trust's diverse patient base and also cooks to request for special diets. Work is continuing with procurement to raise awareness of the standards and the role the Trust plays with suppliers. Nursing and medical staff are also aware of their role within the process. These processes are capture within the Trusts Food Policy which was updated to include the latest guidelines including new guidance on allergens.	Director HR, OD and estates

Heading	Compliance	Evidence	Lead
➢ R11 You have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of the healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.	Yes	The Trust's health intelligence programme of work ~~project~~ includes summary statistics on service activity data to enable comparisons of Trust outcomes with the 'what good looks like' and health needs assessment intelligence to support local decision-making to ensure continuous improvement. The Trust Board and its Committees receive performance and other reports. Trust Board reports are publicly available on the Trust's website. The Trust has a transformational service change programme in place with an ongoing programme of engagement and involvement. Dedicated website pages and inclusion in Like Minds, supported by two-year operational and five-year strategic plans to our regulator. Trust's own programme of visits to all in-patient locations and a range of community teams registered with the Care Quality Commission where compliance with essential standards is reviewed. Supported by 15 Steps Challenge. The Trust continues to work towards the delivery of the action plan agreed with the Care Quality Commission following unannounced visits and has processes in place to learn from the outcome of previous visits to the Trust. The Trust has a programme of PLACE visits undertaken annually, which continue to achieve positive results.	Director of finance and resources / Director of nursing and quality
Quality of care and environment – pledges			
➢ P4 The NHS commits to identify and share best practice in quality of care and treatments.	Yes	The Trust introduced a new leadership and clinical management structure, including Practice Governance Coaches whose role is to ensure best practice is being followed and effective clinical governance is maintained and developed. The Trust has quality improvement and patient safety strategies with implementation plans in place and formal systems in place to share good practice through the Quality Improvement Group. Accreditation for Trust services, such as ECT, memory services in Barnsley, Calderdale and Wakefield, and secure services peer review undertaken annually. Francis values into action group reviewed actions arising out of the Francis Report at Director-level. Living our values and values into excellence introduced in 2014 for staff. Trust unannounced visits programme supported by 15 Steps Challenge. Clinical network for forensic services with providers as part of Allied Health Science Network members and the West Yorkshire Sustainability and	Executive Management Team

Heading	Compliance	Evidence	Lead
		Transformation Plan (STP). Annual staff Excellence Awards which celebrate the difference that our staff and teams make to the lives of local people. (also see R11)	
Nationally approved treatments, drugs and programmes – rights			
➤ R12 You have the right to drugs and treatments that have been recommended by NICE for use in the NHS, if you doctor says they are clinically appropriate for you.	Yes	The Trust is compliant with relevant NICE guidelines. The Trust has a policy and procedures in place with timelines to implement NICE guidance. The Trust has a robust procedure in place for the approval and oversight of medical treatments within the Drug and Therapeutic Subcommittee.	Director of nursing and quality / Medical director
➤ R13 You have the right to expect local decisions on funding of other drugs and treatments to be made rationally following proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain the decision to you.	N/A		
➤ R14 You have the right to receive vaccinations that the Joint Committee on Vaccinations and Immunisation recommends that you should receive under an NHS-provided national immunisation programme.	N/A	The Trust is commissioned by NHS England to provide school age children (5-19) vaccination and immunisation programme including flu. A comprehensive service for immunisation and vaccination to the 0-19 population of Barnsley is delivered by BMBC Public Health following re-commissioning arrangements October 2016. The Trust, in partnership, upholds the principles, values pledges and responsibilities as a significant partner in providing sign-posting arrangements and every contact counts capability in demonstrating partnership working. Pharmacy support continues to be provided by the Trust.	District Director
Nationally approved treatments, drugs and programmes – pledges			
➤ P5 The NHS commits to provide screening programmes as recommended by the UK National Screening Committee.	N/A	Where appropriate, all national screening programmes are in place and managed through the Screening Advisory Committee for South Yorkshire in respect of screening services provided by Barnsley BDU.	District Director
Respect, consent and confidentiality – rights			
➤ R15 You have the right to be treated with dignity and respect, in accordance with your human rights.	Yes	Staff work to professional codes of conduct, Trust policies and CPA standards. The Trust's Equality and Diversity Policy sets out how the Trust accords to an individual's human rights.	District Directors / Medical director /

Heading	Compliance	Evidence	Lead
		Francis values into action group reviewed actions arising out of the Francis Report at Director-level. Living our values and values into excellence were introduced in 2014 for staff. The Trust has values based recruitment and induction programme. The Trust has a strong pastoral care function to support service users and their carers, and staff. The Trust has a contractual duty of candour and has arrangements in place to ensure it meets the extended legal duties of candour introduced by the Care Quality Commission.	Director of corporate development / Director of nursing and quality
➢ R16 You have the right to be protected from abuse and neglect, and care and treatment that is degrading.	Yes	The Trust has a robust policy and arrangements in place through its approaches to safeguarding vulnerable adults and children and is an active member of local safeguarding boards at director-level.	Director of nursing and quality / District Directors
➢ R17 You have the right to accept or refuse treatment that is offered to you, and not be given any physical examination or treatment unless you have given valid consent. If you do not have the capacity to do so, consent must be obtained from a person legally able to act on your behalf, or the treatment must be in your best interests. (NB different rules apply for patients detained in hospital or on supervised community treatment under the Mental Health Act 1983.)	Yes	The Trust has a Consent Policy in place. The Trust has clear policies, procedures and guidance in place for the administration of the Mental Health Act, Mental Capacity Act and for Deprivation of Liberty Standards. The Trust works in partnership with advocacy services provided by local authorities to provide support for service users and carers. The Trust's complaints processes would identify any instances where the Trust has not met or is perceived not to have met this right.	Medical director / Director of nursing and quality
➢ R18 You have the right to be given information about the test and treatment options available to you, what they involve and their risks and benefits.	Yes	The Trust has medicine information leaflets including translation into other languages if required and utilises information available from NHS Choices. Service user information leaflets, which set out service user rights. Service users are given copies of their care plans. Service users and carers are part of developing Trust approach to care planning. Ongoing engagement with service users and carers, particularly around CPA.	Medical director

Heading	Compliance	Evidence	Lead
➤ R19 You have the right of access to your own health records and to have any factual inaccuracies corrected.	Yes	Patient Identifiable Information Policy – service user access. Freedom of Information Policy. The Trust complies with requirements of Information Governance Toolkit, CQC registration and Monitor's licence conditions.	Director of finance and resources / Director of corporate development
➤ R20 You have the right to privacy and confidentiality and to expect the NHS to keep your confidential information safe and secure	Yes	Trust meets Department of Health privacy and dignity guidance and has made a declaration of compliance to Monitor and to service users regarding elimination of mixed sex accommodation. The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area. When breaches do occur they are thoroughly investigated with learning identified and notification to the Commissioner where appropriate.	Director of nursing and quality Director of finance and resources
➤ R21 You have the right to be informed about how your information is used.	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area.	Director of finance and resources / Director of corporate development
➤ R22 You have the right to request that your confidential information is not used beyond your own care and treatment and to have your objections considered and, where you wishes cannot be followed, to be told the reasons, including the legal basis.	Yes	Patient Identifiable Information Policy – service user access. Freedom of Information Policy. The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area.	Director of finance and resources / Director of corporate development
Respect, consent and confidentiality – pledges			
➤ P6 The NHS commits to ensure those involved in your care and treatment have access to your health information so they can care for you safely and effectively.	Yes	The Trust has two main clinical information systems, RiO and SystmOne, across its business delivery units. The Trust is also working with partners to ensure interoperability between systems, such as those used by local authorities, to make accessing information on care easier for staff working in integrated teams. Information sharing protocols in place with partners as appropriate.	Director of finance and resources
➤ P7 The NHS commits that, if you are	Yes	The Trust is able to make a declaration that it complies with the national	Director of

Heading	Compliance	Evidence	Lead
admitted to hospital, you will not have to share sleeping accommodation with patients of the opposite sex, except where appropriate, in line with details set out in the Handbook to the NHS Constitution.		standard in relation to Eliminating Mixed Sex Accommodation.	nursing and quality
➤ P8 The NHS commits to anonymise the information collected during the course of your treatment and use it to support research and improve care for others.	Yes	The Trust has a confidentiality and data protection policy and has systems and processes in place regarding access to and transfer of personally identifiable data. The Trust complies with the requirements of the Information Governance Toolkit and Department of Health requirements to train staff in this area. When breaches do occur they are thoroughly investigated with learning identified and notification to the Commissioner where appropriate. The Trust has robust governance arrangements in place to cover its research and development work.	Director of finance and resources
➤ P9 The NHS commits, where identifiable information is used, to give you the chance to object wherever possible.	Yes	As above (see P8).	Director of finance and resources
➤ P10 The NHS commits to inform you of research studies in which you may eligible to participate.	Yes	The Trust has an in house research and development department that manages, facilitates and governs all research to ensure it reflects services and the geographical area the Trust serves. Support is available to staff, patients/service users and carers who would like to become more involved in research as well as those who are established researchers. Advice and information is available on NHS research approval, ethics, the research passport, letters of access, training and funding opportunities, patient/service user and carer involvement in research and dissemination.	Medical director
➤ P11 The NHS commits to share with you any letters sent between clinicians about your care.	Yes	All service users have access to their clinical records (Patient Identifiable Information Policy – service user access). Service users are offered a copy of their care plan. Service users receive a copy of any correspondence between clinicians about them unless there is a specific risk identified to their physical and/or mental wellbeing.	Director of nursing and quality / Director of finance and resources / District Directors
Informed choices – rights			

Heading	Compliance	Evidence	Lead
➤ R23 You have the right to choose your GP practice and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons.	N/A		
➤ R24 You have the right to express a preference for using a particular doctor within your GP practice and for the practice to try to comply.	N/A		
➤ R25 You have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others nationally.	N/A		
➤ R26 You have the right to make choices about the services commissioned by NHS bodies and to information to support these choices. The options available to you will develop over time and depend on your individual needs.	N/A		
Informed choices – pledges			
➤ P12 The NHS commits to inform you about the healthcare services available to you, locally and nationally.	Yes	Information is available on the Trust's website and in information leaflets. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams.	Director of corporate development / District Directors
➤ P13 The NHS commits to offer you easily accessible, reliable and relevant information in a form you can understand and support to use it. This will enable you to participate fully in your own healthcare decisions and to support you in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.	Yes	Information available on Trust's website, in information leaflets and the Trust's Quality Accounts. The Trust's service offer by district is available on its website, which provides individual service information on services offered and teams. Information on mental health conditions is included on the Trust's website. Service user survey findings are displayed on wards and units. Feedback mechanisms are in place for service users and their carers, including 'real time' collection of customer experience feedback. Advocacy information is available on wards and in patient information. The Trust is compliant with Accessible Information Standards and has implemented Easy Read options for commonly accessed documents.	District Directors / Director of corporate development / Director of nursing and quality

Heading	Compliance	Evidence	Lead
Involvement in your healthcare and in the NHS – rights			
➢ R27 You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers. This includes being given the chance to manage your own care and treatment, if appropriate.	Yes	As above (see R18, P12, P13). The Trust offers and has available interpreter services either face-to-face or by telephone. An agreed end-of-life care pathway in Barnsley involving all agencies involved in end-of-life care is in place.	District Directors / Director of corporate development
➢ R28 You have the right to an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.	Yes	The Trust has a Duty of Candour policy in place supported by robust processes for complaints and redress. The Trust monitors compliance with the policy which is reviewed by the Clinical Governance and Clinical Safety Committee.	Director of nursing and quality / Director of corporate development
➢ R29 You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in the decisions to be made affecting the operation of those services.	Yes	Patients, services users and their carers can be involved in the Trust through the Members' Council, Trust membership and volunteering. Communication, Engagement and Involvement Strategy in place. The Trust is continuing to ensure service users and carer groups to ensure all teams and wards will have the ability to involve, listen and respond to feedback from people who use Trust services at all levels of the organisation. Trust service users/carers on local partnership boards. Information provided to local HealthWatch. There is a programme of public engagement events in place involving service users and carers regarding Trust plans and the transformational change programme.	Director of corporate development
Involvement in your healthcare and in the NHS – pledges			
➢ P14 The NHS commits to provide you with the information and support you need to influence and scrutinise the	Yes	As above (see P2, P3, R29).	Director of corporate development

