South West Yorkshire Partnership NHS Foundation Trust

Trust Board (business and risk)
Tuesday 28 March 2017 at 10:30
Conference Centre Boardroom, Kendray, Barnsley

AGENDA

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

2. **Declaration of interests** (attached)

3. **Minutes and matters arising from previous Trust Board meetings held on 31 January 2017 and 28 February 2017** (attached)

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

5. **Strategies**
   5.1. Workforce strategy (attached)

   5.2. Information Management and Technology strategy update (attached)

   5.3. Operational plan 2017/18 and 2018/19 update (attached)

6. **Performance reports month 11 2016/17**
   6.1. Integrated performance report month 11 2016/17 including finance (attached)

7. **Exception reporting**
   7.1. Serious incidents report quarter 3 2016/17 (attached)

   7.2. Safer staffing (attached)

   7.3. Eliminating mixed sex accommodation declaration (attached)

   7.4. Information Governance position statement (IG toolkit) (attached)

   7.5. NHS staff survey (attached)

8. **Governance matters**
   8.1. Receipt of public minutes of partnership boards (attached)

9. **Assurance from Trust Board Committees** (attached)

- Clinical Governance and Clinical Safety Committee 14 February 2017 (draft minutes attached)
- Remuneration and Terms of Service Committee 21 February 2017 and 28 February 2017
- Mental Health Act Committee 14 March 2017

10. **Use of Trust seal** (attached)

11. **Trust Board Work Programme** (attached)

12. **Date of next meeting**

The next meeting of Trust Board will be held on Tuesday 25 April 2017 at Rooms 5 & 6, Laura Mitchell House, Halifax.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 2

Title:	**Trust Board declaration of interests, including fit and proper persons declaration**
Paper prepared by:	Director of Corporate Development on behalf of the Chief Executive
Purpose:	To ensure the Trust continues to meet the NHS rules of Corporate Governance, the Combined Code on Corporate Governance, Monitor's Code of Governance and the Trust's own Constitution in relation to openness and transparency.
Mission/values:	The mission and values of the Trust reflect the need for the Trust to be open and act with probity. The Declaration of Interests and independence process and the fit and proper person declaration undertaken annually support this.
Any background papers/ previously considered by:	Previous annual declaration of interest papers to the Trust Board. Policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality approved by Trust Board 31 March 2015.
Executive summary:	<u>Declaration of interests</u> The Trust's Constitution and the NHS rules on corporate governance, the Combined Code of Corporate Governance, and Monitor require Trust Board to receive and consider the details held for the Chair of the Trust and each Director, whether Non-Executive or Executive, in a Register of Interests. During the year, if any such Declaration should change, the Chair and Directors are required to notify the Company Secretary so that the Register can be amended and such amendments reported to Trust Board. Trust Board receives assurance that there is no conflict of interest in the administration of its business through the annual declaration exercise and the requirement for the Chair and Directors to consider and declare any interests at each meeting. As part of this process, Trust Board considers any potential risk or conflict of interests. If any should arise, they are recorded in the minutes of the meeting. There are no legal implications arising from the paper; however, the requirement for the Chair and Directors of the Trust to declare interests is part of the Trust's Constitution. <u>Non-Executive Director declaration of independence</u> Monitor's Code of Governance and guidance issued to Foundation Trusts in respect of annual reports requires the Trust to identify in its annual report all Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement. This Trust considers all its Non-Executive Directors to be independent and the Chair and all Non-Executive Directors have signed a declaration to this effect.

	Fit and proper person requirement There is a requirement for members of Boards of providers of NHS services to make a declaration against the fit and proper person requirement for directors set out in the new fundamental standard regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which came into force on 1 April 2015. Within the new regulations, the duty of candour and the fit and proper person requirements for Directors came into force earlier for NHS bodies on 1 October 2014. Although the requirement is in relation to new Director appointments, Trust Board took the decision to ask existing Directors to make a declaration as part of the annual declaration of interests exercise. All Directors have signed the declaration stating they meet the fit and proper person requirements. The Integrated Governance Manager is responsible for administering the process on behalf of the Chief Executive of the Trust and the Company Secretary. The declared interests of the Chair and Directors are reported in the annual report and the register of interests is published on the Trust's website. In February 2016, NHS England released new guidance on Managing Conflicts of Interest in the NHS which will take effect from 1 June 2017. A model policy is due to be released in March 2017 which will be used to update the current policy and will come to Trust Board for approval.
Recommendation:	**Trust Board is asked to CONSIDER the attached summary, particularly in terms of any risk presented to the Trust as a result of a Director's declaration, and, subject to any comment, amendment or other action, to formally NOTE the details in the minutes of this meeting.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board – Declaration of Interests
28 March 2017

All members of Trust Board have signed a declaration against the fit and proper person requirement. All Non-Executive Directors have signed the declaration of independence as required by Monitor's Code of Governance, which requires the Trust to identify in its annual report those Non-Executive Directors it considers to be independent in character and judgement and whether there are any relationships or circumstances which are likely to affect, or could appear to affect, the Director's judgement.

The following declarations of interest were made by Directors.

Name	Declaration
CHAIR	
Ian Black	Independent Non-Executive Director, Benenden Healthcare Society. Chair, Benenden Wellbeing Limited. Chair, Keegan and Pennykidd. Non-Executive Director, Seedrs (with shareholding). Trustee and Director, NHS Providers. Chair, Finance and General Purposes Committee, NHS Providers. Chair, Family Fund (UK charity). Driving Member, Whiteknights, a charity delivering blood and samples on behalf of hospitals in Yorkshire. Private shareholding in Lloyds Banking Group PLC (retired member of staff). Director, Lightcliffe Golf Club.
NON-EXECUTIVE DIRECTORS	
Laurence Campbell	Director, Trustee and Treasurer, Kirklees Citizens' Advice Bureau and Law Centre, includes NHS complaints advocacy for Kirklees Council.
Rachel Court	Director, Leek United Building Society. Chair, Invesco Perpetual Life Ltd (from 24 March 2017). Director, Leek United Financial Services Ltd. (from 27 April 2016). Chair, PRISM. Governor, Calderdale College. Magistrate. Chair, NHS Pension Board. Director, Invesco UK Ltd (from June 2016).
Charlotte Dyson	Independent marketing consultant, Beyondmc (marketing consultancy work for Royal College of Surgeons, Edinburgh). Lay Chair, Leeds Teaching Hospitals NHS Trust Advisory Appointments Committee for consultants (occasional). Lay member, Leeds Teaching Hospitals NHS Trust Clinical Excellence Awards Committee.

Name	Declaration
	Lay member, Bradford Teaching Hospitals NHS Trust. Lay member, Advisory Committee Clinical Excellence Awards, Yorkshire and Humber Sub-Committee. Lay member, Royal College of Surgeons of Edinburgh, MRSC Part B OSCE.
Julie Fox	Chair of Trustees and Advisory Board member, Peer Power (social justice organisation supporting young people). Director, Just Us Associates. Daughter appointed as Independent Hospital Manager.
Chris Jones	Director and part owner, Chris Jones Consultancy Ltd. Trustee, Children's Food Trust.
CHIEF EXECUTIVE	
Rob Webster	Independent Chair of Panel for assessing clinical commissioning group learning disability commissioning (NHS England). Visiting Professor, Leeds Beckett University. Honorary Fellow, Queen's Nursing Institute. Honorary Fellow, Royal College of General Practitioners. Lead Chief Executive, West Yorkshire and Harrogate Sustainability and Transformation Plan.
EXECUTIVE DIRECTORS	
Dr Adrian Berry	No interests declared.
Tim Breedon	No interests declared.
Mark Brooks	No interests declared.
Alan Davis	No interests declared.
COMPANY SECRETARY	
Dawn Stephenson	Voluntary Chair and Trustee, Kirklees Active Leisure. Governor, Membership Council, Calderdale and Huddersfield NHS Foundation Trust (and member of Remuneration and Terms of Service sub-committee).
OTHER DIRECTORS	
Carol Harris	Spouse's company is engaged with Mid-Yorkshire Hospitals NHS Trust in relation to engineering.
Kate Henry	No interests declared.
Sean Rayner	Trustee, Barnsley Premier Leisure.
Karen Taylor	No interests declared.
Salma Yasmeen	No interests declared.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 31 January 2017

Present:	Ian Black	Chair
	Julie Fox	Deputy Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Rachel Court	Non-Executive Director
	Chris Jones	Non-Executive Director
	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:	Nil	
In attendance:	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Salma Yasmeen	Director of Strategy
	Kate Henry	Director of Marketing, Communications and Engagement
	Carol Harris	District Director – Forensic and Specialist Services
	Sean Rayner	District Director – Barnsley and Wakefield
	Karen Taylor	District Director – Calderdale and Kirklees
	Emma Jones	Integrated Governance Manager (author)
	James Drury	Deputy Director Strategic Planning (agenda item 5)

TB/17/01 Welcome, introduction and apologies (agenda item 1)

The Chair Ian Black (IB) welcomed everyone to the meeting, including the new Director of Strategy, Salma Yasmeen. There were no apologies.

TB/17/02 Declaration of interests (agenda item 2)

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

TB/17/03 Minutes and matters arising from previous Trust Board meeting held on 20 December 2016 (agenda item 3)

It was RESOLVED to APPROVE the minutes of the public session of Trust Board held 20 December 2016 as a true and accurate record of the meeting. There were no matters arising.

TB/17/04 Chair and Chief Executive's remarks (agenda item 4)

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

- The NHS continues to be a significant political issue with Brexit, winter pressures, service pressures, and financial issues all widely reported.
- In this changing environment the focus is on collaboration and Sustainability and Transformation Plans (STPs) continue to be a strong driver for collaboration across places. Governance vehicles and service models are starting to emerge which are in line with the Trust's strategy.

- The Trust's women's forensic pathway team was chosen as the winner in the 'Improving care through innovation or improvement' category of Yorkshire and Humber Academic Health Science Network's Innovation, Improvement and Impact awards. Carol Harris (CH) commented that the work on the women's pathway has made a huge difference to the women in our care. Breaking away from traditional services and seeing these results in a short space of time is something that the team should be very proud of. It is testament to their commitment and expertise in this specialist field. It is also an excellent example of the culture of innovation to improve care that we want to run right through our forensic service.
- The Care Quality Commission (CQC) are currently inspecting services and as part of their well-led review. As an organisation we test ourselves against three areas when we have such reviews: do we give a fair account of ourselves, do we get some insight, and do we come together out of an action plan that will lead to improvements.
- The Brief monthly communication to staff has helped staff keep up to date with what is happening across the Trust. When staff were asked in 2015 57% of staff felt they were well communicated with and the latest survey shows this has increased to 83%.

Charlotte Dyson (CD) asked in relation to the gap in investment that commissioners are making towards the Mental Health Five Year Forward View (FYFV), if there were areas that were more supportive. RW commented that each of the contracts with commissioners has a clause around working with the Trust to demonstrate how they are investing in the Mental Health FYFV (and some elements of the GP FYFV) recognising that we would not receive all of the investment as there are other providers. It is a variable position, sometimes to do with the finances of the individual commissioners. However it was important to have timescales for resolving the position on Mental Health FYFV funding and use influence we have through the national system to ensure there is the right level of pressure to encourage commissioners to put the funds into the right areas.

Julie Fox (JF) asked if the issues around workforce and impact of Brexit were being discussed at an STP level. Alan Davis (AGD) commented that the Trust was not as reliant on overseas workers from the EU as other organisations. Discussion is taking place with universities to work with them to get the future supply of staff right. RW commented that NHS Employers had a working group looking at Brexit and there was a Local Workforce Advisory Board working across each of our STP footprints. Workforce strategy will be discussed further at the Remuneration and Terms of Service Committee.

Action: Alan Davis

Chris Jones (CJ) asked what service user engagement there had been in relation to the STPs. RW commented that the arrangements for engagement with the public and service users varied between each STP. Each has involvement by Heathwatch, with input to the Leadership Groups. For example, when the West Yorkshire and Harrogate STP was published there was a compendium published alongside it of the huge amount of engagement that had taken place since 2012 on the issues that the public want to see. In South Yorkshire there was a similar approach, though the STP has been more acute driven as they have an acute sector vanguard and they are looking at enhancing community engagement.

It was RESOLVED to NOTE the context within which the Trust operates and remain focused on the things the Trust can control and influence, remaining true to our mission and our new strategy.

TB/17/05 Strategic overview of business and associated risks (agenda item 5)

James Drury (JD) reported that the business and associated risks have been reviewed in the context of the Trust's strategy and highlighted the following:

- The Political, Economic, Social, Technological, Legal and Environmental (PESTLE) analysis has been revised to reflect changes to the regulatory and policy context in which the Trust operates, and the local context with regard to place based plans and sustainability and transformation plans.
- There is a gap in the Mental Health Five Year Forward View (FYFV) funding in the 2017–2019 contracts, and conversations with commissioners are continuing.
- Changes in Public Health spending has an impact on contracts and jobs with the pace of change increased significantly, linked to continued austerity in local authorities
- Increased impact of market forces on vulnerabilities in NHS markets for staff and flexible bed capacity. Experienced through agency usage and costs (mitigated by agency cap), and independent sector bed-day prices.
- Increased pace of movement towards new organisational forms and partnership vehicles suitable for place based solutions, such as Accountable Care Organisations and specific collaboration. This aligns with the Trust's Strategy.
- The strengths, weaknesses, opportunities, and threats (SWOT) analysis has been revised to reflect the Trust's positioning in relation to the changed external environment. Overall this reflects improved clarity and capability in several of the areas prioritised in our 2016/17 objectives.
- It also reflects the learning from our recent stakeholder engagement processes. This has enabled the SWOT to reflect a greater degree of clarity about the Trust's strengths in the context of the development of Accountable Care Systems

Rachel Court (RC) asked how the information that the report highlighted could be used as a management tool as we look at our strategy. JD commented that it was used to see that areas of risk were consistent with the risk register and that actions were being put practice to mitigate against these with further work on opportunities needed so that they can be realised. RW commented that when opportunities were being assessed they are put through the decision tree and considered by EMT for recommendation to the appropriate sub Committee or Board.

CD asked how the outcome of the recent stakeholder research would apply to opportunities identified. Kate Henry (KH) advised that the final report included seven recommendations and conversations would take place with JD and Salma Yasmeen (SY) on how that could be included within the strategy development. An executive summary would be provided to the Trust Board. SY commented that communication with external stakeholders would be mapped and opportunities identified included as part of communication going forward.

Action: Kate Henry

JF commented that it was fundamentally important that how service users perceived the care they were receiving was considered. She asked how the Trust could work to shift the perception that cuts were not being made to services and changes were being made to improve the quality of what is being delivered. JD commented that the Trust could build on its work in communities. We host Altogether Better, Creative Minds and the Recovery Colleges, which support engagement and social prescribing, which helps service users to be co-producers of their health and the Trust was seen as a leader in this area of work. CD asked how these areas could be brought together in synergy to work together.

Tim Breedon (TB) commented that it was difficult to have the conversation locally when it was not happening nationally. RW commented that through a review of Directors portfolios the need was highlighted to ensure areas such as Creative Minds, Recovery Colleges and the museum were brought together. We are a Foundation Trust with members and our strategy needs include how we communicate our staff and members as part of our ethos. This is part of the membership strategy going through the Members' Council.

Discussions are also taking place internally and with partners on what we are doing to supporting the use of personal budgets throughout integrated teams to give service users choice and control in a way which is safe and appropriate.

CJ commented that it was good to see changes clearly highlighted in the report and requested the inclusion of weaknesses including actions to mitigate and manage them in future reports, linking into other areas such as the risk register.

Action: James Drury

IB commented that one of the risks is decommissioning. With some of the Trust's award winning services having been decommissioned, it was important to see the detail of degree of risk to services being presented in future. RW commented that this was included as part of the Trust Board strategic session in November 2016 and it would be good to review over time including the cycle of contract renewal.

Action: James Drury

It was RESOLVED to NOTE the content of the report.

TB/17/06 Strategies for approval (agenda item 6)

TB/17/06a Update to the risk management strategy (agenda item 6.1)

Dawn Stephenson (DS) reported that the Risk Management Strategy set out our approach to ensure there were risk management processes in place that were adequate and dynamic; as well as to provide a framework for the continuous development of these processes. Changes included the addition of the Board Assurance and Escalation Framework and Risk Appetite Statement as previously agreed by the Board.

The Trust is committed to ensure the safety of staff and service users and has an integrated approach to look across all areas to ensure we have safe arrangements in place. It was important to anticipate risk, make sound decisions on the right information and intelligence, and minimise the likelihood of the risk. Our Members' Council plays a key role in governance arrangements and through development sessions will focus further on areas of performance and risk. The Trust has recently appointed a number of staff governors as Freedom to Speak Up Guardians as another way for staff to raise concerns where they feel unable to do so through the usual mechanisms. Further work will be done in the next quarter by the Executive Management Team (EMT) in accordance with the Risk Appetite to review the procedures that accompany the Strategy and consider issues below the organisational risk register. The update to the Strategy has been reviewed by EMT and the Audit Committee who support it approval.

RW commented that there has been further focus on risk by the EMT including a clinical risk scan every week and a review of the risk register every month. The Risk Appetite Statement was an important development as it says clearly what risk the Trust will and won't tolerate. The processes then link to how risks outside the Risk Appetite would be managed by Board Committees then escalated to the Board if required.

Laurence Campbell (LC) commented that a detailed review had taken place of the Strategy including looking at changes in line with the Risk Appetite. The Trust Board had a session with Deloitte around Risk Appetite that lead to stimulating conversation about how risks are managed. Further work on a process around how risks are anticipated and where challenges emerged how these processes would enabled then to be identify in a timely manner. It was also important to encourage staff to raise risks if they have areas of concern.

Dr Adrian Berry (ABe) commented that differential thresholds for risks as part of the Risk Appetite was important as it leads to informed discussion as some risk may not be solely clinical. Some issues of low level clinical risk had been previously held and managed at team and service level and there had not previously had an escalation process that would identify them easily as an organisational level risk.

TB commented that the Datix reporting system was easily accessible for staff and also included incident reporting. There are good risk scanning systems in place and improvements were being made in terms of triangulating discussions at BDU Governance Groups and inclusion in the Integrated Performance Report. CH commented that areas of concern raised at ward and team level were discussed by BDU Governance Groups then escalated through the Operational Management Group to EMT then included in the IPR linking from ward to Board. Karen Taylor (KT) commented that there was an increased awareness by staff that are raising concerns and was important to look at how that information can be translated to make it user friendly for staff.

RW commented that it was important to ensure that plans under the Organisation Development Strategy reinforce the cultural points around risk.

Action: Alan Davis

The Board discussed the need to define processes around emerging risks and the Risk Appetite and the potential for a threshold to be identified for formal reporting at Trust Board through the Integrated Performance Report and Risk Register.

Action: Dawn Stephenson

It was RESOLVED to APPROVE the update to the Risk Management Strategy.

It was RESOLVED to DELEGATE AUTHORITY to the Chief Executive and Director of Corporate Development to update the supporting Risk Management Procedure and the incorporation of the relevant appendices from the Risk Management Strategy as deemed appropriate.

TB/17/07 Performance reports (agenda item 7)

TB/17/07a Integrated performance report month 9 2016/17 including finance (agenda item 7.1)

Mark Brooks (MB) commented that the revised format of the Integrated Performance Report now included information around agency and out of area bed expenditure. Despite the pressures, the Trust was still meeting most of its performance metrics and targets and credit should be given to staff for maintaining a high level of service despite the financial and demand pressures.

TB reported in relation to Quality:

- Mental Health safety thermometer for medicines admissions data for the quarter had not yet been received. The issue was around follow up of refusals and work was taking place with colleagues in Kirklees and Calderdale. The rest of the areas were reducing in line with plans.

- Safety first new style of reporting was being trialled by the Risk Panel with good feedback received in term of supporting triangulation of information and spotting areas of risk before they occur. A risk scan takes place weekly with an enhanced report to the Operational Management Group and Executive Management Team meeting monthly.
- Incident reporting and lessons learned are received by the Clinical Governance and Clinical Safety Committee.
- Patient experience through the Friends and Family Test shows for Community Services that 99% would recommend community services and 71% would recommend Mental Health services. All service lines achieved 50% or above for patients/carers stating they were likely to recommend the Trust's services.
- Safer staffing fill rate was maintained over Christmas at Trust and service level. Escalation processes were in place for exception reporting. Three wards fell below the threshold for registered staff on day wards used professional processes and guidance to ensure the wards were managed safely.
- RW commented that it was important to highlight that changes in reporting to Board made it clear that all wards overnight had the right levels of registered nurses and during the day time three wards trigger escalation processes and were managed safely. TB commented that it was important to recognise that these are not set at the minimum safety levels they are set at the appropriate level for our services.

JF asked for details on the processes around Duty of Candour incidents. TB commented that we are complaint with the Duty of Candour arrangements. The Patient Safety Team is included in the scan of incidents and processes have been altered to ensure that verbal and written statements are made ass appropriate to those affected. For reporting on stage one and stage two breaches, work is underway on establishing a baseline working with others to benchmark our performance. If an issue is raised as a consequence the Operational Management Group is responsible for approving the closure of cases.

JF asked for details in relation to non-adult placements in adult beds. CH commented that system wide access to Children and Adolescent Mental Health Services (CAMHS) tier 4 beds was an issue and where there was none available individual cases are assessed. In some instances, placing people in an adult bed was seen as a “least worst option” and a safer option than returning them home. In these instances, reports are provided to the CQC and work is done closely with adult colleagues to ensure safe package of care are placed around them. RW commented that we need to work with commissioners on the availability of the Tier 4 beds and services to ensure there are is the capacity including specific specialised beds for people that have a multiple need. ABe commented that these individuals have presented particular challenges but the Trust has provided the best care possible under the circumstances. NHS England has a service review process in place which has not yet moved forward for West Yorkshire.

CJ asked for an update on Information Governance breaches and any potential impact on the Trust or service users. MB reported that over eight weeks there were four breaches reported to the Information Commissioner’s Office (ICO) with three relating to incorrect addresses which are being investigated. Prior to this there was a gap of eight months where no breaches were identified which needed reporting to the ICO. The ICO conducted a review in November 2016 in agreement with the Trust which provided reasonable assurance on the Trust’s processes and recommendations for further improvement. An important area to address is staff culture and there is a communication plan in place which focuses on the potential impact to service users. The communications also focuses on mandatory training required by end March 2017. One of the issues identified is that RiO and national spine do not always update correctly and work is in progress to ensure the synchronising of addresses for the current caseload. Reports on Information Governance are received by the

Executive Management Team, Audit Committee and also Clinical Governance Clinical Safety Committee as part of incident reporting and lessons learned.

MB reported in relation to finances, in month deficit of £27k excluding STF funding. The main issues continue to be out of area bed expenditure which were offset in the month by a range of other savings and income issues, including not needing to recognise a CQUIN loss as the flu vaccination target was achieved. The NHS Improvement risk rating is at 3, relating in large part to agency spend, which in month it increased by roughly £100k. Out of area bed expenditure showed a £50k slowdown in forecast overspend compared to the previous month. More positively there has been a recent reduction in the usage of out of area beds and constructive dialogue with loss adjusters on a potential insurance claim due to business interruption from a fire which impacted out of area bed usage. While the finances are showing an improved position, they are not where they need to be and the Board and Executive continue to focus on managing the financial position.

MB reported in relation to NHS Improvement metrics, the majority were green, falling short within one of the IAPT indicators. However, this had seen an improvement in December 2016. There was a risk to achievement due to data completeness around employment and accommodation for which the Trust only started measuring data in December 2016. It was currently at 42% and the target for end March 2017 was 85%. An action plan was in place to improve the current performance, but whilst performance is improving it is unclear at this point whether the target for March 2017 will be achieved.

Sean Rayner (SR) reported in relation to out of area beds that work was being undertaken to look at flow and capacity and actions were in place to support clinical decision making. Out of area bed placements started to increase in August 2016 and peaked at 22 in December 2016. The actions to date had seen some success with the number of beds at week commencing 27 January 2017 down to 11. Action was focusing on bringing down the number of placements and also sustainability within the system. As a contingency the Trust has an arrangement with Pennine Care to purchase beds at a lower rate than is available from the private sector.

RC asked in relation to agency spend whether improvement was not yet seen because actions were not delivering or because they are longer term plans. ABe commented that some of the plans were long term and agency use reflected a workforce capacity deficit. Work has been undertaken to look at agency use information in detail to ensure there were robust control systems in place, including the high quality of data and centralised authorisation of agency use. The Operational Management Group has weekly oversight of agency spend. There is a forecast for an improvement to be seen in Quarter 4 and the improvement needed to be balanced with managing safety and quality for service users.

RW commented in relation to agency spend it was roughly split into thirds between doctors, nurses, and allied, administration & support. In relation to doctors, there is a plan in place to convert the use of the relatively small number of posts that are locums to alternative solutions. In relation to nursing, it was part of a longer term plan of how a sustainable workforce could be created. In relation to support staff they are only used if a definite need is identified. Those mechanisms should see a reduction but they are moving at different speeds.

It was RESOLVED to NOTE the Integrated Performance Report.

TB/17/07b Customer services report Q3 2016/17 (agenda item 7.2)
DS reported that feedback received is used to improve patient experience. The risk scan process and the risk management process both look at complaints and assess whether they need escalation in parallel with complaints process. In relation to the Friends and Family Test a key area of feedback is around CAMHS and the Trust is working with CCGs on an action plan. There is a decrease from Quarter 2 to Quarter 3 in complaints in comparison to last year and an increase in compliments.

CD asked if there was a plan for improving the response time to complaints. DS commented that complaints are acknowledged within three days and an assigned to a member of staff. Agreement is made with the complainant how often they want to be updated, which is generally weekly. Sometimes delays can be caused by the process of gaining consent or the ability of investigators and work is taking place with services on the investigation process. The Chief Executive signs all complaints and will not do so until they are right. Recently there has been a change to the process where BDU Directors now sign off on responses before they receive final approval.

It was RESOLVED to NOTE the feedback received through Customer Services in Quarter 3 2016/17.

TB/17/08 Governance items (agenda item 8)

TB/17/08a Update to Trust Constitution (including Standing Orders) and Scheme of Delegation (agenda item 8.1)
DS reported that the Trust was required to have a Constitution in place that sets out how it is accountable to local people, who can become a member and what this means, the role of the Members' Council, how Trust Board and the Members' Council are structured and how Trust Board works with the Members' Council. The Constitution also contains a set of model rules that provide the basis for elections to the Members' Council. A review of the Constitution has taken place to check the cross references with other documents and making it easier to read. The proposed amendments have been considered by a subgroup of the Members' Council, the Executive Management Team and the Audit Committee who support its approval by Trust Board and the Members' Council.

RW commented that the Executive Management Team had requested a further review of the Scheme of Delegation that would conclude and bring recommendations for improvements back to the Board in the new financial year.

It was RESOLVED to APPROVE the updated Constitution (including the Standing Orders) and Scheme of Delegation and SUPPORT their approval by the Members' Council in February 2017. It was NOTED that further work on the Scheme of Delegation would follow in the next financial year.

TB/17/08b Update to the Treasury Management Policy (agenda item 8.2)
MB reported that the significant focus on cash management within the NHS and access to borrowings was becoming increasingly restricted and difficult. As such the Trust needs to maintain strong focus on working capital and cash management and this Treasury Management Policy is a key component of clarifying how the Trust will maintain strong control over how it safely makes best use of its cash resources. Minor revisions to the policy were reviewed by the Executive Management Team and the Audit Committee who support the approval by Trust Board.

It was RESOLVED to APPROVE the updated policy to support the overall financial strategy.

TB/17/08c Update to the Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) (agenda item 8.3)
DS reported that the policy supports staff in ensuring consistency and minimising risks within policies and procedures documents. The amendments have been reviewed by clinical leads, Human Resources, Trade Union and the Executive Management Team who support the approval by Trust Board.

RW requested that the required approval of policies for the Board be outlined in the Scheme of Delegation and not in the main body of the Policy. This would provide greater flexibility and reduce confusion and overlap between documents.

It was RESOLVED to APPROVE the updated policy with the amendment.

TB/17/08d Update to the Customer Services Policy: management of complaints, concerns, comments and compliments (agenda item 8.4)
DS reported that the Customer Services Policy provides the framework to respond to enquiries and ensure we learn lessons from the feedback received as well as provide an opportunity for compliments. The Policy makes it easy for people to provide feedback and recognise that every compliment, concern and compliant is an opportunity to improve. The amendments have been reviewed by the Executive Management Team who support the approval by Trust Board.

It was RESOLVED to APPROVE the updated policy.

TB/17/08e Internal meeting governance framework (agenda item 8.5)
DS reported that the Executive Management Team (EMT) had looked at the internal meeting structures to ensure they meet the Trust's needs and the Board's statutory duties. To improve and support the efficiency and effectiveness, ensuring alignment to delivery, risk mitigation and provision of assurance, EMT supported the adoption of the 7Ps meeting framework.

IB commented that external areas of assurance such as auditors and regulators should be incorporated. DS commented that further work would take place around external meeting structures and external assurance processes including the receipt of minutes of partnership boards (agenda item 8.7).

RW commented that it was important that the terms of reference for meetings recognises their role in managing risk and where assurance is provided.

It was RESOLVED to SUPPORT and APPROVE the Internal Meetings Governance Framework, adopting the "7Ps", the rationalisation of meetings and formalisation of 1st and 2nd line assurance reporting.

It was RESOLVED to SUPPORT the further work required to review committee terms of reference and alignment with the proposed internal meetings Governance Framework.

TB/17/08f Guidance for the use of off-pay payroll (agenda item 8.6)
DS reported that the latest guidance for the use of off-pay payroll has been received and the Trust currently had no off-pay payroll office holders as defined in the guidance.

IB asked if there was an approval process in place if required. DS confirmed there was a process which would ensure compliance with best practice.

CJ asked where items wider than off-payroll were discussed. DS commented that the Trust still complies with the original guidance and this was an extra layer. Reports are received by the Remuneration and Terms of Service Committee.

It was RESOLVED to NOTE the Trust currently has no off-payroll office holders in post and to SUPPORT the adoption and implementation of the guidance, including bringing the guidance to the attention of the next meeting of the Members Council and to provide an update on off-payroll arrangements, to the next meeting of the Remuneration and Terms of Service Committee.

TB/17/08g Receipt of minutes of partnership boards (agenda item 8.7)
RW commented that minutes of partnership boards where the Trust is a voting member would be received at Trust Board including Health and Wellbeing Boards and Accountable Care Organisations particularly where there is a Committee in Common.

SR reported that the Barnsley Health and Wellbeing Board received the Health and Wellbeing Strategy and considered the Place Based Plan that will come to a future meeting of the Trust Board.

It was RESOLVED to NOTE the minutes of partnership boards.

TB/17/09 Assurance framework and risk register (agenda item 9)

DS reported that the assurance framework included key areas where the Board can seek its assurance through reports received by Committees and any gaps identified, with links through to Risk Register. The framework is RAG rated risk against principal strategic objectives and the rationale included for the ratings. The Organisation/Corporate Risk Register has been review by the Executive Management Team (EMT) and further work will take place through EMT to review the directorate risk registers and where risk are not being managed within the risk appetite.

RC asked about the pharmacy risk. ABe advised that an extension was now in place until June 2017 with a plan in place to achieve a long term solution prior to that date. JF commented that the risk had been discussed by the Clinical Governance and Clinical Safety Committee.

LC asked which committee would manage IT risks such as RiO. MB commented that it was decided that the IM&T Forum was no longer fulfilling the original intention and any updates from groups and TAGS would come to Board as needed and an item would be included on the Trust Board Work Programme.

Action: Mark Brooks

MB commented that a key element of risk around the clinical records system was that the contract for RiO was due to expire on 31 March 2018. An engagement process has been undertaken in terms of defining the service specification for a clinical record system including ePrescribing and a recommendation would come to Trust Board.

It was RESOLVED to NOTE the controls and assurances against corporate objectives for Quarter 3 2016/17 and NOTE the key risks for the organisation.

TB/17/10 Board self-certification and assessment of operational, clinical and quality risks (agenda item 10)

DS reported that prior to the introduction of the Single Oversight Framework in October 2016, Trust Board was required to sign a quarterly certification along with a quite detailed report for submission to NHS Improvement (NHSI). The paper requested delegated of authority for the approval of an exception report should it be requested by NHSI.

The Board discussed whether a report was required to Trust Board to provide assurance. RW commented that the reports and discussion at Trust Board the assurance is already there such as the Integrated Performance Report and Assurance Framework and Risk Register. NHSI would now also be attending Executive Management Team meetings on a quarterly basis. DS commented that previous indicators that were reported on around Board composition could be included in the Integrated Performance Report.

Action: Dawn Stephenson

It was RESOLVED to include areas from the previously required self-certification within the Integrated Performance Report.

TB/17/11 Assurance from Trust Board committees (agenda item 11)

TB/17/11a Audit Committee 24 January 2017

LC reported that the Audit Committee discussed the assurance framework and risk register which was similar to the discussion under agenda item 9. In relation to the overall head of audit opinion, it was looking that it would be positive. An internal audit report was received on sickness absence with partial assurance and improvements required. AGD commented that the internal audit was part of a review that the Trust Commissioned. An action plan would go into the next Remuneration and Terms of Service Committee meeting and he would attend the next Audit Committee meeting.

Action: Alan Davis

LC reported that most audit recommendation were on track for implementation. However there was a delay on a couple of areas around medicine management. ABe commented that a risk based approach was taken to implementation which was being monitored through the Drug & Therapeutic Committee. Significant risks had been actioned and others have plans in place.

TB/17/11b Equality and Inclusion Forum 30 January 2017

IB reported that attendance was low at the Forum due to exceptional circumstances. However the meeting was still quorate and was able to take place. In relation to equality panels there was a joint approach in Calderdale, Kirklees and Wakefield, with Barnsley being done separately. The Forum felt it should be done jointly as an example of an organisations working together. The BAME staff network were involved in recruitment process of the Director of Strategy and would continue to be involved in Board recruitment in the future. In relation to the Equality Impact Assessments (EIA) the plan set by the Forum was 100% compliance by 31 March 2017, and while the Trust is unlikely to meet this target there were processes in place and the focus is on embedded those across the organisation. DS commented that less than 5% were RAG rated as red, and 15% as amber for completion. It was important to note that it is not just about the EIA process but the follow up actions that are needed as an organisation to ensure all our services are accessible.

TB/17/12 Trust Board work programme 2017 (agenda item 12)

IB highlighted that the work programme is used for agenda setting and focus on difference areas during the year.

RC requested the inclusion of key strategy documents and their review dates.

Action: Dawn Stephenson

It was RESOLVED to NOTE the work programme.

TB/17/13 Date of next meeting (agenda item 13)

The next meeting of Trust Board will be held on Tuesday 28 March 2017 Boardroom, Kendray, Barnsley.

Signed …… Date ……

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Trust Board meeting held on 28 February 2017

Present:	Ian Black	Chair
	Julie Fox	Deputy Chair
	Laurence Campbell	Non-Executive Director
	Charlotte Dyson	Non-Executive Director
	Rachel Court	Non-Executive Director
	Chris Jones	Non-Executive Director
	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:	Nil	
In attendance:	Dawn Stephenson	Director of Corporate Development (Company Secretary)
	Kate Henry	Director of Marketing, Communications and Engagement
	Salma Yasmeen	Director of Strategy
	Carol Harris	District Director – Forensic and Specialist Services
	Sean Rayner	District Director – Barnsley and Wakefield
	Karen Taylor	District Director – Calderdale and Kirklees
	Emma Jones	Integrated Governance Manager (author)

TB/17/14 Welcome, introduction and apologies (agenda item 1)

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

TB/1715 Declaration of interests (agenda item 2)

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

TB/17/16 Healthy Eating CQUIN 2016 – 18 (agenda item 3)

Alan Davis (AGD) reported that within the current national Commissioning for Quality and Innovation (CQUIN) programme there was a requirement to promote healthy eating within the NHS for all service users staff and visitors. The Trust should benefit as the food offer we make becomes increasingly healthy, which is in line with our core values of helping people to live well in their community. The impact on income through compliance with the CQUIN requirements is also material.

All premises owned by the Trust such as the Canteen and Oasis Café at Fieldhead in Wakefield and Laura Mitchell in Halifax were compliant. The premises at Folly Hall in Huddersfield were not owned or controlled by the Trust.,However the team were discussing with the catering providers how they could meet the same standards. The Board discussed how it was positive to see service users working in the Trust's Cafés as volunteers.

Tim Breedon (TB) asked about the availability of healthy choices for staff who worked overnight shifts. AGD advised that healthy choices were available 24 hours a day through the use of vending machines with healthy options and this would also be an area for further work in future.

IB commented that the Trust Board held a strategy meeting at Newton Lodge prior to the public meeting which included the same catering provided to service users. The Board commented that they felt the food was tasty and the service was very clean and friendly. AGD commented that all menus were based on nutritional values for service users and the "Eatwell Plate" sizes were used, in line with national initiatives.

It was RESOLVED to APPROVE that the Trust has met the standards and it's submission to the relevant Quality Boards.

TB/17/17 Date of next meeting (agenda item 4)

The next meeting of Trust Board will be held on Tuesday 28 March 2017 Boardroom, Kendray, Barnsley.

Signed …… Date ……

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
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 cover paper references several of the papers in the public and private parts of the meeting and also external papers and links. It will be supplemented by a verbal update
Executive summary:	➢ *The Brief* for all staff has been shared with Board members as **Annex 1**. This sets out current contextual issues, delivery updates, risks and priorities. Since publication of *The Brief* we have seen: o Publication of the NHS Mandate from the Department of Health NHS England. A briefing is attached at **Annex 2**. The impact of the Mandate on our Trust will be considered by EMT and reported to Board. o Notification that the "NHS Delivery Plan" will be published w/c 27/3. This will set out how Sustainability and Transformation Plans will be strengthened to secure delivery. o Clarification of extra resources in social care for next year, with NHS England, NHS Improvement and the Local Government Association issuing guidance on how these resources support the NHS and Social Care. Local discussions are beginning on these matters. o Substantial and continued debate about whether the NHS is facing an impossible task next year. o Publication of the annual staff survey for the NHS and organisations. We have seen improvements in communications and engagement. Other indicators have largely stayed the same. Diversity issues remain with positive experiences of BAME staff not mirrored in young staff or people with a disability. o Developments in Accountable Care Organisations and alliance contract arrangements in Barnsley and Wakefield, with the papers reflecting the impact on our strategy. o Publication of three more reports by the CQC into our services, with improvements in each. The letter to stakeholders is attached at **Annex 3**. We have also received the draft provider report for factual accuracy checking. o A focus on safety, finance and delivery that means we will end the year showing sustained performance. o A continued emphasis on the cost improvements required for next year, with a revised plan developed which will require significant change ➢ The issues raised within this paper are adequately reflected in the assurance framework and risk register, with due consideration of the risk

	appetite, particularly on safety and finance.
Recommendation:	**The Board is asked to NOTE the Chief Executive's report.**
Private session:	Not applicable.

2 March 2017

South West Yorkshire Partnership NHS Foundation Trust

The Brief

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 put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent, 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 and local news

- Sustainability and transformation plans (STPs) have been heavily featured in the news with a focus on budget and service cuts. An analysis of STPs by The King's Fund says the government must be prepared to back radical changes to secure the future of the NHS, saying they offer the best hope of delivering essential reforms.
- The National Audit Office (NAO) published a report saying the Better Care Fund is not delivering savings in hospitals and that the Government's plan in integrating health and social care is flawed.
- NHS Improvement released figures showing one of the most challenging winters on record due to a huge increase in demand for urgent and emergency care. They also released Quarter 3 finances, showing that 135 of 238 trusts in England are failing to balance their books.
- Our Portrait of a Life e-learning package was profiled on BBC Radio 4 as part of care home work in the Wakefield Vanguard.
- The Care Quality Commission (CQC) published a new report on 2 Mar on 'The state of care in NHS acute hospitals' – it talks about systems needing to change and GPs, hospitals and care homes needing to work together more.
- There's a new investment standard set out in the 'Five year forward view for mental health – one year on report'. It will now be a national requirement for all CCGs to invest in mental health services at a rate that is equivalent to their growth.

What's happening internally?

Safety and quality

During Nov 2016 - Jan 2017 we were pleased to welcome the Care Quality Commission (CQC) back to our services where they had previously found elements that required improvement. They've now published the first three of these service lines reports, all of which have been re-rated 'good':

- Community mental health services for older people
- Mental health wards for older people
- Long stay rehabilitation mental health wards for adults

We're pleased the CQC have seen improvement and we're waiting for four more reports – we'll share these as soon as we can. The CQC have also reviewed whether we're 'well-led', with the right structures and the right governance. We received initial

written feedback where they identified several areas of positive practice, including the caring and compassionate approach of staff.

We had 1,068 incidents in Jan, the vast majority of which were low or no harm:

- Green no harm - 624
- Green - 311
- Yellow - 104
- Amber - 23
- Red - 6

We had five serious incidents reported in Jan, and no never events.

Performance (Jan)

- **All** of our access targets were met in Jan for NHS Improvement – there's still some hotspots around access to psychology and autism spectrum disorder services
- **116%** safer staffing fill rate on wards – we set a minimum threshold of 90%
- **94%** fill rate of registered nurses on wards – we set a minimum threshold of 80%. Eight wards achieved 100% or above, an increase of three wards from Dec
- **12** confidentiality breaches, two of which are serious and reportable to the Information Commissioner's Office (ICO)
- **9%** of complaints with staff attitude as an issue (5 out of 57)
- **31** compliments formally received – please remember to send to customer services.

We welcomed the publication of a review by the Information Commissioner's Office (ICO) into our information governance (IG) processes. We'll be implementing all their recommendations and continue with our efforts to make sure that confidential information remains that way. Please remember to keep information safe and complete your IG training.

Staffing

- Please complete the Staff Family and Friends Test survey, it is confidential and takes no more than five minutes, closing date is 31 March
- NHS staff survey results are out in early March - we'll share via The Headlines
- Voting for our Members' Council governor elections starts on 2 March until 20 Apr - ballot papers will be sent to all qualifying members, who can vote by post or online
- We've recruited eight band 4 associate practitioners – the first of their kind in mental health services. They'll work across forensics and Wakefield adults of working age services, creating a quality career pathway across healthcare support worker roles
- Our IG training rate is 93% against a 95% target - please complete yours asap
- Our Mental Health Act / Mental Capacity Act training is currently at 23% and 48% respectively – our target is 80% by end March so we need to urgently address this
- Our sickness absence increased to 5.9% in Jan and 4.9% for the year to date
- Lindsay Racher has been appointed as one of only 28 health and work clinical champions nationally - Lindsay is supporting the Trust as a pilot for the national programme
- Thanks to those who came along to internal comms sessions - from your ideas we've proposed some actions; please comment on these via i-hub

Month 10 finances (Jan)

We remain in NHS Improvement's segment 3 for finance due to our agency spend – there are four segments that NHS trusts are categorised by, with 1 being the best and 4 being the worst.

In Jan we had a deficit of £94k. Out of area beds contine to be a pressure although late January has seen a slight reduction. We need to continue this trend and reduce both agency spend and out of area beds.

We spent £750k on agency in Jan, a £100k reduction from Dec - thank you for efforts to reduce this. We've spent £8.3m on agency costs this year, which is 88% above our cap year to date.

Our cost improvement programmes (CIPs), which add up to £9m this year, are currently £0.7m behind plan. In addition, £1.1m of our CIPs are rated as red; this has increased following revised expectations on pharmacy and procurement savings.

If we don't deliver on our 2016/17 financial plan by the end of March we will lose £1.6m over the 12 months.

Infrastructure

- Discussions with commissioners in Barnsley continue around intermediate care, which will include the future of inpatient care currently provided at Mount Vernon Hospital. No final decisions have been made and we'll keep you regularly updated as conversations continue.
- All corporate support staff from Castleford, Normanton and District Hospital have now moved to Fieldhead - thanks for your patience and cooperation. When the last operational staff move at the beginning of March the site will be completely emptied as part of its ongoing sale.
- Baghill Health and Wellbeing Centre has received an award from Pontefract Civic Society for the best civic project in the town this year. This was based on us retaining the character of an important old building and substantially improving it for modern care, with a large new contrasting building designed to the latest standards.
- The Drury Lane Health and Wellbeing Centre programme board has been re-instated and more power given to staff using the building. There's also new service user artwork on display - pieces were picked by local artists, volunteers, service users, partners and staff.
- Our mental health clinical system recently went out to tender – the spec was developed based on staff views and requirements. We've had good engagement so far and will soon have demos and site visits to other Trusts as part of the process – please stay involved.
- Following new landline numbers in Wakefield and Barnsley along with office moves, IM&T will be updating staff details in the internal phonebook and on Outlook. You'll need to double check all your details - we'll let you know when via The Headlines.

Change and innovation

The proposed Trust-wide community model for older people has now been signed off by the Mental Health Transformation Board to proceed to develop a business case. The Board gave its approval for the full business case and workforce model to be developed with staff and stakeholders and this work will start soon.

NHS England's director of mental health, Karen Turner, visited Briarfields at Fieldhead to learn about a new clinical tool which keeps a record of the physical health of service users with serious mental health conditions.

Our unique Mental Health Museum has been chosen as an affiliate of the Happy Museum scheme - just one of 15 museums nationally to take part, aimed at maximising the role of museums in community wellbeing.

Yorkshire Smokefree has launched a new campaign aimed at workplaces across the region. Barnsley and Rotherham, and Doncaster chambers of commerce have pledged support.

Every service area now has a named Bureaucracy Buster. Your local Buster will be running mini events and holding conversations in your areas so we can work together to make a difference. You can also join in the discussion at any time on i-hub, via the 'how red is our tape' and 'finance matters' conversations.

Focus on: planning for next year

- We need to deliver a £1m surplus in 2017/18 in order to meet national requirements and to invest in our own services
- This means that we will need to achieve £8.5m savings
- The process we've been through so far has identified £6.5m of savings
- So we're currently £2m short of achieving a balanced plan and we're working to identify the remaining savings needed
- There's still a considerable risk around cost for out of area beds

Focus on: views of our partners

Our Trust Board had a strategy session on 28 Feb and discussed the findings of independent research carried out to better understand what our partner organisations think about us. During Oct-Dec 2016, 40 senior stakeholders took part in phone interviews and another 151 stakeholders responded to a survey. The latter found that:

- 48% felt very or fairly well informed about our work – 49% had only limited or not much knowledge
- 48% found it very or fairly easy to work with us – 12% found it very or fairly difficult, with the remaining 39% neutral or 'don't know'
- 60% rated their interactions with us as very or fairly positive – 32% were neutral and 7% rated their interactions with us as very or fairly negative

The findings are being used to help shape and implement our refreshed strategy. We're also now working on the report's recommendations and developing an improved approach to external engagement and relationship building.

2 March 2017

South West Yorkshire Partnership NHS Foundation Trust

Take home messages

1. The CQC re-visited and found we're making good progress – thank you
2. Finances remain very tight – please keep focusing on out of area, discretionary and agency spend
3. Please complete your training on IG, Mental Health Act and Mental Capacity Act
4. Look after people's information as if it were your own
5. We're working on developing a balanced plan for next year that delivers £8.5m savings
6. Get involved with our staff Friends and Family Test, bureaucracy busting and our new clinical system
7. There are lots of pressures in the system – keep working together and ask for help if you need it

The next issue will start on 30 March 2017

With **all of us** in mind.

THE GOVERNMENT'S MANDATE TO NHS ENGLAND FOR 2017-18

NHS England is responsible for arranging the provision of health services in England. The mandate to NHS England sets the government's objectives for NHS England, as well as its budget. In doing so, the mandate sets direction for the NHS, and helps ensure the NHS is accountable to parliament and the public. Every year, the secretary of state must publish a mandate to ensure that NHS England's objectives remain up to date.

The mandate for 2016-17 set out enduring objectives to 2020, and set NHS England's budget for five years. The 2017-18 mandate published today continues the approach set out in 2016-17, maintaining the direction set and defining annual deliverables for 2017-18 that will keep health services on track to meeting those longer-term goals. In some objectives changes and clarifications have been made to reflect developments since 2016-17.

Key deliverables the mandate sets out for NHS trusts in 2017-18

Below we have highlighted the key deliverables that NHS trusts must meet for 2017-18. The full deliverables for 2017/18 that are set out in the mandate are outlined in a later section.

- Rollout 7-day services in hospitals four priority clinical standards to (1) 50% of the population by April 2018 and (2) the whole population for five specialist services (vascular, stroke, major trauma, heart attack and paediatric intensive care) by November 2017
- Deliver aggregate A&E performance in England above 90% in September 2017, with majority of trusts meeting 95% in March 2018, and aggregate performance in England at 95% by end of 2018
- Meet agreed standards on A&E, ambulances, diagnostics and referral to treatment
- Achieve the 62-day cancer waiting times standard, and maintain performance against the other cancer waiting times standards
- Reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas)
- Support delivery of the 2017-18 Mental Health Five Year Forward View Implementation Plan recommendations

NHS England's objectives

1 Through better commissioning, improve local and national health outcomes, and reduce health inequalities.

- The government expect NHS England to maintain the clinical commissioning group (CCG) improvement and assessment framework. NHS England is also expected to demonstrate improvements against the NHS Outcomes Framework and work with CCGs to ensure commissioning focuses on measurable reductions in inequalities in access to and people's experiences of health services and across a range of health outcomes.

2 To help create the safest, highest quality health and care service.

- NHS England must help ensure the NHS provides the same standards of care, seven days a week, for people who need urgent and emergency hospital care, and that harm is minimised by avoiding unnecessary complications or admissions to hospital.
- The government would like the NHS to become the world's largest learning organisation.
- The mandate states people should be empowered to shape and manage their own health and care and make meaningful choices. This includes carers being routinely given access to information about available support.
- A priority for NHS England will be to improve early diagnosis, services and outcomes for cancer patients.

3 To balance the NHS budget and improve efficiency and productivity.

- NHS England is expected to ensure overall financial balance in the NHS, working with NHS Improvement to support local areas in developing credible operational plans which align with STPs.
- The government want NHS England to ensure aggregate spending by commissioners does not exceed mandate funding, that appropriate contingency funding is maintained and to make sure commissioners discharge their duties in a way which enables commissioners and providers to meet their control totals.
- Commissioners are also expected to work collaboratively with local authorities to make the most efficient and effective use of health and social care funding.
- Both NHS England and NHS Improvement should determine affordable pricing arrangements for commissioners and allow providers to meet their financial duties. NHS England must achieve this while continuing to deliver high quality care and delivering against the objectives set out in the mandate.

4 To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.

- The government want the NHS to do more with partners on the broader prevention agenda: preventing avoidable ill health and premature mortality.
- In particular, NHS England should contribute to the government's goal to reduce child obesity and diabetes. NHS England is also expected to make measurable improvement in the quality of care and support for people with dementia, and to increase public awareness.

5 To maintain and improve performance against core standards.

- The government believe the real terms growth in the NHS budget should ensure the service can continue to perform well over the next four years, with the capacity to deal with rises in demand during the winter months. NHS England are expected to support the NHS to improve and maintain, where possible, access to timely, quality services for all patients.

6 To improve out-of-hospital care.

- The government expect NHS England to ensure easier convenient access to planned GP services, including appointments in the evenings and at weekends, and effective access to quality urgent and emergency care 24 hours a day across the whole week.
- NHS England should support the NHS to achieve the government's aim that health and social care are integrated across the country by 2020, including through the Better Care Fund.
- Overall there should be measurable progress towards the parity of esteem for mental health, particularly for those in vulnerable situations. NHS England must strive to reduce the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, through prevention, early intervention and improved access to integrated services. The also government wants to see a system-wide transformation in children and young people's mental health.

7 To support research, innovation and growth.

- The government expect NHS England to help the NHS contribute to economic growth, to support the NHS to reduce the impact of ill health and disability, and to support research and innovation to enable new cost effective treatments to reach patients more quickly. NHS England should work with the life sciences sector and government as it develops a life sciences strategy.
- NHS England should also support the NHS to make better use of digital services and technology to transform access to and use of health and care, including online access to personal health records.

NHS England's budget

NHS England's indicative revenue and capital budgets for each year of the parliament were set out in the mandate for 2016-17. Details of NHS England's revenue and capital budgets for 2017-18 and the indicative budgets for the remaining years of this parliament are as follows:

	2016-17 (Revised)	2017-18	2018-19 (Indicative budget)	2019-20 (Indicative budget)	2020-21 (Indicative budget)
Total revenue budget (£m)	106,528	109,960	112,461	115,506	119,606
Capital budget (£m)	260	260	260	305	305

A further breakdown of these figures is provided in the published financial directions.

NHS England will work with NHS Improvement to ensure overall financial balance in the NHS. To support this, £1.8bn of NHS England's budget for 2017-18 will be allocated through the sustainability and transformation fund.

Mandate goals and deliverables

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and key deliverables for 2017-18.

Objective 1: Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities	
1.1 CCG and STP performance	Overall 2020 goals: • Improve proportion CCGs rated 'good' or 'outstanding' against the CCG Improvement and Assessment Framework • Working with NHS Improvement, support delivery of agreed plans within each STP area
	2017-18 deliverables: • Publish the results of CCG improvement and assessment framework for 2016-17 • Working with NHS Improvement, ensure commissioners and providers deliver their 2017-18 operational plans, which will deliver year one of locally agreed STPs

Objective 2: To help create the safest, highest quality health and care service	
2.1 Improving service quality and achieving seven-day services	Overall 2020 goals: • Roll out of 7-day services in hospital to 100% of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards) • With NHS Improvement, support providers to publish a Board level service quality improvement plan • Support NHS Improvement to significantly increase the number of trusts rated 'good' or 'outstanding' and reduce the length of time trusts remain in special measures • Work with DH and partners to reduce the 2010 rate of stillbirths, neonatal deaths, maternal deaths and brain injuries in babies that occur during or soon after birth by 20% by 2020 • Support the NHS to be well-led and demonstrate open, learning cultures • Improve antimicrobial prescribing, resistance rates and healthcare associated infection rates to support the Government to meet its ambition to halve inappropriate prescribing of antibiotics by 2020
	2017-18 deliverables: • Work with NHS Improvement to rollout 7-day services in hospitals 4 priority clinical standards to (1) 50% of the population by April 2018 and (2) the whole population for 5 specialist services by November 2017 • Work with NHS Improvement to ensure that providers improve public engagement in developing their service quality improvement plan • Begin implementation of the Maternity Transformation Programme • With DH, support the development and publication of a baseline on brain injuries in babies that occur during or soon after birth • Deliver actions agreed as part of the Leadership Development and Improvement framework for 2017-18 • Support the Government's ambitions on antimicrobial resistance by taking action to improve prescribing and surveillance and reduce E.Coli blood stream infections • Work with partners to ensure NHS services play their part in the Government's Prevent programme
2.2 Patient experience	Overall 2020 goals: • With NHS Improvement, improve percentage of NHS staff who report that patient and service user feedback is used to make informed improvement decisions • Ensure patients and carers are involved in defining, assessing and improving quality of NHS services • 50,000-100,000 people to have a personal health budget or integrated personal budget • Improve patient choice, including in maternity, end-of-life care, elective care and for people with long-term condition
	2017-18 deliverables: • Implement findings from phase 1 and 2 of the Maternity Experience Challenge Fund • Promote rollout of always events in 100 providers by April 2018 • Develop proposals for how complaints, whistleblowing and other feedback can be used more effectively to drive up quality and improve patient safety in primary care and specialised commissioning • Continue to make measurable progress to embed Personal Health Budgets • Identify metrics to assess quality and choice in end-of-life care for inclusion in the CCG improvement and assessment framework for 2018-19 • Develop with partners an implementation plan to take forward the recommendations from the Government's response to the end-of-life care Choice Review
2.3 Cancer	Overall 2020 goals: • Deliver recommendations of the Independent Cancer Taskforce

	2017-18 deliverables: • Set out milestones for 2017-19 and deliver those agreed for 2017-18, building on Achieving World-Class Cancer Outcomes: Taking the strategy forward • Achieve the 62-day cancer waiting times standard and maintain performance against the other standards • With partners, develop IT infrastructure and national guidance to allow data collection for the new 28-day faster diagnosis standard from April 2018 • Improve the proportion of cancers diagnosed at stages 1 and 2 over the previous year • Pilot an approach to measuring long-term quality of life for people living with and beyond cancer and agree an implementation plan to begin data collection in 2018-19 • Invest up to £340m in providing cancer treatments through the Cancer Drugs Fund

Objective 3: Balance the NHS budget and improve efficiency and productivity

3.1 Balancing the NHS budget	Overall 2020 goals: • Work with NHS Improvement to ensure overall financial balance in the NHS and the necessary efficiency and productivity improvements • Ensure that commissioners discharge their duties in a way which enables commissioners and providers to live within their control totals, as individual organisations, across STP footprints, and in aggregate • With DH and NHS Improvement, achieve 2-3% year on year improvements in efficiency and productivity • Work with NHS Improvement to determine pricing arrangements that are affordable for commissioners, allow providers to meet their financial duties and are consistent with FYFW • With NHS Improvement, support the Government's goal to raise £2bn and free space for 26,000 new homes by 2020 from releasing surplus NHS land
	2017-18 deliverables: • Work with NHS Improvement to ensure overall financial balance in the NHS • Ensure aggregate spending by NHS England and CCGs does not exceed mandate funding for 2017-18 • With NHS Improvement, before the end of the 2017-18 contracting round, provide formal assurance to DH that operational plans deliver mandate objectives and are based on credible planning assumptions • Ensure CCGs better manage demand in acute services through implementation of programmes including New Care Models, Right Care and Self Care • Improve primary care productivity • Ensure commissioning aims support delivery of provider productivity, including working with NHS Improvement in securing Carter efficiency savings and reducing spend on agency staff • Support DH to take forward the Government's commitment for the NHS to recover up to £500m from overseas chargeable patients

Objective 4: To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives

4.1 Obesity, diabetes and prevention	Overall 2020 goals: • Measurable reduction in child obesity as part of the Government's childhood obesity plan • 100,000 people supported to reduce risk of diabetes through NHS Diabetes Prevention Programme • Reduce variation in the care for people with diabetes, including improving the achievement of the NICE recommended treatment targets whilst driving down variation between CCGs • With Public Health England, contribute to the reduction of preventable illness and associated hospital admissions through the implementation of preventative interventions in the NHS

	2017-18 deliverables: • Set out NHS England's contribution to the Government's childhood obesity plan by September 2017 • At least 60,000 people referred to the Diabetes Prevention Programme • Fund and deliver with Public Health England a programme from April 2017 to March 2019 to support the implementation of identified preventative interventions at scale by the NHS
4.2 Dementia	Overall 2020 goals: • Deliver the Challenge on Dementia 2020 Implementation Plan
	2017-18 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia • Continue to develop an evidence based framework for a national treatment and care pathway and agree an affordable implementation plan for the 2020 Dementia Challenge

Objective 5: To maintain and improve performance against core patient access standards.

5.1 A&E, Ambulances and Referral to Treatment (RTT)	Overall 2020 goals: • 95% of people attending A&E seen within four hours • 24/7 integrated urgent care service implemented in each footprint • Meet ambulance response time standards for the most urgent calls and the A&E standard. • At least 92% of patients on incomplete non-emergency pathways to have been waiting no more than 18 weeks from referral; no-one waits more than 52 weeks from referral; and less than 1% of patients waiting for a diagnostic test to wait more than 6 weeks from referral • Ensure the NHS plays its part in reducing delayed transfers of care by developing new incentives
	2017-18 deliverables: • Co-implement the agreed A&E recovery plan with NHS Improvement and deliver aggregate A&E performance in England above 90% in September 2017, with the majority of trusts meeting 95% in March 2018, and aggregate performance in England at 95% within the course of 2018 • Agree a plan for staged rollout of integrated urgent care to 2020, and implement for 2017-18 • With NHS Improvement, meet agreed standards on A&E, ambulances, diagnostics and RTT • Test new ambulance service performance metrics which reflect the clinical needs and outcomes for patients contacting 999 in England • Working with NHS Improvement and local government partners, reduce NHS-related delayed transfers of care in support of a total reduction of delayed transfers of care to 3.5% by September 2017 • Implement plans to moderate avoidable growth in demand for elective services, including through sharing benchmarking data with CCGs

Objective 6: To improve out-of-hospital care

6.1 New models of care and General Practice	Overall 2020 goals: • Implement the General Practice Forward View • Reduce age standardised emergency admission rates and inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50% of the population.
	2017-18 deliverables: • Deliver 2017-18 core requirements for access to enhanced GP services, including evening and weekend access, to a total of 40% of the population

	• Work with DH on commitment for all over-75s will be able to access a same-day appointment with a GP • Support NHS Digital and DH to provide practices with clinical data by named GP • Achieve 20% coverage of the population by the New Care Model programme • Assess vanguard progress and identify consistent models that can be replicated across the country
6.2 Health and social care integration	Overall 2020 goals: • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against relevant indicators within the CCG improvement and assessment framework, including new models of care 2017-18 deliverables: • Implement the Better Care Fund in line with 2017-19 Integration and Better Care Fund Policy Framework • Accelerate implementation of health and social care integration • Work with DH, other national partners and local areas to agree and support implementation of those local devolution deals which include health proposals • With DH, increase proportion of NHS Continuing Healthcare assessments outside of an acute setting • Collaborate with local authorities to support the sustainability of social care, including on programmes such as New Care Models, Urgent Care and Right Care 2017-18 requirements - NHS England is required to: • Ring-fence £3.582bn within its allocation to CCGs to establish the Better Care Fund in 2017-18, and ensure the amount spent from within this on schemes identified in Better Care Fund plans as 'social care' in 2016-17 is maintained in line with inflation in every area • Consult DH and DCLG before approving BCF plans drawn up by each local area, and before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund
6.3 Mental health, learning disabilities and autism	Overall 2020 goals: • Implement the Mental Health Five Year Forward View recommendations and ensure 1 million more people with mental health problems are accessing high quality care • At least 70,000 more children and young people to access evidence based treatment. 2017-18 deliverables: • Deliver the 2017-18 Mental Health Five Year Forward View Implementation Plan recommendations. • Work with system partners to deliver the Mental Health Five Year Data Plan, the Mental Health Workforce Strategy, the Future in Mind recommendations • Embed access and waiting time standards for mental health services for Early Intervention in Psychosis, Improving Access to Psychological Therapies and eating disorders • Implement a 5 year improvement programme for crisis and acute mental health care • Work with DH and NHS Digital to collect robust data on acute out of area placements and establish baseline during 2017-18. Agree plans in 2017-18 to deliver year-on-year reductions to eliminate inappropriate acute out of area placements by 2020-21 • Reduce reliance on inpatient care for children, young people and adults with a learning disability and/or autism who display behaviour that challenges to achieve a bed reduction of 35-50% by March 2019

Objective 7: To support research, innovation and growth

7.1 Research and growth	Overall 2020 goals: • Support DH and Health Research Authority to improve UK's international ranking for health research

	• Implement research initiatives in the NHS England research plan • Improve NHS uptake of innovations prioritised by the Accelerated Access Partnership • Work with Genomics England to embed genomic medicine and application of genomic technologies into NHS care, building upon the 100,000 Genomes Project and the UK Strategy for Rare Diseases
	2017-18 deliverables: • Evaluate the implementation of the Excess Treatment Costs guidance • Promote participation by NHS organisations and patients in research funded both by commercial and non-commercial organisations • Improve NHS commissioner input into identifying research needs in the NHS • Work with DH on implementation of the recommendations of the Accelerated Access Review • Develop, jointly with Genomics England, approach to embed genomics into routine care
7.2 Technology	Overall 2020 goals: • Support delivery of the National Information Board Framework on Personalised Health and Care 2020 • 95% of GP patients to be offered e-consultation and other digital services • Ensure all clinical correspondence and transfers of care are shared electronically and the opening up of systems to enable sharing of care records
	2017-18 deliverables: • Implementing, with NHS Digital and NHS Improvement, the 2016 National Data Guardian for Health and Care review recommendations on data security • Ensure high quality appointment booking app with access to full medical record available, implementing the new national opt out model to be finalised following the 2016 independent review • Practices to have a minimum of 10% of patients accessing primary care services online or through apps • Progress towards 100% of GP to first outpatient referrals through NHS e-RS by October 2018
7.3 Health and work	Overall 2020 goals: • Contribute to reducing the disability employment gap • Contribute to the Government's goal to increase integrated working between health services and work-related interventions, including through increasing the use of Fit for Work.
	2017-18 deliverables: • Implement health-led employment trials from spring 2017, which will run for between 2 to 3 years • With the Work and Health Unit and NHS Digital, support an increase in referrals by GPs to occupational health support, including Fit for Work • Work with Government on regular data collection on musculoskeletal patients and services in England

NHS PROVIDERS PRESS STATEMENT

Responding to the document, the chief executive of NHS Providers, Chris Hopson, said:

"In our report, Mission Impossible? The NHS provider ask in 2017/18, we explain why - without additional support - the health service's commitments for the coming year are well beyond reach. The NHS mandate confirms these obligations are being extended, even as it's struggling to cope with unprecedented demand and severe financial constraints.

"In particular our report highlights the added burden of recovering the four hour A & E wait and 18 week surgery targets, and calls for more realistic trajectories. We therefore welcome the more measured language around the A &

E target that appears in the mandate, projecting a longer timetable to reach the 95% standard by the end of 2018. It remains to be seen, given current pressures, whether this timetable can be met. It is disappointing that a similar approach to the 18 week target appears to have not been adopted.

"Taken together with the other commitments set out in the document, the gap between demands on the health service and the resources available in the coming year remains unbridgeable. We maintain that just stabilising the deterioration in performance would be an achievement in itself. We estimate that this year NHS trusts are on course to have a collective deficit of £800 - £900 million pounds. Given the pressures the health service faces, just reproducing that financial performance would be a stretching target."

For further information about this briefing please contact: Cristina Sarb, policy advisor (Regulation) or Ginny Nash, policy officer.

South West Yorkshire Partnership NHS Foundation Trust

24 March 2017

Chief Executive Office
Block 7
Fieldhead
Wakefield
WF1 3SP
Tel: 01924-316302

Ref: RW/JT/LA
Email address: rob.webster@swyt.nhs.uk

Dear colleague

Following my previous letter on 24 February, I'm writing to give a further update regarding our re-inspections by the Care Quality Commission (CQC).

The CQC inspected 14 of our service lines in 2016 and gave us an overall rating of 'requires improvement'. In November 2016 – January 2017 we welcomed inspectors back to our services where they had previously found elements that required improvement.

The first three reports published last month moved three of our service lines from 'requires improvement' to 'good'. Today they have published another three reports:

- Community mental health services for children and young people - now rated as **'good'** overall, with 'good' in 4 out of 5 domains. In 2016, 3 out of 5 domains required improvement.
- Forensic inpatient/secure wards - now rated as **'good'** overall, with 'good' in 4 out of 5 domains. In 2016, 3 out of 5 domains required improvement.
- Community mental health services for people with learning disabilities or autism - still rated as **'requires improvement'** overall, with 'good' in 3 out of 5 domains.

Publication of these latest reports means that 11 of our 13 services are now rated as Good overall. Please see the attached grid.

The CQC continue to find good practice in our services and have consistently highlighted the caring and compassionate approach of our staff. We're pleased that they have seen improvement in many areas and we're developing action plans to further improve. We will continue to focus on improving as we aim to be outstanding.

We are awaiting one more service line report (acute adult wards and psychiatric intensive care units) which we expect to be published within the next 4-8 weeks. The CQC will then also issue our overall re-inspection report with findings from their well-led review. I will update you again when we have these two final reports.

After all of our reports have been published, we're looking to bring key partners back together for a Quality Summit. While this isn't mandatory with the re-visit not being a full inspection, we believe it would be beneficial to consider the outcome of the re-visit collectively and to co-produce our action plan for continuous improvement.

If you'd like to discuss this in more detail, please let me know.

Thank you for your continued support

Yours sincerely

Rob Webster
Chief Executive

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Care Quality Commission ratings grid

Updated 24 March 2017

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding ☆	Good	Good	Good	Good
Community-based mental health services for adults of working age	Good	Good	Good	Requires improvement	Good	Good
Community mental health services for people with learning disabilities or autism	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Good	Good	Good	Requires improvement	Good	Good
Long stay / rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Good	Requires improvement	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good

NB: One service line report still to be published (Acute wards for adults of working age and psychiatric intensive care units)

With **all of us** in mind.

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 5.1

Title:	**Workforce Strategy 2017-2020**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The workforce represents by far the largest investment the Trust makes and has the greatest impact on the delivery of safe, compassionate care and the effective use of resources. The Trust Board is asked to support the strategic development of the workforce over the next 3 years to ensure services are safe, caring and sustainable.
Mission/values:	The aim of the Workforce Strategy is to support the achievement of the Trust's Mission and embedding the Values into the development of the workforce. The model for the Workforce Strategy is built on the foundations of: 1. **Values Driven Human Resource Management** Ensuring the Trust's Values are embedded in the way we manage and develop staff 2. **Workforce Equality and Diversity** Commitment to equality and valuing diversity The strategic workforce objectives are aligned to supporting: • Right People at the Right Time in the Right Place to Improve People's Health and Wellbeing • Improve the Quality and Experience • Improve the use of Resources
Any background papers/ previously considered by:	The Strategic Workforce Framework has been presented to the Extended Executive Management Team and the Executive Management Team. The Remuneration and Terms of Service Committee have discussed the framework and the Workforce Strategy was part of the Board development day.
Executive summary:	The Workforce Strategy is designed to provide a 3 year approach to the leadership, management and development of the Trust's workforce. The strategy is built around 3 strategic workforce goals: • **Workforce Development** Designing, developing, attracting and retaining a workforce based on service needs and the best use of resources • **Staff Wellbeing and Engagement** Building organisational, team and individual resilience and optimising the contribution of the whole workforce

	• **Leadership and Management Development** Developing and supporting current and future leaders and managers to ensure services are well led and contribute to whole system development The strategic workforce goals are not mutually exclusive. The integrated nature of the work will have secondary benefits of supporting resilience to cope with change, enable leaders to be more effective and ensure good change management process are in place. A set of 11 high level workforce objectives have been developed which are backed by detailed delivery tasks. The progress and success of the Workforce Strategy will be mapped against a set of Key Performance Indicators (KPIs). These indicators have been developed from good practice by NHS Improvement and reflect local issues. The summary of the KPIs will be embedded in the integrated performance report and used to build a detailed Workforce Strategy dashboard, which will go to the Executive Management Team (EMT) and Remuneration and Terms of Service Committee (RTSC) on a regular basis. The risks identified in the report will form the basis for a workforce risk register for the RTSC. The Workforce Strategy is a key element of the OD Strategy, it is supported by: • Workforce Plan for 2017 to 2020 • Leadership and Management Development Strategy • Engagement Strategy **Risk Appetite** The delivery of the Workforce Strategy supports the provision of safe, compassionate and high quality services, within available resources, through the effective management, leadership and development of staff. The risks on reputation and financial performance are in line with the organisation's Risk Appetite statement.
Recommendation:	**Trust Board is asked to APPROVE the Workforce Strategy 2017–2020.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Workforce Strategy

2017 – 2020

Contents

1. Introduction

1.1 Our Mission and Values

The Trust undertook an extensive engagement programme involving Service Users, Carers, Staff and Partner Organisations to gain an understanding and appreciation of stakeholders expectations from South West Yorkshire Partnership NHS Foundation Trust. This engagement process was the basis of the Trust developing its Mission Statement and Values.

The Mission of the Trust:

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

Underpinning the Mission is a set of organisation values:

We put the person first and in the centre

We know that families and carers matter

We are respectful, honest, open and transparent

We improve and aim to be outstanding

We are relevant today and ready for tomorrow

The Workforce Strategy is built on a foundation of the Trust's values and its aim is to support the ongoing delivery of the Mission statement.

1.2 Purpose of the Workforce Strategy

The purpose of the Workforce Strategy is to set out a 3 year strategic approach to the leadership, management and development of the workforce. The aim is to ensure that the Trust is well led and has the right people to achieve the strategic direction and deliver the mission and vision, whilst living its values.

The Workforce Strategy recognises that the Trust is operating in a dynamic and uncertain environment with unprecedented challenges facing the NHS and Social Care and therefore there needs to be:

- Continuous development of the workforce aligned to service and financial plans
- The optimisation of the contribution and potential of the whole workforce
- Effective leaders and managers
- The development of strategic partnerships and greater collaboration with other organisations
- Strong role modelling and embedding of the Trust's values

The Workforce Strategy is also designed to ensure the delivery of safe, compassionate care through a highly valued, well trained and engaged staff during a period of massive change. It provides a vision of how the workforce needs to develop over the next 3 years and is an umbrella document supported by the Trust's Strategic Workforce Plan, Leadership and Management Development Strategy, Engagement Strategy and OD Strategy.

2. Context

2.1 Background

The nature of the services the Trust provides means an investment of over 75% of the income received in staff. This means whilst new technologies can and will support the delivery of care, the biggest impact on improving service users outcomes and experiences will be achieved by optimising the contribution of all staff.

NHS Improvement, in partnership with The Kings Fund and Centre for Creative Leadership, emphasises the importance of a healthy and positive organisational culture in delivering high quality services and value for money. The research shows the essential elements of a healthy organisation culture are:

- Strong values
- An engaged and healthy workforce
- An environment where staff feel safe and able to raise concerns
- A well-led organisation
- Commitment to continuous improvement
- A learning culture

The Strategy has used these essential elements to develop a set of strategic workforce goals which will help shape and develop the culture and behaviours within the Trust.

2.2 National and Local Context

The changes to health and social care systems will present major opportunities but also major challenges for the Trust and its workforce. Nationally a number of key strategies will impact on the services the Trust provide. A brief summary of the key ones are shown below:

- **Five Year Forward View (2014)/Five Year Forward View for Mental Health (2016)**

  The two Five Year Forward View, (FYFV) documents set out the challenges the NHS and Social Care systems will have to address to meet the increasing demands within agreed resources up to 2020. The FYFV for Mental Health builds on the overarching FYFV but with specific reference to a large part of services provided by the Trust. New care models, greater collaboration and integrated working across the systems will all have implications for the workforce. The size, shape, skills of the workforce will need to be aligned to the new ways of working and be able to match available resources.

- **Transforming Care for people with Learning Disabilities**

  Nationally it was recognised that improving services for people with learning disabilities and/or autism, who display behaviour that challenges, must be a high priority. Transforming care for people with learning disabilities is designed to be a system wide change which enables more people to live in the community, with the right support, and closer to home. This will require a workforce able to provide person centred care, that is needs led, local and accessible.

- **General Practice Forward View**

  The General Practice Forward View sets out a programme of support for general practice over the coming 5 years. The programme includes commitment to ongoing investment in GP services, support for new ways of care delivery, improving building and environments and redesign of the care system. There will be an increase and greater emphasis on the development of the Primary Care Workforce as a whole.

The Trust operates across two Sustainability and Transformation Programmes (STP) (West Yorkshire and Harrogate STP and South Yorkshire STP), 4 Local Authorities and 5 Clinical Commissioning Groups. The Trust has a strong track record of serving a large geographical spread and diverse population and working in partnership with a number of different health and social care systems.

The local context therefore, varies to some degree across the Trust and its services. However, the Trust is well engaged and a strong partner in a number of key developments including:

- Development of Accountable Care Organisations across the patch
- Vanguards both locally and nationally
- Closer collaboration with Mental Health Providers in providing locally appropriate services
- Collaboration in the provision of back office functions to achieve best value.

There are also significant workforce supply problems, facing both South and West Yorkshire for qualified nursing, allied health professionals, certain medical roles and specialist support services, e.g. IM&T.

The introduction of the agency cap along with the supply problems presents a major challenge for the Trust. There are robust plans are in place to reduce medical, management and administration agency spend. However, the requirements of safer staffing means nursing agency spend will be more difficult to reduce in the short term and will need further work.

The Trust has been financially stable, but every year this has been a greater challenge. The achievement of cash releasing Cost Improvement Programme will present even further challenges for the workforce given this represents 75% of spend.

Despite the challenges the Care Quality Commission have, without exception, said our staff are caring and the vast majority of service elements were assessed as good or outstanding. The Trust has a strong value base which has been evidenced by external regulators and partners.

3. STRATEGIC WORKFORCE GOALS

3.1 Strategic Workforce Goals

The national and local context means over the next 3 years we need a resilient workforce who can cope with the inevitable change ahead, whilst continuing to deliver safe and compassionate services.

In order to achieve this, 3 strategic workforce goals have been identified:

- **Workforce Development**
  - Designing, developing, attracting and retaining a workforce based on service needs and best use of resources
- **Staff Wellbeing and Engagement**
  - Building organisational, team and individual resilience and optimising the contribution of the whole workforce, through proactive staff engagement
- **Leadership and Management Development**
  - Developing and supporting current and future leaders and managers to ensure services are well led and contribute to whole system development

3.2 FOUNDATION OF TRUST VALUES, EQUALITY AND DIVERSITY

These 3 strategic workforce goals need to be built on a solid foundation of:

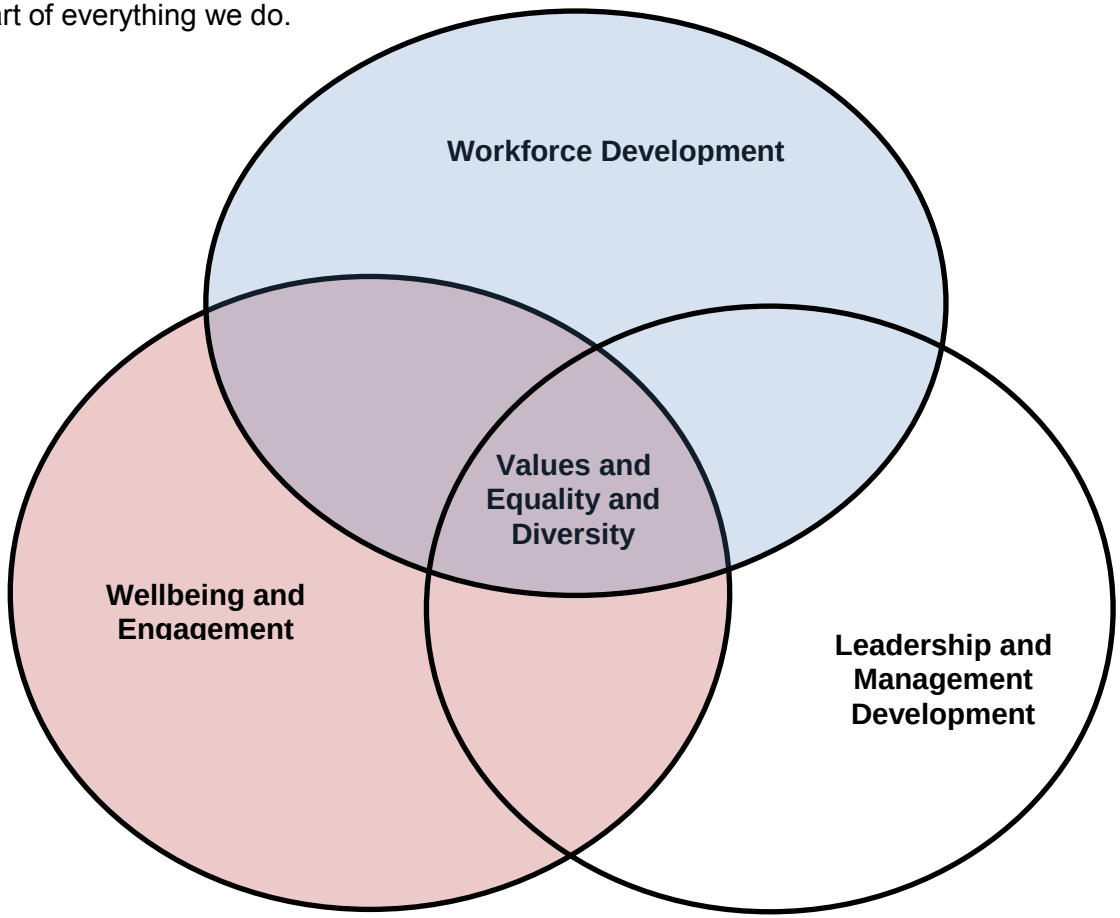
- **Values Driven Human Resource Management**
  - Ensuring the Trust's values are embedded in the way we manage and develop the workforce
- **Workforce Equality and Diversity**
  - Commitment to equality and valuing diversity in the workforce

3.3 An Integrated Approach

The complexity of the workforce agenda means that the 3 Strategic Workforce Goals are not mutually exclusive and must be integrated. The integration of the 3 goals will provide important secondary benefits:

- An engaged and healthy workforce creates the resilience to deliver the workforce development agenda
- To be effective leaders and managers they must proactively engage with staff
- Workforce development requires capable leaders and managers to ensure good change management processes

A model for the integrated approach to the Strategic Workforce Goals is represented below with Values and Equality and Diversity remaining firmly at the heart of everything we do.



3.4 Key Organisational Outcomes

The Workforce Strategy success will be in its ability to support the delivery of the 3 Trust Strategic objectives:

- Right People at the Right Time in the Right Place to **Improve Health and Wellbeing**
- **Improving Quality and Experience**
- **Improving the Use of Resources**

These strategic objectives need to be built into an overall approach and model for the leadership, management and development of the workforce.

4. Model for Workforce Strategy 2017 – 2020

The model for the Workforce Strategy takes a whole system approach. It starts with the strategic workforce goals which reflect the national and local context. It recognises that the integration of these 3 goals will also provide for greater workforce resilience, better change management and more effective leaders and managers. This supports the delivery of the 3 strategic Trust objectives of improving health and wellbeing, improving quality and experience and improving the use of resources.

An important element of the strategy is the development of a collective leadership model for the Trust. In simple terms, collective leadership means everyone taking responsibility for the success of the Trust in delivering safe and compassionate care. A collective leadership culture focuses on continual learning and through this, improvement in patient care.