Heading	Compliance	Evidence	Lead
planning and delivery of NHS services.			
➤ P15 The NHS commits to work in partnership with you, your family, carers and representatives.	Yes	As above (see P2, P3).	District Directors / Director of corporate development
➤ P16 The NHS commits to involve you in discussions about planning your care and to offer you a written record of what is agreed if you want one.	Yes	Service users are offered a copy of their care plan. The Trust endeavours to consult and involve all service users and, where appropriate, their carers, in decisions about their care; however, there will be occasions when the nature of an individual's illness makes this inappropriate.	District Directors / Director of nursing and quality / Medical director
➤ P17 The NHS commits to encourage and welcome feedback on your health and care experiences and use this to improve services.	Yes	The Trust welcomes feedback from service users and carers and actively encourages people to comment on its services. The Trust uses this information to inform service development and improvement. The Trust is working towards real time service user feedback through the Friends and Family service user test. Service user surveys are undertaken as part of commissioner-agreed CQUINs across all BDUs. Public engagement events held throughout the year. Feedback facility on the Trust's website. Feedback is provided through the Customer Services Team, which is reported to Trust Board quarterly and annually.	Director of corporate development
Complaints and redress – rights			
➤ R30 You have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated.	Yes	Customer Services Policy and Customer Service Team structure with quarterly reports to Trust Board. Performance measures in place.	Director of corporate development
➤ R31 You have the right to discuss the manner in which the complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response sent.	Yes	As above. The Trust encourages face to face meetings to discuss complaints.	Director of corporate development
➤ R32 You have the right to be kept informed of the progress and to know	Yes	Customer Services Policy and Customer Service Team structure. All responses are shared with complainants and personally signed by the	Director of corporate

Heading	Compliance	Evidence	Lead
the outcome of any investigation into your complaint, including an explanation of the conclusions and confirmation that any action needed in consequence of the complaint has been taken or is proposed to be taken.		Chief Executive. Learnings are discussed by the Trust Board.	development
➤ R33 You have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman or Local Government Ombudsman if you are not satisfied with the way your complaint has been dealt with by the NHS.	Yes	Customer Services Policy and Customer Service Team structure.	Director of corporate development
➤ R34 You have the right to make a claim for judicial review if you think you have been directly affected by an unlawful act or decision of an NHS body or local authority.	Yes	Customer Services Policy and information on Trust websites.	Director of corporate development
➤ R35 You have the right to compensation where you have been harmed by negligent treatment.	Yes	Claims Management Policy.	Director of nursing and quality
Complaints and redress – pledges			
➤ P18 The NHS commits to ensure you are treated with courtesy and you receive appropriate support throughout the handling of a complaint and the fact that you have complained will not adversely affect your future treatment.	Yes	Customer Services Policy and Customer Service Team structure.	Director of corporate development
➤ P19 The NHS commits to ensure that, when mistakes happen or if you are harmed while receiving health care, you receive an appropriate explanation and apology, delivered with sensitivity and recognition of the trauma you have experienced, and know that lessons will be learned to help avoid a similar incident occurring again.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. Arrangements in place to ensure the Trust and its staff meet the Trust's Duty of Candour responsibilities.	Director of nursing and quality

Heading	Compliance	Evidence	Lead
➤ P20 The NHS commits to ensure that the organisation learns lessons from complaints and claims and uses these to improve NHS services.	Yes	The Trust has robust processes in place to investigate and learn from its mistakes and to share lessons across services and districts. Quality Improvement Group established to share learning between and across BDUs. Learning lessons reports are reviewed by the Clinical Governance and Clinical Safety Committee. Post investigation meetings are held at a local level.	Director of nursing and quality / Medical director

The NHS Constitution also sets out nine responsibilities of patients and the public.

- ➤ Please recognise that you can make a significant contribution to your own, and your family's, good health and well-being, and take some personal responsibility for it.
- ➤ Please register with a GP practice – the main point of access to NHS care as commissioned by NHS bodies.
- ➤ Please treat NHS staff and other patients with respect and recognise that violence or the causing nuisance or disturbance on NHS premises could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.
- ➤ Please provide accurate information about your health, condition and status.
- ➤ Please keep appointments, or cancel within reasonable time. Receiving treatment within the maximum waiting times may be compromised unless you do.
- ➤ Please follow the course of treatment which you have agreed, and talk to your clinician if you find this difficult.
- ➤ Please participate in important public health programmes such as vaccination.
- ➤ Please ensure that those closest to you are aware of your wishes about organ donation.
- ➤ You should give feedback – both positive and negative – about your experience and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

The NHS Constitution – staff
How the Trust meets its obligations
Trust Board 20 December 2016

Heading	Compliance	Evidence	Lead
The rights are there to help ensure staff:			
➢ have a good working environment with flexible working opportunities, consistent with the needs of patients and with the way that people live their lives;	Yes	HR policies and procedures on annual leave, sickness absence, flexible working, carer leave, adoption rights and benefits, age retirement, equal opportunities in employment, job share, paternity leave, maternity leave, special leave, stress, etc. Also Harassment and Bullying Policy and Grievance Policy and Procedures in place. Friends and Family Test for staff. Wellbeing survey/national staff survey. Occupational health policy and service in place. Values-based recruitment, induction and appraisal policies in place.	Director HR, OD and estates
➢ have a fair pay and contract framework;	Yes	HR Strategy framework. Trust pay structure based on Agenda for Change and Trust follows guidance issued by National Pay Bodies as appropriate. HR Policies and Procedures as above. HR Strategy sets out Trust approach to pay. Commitment to the Living Wage.	Director HR, OD and estates
➢ can be involved and represented in the workplace;	Yes	Disciplinary Policy and Procedures. Grievance Policy and Procedures Set out in the Social Partnership Agreement between the Trust and staff side organisations. Staff engagement strategy. Staff engagement events. Annual staff survey.	Director HR, OD and estates
➢ have healthy and safe working conditions and an environment free from harassment, bullying or violence;	Yes	HR policies and procedures. Staff survey. Health and Safety Policy. Health and Safety Steering Group. Health and Safety annual audit and work programme. Occupational health service. Risk assessments of workplace. Managing Aggression and Violence lead in place with supporting Management of Violence and Aggression Trust Action Group (MAV TAG).	Director HR, OD and estates
➢ are treated fairly, equally and free from	Yes	HR policies and procedures.	Director HR,

Heading	Compliance	Evidence	Lead
discrimination;		Equality and inclusion Trust Action Group (TAG) in place. Trust staff are required to undertake mandatory equality training. Equality networks, annual workforce equality impact assessment. Equality impact assessment of all policies and procedures.	OD and estates
➢ can, in certain circumstances, take a complaint about their employer to an Employment Tribunal;	Yes	Disciplinary and Grievance Policies and Procedures.	Director HR, OD and estates
➢ can raise any concern with their employer, whether it is about safety, malpractice or other risk, in the public interest.	Yes	HR Policies and Procedures. Information given to staff and Trust welcome events include information for staff. Whistleblowing Policy. Raising concerns leaflet widely available.	Director HR, OD and estates

The NHS Constitution also sets out seven staff pledges, which, although not legally binding, represent a commitment by the NHS to provide high-quality working environments for staff.

➢ The NHS commits to provide a positive working environment for staff and to promote supportive, open cultures that help staff do their job to the best of their ability.
➢ The NHS commits to provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.
➢ The NHS commits to provide all staff with personal development, access to appropriate training for their jobs and line management support to enable them to fulfil their potential.
➢ The NHS commits to provide support and opportunities for staff to maintain their health, well-being and safety.
➢ The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.
➢ The NHS commits to have a process for staff to raise an internal grievance.
➢ The NHS commits to support all staff in raising concerns at the earliest reasonable opportunity about safety, malpractice, or wrongdoing at work, responding to and, where necessary, investigating the concerns raised and acting consistently with the Public Interest Disclosure Act 1998.

The NHS Constitution also sets out six existing legal duties that staff must observe. (This list is not meant to be exhaustive.)

➢ To accept professional accountability and maintain the standards of professional practice as set by the appropriate regulatory body applicable to your profession or role.
➢ To take reasonable care of health and safety at work for you, your team and others, and to co-operate with employers to ensure compliance with health and safety requirements.

- To act in accordance with the express and implied terms of your contract of employment.
- Not to discriminate against patients or staff and to adhere to equal opportunities and equality and human rights legislation.
- To protect the confidentiality of personal information that you hold unless to do so would put anyone at risk of significant harm.
- To be honest and truthful in applying for a job and in carrying out that job.

The Constitution also sets out how staff should play their part in ensuring the success of the NHS.

- You should aim to provide all patients with safe care, and to do all you can to protect patients from avoidable harm.
- You should follow all guidance, standards and codes relevant to your role, subject to any more specific requirements of your employers.
- You should aim to maintain the highest standards of care and service, treating every individual with compassion, dignity and respect, taking responsibility not only for the care you personally provide, but also for your wider contribution to the aims of your team and the NHS as a whole.
- You should aim to find alternative sources of care or assistance for patients, when you are unable to provide this (including for those patients who are not receiving basic care to meet their needs).
- You should aim to take up training and development opportunities provided over and above those legally required of your post.
- You should aim to play your part in sustainably improving services by working in partnership with patients, the public and communities.
- You should aim to raise any genuine concern you may have about a risk, malpractice or wrongdoing at work, (such as a risk to patient safety, fraud or breaches of patient confidentiality), which may affect patients, the public, other staff, or the organisation itself at the earliest reasonable opportunity.
- You should aim to involve patients, their families, carers or representatives fully in decisions about prevention, diagnosis and their individual care and treatment.
- You should aim to be open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.
- You should contribute to a climate where the truth can be heard and the reporting of, and learning from, errors is encouraged and colleagues are supported where errors are made.
- You should aim to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care.
- You should aim to take every appropriate opportunity to encourage and support patients and colleagues improve their health and wellbeing.
- You should aim to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access and outcomes between differing groups or sections of society requiring health care.
- You should aim to inform patients about the use of their confidential information and to record their objections, consent or dissent.
- You should aim to provide access to a patient's information to other relevant professionals, always doing so securely, and only where there is a legal and appropriate basis to do so.

Trust Board 20 December 2016
Agenda item 9.2

Title:	**CQC Revisit – well led review update**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To update on preparation for the forthcoming CQC well led review revisit.
Mission/values:	The paper describes our understanding of the well led review revisit process and the work required to ensure that we can all explain how we have responded positively to our CQC report, in a manner consistent with our desire to improve and aim to be outstanding. Our approach is also consistent with our strategic objective to improve the quality and experience of all that we do.
Any background papers/ previously considered by:	Progress against our CQC action plan has been reported on a monthly basis through our IPR with more detailed reports taken in Clinical Governance and Clinical Safety Committee and Mental Health Act Committee.
Executive summary:	**Introduction** The CQC will return to the Trust in January 2017 to undertake a 'well led 'review, which the CQC define as, 'By well led, we mean that the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture. We have a common understanding of what a good organisation looks like and what it should be able to demonstrate, creating coherence, consistency and transparency across our regulatory activities'. ***In essence the CQC want to see evidence of the 'golden thread' that runs through the organisation that demonstrates ward to board connectivity***. This paper has been prepared to assist members of the Board understand and prepare for this review. Within the details below you will note there is a strong operational delivery system focus, as the CQC will want strong evidence of staff engagement with the areas they identified as actions we 'must' take. That said each Director needs to be aware of what actions are being taken across the system as the CQC will want to see connectivity i.e. that each corporate service is aligned to ensure we have a focus on ***the delivery of sustainable high quality person-centred care***. The main purpose of the paper is to describe our state of readiness and consider what is required to ensure that we are fully prepared for the review. **Well led review** The exact format of the review is not clear but we anticipate the key lines of enquiry to be against the actions in the overall report. The previous visit included professional discussion groups and interviews with key senior managers and directors. The well led review will be conducted after the majority of the service line revisits have taken place, with the exception of the MH acute wards. Any new

intelligence from these visits will be used to inform the preparation.