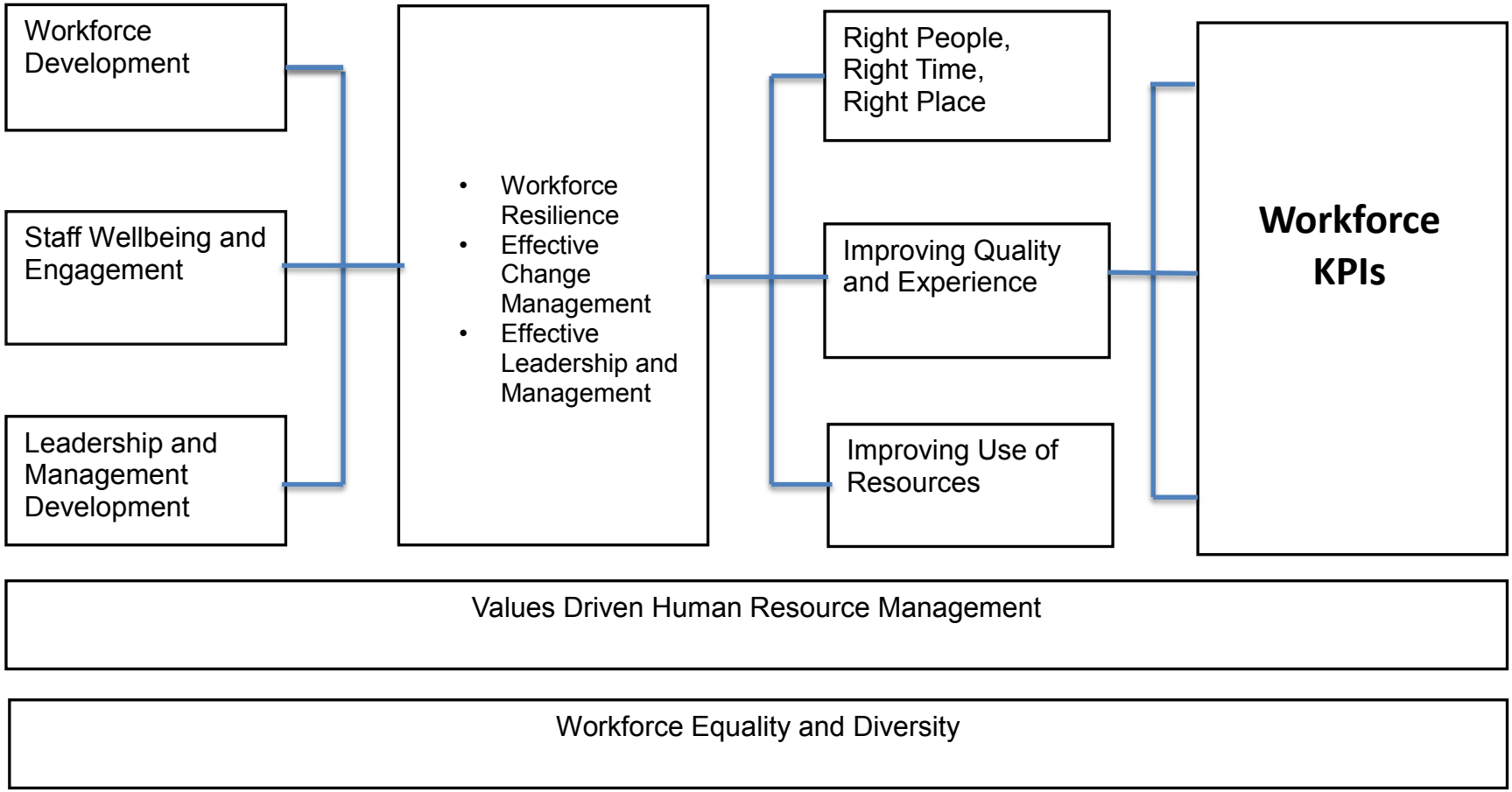
The model also recognises that a Volunteer Workforce has an important role in enhancing service delivery.

In order to measure progress and success, there needs to be a set of key performance indicators (KPIs). These KPIs will be developed into a Workforce Strategy Dashboard with ambitious but achievable targets of performance.

To ensure that the Trust's values and commitment to Equality and Diversity needs to be a consistent theme running through everything.

All the above are brought together in a simple overarching model for the Strategy:

Model for Workforce Strategy



5. Strategic Workforce Objectives 2017 – 2020

5.1 High Level Workforce Objectives

The Workforce Strategic goals have been broken into a set of 12 high level objectives linked to the Trust's strategic objectives. The 12 objectives are:

1. **Development of robust workforce plans with clear trajectories and goals aligned to service and financial plans: Impact**

   - Reduces vacancy levels of hard to recruit staff groups by 10% per year
   - Reduces agency spend to target levels by end of 2017
   - Increase the future supply of newly qualified nurses by up to 30 per year from 2019

2. **Developing and introducing new roles to support service transformation and delivery: Impact**

   - Increase Clinical Apprenticeships by at least 20 per year over the next 3 years
   - Support national Associate Nurse pilot with 8 new posts in 17/18
   - Increase Advance Clinical Practitioners in line with Nursing Strategy
   - Explore the introduction of Physician Associate in line with Medical Workforce Strategy
   - Increase the use of Volunteer Workforce to enhance service provision in line with Volunteer Strategy
   - Valuing lived experience in the workforce through increasing support worker roles by about 20% over the next 3 years

3. **Ensuring we have a flexible and well trained workforce: Impact**

   - Expanding the development and recruitment of apprenticeship roles to at least 110 per year from (Q1 18/19)
   - Increase supply of qualified bank staff and share overhead costs through a partnership approach (Q3 17/18)
   - Develop a zero approach to clinical support worker agency spend (Q2 17/18)

- Maximise the use of the whole Trust's Apprentice Levy in the delivery of training and development (Q1 18/19)

4. **Development of a resilient workforce through health promotion and leading edge occupational health and wellbeing services. Improve staff commitment to the Service User/Patient Safety through: Impact**

   - Increase job satisfaction, morale and engagement to best in class over the next 3 years

   - Achieve the 17/18 and 18/19 CQUIN for staff

5. **Ensuring Staff wellbeing supports the delivery of safe services and reduce sickness absence rates: Impact**

   - Reduce sickness absence to overall target level for the Trust of 4.4% by 2018 with a view to reducing to 4% before 2020

6. **Development and roll out of staff engagement toolkit for teams and services: Impact**

   - Developing effective teams for service delivery in line with NHSI Culture and Leadership programme (Q1 17/18)

   - Reduce bullying and harassment levels across the Trust to average and best in class levels over 17/18 and 18/19 respectively

7. **Ensure we have the leadership and management capabilities to deliver well led services: Impact**

   - Increase the number of potential internal candidates to assure the Trust can fill business critical roles (Q4 17/18)

   - Develop strategic partnerships for delivery of leadership management programmes (Q2 1718)

8. **Development and support collective leadership model: Impact**

   - Ensure the Trio, of General Managers, Clinical Lead and Practice Governance Coach, is effective at managing quality, resources and operational targets: Ongoing

   - Extension of the Trio approach to service teams (Q4 17/18)

   - Ensure the collective leadership model for the Trust is embedded across the organisation (Q1 18/19)

9. **Support to devolved decision making closer to front line services: Impact**

- Ensure managers have the skills and competencies for devolved decision making (Q3 17/18)
- Ensure that managers are able to manage an agile workforce (Q3 17/18)

10. **Embed Trust Values in key HR processes: Impact**

- Streamlining of recruitment process to reduce time to fill vacancies (Q1 17/18)
- Refresh value based approach, using organisational learning, Recruitment, Induction and Appraisal (Q1 17/18)

11. **Ensure the Trust promotes equality and values: Impact**

- Develop a diverse workforce which reflect the population served (Ongoing)
- Ensure we have representative and inclusive leadership (Ongoing)

The Strategic HR Framework 2017/2020 summarises the high level objectives linked to the workforce goals and strategic and strategic objectives:

Strategic HR Framework 2017/2020: Summary Strategy on a Page

Trust Strategic Objectives Strategic HR Priorities	Right People Right Time Right Place	Improving Quality and Experience	Improving Use of Resources
Workforce Development	EMBEDDING ROBUST WORKFORCE PLANNING	DEVELOPING NEW ROLES	CREATING A FLEXIBLE WORKFORCE AND WELL TRAINED
Wellbeing and Engagement	BUILDING A RESILIENT WORKFORCE	MAINTAINING A HEALTHY WORKFORCE	AN ENGAGED WORKFORCE
Leadership and Management Development Strategy	SUCCESSION PLANNING AND TALENT MANAGEMENT	COLLECTIVE LEADERSHIP	SUPPORT TO DEVOLVED DECISION MAKING
Values Based HRM	DEVELOPING A DIVERSE WORKFORCE	VALUE BASED AND INCLUSIVE LEADERSHIP	VALUE BASED HUMAN RESOURCE MANAGEMENT
Equality and Diversity			

5.2 Delivery Objectives

The high level workforce objectives have been broken into a set of 42 delivery objectives with timescales, again linked to strategic goals and objectives:

Workforce Strategy: Action Plan

	Right People, Right Time, Right Place	Improving Quality and Experience	Improving Use of Resources
Workforce Development	Development of Robust Workforce Plans with clear trajectories and goals aligned with service and workforce plans: • Strategic Workforce Plan for 17/20 **(Q1 17/18)** • Annual Workforce Plan linked to Annual Plans **(Q4 16/17)** • Recruitment and Retention Plan for Key Areas of Shortage **(Q1 17/18)** • Strengthen Links with Universities to Connect Qualified Training Numbers to Workforce Plans **(Q3 17/18)** • Develop International Recruitment programme **(Q2 17/18)**	The development of new roles to service transformation: • Clinical Support Workforce Strategy including Clinical Apprenticeships, Senior HCAs and Associate Practitioner **(Ongoing)** • Development of Associate Nurse Role • Advance Clinical Practitioner (**Q4 17/18)** • Explore the role of Physician Associate **(Q1 18/19)** • Expand Peer Support Workers **(Q4 17/18)**	Ensure we have a flexible and well trained workforce: • Expand the development Apprenticeship Roles across **(Q1 18/19)** • Development of Wider Bank Partnership **(Q3 17/18)** • Develop a Zero Approach to Agency Clinical Support Workers **(Q2 17/18)** • Explore Employer Provider Status in Collaboration with Strategic Partners **(Q4 17/18)**
Staff Health and Wellbeing	Development of a resilient workforce through health promotion and leading edge Occupational Health and Wellbeing Service: • Use NHS Employers 8 Signs for Health and Wellbeing as Framework for the Trust **(Ongoing) (Q2 17/18)** • Rapid Referral Process for Stress and MSK **(Q1 17/18)**	Ensuring staff wellbeing supports the delivery of safe services and reduces sickness absence rates Focus Programme of Wellbeing Support for Staff **(Q3 17/18)** • Development of Staff Health Trainer Role **(Q1 17/18)** • Development of Support Programme for Managers on Managing Staff Wellbeing **(Q3 17/18)**	Development and roll out of engagement toolkit for teams and services: • Programme of Creating Health Teams **(Q2 17/18)** • Development of Toolkit for Managers to Improve Staff Engagement **(Q2 17/18)** • Programme to Develop a Healthy Culture which Tackles Bullying and Harassment **(Q2 17/18)** • Support Freedom to Speak Up Guardians to promote a culture of openness and safety **(Q3 17/18)**

Workforce Strategy: Action Plan

	Right People, Right Time, Right Place	Improving Quality and Experience	Improving Use of Resources
Leadership and Management Development	Ensure that we have the leadership and management capabilities for the future through effective talent management and succession planning: • Development of the Optimising Potential Conversation **(Q1 18/19)** • Succession Plans Linked to Workforce Plans **(Q4 17/18)** • Talent Management Linked to Value Based Appraisal **(Q1 18/19)** • Working in Collaboration on System Leadership Development **(Ongoing)**	Development and support of collective leadership Model: • Continue Development of Trios **(Ongoing)** • Collective Leadership Approach for Service Teams **(Ongoing)** • Development of Clinical Leadership Programmes **(Q3 17/18)** • Development of Shadow Board **(Ongoing)** • Next Phase of Middleground Programme Linked to Collective Leadership **(Q2 17/18)**	Support to devolved decision making closer to frontline services: • Management Skills Programme **(Q3 17/18)** • Coaching/Mentoring Model for the Trust **(Q4 17/18)** • Supporting Frontline Innovation **(Q3 17/18)**
Value Based HRM	• Streamlining and updating of Value Based: Recruitment; Induction; Appraisal **(Q2 17/18)** • Development of Value Based Contracts of Employment **(Q1 18/19)** • Development of E-Appraisal to Support Value Based Appraisal and Talent Development **(Q1 18/19)**		
Equality and Diversity	• Positive Action leadership and management development programme for BME Staff **(Q3 17/18)** • Action Plan for WRES, WDES and EDS **(Ongoing)** • Extension of Staff Networks **(Ongoing)**		

The delivery objectives have deliberately been front loaded for 17/18 and 18/19 and will be refreshed in Quarter 4 17/18 for the remaining 2 years.

5.3 Outcomes Measures (Key Performance Indictors)

The basis for the measuring outcomes of the Workforce Strategy is a set of KPIs based on the metrics from the NHS Improvement Culture and Leadership Programme published in September 2016. The metrics draw heavily from the NHS Staff Survey results as well as well as established workforce data. They are designed to be built into a Workforce Strategy dashboard with a set of measures which reflect the ambitions of the Trust. A summary of the indicators will be built into the Integrated Performance Report

The 2016 NHS Staff Survey (published on 7th March 2017) will be the base line for setting impact targets for 2017 NHS Staff Survey (due to be published in March 2018). The Trust targets will be developed during March/April and be published by the end of April 2017 as part of the Dashboard.

In previous years the Trust has only used a random sample of staff (between 850 and 1200) for the survey. The survey from 2017 onwards will be sent to all members of staff to ensure as broad a range of responses as possible. Using a census approach will allow the results to be broken down by service areas, staff group and protected characteristics.

The KPIs with appropriate relevant evidence on their impact is shown below:

	Workforce KPIs	Outcomes
Workforce Development	• Workforce trajectories against plan • Time to fill vacancies • Stability Rates • Staff friends and family tests • Number of new roles created and saving accrued • Apprenticeship post • Use of Apprenticeship Levy • Bank and agency costs overall cost and as a % of paybill • Performance against ongoing Agency Cap • **NHS Staff Survey** **a) % staff saying ability to contribute towards improvement at work** **b) % staff saying they have opportunities to show initiative in their role** **c) % staff saying they are able to make suggestions to improve the work of their team department** **d) % staff able to make improvements happen in their area of work** • **NHS Staff Survey:** **a) Quality of non-mandatory training, learning and development** **b) % staff agreeing that training, learning and development has helped them do their job more effectively** **c) % agreeing that training, learning and development has helped them stay up-to-date with professional requirements** **d) % agreeing that training, learning and development has helped them deliver a better patient/service user experience** **e) Effective use of patient/service user feedback** **f) %agreeing that the Trust acts on concerns raised by patients/service users** **g) % receiving regular updates on patient/service user experience feedback** **h) % agreeing that feedback from patient/service users is used to make informed decisions within the directorate/department**	Proxy measure for innovation Have been related to productivity and innovation in the private sector

	Workforce KPIs	Outcomes
Staff Wellbeing and Engagement	• **NHS Survey: Overall engagement score** • **Sickness absence rates** • **NHS Survey: % staff saying they felt unwell in the last 12 months as a result of work related stress** • **% voluntary turnover** • **NHS Staff Survey:** **a) % experiencing harassment, bullying or abuse from staff in the last 12 months** **b) % experiencing harassment, bullying or abuse at work from managers in the last 12 months** **c) % experiencing harassment, bullying or abuse at work from other colleagues at work** • **NHS Staff Survey:** **a) Quality of appraisal** **b) % saying their appraisal definitely helped them improve how they do their job** **c) % saying their appraisal definitely helped them agree clear objectives for their work** **d) % saying their appraisal definitely made them feel their work was valued by the organisation** • **NHS Staff Survey:** **a) % agreeing they are able to make suggestions that improve the work of their team/department** **b) % agreeing the team I work in has a set of shared objectives** **c) % agreeing the team I work in often meets to discuss the team's effectiveness** **d) % agreeing team members have to communicate closely with each other to achieve the Team's objectives** **e) % agreeing their immediate manager encourages those who work from them to work as a team**	Predictor of Trust outcomes Measure of organisational health Predictor of Patient and Financial Performance Is linked to organisation productivity, profitability and innovation Important indicators of fairness and equality and predictor of overall staff satisfaction Important predictors of outcomes and engagement Much evidence of the importance of team working to outcomes including patient/service user satisfaction, staff stress, care quality

	Workforce KPIs	Outcomes
Leadership and Management Development	• **NHS Staff Survey:** **a) Support from immediate managers** **b) % satisfied with support from their immediate manager** **c) % agreeing that the immediate manager encourages those who work for them to work as a team** **d) % agreeing that immediate manager can be counted on to help with difficult tasks at work** **e) % agreeing that immediate manager gives clear feedback on work** **f) % agreeing that immediate manager asks for their opinion before making decisions that affect their work** **g) % agreeing that manager is supportive in a personal crisis**	Important influences on Trust performance
Value Based HRM	• **NHS Staff Survey:** **a) Staff awareness of Trust values** **b) Managers demonstrating values at work** **c) Other colleagues demonstrating values at work** **d) Trust has a clear vision for the future** **e) Staff feeling part of the organisation**	Identified as an important influence on organisation culture
Workforce Equality and Diversity	• Workforce representative of the population served by the Trust • Above NHS Staff Survey Questions Broken down by protected characteristics • WRES and EDS2 Standards and Targets • Gender and race pay audits • BAME staff grade 8a and above	

The KPIs in bold are those indicators with an evidence base as detailed in NHS Improvement report Culture and Leadership Programme (September 2016) produced in partnership with The Kings Fund and the Centre for Creative Leadership.

Those KPIs not in bold are largely well established national measures of care, quality and financial efficiency.

6. Risk

The key risks identified in the delivery of the strategy are:

External

- The organisational form dominates the agenda rather than service models and sustainability.
- Universities fail to respond to changes in funding of training.
- Health Education England fail to support the development of new roles.
- Regulators fail to accept the regulation of new roles
- Decommissioning of services
- Lack of collaboration across geographic health and social care
- Funding for Social Care fails to materialise
- External pressures impacting on quality
- Growing demand outstrips capacity and resources

Internal

- Failure to align workforce plans with service and financial plans
- Trust ability to achieve CIPs and financial targets
- Failure to devolve decision making closer to service provision
- Senior managers and leaders fail to commit to the key objectives
- Lack of commitment to staff health and wellbeing
- Availability of staff to be released for training and development
- Lack of resources for leadership and management training
- Not prioritise in annual planning process

7. Resourcing, Staffing and Technology Related Issues

The implementation of the Workforce Strategy will be the key focus for the HR function annual plans. It will require re-prioritising of activities to ensure a strong focus on delivery.

A key part of the Strategy is the use of technology to support the streamlining of transaction and routine work.

The Trust's commitment to devolved decision making will need to be supported by management development. An important element of the strategy is therefore the development of capable leaders and managers.

The Workforce Strategy and Workforce Plan are aligned to and supports the achievement of the Trust's financial plan.

8. Next Steps and Governance Arrangements

The Workforce Strategy will be subject to Trust Board approval.

A new Workforce Trust Action Group will be established to oversee the implementation of strategy. The Workforce TAG will for governance purposes, report into the Remuneration and Terms of Service Committee (RTSC).

To achieve Workforce Strategy, there are a number of key supporting documents which will be agreed during the first quarter of 2017.

1. Detailed Strategic Workforce Plan with trajectories aligned to service and financial plans. This will include the cost benefit of new workforce models/roles and actions April 2017 EMT then to RTSC in May 2017.

2. Workforce Strategy Dashboard with clear stretch targets to reflect ambition as an employer. April 2017 EMT then to RTSC in May 2017.

3. Refreshed Leadership and Management Strategy. June 2017 EMT.

4. 17/18 Organisational Development Plan to EMT. April 2017.

Business Delivery Units annual plans will be supported by service workforce plans.

Progress against the Key Performance Indicators will be reported into the Workforce TAG, EMT and RTSC.

The Members Council will have a key role in promoting a culture of safety and openness which underpins the strategy.

9. Equality Impact Assessment (EIA)

The EIA for the Strategy is attached in Appendix 1.

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Appendix 1

Equality Impact Assessment template to be completed for all policies, procedures and strategies

Date of assessment: March 2017

	Equality Impact Assessment Questions:		Evidence based answers & actions:
1	Name of the document that you are Equality Impact Assessing		Workforce Strategy 2017-2020
2	Describe the overall aim of your document and context? Who will benefit from this policy/procedure/strategy?		The Strategy develops a 3 year approach to the leadership, management and development of the whole workforce. The Strategy applies to all staff and is designed to benefit the whole workforce
3	Who is the overall lead for this assessment?		Alan Davis, Director of HR, OD and Estates
4	Who else was involved in conducting this assessment?		The strategy has been subject to wide engagement and this is the basis of the assessment.
5	Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy? What did you find out and how have you used this information?		Yes The engagement identified a number of key organisational which have been built into the strategy.
6	What equality data have you used to inform this equality impact assessment?		Workforce Equality Report, NHS Staff Survey, Trust Wellbeing and Engagement Survey have all been used in this assessment.
7	What does this data say?		The data has shown that by BDU there are gaps in a representative workforce compared to the local population. The NHS survey says that in terms of WRES section BAME staff more positive than White staff in most areas although sample size is small. A key area for the Trust staff and slightly higher for BAME staff is harassment and bullying by service users, carers and visitors
8	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:	Yes/No	Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.
8.1	Race	No	Designed to have a positive impact

8.2	**Disability**	**No**	**Designed to have a positive impact**
8.3	**Gender**	**No**	**Designed to have a positive impact**
8.4	**Age**	**No**	**Designed to have a positive impact**
8.5	**Sexual orientation**	**No**	**Designed to have a positive impact**
8.6	**Religion or belief**	**No**	**Designed to have a positive impact**
8.7	**Transgender**	**No**	**Designed to have a positive impact**
8.8	**Maternity & Pregnancy**	**No**	**Designed to have a positive impact**
8.9	**Marriage & civil partnerships**	**No**	**Designed to have a positive impact**
8.10	**Carers (Our Trust requirement)**	**No**	**Designed to have a positive impact**
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		**The policy has a set of KPIs including Equality and Diversity**
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		**Yes**
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		**Includes tackling harassment and bullying**
9c	**Promotes good relations between different equality groups;**		**Yes**
9d	**Public Sector Equality Duty – "Due Regard"**		**Yes**
10	**Have you developed an Action Plan arising from this assessment?**		**Yes, included in action plan**
11	**Assessment/Action Plan approved by (Director Lead)**		**Sign: Date:** **Title:**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** **partnerships@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web.** **Failing to complete an EIA could expose the Trust to future legal challenge.**		

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 5.2

Title:	**Information Management and Technology Strategy update**
Paper prepared by:	Director of Finance
Purpose:	To provide the Trust Board with a review of the progress made on the 2016/17 IM&T strategy milestones. To explain the 2017/18 priorities and milestones to enable delivery of the IM&T strategy.
Mission/values:	The IM&T Strategy covers a 3 year period 2016–2019 and aims to support the Trust in working towards achieving the Trust's strategic vision and objectives by delivering the 'right information at the right time in the right format to the right person'.
Any background papers/ previously considered by:	IM&T Strategy 2016 – 2019 presented to and approved by Board April 2016. Bi Monthly updates to the Executive Management Team in relation to progress made on IM&T developments throughout 2016/17.
Executive summary:	The purpose of this report is to inform the Board of the progress and developments made during the last 12 months in respect of the 2016/17 IM&T Strategy milestones. Information Management and Technology (IM&T) is a critical lynchpin for the Trust in respect of the way in which the organisation uses technology and how information impacts on the care we provide, all the activities we undertake and the decisions we make both individually and corporately. The aims of the strategy are to deliver the following: ➢ Integrated systems that remove the requirement for paper records and support the Trust in becoming paper free by 2020 ➢ Using technology and information innovatively to make the most effective and efficient use of resources and as an enabler in re-designing services. ➢ Information sharing that supports the improvement in data and information accuracy, ensuring relevant information is shared in a timely and automated way. ➢ Use of Business Intelligence tools to deliver information in a standardised, user-friendly way (e.g. dashboards/graphics) and an increased use of forecasting, benchmarking and statistical techniques to deliver information rather than data. The strategy is based around 6 key domains: ➢ Infrastructure ➢ Clinical & Corporate Systems ➢ Information Sharing ➢ Digitisation ➢ Business Intelligence ➢ Training & Skills Development

	Detailed within this report are the activities that have and are currently being implemented and progressed in support of the agreed 2016/17 IM&T Strategy key domain milestones and a brief outline of the proposed 2017/18 milestones for each domain of the Strategy. The priorities for next year are in line with the strategy which considered the business plan at time of generation. The strategy will be reviewed in the coming financial year given updates in the operating environment, an updated operating plan, and completion of a number of actions. Capital investment to support the plan will amount to circa £1m in 2016/17, with likely spend of £1.5m in 2017/18. **Risk appetite** The IM&T service is vital in enabling staff to deliver safe care. As such risk appetite is considered low with a target score of 1-3. The level of risk score given the impact for a number of risks is currently higher than this (4-6). The priorities in 2017/18 will continue to reduce the likelihood of risk of system failure. This includes the work scheduled on infrastructure and data centres. Risks that need to be highlighted include the availability of suitably qualified and experienced resource, particularly relating to a potential mental health clinical records system implementation and specialist informatics staff. Once a decision has been made with regard to mental health clinical records system associated risks will need to be considered with mitigating actions put in place.
Recommendation:	**Trust Board is asked to NOTE the achievements made in respect of the 2016/17 milestones and AGREE and comment on the proposed 2017/18 priorities.** The IM&T service will ensure that the Board and other stakeholders are kept informed of all current and future IM&T developments on a regular basis.
Private session:	Not applicable.

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IM&T Strategy

Progress Report

Deputy Director of IM&T

March 2017

With **all of us** in mind.

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Purpose of Report

The purpose of this report is to inform the Board of the progress and developments made during the last 12 months in respect of the 2016/17 Information Management and Technology (IM&T) Strategy milestones.

Summary

The existing IM&T strategy was approved by the Trust Board in April 2016. It covers a 3 year period 2016–2019 and aims to support the Trust strategy by delivering the right information at the right time in the right format to the right person.

The ambitions of the IM&T strategy are to:

- Deliver integrated systems that remove the requirement for paper records and supports the Trust in becoming paper free by 2020
- Use technology and information innovatively to make the most effective and efficient use of resources and as an enabler in redesigning services.
- Share information that supports the delivery of care, improves data and information accuracy and ensures relevant information is shared in a timely and automated way.
- Successfully work in partnership to deliver an integrated approach to the delivery and sharing of information and technology across the local health community to improve patient care
- Make better use of clinical information systems.
- Use of Business Intelligence tools to deliver information in a standardised, user-friendly way e.g. dashboards/graphics, and an increased use of forecasting, benchmarking and statistical techniques to deliver information rather than data.
- Improve skills within services with all staff having access to or being provided with the appropriate skills to use current and future technologies to meet the changing demands of the organisation and the services we provide.

There are 6 key domains that support the delivery of the IM&T Strategy. These are Infrastructure, Clinical and Corporate Systems, Business Intelligence, Information Sharing, Digitisation and Training & Development. Detailed within this report are the activities that have and are currently being implemented / progressed in support of the agreed 2016/17 IM&T Strategy milestones and a brief outline of the proposed 2017/18 milestones for each domain of the strategy.

The provision of an effective IT service is critical to ensuring safe patient care and enabling effective use of staff time. Many of the priorities included in the IM&T strategy are viewed as being critical to enable the continuation of provision of safe patient care and to delivering Trust objectives. The work completed on infrastructure replacing legacy networks, hardware and the email platform has provided much greater resilience in this respect. Similarly the improvements to vpn access have had a positive effect on agile working and enabling records to be kept up-to-date.

At the time of developing the IM&T strategy consideration was given to how it would link to the Trust's business plan. Given the strategy was approved almost one year ago combined with a number of changes in the operating environment, the submission of an updated operating plan in December 2016, and the completion of a number of actions it is worthwhile re-appraising the IM&T strategy in line with the most recent plan. Thought has been given to key IM&T priorities for 2017/18 and these have been approved by EMT.

Financial Investment

In order to meet the priorities outlined in this report capital investment of circa £1.5m will be made next year in addition to the investment of close to £1m being made in 2016/17. The table below provides indicative details of the capital expenditure requirements over the next two years. Spend on all of these initiatives has yet to be built up in detail and therefore finalised, particularly the Mental Health Clinical Records System. As such these numbers are subject to change, but will be managed within total resources available.

Scheme	17/18 (£k)	18/19 (£k)
Data Centre/ Disaster rec	400	400
Infrastructure and WAN	250	250
Server refresh		200
Mental Health System	500	250
Integration & Portals	100	60
Digital dictation	75	225
Inter-operability	100	100
Other	96	0
Total	**1,521**	**1,485**

Infrastructure - Good Connection, Good Performance

The programme of work undertaken within this domain enables the Trust to deliver the technology that will ensure staff have access to Trust IT services and systems whenever and wherever they are needed regardless of location, be that in a Trust site, client's home or other partner premises.

*The infrastructure milestones identified within the Strategy for **2016/17** and progress made:*

Work Programme	*Description*	*Milestone*	*Date Achieved*
Infrastructure Modernisation Programme: ○ **Phase 1 - rationalisation of legacy networks and improved network links** ○ **Phase 2 – replacement of legacy hardware and email platform upgrade**	included the following developments: ○ Network enhancements **-** The network connecting Fieldhead and Kendray upgraded to remove bottlenecks and significantly improve the overall network performance and resilience between the two main Trust sites. Provision of new network links and access, equipment and telephony for Trust Moves (including new Hubs). ○ Email migration of the 6,000 Trust mailboxes from the old Exchange 2003 platform to the new 2010 platform **Outcomes Achieved:** Network hardware and software upgraded to latest standards ensuring operational resilience and network security provided and supported. The Email upgrade has enabled the Trust to move forward and replace the end of life Exchange platform and introduce new solution functionality enhancements which has resulted in improved performance and resilience.	***Q1*** ***Q1 – Q4***	**Phases 1 & 2 *completed in 2016/17***
Wifi on Trust sites, NHS Partner sites, Local Authority sites and service user internet access	included the following developments: ○ Access to the academic network for medical students, Eduroam, enabled and accessible from all Trust sites. ○ NHS Partner sites - Access to the SWYPFT network for staff working out of Barnsley District General Hospital enabled (Mid Yorkshire is the only NHS organisation yet to enable Wifi connectivity with SWYPFT) ○ Service User Internet Access for Forensic unit only, to be implemented by April 2017. **Outcomes Achieved:** opening up wireless connectivity across Trust and partner organisation sites has provided a foundation from which to enable agile working and supports the Local Digital Roadmaps and STPs and demonstrates our commitment to joint working and commissioner intentions	***Q1 2016/17 – Q3 2017/18***	***Q2 2016/17*** ***Q3 2016/17***.
Telecommunications replacement	A 2 year programme of work to replace and rationalise the existing desktop telephony estate across the Trust, (5 separate contracts & legacy systems) with the increases in staff working agile and utilising hot desk arrangements, this has enabled the Trust desktop telephone estate to be reduced by at least 40%. **Outcomes Achieved:** single integrated fully managed service implemented that enables the Trust to	***Q1–Q4***	***Q4***

	make calls internally free of charge and provides additional reduced tariff costs.This has provided the Trust with a cost effective solution to delivering a new telephony system. (Legacy telephony costs were £737k pa based on 3902 telephones and by reducing desktop telephones by 40% has saved the Trust approx. £250k pa.)		
Smartphone / Mobile phone provision	○ the Trust's Blackberry estate (650 blackberry devices) being replaced with smartphone devices ○ the mobile phone contract migrated to new reduced Vodafone tariffs **Expected Outcomes: -** the smartphone deployment will enable the Trust to move away from its blackberry handset estate and replace with Android devices allowing staff to utilise apps approved for use by the Trust and the migration of the mobile phone contract resulted in a cost reduction of £75k pa. being achieved.	***Q4***	**Q4-Q1 2017/18** ***Q1 2016/17***.
New Remote Access (VPN) solution	Users successfully migrated to the new VPN platform to provide users with improved access and reliability when working remotely. **Outcomes Achieved: -** This solution provides the Trust with the ability to grow its remote/agile user base whilst still ensuring that performance and accessibility are not impacted. This solution migration achieved an actual cost reduction of £28k in year 1 with a further £14k saving anticipated in year 2.	***Q1***	***April 2016***
Data centres/business continuity arrangements.	Business case being developed for the future provision of data centre services and improved business continuity facilities		***Q4-Q1 2017/18***
User Engagement	IM&T operational drop-in clinics being held across all BDU sites and are scheduled up until June 2017. **Outcomes Achieved: -** improved communication and links with operational services, ability to address issues and investigate options for developments with services in a timelier manner. Improved user and service experience of IM&T and technology.		***ongoing***

*The proposed **2017/18** milestones for the infrastructure domain are:*

Work Programme	***Description***	***Milestone***
Infrastructure Modernisation Programme -Phase 3 – Data Centre Rationalisation	This programme of work will focus on the review and modernisation of the Trust's existing 2 data centres at Fieldhead and Kendray (both of which require significant future investment). **Expected Outcomes: -** improved resilience and development potential. This programme of work will provide the Trust with the ability to easily switch from 1 data centre to another in the event of a disaster.	***Timeframe 2- 3 years***
Wifi Access on Local Authority sites	Participation in the Wakefield locality pilot using the public sector network solution 'Gov Roam' **Expected Outcomes: -** Improved ability for agile and remote working for Health and Social care staff by provision of access to Trust systems when and where required rather than being limited to only Trust sites.	***Q3 2017/18***
Microsoft Licensing Review	Survey commissioned from licensing specialists to identify the future software licensing options available to the	***Q3 2017/18***

	Trust moving forward. Once survey completed a business case will be developed outlining the options and funding requirements involved in replacing the existing Microsoft licenses purchased under a Department of Health Enterprise-wide Agreement that ceased in 2010.	
Trust Email Review	Review of future options for the Trust with regards to utilising NHS mail	***Q4 2017/18***

Clinical & Corporate systems – *delivering key systems that are fit for purpose and user friendly*

This domain focuses on the delivery and development of operational systems both clinical and non-clinical that support the Trust in the provision and delivery of effective care and support to its service users, making it easy to access information held within the systems and delivering a service that is paper-free at the point of care.

*The Clinical & Corporate Systems milestones identified within the Strategy for **2016/17** and progress made:*

Work Programme	***Description***	***Milestone***	***Date Achieved***
Clinical Portal Phases 1 & 2	This development enables the Trust to bring together information from different clinical information systems such as RiO and SystmOne into a single integrated record view, enhancing the care we provide through improved information accessibility and reducing the time staff spend locating the clinical information they need. ○ Phase 1 consisted of the installation of IT hardware/software infrastructure, the establishment of a 'mock' portal demo containing test SystmOne and RiO data and the initiation of integration capabilities between SystmOne/RiO. ○ Phase 2 pilot phase went live in initial pilot service areas, it will then be rolled out to clinical staff to support informed care decision making by Q2 2017 /18. **Expected Outcomes: -** Provision of a single integrated holistic patient record view, sourcing data from Trust internal systems & moving forward from partner systems to support informed clinical decision making and patient care delivery. Will enable the Trust to develop electronic interfacing capabilities that support care delivery and reduce operational overheads & inefficiencies in the health system e.g. the ability to send discharge letters etc. electronically rather than traditional printing/posting channels	***Q1–Q4***	***completed as planned in 2015/16*** ***Q3 2016/17*** ***Q2 2017/18***
Clinical Systems – SystmOne Clinical Deployment	Development of SystmOne to support service re-design and transformation agendas. Activities have progressed throughout 2016/17 with a number of services within Barnsley BDU with current focus areas being Inpatient Wards at Mount Vernon, Stroke Unit at Kendray. **Outcomes Achieved: -** to ensure continuity of care key clinical documentation has been re-designed to meet service needs and provide easier access to clinical information. For example: when a patient is now discharged from the Stroke unit into the care of the Trusts community services, the community staff automatically have access the patients information relating to their stay on the Stroke unit,	**Q1 2016/17 – Q4 2017/18**	***Ongoing throughout 2016/17***

	previously this was not the case.		
SystmOne EPR Core (Trust wide)	This is the read-only module of SystmOne and provides non SystmOne users (i.e. Mental Health Clinicians) with access to SystmOne records for patients currently receiving health care services from this Trust (only where there is a legitimate relationship with the patient). **Outcomes Achieved: -** To date 269 staff have been provided with access across the Trust and further service specific demonstrations are being arranged	***Q2***	***Deployment on-going***
SystmOne Contract Re-provisioning	National Local Service Provider contract for SystmOne expired on 7 July 2016. The Trust completed a mini-competitive tender exercise and new contract was successfully ***in place by 7th July***.	***Q1***	***Q1***
RiO Version 7 Upgrade	Following the upgrade to version 7 the majority of the major issues have been resolved to Trust satisfaction or are in the process of being deployed via software fixes. There remain some instances of users being logged out without warning. Whilst the system appears to be more stable we have continued to work with Servelec to try and determine the root cause of several system issues which have been persistent since the launch of RiO version 7 in November 2015. In light of how long these issues have been investigated for it was recommended and approved at the Systems Development Board on 24/2/2017 that the Trust will continue to monitor and feedback issues to Servelec for investigation and that continued efforts to capture errors in clinical teams which have an operational overhead would cease and the IM&T staff would focus on providing day-to-day user support.	***Q1***	***ongoing***
RiO Patient Viewer	After review of this solution the IM&T team identified that the Clinical Portal would be more suitable to provide this functionality so the decision was taken not to pursue this with the RiO system supplier.	***Q3 – Q4***	***Not progressed***
Paperlight	During 2015/16 IM&T established a time limited project role to assist services to become Paperlight accredited, due to changes in staff and resourcing issues this programme of work as had to be put on hold. In 2017/18 the service is planning to review the paperlight agenda with a view to it forming part of a wider Care Record Digitisation Programme. All clinical services (predominantly those services on RiO and SystmOne) currently working towards Paperlight accreditation continues to be supported by IM&T in completing the necessary activities.	***Q2 2016/17 – Q4 2018/19***	***Delayed***
RiO Contract & Mental Health System Procurement	The Trust's current contract for the RiO system expires on 31 March 2017. The Trust has extended the contract with the RiO systems supplier for initially 12 months with the option to extend the contract period for up to a further 12 months. As this is a major piece of work the Trust secured for the period of 6 months a dedicated project manager on a part-time basis to project manage from staff engagement to specification design to recommendation on the preferred approach for the Trust. The tender specification was issued on the 13th February with a closing date of the 29th March. 3 suppliers have indicated they intended to respond to the tender and undertook system demonstrations between the 15th & 17th March. To enable our clinical and operational staff to see the systems being used in practice and speak to peers about the systems, reference site visits were undertaken during March, upon completion of all tendering activities the recommendations will be presented to EMT and Trust Board in April 2017.	**Q1 2016/17 – Q3 2017/18**	***ongoing***
MIG (Medical	The Medical Interoperability Gateway is the primary care (GP) system supplier's solution to providing	***Q3–Q4***	***Q3***

Interoperability Gateway)	access for care professionals in other settings to high level electronic patient information held on GP systems. The system stores Summary information for each patient which includes Patient Details, Diagnosis, Events (inc. encounters, referrals & admissions), Examination details, Investigations (including X-rays, Blood tests etc.) , Medications (Inc. current, past and any issues); Procedures and Risks & Warning. With access to this type of information it reduces the need for Trust staff to directly contact GP practices for patient related enquiries. **Outcomes Achieved: -** The MIG solution has been successfully implemented within the SystmOne EPR Core read-only module for Barnsley based residents. Access to this information reduces the amount of time staff spend on searching physical and electronic systems to obtain the information recorded by the GP's.		
eDischarge Messaging	A revised standardised discharge summary document developed that enables information extracted from RiO to be processed via the Trusts integration engine and sent to GP practices electronically. Technical testing activities are progressing and pilot messaging with nominated GP practices was initiated during March 2017 **Outcomes Achieved: -** Potential to improve ongoing client care by the provision of discharge information to the GP in an improved timeframe.	***Q1–Q2***	***Q4***
Medicines Management	Procurement of a medicines management system	***Q2–Q4***	***Commenced Q4***
eReferrals	Implementation of the e-referral solution in to the Trusts Clinical Information systems	***Q4***	***Not started***

*The proposed **2017/18** milestones for the Clinical & Corporate Systems domain are:*

Work Programme	***Description***	***Milestone***
Clinical / Client Portal	Continued development of the clinical portal including the integration of the MIG to enable users to access via the Trusts Clinical Portal the information stored on the MIG. Wider opportunities will also be investigated to develop integration capabilities with our partners across health & social care and following this the development of client portals providing our clients with access to their own electronic care record. **Expected Outcomes: -** development of a client portal that allows clients to access their own medical records electronically. This is a national target for 2020	***To commence Q2 2017/18***.
Clinical Systems – Transformation Programme(s)	Support & Alignment of clinical systems to meet BDU requirements **Expected Outcomes: -** ensure systems have the ability to record and report on required clinical information following the transformation of services.	***Ongoing throughout 2017/18.***
SystmOne Clinical Development	Assessment of system reconfiguration requirements to support the Intermediate Care Service Transformation, the Alliance Contract developments and the system implications of the Diabetes MCP SPA **Expected Outcomes: -** meet the clinical recording and reporting requirements of the operational services moving	***Q1–Q4***

	forward.	
Paperlight / Care Record Digitisation Programme	Investigate and assess options available to the Trust to move towards paper free by 2020	***2017/18***
Mental Health Information System Implementation	Provision of specialist technical, configuration and training support to the implementation team in delivering the chosen mental health clinical information system.	***ongoing***
Medicines Management	provision of specialist technical support to the pharmacy led procurement of a medicines management system	***Q2***
eReferrals	Functionality will be reviewed and requirements will be built into the Trusts current and future clinical systems **Expected Outcomes: -** meet the needs of the primary care community in providing the ability to electronically refer clients to the Trust services. This will improve the client experience in being referred to the Trust services.	***Q1***
Legacy Systems	Data repatriation of iPM and SAP data previously held by NHS Digital	***Q2***

Business Intelligence – *Turning data into information*

This domain focuses on delivering solutions that support the provision of *actionable* information that teams and individuals can use on a daily basis to understand how they are performing and take appropriate action to improve outcomes.

*The Business Intelligence milestones identified within the Strategy for **2016/17** and progress made:*

Work Programme	***Description***	***Milestone***	***Date Achieved***
Business Intelligence / Data warehouse– phase 1	This is a long term programme of releases of reporting suites to provide real time operational intelligence to services so that they are clear on how they are performing and where they can take action to improve. Each release contains a suite of reports covering data quality, operational reports and summary reports (e.g. KPIs and performance against targets). ○ Release 1 - concentrated on Mental Health Acute Working Age Adults and Intensive Home Based Treatment. This is still in development as it is impacted by the shortage of qualified technical staff. Acute & Community Transformation work commenced and reporting requirements from all transformation agendas being reviewed.	***Q2***	***Pilot comp. Q4.***
Business Intelligence / Data warehouse (information hub & dashboards)	○ Capacity to support BI – as a result of several unsuccessful recruitment processes this programme of work has suffered from insufficient dedicated capacity to support its development which has resulted in delayed delivery timescales. To support the business intelligence work programme the Trust successfully recruited to the specialist reporting post and the skills transfer of key technical requirements from specialist contractor to existing IM&T staff has commenced. The Trust will likely lose the specialist skills provided by a member of agency staff shortly, which will have further impact on this initiative. ○ Reporting - New style Board Report produced that includes more financial and quality information and the Cardio Metabolic Assessment screening report deployed to assist with monitoring of compliance with the national CQUIN on physical healthcare for people with severe	***Q3–Q4 2018/19***	***Q4*** ***Q2***

	mental illness. **Outcomes Achieved: -** access to real time information to support transformation agendas, which enables the operational services to actively monitor and respond to variations in activity and where required improve performance and activity recording.		

*The proposed **2017/18** milestones for the Business Intelligence domain are:*

Work Programme	*Description*	*Milestone*
Business Intelligence / Data warehouse (information hub & dashboards)	○ Release 1 – continue to develop the work involved in delivering information to support the pilot teams and the requirements of all the transformation agenda's. ○ Release 2 - Further roll out of Business Intelligence to include Community services (SystmOne) and look to focus on Intermediate Care requirements. ○ Release 3 - the introduction of DATIX into the data warehouse and the development of a suite of reports for corporate and operational use. This is currently at requirements stage and scheduled to commence development phase. ○ Release 4 - Review and inclusion of requests from other services. **Expected Outcomes: -** Continue to improve and make available the use of real time information to support operational services and transformation agendas.	***on-going*** ***tbd*** ***Q1 2017/18*** ***tbd***
Mental Health Information System Implementation – Reporting Requirements	Establish and configure the Mental Health system to meet the reporting requirements of the Trust	***Q4 2017/18***

Information sharing - ***Information Governance seen as an enabler rather than barrier to sharing information***

The focus of this domain is to ensure the Trust data / information is securely stored and appropriately shared with other health & social care providers, that easy access exists for staff and service users to information held within relevant clinical systems and partnership working activities are supported.

*The Information sharing milestones identified within the Strategy for **2016/17** and progress made:*

Work Programme	*Description*	*Milestone*	*Date Achieved*
Partnership Working – Digital Road Maps	Local Digital Road Maps (LDR) **–** as part of the STP work each Local Health Community was required to working jointly to develop the Local Digital Road Maps. The Trust is participating in the development of a five-year vision for digitally-enabled transformation which will look at capability,	***on-going***	***Ongoing***.

	outlining how, through driving digital maturity, professionals will increasingly operate 'paper-free at the point of care'. The roadmap is not a technical document; it aims to identify our readiness, capability and capacity to deliver transformation. A specific requirement of the LDR is that there is a commitment and plan to deliver interoperability and enable information sharing		
Records Scanning	Project established to set up an on-site scanning bureau to scan records retrieved from or going to off-site storage with destruction of paper record post scanning and quality assurance. These records will be accessible electronically in a bespoke, controlled, web-based document management system available to clinical staff whenever they need it. Since the initial business case, estates moves and hub developments have resulted in a change of focus for this project away from the planned scanning of records scheduled for offsite storage to one where records which cannot be accommodated in the new hubs being scanned ahead of all other records.	***Q1 2016/17 – Q2 2017/18***	***commenced***
0-19	safe transfer of 0-19 patient records paper & electronic information from SWYPFT to BMBC completed		***Q3 2016/17***.
Information Governance	○ A data protection audit undertaken by the Information Commissioner Office (ICO) in November 2016, the recommendations from this audit are being implemented and the ICO published the executive summary on their website. ○ As part of the 2016/17 IG Toolkit submission, classroom based IG Training has been rolled out for staff groups who do not have ready access to a computer and spot inspections undertaken to ensure good IG practice compliance across clinical teams.		***Q3/ Q4*** ***Q4***

The proposed 2017/18 milestones for the Information sharing domain are:

Work Programme	***Description***	***Milestone***
Partnership Working	Continue to participate in the Digital Road Maps development with Health community partners.	***throughout 2017/18***
Records Scanning	Continue to develop the onsite scanning bureau and work towards meeting the 2010 paper free target. Plan and implement access to records via the Trust's clinical portal. **Expected Outcomes:** - continue to reduce off-site storage costs (over the last 2 years these costs have increased by £32k), improved governance through having access to all records related to Trust clients	**Q4 2017/18 to initiate work**

Digitisation - *Using technology in the care environment as we do in our everyday life.*

The programmes of work in this domain support the Trust to use technology to improve and transform how we deliver care and services, how we improve and develop communications with service users and how technology can support staff in service delivery and improve internal efficiencies.

*The Digitisation milestones identified within the Strategy for **2016/17** and progress made:*

Work Programme	*Description*	*Milestone*	*Date Achieved*
Agile Working	Work continued to enable all BDUs to become agile and support estate moves and hub developments. Additional hot desking capabilities created at across several Trust sites. **Outcomes Achieved: -** 74 (of 80 identified by BDUs) additional clinical services across Calderdale, Wakefield and Barnsley have been supported to become agile. The IM&T service has deployed 2,285 laptops (Circa. 1200 of these to community based clinical staff) & 400+ Store & Forward users (offline access to RiO clinical record).	***Q1- Q4***	***throughout 2016/17***
Digital Dictation	Project commenced to assess the solutions available to support the delivery of a digital dictation solution to improve efficiencies and reduce administration overheads. Due to capacity constraints within IM&T this project was put on hold during 2016/17.	**Q1 2016/17 – Q2 2017/18**	***put on hold during 2016/17***
Skype for Business (Lync)	Upgraded and deployed across the Trust**,** this system supports staff working remotely by enabling them to communicate via phone, desktop video conferencing or instant messaging with colleagues at other sites and organisations. **Outcomes Achieved: -** Over 1,500 Skype for business users within the Trust now able to undertake video conference meetings/ calls. Within the Priestly Unit a video conferencing facility has been set up to enable clinical staff working in the community to join ward rounds and MDTs and the new Health & Wellbeing centres are equipped with Skype for Business video conferencing facilities. In the next couple of months the Fieldhead and Kendray sites are to be set up with a fixed skype for business video conferencing facility, meaning all the Trusts main sites will have access to the video conferencing facility.	***Q1***	***Q1***

*The proposed **2017/18** milestones for the Digitisation domain are:*

Work Programme	*Description*	*Milestone*
new technologies	Continue to assess, review and implement new technologies to support the Trusts programme of transformation and development.	***Ongoing.***
centralised mailing	Review options for centralised mailing **Expected Outcomes: -** reduced mailing costs and potential to reduce IG incidents related to clients being mailed to incorrect address.	***Q4 2017/18***

Training & Skills Development – *Skills and confidence to use systems and technology to support the role.*

This domain focuses on the delivery of the skills and training to enable staff to effectively use technology and information to deliver services and client care and access Information and systems.

*The Training & Skills Development milestones identified within the Strategy for **2016/17** and progress made:*

Work Programme	***Description***	***Milestone***	***Date Achieved***
Basic IT Training	Basic IT training to be provided in conjunction with the agile working programme of work **Outcomes Achieved: -** IT Skills training now available on rolling basis to all Trust staff	***Ongoing***	
Establish a Roles based approach to training	**RiO Training Review –** in response to user feedback a new Trust wide training schedule commenced where users are now offered a 1 day course rather than 2 half days and a 'what's new', revised user guides and videos are now available via the intranet. To ensure the training being provided continues to be appropriate and meeting the needs of the services, staff will be surveyed on a regular basis and training adapted as required. To address how training can be provided to junior doctors, discussions are on-going with the Medical Directorate with the aim being to have an agreed lesson plan in place for Q1 2017/18. **Outcomes Achieved: -** customer focused training provided to staff and improved availability of training across each locality making it easier for staff to access or attend training sessions. The Training team are more responsive to the services training needs and moving forward the recording of the training requirements on the Trusts L&D training system will help configure and provide future training to meet the needs of the services	***Ongoing***	

*The proposed **2017/18** milestones for the Training & Skills Development domain are:*

Work Programme	***Description***	***Milestone***
Development of IT Training	Development of IT Training and change management capabilities	***ongoing.***
Mental Health Clinical Information System	System and user Training support for the Mental Health Clinical Information System	***Q1 2016/17 – Q3 2018/19***

Risks and hotspots

The IM&T service is vital in enabling staff to deliver safe care. As such risk appetite is considered low with a target score of 1-3. The level of risk score given the impact for a number of risks is currently higher than this (4-6). The priorities in 2017/18 will continue to reduce the likelihood of risk of system failure. This includes the work scheduled on infrastructure and data centres to improve resilience.

Ability to deliver on all of these priorities in line with the timescales identified is very much dependent on availability of suitable resource. There are two particular points to note. The first of which relates to the additional staffing that will be required both in IM&T and other areas of the Trust to implement the Mental Health clinical records system. It is a very competitive market for this type of resource in this region. The guidance and restriction on use of personal service companies and agency staff may heighten this issue. The other notable staff hotspot relates to Informatics staff. This has already impacted the pace of introduction of the data warehouse and resulting business intelligence reporting. This issue could become more acute in the short term as agency staff exit, given that recruitment has proven challenging in the past with significant competition for staff with these specialised skills. A range of recruitment approaches are being taken to minimise this risk.

The RiO7 upgrade in November 2015 experienced a number of well documented issues. Learning from these issues has been captured in a number of ways and each of the resulting recommendations has been implemented so as to reduce the risk. The issues arising from the initial upgrade have been largely addressed through system fixes, changes to ways of working where appropriate and increased staff training where it was felt necessary. Once a decision has been made with regard to mental health clinical records system, associated risks will need to be considered with mitigating actions put in place.

Summary

The information included in this update report clearly articulates the breadth and volume of technology priorities completed within the Trust during 2016/17 and those scheduled for 2017/18. The schemes undertaken in 2016/17 have been managed and run with limited resources and have been impacted by the well documented issues we have experienced with the RiO 7 upgrade.

A high number of the projects in 2016/17 were focussed on addressing the remedial work that was required to resolve and upgrade the Trust's legacy and end of life systems following the IT Support

service transfer from the Health Informatics Service to Daisy. The IM&T service has spent a considerable amount of time in the planning and testing of all the activities it has undertaken in the last 12 months. This has meant timescales for delivery of these projects have been realistic and achievable, and that any associated risks have been managed with mitigating actions put in place where required. As a significant number of the IM&T priorities are now complete the IM&T services are in a better position in 2017/18 to move the Trust forward with new developments to support national and local digital agendas.

During 2017/18 the Trust will be undertaking the procurement and implementation of a Mental Health Clinical Information System. Dependent upon the outcome of this procurement process the IM&T service may be required to release specialist IM&T staff to support the implementation of the chosen solution. This in turn will impact on the ability of the IM&T service to deliver on all other IM&T priorities within current planned timescales. In preparation for the Mental Health Clinical Information system implementation the IM&T priorities for 2017/18 are currently being reviewed by EMT. The priorities from the 2017/18 Strategy milestones that have been identified as having the potential to be deferred to release IM&T staff are Digital Dictation Project and Business Intelligence reporting Releases 2 & 4.

During 2017/18 through a series of workshops with operational services and following the development of the Digital Strategy by the Director of Communications & Marketing the IM&T Strategy will be reviewed and refreshed to ensure it continues to support the Trust in moving forward and meets the needs of the national and local digital roadmaps.

The Board is asked to note the achievements made in respect of the 2016/17 milestones approved IM&T strategy and agree and comment on the proposed 2017/18 milestones. The IM&T service will ensure that the Board and other stakeholders are regularly kept informed of all current and future IM&T developments.

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 5.3

Title:	**Operational Plan 2017/18**
Paper prepared by:	Director of Finance
Purpose:	To advise the Trust Board of the current status of the development of the financial plan for 2017/18 and 2018/19.
Mission/values:	Relates to all Trust objectives.
Any background papers/ previously considered by:	Previous papers provided to Trust Board . Updates on plan development have been provided on a regular basis outside of Board meetings.
Executive summary:	➢ Operating plans including the Financial plan approved at December Trust Board with a number of assumptions clearly stated within the submission of the plan to NHSI ➢ Trust outturn position for 2016/17 has changed since the plan was submitted with an increase in pre STF surplus to £0.75m. There are also changes in the various components of the plan including a £0.3m reduction in capital charges projected. ➢ Priorities for 2017/18 will be generated through engagement in March with a recommendation coming to Trust Board in April ➢ Financially a gap of £1.3m needs to be bridged in order to meet the control total. It would also be appropriate to identify circa £1m contingency. ➢ A range of actions are taking place to close the gap. These are identified in the main report ➢ The level of risk and potential upside remains largely the same as December. The main risks relate to out of area beds, cquin, and the impact of tenders/re-commissioning. ➢ Quality Impact Assessment (QIA) process for CIPs is taking place. Majority of schemes rated as green, but process needs to conclude so that all schemes have been assessed. CIPs identified total £6.8m. ➢ Five year forward view for mental health does offer some opportunity for further service and income growth. ➢ Current run rate suggests that without action a deficit of circa £0.4m will be recorded in each of April and May
Recommendation:	**Trust Board is asked to NOTE:** ➢ **the update to the operating plan identified in this paper and comment accordingly.** ➢ **that priorities and metrics are developed in March 2017 with a recommendation coming to Trust Board in April 2017.** ➢ **options identified for bridging the financial gap continue to be pursued with an update provided to Trust Board in April 2017.**
Private session:	Not applicable.

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2017/18 Operating Plan Update

Introduction

The Trust submitted its two year operating plan on December 23rd, 2016. This was at least three months ahead of previous year submissions. Before entering the new financial year it is important to note any updates in the operating environment that have taken place since the submission date and how they impact upon the delivery of the plan.

Priorities and Metrics

The appointment of Salma Yasmeen into the role of Director of Strategy is enabling a refresh of the Trust strategy to take place. The aim is to agree key Trust priorities at EMT on March 23rd and discuss these at an extended EMT meeting on March 30th. These priorities will be aligned to Trust objectives and have key metrics identified. A recommendation will be taken to Trust Board in April in this respect.

Outturn Position

The financial plan was based on a number of assumptions and an outturn position for 2016/17 as agreed during December 2016. The outturn position has changed, both in value and make-up since that time. This is illustrated in table 1 below:

	Forecast as at Dec-16 £m	Forecast as at Mar-16 £m	Movement £m
Income	225.9	226.0	0.1
Pay Costs	(172.0)	(171.6)	0.4
Non Pay	(46.2)	(46.2)	(0.1)
Provisions	3.1	2.6	(0.5)
EBITDA	10.8	10.8	(0.1)
Capital Charges	(10.3)	(10.0)	0.3
Pre STF Surplus/(Deficit)	0.5	0.7	0.2

As can be seen from the table above there have been a number of movements in the projected year-end position since December. These movements include a continuation of the overspend on out of area bed costs, although there has been an improvement in the size of the overspend since late January. Offsetting this to a degree has been an insurance settlement of £0.5m. It will be possible to claim up to another £0.5m of insurance relating to the fire. Capital charges will be £0.3m lower than projected at December, largely due to an update in the PDC calculation and the impact of the asset impairment.

The Trust Board has also agreed a change in the pre STF surplus position from £0.5m to £0.75. This is above the control total previously agreed and will entitle the Trust to an additional £0.25m of STF monies in 2016/17. It should be noted though that achievement of this position is via non-recurrent means.

Financial Plan

The submitted financial plan for 2017/18 was to achieve a pre STF control total of £1.02m. This was agreed by the Board, whilst acknowledging there was further work to do in identifying exactly how it could be fully delivered, and that a number of risks and potential upsides existed.

The current status of the plan internally is that a gap of £1.3m needs to be addressed in order to achieve the control total. In addition some contingency needs to be identified leaving a gap of circa £2.3m.

Work continues to be undertaken to identify means by which the gap can be bridged. The Executive Management Team has committed to completing a range of actions in order to both safeguard existing assumed savings and to identify further savings. These actions include reviewing actual achievement and under-achievement of CIPs over the last two years, focus on non-pay, empowering teams to identify real cash releasing savings and short-term actions. Where it would add benefit and value can be gained external expertise and/or capacity may be considered.

CIPs

The annual planning process required both BDUs and corporate services to identify cost improvement schemes to enable the Trust to remain in reasonable financial health and meet appropriate financial targets. All schemes are captured on a template and are subject to the Quality Impact Assessment (QIA) process. This process is framed against the five CQC domains of safe, effective, caring, responsive and well-led. A RAG rating is provided for the impact of the scheme on quality.

The value of potential CIPs identified in December was £6.5m. This amount is now £6.8m. The Quality Impact Assessment Process has taken place since December. In summary greater emphasis has been placed on cost reductions being made in support and non-pay than BDU operations. Typically BDU cost savings as a percentage of current budget range from 0.4% to 2.5%. For corporate services this percentage ranges from 2.5% to 4.5%. Greater detail of CIP schemes is shown in appendix 2. QIAs have been completed for £2.9m of CIP value, with £1.6m deemed as not requiring a QIA. This leaves £2.3m to be rated. Of those schemes rated to date £2.7m have been given a green rating and £0.2m amber. Total risk is in the region of £1m based on timescales of delivery and track record.

Ongoing governance is driven by the Deputy Director of Nursing and Deputy Director of Finance, taking the form of monthly reviews. In addition to this there is regular monitoring of progress at BDU management meetings, the Operations Management Group, and EMT.

Risks and Opportunities

A number of risks were identified in the plan submitted to NHS Improvement in December. These include risks around CQUIN, the use of out of area bed placements and re-commissioning of services. All risks continue to be managed with the aim of eliminating or reducing any financial impact.

It should be noted that whilst the overspend on out of area beds has reduced in value in February the current run rate is circa £0.3m per month. In order to achieve the assumptions included in the plan submission this level of spend needs to fall to well below £0.1m per month.

In addition to these risks a number of potential upsides exist, all of which are being pursued. These include procurement opportunities, income opportunities and non-recurrent income and costs.

Current Run Rate for Q.1

It should be noted that given current out of area bed spend, known inflationary uplifts and application of the apprenticeship levy combined with the timing of CIPs the current run rate for April and May will result in a deficit of circa £0.4m per month. This will place significant pressure on the remainder of the year. As a consequence short-term savings and timing of expenditure is being carefully assessed.

Five Year Forward View Update

Since the plan was submitted there has been an increase in national focus on the planned investment in Mental Health services relating to the five year forward view. Each CCG has been required to outline their Mental Health investment plans in a letter to NHS England. These letters were also signed by the Chief Executive of its primary mental health provider. This exercise has been designed to provide greater transparency of plans and identify how the identified monies are included or planned to be included in provider contracts.

The Trust has participated in this exercise along with its commissioners. Some opportunities for service and income growth remain and these will be negotiated in the coming weeks.

Operating Environment

The operating environment in which the Trust operates is largely the same as when the plan was submitted. The Trust continues to play an active role in both the West and South Yorkshire STPs. At this point in time there are no agreed implications from the STPs that will impact on the 2017/18 Trust plan.

Conclusion and recommendations

In summary the fundamentals of the operating plan are in line with what was submitted to NHS Improvement in December, although the 2016/17 outturn position has changed. Whilst work continues on the financial position the current plan remains short of the control total by over £1m and contingency needs to be identified. Engagement on priorities and metrics for measuring progress against them is taking place during March.

It is therefore recommended that:

- The Board notes the update to the operating plan identified in this paper and comments accordingly.
- That priorities and metrics are developed in March with a recommendation coming to Trust Board in April.
- Options identified for bridging the financial gap continue to be pursued with an update provided to Trust Board in April

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 6.1

Title:	**Integrated Performance Report Month 11 2016/17**
Paper prepared by:	Director of Finance and Director of Nursing and Quality
Purpose:	To provide the Board with the Integrated Performance Report (IPR) for February, 2017.
Mission/values/objectives	All Trust objectives.
Any background papers/ previously considered by:	Not applicable.
Executive summary:	**Quality** ➢ Safer staffing fill rates remain positive but increased acuity remains a challenge across services ➢ Incident reporting levels are within the anticipated range ➢ 5 serious incidents reported during the month. ➢ We have received our reports for the adult inpatient Mental Health wards and our well led review. They are subject to factual accuracy check at present. **NHSI Indicators** ➢ Data completeness metrics (MH) remains under threshold at 60.7%. This remains below the March target of 85%. ➢ Confirmation of calculation details for a number of new metrics awaited from NHSI. ➢ IAPT proportion of people completing treatment who move to recovery is only marginally above the threshold and Q4 is therefore at risk of not achieving the target for the second consecutive month ➢ Good improvement in early intervention in psychosis **Finance** ➢ Pre STF surplus of £0.5m in February including an interim insurance settlement of £0.5m ➢ Cumulative pre STF surplus of £0.3m ➢ Out of area beds (£0.3m) and agency costs (£0.7m), whilst improving , continue to be financial pressures ➢ Use of resources risk rating of 3 due to agency spend above the ceiling ➢ CIP delivery of £8.2m is £0.9m below plan ➢ Cash is currently £28.3m with capital expenditure £2.4m below plan **Workforce** ➢ Sickness absence of 5.9% in the month, taking the cumulative position to 5.1% ➢ Information Governance training has now reached 95.2% ➢ Mental Capacity Act raining is now at 53.1% and Mental Health Act training is 30.5%

Recommendation:	**Trust Board is asked to NOTE the Integrated Performance Report and COMMENT accordingly.**
Private session:	Not applicable

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Integrated Performance Report

Strategic Overview

February 2017

With **all of us** in mind.

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Introduction

Please find the Trust's Integrated Performance Report for February 2017. 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.

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	2	2		2
CQC	CQC Quality Regulations (compliance breach)	Green	Green	Green	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:

Finance
• Pre STF surplus of £0.5m in February including an interim insurance settlement of £0.5m
• Cumulative pre STF surplus of £0.3m
• Out of area beds (£0.3m) and agency costs (£0.7m), whilst improving , continue to be financial pressures
• Use of resources risk rating of 3 due to agency spend above the ceiling
• CIP delivery of £8.2m is £0.9m below plan
• Cash is currently £28.3m with capital expenditure £2.4m below plan

Quality
• Safer staffing fill rates remain positive but increased acuity remains a challenge across services
• Incident reporting levels are within the anticipated range
• 5 serious incidents reported during the month.
• The remaining CQC reports are expected by the end of March

NHSI
• Threshold for vast majority of NHSI metrics is being achieved
• Data completeness of 60.7% is well below the 85% threshold

Contracting
• The Trust has worked with its CCGs to respond to the NHS England request to identify mental health investment plans in line with the five year forward view

Workforce
• Sickness absence in February was 5.9% taking the cumulative position to 5.1%
• Staff appraisal rate is now 93.4%

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.

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	Dec-16	Jan-17	Feb-17	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	1	0	1	4
C-Diff	C Diff avoidable cases	Quality & Experience	Safe	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	data not avail	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%	6.5%	6.2%	6.18%	6.45%	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%	63.7%	62.9%	62.56%	62.89%	4
Complaints	% of feedback with staff attitude as an issue	Quality & Experience	Caring	DS	< 20%	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	13% 8/60	9% 9/57	6% 3/52	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%	71%	87%	76%	2
	Friends and Family Test - Community	Quality & Experience	Caring	DS	95%	98%	99%	97%	98%	99%	98%	99%	98%	98%	97%	97%	98%	99%	99%	99%	4
Quality	Total number of reported incidents	Quality and Experience	Safety Domain	TB	N/A					1083	1195	1231	1168	1128	1108	1006	1173	1114	1097	924	N/A
	Total number of patient safety incidents resulting in severe harm and death	Quality and Experience	Safety Domain	TB	N/A					3	6	1	2	11	8	7	5	7	7	8	N/A
	Total number of patient safety incidents resulting in moderate or severe harm and death	Quality and Experience	Safety Domain	TB	N/A					17	35	21	19	29	32	29	23	21	22	24	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%	data not avail	data not avail	data not avail	3
	Safer staff fill rates	Quality and Experience	Safety Domain	TB	90%					108%	107%	111%	111%	109%	109%	113%	117%	112%	116%	115%	4
	Safer Staffing % Fill Rate Registered Nurses	Quality and Experience	Safety Domain	TB	80%					98%	98%	101%	98%	93%	91%	95%	99.5%	96.1%	93.8%	96.3%	4
	Number of pressure ulcers (attributable) 1	Quality and Experience	Safety Domain	TB	N/A					24	40	34	23	38	34	21	23	34	33	32	N/A
	Number of pressure ulcers (avoidable) 2	Quality and Experience	Safety Domain	TB	0					0	0	1	1	1	2	0	2	0	1	1	3
	Complaints closed within 40 days	Quality and Experience	Responsive	DS	80%	Reporting established from Sept 16									8	8	7% 1/14	0.00%	47% 7/15	10% 1/10	1
	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 16									2.2%	3.2%	3.5%	2.9%	2.9%	2.7%	
	Data completeness	Quality and Experience	Effective	KT/SR/CH	TBC	KPI under development															
	Number of Information Governance breaches 3	Quality and Experience	Effective	MB	<=8	Reporting from April 16				16	8	12	8	10	7	10	8	11	12	10	n/a
	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 16									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 16									65.19%						N/A
	Number of compliments received	Quality and Experience	Caring	DS	N/A	To be included from October 16									26	33	79	29	31	12	
	Eliminating Mixed Sex Accommodation Breaches	Quality and Experience	Safety Domain	TB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
	Number of Duty of Candour applicable incidents	Quality and Experience	Caring	TB	N/A					73				86		31	26	26	33	35	N/A
	Duty of Candour - Number of Stage One exceptions	Quality and Experience	Caring	TB	N/A	Reporting established from Oct 16										0**	0**	0**		1	N/A
	Duty of Candour - Number of Stage One breaches	Quality and Experience	Caring	TB	0	Reporting established from Oct 16										0***	0***	0***		0	
	% Service users on CPA given or offered a copy of their care plan	Quality and Experience	Caring	KT/SR/CH	80%	85.8%	84.3%	85.2%	85.6%	85.8%	85.6%	85.6%	85.3%	85.0%	85.0%	85.2%	83.0%	83.0%	82.6%	82.8%	4
	% of prone restraint with duration of 3 minutes or less	Quality and Experience	Safety Domain	KT/SR/CH	80%	Reporting Established from July 16							72%	89%	80%	80%	83%	62%	61%	64%	3

** See key included in glossary*

1 - Attributable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of 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

2 - Avoidable - A pressure ulcer (Grade 2 and above) that has developed after 72 hours of the first face to face contact with the patient under the care of 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

3 - The IG breach target is based on a year on year reduction of the number of breaches across the Trust. The Trust is striving to achieve zero breaches in any one month. This metric specifically relates to confidentiality breaches

** Data will be added retrospectively when the housekeeping is completed.

*** we currently have no confirmed breaches but housekeeping is underway regarding any outstanding incidents where clarification is required.

Quality Headlines (& CQUINS performance on a quarterly basis)

We have previously reported that work had been undertaken to identify some additional key quality measures relating to eliminating mixed sex accommodation, Duty of Candour, service users on CPA given or offered a copy of their care plan and prone restraint. 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 remaining 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.

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.

NHS Safety Thermometer - Medicines Omissions – this is an indicator within the CQUINs for the west and has been identified as at risk of achievement. Data remains unavailable due to problems with national software system, however work continues to improve the position and has been positively reviewed by commissioners.

Friends and Family Test - 76% would recommend mental health services. This has reduced from 87% in January, in the main as a consequence of the inclusion of Forensic Services (in January a detailed survey was substituted for the friends and family test in Forensics).

Some minor amendments have been made to this dashboard since last month, these relate to:

• % Complaints with Staff Attitude as an Issue – we have amended the wording of this to % of feedback with staff attitude as an issue. We have also amended the threshold to be <20% rather than <25%. This has changed the achieved performance in May and October to red rather than green.

• Complaints closed over 40 days – we have removed this indicator as this can be derived from the existing indicator Complaints closed within 40 days which we will report as a %.

• Complaints closed within 40 days – we have change the objective to quality and experience as this was linked to the wrong objective in previous reports. We have also identified a target of 80%.

Commissioning for Quality and Innovation (CQUIN)

The Trust submitted its quarter 3 returns at the end of January. Validation by all commissioners has not yet been undertaken due to a national delay with the Mental Health Safety thermometer reports - this is expected to be available during March. The final quarter 3 position is expected to be included in next months report.

A financial loss of £119k is anticipated in Q3. Areas of under-performance relate to:

• Mental Health Currencies adherence to red rules in Barnsley and Calderdale.

• Cluster review (clusters 4-17 and cluster 18-21) in Barnsley and Calderdale.

• Medicine omissions - some risk associated with achievement of this for Calderdale, Kirklees and Wakefield.

The Trust forecast out turn for 16/17 based on Q3 forecast performance is 87% achievement. Focus is on improving this position.

For 2017/18 the CQUIN schemes will be part of a national two year scheme and will run until 2018/2019. The scheme is intended to deliver clinical quality improvements and drive transformational change, supporting the ambitions of the Five Year Forward View and directly linking to the NHS Mandate. A number of the indicators work across partner organisations and collaboration will be required. The national CQUIN indicators on improving the health of our staff, and Physical Health for people with Severe Mental Illness are retained from the 2016/17 scheme and new indicators for the Trust will be:

• Proactive and Safe Discharge

• Wound Care

• Preventing ill health by risky behaviours – alcohol and tobacco

• Personalised Care / support planning

• Child and Young Person MH Transition

• Improving services for people with mental health needs who present to A&E

A Trust lead for each of these indicators have been identified, some preliminary discussions have taken place with commissioners and work continues to review the indicators in conjunction with the commissioner and work streams are being established. Progress on this will be monitored via the Trust CQUINS leads group.

0.5% of CQUIN for 17/18 is dependent upon achievement of 16/17 control total and 17/18 STP performance.

Forensic services will continue with the national forensic scheme, this will include 2 indicators, both of which the indicators are a continuation of the 2016/17 scheme:

• Recovery colleges for medium and low secure patients

• Reducing restrictive practices within adult low and medium secure services.

Quality Headlines (& CQUINS performance on a quarterly basis)

Safety First

Summary of Q1, Q2, Q3 and Jan, Feb 17

Summary of Incidents	Q1	Q2	Q3	Jan-17	Feb-17
Green no harm	2148	2039	1931	649	526
Green	978	966	969	316	281
Yellow	292	310	290	99	85
Amber	80	73	66	26	26
Red (should not be compared with SIs)	9	15	23	7	6
Total	3507	3403	3279	1097	924

• 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. Monthly report for Operational Management Group now in place.

No never events reported in February.

Summary of SIs reported in Q1, Q2, Q3 and Jan 17, Feb 17

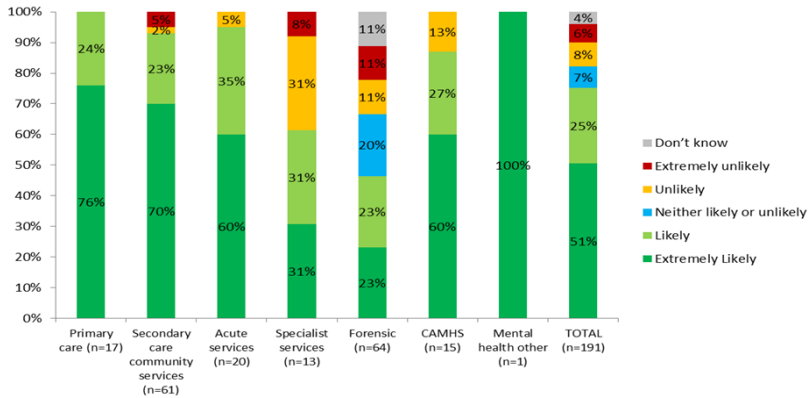
Summary of Serious Incidents	Q1	Q2	Q3	Jan-17	Feb-17
Suicide (incl apparent) - community team care - current episode	2	7	5	0	2
Death - other cause	1	1	3	1	0
Suicide (incl apparent) - community team care - discharged	3	0	1	0	0
Self harm (actual harm) with suicidal intent	1	0	2	0	1
Pressure Ulcer - grade 3	1	1	0	0	2
Information disclosed in error	2	0	0	4	1
Physical violence (contact made) against other by patient	1	0	1	1	0
Slip, trip or fall - patient	1	0	1	0	0
Suicide (incl apparent) - inpatient care - current episode	0	1	1	1	1
Suicide (incl apparent) - inpatient care - discharged	0	0	0	0	1
Fire / Fire alarm related incidents	0	0	1	0	0
Formal patient absent without leave	0	1	0	0	0
Inappropriate Sexual Behaviour (including assault)	0	1	0	0	0
Physical violence (contact made) against patient by patient	0	1	0	0	0
Patient healthcare record issues	0	0	0	0	1
Physical violence (contact made) against staff by patient	1	0	0	1	1
Total	13	13	15	8	10

The DoN and Deputy Chair attended a NHSI seminar on the revised reporting arrangements for mortality reviews which confirmed that the requirements will have resource implication.

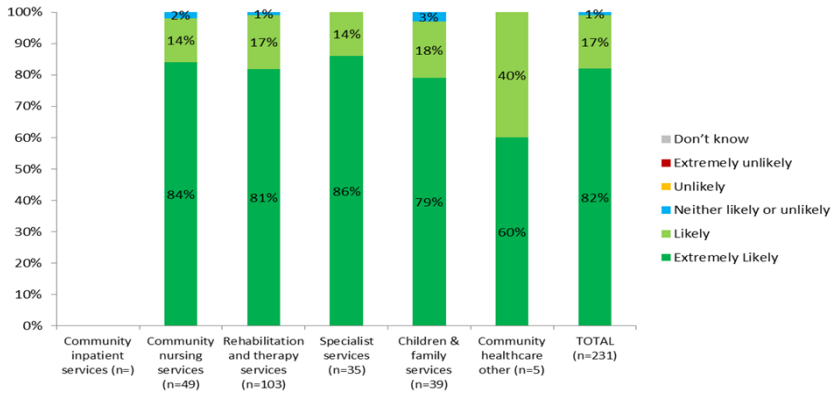
Patient Experience

Friends and family test shows
• Community Services – 99% would recommend community services.
• All service lines achieved 60% or above for patients/carer's stating they were extremely likely to recommend the Trust's services.
• Mental Health Services – 76% would recommend mental health services.
• Significant variance across the services in the numbers extremely likely to recommend the Trust– between 23% (Forensic) and 100% (Mental Health Other)
• Small numbers stating they were extremely unlikely to recommend.
• We have seen an increase in the number recommending CAMHs services from 75% in January to 87% in February.

Mental Health Services



Community Services



Quality Headlines (& CQUINS performance on a quarterly basis)

Safer Staffing

% overall Trust - safer staff fill rates - 115%
% Fill Rate Registered Nurses - 93.4% Day duty, 101.5% Night duty

Average Fill Rate by BDU

Average Fill Rate	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Specialist Services	243%	224%	237%	222%	225%	197%
Barnsley	111%	110%	113%	111%	112%	110%
C & K	109%	114%	121%	111%	117%	108%
Forensic	106%	109%	112%	107%	116%	120%
Wakefield	105%	110%	109%	109%	109%	113%
Grand Total	**111%**	**113%**	**117%**	**112%**	**116%**	**115%**

Barnsley and Wakefield fill rates have remained consistent over the last 3 months, with Calderdale dropping 8% following a rise in January. Forensic fill rate has continued to climb and is now 121% which is reflective of the reported acuity within the MSU in particular. Specialist services has shown a significant drop in fill rates which is due to several things including the absence of a bespoke care package, increased scrutiny and flexibility from the management team in the utilisation of its resources.
No ward fell below a 90% overall fill rate in the period of February 2017 which is an improvement from 1 ward last month and safe levels have been maintained utilising the professional guidance tool.

The number of wards who are achieving 100% and above overall fill rate has remained around 80%, >< 4%, for the last few months. Several areas have maintained the percentage of rates for qualified to 100% and above.

Safer Staffing % Fill Rate Registered Nurses nights = Feb 17 101.5% (4.5% decrease on January)

On Night duty 20 inpatient areas (66%) achieved this, which is an decrease of 5 wards, with 2 areas falling below 80%. These were Ashdale and Elmdale. Ashdale have currently 3 x band 5 vacancies and 1 on secondment reports the ward. Both are less than 6% below our 80% threshold.

Safer Staffing % Fill Rate Registered Nurses days = Feb 17 93.4% (0.4% decrease on January)

In days it remains 8 wards (26.4%) achieving at least 100% qualified fill rate, which is consistent with the previous month. There continues to be high levels of acuity, in particular levels of observation and other clinical acuity, and the resultant need being fulfilled through non-registered staff.

Two wards had a monthly aggregate of less than 80% RN on days fill rate. This was a decrease of 1 ward on the previous month. This was Waterton from the forensic BDU ,which continues to support the service as a whole, and again Enfield Down.

Quality Headlines (& CQUINS performance on a quarterly basis)

CQC Inspection Update

The following shows the Trust's progress to date against the findings from the CQC action plan. This table was last updated in February 2017.

	Feb-17	
	Must (N=33)	Should (n=60)
Blue	27 (82%)	49 (83%)
Green	2 (6%)	6 (11%)
Amber/Green	3 (9%)	1 (2%)
Amber/Red	1 (3%)	1 (2%)
Red	0	1 (2%)

	Jan-17	
	Must (N=33)	Should (n=60)
Blue	27 (82%)	56 (93%)
Green	3 (9%)	2 (3%)
Amber/Green	3 (9%)	0
Amber/Red	0	1 (1.5%)
Red	0	1 (1.5%)

NB-See key in glossary for RAG rating definition

CQC action plan headlines

• Services continue to actively monitor their progress with their action plans.
• The majority of actions have been fully completed.
• Only a few actions have not been fully met which is reflected in the amber/green and amber/red ratings. In some cases this is because the timescales for completion of actions have not yet lapsed e.g. MHA/MCA.
• We now understand that the CQC will not be holding a Quality Summit once the revisit results are published, however we are considering holding a similar style event with partners.

Monitoring of actions against our CQC action plan by The CQC

The CQC have now re-visited all of our core services that required improvement or had a regulatory breach from their previous visit in March 2016. They also carried out our 'well-led review in January 2017.

CQC re-visit reports have now been finalised for the following core services:

• Community services for older people and Long stay and rehabilitation services have received a re-rating status of overall good. There are no requires improvement domains in any of these services.
• Wards for Older People remains rated as good. However the previous CQC Requirement Notice (Regulation breach) in relation to an issue with lines of sight no longer applies and the service is complaint in every domain.
• Re-visit draft reports for Community services for people with Learning Disability and Autism, Forensic service and CAMHS are at the draft stage and we have now returned our factual comments. Subject to any changes to ratings our Forensics and CAMHS services have been re-rated to good whilst the Community LD and Autism remained as 'requires improvement.'
• We have received our reports for the adult inpatient MH wards and our well led review. They are subject to factual accuracy check at present.

CQC findings-risks and mitigating actions:

The following findings will need addressing following our CQC re-visit and progress will be monitored through governance groups and our CQC action plan. Further actions may be required depending on the findings from our Adult Mental Health In-patient Services for WAA and 'well-led' review report.

• Recording of capacity & consent remains inconsistent although we have told CQC about the actions we are taking to address this. There is an ongoing range of MHA/MCA training across a number of venues and staff training figures are improving. CQC identified Gaskell ward as an area of 'excellence' in the recording of capacity assessments and their recording templates are being shared with other teams and services to implement. Audits are also being undertaken to make sure learning and good practice is being implemented within practice.
• Waiting times to initial assessment and treatment for specialist clinics are an issue within our Community LD and Autism service, mainly within Barnsley and Kirklees. Access to treatment in Barnsley CAMHS also remains an issue although CQC did find that progress was being made in managing risks and reducing waiting times.
• Within Community LD services staff were unable to access risk assessment information because they were either stored in different formats, locations or had not been migrated onto the electronic records. Actions are being considered as to how we improve this practice to make sure any risks to service users are fully understood and properly managed.

Other CQC information
• CQC have increased regulatory service provider fees. For NHS Trusts this will mean an increase of annual fees which will be from £115,565 to £332,249 depending on annual turnover.
• The CQC have completed their consultation with providers about 'Next Phase of Regulation' proposals. The new approach will begin in April 2017 and is a more risk based model. Service providers will have an annual 'well-led' review and at least one core service will be inspected. Frequency of inspects is linked to overall ratings and there are a number of changes and additions to the existing Key Lines of Enquiry (KLOE's).

Quality Headlines (& CQUINS performance on a quarterly basis)

Safeguarding Children and Adults Quality Headlines

Prevent:
Data flow to NHS England and the CCG's has received positive comment in the operational actions the Trust has taken in regards to the provision and uptake of training. The Operational Lead for Prevent and the Assistant Director of Nursing and Quality have maintained strong links with the regional NHS England Prevent Co-ordinator. This relationship has ensured that the trust remains knowledgeable about changes in legislation and provides intelligence which can assist in preventing people being drawn into terrorism. The prevent leads for Kirklees and Calderdale recently provided a presentation to the Safeguarding Children Link professional Forum; this demonstrates multi-partnership working and was well received by the attendees.