The Board has received regular updates on action plan progress with progress reports being provided to Trust Board via the IPR with further discussion and review taking place at the Clinical Governance & Clinical safety Committee and Mental Health Act Committee.

The Board is aware that the action plan covers both the 'must do' and the 'should do' actions for all service areas but also includes the actions relating to the overall report which will form the main focus of the well led review.

CQC inspection action plan – anticipated key lines of enquiry

- The CQC action plan governance arrangements – process for assuring the delivery of the action plan.
- Awareness of the trust wide actions in relation to key areas cited in report
  - o Safer staffing
  - o Mental Health Act/Mental Capacity Act
  - o Duty of candour
  - o Patient safety strategy
  - o Quality improvement
  - o Fit and proper person
  - o Monitoring of high dose antipsychotic medication
  - o Lines of sight
  - o Ligature risk assessments
  - o Learning lessons locally and trust wide.
- Changes in operational governance arrangements in response to the report.
- Staff engagement on revisit.

Action to date

EMT has considered our state of readiness by reviewing the CQC report findings, and understanding of action taken. Progress against our action plan is positive and this can be demonstrated. Coordination of our key messages around action to date will be required prior to the visit. A plan will be put into place following the next CQC meeting (held 15th December 2016) where further details may become available.

Next steps

- Briefing sessions to be provided to NEDs on the KLOE.
- Further dialogue with CQC on well led review format and expectations.
- Maintain action plan reporting.
- Collation of evidence in anticipation of review.

Recommendation:	**Trust Board is asked to NOTE the update and consider if any further preparation for Board members is required.**
Private session:	N/A

With **all of us** in mind.

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 9.3

Title:	**Agency staff self-certification**
Paper prepared by:	Medical Director/Deputy Chief Executive
Purpose:	For Trust Board to note the submission of the Statement of Self-Certification
Mission/values:	To ensure the appropriate use of resources in line with the Trust's strategic objective, to improve people's health and wellbeing and to improve the quality and experience of all that we do
Any background papers/ previously considered by:	Agency use and impact on financial governance rating included in previous Trust Board finance and performance reports
Executive summary:	The Trust's use of agency staff is currently significantly above the cap prescribed by NHS Improvement. Review of agency spend has demonstrated an increased overall spend in the current financial year compared to previous. Regional comparator data also shows the Trust to be in the lower quartile in performance terms of agency spend, relative to total staff costs.
	The Trust Board was required to submit a completed agency checklist to NHS Improvement, signed on behalf of the Board by the Chair and Chief Executive. This was duly submitted on 30 November 2016.
	The self-certification process allows for the description of current control measures in place and further proposed actions. This will ensure that there is a robust operational grip on agency usage together with a strategic plan for more effective resource utilisation. The process also ensures that there is clear executive level accountability for reducing specific areas of agency spend. Specific plans are outlined with regard to governance and accountability, the timely use of data, adopting robust process for approving and reducing agency use and working within the wider health economy.
	Key identified risks include recruitment difficulties secondary to procurement activity and unpredictable levels of acuity or bespoke package of care delivery, which have historically driven agency staff spending. The overall level of risk is assessed at moderate on the basis of the level of completed actions and processes in place.
Recommendation:	**Trust Board is asked to NOTE the submission of the self-certification.**
Private session:	Not applicable.

With **all of us** in mind.

Self-certification checklist Please discuss this in your board meeting	Yes - please specify steps taken	No. We will put this in place - please list actions
Governance and accountability		
1 — Our trust chief executive has a strong grip on agency spending and the support of the agency executive lead, the nursing director, medical director, finance director and HR director in reducing agency spending.	Upon joining the Trust the CE instigated a review into agency spend and wrote to NHSI explaining the key reasons for agency spend being incurred and actions being taken to address. The full executive team review agency spend and actions on a monthly basis. The Operational Management Group review agency spend fortnightly. The Business Delivery Units review agency spend at least monthly and medical locum usage - our biggest spend - is reviewed every week.	
2 — Reducing nursing agency spending is formally included as an objective for the nursing director and reducing medical agency spending is formally included as an objective for the medical director.	Achievement of financial targets are included in all director objectives. Additionally, within the Medical Workforce Strategy there is a stated objective to reduce the dependency on agency staff, for which the Medical Director is accountable.	From November, the Nursing Director's objectives have been revised to explicitly include the requirement to reduce agency expenditure.
3 — The agency executive lead, the medical director and nursing director meet at least monthly to discuss harmonising workforce management and agency procurement processes to reduce agency spending.	The Executive team meets weekly. The Executive team discusses this issue at least monthly as part of the business cycle. It is supported by a monthly safer staffing meeting, where a review of staffing complements is undertaken in detail.	From November, the Executive lead for reducing agency spend is the new Deputy CEO, who is also the Medical Director.
4 — We are not engaging in any workarounds to the agency rules.	The Trust expects all staff to live the values of the organisation and behave accordingly. The national frameworks and agency rules are used and agency usage is reviewed regularly to identify if there are any issues which need to be addressed. There have not been any workarounds identified.	Given the current state of expenditure, agency rules will be reinforced by updating Trust procedures with effective communication and management of the changes.
High quality timely data		
5 — We know what our biggest challenges are and receive regular (eg monthly) data on: - which divisions/service lines spend most on agency staff or engage with the most agency staff - who our highest cost and longest serving agency individuals are - what the biggest causes of agency spend are (eg vacancy, sickness) and how this differs across service lines.	This information is reviewed at BDU level and total Trust level on at least a monthly basis. It is also a regular item at the Trust Operational Management Group (OMG) meetings which occur fortnightly. Workforce performance data is produced on this issue which is reviewed at all levels of the organisation and available on the Workforce Performance Wall on the intranet.	The medical agency staff are reviewed on a weekly basis by the medical director and individual plans for the discontinuation of each post will be agreed with the clinical leads from November with a focus on high cost areas.
Clear process for approving agency use		
6 — The trust has a centralised agency staff booking team for booking all agency staff. Individual service lines and administrators are not booking agency staff.	The Trust has introduced a central bank function in September to help control temporary staffing. Prior to booking an agency worker, the centralised bank is used as the first port of call. We do not have a centralised agency booking team. Responsibility for booking sits within individual service lines. We believe this is the most appropriate place for bookings to sit to ensure quality of care. There is centralised oversight and scrutiny of all medical locums used, on a weekly basis.	The Trust will investigate whether a centralised agency booking system would provide any benefits and help balance cost and quality.
7 — There is a standard agency staff request process that is well understood by all staff. This process requires requestors and approvers to certify that they have considered all alternatives to using agency staff.	The Trust has a temporary and agency staffing policy and also an e-rostering policy. The e-rostering policy clearly states the process that must be undertaken before agency staffing can be used and that it must be approved by the General Manager.	

8	There is a clearly defined approvals process with only senior staff approving agency staff requests. The nursing and medical directors personally approve the most expensive clinical shifts.	The process for booking the highest value medical agency locums requires sign off by the Operational Director, Director of Human Resources and Medical Director. There is an approvals process for all agency staffing and all alternatives are assessed first. There needs to be some flexibility in the approval process to ensure there is appropriate delegation for staff working on a weekend or night shift to make a decision based on quality of care.	The Trust will re-visit its approvals process to identify if any further controls are necessary.
	Actions to reducing demand for agency staffing		
9	There are tough plans in place for tackling unacceptable spending; eg exceptional over-reliance on agency staffing services radiology, very high spending on on-call staff.	Areas of higher relative use of medical agency are identified during the weekly review and focus on specialist services CAMHS and LD for which targeted recruitment is underway (8 new consultants have been appointed in the last 24 months from a total establishment of 18 posts)	Over reliance on specialty doctor roles, which are hard to recruit nationally, is being addressed as part of the medical workforce strategy and required significant redesign of both medical and non medical workforce. The safer staffing group - led by the Director of Nursing and Director of Workforce, OD & Estates - receives reports on bank and agency usage. Future reports will include greater detail on hotspot areas at service line and team level. Any action required is routed through the OMG meeting described at item 5. Development of flexibly deployed, substantive HCSW and administrative staff will significantly reduce reliance on agency use in these areas.
10	There is a functional staff bank for all clinical staff and endeavour to promote bank working and bank fill through weekly payment, auto-enrolment, simplifying bank shift alerts and request process.	Confirmed. Strong focus is being applied to how the use of bank as opposed to agency can continue to increase. This includes developments like a centralised bank and a pilot for increasing incentives for bank staff working in our inpatient units to test whether this reduces agency spend overall.	
11	All service lines do rostering at least 6 weeks in advance on a rolling basis for all staff. The majority of service lines and staff groups are supported by eRostering.	Confirmed	
12	There is a clear process for filling vacancies with a time to recruit (from when post is needed to when it is filled) of less than 21 days.	This is not always the case. There are particular issues for medical staff - given the timescales set out nationally - and supply in a number of professions. We have conducted two recruitment summits across the Trust with substantial actions to improve recruitment and retention.	The Trust will consider learning from best practice on tightening up recruitment processes and the benefits of over-recruiting in some roles. Avoidable delays relating to Royal College approval of job descriptions will be addressed, if necessary by use of alternative validation process.
13	The board and executives adequately support staff members in designing innovative solutions to workforce challenges, including redesigning roles to better sustain services and recruiting differently.	The Trust has a number of innovative approaches to workforce in its transformation programmes. For example, all programmes include advanced practitioner and assistant practitioner roles that have changed the skill mix, with clinical leaders taking on multidisciplinary roles. So far our LD and MH teams have been through transformation. We also have a thriving clinical apprentice scheme and a new locally designed nursing associate programme. These are enshrined in our nursing and clinical support worker strategies.	
14	The board takes an active involvement in workforce planning and is confident that planning is clinically led, conducted in teams and based on solid data on demand and commissioning intentions.	The Board is engaged in annual planning including the workforce plan contained within it. Workforce issues are also discussed regularly at Board and Sub-Committee meetings.	The Board has agreed that the Remuneration and Terms of Service Committee will strengthen its Terms of Reference to consider: strategic workforce plans and workforce risks at every meeting.

	Working with your local health economy		
15	The board and executives have a good understanding of which service lines are fragile and currently being sustained by agency staffing.	The executives have a good understanding of this given the regular and detailed reporting. The Board has recently increased the level and detail of reporting on safer staffing to ensure they are sighted on services under pressure.	The increased reporting of agency spending and safer staffing issues will continue to improve to ensure the Trust Board are sighted at every meeting.
16	The trust has regular (eg monthly) executive-level conversations with neighbouring trusts to tackle agency spend together.	This process is linked to the Workforce strand of the West Yorkshire & Harrogate STP and the Mental Health workstream in WY&H. Work has recently commenced, including the potential for international recruitment and shared bank approaches.	Both the Medical Director and HR Director will continue meeting with peers in other local provider organisations to identify what measures can be practically taken. This includes across the Pennines into Lancashire.