FGM:
The relationship between safeguarding and the performance management team has ensured that the appropriate systems are in place to capture this data. Consequently the safeguarding team have been able to offer assistance and guidance to practitioners to ensure that the service users receive the appropriate support and intervention. The data also assists with the development of services nationally to support women and their children.

Human Trafficking:
The safeguarding adults team have attended a train the trainer session and Human Trafficking training has been delivered to the safeguarding children link professionals and a community mental health team.

The Safeguarding Adults forum:
This has been opened up to all practitioners and also partner agencies. An external speaker has also presented at the forum.
Following two incidents, a liaison meeting has been established to improve professional relationships, share good practice between SWYPFT and CHFT and ultimately improve outcomes for people who use our services. The meeting is quarterly and involves a number of professionals including, Matron's, Clinical leads for A&E, PGC's, Safeguarding Specialist Adviser and a Medic from IHBTT.

Safeguarding weeks:
The safeguarding team participated in the West Yorkshire safeguarding week in October 2016. Plans are already in progress to further support this in 2017 and also the safeguarding week in Barnsley in July 2017.

Comms:
The safeguarding team have worked closely with the Trust Comms team to ensure that information is provided to practitioners in a timely manner, thus ensuring that practitioners have up to date information and knowledge to assist them in the delivery of care. The team have also contributed to national campaigns and with the support of the comms teams have tweeted information and supported a 'thunderclap'.

Training Figures:
SWPFT remain above the set target of 80% for all levels of safeguarding adult and children training.
Adults – Level 1: 88.74%; Level 2: 89.70%;
Children – Level 1: 91.06%; Level 2: 86.89%; Level 3: 80.60%

Information Governance

- 1 of the 10 breaches incidents was reportable to the ICO as a SIRI.
- Specialist Information Asset Owner training is taking place on March 22nd
- 95.2% training compliance was achieved as at 8th March.

Infection Prevention

- The IPC Annual Plan is being developed and the Annual Programme and Annual Report are on track to deliver the 73 legislative requirement including improvement .
- C.difficile targets have been set – in Barnsley BDU the target is 6 and there is 1 case to date. Zero has been agreed for all other areas of the Trust with the judgement being made in relation instead to "lapses in care"

Outbreaks – 2 influenza A in Barnsley BDU
1. January 2017 - Ward 4 resulting in 9 days closure, Ward 5 resulting in 7 days closure. There were 47 patients affected and 12 confirmed cases
2. February 2017 - Ward 4 resulting in 7 days closure. There were 24 patients affected and 10 confirmed cases.

- Training - figures above target.
- Area for improvement – TAG

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 - Proportion of people with depression/anxiety disorders receiving psychological therapies – data quality issues have now been addressed which may mean local but not national figures will show improvement on refresh; service using all available resources and working practice reviews to optimise performance.
• IAPT - Proportion of people who complete treatment who are moving to recovery - 50% threshold has been achieved for the month of February. There is some risk in maintaining this position for quarter end. Further dips projected for April due to numbers having come through in November / December, before improving in Q2 based on current flow-through.
• Finance - through trust wide action, the number of predicted redundancies (through Health and Wellbeing Services decommissioning) is significantly less than originally forecast - suitable alternative employment has been secured has been found for 5.31wte

Calderdale & Kirklees BDU:

• Significant pressure on acute working age adult inpatient services continues.
• Admission of under 18's to acute wards remains an issue of concern.
• Delayed transfers of care in Calderdale continues to present a challenge although all efforts continue to address the issues.
• Sickness rates above target in 3 of 4 service lines.

Forensics BDU:

• The detailed review of the 25 hours structured activity is continuing. Significant improvements have been noted in February, with still more work to do.
• Mandatory training compliance in Cardio Pulmonary Resuscitation, Mental Capacity Act and clinical risk shows some improvement, but is still slow. Focus on this will be maintained.
• Targeted management actions are in place to monitor bank and agency use and a robust plan to recruit to vacant posts is in place.
• The team are forecast to achieve CQUINs in quarter four which will mean the team have achieved the full CQUIN value for the year.
• The forensic team will support police training from March 2017. Each week two trainee police officers will spend a day with a ward team. We are working with West Yorkshire Police and our service users to agree how we will evaluate the outcomes from this.

Specialist BDU:

CAMHS

• Following release of additional 2016/17 NHSE funding CAMHS waiting time initiatives and improvement trajectories have been agreed with local CCGs. Reduction of vacancy levels will be a key improvement challenge in 2017/18. Following re-procurement processes strengthened pathways for Autism spectrum disorder (ASD) assessment have been agreed in Calderdale and Kirklees. In Kirklees an additional £150k has been available by the CCG for a 2017/18 waiting list initiative.

• Action implemented has improved ethnic coding on patient records and to be reinforced with Calderdale & Kirklees team. Systems in place to ensure ongoing accurate recording and maintenance of performance.

LD

• Service transformation – including a strengthening of operational management and introduction of SPA arrangements – has enabled a sharper focus on access standards. Reduction of vacancy levels will be a key improvement challenge in 2017/18. A new KPI set has been agreed with commissioners – with data flow expected by end Q1.

Wakefield BDU:

• Assessed within 4 Hours (Crisis) Adults of working age – in month performance has been impacted on by vacancies and balance of 12 hour shift patterns potentially affecting capacity at key times. Recruitment underway, referral patterns and shift handover practice being reviewed. A piece of work taking place to review referral priority and interface between Single Point of Access and Intensive Home Based Treatment.

• Treated within 16 weeks of Assessment Older Peoples Services (Psychological Therapies Service) – data being reviewed for month, issues re capacity affected by leave in small team, clinical capacity being released by review of team management responsibilities.

• Early Intervention in Psychosis 2 weeks (NICE approved care package) - Clock Stops and waiting at month end – some data quality issues impacting on current performance. Data is being reviewed. It is anticipated that performance should be achieved. Action plan is in place re data quality and process.

• Intensive Home Based Treatment episodes – continues to remain below threshold, intensity of input per episode being looked at as a more accurate reflection of appropriate performance, practice governance coach leading, work being undertaken with commissioners to this effect.

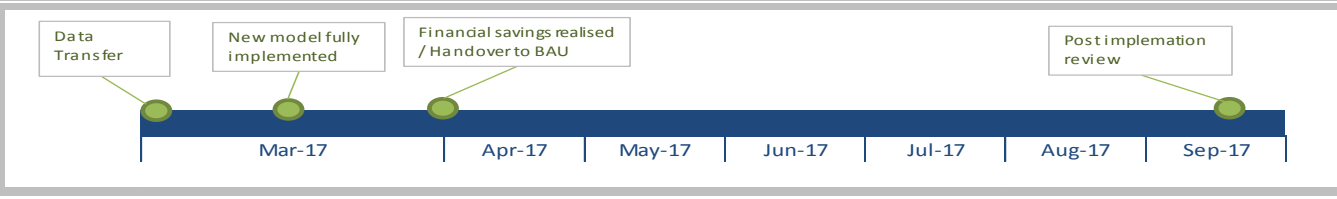
• Sickness continues to be managed robustly and specific work on health and wellbeing underway in community services with HR and Robertson Cooper.

• Mental Health Act and Mental Capacity training - improving trajectory managers prioritising release extra dates being attended close tracking through team and BDU meetings.

This section of the report reports the Trust's progress against the identified transformation projects.

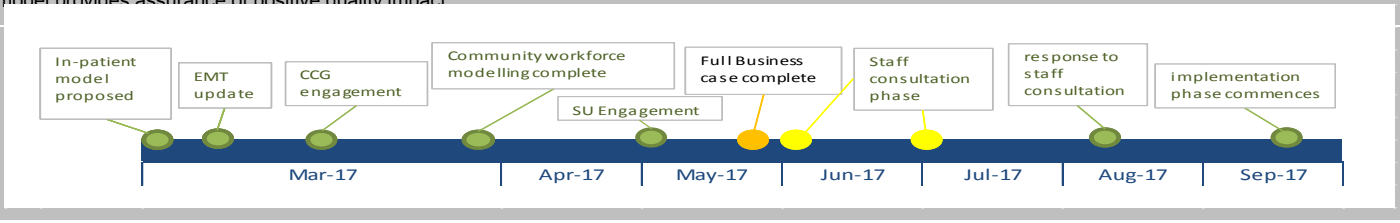
Acute & Community Mental Health Transformation Project

BDUs are currently implementing the 'core and enhanced' community pathways which have been devised through this project. This remains on target and will be completed by end of March 2017. A project closure report will be completed and shared with the transformation board in April. A post implementation review document is also in development and includes the project benefits, when they will be realised and how they will be measured.	Delivery against plan	
The recent risks in relation to RiO and cost impact of moving data in the system have reduced and the mass transfer of data work is planned for this month. Task and finish groups are in place to manage other key risks including the need to manually transfer outpatient appointments and to ensure that mandatory reporting isn't compromised by the transition.	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 in BDU CIP delivery for the year.	Benefits Realisation	
Quality Impact Assessment completed 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	



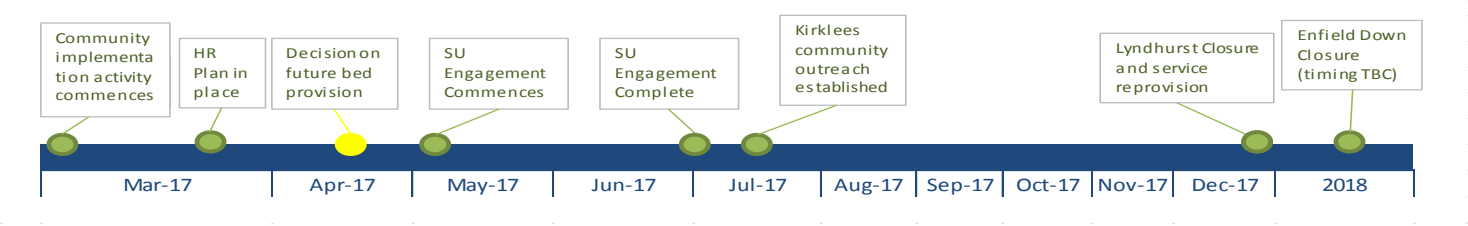
Older Peoples Mental Health Transformation Project

Work on the business case has commenced but completion of full business case has slipped and will be delivered in May 2017. The community workforce modelling is ongoing. The work on future in-patient provision is progressing well and there is now an agreed future bed number and long list of configuration options for consideration. Commissioner engagement has started and Service User engagement is scheduled for early May. A more detailed update for EMT, which will cover progress to date, issues/risks and the scale of the emerging opportunities, took place on 16 March.	Delivery against plan	
Ongoing resourcing is required to enable dedicated clinical leadership and change management resource to deliver the project.	Management of risk	
Benefits are targeted in18/19 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	



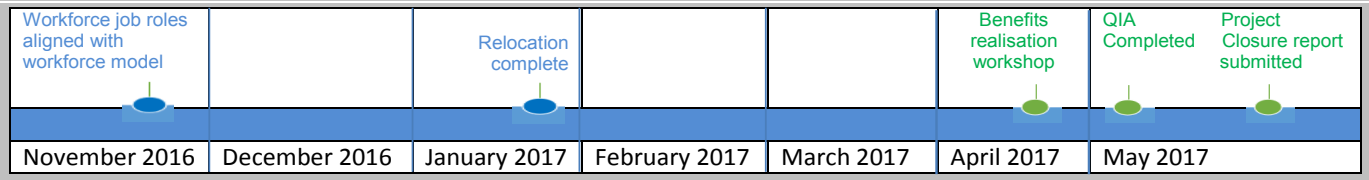
Rehab and Recovery Transformation Project

A community service model is agreed in principle with local CCGs and implemented in Wakefield. Implementation in Calderdale is expected in 2017/2018. In Kirklees a plan is now in place to reduce patient numbers in Enfield Down and establish resource that could support a community service model. More work continues to establish whether there is system demand and viable accommodation for a High Dependency Unit, as well as options for people with long term complex care needs currently in Enfield Down.	Delivery against plan	
Whilst there are challenges work continues to develop the capacity required in Kirklees to establish new ways of working. The commissioner has sated it would like provision for 8 high dependency rehab beds.	Management of risk	
Financial benefits have already been realised in Wakefield and further financial savings are anticipated in Calderdale during 2017/18. The extent to which this contributes to providers CIP requirement is subject to negotiation. All parties are keen to reinvest savings in mental health where possible.	Benefits Realisation	
The project undertook a Quality Impact Assessment in design phase, and a new QIA plus further engagement is likely to be required following decisions on how to progress activity in Kirklees.	Quality impact	



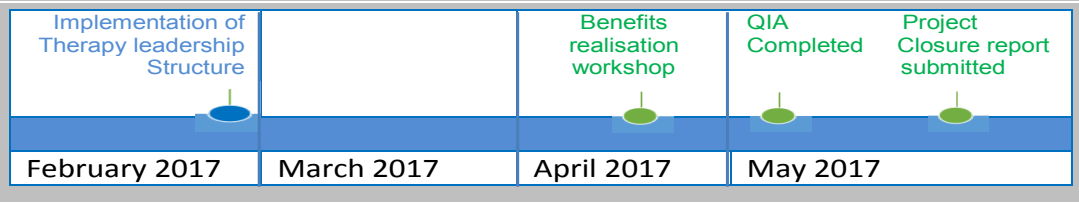
Barnsley Administrative Services Review

Work has commenced on completing the project closure report and is on track for submission by end of March 2017. Pooling secretarial resource and relocating staff to Kendray is taking place. The project is on schedule to move to 'business as usual' to support community services in April 2017.	Delivery against plan	
	Management of risk	
Standardised job descriptions and person specifications are complete; remodelling the inpatient and reception admin functions is complete; a single management structure is in place; key functions such as cashiering have been consolidated onto one site; Savings of £65k have been realised as a result of the reconfiguration of admin services; details of savings on cashiering and franking services are currently being worked through. A benefits realisation workshop is to be scheduled for April to support the internal benefits tracking of the service transformation as the service progresses into business as usual. These benefits will be summarised in the project closure report.	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. Now the project is almost completed, we will revisit the QIA section and bring it up to date.	Quality impact	



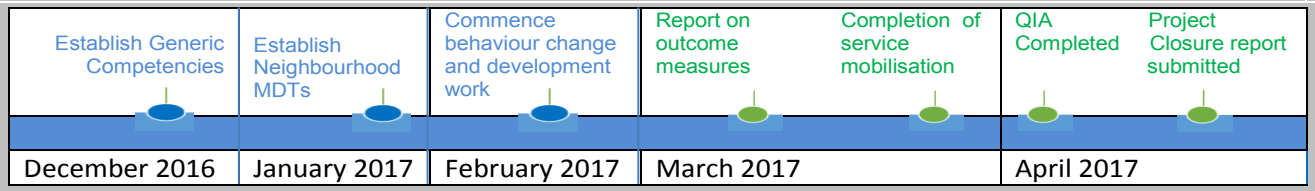
Barnsley Therapy Services Review

Work has commenced on completing a project closure report. Operational work continues on implementation of a therapy leadership structure and roll out of system one across all therapy services. The project is on schedule to move to 'business as usual' in May 2017.	Delivery against plan	
	Management of risk	
The purpose of phase one of this project was to bring together therapy administration to create a therapy single point of access and bring together appropriate clinical therapies to efficiently utilise skills and knowledge across services and provide most effective quality care to patients. Phase one was completed successfully. Any savings made through Therapy administrative services reconfiguration have been counted as part of the Barnsley Administrative Services Review. Where it has been possible to co-locate services ,significant improvements of service delivery have been made such as reduced waiting times and reduced duplication of referrals and visits. Whilst these benefits will be summarised in the project closure report, a benefits realisation workshop is to be scheduled for April to support the internal benefits tracking of the service transformation.	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. The QIA will be revisited and updated to reflect the changes undertaken in service.	Quality impact	



Barnsley Community Nursing Transformation

The reconfiguration of the workforce and supportive training and development, including systems leader sessions and agile working rollout, are currently being mobilised across the six neighbourhoods. Work has commenced, in conjunction with CCG, to plan a celebrating success event scheduled for the summer.	Delivery against plan	
There are key elements of service to mobilise by end of March 2017, which require significant collaboration between partner agencies including keyworker assigning, peer review processes and approval of core offer to care homes. Engagement is good and associated risks are being managed.	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, care navigation teams, and establish integrated teams in localities which align with primary and social care. In 2016, the delivery direction of the project changed to reflect local commissioner intentions and the issue of a new service specification. Outcome measures have been agreed with BCCG and monthly reports on attainment are provided to BCCG.	Benefits Realisation	
This project had a QIA conducted in the business case phase – it indicated positive impact on quality. This is being repeated and updated to reflect the changes in services. Patient and carer surveys have been undertaken and submitted to BCCG.	Quality impact	



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

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. Other metrics score as 1 or 2.
2	Normalised Surplus	£1m	£2.4m	February 2017 financial performance excluding STF is a surplus of £0.5m. The cumulative position excluding STF is a surplus of £0.3m, £1.0m surplus including achieved Q1 and Q2 STF. Out of Area beds and agency staff continue to be pressures although both have reduced in month. £0.5m insurance monies have been received in month.
3	Agency Cap	£9m	£9.8m	Agency expenditure in February 2017 is £0.7m which is similar to January 2017. The year to date position is 89% over the NHSI cap. Actions continue at an individual post level and February has seen reductions in the number of medical and admin agency posts.
4	Cash	£28.3m	£25.5m	The Trust cash position is £28.3m which is £3m higher than plan at month 11. This arises mainly from reduced expenditure on the capital programme (as noted below) and additional cash receipts for disposal of Trust assets.
5	Capital	£8.6m	£11m	Capital expenditure is behind plan at February by £2.4m excluding VAT reclaims. Forecast expenditure are reviewed at a detailed scheme level. As such expenditure of £11.0m reflects current expectations.
6	Delivery of CIP	£8.2m	£9m	Year to date CIP delivery is £0.9m behind plan. Overall the forecast position is £1.1m below plan. This position also includes £1.5 delivered non-recurrently for which recurrent solutions need to be found.
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

The new Mental Health Investment Standard requires CCGs to uplift Mental Health spending in line with growth allocations. Following the 23rd December planning and contracting round submissions NHS E have subsequently sought further assurance from CCGs and their main NHS mental health provider, confirming that CCG mental health finance returns are an accurate reflection of health economy investment in mental health and ensure a joint commitment to meeting national expectations set out in the Five Year Forward View. Triangulation with NHS mental health providers has been sought to demonstrate that this investment is flowing through contracts into services. Joint assurance letters with CCGs have been produced. The CCGs and Trust acknowledge that the assurances provided are preliminary and subject to further work. Work will now commence with each CCG to identify how the points raised in the letter can be implemented in practice.

CQUIN

A key priority remains the drive to secure maximum CQUIN benefits and income and there continues to be invested Trust wide scrutiny and support in order to assist with CQUIN delivery. Work continues internally and with commissioners to ensure clarity on definitions and required data sets in relation to 17/18 CQUINs and plans are being made in preparation of systems/work for implementation.

Contracting Issues – Barnsley

The main contracting focus relates to the agreement of detail in relation to the Alliance Contract which from April 1st will cover Rightcare Barnsley and Neighbourhood Nursing Services. A commercial work stream has now been established as part of the governance arrangements for the creation of Accountable Care Organisation in Barnsley. The work stream will focus on the development of new contracting models to support accountable care including implementing risk and reward in contracts. The intention is that contracts are based on programme budgeting and monitored through use of outcomes frameworks. Joint assurance between the CCG and SWYPFT was submitted to NHSE relating to funding growth in line with the Mental Health Investment Standard and FYFV priorities. Both acknowledge that the assurances are preliminary and subject to further work.

Contracting Issues – Calderdale

Joint assurance between the CCG and SWYPFT is being produced for NHSE relating to funding growth in line with the Mental Health Investment Standard and FYFV priorities. Both parties acknowledge that the assurances are preliminary and subject to further work. Key priorities for in year resolution remain the commissioning of a sustainable 24/7 crisis resolution service and pressures within Psychology services. Discussions continue regarding the commissioning of sustainable specialist ASD Services for Adults.

Contracting Issues – Kirklees

Joint assurance between the CCG and SWYPFT was submitted to NHS E relating to funding growth in line with the Mental Health Investment Standard and FYFV priorities. Both acknowledge that the assurances are preliminary and subject to further work. The current priority areas of work related to Kirklees CCGs contracts include IAPT services and expansion to Long Term Conditions, and the reconfiguration of adult mental health rehabilitation services. Discussions continue regarding the commissioning of sustainable specialist ASD Services for Adults.

Contracting Issues- Wakefield

Joint assurance between the CCG and SWYPFT was submitted to NHSE relating to funding growth in line with the Mental Health Investment Standard and FYFV priorities. Both acknowledge that the assurances are preliminary and subject to further work. The 17/18 contract will include the commissioning of an Adult ASD assessment, diagnostics and treatment service commencing from 1 April 2017. The 2016/17 QIPP position has been closed. A virtual MCP model will be mobilised in April 2017, and an alliance contract arrangement with other system partners will be entered into.

Contracting

Contracting Issues - Forensics

The key area of monitoring relates to the occupancy target. The sub-contract for advocacy services with an external supplier has been extended to July. A formal procurement for re-tender of the advocacy services is commencing.

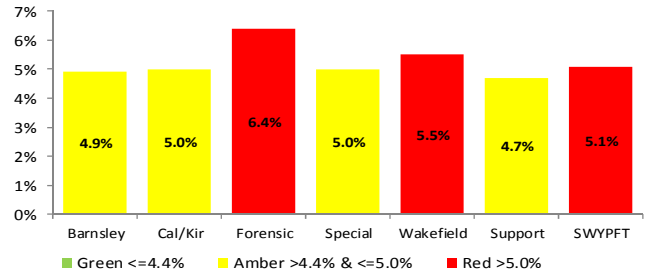
Contracting Issues – Other

The contract variation covering the extension of Rotherham/Doncaster smoke free services for 17/18 has been signed. The contract extension for Sheffield smoke free services is awaited. Sheffield LA has confirmed that the re-procurement for smoke free services will commence in April 2017. Work continues to manage the exit from the Kirklees Smoke free services contract which ends on 31st March 2017. In Calderdale work is ongoing with commissioners to secure a smooth continuation of CAMHS services from April 2017. In Kirklees work is ongoing with Locala to secure a smooth continuation of CAMHS within a wider 0-19 contract which is due to commence in April 2017.

Workforce

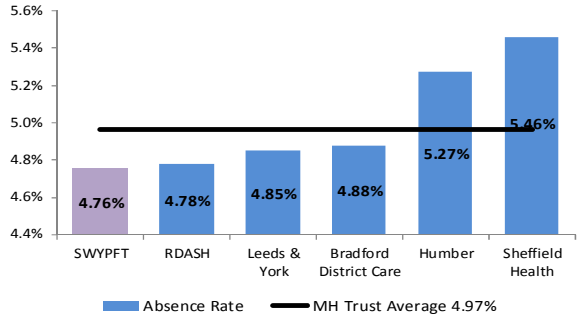
Human Resources Performance Dashboard - February 2017

Sickness Absence



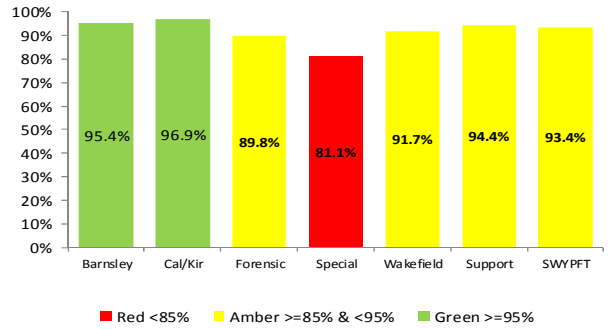
	Barn	Cal/Kir	Fore	Spec	Wake	Supp	SWYPFT
Rate	5.8%	5.1%	6.8%	6.4%	7.7%	5.4%	5.9%
Trend	↓	↔	↓	↔	↑	↑	↔

The Trust YTD absence levels in February 2017 (chart above) were above the 4.4% target at 5.1%.



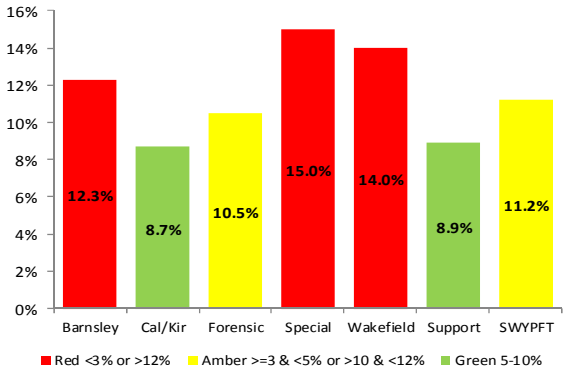
The above chart shows the YTD absence levels in MH/LD Trusts in our region for 6 months from April to September 2016.
During this time the Trust's absence rate was 4.76% which is below the regional average of 4.97%.

Appraisals - All Staff

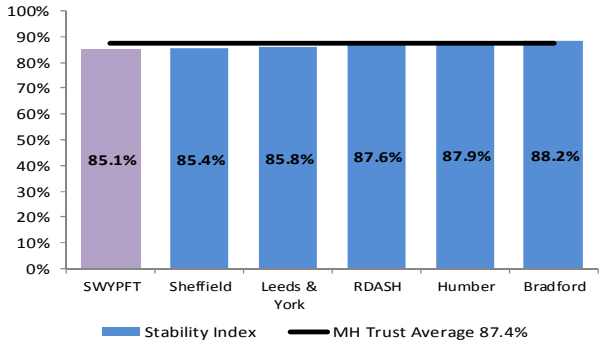


The above chart shows the appraisal rates for all staff for the Trust to the end of February 2017. The figures are calculated over the financial year from April 2016 to March 2017. The total percentages have decreased slightly since the inclusion of Band 1-5 but all areas continue to show improvement over the course of the financial year.

Turnover and Stability Rate Benchmark

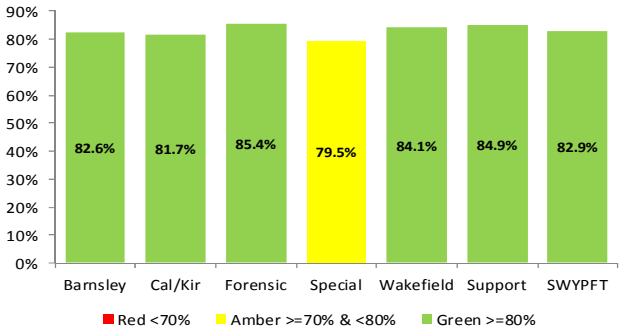


This chart shows the YTD turnover levels up to the end of February 2017.
All staff TUPE'd outside the Trust have been excluded from from the above data. Only 50% of all leavers have left voluntary , (60% last year) the other 50% is due to retirements, redundancy, etc.



This chart shows stability levels in MH Trusts in the region for the 12 months ending in November 2016. The stability rate shows the percentage of staff employed with over a year's service. In this period, the Trust's rate has been affected by the staff TUPE'd out e.g., the 0-19 service in Barnsley.

Fire Training Attendance



The chart shows the YTD fire lecture figures to the end of Feb 2017. The Trust continues to achieve its 80% target for fire lecture training although Specialist Services have dropped to just below the target this month.

Workforce - Performance Wall

Trust Performance Wall

Month	Objective	CQC Domain	Owner	Threshold	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.7%	4.5%	4.6%	4.7%	4.7%	4.7%	4.8%	4.9%	5.0%	5.1%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.7%	4.4%	4.8%	5.0%	4.7%	4.6%	5.3%	5.8%	6.2%	5.90%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	20.1%	43.1%	56.7%	71.0%	81.4%	84.8%	89.8%	93.2%	93.7%	94.4%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	6.3%	14.1%	26.8%	44.3%	68.5%	76.8%	84.9%	89.0%	91.4%	92.8%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	82.6%	81.7%	80.8%	81.0%	82.4%	80.0%	78.8%	78.4%	77.6%	77.2%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80% by 31/3/17			62.0%	60.6%	63.2%	65.0%	66.9%	69.7%	72.8%	73.8%
Clinical Risk	Quality & Experience	Well Led	AD	>=80% by 31/3/17			28.2%	39.0%	41.0%	39.9%	45.1%	53.5%	55.3%	60.4%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.0%	91.5%	91.9%	91.7%	90.9%	90.3%	89.4%	90.1%	89.0%	89.4%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.2%	82.8%	84.5%	85.1%	84.6%	83.7%	82.9%	85.5%	84.0%	82.9%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.1%	80.0%	80.8%	82.2%	81.8%	82.6%	82.9%	83.9%	82.9%	82.6%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.4%	84.5%	84.8%	83.4%	82.5%	81.3%	81.9%	83.8%	83.6%	83.6%
Information Governance	Resources	Well Led	AD	>=95%	90.0%	89.9%	90.2%	89.2%	88.2%	86.5%	85.9%	86.5%	91.9%	95.2%
Moving and Handling	Resources	Well Led	AD	>=80%	84.4%	82.2%	82.2%	79.4%	78.2%	77.0%	78.1%	78.8%	80.5%	81.9%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80% by 31/3/17							12.9%	46.0%	48.2%	53.1%
Mental Health Act	Quality & Experience	Well Led	AD	>=80% by 31/3/17							11.0%	20.9%	23.2%	30.5%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.0%	90.0%	90.1%	89.7%	89.2%	89.0%	88.6%	89.5%	89.7%	89.4%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	87.1%	88.0%	88.3%	88.2%	88.0%	86.7%	87.0%	87.8%	87.6%	87.0%
Sainsbury's clinical risk assessment tool	Health & Wellbeing	Well Led	AD	>=80%			97.1%	96.9%	96.6%	93.2%	93.8%	94.8%	95.1%	94.7%
Bank Cost	Resources	Well Led	AD	-	£370k	£434k	£434k	£512k	£605k	£486k	£458k	£477k	£505k	£493k
Agency Cost	Resources	Effective	AD	-	£842k	£925k	£791k	£989k	£833k	£833k	£753k	£885k	£662k	£729k
Overtime Costs	Resources	Effective	AD	-	£33k	£35k	£23k	£17k	£9k	£16k	£14k	£26k	£19k	£15k
Additional Hours Costs	Resources	Effective	AD	-	£60k	£68k	£78k	£52k	£48k	£40k	£41k	£47k	£41k	£48k
Sickness Cost (Monthly)	Resources	Effective	AD	-	£469k	£456k	£481k	£504k	£501k	£462k	£457k	£513k	£581k	£536k
Business Miles	Resources	Effective	AD	-	321k	267k	286k	300k	273k	328k	330k	316k	284k	287k

Workforce - Performance Wall cont…

Notes:

Sickness

• Year to date absence increased slightly to 5.1%. Sickness generally increases across December to February, however, this year the rise has been higher than last year. The two main identified reasons for absence are stress/anxiety and musculoskeletal/back. In Calderdale and Kirklees, Wakefield, Specialist Services and Support Services the highest single reason for absence is stress/anxiety and in Barnsley and Forensic it's musculoskeletal/back. A pilot in Forensic and Facilities on staff wellbeing and sickness absence management, which will focus on early referral to Occupational Health, wellbeing interviews and compliance with policy, will commence at the beginning of April. Whilst the Trust overall target will remain at 4.4% individual stretch targets for BDUs and Support Services will be introduced for 17/18.
• All areas except Specialist services have seen a decrease in sickness during February. Specialist service monthly sickness absence rate increased from 5.8% in January to 6.4% in February.
• The year to date position for all areas remains above the 4.4% threshold with Forensic (6.4%) and Wakefield (5.5%) being the areas with highest reported levels of sickness absence.
• Due to the continued increased level of sickness absence during February, the position remains across the Trust that no services are currently achieving tolerance for the year to date position.

Mandatory Training

• The Trust is achieving above threshold for all areas with the exception of Aggression Management (77.6%). This is an improvement on last month's position, where Information Governance was also under threshold – this has now reached 95.2% which is above the 95% threshold.
• Continued focus being placed on IG across the trust given recent ICO reportable incidents.
• In March 2016, a review of MCA and MHA training reported to EMT revealed that 47% of staff within SWYPT had received training in the previous three years. Since March 2016, MCA/MHA training has been made mandatory and we have conducted a detailed training needs analysis around MCA/MHA training to ensure the mandatory training provided matches the competencies and needs of the staff. We have developed new, up-to-date evidence-based training and learning resources on the MHA and MCA and we are currently running extensive training programmes for all staff across the Trust. The Mental Health Act training figure is the overall figure for staff that have completed the MHA component of training that are required to i.e. All Clinical Staff working in MH and LD services. The Mental Capacity Act/DoLs training figure is for all staff in the workforce both clinical and non-clinical that have completed training, as all staff are required to complete some level of training. Although a challenge to achieve across the whole Trust, our trajectory for mandatory MCA/MHA training compliance is 80% by end of March 2017. We are continuing to work on mapping and accrediting previous training and learning to the current mandatory training performance wall, although this might not be fully represented until March 2017.
MHA-MCA training figures gradually improving overall and 51% of inpatient registered staff received the MCA-MHA training by end of February 2017.
• Cardiopulmonary resuscitation training and clinical risk continue on an upward trajectory
• Appraisal figures are just below the higher target level set in 16/17 and the EMT expectation is the targets will be achieved in 17/18. The NHS Staff Survey puts the Trust above average for % of appraisals completed in the last 12 months at 93%, with the best rate for our peer group being 96%. A new streamlined Value Based Appraisal will be piloted in 17/18 with a new system in place for the start of 18/19.

Publication Summary

The following section of the report identifies publications that may be of interest to the Trust and it's members.

National Institute for Health and Care Excellence (NICE)

Care of dying adults in the last days of life

This guidance calls for health care professionals to ask adults in the final days of life about their religious or spiritual beliefs. In response to estimates that three out of four deaths are anticipated by medical staff, it provides guidance to help health care professionals identify patients who are nearing death in order to allow the patient and those close to them prepare accordingly.
Click here for link to guidance

The following section of the report identifies publications that may be of interest to the Trust and it's members.

Provisional monthly hospital episode statistics for admitted patient care, outpatients and A&E data, April 2016 - December 2016

Mixed-sex accommodation data, January 2017

Direct access audiology referral to treatment data, December 2016

NHS Improvement provider bulletin, 15 February 2017

Quarterly performance of the provider sector as at 31 December 2016 (NHSI)

Seasonal flu vaccine uptake in health care workers, September 2016 to January 2017

Improving access to psychological therapies report, November 2016 final, December 2016 primary and most recent quarterly data (quarter 2, 2016/17)

Improving access to psychological therapies report, November 2016 final, December 2016 primary and most recent quarterly data (quarter 2, 2016/17)

Mental health services monthly statistics: final November, provisional December 2016

NHS sickness absence rates, October 2016

NHS workforce statistics - November 2016, provisional statistics

NHS provider bulletin: 22 February 2017

Seasonal flu vaccine uptake in children of primary school age: 1 September 2016 to 31 January 2017

NHS inpatient and outpatient events, quarter ending 31 December 2016

Diagnostic imaging dataset, October 2015 - October 2016, provisional monthly release

Department of Health workforce information, January 2017

Learning disability services monthly statistics - England commissioner census (assuring transformation), January 2017, experimental statistics

Five year forward view for mental health: one year on (NHS England)

NHS Improvement provider bulletin, 1 March 2017

Publication Summary cont...

Out of area placements in mental health services, January 2017

NHS Improvement update, February 2017

NHS safety thermometer report - February 2016 to February 2017

Early intervention in psychosis access and waiting time experimental statistics, January 2017

Diagnostics waiting times and activity, January 2017

NHS provider bulletin: 8 March 2017

Combined performance summary, January 2017

Children and young people's health services monthly statistics, England - November 2016, experimental statistics

South West Yorkshire Partnership NHS
NHS Foundation Trust

Finance Report

Month 11 (2016/2017)

Appendix 1

www.southwestyorkshire.nhs.uk

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. Other metrics score as 1 or 2.
2	Normalised Surplus	£1m	£2.4m	February 2017 financial performance excluding STF is a surplus of £0.5m. The cumulative position excluding STF is a surplus of £0.3m, £1.0m surplus including achieved Q1 and Q2 STF. Out of Area beds and agency staff continue to be pressures although both have reduced in month. £0.5m insurance monies have been received in month.
3	Agency Cap	£9m	£9.8m	Agency expenditure in February 2017 is £0.7m which is similar to January 2017. The year to date position is 89% over the NHSI cap. Actions continue at an individual post level and February has seen reductions in the number of medical and admin agency posts.
4	Cash	£28.3m	£25.5m	The Trust cash position is £28.3m which is £3m higher than plan at month 11. This arises mainly from reduced expenditure on the capital programme (as noted below) and additional cash receipts for disposal of Trust assets.
5	Capital	£8.6m	£11m	Capital expenditure is behind plan at February by £2.4m excluding VAT reclaims. Forecast expenditure are reviewed at a detailed scheme level. As such expenditure of £11.0m reflects current expectations.
6	Delivery of CIP	£8.2m	£9m	Year to date CIP delivery is £0.9m behind plan. Overall the forecast position is £1.1m below plan. This position also includes £1.5 delivered non-recurrently for which recurrent solutions need to be found.
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

1.1 NHS Improvement Risk Rating - Use of Resources

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 based 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.

				Actual Performance		Plan - Month 11	
	Financial Criteria	Weight	Metric	Score	Risk Rating	Score	Risk Rating
Continuity of Services	Balance Sheet Sustainability	20%	Capital Service Capacity	4.0	1	3.5	1
	Liquidity	20%	Liquidity (Days)	16.8	1	8.0	1
Financial Efficiency	Underlying Performance	20%	I & E Margin	0.5%	2	0.9%	2
	Variance from Plan	20%	Variance in I & E Margin as a % of income	-0.5%	2	-0.4%	2
Agency Cap	Variance from Plan	20%	Agency Margin	89%	4	#N/A	#N/A
	Weighted Average - Financial Sustainability Risk Rating				3		2

Impact

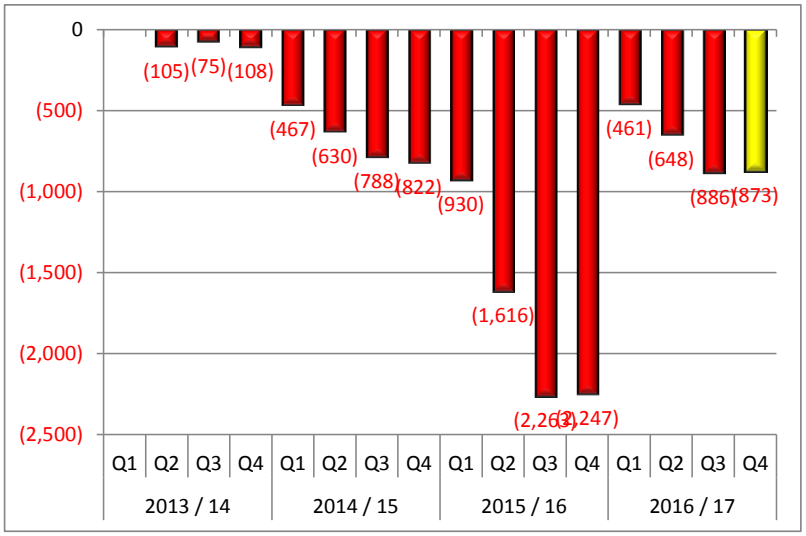
The impact of the breach of the agency cap by more than 50% means that this metric scores 4. As a result any trust scoring 4 on a particular metric can only score a maximum of 3 overall.

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.

1.2 NHS Improvement Benchmarking

YTD surplus / deficit for FT and Trust sector combined (£m)



The source information is no longer available in order to produce previous benchmarking information in the same format. (Governance and finance risk ratings) As such this revised format utilises information readily available from NHS Improvement, NHS Providers and other sources to summarise national financial performance.

The graph on the left shows the trend of increased deficits sector wide, as per NHS Providers at Quarter 3 2016 / 2017.

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

* Financial performance includes release of Sustainability and Transformation funding, £1.8 billion in total for 2016 / 2017. (£994m allocated by Q3)
* Deficit by the end of Q3 is £886m (£202m lower than plan). 135 providers reporting deficit (153 at Q1, 142 at Q2)
* Current forecast deficit is £873m (£293m below plan) with 121 providers forecasting a year end deficit.
* Agency spend £2.2 billion. League tables published alongside NHSI quarterly performance report. Overall agency costs exceed plan by 19%. More than two thirds of providers have reduced their agency costs since November 2015.
* CIP - £229m short of plan (£92m at Q1)
* Capital expenditure was £1.8bn at month 9, £1bn below plan. Forecast spend is £2.98bn

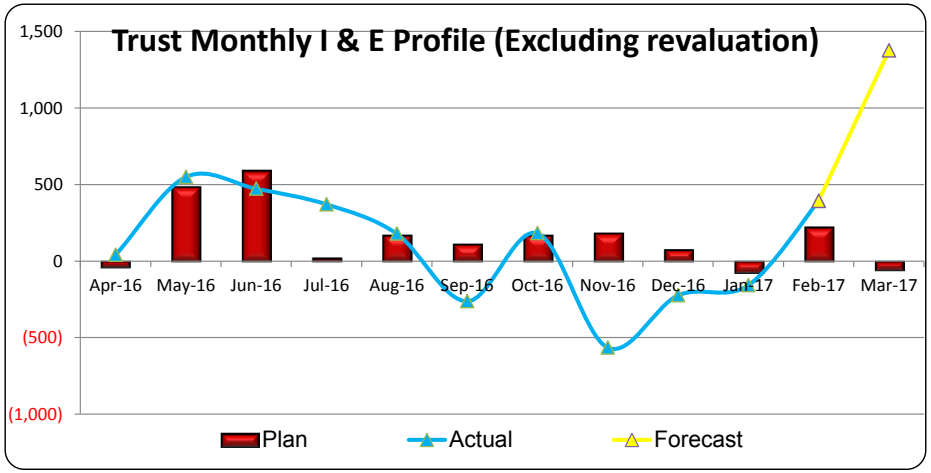
Actions being taken by NHS Improvement include:

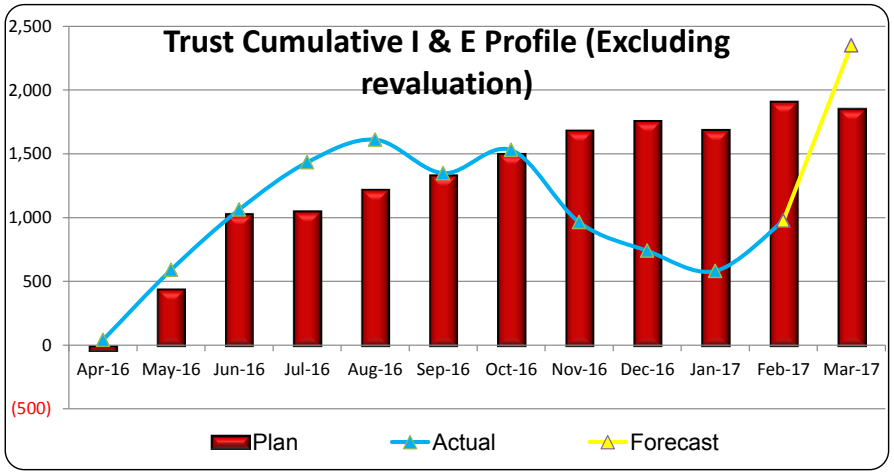
* Extending the financial special measures programme - third wave is 12 Trusts
* New rules to ensure continued focus on agency spending including revised medical agency caps
* Support for providers to reduce pay bill growth

Overall the challenge of delivering the financial plan cannot be underestimated given the operating environment. 66% of Trusts predicted they could only meet 16/17 challenges as a result of one off savings.

2.0 Income & Expenditure Position 2016 / 2017

Budget Staff in Post	Actual Staff in Post	Variance		This Month Budget	This Month Actual	This Month Variance	Description	Year to Date Budget	Year to Date Actual	Year to Date Variance	Annual Budget	Forecast Outturn	Forecast Variance
WTE	**WTE**	**WTE**	**%**	**£k**	**£k**	**£k**		**£k**	**£k**	**£k**	**£k**	**£k**	**£k**
				17,643	17,533	(110)	Clinical Revenue	194,930	194,307	(624)	212,354	212,429	75
				17,643	**17,533**	**(110)**	**Total Clinical Revenue**	**194,930**	**194,307**	**(624)**	**212,354**	**212,429**	**75**
				1,206	1,283	77	Other Operating Revenue	14,193	13,999	(193)	15,385	15,211	(175)
				18,849	**18,816**	**(33)**	**Total Revenue**	**209,123**	**208,306**	**(817)**	**227,739**	**227,640**	**(99)**
4,341	4,062	(280)	6.4%	(14,131)	(14,081)	50	Pay Costs	(159,178)	(157,237)	1,940	(173,396)	(171,634)	1,762
				(3,584)	(3,809)	(225)	Non Pay Costs	(40,762)	(42,355)	(1,593)	(44,222)	(46,246)	(2,025)
				(67)	199	266	Provisions	2,111	1,663	(448)	1,965	2,596	631
4,341	**4,062**	**(280)**	**6.4%**	**(17,782)**	**(17,691)**	**91**	**Total Operating Expenses**	**(197,828)**	**(197,929)**	**(101)**	**(215,652)**	**(215,284)**	**368**
4,341	**4,062**	**(280)**	**6.4%**	**1,067**	**1,125**	**58**	**EBITDA**	**11,295**	**10,377**	**(918)**	**12,087**	**12,356**	**269**
				(596)	(479)	117	Depreciation	(6,636)	(6,639)	(3)	(7,233)	(6,990)	243
				(257)	(257)	0	PDC Paid	(2,823)	(2,823)	0	(3,080)	(3,080)	(0)
				6	3	(3)	Interest Received	69	60	(9)	75	63	(12)
4,341	**4,062**	**(280)**	**6.4%**	**220**	**393**	**173**	**Normalised Surplus / (Deficit)**	**1,904**	**974**	**(930)**	**1,850**	**2,350**	**500**
				0	87	87	Revaluation of Assets	0	(4,102)	(4,102)	0	(4,102)	(4,102)
4,341	**4,062**	**(280)**	**6.4%**	**220**	**480**	**260**	**Surplus / (Deficit)**	**1,904**	**(3,128)**	**(5,032)**	**1,850**	**(1,752)**	**(3,602)**





Note that M12 forecast position includes £675k of STF income and an additional £250k relating to STF incentive schemes.

Income & Expenditure Position 2016 / 2017

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

The Trust year to date and forecast finance positions including and excluding STF funding are highlighted below. This excludes exceptional items such as the revaluation of Trust Estate. As a result of the unfavourable performance in the third quarter and month 10 the STF for this period has not been achieved (£0.56m) and this is reflected in our position. It remains possible to receive these monies if the full year control total plan is achieved. The forecast position is £0.25m ahead of plan as a result of improved performance in Quarter 4, a degree of risk remains attached to this achievement.

	Year to Date			Forecast		
	Plan	Actual	Variance	Plan	Actual	Variance
	£k	£k	£k	£k	£k	£k
Surplus (Excluding STF)	667	299	(368)	500	750	250
STF	1,238	675	(563)	1,350	1,600	250
Surplus - Total	**1,904**	**974**	**(930)**	**1,850**	**2,350**	**500**

Two key components need to be achieved in order to receive STF monies. Referral to Treatment STF can only be received if the financial performance criteria has been met. This is currently ahead of target and therefore will be secured alongside the achievement of the financial performance metric.

Financial Performance	1,083	591	(492)	1,181	1,431	250
Referral to Treatment	155	84	(70)	169	169	0
STF - Total	**1,238**	**675**	**(563)**	**1,350**	**1,600**	**250**

Month 11

The normalised year to date position is a surplus of £974k including the secured Q1 and Q2 STF funding. This is £0.9m less than planned and the key headlines are below:

In month there have been favourable movements in the financial position resulting in a normalised surplus position for February of £393k. In terms of variance to plan (£173k) the key headlines behind this are:

	£k	
Income	(33)	Includes £113k STF shortfall and £55k shortfall in CQUIN. This is partly offset by additional cost per case income for increased activity.
Pay	721	Agency staff continue to be employed by the Trust to meet clinical and service requirements. Actions continue to ensure that the clinical and financial consequences are minimised. These include ongoing recruitment, expansion of the peripatetic staffing model.
	(671)	Offset by underspends in pay arising from vacancies
Non Pay	(225)	Underspends on non pay greater than expenditure on out of area beds. Underspends are mainly on non clinical areas such as travel and office supplies.
	500	Receipt of interim insurance payment to offset additional costs incurred and already within the financial position.
	(234)	Provisions, and budgets held centrally, have been released in order to achieve this position. This includes not spending Trust contingencies.
	115	Reduced capital charges following the impairment of a Trust asset as a result of the fire in 2016.
	173	

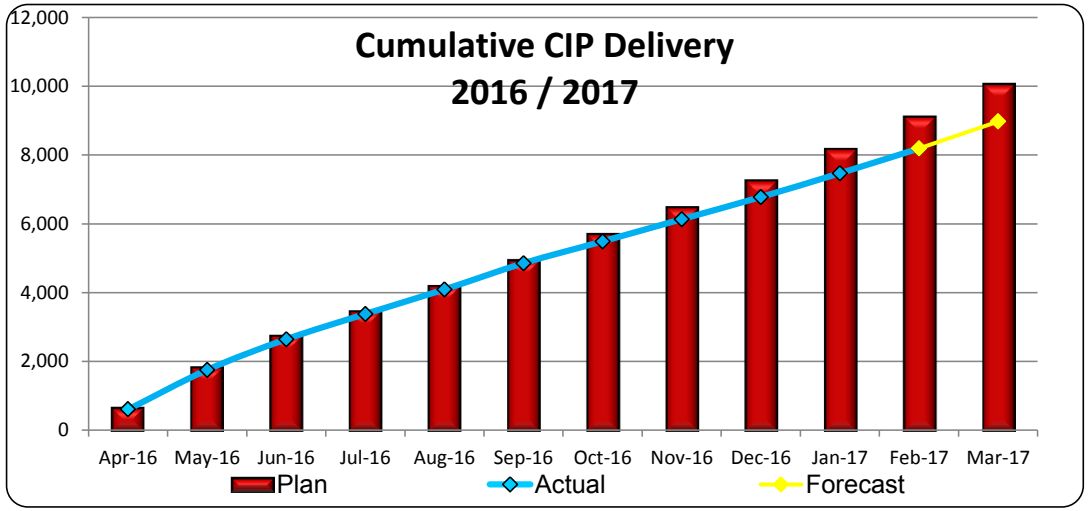
Forecast

The full year pre STF surplus forecast has improved to £0.75m but there remains some risk attached with its delivery. These risks, and also any opportunities, continue to be assessed to ensure that the plan is delivered.

If the financial position is not back in line with plan this risks achievement of the STF funding and cash. This would total £675k for Quarter 3 and 4. The Q3 STF has not been achieved but can be recovered if the full year control total is delivered. Additional STF incentive funding is available for acheiving an out-turn position higher than the Trust control total.

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	7,946	8,837
Target - Non Recurrent	9	509	259	49	49	49	49	49	49	49	49	49	1,173	1,223
Target - Monitor Submission	670	1,172	922	715	729	744	766	772	777	912	940	940	9,119	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	9,119	10,059
Delivery as planned	452	1,446	2,147	2,686	3,232	3,826	4,338	4,859	5,379	5,947	6,543	7,201	6,543	7,201
Mitigations - Recurrent	0	6	9	14	18	22	26	30	34	38	42	46	42	46
Mitigations - Non Recurrent	146	299	485	678	841	1,005	1,125	1,245	1,365	1,485	1,606	1,726	1,606	1,726
Total Delivery	**598**	**1,751**	**2,641**	**3,377**	**4,091**	**4,853**	**5,489**	**6,134**	**6,779**	**7,471**	**8,191**	**8,973**	**8,191**	**8,973**
Shortfall / Unidentified	72	92	123	101	116	99	229	356	488	708	928	1,086	928	1,086



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.

The forecast shortfall is £1.1m. The majority of schemes are rated as green (and delivering), although £1.6m is non recurrent for the year to date, with notable exceptions being:

Procurement / Non pay savings which are delayed compared to original milestones. The main financial impact relates to savings from medical and nursing agency providers (fye - £750k).

Planned savings relating to drugs costs have not come to fruition during the year.

3.0 Balance Sheet 2016 / 2017

	2015 / 2016 £k	Plan (YTD) £k	Actual (YTD) £k	Note
Non-Current (Fixed) Assets	114,134	120,434	109,852	1
Current Assets				
Inventories & Work in Progress	190	190	190	
NHS Trade Receivables (Debtors)	2,623	1,973	1,499	2
Other Receivables (Debtors)	7,541	5,217	6,155	3
Cash and Cash Equivalents	27,107	25,341	28,310	4
Total Current Assets	**37,461**	**32,721**	**36,153**	
Current Liabilities				
Trade Payables (Creditors)	(6,430)	(5,930)	(6,834)	5
Other Payables (Creditors)	(3,481)	(4,764)	(4,418)	5
Capital Payables (Creditors)	(785)	(785)	(552)	5
Accruals	(8,576)	(10,776)	(7,621)	6
Deferred Income	(789)	(789)	(950)	
Total Current Liabilities	**(20,060)**	**(23,043)**	**(20,375)**	
Net Current Assets/Liabilities	**17,401**	**9,677**	**15,779**	
Total Assets less Current Liabilities	**131,535**	**130,111**	**125,631**	
Provisions for Liabilities	(10,017)	(7,927)	(7,963)	
Total Net Assets/(Liabilities)	**121,518**	**122,184**	**117,667**	
Taxpayers' Equity				
Public Dividend Capital	43,492	43,492	43,665	
Revaluation Reserve	19,446	19,446	18,413	
Other Reserves	5,220	5,220	5,220	
Income & Expenditure Reserve	53,361	54,027	50,369	7
Total Taxpayers' Equity	**121,518**	**122,184**	**117,667**	

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 year capital spend (less than plan) and accelerated depreciation charges. This also includes the impact of the revaluation exercise, and asset impairments.

2. NHS debtors are lower than plan, those remaining are being actively chased ahead of the financial year end.

3. As per previous months other debtors are higher than year to date plan but at an overall lower level than at 2015 / 2016 year end. These have reduced from previous month and will reduced further as debtors are chased and the majority of accrued income raised for year-end.

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.

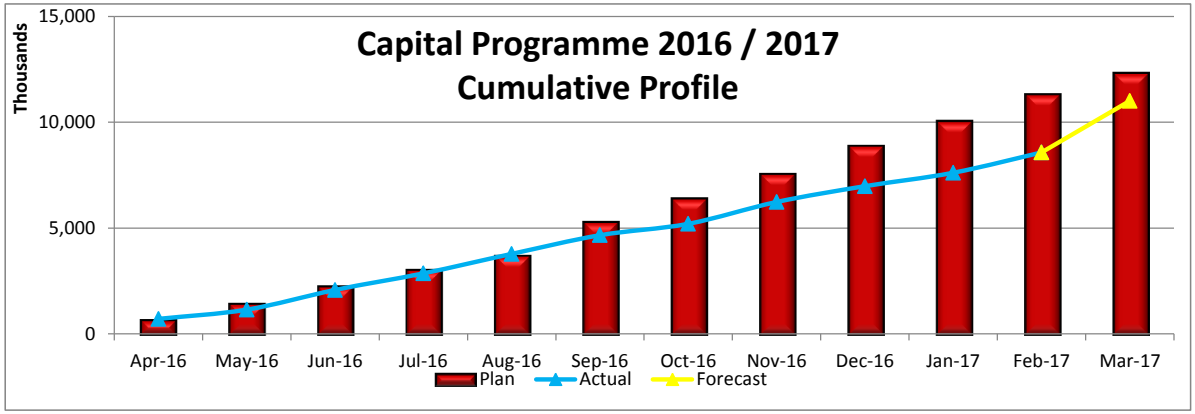
5. Overall creditors are slightly higher than plan. Payments continue to be made to support the Trust Better Payment Practice Code and ensure that no issues remain outstanding.

6. As per previous months the level of accruals remains lower than planned and lower than previous trends.

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

3.1 Capital Programme 2016 / 2017

	Annual Budget £k	Year to Date Plan £k	Year to Date Actual £k	Year to Date Variance £k	Forecast Actual £k	Forecast Variance £k	Note
Maintenance (Minor) Capital							
Facilities & Small Schemes	2,050	1,863	1,236	(627)	1,924	(126)	
IM&T	1,210	1,084	492	(592)	952	(258)	
Total Minor Capital & IM &T	**3,260**	**2,947**	**1,728**	**(1,218)**	**2,876**	**(384)**	
Major Capital Schemes							
Pontefract Hub	1,795	1,795	1,900	105	1,900	105	
Wakefield Hub	735	735	808	73	808	73	
Fieldhead Non Secure	4,725	4,045	3,473	(572)	4,660	(65)	
Fieldhead Development	1,300	1,300	460	(840)	558	(742)	
Other	498	498	516	19	516	19	
Total Major Schemes	**9,053**	**8,372**	**7,157**	**(1,215)**	**8,443**	**(610)**	
VAT Refunds	0	0	(315)	(315)	(315)	(315)	
TOTALS	**12,313**	**11,319**	**8,571**	**(2,748)**	**11,005**	**(1,309)**	2



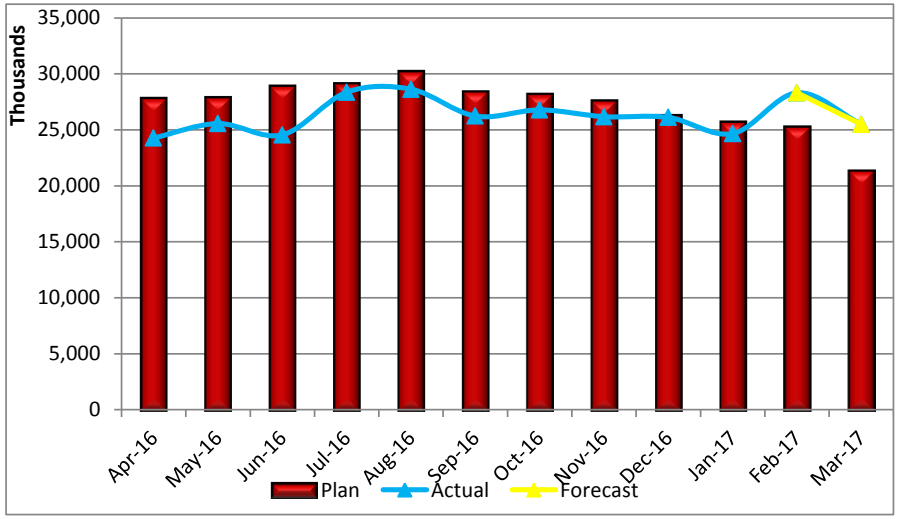
Capital Expenditure 2016 / 2017

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 £2.7m behind plan (24%). Excluding the benefit arising from successful VAT recovery agreed with HMRC this is £2.4m behind plan (21%).

Current forecast expenditure is £11.0m. This is a reduction of £0.5m from last month primarily due to a review of the timings relating to the major Fieldhead non-secure and continued cost control and mitigation for the Fieldhead development schemes.

The change in spend profile for Fieldhead Non-secure will have an impact on the 17/18 capital programme. This will not, however, change the overall expenditure planned for the scheme.

3.2 Cash Flow & Cash Flow Forecast 2016 / 2017



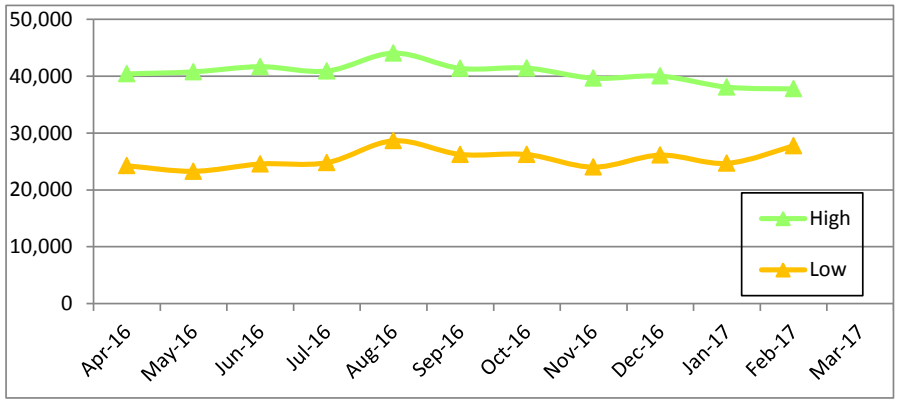
	Plan £k	Actual £k	Variance £k
Opening Balance	27,107	27,107	
Closing Balance	25,341	28,310	2,969

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 Trust cash position is higher than planned, this has been helped in month by the sale of Margaret Street and the lower than planned capital expenditure.

A detailed reconciliation of working capital compared to plan is presented on page 11.



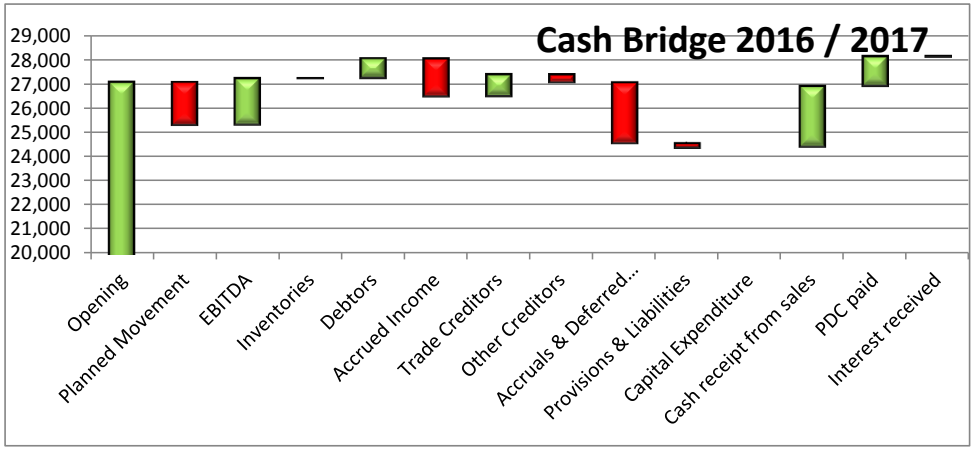
The graph to the left demonstrates the highest and lowest cash balances within each month. This is important to ensure that cash is available as required.

The highest balance is: £37.8m
The lowest balance is: £27.8m

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)	8,440	10,367	1,927	
Movement in working capital:				
Inventories & Work in Progress	0	0	0	
Receivables (Debtors)	3,225	4,032	807	3
Accrued Income	0	(1,562)	(1,562)	4
Trade Payables (Creditors)	(500)	404	904	3
Other Payables (Creditors)	0	(326)	(326)	
Accruals & Deferred income	1,700	(794)	(2,494)	5
Provisions & Liabilities	(2,140)	(2,312)	(172)	
Movement in LT Receivables:				
Capital expenditure & capital creditors	(11,319)	(8,804)	2,515	1
Cash receipts from asset sales	299	1,525	1,226	2
PDC Dividends paid	(1,540)	(1,560)	(20)	
PDC Dividends received		173	173	
Interest (paid)/ received	69	60	(9)	
Closing Balances	**25,341**	**28,310**	**2,970**	



The plan value reflects the April 2016 submission to NHS Improvement.

Factors which increase the cash positon against plan:

1. Capital expenditure, including capital creditors, is less than plan as noted within the capital expenditure report.

2. Cash receipts from the sale of Trust properties is higher than originally planned. To date 4 properties, totalling £1m, have been sold compared to 1 included within the plan.

3. Both debtors and creditors are better than planned giving rise to a cash benefit.

Factors which decrease the cash position against plan:

4. Accrued income continues to be reviewed on a monthly basis to ensure that all invoices are raised in a timely fashion. A key component of this remains the timing of agreeing, and invoicing, CQUIN payments

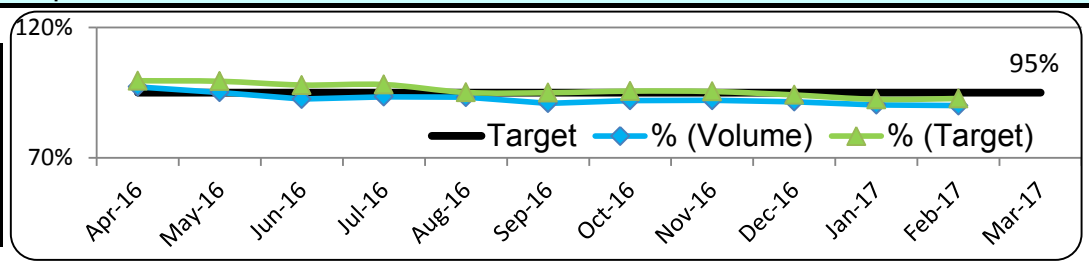
5. Expenditure accruals remain at a low level. Issues with receiving invoices from NHS bodies, and reflected in the plan, have not been experienced to date in 2016 / 2017.

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

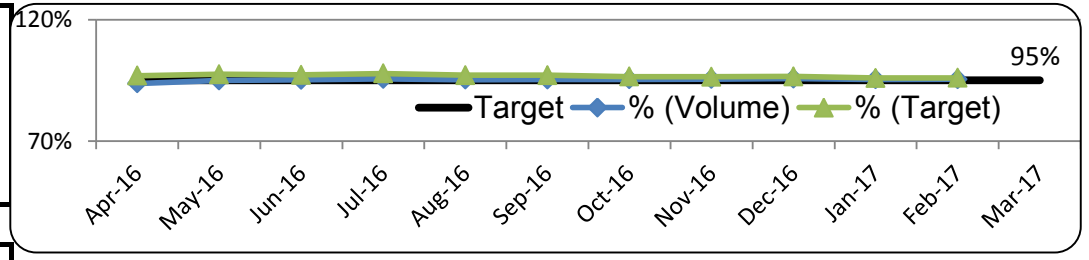
4.0 Better Payment Practice Code

The Trust is committed to following the Better Payment Practice Code; payment of 95% of valid invoices by their due date or within 30 days of receipt of goods or a valid invoice whichever is later.
In November 2008 the Trust adopted a Government request for Public Sector bodies to pay local Suppliers within 10 days. This is not mandatory for the NHS.
The team continue to review reasons for non delivery of the 95% target and identify solutions to problems and bottlenecks in the process. Overall year to date progress remains positive.

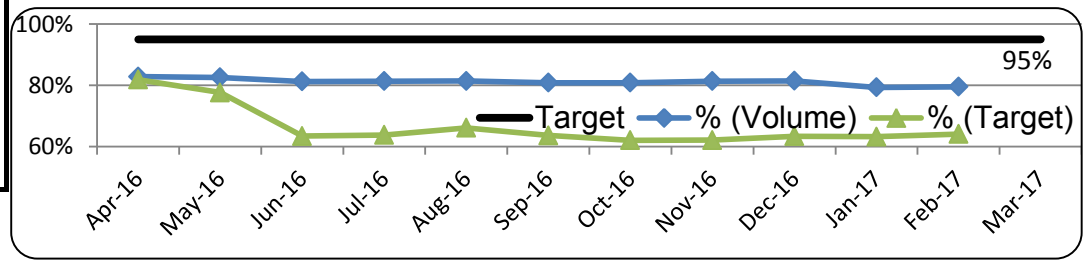
NHS	Number %	Value %
Year to January 2017	90%	92%
Year to February 2017	90%	93%



Non NHS	Number %	Value %
Year to January 2017	95%	96%
Year to February 2017	95%	96%



Local Suppliers (10 days)	Number %	Value %
Year to January 2017	79%	63%
Year to February 2017	79%	64%



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 (£)
10/02/2017	Lease Rents	Calderdale	Calderdale and Huddersfield NHS Foundation Trust	3025460	209,476.36
16/12/2016	Drugs	Trustwide	Mid Yorkshire Hospitals NHS Trust	3019498	134,786.65
30/01/2017	Switchboard SLA	Barnsley	Barnsley Hospital NHS Foundation Trust	3024044	82,618.00
29/12/2016	Staff Recharge	Wakefield	Wakefield MDC	3020689	53,793.11
19/01/2017	Lease Rents	Kirklees	Mid Yorkshire Hospitals NHS Trust	3023079	30,065.84
30/01/2017	Switchboard SLA	Barnsley	Barnsley Hospital NHS Foundation Trust	3024042	41,309.00
30/01/2017	Switchboard SLA	Barnsley	Barnsley Hospital NHS Foundation Trust	3024043	41,309.00

4.2 Agency Expenditure Focus

Agency costs continue to remain a focus for the NHS nationally including publication by NHS Improvement performance against maximum levels of spend. Quarter 3 results were published in February 2017 covering the period of April to December 2016. This confirms for the year to date the Trust is 89%

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%).

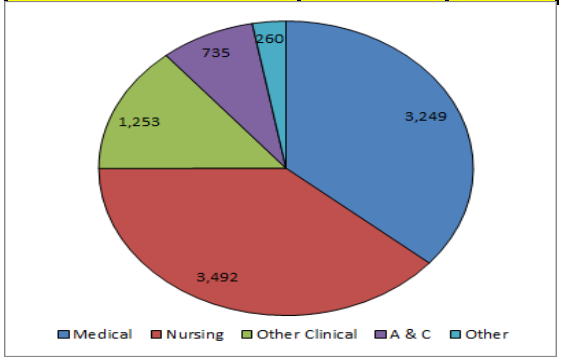
Agency expenditure, for the year to date is £9.0m, with average spend of £817k per month. In month spend is £721k which is £35k less than last month. Detailed analysis has been completed but no significant trends or stepped changes have been noted. This reduction covers a number of different BDUs and a number of different categories.

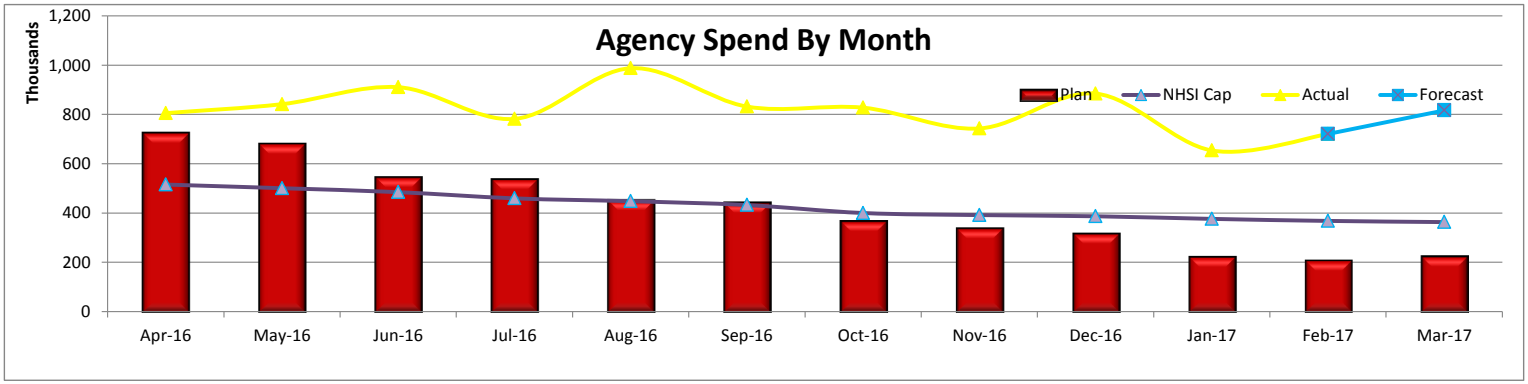
Monitoring of individual medical and admin posts continues and is reviewed on a weekly basis within the Operational Management Group. Trustwide this highlights that there have been 4 medical leavers and 1 new starter to cover maternity leave leaving 23 in post. Admin has reduced from 13 to 11 with actions continuing towards the target of 0 from 1st April 2017.

Individually the movement in agency usage is reported to Executive Management Team (EMT) and the impact on clinical services and safety are continually monitored.

In addition to usage the Trust continues to review and take actions to ensure that agency are procured under the best value for money methodology. This includes ensuring that agencies provide staff who are at least under the NHSI capped rate or through exploring other direct engagement approaches.

	Year to Date £000	Forecast £000
Total Trust Position	**8,990**	**9,806**
Less Agency Social Workers	(496)	(544)
Less Bespoke Packages of Care	(791)	(808)
Less CAMHS Waiting List (Commissioner funded)	(122)	(210)
Net Trust Position	**7,581**	**8,244**





4.2 Out of Area Expenditure Focus

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 with commissioners.

Out of Area Expenditure 2015 / 2016 & 2016 / 2017

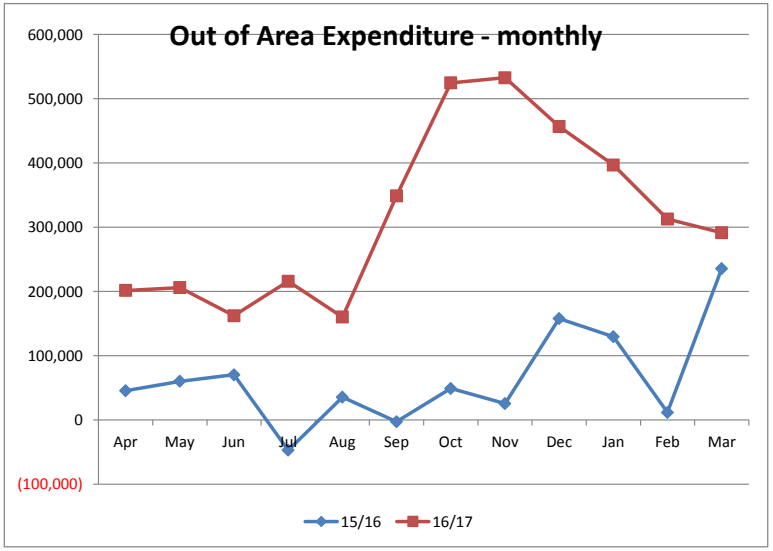
	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
15/16	46	60	71	(47)	36	(3)	49	25	158	130	12	236	**772**
16/17	202	206	162	216	160	349	525	533	457	397	313	292	**3,811**

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	679	625	424		**5,139**

Bed Day Information 2016 / 2017 (by category)

PICU	138	167	196	144	70	211	367	377	222	280	181		**2,353**
Acute	96	43	100	89	62	154	288	309	426	328	243		**2,138**
Gender	60	62	47	77	84	130	100	40	31	17	0		**648**



This shows that expenditure has increased from £0.8m in 15/16 to forecast spend of £3.8m in 16/17. February 2017 has seen a continued reduction in usage and expenditure from the peak in October - December 2016.

Factors which have influenced the increased usage in 2016 / 2017:
- 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:
- Purchase of bed capacity with a local NHS Trust at rates lower than spot purchases
- Continued project management including a thinking differently workshop and virtual OOA ward
- Trustwide bed management team approach including task and finish groups and patient flow
- Discussions with partner Trusts to assess best practice and learn from actions they have taken
- Ensure that wards are appropriately staffed to allow full bed capacity to be used

* Dialogue continues with Trust insurance as a result of the fire. An interim payment has been received which is reflected within the month 11 financial position and forecast. This helps to offset the cost pressures associated with additional out of area bed usage. It is expected that costs, however, will exceed the value of insurance leaving a cost pressure with the Trust.

4.3 Glossary

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

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

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

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

* Recurrent Underlying Surplus - We would not expect to actually report this position in our accounts, but it is an important measure of our fundamental financial health. It shows what our surplus would be if we stripped out all of the non-recurrent income, costs and savings.

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

* Target Surplus - This is the surplus the Board said it wanted to achieve for the year (including non-recurrent actions), and which was used to set the CIP targets. This is set in advance of the year, and before all variables are known. For 2016 / 2017 the Trust were set a control total surplus.

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

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

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

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

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

Appendix 2 - Workforce - Performance Wall

Barnsley District

Month	Objective	CQC Domain	Owner	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.30%	4.40%	4.60%	4.70%	4.80%	4.90%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.50%	5.40%	6.10%	5.60%	5.90%	5.80%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	91.50%	92.10%	94.10%	95.00%	95.00%	95.50%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	77.50%	83.20%	91.40%	94.10%	94.60%	95.30%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	88.00%	84.50%	83.20%	84.10%	82.30%	77.60%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	76.80%	79.00%	80.80%	81.90%	82.40%	82.50%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	58.50%	64.30%	66.50%	70.80%	75.50%	78.20%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.60%	92.10%	90.40%	91.70%	88.60%	89.40%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	88.50%	87.50%	86.20%	87.60%	86.20%	82.60%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.00%	80.70%	81.50%	81.30%	80.70%	80.30%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	88.50%	87.30%	87.70%	88.40%	88.80%	87.80%
Information Governance	Resources	Well Led	AD	>=95%	89.00%	89.10%	88.80%	87.50%	91.80%	94.90%
Moving and Handling	Resources	Well Led	AD	>=80%	80.30%	79.60%	80.50%	80.60%	82.20%	83.70%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	91.20%	91.20%	91.40%	91.90%	90.60%	90.40%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	89.50%	89.30%	90.10%	90.30%	88.90%	88.40%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	97.40%	96.30%	95.70%	97.10%	98.20%	97.40%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%			16.80%	45.00%	47.10%	51.50%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%			11.30%	33.70%	34.40%	38.30%
Agency Cost	Resources	Effective	AD		£180k	£152k	£143k	£190k	£148k	£143k
Overtime Costs	Resources	Effective	AD		£4k	£6k	£5k	£6k	£6k	£4k
Additional Hours Costs	Resources	Effective	AD		£24k	£22k	£26k	£26k	£18k	£23k
Sickness Cost (Monthly)	Resources	Effective	AD		£171k	£157k	£170k	£191k	£179k	£167k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		169.35	97.45	116.31	133.76	133.8	136.67
Business Miles	Resources	Effective	AD		116k	130k	115k	112k	107k	101k

Calderdale and Kirklees District

Month	Objective	CQC Domain	Owner	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	5.30%	5.10%	4.90%	4.90%	4.90%	5.00%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.70%	3.70%	4.10%	4.50%	5.30%	5.10%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	82.40%	85.00%	95.10%	98.50%	98.50%	98.20%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	63.50%	72.30%	87.90%	93.80%	95.30%	95.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	84.30%	80.80%	79.70%	78.30%	77.40%	77.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	53.70%	57.90%	61.00%	66.70%	70.10%	72.10%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	35.60%	41.90%	50.00%	57.60%	63.80%	65.80%
Equality and Diversity	Resources	Well Led	AD	>=80%	89.30%	88.10%	88.10%	89.70%	89.00%	89.70%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	83.00%	83.10%	82.20%	83.80%	80.20%	81..7%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	79.90%	79.80%	79.90%	81.30%	79.20%	79.10%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	77.90%	74.80%	78.00%	79.00%	78.20%	78.30%
Information Governance	Resources	Well Led	AD	>=95%	88.70%	84.00%	83.80%	86.60%	94.50%	96.70%
Moving and Handling	Resources	Well Led	AD	>=80%	73.50%	72.70%	73.40%	75.80%	77.40%	79.50%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	90.00%	89.40%	89.50%	90.70%	90.40%	89.60%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	85.30%	84.10%	85.50%	86.30%	85.30%	84.20%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	96.40%	95.40%	95.90%	96.60%	96.40%	95.90%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%			13.10%	30.80%	33.30%	39.60%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%			12.40%	19.80%	22.70%	30.30%
Agency Cost	Resources	Effective	AD		£165k	£165k	£195k	£228k	£173k	£177k
Overtime Costs	Resources	Effective	AD		£2k	£5k	£2k	£6k	£9k	£5k
Additional Hours Costs	Resources	Effective	AD		£2k	£3k	£1k	£0k	£1k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£119k	£98k	£77k	£84k	£93k	£97k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		69.49	61.86	55.8	50.95	50.69	47.64
Business Miles	Resources	Effective	AD		50k	64k	71k	75k	58k	54k

Appendix - 2 - Workforce - Performance Wall cont…

Forensic Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	6.00%	5.90%	6.00%	6.20%	6.40%	6.40%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	5.70%	5.20%	6.30%	8.20%	8.00%	6.80%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	80.90%	87.30%	90.50%	92.00%	92.20%	93.70%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	49.20%	62.20%	71.80%	77.80%	82.50%	88.50%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	80.70%	80.30%	82.90%	83.70%	85.40%	83.40%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	60.80%	51.60%	49.20%	53.10%	60.50%	62.60%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.00%	0.00%	0.00%	10.50%	26.70%	45.10%
Equality and Diversity	Resources	Well Led	AD	>=80%	91.90%	90.50%	89.20%	90.80%	91.90%	92.30%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	84.60%	85.10%	84.80%	87.80%	84.60%	85.40%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	88.50%	86.60%	88.30%	89.00%	87.10%	86.70%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	83.00%	81.10%	81.90%	83.90%	81.50%	82.70%
Information Governance	Resources	Well Led	AD	>=95%	84.60%	83.90%	84.60%	85.20%	90.90%	95.50%
Moving and Handling	Resources	Well Led	AD	>=80%	83.60%	83.40%	84.10%	84.40%	85.50%	85.40%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	88.10%	86.60%	85.30%	89.00%	90.90%	92.10%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	88.40%	89.00%	85.50%	87.30%	87.90%	87.60%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	80.00%	82.40%	77.80%	78.90%	82.40%	93.80%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%			12.30%	29.10%	33.80%	42.40%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%			8.90%	14.20%	18.50%	30.10%
Agency Cost	Resources	Effective	AD		£62k	£117k	£80k	£95k	£114k	£128k
Overtime Costs	Resources	Effective	AD		£0k	£0k		£9k	£-1k	£0k
Additional Hours Costs	Resources	Effective	AD			£0k	£0k	£1k	£0k	£1k
Sickness Cost (Monthly)	Resources	Effective	AD		£62k	£49k	£52k	£63k	£81k	£53k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		49.49	41.34	33.25	37.55	46.25	49.44
Business Miles	Resources	Effective	AD		9k	8k	7k	8k	5k	15k

Specialist Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.80%	4.60%	4.60%	4.80%	4.90%	5.00%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.10%	3.90%	4.70%	5.60%	5.80%	6.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	58.90%	63.80%	69.30%	82.70%	84.30%	87.40%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	50.40%	55.60%	61.80%	62.50%	66.70%	70.30%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	78.20%	77.00%	73.50%	74.60%	73.10%	72.00%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	52.00%	61.20%	65.90%	65.70%	71.50%	71.80%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%		9.60%	15.80%	28.60%	33.20%	38.10%
Equality and Diversity	Resources	Well Led	AD	>=80%	92.30%	89.50%	89.30%	89.90%	89.10%	88.30%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.00%	75.60%	75.70%	82.90%	80.40%	79.50%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	60.00%	57.70%	53.80%	60.00%	58.30%	62.50%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	85.10%	84.20%	84.50%	87.40%	86.30%	86.50%
Information Governance	Resources	Well Led	AD	>=95%	85.00%	81.00%	82.70%	84.20%	92.70%	96.00%
Moving and Handling	Resources	Well Led	AD	>=80%	79.00%	77.30%	79.50%	80.70%	80.90%	80.90%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	86.50%	84.80%	84.10%	85.90%	85.20%	83.80%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.70%	84.40%	86.70%	88.90%	88.10%	87.30%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%		83.60%	87.40%	88.50%	89.30%	87.80%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%			4.20%	28.90%	31.60%	37.50%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%			4.30%	9.50%	11.70%	17.50%
Agency Cost	Resources	Effective	AD		£227k	£266k	£197k	£185k	£88k	£165k
Overtime Costs	Resources	Effective	AD		£1k	£2k	£2k	£2k	£2k	£3k
Additional Hours Costs	Resources	Effective	AD		£10k	£3k	£2k	£5k	£3k	£4k
Sickness Cost (Monthly)	Resources	Effective	AD		£40k	£38k	£40k	£40k	£48k	£69k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		76.83	86.37	77.57	75.78	71.96	64.87
Business Miles	Resources	Effective	AD		20k	43k	47k	40k	38k	38k