Signed by   [Date]   **30.11.16**

Trust Chair: [Signature]

Trust Chief Executive: [Signature]

Please submit signed and completed checklist to the agency inbox (NHSI.agencyrules@nhs.net) by 30 November 2016

South West Yorkshire Partnership NHS

NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 9.4

Title:	Operational Plan 2017/18 and 2018/19
Paper prepared by:	Interim Director of Strategic Planning and Contracting
Purpose:	To provide the Trust Board with a summary of the process undertaken in developing the operational plan and enable approval of that plan.
Mission/values:	Our Trust plan is relevant to all values and objectives
Any background papers/ previously considered by:	Trust Board has received regular updates on the development of the plan and received papers at previous Board and sub-group meetings. All directors have kept appraised of the content of the plan and feedback has been factored in to this final draft. The full draft plan is a separate agenda item in the private session of the Trust Board
Executive summary:	• The Trust submitted its draft annual plan to NHS Improvement on November 24th following Board approval • The final plan needs to be submitted by December 23rd. • The Trust Board has been kept up to date with progress on the plan and had opportunity to provide input and feedback through Board meetings, sub-group meetings and other communication channels Since the draft plan was submitted further work has been carried out, particularly in development of financial plans and high level quality impact assessments of potential savings schemes • Initial feedback on the draft plan submission has been received from NHSI which acknowledges the conditional acceptance of the control total and explains the consequences of not accepting it. The Trust was also encouraged o progress with agency reduction and to seek NHSI assistance if required. • The updated plan has been reviewed in more detail at the earlier private session of the Trust Board • The plan reflects the uncertain context that we are in and the current state of play with our contractual discussions with our commissioners. These have not yet concluded.
Recommendation:	**Trust Board is asked to APPROVE the submission of the operating plan subject to any changes agreed at the private session of the Trust Board.** **Trust Board is asked to CONFIRM the *conditional* acceptance of the control totals pre Sustainability and Transformation Funds of £1.02m for 2017/18 and 2018/19 based on the assumptions identified in the plan.** **Trust Board is asked to DELEGATE approval of the final document to the Trust Chair and Chief Executive for final submission in line with the timescales outlined.**
Private session:	The detailed plan was reviewed in the private session of the Board given the fact some items are currently commercial in confidence. The final version of the plan will come to the Board following submission. A summary version of the plan is being developed which will be public facing.

With **all of us** in mind.

1. How we plan what we do

We provide services to diverse urban and rural communities, working closely with a range of partners. We always keep the person in the centre so that our services are not only effective but also efficient.

Meeting demand and ensuring capacity

We have to understand when someone may need our services (demand) and how we meet these needs, including making sure we have enough staff (capacity). During 2016/17 we developed a demand and capacity modelling tool and we've used this to review our services as well as to inform tenders and negotiate contracts. Over the next year we plan to further develop this, starting in CAMHS, autistic spectrum disorders and psychology because we often see more people needing our services (demand) than what was planned for (capacity). In our ward areas, we use our Safer Staffing programme.

Trevor Jones, Rising Star - Excellence 2016

Our planning assumptions

We have looked at population growth and health needs data and reflected this in our plan. Broadly, in 2017-19 we expect to see a rise in demand of around 0.5 -1%. Going forward, our plan assumes more investment in areas with long waiting times such as CAMHS, ASD and ADHD and psychology.

The landscape of the NHS is changing - from the development of integrated pathways and the early beginnings of multi-specialty community providers and accountable care models. Our plan takes into account the impact this may have.
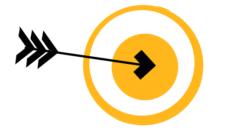
People have told us they would prefer to be cared for in their community and we expect to see a continued focus on this; including our work to transform older peoples' mental health and mental health rehabilitation. When people do need to be in hospital sometimes they need to travel out of our local area. In 2017-18 we'll reduce the number of times this happens.

The Five Year Forward View for Mental Health and the learning disabilities transforming care agenda is also something we're planning for. We'll introduce a specialist community perinatal mental health team, increase our IAPT activity and support the independence of people with learning disabilities.

Meeting key standards

Our plans will support the Five Year Forward View (FYFV), including:

- We'll meet new standards for Early Intervention in Psychosis (EIP) by getting more people into the service and having the right staff.
- We'll be within the referral to treatment time (RTT) thresholds for applicable services including musculoskeletal (MSK), and paediatric audiology.
- We'll continue our positive progress in IAPT, including the number of people using the service and their recovery rate. Our Kirklees IAPT service will be an early implementer of the national programme to support people with long term conditions and will recruit more staff to help with this.

As we provide a range of both mental health and community and wellbeing services, we have a number of other key standards to meet including:

- Smoking cessation
- Musculoskeletal (MSK)
- Community nursing and intermediate care
- ADHD and ASD assessments
- Access to psychology.

2. Quality planning

How we improve quality

Everything we do starts with our mission and values, which includes a value to 'improve and be outstanding'. Our approach to quality improvement is clearly reflected in our OD strategy, making sure quality improvement happens as close to people who use our services as possible.

Our plans include:
- Delivering our CQC action plan
- Building on our existing work using clinical microsystems.
- Expanding the use of our innovation hub.
- Developing improvement skills, working with our local Academic Health Science Network.
- Considering an assessment and accreditation model
- Meeting the targets of our 20+ quality indicators
- Learning through a clinical audit programme
- Research and development
- Eternal benchmarking and reporting initiatives
- Quality monitoring visits

Our Clinical Governance and Safety Committee (CGSC) plays a key role in improving quality and reports directly to our Trust Board.

Our Quality Impact Assessment (QIA) process

Efficiency opportunities and service improvements are identified through both Trust-wide transformation and through annual service line planning exercises. Services undertake a QIA self-assessment, following the CQC domains. Peer review QIA panels follow and an overall rating given before further internal scrutiny and Board approval.

Throughout the year we maintain a focus on quality including the impact of change through the weekly Operational Management Group, escalating where required. Each month a performance report is reviewed by executive directors and also presented to Board.

Workforce and finance (triangulation)

This plan forms the basis of our single balanced scorecard approach – a dashboard that can be used at all levels and covers quality, performance, workforce and finance.

This supports triangulation of data that takes place at Trust Board, executive team, locality and service line levels. Our balanced scorecard will directly reflect the measures in this plan.

During 2017/18 we will put individual service level scorecards in place – reviewed by the executive team and publicly discussed at Board.

Our quality improvement plan

The CQC's 5 key domains are our quality framework. Under each domain we have a set of key performance indicators and our quality priorities reflect the needs of our service users and learning from our quality improvement systems.

Our priorities are linked to national drivers and align to the STPs for West and South Yorkshire

Domain	Priority
SAFE	Improving physical health for patients with severe mental illness
	Improve safer staffing fill rates
	Improved integration of physical and mental health offer
	Implementation of suicide prevention strategy
	Frequency of falls - reduction
	Pressure ulcer – reduction in attributable and avoidable cases
	Prone restraint reduction
	Mortality reviews and Incident investigation system
EFFECTIVE	New competency framework for community nursing
	Timely assessments and reviews of care and treatment (IAPT/EIP)
	Transitions of care from CAMHS to adult services
	Staff health and wellbeing
	Recruitment and retention
CARING	Quality of care planning and clinical information recording
	Patient experience – accessible information standards
	Volunteering strategy implementation
RESPONSIVE	Access waiting times – CAMHS and psychological therapies
	Complaint closure and resolution timescales
WELL LED	Quality dashboard development
	Improving clinical information

3. Workforce planning

Planning our workforce

Workforce planning is an integral part of our service line planning process, which includes clinical engagement. In early 2017, we will publish our first two year workforce strategy which will define key workforce objectives, direction, demand, succession planning and KPIs. It will be supported by our organisational development strategy.

Laura Habib, Unsung Hero - Excellence 2016

Our workforce strategy

We have a strategic HR framework which aims to make sure we have the right staff in the right place, at the right time and will respond to the changes in our workforce that we are anticipating over the next 2-5 years.

Our plans include:
- Implementation of Junior Doctors Terms and Conditions
- Readiness for workforce changes against the Apprenticeship levy
- Continued redesign and recruitment for our clinical support workforce
- In 2017, we will be one of six national sites introducing peer support workers
- Development of our new perinatal workforce
- Development of our workforce to meet Early Intervention in Psychosis standards
- Continued focus on improving staff wellbeing, resilience and engagement
- Workforce transformation of our older peoples mental health services.
- Community nursing workforce redesign
- Public Health Commissioning of Yorkshire Smokefree contracts
- Reducing our use of agency doctors
- Recruitment strategy of current and future workforce

Enhancing quality and productivity of our workforce

The focus on enhancing quality and productivity of the workforce will include:
- Reducing administration and management costs - reducing by 5% in 2017
- Implementing a lean approach to services
- A further review of our back office functions linked to collaborative STP opportunities
- Implementing the workforce elements of our nursing strategy
- Maximising workforce opportunities from the Five Year Forward View for Mental Health

Addressing the use of agency staff

This is a key priority and will be achieved through:
- **Clear responsibilities** – our medical director and deputy chief executive has taken oversight. Director objectives have been aligned to achieve this priority.
- **Controls on booking agency** – a clear process is in place so we're confident we have exhausted all other options. The process includes senior management sign-off.
- **Oversight and scrutiny** – there is central weekly oversight and scrutiny of all medical locums. This has also been assessed by our operational management group.
- **Alternatives to agency** – Our centralised bank is trialling initiatives to encourage sign-up. We're looking at innovations in our recruitment process and working with our STP partners to identify opportunities for collaboration including overseas recruitment.
- **Sustainable staffing** - Over the next 12 months our medical agency spend will be reduced through new models of service and also recruitment into these.

4. Financial planning

Control total

Our Trust Board conditionally agreed to the revised control total for 2017/18 of £1.02m and the same total for 2018/19 when we submitted our draft plan in November 2016. The agreement was conditional due to a number of factors including contract negotiations, tenders and the delivery of our 2016/17 financial targets.

Our assumptions

We have made sure our commissioners are clear on our assumptions and position and we will continue to liaise closely with NHS Improvement during this time of uncertainty and change for the NHS. We will accept offers for help on pressure points and hot spots, where capacity and sharing of good practice will benefit the Trust, our staff and people who use our services.
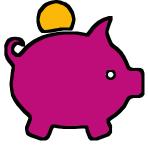
In the latter part of 2016 we have seen increased expenditure on out of area beds, continuing pressure on agency expenditure and CQUIN achievement at risk. Our forecast remains in line with our plan but there is a risk it will not be achieved; we're taking action to mitigate this risk.

It's important that we're clear about the assumptions we have used when agreeing to our control total. A variation from these could potentially have a significant impact on our ability to meet the control total, particularly for the second year of the plan. The assumptions are shown in the table opposite.

Key assumptions	
Income deflation	2.0%
Funded cost inflation	2.1%
CNST costs	45.0%
CQUIN income	2.5%
Pay inflation	1.0%
AfC increments	0.7%
Apprenticeship Levy	0.5%
Drugs costs	4.0%

Tenders

A number of services that the Trust currently provides are currently out to tender and other services are likely to be tendered over the course of the next six months and indeed over the two year life of this plan. Not retaining services will impact on our ability to meet the control total.

Retaining services at similar values to today is assumed within our plan with the exception of where definitive decisions have already been taken either by the Trust or commissioners. As such provision of 0 – 19 services in Barnsley and Health & Wellbeing services in Wakefield, which ceased during 2016/17, are excluded from the financial plan.

Sustainability and transformation plans (STPs)

We are fully engaged in the work of both the West Yorkshire and South Yorkshire STPs.

At the moment it is not clear exactly what impact STP development will have on our services; this is still a matter of further work but intended changes may impact on our specialist, bed based and community services in each district.

For the purpose of this plan, we have tried to deal only in known changes and it is therefore assumed that there is no change.

Five Year Forward View for mental health

We have assumed that income for mental health services will grow in line with the plans of the Five Year Forward View. The impact of income deflation, provision of cost inflation, loss of some services and growth in income reduction and growth in mental health line results in an income reduction compared to 2016/17 outturn, but then remaining relatively flat into 2018/19.