Appendix 2 - Workforce - Performance Wall cont…

Support Services

Month	Objective	CQC Domain	Owner	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.20%	4.30%	4.40%	4.60%	4.70%	4.70%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.60%	4.30%	5.10%	6.10%	5.60%	5.40%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	79.30%	83.70%	89.70%	91.60%	92.10%	92.20%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	76.90%	84.30%	87.20%	89.90%	94.30%	95.30%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	70.30%	70.10%	66.80%	64.10%	64.80%	68.70%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	66.70%	65.60%	64.70%	90.90%	84.80%	90.90%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	0.00%	100.00%	50.00%	100.00%	100.00%	100%
Equality and Diversity	Resources	Well Led	AD	>=80%	87.20%	87.80%	87.10%	85.80%	87.10%	87.90%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	81.40%	82.30%	82.00%	84.00%	84.90%	84.90%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	92.20%	95.90%	95.00%	97.50%	98.40%	98.40%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	75.40%	76.90%	76.30%	82.20%	83.20%	83.90%
Information Governance	Resources	Well Led	AD	>=95%	88.30%	86.20%	86.10%	89.20%	89.10%	93.00%
Moving and Handling	Resources	Well Led	AD	>=80%	81.30%	77.60%	80.00%	79.70%	82.60%	85.90%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	86.20%	88.10%	87.20%	87.40%	89.70%	89.70%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	89.90%	87.50%	88.00%	88.80%	90.80%	91.00%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	0.00%	50.00%	50.00%	100.00%	100.00%	100%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%			9.20%	90.10%	91.00%	91.60%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%			9.10%	16.30%	19.10%	29.80%
Agency Cost	Resources	Effective	AD		£48k	£34k	£42k	£40k	£32k	£26k
Overtime Costs	Resources	Effective	AD			£4k	£3k	£2k	£1k	£1k
Additional Hours Costs	Resources	Effective	AD		£9k	£10k	£10k	£11k	£18k	£16k
Sickness Cost (Monthly)	Resources	Effective	AD		£61k	£59k	£61k	£79k	£99k	£73k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		73.63	66.29	57.4	58.56	60.89	55.36
Business Miles	Resources	Effective	AD		39k	44k	50k	46k	40k	47k

Wakefield District

Month	Objective	CQC Domain	Owner	Threshold	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Sickness (YTD)	Resources	Well Led	AD	<=4.4%	4.80%	4.80%	4.80%	5.00%	5.30%	5.50%
Sickness (Monthly)	Resources	Well Led	AD	<=4.4%	4.90%	4.60%	4.90%	6.40%	8.00%	7.70%
Appraisals (Band 6 and above)	Resources	Well Led	AD	>=95%	80.60%	88.50%	91.50%	93.30%	94.60%	95.20%
Appraisals (Band 5 and below)	Resources	Well Led	AD	>=95%	58.80%	74.80%	78.80%	87.60%	89.00%	88.80%
Aggression Management	Quality & Experience	Well Led	AD	>=80%	86.90%	83.90%	83.20%	83.30%	80.80%	82.60%
Cardiopulmonary Resuscitation	Health & Wellbeing	Well Led	AD	>=80%	50.80%	52.80%	55.20%	56.20%	60.40%	61.30%
Clinical Risk	Quality & Experience	Well Led	AD	>=80%	36.60%	40.20%	41.80%	52.30%	57.10%	60.60%
Equality and Diversity	Resources	Well Led	AD	>=80%	93.00%	93.30%	92.80%	93.40%	91.00%	89.60%
Fire Safety	Health & Wellbeing	Well Led	AD	>=80%	82.60%	81.20%	81.20%	85.70%	86.00%	84.10%
Food Safety	Health & Wellbeing	Well Led	AD	>=80%	75.20%	77.80%	76.50%	78.00%	77.90%	76.50%
Infection Control and Hand Hygiene	Quality & Experience	Well Led	AD	>=80%	81.60%	80.10%	79.00%	78.80%	78.70%	78.50%
Information Governance	Resources	Well Led	AD	>=95%	90.80%	90.90%	85.20%	81.80%	92.30%	95.50%
Moving and Handling	Resources	Well Led	AD	>=80%	70.60%	70.80%	69.70%	71.10%	73.10%	72.20%
Safeguarding Adults	Health & Wellbeing	Well Led	AD	>=80%	89.30%	89.00%	87.60%	87.00%	88.70%	88.40%
Safeguarding Children	Health & Wellbeing	Well Led	AD	>=80%	86.10%	83.10%	80.10%	80.40%	82.30%	80.70%
Sainsbury's clinical risk assessment tool	Quality & Experience	Well Led	AD	>=80%	97.60%	95.00%	94.10%	95.00%	94.90%	95.20%
Mental Capacity Act/DOLS	Quality & Experience	Well Led	AD	>=80%			15.30%	33.00%	34.00%	40.90%
Mental Health Act	Quality & Experience	Well Led	AD	>=80%			15.40%	25.60%	26.50%	33.40%
Agency Cost	Resources	Effective	AD		£152k	£97k	£96k	£146k	£107k	£84k
Overtime Costs	Resources	Effective	AD		£1k		£3k	£1k	£2k	£91k
Additional Hours Costs	Resources	Effective	AD		£2k	£3k	£1k	£5k	£2k	£3k
Sickness Cost (Monthly)	Resources	Effective	AD		£57k	£55k	£51k	£60k	£80k	£76k
Vacancies (Non-Medical) (WTE)	Resources	Well Led	AD		67.1	73.43	75.95	75.44	68.48	69.36
Business Miles	Resources	Effective	AD		37k	38k	40k	35k	36k	32k

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Glossary

ADHD	Attention deficit hyperactivity disorder
AQP	Any Qualified Provider
ASD	Autism spectrum disorder
AWA	Adults of Working Age
AWOL	Absent Without Leave
B/C/K/W	Barnsley, Calderdale, Kirklees, Wakefield
BDU	Business Delivery Unit
C&K	Calderdale & Kirklees
C. Diff	Clostridium difficile
CAMHS	Child and Adolescent Mental Health Services
CAPA	Choice and Partnership Approach
CCG	Clinical Commissioning Group
CGCSC	Clinical Governance Clinical Safety Committee
CIP	Cost Improvement Programme
CPA	Care Programme Approach
CPPP	Care Packages and Pathways Project
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CROM	Clinician Rated Outcome Measure
CRS	Crisis Resolution Service
CTLD	Community Team Learning Disability
DoC	Duty of Candour
DoV	Deed of Variation
DoC	Duty of Candour
DQ	Data Quality
DTOC	Delayed Transfers of Care
EIA	Equality Impact Assessment
EIP/EIS	Early Intervention in Psychosis Service
EMT	Executive Management Team
FOI	Freedom of Information
FOT	Forecast Outturn
FT	Foundation Trust
FYFV	Five Year Forward View
HEE	Health Education England
HONOS	Health of the Nation Outcome Scales
HR	Human Resources
HSJ	Health Service Journal
HSCIC	Health and Social Care Information Centre
HV	Health Visiting
IAPT	Improving Access to Psychological Therapies
ICD10	International Statistical Classification of Diseases and Related Health Problems
IG	Information Governance
IHBT	Intensive Home Based Treatment
IM&T	Information Management & Technology
Inf Prevent	Infection Prevention
IPC	Infection Prevention Control
IWMS	Integrated Weight Management Service
KPIs	Key Performance Indicators
LA	Local Authority
LD	Learning Disability
Mgt	Management
MAV	Management of Aggression and Violence
MBC	Metropolitan Borough Council
MH	Mental Health
MHCT	Mental Health Clustering Tool
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MT	Mandatory Training
NCI	National Confidential Inquiries
NHS TDA	National Health Service Trust Development Authority
NHSE	National Health Service England
NHSI	NHS Improvement
NICE	National Institute for Clinical Excellence
NK	North Kirklees
OOA	Out of Area
OPS	Older People's Services
PbR	Payment by Results
PCT	Primary Care Trust
PICU	Psychiatric Intensive Care Unit
PREM	Patient Reported Experience Measures
PROM	Patient Reported Outcome Measures
PSA	Public Service Agreement
PTS	Post Traumatic Stress
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QTD	Quarter to Date
RAG	Red, Amber, Green
RiO	Trusts Mental Health Clinical Information System
SIs	Serious Incidents
S BDU	Specialist Services Business Delivery Unit
SK	South Kirklees
SMU	Substance Misuse Unit
STP	Sustainability and Transformation Plans
SU	Service Users
SWYFT	South West Yorkshire Foundation Trust
SYBAT	South Yorkshire and Bassetlaw local area team
TB	Tuberculosis
TBD	To Be Decided/Determined
WTE	Whole Time Equivalent
Y&H	Yorkshire & Humber
YTD	Year to Date

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

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 7.1

Title:	**Serious incident report Quarter 3 2016/17**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This report provides an overview of serious incidents in Quarter 3. The report sets out the recommendations themes from the serious incident investigations completed during quarter 3.
Mission/values:	We are respectful, honest, open and transparent. We put the person first and in the centre.
Any background papers/ previously considered by:	A more detailed report is sent quarterly to the Clinical Governance and Clinical Safety Committee. The annual report which is submitted to Clinical Governance and Clinical Safety Committee.
Executive summary:	➢ There have been no 'Never Events' reported in the Trust during quarter 3 as per the rest of the year. ➢ The total number of serious incidents in quarter 3 is 16.This is slightly higher than the previous two quarters which both had 13 incidents. Across this year the number of serious incidents is lower than the previous year at this stage by 14. ➢ The highest category of serious incident is Suicide (including apparent) - community team care –current episode (5). ➢ The category of apparent suicide at point of reporting is lower numbers in the rolling last 4 quarters -9, 5, 8, 7 (29) in total than the level of expected cases based on National Confidential Inquiry numbers for a population this size which is 33/34. ➢ 16 investigations have been submitted to the Commissioner during the quarter and 10 have been closed by Commissioners. ➢ The Quarterly reports have been produced and shared with the Clinical Governance and Clinical Safety Committee and BDUs. ➢ Included is some analysis of the themes from the completed investigation report. ➢ The next learning lessons report will give examples of how the learning is shared and embedded from such incidents. **Risk appetite** Serious incidents could potentially be a clinical, commercial (reputation) or compliance risk. Through the Trust governance process the clinical and compliance risk is mitigated in line with the Trust's risk appetite. Commercial, reputational and clinical risks are mitigated through the serious incident process and through the being open policy to engage service users and families/carers.
Recommendation:	**Trust Board is asked to RECEIVE the report and NOTE the content.**
Private session:	Not applicable.

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TRUST WIDE SERIOUS INCIDENT (SI) REPORT FOR QUARTER 3 2016/17 (DATA AS AT 6 JANUARY 2017)

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

1. Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Q1	Q2	Q3	Q4
0	0	0	

2. Serious Incidents reported to the Commissioners

Serious incidents are incidents requiring investigation and are defined as an incident that occurred in relation to NHS funded services and care resulting in one of the following:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- serious harm to one or more patients, staff, visitors or members of the public or where outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm)
- a scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment. IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a larger population
- allegations of abuse
- adverse media coverage or public concern for the organisation or the wider NHS one of the core set of *Never Events.*

During Quarter 3 there have been 16 serious incidents reported on STEIS.

Total SIs reported to the Commissioner by financial year and quarter up to the date of this report (2012/13 - 2016/17)					
Financial quarter	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**
Quarter 1	15	14	31	18	13
Quarter 2	7	27	24	23	13
Quarter 3	10	31	30	15	16
Quarter 4	12	29	21	20	
Totals	**44**	**101**	**106**	**76**	**42**

SIs reported by team types and BDU for Q3	Barnsley Mental Health & Substance Misuse	Barnsley General Community	Kirklees	Wakefield	Forensic	Total
CMHTs (Adult)	2	0	1	3	0	**6**
Acute Inpatients (Adult)	1	0	0	2	0	**3**
Assertive Outreach Team (Adult)	1	0	0	0	0	**1**
Crisis/IHBTT (Adult)	1	0	0	0	0	**1**
District Nursing	0	1	0	0	0	**1**
General Community Inpatient wards	0	1	0	0	0	**1**
Rapid Intensive Intervention (OPS)	0	0	1	0	0	**1**
Single Point of Access (SPA)	0	0	1	0	0	**1**
Learning Disability Inpatient units [Appleton, Chippendale]	0	0	0	0	1	**1**
Total	**5**	**2**	**3**	**5**	**1**	**16**

SIs reported by incident category and BDU for Q3	Barnsley Mental Health & Substance Misuse	Barnsley General Community	Kirklees	Wakefield	Forensic	Total
Suicide (incl apparent) - community team care - current episode	2	0	1	2	0	5
Death - other cause	1	0	0	2	0	3
Self harm (actual harm) with suicidal intent	0	0	1	0	1	2
Fire / Fire alarm related incidents	0	0	0	1	0	1
Physical violence (contact made) against other by patient	1	0	0	0	0	1
Slip, trip or fall – patient	0	1	0	0	0	1
Suicide (incl apparent) - community team care – discharged	0	0	1	0	0	1
Suicide (incl apparent) - inpatient care - current episode	1	0	0	0	0	1
Total	**5**	**2**	**3**	**5**	**1**	**16**

The highest category of serious incidents during Quarter 3 is apparent suicides of current services in contact with community teams (5). This compares with 7 in Q2, when this was also the highest category. The death other category (3) is any unexpected deaths where on the balance of information reviewed, it does not look like it was natural causes. Two of the deaths have been investigated but there is still no update about cause of death –one is thought to be substance misuse related and the other is unknown. The third death was later found out to be natural causes and has been removed off the system so will not show on the annual figures.

3. Suspected Suicide reported to the Commissioners

The National Confidential Inquiry figures **October 2016** indicate that:

- Based on an average of the suicides recorded in the general population over the 10 years 2004 to 2014 there are approximately 10.2 (West Yorkshire STP) and 9.8 (South Yorkshire & Bassetlaw) suicides per 100,000 general populations each year.
- On average during 2004-2014 patient suicides accounted for 28% of the general population suicide figures

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

District	Population ONS – population estimates Mid 2015	General population suicide rate (NCI) 10.2(West Yorkshire STP) & 9.8 (South Yorkshire and Bassetlaw) per 100,000	Patient suicide rate (28% general pop) (NCI)
Barnsley	239,319	23	6-7
Calderdale	208,402	21	6
Kirklees	434,321	44	12
Wakefield	333,759	34	9-10
Trust wide	1215801	122	33-34

ONS – Office of National Statistics mid 2015 population estimate
NCI – National Confidential Inquiry into Suicide and Homicide by people with Mental Illness

Suspected Suicides reported on STEIS between 01/01/16 – 31/12/16 by Quarter

	Barnsley MH&SMS	Calderdale	Kirklees	Wakefield	Total
15/16 Q4	2	2	3	2	9
16/17 Q1	1	0	4	0	5
16/17 Q2	0	2	4	2	8
16/17 Q3	3	0	2	2	7
Rolling 4 quarter total					**29**

The rolling 4 quarter data shows that the Trust is below the expected number of suicides based on the National Confidential Inquiry figures for a population the size of the Trust and patient suicide (28%). Calderdale and Wakefield BDUs are below the expected number, Barnsley have the expected number and Kirklees is slightly above the expected number above. Caution is advised with these comparisons due to the sensitivity of the figures if just one or two more incidents occur, and because the figures are not weighted by characteristics such as age, gender or socio-economic status.

Breakdown of Suspected Suicides reported in Quarter 3 16/17 by Subcategory

	Barnsley MH&SMS	Kirklees	Wakefield	Total
Contact with moving vehicle (car, train) - self injury	2	0	1	3
Hanging - self injury	1	1	0	2
Cutting - self injury	0	0	1	1
Prescription medication - self poisoning	0	1	0	1
Total	3	2	2	7

The most common method of suicide is hanging in England (43%), self-poisoning (25% and jumping/multiple injuries (15%). The Trust data for quarter 3 is small in numbers but includes these methods. Of note in Q3, there have been 3 incidents involving deaths on railways.

All serious incidents are subject to investigations**. It must be noted that the figures above are apparent suicides and not confirmed by the Coroner**.

The data from the National Confidential Inquiry may not reflect trends until two years later. To control for this, the Trust looks at undetermined deaths on an annual basis and reports any difference between the national data and that of the Trust. The Trust may on occasions report and investigate deaths that are later removed from the numbers as the death was not found to be due to suicide. However, when we have compared apparent suicides with results from the Coroner there is minimal data change.

Performance Management of Serious incidents

- **16** SI Investigation Reports have been completed this quarter and sent to the Commissioners
- **10** SI reports have been closed by the Commissioners during the quarter
- There are currently **19** open SI investigations taking place across the Trust which are at the following stages (as at 06/01/17):

	Barnsley MH&SMS	Barnsley General Community	Calderdale	Kirklees	Wakefield	Forensic Service	Specialist Services	Trust wide (Corporate support services)	Total
Lead Investigator being allocated	1	0	0	0	2	0	0	0	3
Investigation panel being established	0	0	0	1	1	0	0	0	2
Investigation within 60 working days and on track	2	1	0	2	2	0	0	0	7
Investigation within 60 working days but off track	1	1	0	0	1	0	0	0	3
Investigation report over 60 working days but extension agreed	0	0	1	0	0	0	0	0	1
Investigation sign off process - off track	1	0	0	0	0	0	0	0	1
Requested SI delog, awaiting written response from Commissioner	1	0	0	0	0	0	0	0	1
Investigation being led by external investigator	0	0	0	0	0	1	0	0	1
Total	6	2	1	3	6	1	0	0	19

Breakdown of those above, which are over the original timescale

Overdue breakdown	Calderdale	Wakefield	Total
4-6 months since reported on STEIS	1	1	**2**
Total	**2**	**2**	**2**

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

Of the 2 reports that are more than 60 working days since the incident was reported, one is expected to be delivered within the next month. The reasons for delays varying but relate to issues such as complexity, staff availability to conduct interviews and investigation allocation delays due to capacity. The second incident was reported as an SI by SWYPFT, however the investigation is being led by the CCG.

The Patient Safety Support Team occasionally experiences difficulties in allocating investigations due to fluctuations in reporting rates. Capacity in the investigation team is limited at present due to a secondment of one member of staff which is 25% of the resource. Bank investigators have been used to manage some of this pressure.

4. SI Action Plans

Each BDU monitors the implementation of action plans. The Patient Safety Support Team send out information on the current position status based on information completed on Datix each month in the Incident management monthly edition of the SI information and a detailed report to Directors and Deputy Directors of the BDUs. This is providing real time data more regularly and reducing overdue action plans. The Greater Huddersfield Clinical Commissioning Group (on behalf of West CCGs) is randomly reviewing completed action plans to provide Clinical Commissioning Group Assurance. There is a move towards CCGs seeking to assess the effectiveness of action plans in changing practice.

5. Updates on other SIs

Independent Reviews (DOH guidance HSG (94)27)

No update on previous Quarter:

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

- **Kirklees BDU: 2010/9926** –An internal investigation was completed in Feb 2011, and the action plan to address the recommendations has been implemented by the BDU and has evidence to demonstrate this. The commissioners have agreed to close the action plan, and it has been sent to the Local Area Team requesting closure.

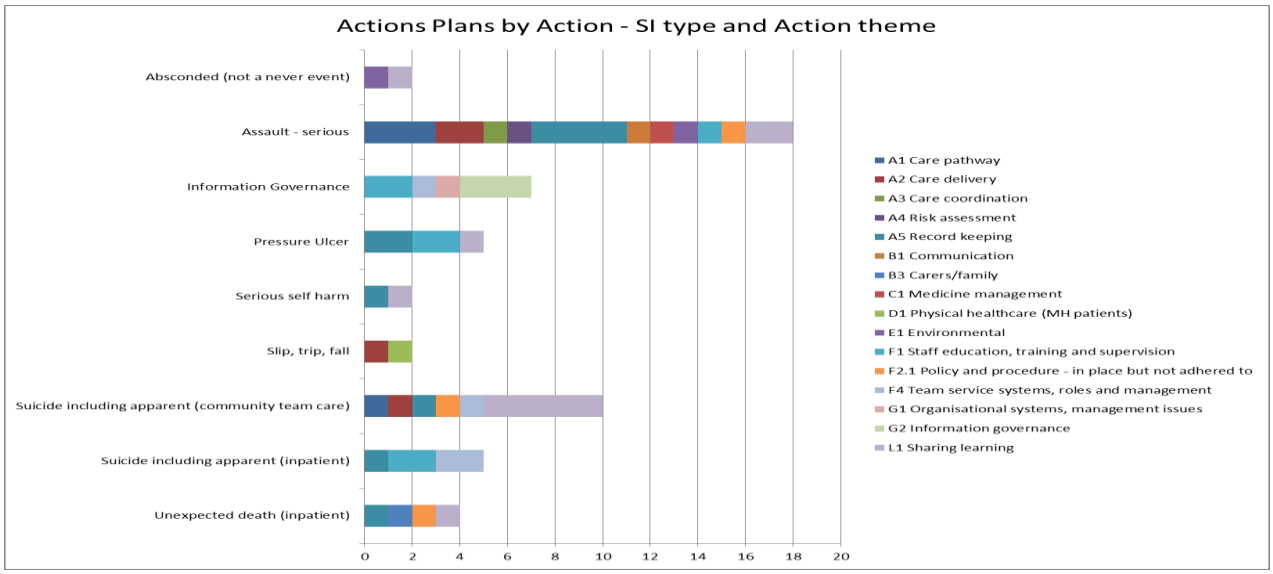
- **2011/11502 -** 2 recent alleged homicides by ex-service users have been confirmed as homicide cases. The internal Trust investigations into these cases are completed and action plans are being implemented. The commissioners have agreed to close the action plan, and it has been sent to the Local Area Team requesting closure.

- **2011/11370** has been subjected to a domestic homicide review which is a multi-agency review and overseen by the Home Office. The Local Area Team have reed to close the action plan.

6. Serious Incident themes

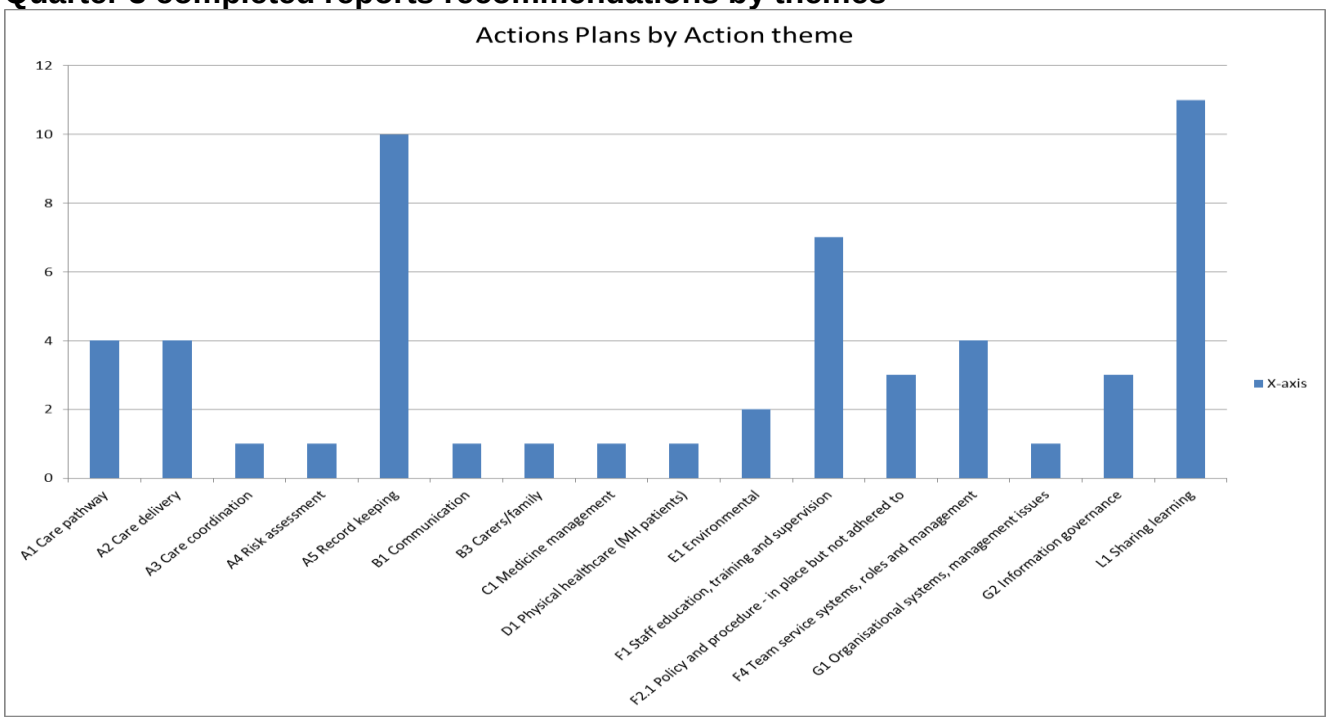
Reporting on SI learning is included in '*Our learning reports'* which are on the Trust's intranet. During quarter 3 the number of investigations completed and sent to the commissioners was 16 all had an action plan. There were 55 separate recommendations made to improve the system or process to prevent recurrence.

Quarter 3 Completed report Action plan recommendations by theme and serious incident type



Serious assaults had the largest number of recommendations (18), these related to three investigations each of which involved a different BDU. The largest type was record keeping (4) and these were in relation to accessing past records, recording discussions and decisions in records. The learning has been communicated widely in the BDU and an audit is planned to ensure change in practice around use of risk assessments heading in MDT meetings and evidence of recording action in MDT

Quarter 3 completed reports recommendations by themes



Sharing learning is an action the patient safety support team have added to action plans; this is to support learning being shared across the teams, service, BDU, Trust and wider health economy. The next largest recommendation was in relation to record keeping, this featured in 8 reports. Record keeping continues to be within the top three in each annual report.

Patient Safety Support Team
9.1.17 updated 21.3.17

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 7.2

Title:	**Safer staffing report**
Paper prepared by:	Director of Nursing and Quality
Purpose:	This paper builds upon the previous six-monthly papers submitted since July 2014. It outlines the work being done to ensure ward areas provide staffing levels that are safe and effective.
Mission/values:	Honest, open and transparent, person first and in the centre and improve and be outstanding.
Any background papers/ previously considered by:	Monthly safer staffing exception reports are submitted to the Trust Safer Staffing Group, Executive Management Team and Deputy District Directors. Business case August 2015 and updated paper May 2016 both presented to Executive Management Team.
Executive summary:	The national commitment to safer staffing is ongoing and the Trust needs to maintain the progress already made in delivering safer staffing. At a national level, there continues to be key changes around the delivery of this agenda and despite the lead on Safer Staffing having changed to NHS Improvement there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health/LD wards. However, a national consultation process began in January 2017 and has recently resulted in the publication of a draft paper "Safe, sustainable and productive staffing An improvement resource for mental health" draft published 15th March 2017 through Ruth May, Executive Nurse Director at NHS Improvement. This together with the QNI tool will be incorporated into the ongoing community safer staffing project. The Trust currently meets its safer staffing requirement overall although the planned levels of qualified (registered) staff are not always met. This results in use of existing staff doing additional hours, bank and agency staff. Staff survey and Datix reports suggest concerns remain regarding safer staffing on wards but action throughout 2016 has resulted in increased staffing fill rates, successful recruitment of registered and non-registered staff and initiatives to respond quickly to areas of need. Following their inspection of the Trust in March 2016, the Care Quality Commission (CQC) identified that in working age adult and forensic mental health wards, we do not always meet our planned 'minimum' staffing fill rates and they raised concerns about the impact on the quality and safety of patient care. The Trust provided a full response and an action plan. The CQC revisited the Trust to review progress in addressing regulation breaches and progress in achieving our CQC action plan between October 2016 and February 2017. In relation to safer staffing, they requested comprehensive documentation on staffing which they triangulated with feedback from staff. We await the results of their re-inspection, which are due around mid-March 2017.

	Throughout this period, we have seen improvements in reporting to the Board and Members' Council. The Integrated Performance Report now includes richer data on safer staffing and the number of exception reports each month. This shows good practice overnight and relatively few escalations in the daytime – between 3 and 5 per month. A comprehensive action plan is ongoing and we have developed further plans to enhance safer staffing in the community, learn from national NHSi guidance and resources and align the safer staffing agenda with the new Trust Workforce Strategy and Workforce Plan. **Risk appetite** Failing to maintain safer staffing within the clinical, operational and support services within the Trust is likely to result in risks to service users, staff and other stakeholders. There are also significant reputational risks. The Trust has invested in a safer staffing project to mitigate the risk to supplement existing environmental, procedural and relational solutions and policies and procedures.
Recommendation:	**Trust Board is asked to RECEIVE the report as assurance that the organisation is meeting safer staffing requirements.**
Private session:	Not applicable.

South West Yorkshire Partnership NHS Foundation Trust

Safer Staffing

Trust Board Paper

Safer Staffing Project Manager
14th March 2017

Supported by
Deputy Director of Nursing and Quality
Assistant Director of Nursing and Quality

PURPOSE OF THE PAPER

This paper provides an update and overview of work undertaken by SWYPT in response to the safer staffing challenge. The paper outlines what we have done and plan to do to ensure our clinical areas are staffed appropriately so that they can run safely and effectively.

1.0 INTRODUCTION

At a national level, there continues to be key changes around the delivery of this agenda. Despite the national lead on Safer Staffing having changed to NHS Improvement, there has been no definitive publication of Safer Staffing guidance for inpatient Mental Health wards.

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

Given the lack of progress in the area of 'Safe Staffing' guidance we continue to utilise the decision support tool adapted previously for our Trust, to look at establishments and rosters on our ward areas. This will also cross reference levels and trends of acuity, fill rates and anomalies such as bespoke care packages.

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

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

- *Inpatient areas* –6.5% *compared to the Trust 5.1%*

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

- Inpatient areas: 84.7%% compared to the Trust figure of 86%%

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

- Inpatient areas – 93.8% compared to the Trust figure of 93.7% (target 95%)

4. Staff views on staffing, taken from the 2015 National staff survey measure; Awaiting 2016 results

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

Based on these indicators, there are some positive findings but also some challenges facing inpatient services. Within SWYPFT, significant financial investments have already been made since 2014 to develop interventions around the Safer Staffing agenda including increasing some ward establishments after the presentation of a business case, establishing a peripatetic workforce and centralising the Trust staff bank.

The Trust set aside a safer staffing budget of £750,000 in 2016 to support various projects influencing this agenda and aid the Trust in meeting the demands arising from staffing shortfalls while supporting areas with increased clinical needs and risks. This includes appointment of safer staffing specialist adviser, centralising of the staff bank, recruitment of band 4 associate practitioners, recruitment of band 2 staff to the peripatetic workforce, funding for central recruitment co-ordinator and funding for staffing shortfall in ward establishments. The budget is forecast to underspend in 2016-17 due to a number of factors, including slippage during quarter 1, inability to recruit to band 4 posts, band 2 peripatetic staff taken on by BDUs in substantive posts, vacancies, savings from advertising agency costs and lower admin/office costs.

2.0 SUMMARY OF PREVIOUS REPORT AND ACTIONS

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

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

Action

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

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

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

Action

To date the staffing tool which was devised specifically within SWYPFT was used in May 2015 and showed that the majority of inpatient ward areas were staffed beyond the "minimum" levels informed by the tool. Due to changes within the trends of ward acuity and the evolution of the nursing workforce within our Trust, this work has been revisited and a report will be presented to the Safer Staffing Group in March 2017. There will be a consultation being led by NHSI regarding 'Safe and Sustainable Staffing' in January 2017 which will affect our direction of travel

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

Action:

This was completed as part of the business case supporting the development of a peripatetic workforce. Since the approval of the business case in August 2016, the high level of staff vacancies on the wards has meant that recruitment to the supplementary peripatetic workforce has been delayed while vacancies are filled. However, the recruitment of apprentices and health care support

workers onto the peripatetic workforce continues and the first deployment within the BDUs began with secondments in March 2016 and continues with the most recent peripatetic deployment from July and September this year. It continues to be analysed on a monthly basis. Currently, there are fourteen non-registered band 2 staff as well as four band 3 staff deployed throughout all BDUs with recruitment ongoing throughout 2017.

As a result of these deployments the BDUs have been able to, or are looking at, recruiting peripatetic workers into vacancies. This reduces their vacancy fill waiting times meaning less reliance on bank/agency to cover a shortfall caused by the recruitment process. This is in line with an expected outcome of developing a peripatetic workforce and has been practiced in 3 areas where peripatetic workers have been able to fill vacancies with the aforementioned advantages for the Service Users and wards.

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

Action:

We are updating the safer staffing action plan (appendix) to form part of the overall supplementary workforce agenda. This will support the implementation of the Recruitment plan.

5. <u>A systematic review of the staff bank</u>

Action:

A systematic review has taken place and the process of re-centralising the Trust staff bank began with the centralised office being opened on the 12th September 2016. This supports all areas in their temporary staffing needs with a particular focus, initially, on inpatient nursing, thus releasing time of senior clinicians into patient care, reducing any potential risks to Service Users, staff and the Trust as well as promoting cost savings. This will be constantly monitored to assess the impact and the Trust bank will be peer reviewed in April 2017. In March 2017, a survey will to be undertaken with regard to its potential impact within ward areas.

Since the centralisation of the Trust staff bank, there has been a focused recruitment drive for Registered and Non-Registered staff as part of the process of increasing the pool of supplementary staff available to support services. This has include local advertising for Non-Registered staff which will hopefully increase the levels of staff available, in addition to a range of employees who will represent their local communities and have a range of life experiences and skills.

An unexpected cost pressures has arisen as a result of the bank centralisation due to need for staff bank manager. This was previously supplied by HR but additional resource now required to fill this role.

A procurement process has been completed to identify a Master Vendor Agency supplier ensuring compliance with agency frameworks and caps

A new band 4 role has been established to develop the Heath Care Support Worker's role into a post with enhanced knowledge and skills to support the Registered Nursing workforce. SWYPT is also a partner in the new Nursing Associate pilots in West and South Yorkshire.

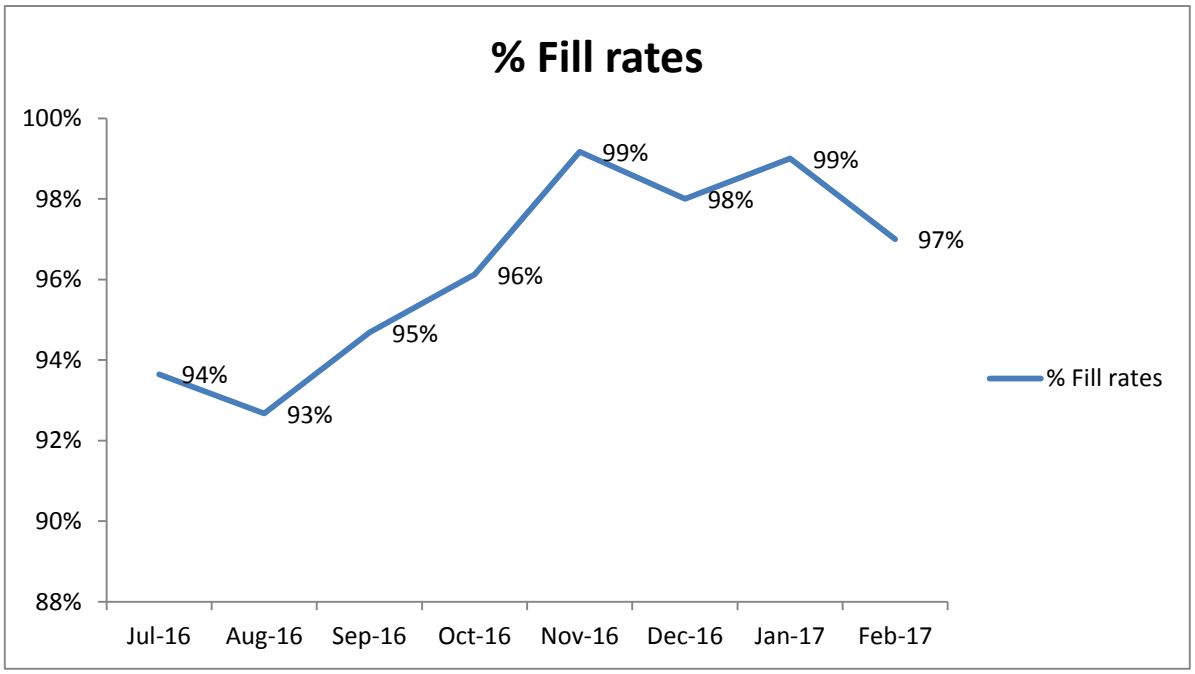
Developing a career structure to enhance staff's opportunities across all areas is in progress. This will include developing ways to respond positively to staff aspirations and for inter-area transfer of staff to maintain career development.

Recent advertisement inviting people to apply for staff bank attracted over 428 applications of which 95 have so far been short-listed. This is very welcome but does cause some pressure on recruitment and selection processes and future care certificate requirements and resources.

3.0 ANALYSIS OF FILL RATES July 2016 – February 2017

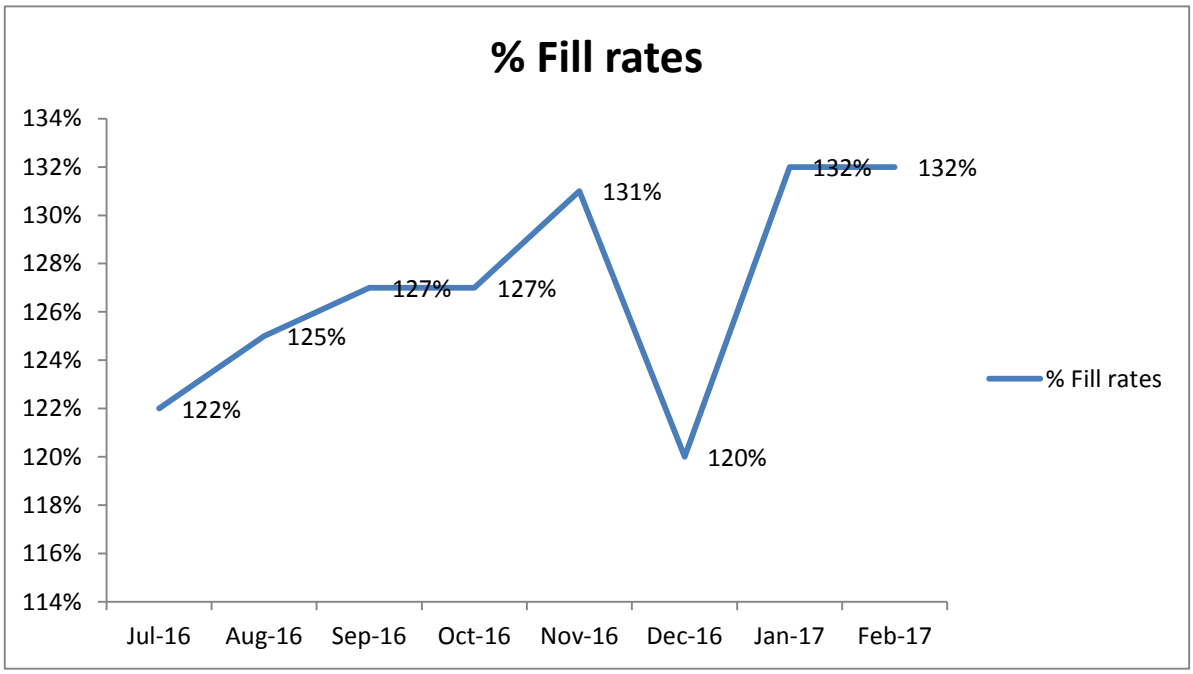
The Deputy District Directors and EMT receive monthly exception reports on fill rates (figures 1 and 2) within our inpatient areas with particular emphasis on areas where fill rate overall (Registered nurses and nursing support) is below 90%, and where Registered nurses on days or nights falls below 80%. Managers are asked to provide exception reports on why fill rates are not achieved, how it was managed and actions to prevent recurrence.

Figure 1. **Registered Nurse Fill Rate Inpatient Areas**



NB - *Minimum requirement for registered nurses is a fill rate of 80%*

Figure 2. **Non-Registered Nurse Fill Rate Inpatient Areas**



Summary

Based on above graphs, overall combined fill rates remain above the 100% level and have remained consistent for both registered and non-registered staff with December being the expected exception due to increased annual leave, sickness and a general reluctance to fulfil bank shifts over the festive period. This trend shows an improvement in overall fill rate for registered nurses particularly since September 2016, which is a result of our centralised recruitment process where we recruited over 60 registered staff throughout the year, the majority being students who finished their courses in September. This process continues and indeed has been extended to a centralised process of recruiting band 2's into our Trust.