We know some of these resources will only be available to services via bids.

CQUINs

Within the operating guidance it is clear that an element of CQUIN will be dependent upon the STP area delivering its control total.

We have assumed this will be delivered when generating our financial plan. Similarly, we are assuming the new national CQUINs will be achieved.

4. Financial planning continued

Achievement of the pre STF surplus of £1.02m in each year of the plan enables access to £1.4m of STF in both 2017/18 and 2018/19. This is included within the financial plan.

To deliver our financial plan we need income growth for mental health services to be in line with what was set out in the five year forward view and an element of growth where mental health investment is below national averages.

Other operating expenses movements include:
- CNST and CQC cost increases
- Drugs costs
- Reduction in out of area bed placements
- Procurement savings and CIPs.

We are committed to putting plans in place to deliver our CIP plans, identifying further savings opportunities and mitigating risk. The financial plan assumes that enough additional CIPs will be implemented.

An element of the CIP Delivery for 2016/17 (£3.4m) is being delivered non-recurrently. This therefore adds to the financial challenge for next year. In total 4.2% of efficiency needs to be delivered to achieve the control total. To deliver the control total and allow for a small contingency we need 4.7%.

When developing this plan we also considered activity, workforce and quality plans to ensure they triangulate.

Efficiency savings

Our structure is based on five Business Delivery Units – Calderdale, Kirklees, Barnsley, Wakefield and Specialist Services that are supported by a corporate Quality Academy.

The BDUs and Quality Academy are accountable for their own financial performance and identify specific cost improvement schemes. These specific schemes are augmented by Trust-wide schemes.

The Trust has a very clear principle of operating with a safety first approach.

Quality Impact Assessments are therefore carried out on all proposed cost improvement schemes.

This process enables full review and discussion to take place with a range of professions, skills and experience present. This is then further reviewed at executive level.

4. Financial planning continued

For 2017/18 there are a number of key areas of focus which will help drive financial improvement.

Out of area beds

We have an increased demand for out of area bed usage. We'll take the learning from when we reduced our reliance, along with learning from other Trusts to make sure we can make a saving

Workforce

There continues to be firm focus on workforce, particularly staff in non-clinical roles. Additional savings are possible and are being factored into our savings plans. Wherever possible we will utilise vacancies to reduce staffing, to minimise disruption and redundancy costs.

Non-pay and contracts

We'll place greater emphasis on achieving non-pay efficiencies. There are also some elements of our contracts which are incurring sizeable overspends. One example is the use of continence products where demand growth was not matched with a funding increase. We've addressed this through contracting.

Agency spend

A number of actions are in place to reduce our agency spend, including recruitment and retention, effective deployment of staff and learning from other organisations. This is a key part of our cost saving plans.

Estates

By delivering our estates strategy, approved in 2012, we have much improved and reduced estate and staff working agilely. We will now maximise use of our estate and continue to reduce the number of buildings we use. We'll make sure we're using our estate as efficiently as possible.

Service transformation

This is a key part of our plans. We know that substituting services through alternative provision – such as Recovery Colleges' role in CMHTs – can provide good outcomes at lower cost.

It's difficult to identify significant incremental saving for 2018/19 so more radical and system wide schemes will need to be identified and implemented. These include older people's service redesign, review of bed base, estate rationalisation, back office consolidation and service pathway configuration via the STP.

CIPs

The Trust has a history of delivering CIPs but this has become harder recently – with an unhealthy balance of recurrent and non-recurrent CIPs. Additional controls are now being introduced. CIPs as a % of our income is shown below.

15/16 actual	16/17 plan	16/17 forecast	17/18 plan	18/19 plan
3.6%	4.5%	4.1%	4.0%	2.7%

Capital planning

We are currently re-developing our Fieldhead site which provides both inpatient and support services. This began in 2016 and is due to complete in 2018.

Our estates strategy aligned with our overall and clinical strategy. We therefore have pre-committed capital expenditure plans that are incorporated in this plan.

In developing the capital plan for the next two years a full prioritisation process has taken place.

Investment is also required for IT. The Trust's contract for its current clinical record system expires in March 2018. As such a specification is being developed with the aim of undertaking a mini-tender exercise in quarter 4 2016/17. This may lead to the need to purchase a new system. This is allowed for in the capital plan as is replacement of aged infrastructure which is approaching end of useful life.

Debs Taylor, Outstanding Contribution- Excellence 2016

5. Sustainability and Transformation Plans (STPs)

The STP vision and our role

We are part of both the South Yorkshire and West Yorkshire STP (which our chief executive also chairs)

We're actively involved in the development of local place-based plans which are the building blocks of our STPs. These potential developments will have a significant impact on the future of our Trust and involvement in them is a key feature of our plans for 2017-19.

STPs emphasise the importance of prevention and integrated holistic care which is well aligned to our core strengths. The 'triple aim' of the STPs is reflected in our strategic objectives.

Work streams and cross cutting themes

We are working with partners to deliver improvements in:
- Suicide prevention – we are leading this
- South Yorkshire hyper acute stroke service review
- South Yorkshire Healthy Lives Programme
- West Yorkshire Prevention at Scale Programme
- Low and medium secure mental health
- CAMHS pathway
- Mental health liaison
- Mental Health rehabilitation and out of area placements
- Back office collaboration

Our role in local place based plans

Barnsley: We are working with the local GP federation and hospital to put in place integrated clinical pathways eg diabetes, respiratory and intermediate care. These pathways will be supported by alliance contracts that align providers around achievement of outcomes. Additionally we are working with commissioners and providers to reform the pattern of commissioning and provision.

Kirklees: In 2017 we hope to integrate children's health provision. We'll focus on enabling communities to be resilient and will extend our role in prevention and wellbeing; including the expansion of our IAPT services to support people with long Term conditions.

Calderdale: In 2017 we are focused on working with the voluntary and community sector and with local commissioners to make improvements in CAMHS pathways. We're also working as part of a multi-speciality community provider Vanguard to deliver integrated community services. We will also continue to act as system leaders alongside local commissioners.

Wakefield: We will continue to work in partnership through local Vanguard initiatives, providing care navigation and wellbeing support to reduce unnecessary demand in primary care and the urgent care system. We will continue to work with commissioners and providers to explore future contracting arrangements for a range of services.

6. Membership and elections

Our Members' Council
Our Members' Council is made up of elected representatives of our members and staff, and also nominated members from key local partner organisations. Our Council make sure that our Board, which retains responsibility for our day-to-day running, is accountable to local communities.

We currently have 34 governors:

18 public | 7 staff | 9 appointed

Governor recruitment, training, development and engagement
- We encourage our members to stand for election.
- We're currently reviewing our approach to the training and development of governors to reflect governor feedback.
- We have a number of engagement opportunities between governors, members and the public, including our annual meeting and Insight events.
- Our Council helps us shape future strategy and is, for example, directly engaged in the development of our annual plan and quality account.

Our membership strategy and supporting diversity
- Membership of the Trust means local people have a greater say in how services are provided, shaping our future.
- Membership is free, from 11 years old and with no upper age limit.
- Our service users and carers are included in the public constituency.
- Our public constituencies reflect our geography in proportion to the population of each area
- We aim to retain a membership of 1% of our populations with a focus on active involvement
- We compare our membership with local population demographics and focus on areas of under representation.

Developments
Key areas for the next 12 months are:
- Refresh of our membership strategy
- Refresh of Members' Council objectives
- Elections to ur Members' Council
- Involvement in Customer Service Excellence Accreditation
- Input into transformation work streams
- Service visits through 15 steps programme
- Supporting staff governors as Freedom to Speak up guardians.

Governor elections
- The Trust holds elections each year, managed by the Electoral Reform Services (ERS).
- The last election was held in April 2016 for two seats in Calderdale and three seats in Kirklees, with candidates elected from 1 May 2016.
- We also appointed a new lead governor - our publicly elected governor for Barnsley.
- The next election will take place in April 2017; we currently have 3 vacant seats.

Dr Subha Thiyagesh, Leader of the year - Excellence 2016

Trust Board 20 December 2016
Agenda item 9.5

Title:	**Trust Board Work Programme 2017**
Paper prepared by:	Chair and Chief Executive
Purpose:	The purpose of this report is to seek approval from the Trust Board for their annual work programme for 2017.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	In line with Trust Board Committee work programmes.
Executive summary:	The Trust Board should annually review its work programme for the following calendar year as part of best practice to have a well thought out Board work programme. The work programme identifies key Board considerations and actions required in a Boards year, ensuring allocation to relevant meetings and allows for both management and the Board to be aware of the planned approach. The work programme allows for better quality of report content, debate and for items to be scheduled at an appropriate time in accordance with the Board cycle of meetings.
	The work programme links to the organisational risk register and assurance framework, addressing principle risks to the delivery of the Trust's strategic objectives.
Recommendation:	**Trust Board is asked to AGREE the work programme for 2017.**
Private session:	Not applicable

With **all of us** in mind.

South West Yorkshire Partnership NHS

NHS Foundation Trust

Trust Board annual work programme 2017

🟥	Business and Risk (includes quarterly performance reports and quarterly reports to Monitor/NHS Improvement)
🟩	Performance and monitoring
	Strategic sessions are held in February, May, and November which are not meetings held in public.
	There is no meeting scheduled in August.
	# Corporate Trustees for the Charitable Funds which are not meetings held in public.

Committee / forum key:	
A	Audit Committee
CG	Clinical Governance and Clinical Safety Committee
MH	Mental Health Act Committee
R	Remuneration & Terms of Service Committee

Agenda item/issue	Jan	Mar	Apr	June	July	Sept	Oct	Dec
Standing items								
Declaration of interest	✖	✖	✖	✖	✖	✖	✖	✖
Minutes of previous meeting	✖	✖	✖	✖	✖	✖	✖	✖
Chair and Chief Executive's report	✖	✖	✖	✖	✖	✖	✖	✖
Integrated performance report	✖	✖	✖	✖	✖	✖	✖	✖
Scheduled items								
Customer services quarterly report	✖		✖		✖		✖	
Assurance framework and risk register	✖		✖		✖		✖	
NHS Improvement quarterly return	✖		✖		✖		✖	
Investment appraisal framework	✖		✖		✖		✖	
Strategic overview of business and associated risks	✖		✖		✖		✖	
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✖		✖		✖		✖	
Serious incidents quarterly report		✖		✖		✖		✖
Use of Trust Seal		✖		✖		✖		✖
Assurance from Trust Board Committees		✖ A, CG, MH, R		✖ A, CG, MH, R, MH		✖ A, CG, MH, R H		✖ A, CG, MH, R H
Annual items								
Review of Treasury Management Policy	✖							
Draft Annual Governance Statement (final approval by Audit Committee)		✖						
EMSA declaration		✖						
Information Governance toolkit		✖						
Strategic objectives		✖						

With **all of us** in mind.

Agenda item/issue	Jan	Mar	Apr	June	July	Sept	Oct	Dec
Audit Committee annual report			✖					
Planned visits annual report			✖					
Risk assessment of performance targets, CQUINs and SOF and agreement of KPIs for 2017/18			✖					
Annual report and quality accounts				✖				
Customer services annual report				✖				
Health and safety annual report				✖				
Serious incidents annual report				✖				
Equality and diversity annual report					✖			
Sustainability annual report						✖		
Code of Governance compliance						✖		
Assessment against NHS Constitution							✖	
Operational plan								✖
Trust Board annual work programme								✖
Compliance with NHS Improvement/Monitor licence *(date to be confirmed by NHS Improvement)*								
Biannual items								
Policy on policies *(due in July 2018)*								
Review of standing orders, standing financial instructions and scheme of delegations *(due in January 2018)*								

South West Yorkshire Partnership NHS
NHS Foundation Trust

Trust Board 20 December 2016
Agenda item 9.6

Title:	**Membership of Wakefield New Models of Care Partnership Board**
Paper prepared by:	Director of Corporate Development
Purpose:	To agree that the Trust becomes a member of Wakefield New Models of Care Partnership Board.
Mission/values:	Being involved in the establishment of the Wakefield New Models of Care Partnership Board will support the Trust to adhere to its mission and values in the development and delivery of high quality accessible services.
Any background papers/ previously considered by:	The proposal has been discussed and considered by the Executive Management Team.
Executive summary:	This paper describes the plan to establish a Multispecialty Community Provider (MCP) to serve the population of Wakefield Metropolitan District and for the Board to agree that the Trust is a member of the Wakefield New Models of Care Partnership Board, established as a ''Committee in Common'' (CiC), as the first stage of the governance arrangements for the new MCP organisation. In November 2014, NHS England published ''a Five Year Forward View'' which outlined five innovative models of service and organisation, one of which is the establishment of an MCP. MCPs are vehicles for driving closer integration of out of hospital services, to best meet the needs of the local population and individual patients, particularly supporting those who have multiple long term conditions; supporting independence, their ability to live at home for as long as possible and at the same time, supporting primary care. Another model outlined in the ''Five Year Forward View'' was the establishment of ''Accountable Care Organisations''. In Wakefield there is an aspiration that the Wakefield MCP in due course, becomes an Accountable Care Organisation. It is essential that all partner organisations involved in the services that are proposed to be in the scope of the MCP, have a forum in which they can reach decisions and which will facilitate the establishment of the MCP during 2017/18. Two meetings have been held to date about the establishment of the Wakefield MCP in a virtual form. At the most recent meeting it was agreed that a CiC should be established from January 2017. A CiC allows for collective decision making around areas of common interest, members having delegated powers from their respective governing bodies to make certain decisions. Each member retains its own decision making accountability. *The latest draft terms of reference V.07 is attached for information together with an appendix showing an MCP outcomes framework proposal.* The services that are proposed to be in the scope of the MCP are: ➢ Adult Community services provided by MYHT ➢ Public Health Services

With **all of us** in mind.

	➢ Adult Social Care assessment and care management ➢ Community equipment ➢ Non – care primary care services ➢ Some community mental health services The proposed governance arrangements will support the necessary change in culture and behaviours, transparency about the services in scope and the performance of those services from a quality, quantity and financial perspective. Alongside the terms of reference and governance arrangements, it is likely that each organisation will be asked to develop and agree a Memorandum of Understanding to further support the development of the MCP; this will include commitment to confidentiality, management of conflict of interest and dispute resolution. The main duties of the New Models of Care Partnership Board will be: ➢ Support the establishment of the MCP ➢ Oversee system wide integration programme to deliver improved individual and population health in a sustainable health and social care system. ➢ Oversight of performance of services in the scope of the MCP ➢ Oversight of financial position related to services in scope of the MCP ➢ Drive the development of the MCP to an agreed timetable for its formal establishment ➢ Address risks and challenges to establishment of the MCP. **Risk appetite** It is important that we are a member of the New Models of Care Partnership Board to ensure a greater degree of influence on what may or may not happen in the future, as well as having a major stake in improving out of hospital services. Being a member of the proposed Partnership Board involved in the establishment of an MCP, will support the Trust's endeavours to provide high quality and equitable services, improving the Trust's reputation in line with the Trust's Risk Appetite Statement.
Recommendation:	**Trust Board is asked to:** ➢ **SUPPORT the Trust being a member of the Wakefield New Models of Care Partnership Board and the creation of a Multi-Speciality Community Provider, serving the population of Wakefield CCG.** ➢ **AGREE that the Chief Executive works with partner organisations in the development of the details regarding the Committee in Common, and that the Chief Executive provides timely updates to the Board.**
Private session:	Not applicable.

Wakefield New Models of Care Partnership Board

Terms of reference

1. **Background**

   1.1. NHS Wakefield Clinical Commissioning Group, Wakefield Council, Mid-Yorkshire Hospitals Trust, South West Yorkshire Partnership Trust, Novus, Turning Point, Spectrum, VCS representation and GP Federations and other providers that deliver services that are in scope of the new model of care (the 'Parties') have agreed to form the New Models of Care Partnership Board.

   1.2. The New Models of Care Partnership Board is intended to facilitate development of an 'accountable care' system in Wakefield. The accountable care system is about integration and removing historical barriers that have prevented joined-up preventative patient care across primary, community, mental health, social care and acute services.

   1.3. The New Models of Care Partnership Board will act as a forum through which partners can reach decisions about the establishment of a virtual multi-specialty community provider (MCP) during 2016/17. The virtual MCP means that providers of services within the scope of the MCP care model and Wakefield CCG will enter into 'alliance arrangements'. These alliance arrangements will overlay, but not replace, traditional commissioning contracts. This will help achieve a shared vision, together with agreement about how services should be delivered.

   1.4. The New Models of Care Partnership Board will operate throughout the proposed virtual MCP period of 2017/18 before handing over responsibility for operating and further developing the MCP / ACO to a new long term governance structure.
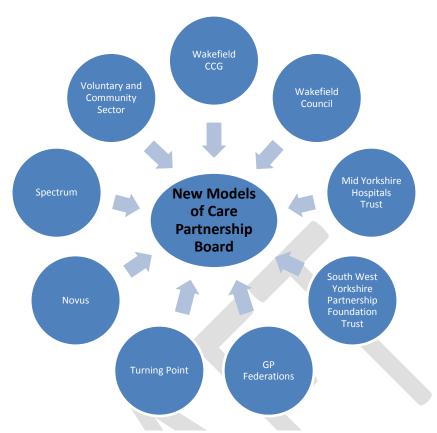
2. **Purpose**

   2.1. The New Models of Care Partnership Board will, in relation to the virtual MCP:

      2.1.1. Provide visible leadership, direction and commitment to the establishment of the virtual MCP and individuals working within it, establishing and promoting effective communication of the virtual MCP's goals and progress.

      2.1.2. Supporting innovation and the necessary change in culture/behaviour between all parties.

      2.1.3. Ensure the transition from the current to the virtual MCP is managed effectively, efficiently and safely. Seeking assurance that risks are understood and managed (including provider sustainability) and that the safety of patients and service users is never compromised by development of the virtual MCP.

2.1.4. Facilitate providers to work more closely together in order facilitate greater standardisation and integration of pathways, resulting in improved outcomes.

2.1.5. Facilitate better access for patients to specialist care;

2.1.6. Maintain a focus on prevention and early intervention;

2.1.7. Facilitate transparency about services in scope of the virtual MCP; including performance of these services and financial/budget positions.

2.1.8. Ensure patients and service users, staff, the public and wider community are fully engaged and consulted.

2.1.9. Ensure key stakeholders are fully informed with the progression of the virtual MCP through regular reporting.

2.1.10. Ensure the capacity and competence of the workforce is strengthened.

2.1.11. Manage appropriately the resources delegated to the virtual MCP.

2.1.12. Review and if appropriate, adapt the virtual MCP objectives, milestones and governance in light of internal or external strategic changes.

2.1.13. Provide a mechanism to consistently report on the progress of the virtual MCP both within Wakefield but also to NHS England, NHS Improvement and the Care Quality Commission as appropriate.

2.2 To avoid doubt, the New Models of Care Partnership Board will not make decisions on any matters which fall within the statutory functions of the CCG or the Council. The CCG and the Council may engage with the New Models of Care Partnership Board to obtain feedback to inform such decisions, but will not be bound by any views or feedback expressed by the New Models of Care Partnership Board or any other Party.

3. Governance Structure

3.1. The diagram below outlines the proposed governance structure supporting the virtual MCP.

3.2. The New Models of Care Partnership Board is a 'committee in common'. It is not a joint committee of the Parties and has no authority to bind any Party against its will. Each of the Party Representatives will have the appropriate delegated authority from the relevant Party in order to make decisions which bind that Party.

4. Responsibilities

4.1. The New Models of Care Partnership Board acts as the top tier of leadership for the virtual MCP.

4.2. The New Models of Care Partnership Board will:

4.2.1. Provide mutual assurance to the Parties through regular reports from the New Models of Care Partnership Board to the boards / governing bodies of the Parties.

4.2.2. Support the new model of care outcomes which have been developed by the Connecting Care Health and Social Care Partnership in Wakefield:

- people can access information and advice that is clear, up to date and consistent;
- care and support is responsive, timely and joined up;
- support is provided by caring, considerate people with the right skills;
- people live in safe and positive communities;
- people are encouraged and supported to be healthy; and
- people are assured that services and resources are efficient.

4.2.3. Review progress and guide the virtual MCP towards the overall agreed objectives and benefits.

4.2.4. Ensure the delivery of all aspects of the virtual MCP to the appropriate levels of quality, time and budget, in accordance with the agreed implementation plan and virtual MCP governance arrangements.

4.2.5. Ensure all risk is assessed and assure that mitigating actions are in place.

4.2.6. Ensure an agreed economy position on any disputes which may arise.

4.2.7. Ensure transition to the virtual MCP becomes a 'business as usual' position.

4.2.8. In compliance with all relevant law and guidance. determine the standards for clinical service and helping develop working practices that achieve them effectively.

5. Membership

5.1. The membership shall comprise of the following Representatives:

Organisation	Title
NHS Wakefield Clinical Commissioning Group	Chief Officer
Wakefield Council	Corporate Director, Adults, Health & Communities
Mid-Yorkshire Hospitals NHS Trust	Chief Executive
South West Yorkshire Partnership NHS Foundation Partnership Trust	Chief Executive
All GP Federations within Wakefield district	Chair representatives (one of which will Chair)
Turning Point	Chief Executive
Novus	Chief Executive
One Representative for the Voluntary and Community Sector (nominated by NOVA).	Chief Executive level representative TBC
Spectrum	Chief Executive

5.2. Each Party will ensure that their Representative has the necessary delegated authority to make the relevant decisions and bind their appointing Party (subject to each Party's internal governance procedures).

5.3. Representatives may invite such other persons to attend meetings as agreed by the Chair.

5.4. No such persons invited to attend meetings shall be able to vote on a matter.

5.5. In addition to the members listed above the following individuals will be invited to be in attendance at meetings of the New Models of Care Partnership Board:

Organisation	Title
NHS Wakefield Clinical Commissioning Group	Programme Commissioning Director Integrated Care
Wakefield Council	Deputy Director of Public Health and Commissioning Lead for Adult Social Care
Healthwatch	Chief Executive

6. Frequency and notice of meetings

6.1. Meetings shall be held monthly or other such frequency as agreed by the Parties.

7. Quorum

7.1. Meetings of the New Models of Care Partnership Board shall be quorate when one Representative from each Party is present.

7.2. A Party may send to a meeting of the New Models of Care Partnership Board a deputy (a "Deputy") to take the place of the Representative. Where a Party sends a Deputy to take the place of the Representative, the references in these Terms of Reference to Representatives shall be read as references to the Deputy. The Parties must ensure that a Deputy attending a meeting of the New Models of Care Partnership Board has the necessary delegated authority to make the relevant decisions on behalf of that Party.

8. Voting

8.1. Each Representative has one vote.

8.2. The Parties acknowledge that there needs to be unanimity across all Representatives in order for decisions to be determined.

8.3. Where unanimity is not reached, the Parties agree that the matter will be referred to dispute resolution in accordance with Clause **Error! Reference source not found.** (Dispute Resolution).

9. Chair

9.1. The chair of the meeting shall be one of the representatives from a GP federation.

10. Sub-Groups

10.1. The New Models of Care Partnership Board may establish groups to support it in its role. The scope and membership of those groups will be determined by the New Models of Care Partnership Board.

11. Administration

11.1.   Programme Commissioning Director Integrated Care will be responsible for ensuring that the Board has all the administrative and programme support and advice that it requires.

11.2.   NHS Wakefield Clinical Commissioning Group shall provide administrative support and advice including but not limited to:

11.2.1. taking the minutes and keeping a record of matters arising and issues to be carried forward;

11.2.2. advising the Representatives as appropriate on best practice, national guidance and other relevant documents

12. Reporting

12.1.   The minutes of the New Models of Care Partnership Board will be agreed by the Chair and circulated to all members for approval and ratification.

12.2.   Minutes will be circulated to the Parties' boards / governing bodies, except where, at the Chair's discretion, parts need to be redacted or withheld for reasons of commercial or personnel confidentiality.

12.3.   Reports and paper will be circulated a week in advance of the meeting. Verbal reports will be accepted only on an exceptional and / or urgent basis.

12.4.   It will be the responsibility of the representatives of each Party to ensure appropriate briefings and soundings of their governing bodies and their staff.

13. Special Meetings

13.1.   Special meetings of the New Models of Care Partnership Board on any matter may be called by any of the Parties acting through its Representative by giving at least forty-eight (48) hours notice by e-mail to the other Representatives in the following circumstances:

13.1.1. where that Party has concerns relating to the safety and welfare of service users under a service contract;

13.1.2. in response to a quality performance or financial query by a regulatory or supervisory body (including but not limited to NHS England, NHS Improvement and the Care Quality Commission);

13.1.3. to convene a dispute resolution meeting;

13.1.4. for the consideration of any matter which that Party considers of sufficient urgency and importance that its consideration cannot wait until the date of the next meeting;

14. Conflicts of Interest & Conduct

14.1.   Each Representative and those in attendance at meetings will abide by the 'Principles of Public Life' and the NHS Code of Conduct, and the Standards for members of NHS boards and governing bodies, Principles of the Citizen's Charter and the Code of Practice on Access to Government Information.

14.2.   Each Representative must abide by all policies of the Party it represents in relation to conflicts of interest.

14.3.   Where any Representative has an actual or potential conflict of interest in relation to any matter under consideration at any meeting, the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that Representative may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed. Where the Chair decides to exclude the Representative, the relevant Party may send a Deputy to take the place of the conflicted Representative in relation to that matter.

15. Approval and Review

15.1.   These terms of reference have been approved by each of the Parties and are effective from [   ] 2017.

15.2.   These terms of reference will be reviewed on [   ] 2017 [six months after the above date] and bi-annually thereafter.

MCP Outcomes Framework - Proposal

September 2016

The Outcomes Framework is designed to give a high level snapshot of data across Wakefield District to enable Board members to see how well we are achieving our outcomes and better understand how the system working. If areas of concern are identified "deep dive" data exercises can then explore these areas in more detail.

Key:
- Better (green)
- Similar (yellow)
- Worse (red)
- Unable to compare (white)

Indicator	Gender	Age Group	Latest Time Period	Wakefield Latest Compared to previous time	Wakefield Trend	Previous Time period	Wakefield Previous Value	England Latest Wakefield Latest compared to England latest
Outcome 1: People can access information and advice that is clear, up to date								
Patient care records are available at the appropriate level to all who need it								
Mystery shopper score on a patient's ability to find information/advice in the system								
% positive answers to CollaboRATE questions measuring the volume and quality of shared decision making (see footnote)								
If several different people were involved in your care did you find that everyone worked well together?								
Proportion of people who use services who find it easy to find information on those services								
Proportion of staff who report being able to find the information they need to do their job easily								
Outcome 2: Care and Support is responsive, timely and joined up								
Primary care quality								
Number of A& E attendances are reduced								
Hospital waiting times (days)								
Total non- elective admissions are reduced								
Total number of emergency bed days are reduced								
Average LOS in the 65 and over population is reduced								
Rate of emergency readmission within 30 days is reduced								
Emergency admissions for acute conditions that should not usually require hospital admission are reduced								
Proportion of people living with a long term condition who report having a care plan is increased								
Number of patients discharged by 1pm from Mid Yorkshire Hospital Trust increases								
% of available beds with midnight occupancy								
Number of referrals to the emergency dept. for mental health								
Time taken from first contact to suitable Connecting Care intervention								
Number of days spent in hospital once considered medically fit for discharge								
Social care assessments are timely								
Did you get the help and care when you needed it, or did you have to wait?								
Outcome 3: Support is provided by caring, considerate people with right skills								
Were you treated with kindness and compassion?								
Health related quality of life for carers								
Support for carers with skills/training/respite (placeholder measuring support services for carers)								
Staff report they have the training they need (self reported)								
Staff are happy in their job (self reported)								
Thinking about your family and friends who care for you, do you feel that they have had as much support from health and social services as they needed?								
Outcome 4: People live in safe and positive communities								
Would you say that you feel safe living at home?	Persons	18+ yrs	2014/15	44.7		2013/14	43.9	44.8
% adult social care users who have as much social contact as they would like	Persons	<75 yrs	2012 - 14	86.87		2011 - 13	88.19	75.72
Under 75 CVD mortality gap between the most deprived and least deprived is reduced								
% of people active increases								
People die in their place of residence								
Increasing community assets (placeholder)								
Alcohol- related admissions decrease								
% population volunteering								
Outcome 5: People are encouraged and supported to be healthy (and independent?)								
Employment of people with long term conditions								
% of eligible patients have a care plan								
Smoking prevalence is reduced								
Falls admission and repeat fallers is reduced								
% of population with uncontrolled high pressure								
% of people with a longstanding health condition who feel they are supported to manage their condition								
Flu vaccination uptake in at risk population								
Permanent admissions of older people (65+) to residential and nursing care homes per 100,000 population								
% of eligible patients leaving hospital who have a review in primary care within 3 days								
Health related quality of life for people with a long term mental health condition								
% of people who feel socially isolated								
Health related quality of life for people with a long term condition								
Outcome 6: People are assured service and resources are efficient								
Time spent in hospital during the last 6 months of life								
Did Not Attend appointments are reduced								
% of cancelled appointments								
Patient perception: time wasted (see CollaboRATE and additional questions)								
SROI measure								
Community equipment is supplied in a timely manner								
% technological solutions used to assist consulting and monitoring								

CollaboRATE and additional questions

We will be asking patients/ service users the following:

1.   If several people were involved in looking after you did you find that everyone worked well together? (National Voices)
2.   How much effort was made to help you understand your health issues? (CollaboRATE)
3.   How much effort was made to listen to the things that matter most to you about your health issues? (CollaboRATE)
4.   How much effort was made to include what matters most to you in choosing what to do next? (CollaboRATE)
5.   Did you get the help and care when you needed it, or did you have to wait? (NV)
6.   Thinking about your family and friends who care for you, do you feel that they have had as much support from health and socia l care services as they need? (NV)
7.   Would you say that you feel safe living at home? (NV)
8.   Do you have as much social contact as you would like?

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integRATE Questions

1. How often did you have to do or explain something because people did not share information with each other?
☐ ☐ ☐ ☐
Never A little A lot Always

2. How often were you confused because people gave you conflicting information or advice?
☐ ☐ ☐ ☐
Never A little A lot Always

3. How often did you feel uncomfortable because people did not get along with each other?
☐ ☐ ☐ ☐
Never A little A lot Always

4. How often were you unclear whose job it was to deal with a specific question or concern?
☐ ☐ ☐ ☐
Never A little A lot Always

South West Yorkshire Partnership NHS

NHS Foundation Trust

Trust Board 20 December 2016

Agenda item 10 – Assurance from Trust Board Committees

Remuneration & Terms of Service Committee

Date	4 November 2016
Presented by	Rachel Court
Key items to raise at Trust Board	➢ Approval of the final metrics in the Directors Performance related pay scheme ➢ Consideration of the results of the staff wellbeing and engagement survey and discussion of the resulting action plan.

Clinical Governance & Clinical Safety Committee

Date	8 November 2016
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Update on Child and Adolescent Mental Health Services (CAMHS). ➢ CQC action plan and plan for meeting scheduled on 9 November 2016. ➢ NICE InPhase assurance and QI monitoring system. ➢ Quality Impact Assessment of cost improvement programme. ➢ Outcome of the Trinity 2 fire and next steps

Estates Forum

Date	15 November 2016
Presented by	Jonathan Jones
Key items to raise at Trust Board	➢ St Lukes Hospital ➢ Capital Plan 2016/17 and 2017/18 ➢ Pontefract and Wakefield Community Hubs ➢ Fieldhead Masterplan ➢ Trinity 2 fire ➢ Castleford, Normanton and District Hospital ➢ Disposals ➢ Hospital sites in Barnsley

Mental Health Act Committee

Date	15 November 2016
Presented by	Chris Jones
Key items to raise at Trust Board	➢ Compliance with Code of Practice and reluctance from staff. ➢ Peer review. ➢ Collective partnership support for transformation presentation. ➢ Ethnicity data. ➢ Data collection.

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South West Yorkshire Partnership NHS

NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 8 November 2016

Present:	Ian Black	Chair of the Trust
	Alan Davis	Director of Human Resources and Workforce Development
	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair of the Trust (Chair)
	Adrian Berry	Medical Director
	Tim Breedon	Director of Nursing, Clinical Governance and Safety
	Dawn Stephenson	Director of Corporate Development
Apologies:	Karen Taylor	District Director, Calderdale and Kirklees
In attendance:	Kiran Bali	Attendee from The Insight Programme
	Mike Doyle	Deputy Director, Nursing, Clinical Governance and Safety
	Carol Harris	District Director, forensic and specialist services
	Emma Jones	Integrated Governance Manager (author)
	Gemma Pickup	Quality improvement & assurance lead (item 7)
	Sean Rayner	District Director, Barnsley and Wakefield

CG/16/84   Welcome, introduction and apologies (agenda item 1)
The Chair (JF) welcomed everyone to the meeting. The, apologies, as above, were noted.

CG/16/85   Minutes of the previous meeting held on 13 September 2016 (agenda item 2)
It was RESOLVED to APPROVE the minutes of the meeting held on 13 September 2016.

CG/16/86   Matters arising (agenda item 3)
The following actions from the meeting held on 13 September 2016 were discussed.

CG/16/38 Present revised Trust protocol in relation to transition from child to adult services in light of revised NICE guidance following approval by EMT
Update included under agenda item 4.

CG/16/79 Consider suggestion to identify learning from an incident that has been applied Trust-wide for use as an exemplar
Tim Breedon (TB) advised that the learnings were included in the quarterly report. JF asked that an incident be provided as an example at the next meeting.

Action: Tim Breedon/Mike Doyle

There were four matters arising.

CG/16/66 Provide update on PLACE in terms of benchmarking, action to achieve higher ratings, next steps and ensuring membership of teams is patient-led (agenda item 3.1)
Alan Davis (AGD) highlighted that the paper provided the current position and a follow up paper would be provided to the next meeting on the actions identified during the business

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planning process. Key areas to target have been identified as cleanliness; food; privacy, dignity and wellbeing; dementia; and disability audits.

The next review would be due in February/March 2017 and a series of pre-PLACE audits would be conducted before the end of 2016. JF requested that the paper was clear about patient involvement, as identified previously by Rob Webster.

Action: Alan Davis

CG/16/71 Benchmark Trust experience of smoke-free with other appropriate organisations (agenda item 3.2)
Adrian Berry (ABe) advised that there was currently no standardised benchmarking information available. Information from other organisations echoed that of the Trusts in that the smoke-free policy was introduced easily, initially there was a peak of issues which then reduce. The Trust needs to continue to manage smoking issues explicitly within buildings and grounds. The Trust has taken part in a smoke free survey focusing around estates and facilities and an interim report due in December 2016 would be provided to the next meeting.

Action: Adrian Berry

CG/16/80 Provide update on review of internal controls and risk management (agenda item 3.3)
Dawn Stephenson (DS) advised that the Trust Board agreed the risk appetite which has been incorporated in the front cover template for Trust Board papers. The Executive Management Team (EMT) are reviewing individual risks, focusing on control measures, new measures, and type of risk in line with the risk appetite. Once the discussion has taken place by EMT then details would progress to the appropriate committee. Further work has progressed on the consistent definition and use of Red, Amber,Green (RAG) ratings across the Trust. A risk appetite session by the external auditors has been scheduled for the Trust Board in December 2016.

CG/16/26 Committee annual report – outcome of self-assessment (agenda item 3.4)
JF requested that in relation to the self-assessment, the work plan be included with the meeting papers after the matters arising.

Action: Emma Jones

JF requested an update in relation to the self-assessment for members, particularly those new to the Committee, be provided with training. DS advised that it could be added to the induction list for Non-Executive Directors including a range of service visits with BDU Directors 6 to 9 months after taking up post.

Action: Emma Jones

JF requested an update in relation to the self-assessment for the Committee to have a mechanism to keep it aware of topical, legal and regulatory issues. TB advised that these are included under the key clinical risks; how this would be addressed will be agreed at the next agenda setting meeting.

Action: Tim Breedon

JF requested that in relation to the self-assessment, the Committee was briefed on its assurance responsibilities with regard to internal control and risk management, and other areas of compliance, particularly that of clinical risk and that an annual input is added to the work plan for April.

Action: Emma Jones

CG/16/87   Transformation update (agenda item 4)

TB highlighted that the transformation update on the agenda was in relation to item 8 Child and adolescent mental health services – update. Mike Doyle (MD) advised that it was based on NICE guidance with the consultation process ending next week. Charlotte Dyson (CD) asked how the process was managed when the transfer takes place outside of the Trust. ABe commented that it was more common where people had services outside the Trust and then returned with a well-established system in place.

CD, Rachel Court, Mark Brooks and James Drury would be meeting to discuss how transformation information is presented with a proposal to go to the Trust Board.

CG/16/88   Quality accounts (agenda item 5)

TB advised that the quality accounts production timetable remains on target although new guidance was expected to be published. The development of a local indicator had been difficult to manage but a solution has been proposed. This year the focus would be on measuring the Trusts partnership arrangements with other organisations and the proposal is to measure the impact of the introduction of revised referrals and assessments into children and adolescents mental health services (CAMHS), which has seen an improvement in the level of appropriate referrals into Tier 3 services.

IB asked about the involvement of governors in the quality accounts. TB commented that feedback received from external auditors was that it was unusual to have the level of engagement that the Trust has with the Members' Council, but that it was seen as good practice. TB to provide details to IB to see if it can be put forward as best practice.

Action: Tim Breedon/Ian Black

CG/16/89   Improving the quality of the mortality review process (agenda item 6)

TB highlighted that following the independent review of deaths of people with learning disabilities and mental health problem in contact with Southern Health NHS Foundation Trust (April 2011-2015), work has continued to improve the Trusts investigation and reporting. MD advised that work was in progress in relation to benchmarking, reporting deaths of those with a learning disability, and a mortality review training day was scheduled for 2 December 2016.

CG/16/90   Child and adolescent mental health services – update (agenda item 8)

Carol Harris (CH) presented the paper on behalf of Dave Ramsay, Deputy Director Operations which provided an update on the clinical governance/risk issues and service development plans in Calderdale/Kirklees, Wakefield and Barnsley child and adolescent mental health services (CAMHS). The 0-19 Kirklees bid was submitted on 4 November 2016. The Trust has also supported commissioners in applying for additional national funding under 'Future in mind' to help address waiting lists and are waiting to hear if it has been allocated. CH highlighted that there may be an impact on the Trust's agency spending which adds an additional risk, but the use of bank and short term contracts would be explored first. If successful the Trust would write to NHS Improvement to explain the potential increase in agency spend in order to promote patient safety and address the waiting list.

CH advised that they are using the lessons learned from Kirklees single point of access (SPA) in Barnsley and Wakefield and they are working with Wakefield to redesign the

pathway as part of 'Future in Mind'. The Friends and Family Test shows a poor rating in relation to CAMHS which is thought to be due to the wait time for access to services. Healthwatch have offered to do a survey in conjunction with the Trust of people on the waiting list to see what assistance could be provided. In relation to SPA, the data is showing that it is having an impact and the number of people needing a full CAMHS assessment is reducing the waiting time for appointments and treatment. The Executive Management Team had requested some clarity around ASD referrals in Barnsley with the acute hospital now managing new referrals.

IB asked if the Trust should be the lead for a West Yorkshire approach to CAMHS. CH advised that she would raise the question with the Mental Health Sustainability and Transformation Plan (STP) Group.

Action: Carol Harris

CG/16/91   NICE InPhase assurance and QI monitoring system (agenda item 7)

Gemma Pickup (GP) provided a presentation to the Committee on the NICE InPhase assurance and monitoring system. A review would be conducted in Quarter 1 of 2017/18 to assess how the system worked in relation to the CQC action plan and NICE guidance and other areas for use going forward. The Committee understood the benefits of the system described and look forward to implementation as it supports our assurance and improvement activity.

CG/16/92   Quality Impact Assessment of cost improvement programme (agenda item 9)

MD highlighted that existing operational processes for quality impact assessments (QIA) were now formalised into a standard operating procedure (SOP) which was simple and useful. TB commented that positive feedback was received initially from the external auditors in relation to the process and the SOP would further improve the process. Our QIA timetable for 2017/18 CIPs will be started in December.

CG/16/93   Safer staffing (agenda item 10)

TB advised that the paper went to the Trust Board on 25 October 2016 to provide an update on the current position and includes a board checklist of areas that should be considered. Reporting is now done on a monthly basis and includes the breakdown by BDU and team.

MD highlighted that the bank centralisation was maturing and recruitment was increasing with the non-registered/registered vacancies showing a reduction. New initiatives were in place regarding Band 4s, recruitment was continuing for Band 2s, and work was commencing with Human Resources to look at how to recruit more people onto the bank and make it more accessible and easier to join. Sean Rayner (SR) chaired a peer review across the system in relation to bed usage and staffing which was positively received.

AGD commented that the Trust was also looking at opportunities and relationships with universities as part of the changes to national funding for nursing training and the nursing associate role.

CG/16/94   Care Quality Commission (agenda item 11)

Care Quality Commission inspection and action plan (agenda item 11.1)

TB commented that a high level report including action items that are amber and red went to the Trust Board meeting on 25 October 2016 and significant progress has been made since then . In relation to the areas showing as red, (high temperatures in a clinic room) mitigation is in place; RIO still shows issues in the system and work was ongoing. Consent and capacity assessment, work was needed to ensure consistency; and the Mental Health Act (MHA) and Mental Capacity Act (MCA) training had been clarified to ensure those who need to attend the training and ensure the right reporting is in place. TB advised that an orientation visit from the CQC was scheduled on 9 November 2016 for them to further understand how the Trust's services work. The visit would include a conversation about what would be expected when the CQC re-inspect to sign off actions as complete and understand any impact due to the fire at Trinity 2.

The Committee agreed that future updates could now exclude areas currently RAG rated as blue and green.

Mental Health Act visits – clinical and environmental issues (agenda item 11.2)

CH commented that the individual reports had been included in the papers, but the process was review by the Operational Management Group and BDU governance groups with only exceptions to be reported to the Committee in the future.

CG/16/95   Incident management Q2 2016/17 (agenda item 12)

MD highlighted that the quarterly report showed a downward trend on amber and red incidents; incorporated some significant lessons learnt; information around PREVENT; and work taking place around early health assessments.

JF requested as part of the annual report, trends and lessons learned are included from the last five years.

Action: Mike Doyle

CG/16/96   Sub-groups – exception reporting (agenda item 13)

Medicines management (agenda item 13.1)

ABe highlighted that one of the key issues was around the agreement for a shared care guideline for melatonin which is a high cost drug. The agreement means it can now be prescribed at the primary care level. A detailed analysis of drug expenditure had been conducted which demonstrated some areas in which the Trust was performing extremely well and areas identified for potential efficiencies. In relation to the risk of medication supply an NHS acute Trust had now been identified to provide the service.

Health and Safety and Emergency Preparedness Steering Group (agenda item 13.2)

AGD highlighted that the paper summarised the discussion from the Health, Safety and Emergency Preparedness Trust Action Group meeting held on 6 September 2016, including the importance of monitoring the process and audit of Health and Safety to ensure the Trust has full coverage.

IB asked for an update on the fire at Trinity 2. AGD advised that the services had done extremely well in managing the situation with contingency plans put in place. A root cause analysis would be conducted. TB commented that they were looking at the possibility of moving PICU into Gaskell Ward in Newton Lodge and the female PICU would need to go out of area in the short term. The CQC had been advised. As a result of the longer term estates

plan for Fieldhead it was not envisaged that Trinity would be rebuilt in its current form. The Committee thanked staff involved for their professionalism.

CD asked for an update on flu shots. TB advised that the current uptake from staff was 46% which was better than previous years but there is still a long way to go to meet the CQUIN target of 75%.

Infection Prevention and Control (agenda item 13.3)
TB advised that the areas which were below target around hand hygiene had been addressed and were improving.

Safeguarding children and adults (agenda item 13.4)
TB advised that the CQC had conducted a Calderdale thematic Safeguarding review and the draft report had been received for comment.

Managing Aggression and Violence annual report (agenda item 13.5)
MD highlighted that the annual report shows an increase but that there was also a 13% increase in reporting of incidents. The focus is on reducing physical intervention, particularly prone restraint. Training has been merged between Learning Disabilities and Mental Health services looking at the least restrictive positive behaviour support plans. One of the successes was the implementation of the seclusion policy. In relation to seclusion there was an increase but the duration had reduced. The focus next year is the reduction of restrictive physical interventions

JF requested an update for the next meeting with a identified service user in Horizon removed to see if there would be an impact on the data.
Action: Mike Doyle

Any feedback from other TAGSs/groups (agenda item 13.6)
No further feedback was given.

CG/16/97   Clinical Audit & Practice Evaluation (agenda item 14)
MD highlighted that the paper provided an update on the progress with projects RAG rated and the vast majority completed and a verbal update would be provided to the next meeting.
Action: Mike Doyle

CG/16/98   Issues and items to bring to the attention of Trust Board (agenda item 15)
Issues were identified as:

- Update on Child and Adolescent Mental Health Services (CAMHS).
- CQC action plan and plan for meeting scheduled on 9 November 2016.
- NICE InPhase assurance and QI monitoring system.
- Quality Impact Assessment of cost improvement programme.
- Outcome of the Trinity 2 fire and next steps

CG/16/99   Date of next meeting (agenda item 16)
The next Committee meeting will be held on Tuesday 14 February 2017 at 14:00 in the Boardroom, Kendray, Barnsley.

Trust Board 20 December 2016
Agenda item 11

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 seven times since the report to Trust Board in June 2016 in respect of the following. ➢ Supplemental agreement relating to Elmfield House, Prescott Street, Halifax, extending the time for the long stop date. ➢ Transfer of registered titles for Elmfield House, Prescott Street, Halifax, extending the time for the long stop date. ➢ Contract for the sale of freehold land at Bridge House and Cherry Trees, Mayors Walk, Pontefract between the Trust and Thompson Assets Ltd. ➢ Transfer of registered titles for freehold land at Bridge House and Cherry Trees, Mayors Walk, Pontefract between the Trust and Thompson Assets Ltd. ➢ Contract for the sale and transfer of freehold land at Horbury Health Centre, Westfield Road, Horbury between the Trust and Stokers Holdings Ltd. ➢ Transfer of registered titles for of freehold land at Horbury Health Centre, Westfield Road, Horbury between the Trust and Stokers Holdings Ltd. ➢ Warranty in relation to the Wakefield Hub (requirement for completion of lease) between the Trust and Conroy Brook Construction Ltd.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in September 2016.**
Private session:	Not applicable

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