The majority of wards are achieving the set targets in all three areas with only Watterton, Enfield Down and Beamshaw not achieving the overall fill rate on a consistent basis but being well above 90%. This is due to a variety of reasons, including supporting other areas within their BDU where a clinical judgement was used to reduce the fill rate to support clinical acuity on other wards. Additionally, most areas are experiencing an increase in acuity particularly around observation levels. This has led to the increase in Non-Registered fill to support these levels as well as any shortfalls in registered staff. This has been an issue for all areas, including our adult physical health wards that, unlike the Mental Health wards, did not have any scope for observation levels built into their original ward establishments; this has shown that our BDUs can be adaptable and flexible.

Many of the areas continue to achieve the overall fill rate through the use of health care support workers to cover temporary vacancies. Again a strategy for filling the vacancies is being developed and supported constantly. There is also a pattern of a higher fill rate of Registered Nurses on nights in comparison to days and this is explained in the exception reports as being reflective of a sustained increase in acuity on nights and the need for covering a time span out with the working patterns of other disciplines and senior clinical staff. Due to this sustained increase of acuity, the Safer Staffing Project Manager has revisited the ward establishments; acuity and ward fill rates, the findings of which will be reported into the Safer Staffing Group in March 2017.

4.0 ANALYSIS OF DATIX INCIDENTS RELATED TO STAFFING

In the 12 months leading up to the 31st December 2016, there were 559 Datix incident reports highlighting staff issues. Although this is a large increase from the previous 12 months in the number of reported incidents, it continues to equate to less than one Datix incident per 48 shifts and none in the serious incidents category. This excludes all mid shifts. This increase coincides with the appointment of the Safer Staffing Project Manager and a presence on the units encouraging accurate and increased reporting. However, it is important that the Trust triangulate Datix information with safer staffing fill rates and exception reporting to ensure safer staffing is maintained and this is considered within the Safer Staffing Group. There is also a change to the classification of Datix to ensure a more accurate and transparent analyses of incidents.

5.0 PERIPATETIC STAFFING BUSINESS CASE

The Safer Staffing Project Manager commenced in post in January 2016. As part of the development of a supplementary workforce, a peripatetic workforce (PW) was developed to enhance flexibility and sustainability of the workforce and giving more opportunities to cover the shortfalls as they arise. This has resulted in 17 x new Non-Registered staff being deployed throughout the Trust as well as four x band 3 at risk staff who joined the PW. This has led to an increase in the wards staffing capacity in dealing with today's challenges.

However, since the original proposal it has become evident that nationally and locally there is a serious shortfall in registered Nurses leading to significant vacancies in staffing establishments, especially on ward areas (> 20% in some areas). Therefore, recruiting registered nurses onto the

peripatetic workforce will not be possible until substantive vacancies are filled. In the interim, Non-Registered staff who are being recruited onto the peripatetic workforce, providing much needed capacity. Should the situation change regarding the challenges facing the recruitment of registered staff, then we would obviously look to recruit and deploy registered staff through the peripatetic workforce. The next stage of over-recruitment to peripatetic workforce will be conducted via respective BDUs, to ensure local priorities are met.

6.0 CQC INSPECTION AND REPORT ON SAFER STAFFING

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

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

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

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

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

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

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

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

- Planned over-recruitment of staff onto a supplementary-peripatetic workforce

- Appointment of a Safer Staffing Project Manager from the Forensic Service
- The establishment of a Safer Staffing Group and staffing exception reporting that includes staff-side representation
- Registered and Non-Registered nursing staff recruited and aligned to BDUs
- A pilot project where peripatetic workforce is rostered on to shifts within the BDUs to cover increases in acuity, staff sickness and activity levels
- Review of the staff bank
- Recruitment campaign running monthly since February 2016
- Recruitment and Retention summit

Neither the CQC report nor the judgments reached reflected this significant piece of work. However, the CQC report and response affords us an opportunity to respond positively and we have identified further remedial action aimed at improving staffing across the Trust (see action plan, appendix). We also discussed our minimum-optimum reporting dilemma with the CQC in September 2016 and they welcomed the clarification of our position. The dilemma is that lowering our planned-expected staffing number would increase the chances of achieving the planned staffing level consistently, but in effect this would reduce the number of staff rostered onto the wards.

6.1 CQC revisits October 2016-February 2017

The CQC revisited the Trust to review progress in addressing regulation breaches and progress in achieving our CQC action plan since report comprehensive inspection report in June 2016. In relation to safer staffing they requested documentation on staffing fill rates, recruitment figures, unfilled shifts, recruitment data, recruitment summit/plans, exception reports, communications with staff, safer staffing meeting minutes and action plan and safer staffing decision support tool. They also triangulated this information with feedback from staff during visits to wards and services and from senior managers and directors as part of the well-led review.

Although staffing remains a challenge, initial feedback immediately following the well-led review was generally positive. We await the results of their re-inspection, which are due around mid-March 2017.

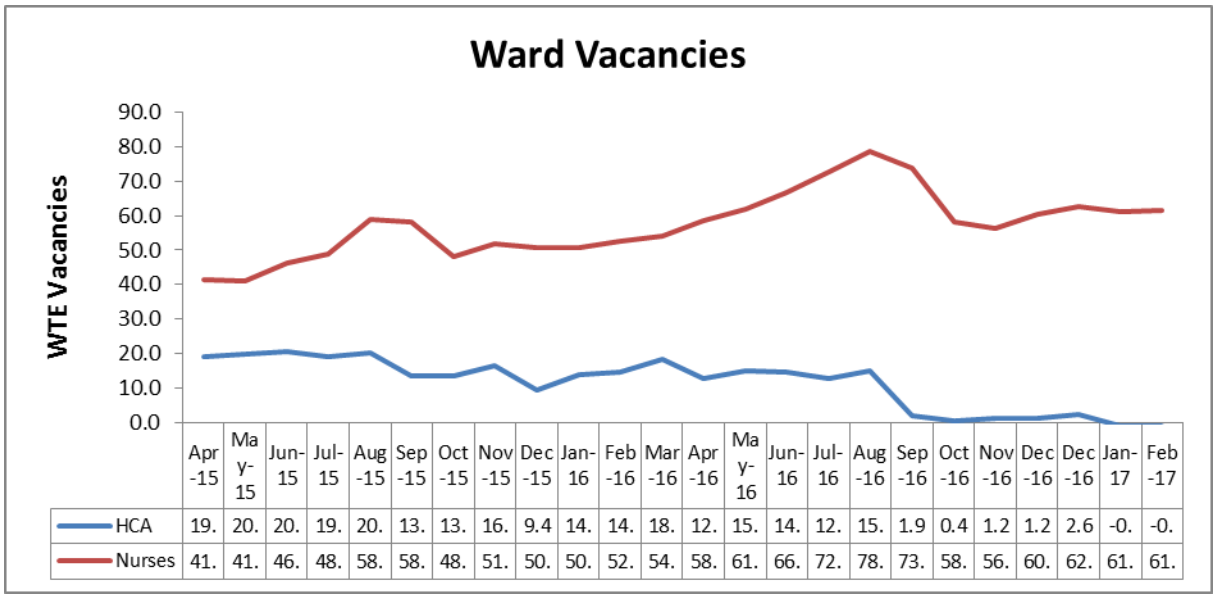
6.2 Recruitment since last CQC visit

The Trust has embarked on a centralised recruitment process for both registered and non-registered nursing staff within inpatient areas. Since February 2016 the Trust has held monthly assessment centres to recruit Band 5 nurses. 11 assessment centres have been held in total with an overall attendance of 132 shortlisted candidates. Of the 132 candidates who have attended a total:

- 127 have been offered posts within the inpatient services.
- 65 have accepted and commenced employment with SWYPFT.
- 54 have verbally accepted their offer but are yet to have completed the pre-employment checks and/or are yet to complete their nurse training and obtain registration.
- 8 declined the offer of employment. Reasons ranged from 2 candidates accepting community posts within SWYPFT, 3 accepting posts nearer to home, 3 declined the offer without reason.

In terms of non-registered staff, there will be four cohorts of fifteen band 2 non-registered staff recruited onto the Apprentice Scheme per year. In addition, a recruitment drive has been implemented across West and South Yorkshire to recruit non-registered and registered staff onto the staff bank.

The table below shows the effect this process has had on recruitment within SWYPT both for Registered and Non-Registered staff.



	Apr -15	May-15	Jun-15	Jul-15	Aug -15	Sep -15	Oct -15	Nov -15	Dec -15	Jan-16	Feb -16	Mar -16	Apr -16	May-16	Jun-16	Jul-16	Aug -16	Sep -16	Oct -16	Nov -16	Dec -16	Dec -16	Jan-17	Feb -17
HCA	19.	20.	20.	19.	20.	13.	13.	16.	9.4	14.	14.	18.	12.	15.	14.	12.	15.	1.9	0.4	1.2	1.2	2.6	-0.	-0.
Nurses	41.	41.	46.	48.	58.	58.	48.	51.	50.	50.	52.	54.	58.	61.	66.	72.	78.	73.	58.	56.	60.	62.	61.	61.

This chart shows the difference between the budgeted establishment and staff on Health Roster at the end of each month. Staff on maternity leave and long-term sick are not excluded from the staff numbers but those on secondment (eg full-time nurse training) are.

As with most mental health services and inpatient wards across the country, SWYPT experienced a sharp rise in registered nurse vacancies from October 2015 to August 2016. Since then, there has been a steady decline between August and December 2016 reflecting the efforts to recruit staff since January 2016.

In December 2016, Ruth May, Executive Director for Nursing at NHS Improvement, shared draft guidance for Trusts, *Safe, Sustainable and Productive Staffing improvement resources* – for consultation and review. We broadly agreed with the guidance offered. As an organisation, we are on track with the majority of the suggestions including the established integrated multi-disciplinary community teams. There are established pathways between inpatient services and community care with a focus on short term inpatient interventions to ensure the people who use our services can remain in the community for as long as possible. Our approach is to support people who use our services to make decisions which affect their lives and care packages. We look forward to the final guidance and resources.

6.3 Safer Staffing in the community

Despite a focus on the inpatient areas there have been numerous discussions around safer staffing in community areas, mainly through transformation projects. There has been a meeting with Sue Barton Deputy Director of Health Intelligence and Innovation and the Safer Staffing Project Manager to initiate the development of an implementation plan which will include a pilot project within a community team to look at the needs and viability of a model before rolling it out throughout the service. It's recognised that it is essential that this is led by the community teams and supported by Sue Barton and the Safer Staffing Project Manager. Within this schedule of work, we shall be evaluating the possible impact that the proposed QNI tool on integrated community health and social teams may have

7.0 SUMMARY AND NEXT STEPS

The national commitment to safer staffing is ongoing and SWYPFT need to maintain the progress already made in delivering safer staffing as well as being engaged in the national development of the mental health safer staffing tool and related initiatives. The Trust currently meets its safer staffing requirement overall, although there is regularly a shortfall in Registered Nurses and in some areas difficulty in sustaining sufficient numbers in times of increased demands. This has resulted in the use of existing staff, bank and agency staff.

Planned inpatient staffing numbers rostered onto shifts meet or exceed the requirements for planned, appropriate staffing and measures are in place to manage demand and capacity to ensure our wards are safe.

However, staff survey and Datix reports suggest concerns remain regarding safer staffing on wards and a more proactive, flexible and sustainable workforce is required to respond to fluctuations in need and demand. The peripatetic workforce supported by an enhanced centralised bank staff management system is likely to result in financial savings whilst providing higher quality staffing and safer care for service users.

In March 2016 the Trinity 2 and PICU within Wakefield BDU reduced their bed capacity over a projected time period due to high demand and low staff capacity issues. The trend analysis identified a peak in vacancies at this time. On the 28th October 2016 a Peer Review was undertaken regarding the bed reduction and as a result a plan was developed to increase bed numbers to full capacity on Trinity 2 and PICU in November 2016. However, since then a fire broke out on Trinity 2 which resulted in a reconfiguration of the Wakefield service with the PICU moving to an available ward within the Forensic BDU which resulted in a reduction of beds. However, a timely and near-complete service offer was re-established.

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

- Continue to build upon and improve data in exception reports including;
    - Utilise the new dashboards for Datix incidents and reporting
    - Triangulation of DATIX, exception reporting and HR information
    - Extend the narrative and analysis of the information
- Extend and maximise functionality within current e-rostering system as part of the centralisation programme for the trust staff bank
- Continue to provide effective and efficient support to meet establishment templates
- Project manager to work closely with 'hotspot' wards where there is pressure on meeting staffing numbers
- Involvement in the development of a National Safer Staffing tool for inpatient Mental Health areas
- Continue to develop, manage and deploy the peripatetic workforce
- Continue the Safer Staffing Group, and monitor the action plan and new initiatives
- Safer Staffing Project Manager will work with Practice Governance Coaches to review safer staffing in the community and improve understanding and monitoring of direct care contact time
- Develop a Safer Staffing strategy for both our physical and mental health community teams.
- Support recruitment of AHPs and assist in the development of links with Universities

- Support the development of the Trust staff bank to enhance the support offered to all areas within the Trust and continue recruitment onto staff bank
- Establish safer staffing specialist advisor post on a permanent basis
- Support over-recruitment of peripatetic staff within BDUs
- Respond to Ruth May NHS Improvement guidance for safer staffing once confirmed
- Align Safer Staffing initiatives with new Trust Workforce Strategy

Appendix

Safer Staffing Action Plan
February 2017

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

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

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
1. Bank Workers Changes	• Increase number of shifts required to remain on bank workforce (1 in 6 months to 4 in 6 months)	Colin Hill	- Communications Team - Engagement events - Bank Staff	July 2016 Update: end of January 2017	- as per updated paper May 2016 - discussed and accepted at EMT May 2016	
	• Introduce enhanced bank payments for limited period • Review of impact February 2017	Mike Doyle	Alan Davis	March 2017	- as per updated paper May 2016 - discussed and accepted at EMT May 2016 - Extended until end of March 2017	
	• Extend enrolment to 2nd and 3rd year Nursing students who haven't had a placement within SWYT	Colin Hill	- Practice Learning facilitator team - bank office	February 2017		

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
	• Finalise Staff Bank Policy	Colin Hill	- HR department - Safer Staffing Group - Clinical Governance Group - EMT	March2017	- Policy is in draft - ensure changes to staff bank are incorporated	
	• Explore partnership working with local providers to look at bank and agency working	Colin Hill	- Mike Doyle - Workforce planning -Tony Cooper	November2016 Update and ongoing March 2017	- Meeting with Tony Cooper and providers around cloud bank	
2. Workforce planning	• Centralised inpatient Band 5 Recruitment	Sue Hastewell-Gibbs	- Recruitment Group - Safer Staffing - Recruitment/HR teams -BDU's	July 2016 Completed and ongoing	- Process established and ongoing from Feb 2016 - engagement event established for new recruits	
	• Centralise inpatient Band 2 recruitment	Claire Hartland	- Colin Hill - Recruitment - Care Certificate co-ordinators	October 2016	- Courses planned - Partnership with Barnsley College	
	• Review and enhance preceptorship Programme	George Smith		September 2016 and ongoing	- meeting with various parties established	
	• Review of establishment templates	Colin Hill	- BDU Trios - Ward Managers	March 2017	- Meetings arranged - Data review	

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
	• Set up a steering group to develop a recruitment and retention strategy	Ashley Hambling	- Colin Hill - Kate Henry - Diane Traynor - Recruitment - Richard Butterfield - Nursing Directorate	October 2016	Nursing/HR directorate recruitment summit meeting in July to look at safer staffing	
	• Review cost pressures on Safer Staffing including bank, agency and Peripatetic working	Mike Doyle	- Colin Hill - Dawn Eastwood - Andrew Prince - HR/ Safer Staffing group	ongoing		
	• Explore an Overseas recruitment strategy	Recruitment summit	- Sue Hastewell-Gibbs - Colin Hill - Diane Townend - Andrea Horton - Mike Doyle	January 2017		
	• Identify recruitment issues within other disciplines	Recruitment summit	- HR business partners - Colin Hill	March 2017		
	• Localised bank non Registered staff recruitment	Colin Hill	- Claire Hartland - Comms dept	Jan 2017	- Job description and Person spec reviewed Update Feb 2017 advert has been placed	
3. New ways of working	• Set up a steering group to review band 6 – 8a Nurse Practitioner roles	Kathryn Padgett	- Richard Butterfield - Claire Hartland - Kathryn Hemming - Mike Doyle - Colin Hill	July 2016	- Practitioners Meeting already established	

Goal	Action	Lead	Support	Completed by end of:	Progress	RAG
	• Development of band 4 strategy	Richard Butterfield	- Colin Hill - Kate Henry - Diane Traynor - Recruitment - Richard Butterfield - Nursing Directorate - Jackie Davis/Lynne Nightingale - BDUs	Ongoing	- evolvement of the band 2 strategy group - explore potential cohort with local partnership organisations	
	• Trust wide inter area transfer procedure	Richard Butterfield	- HR Directorate - Colin Hill - Sue Hastewell-Gibbs - Richard Butterfield	January 2017		
	• Utilising the Peripatetic Workforce as a recruitment stream for the organisation	Colin Hill	- Claire Hartland - Sue Hastewell-Gibbs - Diane Traynor	November 2016 and ongoing		
	• Safer Staffing review within the community to begin	Colin Hill Sue Barton	- community teams	April 2017	- initial discussions with 2 community areas - Deployment of peripatetic workers to support transformation projects from January - initial strategy meeting with Sue Barton	

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 7.3

Title:	**Eliminating mixed sex accommodation declaration of compliance**
Paper prepared by:	Director of Nursing and Quality
Purpose:	To appraise the Board of the Trust position in relation to eliminating mixes sex accommodation (EMSA) and to approve the annual declaration.
Mission/values:	Safeguarding the privacy and dignity of service users when they are often at their most vulnerable.
Any background papers/ previously considered by:	Trust Board reviews the compliance statement on an annual basis. Any exception reports regarding EMSA are reported to the Clinical Governance and Clinical Safety Committee by the Director of Nursing. There have been no exception reports in 2016.
Executive summary:	**Background** This paper is intended to assure Trust Board of the organisation's level of compliance with the national standard in respect of eliminating mixed sex accommodation. The declaration of compliance, which will appear on the Trust's website, is shown below. The Trust is expected to make a declaration to commissioners by 31 March 2017 to confirm the Trust's position regarding compliance with the EMSA standard. The statement of compliance is then required to be posted on the Trust website. The guidance in relation to EMSA expects Trusts to provide the following accommodation. Single Sex accommodation can be provided in: ➢ single sex wards (the whole ward is occupied by men or women but not both); ➢ single rooms with adjacent single sex toilet and washing facilities; ➢ single sex accommodation within mixed wards (bays or rooms that accommodate either men or women, not both) with designated single sex toilet and washing facilities preferably within or adjacent to the bay or room. In addition, service users should not need to pass through accommodation or toilet/washing facilities used by the opposite sex to gain access to their own. In order to reduce the burden on frontline services, 2016 audit was conducted only on mixed sex areas or any area where any regulator made any comments or raised any issues in the past year. The main conclusions are: ➢ No EMSA breaches were reported in 2016. All service users admitted to in-patient areas were accommodated in a single sex ward or a single sex bedroom. ➢ 93% of wards audited reported consultations took place in a private room or in a space that facilitates private discussion ➢ 91% I of wards audited reported lockable bedroom doors were 'always' available

	➢ Ward 18 in North Kirklees is the only mixed sex acute adult admission unit in the trust. It is split into a male and female side, however all accommodation is single bedrooms. Where a service user needed to be admitted in a clinical emergency to a bed designated for the opposite sex, they were accommodated in a single room and managed with enhanced levels of observation in accordance with the policy. *All incidents related to service users requiring urgent admission to maintain safety and being placed in a single room in an opposite sex area where no bed in appropriate sex area was available. All were managed via policy and increased levels of observations* **Current Trust position** During 2016 there have been no reported EMSA breaches. The Trust is, therefore, in a position to declare EMSA compliance as follows. *"Every service user has the right to receive high quality care that is safe, effective and respects their privacy and dignity. The South West Yorkshire Partnership NHS Foundation Trust is committed to providing every service user with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.* *"We confirm that mixed sex accommodation has been eliminated in our organisation. Service Users that are admitted to any of our hospitals will only share the room where they sleep with members of the same sex, and same sex toilets and bathrooms will be close to their bed. Sharing of sleeping accommodation with the opposite sex will never occur. Occupancy by a service user within a single bedroom that is adjacent or near to bedrooms occupied by members of the opposite sex will only occur based on clinical need. If this occurs the service user will be moved to a bedroom block occupied by members of the same sex as soon as possible. On all mixed gender wards there are women only lounges or rooms which can be designated as such."* **Compliance monitoring** The Clinical Governance and Clinical Safety Committee receive assurance through the Director of Nursing about the Trust's compliance with eliminating mixed sex accommodation. Any potential areas of risk are considered at quarterly EMSA review group meetings. During 2016, the EMSA review group has monitored all reported instances where service users have had to sleep in a single room on a corridor or pod designated for the opposite sex. From January to December 2016, there were 25 such instances reported on Datix compared with 21 for the same time period in 2015. The 2016 EMSA Best Practice Guidance Audit Report indicates that the Trust continues to perform well against best practice standards. The EMSA review group will implement action against any areas where improvements can be made. The Trust also has an action plan for continued monitoring and improvement, which is linked to the Patient-led Assessment of the Care Environment (PLACE). Provision of high quality facilities that meet the privacy and dignity of service users is a prime consideration when any changes to the Trust estate are made. The trust increased the numbers of single sex wards in 2016. Going forward, transformation projects will work with commissioners to look for opportunities to create new, and improve current single sex environments.

	Financial implications Non-compliance against the eliminating mixed sex accommodation standard is a 'nationally specified event'. An EMSA breach will continue to carry financial penalties. **Legal implications** The Trust will need to ensure that it is compliant with safeguarding issues related to the provision of services through safe delivery of the Department of Health guidance on eliminating mixed sex accommodation. **Equality and diversity** The Trust's statutory duties relating to equality and diversity have been met. The Trust has considered equality and diversity when developing its estate to meet the privacy and dignity needs of service users. **Risk Appetite** An EMSA breach could potentially be a clinical risk as well as a compliance risk. Through the flexibility within the Trust's accommodation the risk is mitigated in line with the Trust's risk appetite. However, it may be deemed safer to breach EMSA on an individual basis than not to admit in a clinical emergency and actions would be put in place to manage the individual risk.
Recommendation:	**Trust Board is asked to APPROVE the compliance declaration.**
Private session:	Not applicable

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Eliminating Mixed Sex Accommodation Trust Audit 2016

Report commissioned by:
George Smith – Assistant Director of Nursing
On behalf of the
Eliminating Mixed Sex Accommodation
Quarterly Review Group

Report produced by:
Suzy Daly
Quality Improvement & Assurance Team

Project reference 16/17CA506

January 2017

With **all of us** in mind.

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Acknowledgements

Grateful thanks to members of the Eliminating Mixed Sex Accommodation Quarterly Review Group and the ward staff for completing the audit

Peer reviewed by Gillian Marley and Marie Dawson

Please note:
Percentages throughout this report may add up to +/- 100% due to rounding up/down.

EXECUTIVE SUMMARY

South West Yorkshire Partnership NHS Foundation Trust provides a variety of services to a diverse population across the geographical localities and is committed to achieving the Trust's 'Mission and Values'.

Our mission

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

Our values

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

Trust inpatient services are provided in Calderdale, Kirklees, Wakefield and Barnsley. As part of the annual audit programme and identified as a priority area for the Eliminating Mixed Sex Accommodation (EMSA) Quarterly Review Group is an audit of the inpatient accommodation. The current report details the findings from the 2016 audit against best practice standards. In the 2016 audit it was decided to only include any mixed sex ward areas, or any areas identified as having any EMSA issues within the 2016 CQC Inspection.

The main conclusions are:

- No EMSA breaches were reported in 2016. All service users admitted to in-patient areas were accommodated in a single sex ward or a single sex bedroom.
- 93% of wards audited reported consultations took place in a private room or in a space that facilitates private discussion
- 91% of wards audited reported lockable bedroom doors were 'always' available
- Ward 18 in North Kirklees is the only mixed sex acute adult admission unit in the trust. It is split into a male and female side, however all accommodation is single bedrooms. Where a service user needed to be admitted in a clinical emergency to a bed designated for the opposite sex, they were accommodated in a single room and managed with enhanced levels of observation in accordance with the policy.

The main recommendations are:

To continue to explore opportunities through the transformation agenda for wards to be designated single sex or to improve the availability of en-suite accommodation in mixed sex units.

INCIDENT REPORTING

There were no breaches of EMSA policy in 2016.

In instances where a service user has been allocated to a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trust reporting procedure using the 'Datix' system. These incidents are reviewed by the general managers and any actions are recorded.

Where such an incident occurs mitigating action includes:

- Increased observation
- Updated risk assessment and monitoring
- Review of care plan

The following table details the number of incidents recorded on Datix by BDU and ward during 2016.

Table 1: Summary of reported EMSA incidents

Ward and BDU	Number of Incidents	Risk Category GREEN – no harm or injury/minor injury, impact, intervention YELLOW – moderate injury, impact or intervention AMBER – major injury, impact or intervention
Wakefield	***2***	
Chantry	2	2 green
Trinity 2	1	1 green
Kirklees/Calderdale	***22***	
Beechdale	2	2 green
Elmdale	1	1 green
Ward 18	16	13 green / 3 yellow
Ward 19	3	2 green / 1 yellow
Total	**25**	

All incidents related to service users requiring urgent admission to maintain safety and being placed in a single room in an opposite sex area where no bed in appropriate sex area was available. All were managed via policy and increased levels of observations.

BEST PRACTICE STANDARDS

The following table shows a summary of the audit against best practice standards result. It should be noted that where wards identified questions as 'not applicable' these have been deducted from totals. **The results have been colour coded as follows: 100% in green, 90% and over in blue, 50% and less in red.**

Table 2: Summary of results - Ward/Unit

Standard	2016 % compliant
Service users are accommodated in single rooms, single sex bed bays, separate corridors or pods	100%
Bedroom doors are fitted with observation peephole or panel window and these can be operated by members of staff	87%
Consultations take place in a private room	93%
Toilets and bathroom doors are lockable from the inside and fitted with fail safe entry mechanisms which can only be opened by staff	91%
Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department	92%
Toilets & washing facilities are fitted with internal privacy curtains and staff ensure these are closed when assisting service users	77%
Bedroom doors are lockable from the inside with both fail safe entry mechanisms to ensure service user safety	91%
Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained	93%
Staff carrying out physical examinations are the same gender as the service user or if not are accompanied by a chaperone of that gender	93%
Staff using restraint are the same gender as the service user or if not are accompanied by a chaperone of that gender	64%
Toilets have nurse call systems to ensure safety	53%
Where toilets do not have nurse-call systems the service user is risk assessed and a personal alarm provided	83%
Service users are asked if they have a preference regarding same sex key worker	60%
Bedroom doors have observation mechanisms to ensure service user safety	100%
Male and Female toilets and washing facilities are clearly labelled male or female	77%
Staff have access to emergency clothing if required	54%
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix)	100%
In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex appropriate safeguarding measures such as enhanced observation are applied	100%

*Please note a comparison cannot be done with 2015 responses, as not all wards were included in the 2016 audit.

Table 3: Summary of results - Trust Board

	Trust Board Self-Assessment		
	The Trust does not have any mixed sex accommodation so the standards are judged to be met as determined in previous audits. Commentary given is related to maintaining good practice in regard to Trust Board information		
	Mechanisms are in place to provide the Board of Directors with regular information on the views of patients and service users	**met**	The board receives regular reports providing service user feedback which capture any views expressed about mixed sex accommodation
	The Board receives regular reports on the Trust's progress in eliminating mixed sex accommodation	**met**	The board receives information in the quarterly quality reports where any EMSA breaches would be highlighted. There is also the annual EMSA statement from the lead Director
	The Board receives information from patient complaints and incidents, categorised on the basis of mixed sex accommodation issues. These should also include abuse and sexual safety issues	**met**	• The Board receives regular customer services reports including information on complaints broken down into themes which would capture mixed sex accommodation concerns. • The quarterly compliance report which goes to Executive Management Team specifies incidents which have occurred relating to people accommodated on other gender ward areas and associated safeguarding processes (increased observation levels etc.)
	The Board reviews and amends policies on mixed sex accommodation in light of experience, incidents and changes to the service	**met**	• There is now an EMSA policy. • Trust uses national guidance to inform practice. Trust Board would respond and require practice change if breaches were to occur
	The Board sets annual measurable targets for improvement	**N/A**	N/A as declared that mixed sex accommodation has been eliminated in all SWYPFT hospitals
	The Trust considers the elimination of mixed sex accommodation in any refurbishment or new-build capital development schemes	**met**	This is an integral part of the planning procedure
	The Trust provides training to support the elimination of mixed sex accommodation & promote the protection of privacy & dignity	**met**	Not specifically - however safeguarding training links to protection of privacy and dignity

1. INTRODUCTION

South West Yorkshire Partnership NHS Foundation Trust is committed to undertake an annual audit programme. An annual audit against best practice guidelines on eliminating mixed sex accommodation has been commissioned and undertaken since 2010. Previous audits involved all Trust inpatient units including bed based rehabilitation and recovery units, but the 2016 audit only included mixed sex wards or any with EMSA actions within any CQC report i.e. all wards that are single sex were deemed to be EMSA compliant and were not included in the audit.

1.1 Aim

To evaluate adherence to EMSA good practice guidelines in inpatient units.

1.2 Objectives

The main objectives of the audit are:

- To ascertain whether the adherence to the guidelines was 100% to maintain the highest standards of risk management
- To determine the nature and reasons for discrepancies
- To highlight any areas of concern and make recommendations

1.3 Methodology

An initial self-assessment audit tool based on national guidance was developed to collect relevant data in 2010 with annual revisions. The latest re-audit was undertaken in November 2016 using Survey Monkey.

The data analysis and production of a report were completed by the Quality Improvement and Assurance Team.

1.4 Sample size

14 inpatient units/wards across the Trust undertook the self-assessment, but there were 15 completed surveys as Ward 19 completed 2 – one for each side of the ward (male and female).

1.5 Staff involved in developing and conducting the audit

Inpatient ward managers

Suzy Daly	Projects Manager - Clinical Audit, Quality Improvement & Assurance Team
Victoria Hitchman	Projects Manager – Service Evaluation, Quality Improvement & Assurance Team
Gillian Marley	Team Manager, Quality Improvement & Assurance Team
George Smith	Assistant Director of Nursing

2. RESULTS FOR WARD SELF-ASSESSMENT

The results are shown as overall (Trust wide), by Business Delivery Unit and in 2016 it has not been possible to provide a comparison with the previous year's audit results due to single sex wards not being included in this year's audit. Also please note, there are 2 completed surveys for Ward 19, as this unit is now split into 2 sections, 1 for male and 1 for female. Comments have been included where appropriate.

2.1 Sample

14 inpatient units/wards were included in the self-assessment, but we had a total of 15 completed surveys due to Ward 19 completing one for each side of the ward due to it being split into 2 sections male and female.

Table 4: Description of wards/units

Ward/Unit	Description	Business Delivery Unit
Lyndhurst	Adult unit, 14 single rooms with wash basin, 5 shared bathrooms, 3 mixed sex lounges	Calderdale
Beechdale	Older peoples mental health unit, 16 rooms, 4 single en-suite rooms, 12 single rooms with wash basin, 4 bathrooms (2 assisted), 4 lounges	
Ward 18	Adult mental health unit, 23 single rooms with wash basin, 5 bathrooms (2 assisted), 3 lounges	Kirklees
Ward 19 (now split into 2 sides male and female)	Older people's mental health unit, 30 single rooms with wash basin, 5 bathrooms (2 assisted), 4 lounges. Ward is now split into 2 sections incorporating a male and female side	
Enfield Down	Adult mental health unit, 28 single rooms with wash basin, 4 shared bathrooms (2 assisted), 4 mixed sex lounges	
Chantry Unit	Older peoples mental health unit, 16 single rooms with wash basin, 3 assisted bathrooms, 3 mixed sex lounges	Wakefield
Poplars	Older peoples mental health unit, 15 single rooms with wash basin, 2 assisted bathrooms, 2 mixed sex lounges	
Horizon	Learning disabilities unit, 4 single en-suite rooms, 1 assisted bathroom, 2 mixed sex lounges	
Newhaven	Low secure learning disabilities unit, 16 male beds, 16 single rooms with en-suite, 2 assisted bathrooms, 2 lounges	
Willow	Adult mental health unit, 5 male beds, 5 female beds, 10 single rooms with en-suite, 3 bathrooms (2 assisted), 3 lounges	
Stroke Unit (Mount Vernon)	General unit (any age), 16 beds, 16 single rooms with en-suite, 1 assisted shared bathroom, 2 lounges	Barnsley
Ward 5 (Mount Vernon)	Older peoples unit, 24 beds, 3 single rooms with wash basin, 1 ensuite, 4 bays with 5 beds designated male or female bays plus bathroom, 2 assisted bathrooms, 3 lounges – 1 male, 1 female and 1 shared	
Neurological Rehabilitation Unit (NRU)	General unit (any age), 12 beds, 12 single rooms with en-suite, 2 assisted bathrooms, 2 mixed sex lounges	
Psychiatric Intensive Care Unit (PICU)	Adult mental health, 6 beds, 6 single rooms with en-suite, 2 shared bathrooms (1 assisted), 2 mixed sex lounges	

The wards that weren't included in the 2016 audit are listed below in table 5, these wards are single sex only and are designated for use by males or females only:

Table 5: Description of wards/units not included in the 2016 audit

Ward/Unit	Description	Business Delivery Unit
Elmdale	Adult unit, 24 single ensuite rooms, 1 assisted bathroom, 3 lounges	Calderdale
Ashdale	Adult mental health unit, 24 single ensuite rooms, 1 assisted bathroom, 3 lounges	Kirklees
Savile Park View	Older peoples mental health unit, 10 single rooms, 4 shared bathrooms, 2 mixed sex lounges	Wakefield
Fox View	Learning disabilities unit, 5 single rooms with wash basin, 2 bathrooms (1 assisted), 2 mixed sex lounges	
Trinity 1	Adult mental health unit, 14 single ensuite rooms, 2 bathrooms, 3 lounges	
Trinity 2	Adult mental health unit, 22 single rooms with wash basin, 2 bathrooms, 2 shower rooms, 3 lounges	
Priory 2	Adult mental health unit, 22 single rooms with wash basin, 2 bathrooms, 2 shower rooms, 3 lounges	
Castle Lodge	Adult mental health, 12 single rooms with wash basin, 3 bathrooms, 2 lounges	
Appleton	Medium secure learning disabilities unit, 7 male beds, 8 single ensuite rooms, 1 bathroom, 2 lounges	Forensic Services
Bronte	Forensic unit, 7 single ensuite male rooms, 1 bathroom, 2 lounges	
Chippendale	Medium secure learning disabilities unit, 13 male beds, 12 single ensuite rooms, 2 lounges	
Johnson	Forensic unit, 15 single ensuite female rooms, 2 bathrooms, 3 lounges	
Hepworth	Forensic unit, 15 male beds, 13 single rooms with wash basin; 2 with no facilities, 3 bathrooms, 3 lounges	
Priestley	Medium secure unit, 17 male beds, 17 single rooms with ensuite, 1 bathroom, 2 lounges	
Waterton	Forensic unit, 16 male beds, 16 single rooms with ensuite, 1 bathroom, 2 lounges	
Ryburn	Low secure unit, 7 male beds, 7 single rooms with ensuite, 2 lounges	
Sandal	Low secure unit, 16 male beds, 6 single rooms with no facilities, 2 bathrooms, 2 lounges	
Thornhill	Low secure unit, 15 male beds, 15 single rooms with no facilities, 8 bathrooms, 2 lounges	
Beamshaw	Adult mental health unit, 14 male beds, 14 single rooms with ensuite, 1 assisted bathroom, 2 lounges	Barnsley
Clark	Adult mental health unit, 14 female beds, 14 single rooms with ensuite, 1 assisted bathroom, 2 lounges	

2.2 Service user accommodation

Service users (including those admitted in emergencies) are accommodated in a variety of settings. This question gave the respondents options for completion. It must be noted that some of the wards have more than one type of accommodation.

Table 6: Accommodation

BDU	Pods	Single sex bed bays	Separate corridors	Single rooms
Calderdale	1	1	1	1
Kirklees	-	-	1	4
Wakefield	-	-	2	2
Forensic	1	-	-	-
Barnsley	-	1	1	5
Trust total	2/15	2/15	5/15	12/15

100% of service users were accommodated in single sex accommodation

2.3 Consultations

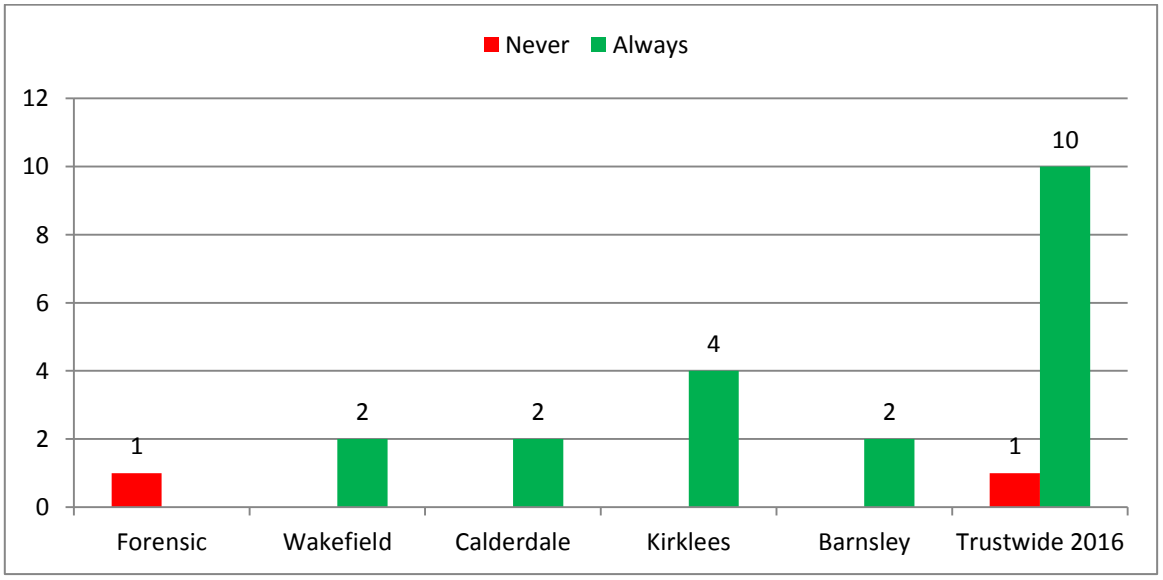
Consultations take place in a private room or in a space that facilitates private discussion. 14/15 (93%) of the wards/units were compliant with this standard. Ward 5 Mount Vernon said sometimes.

Comments included: Ward 5 – *Some patients are bed bound and therefore unable to be seen in the private room however every effort is taken to ensure conversations are private e.g. Curtains are drawn.*

2.4 Bedroom doors are lockable

Bedroom doors are lockable from the inside with fail safe entry mechanisms to ensure service user safety. Of the 15 responses, 4 were not applicable. The following chart shows the results Trust wide and by BDU:

Figure 1: Lockable bedroom doors (n=11)



The ward that stated never was:

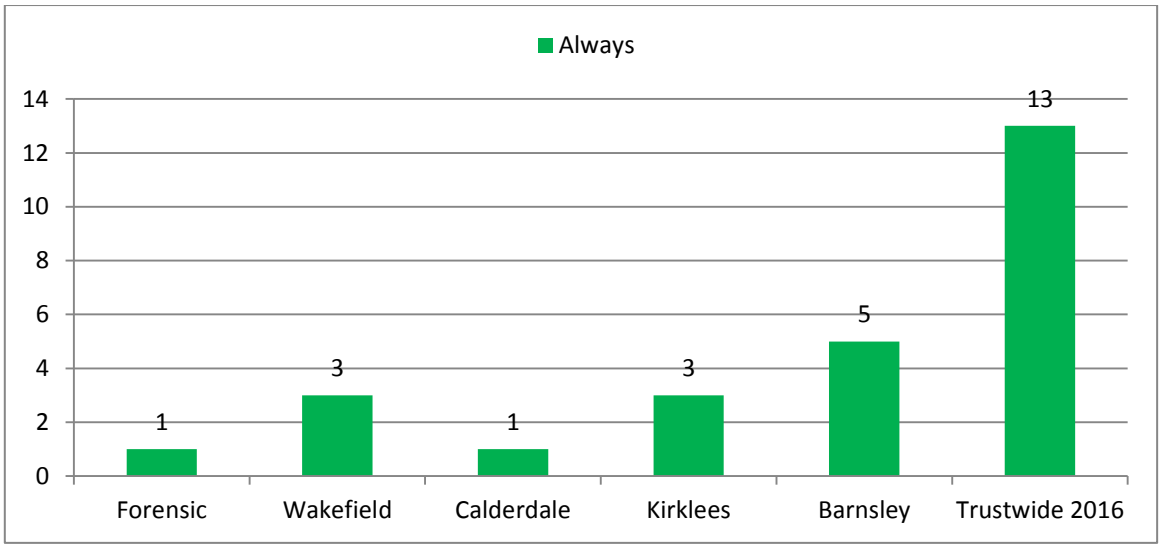
- Newhaven – *Doors can only be opened with a key externally. Internally there is a door handle. Staff can observe into the room via vistamatic windows. Are also anti-barricade strips on all doors.*

Results indicate that lockable bedroom doors were 'always' available on 10/11 (91%) of the wards/units.

2.5 Bedroom doors have observation mechanisms

Bedroom doors have observation mechanisms to ensure service user safety. Of the 15 responses, 2 were not applicable. The following chart shows the results Trust wide and by BDU:

Figure 2: Observation mechanisms (n=13)



The wards not applicable were:

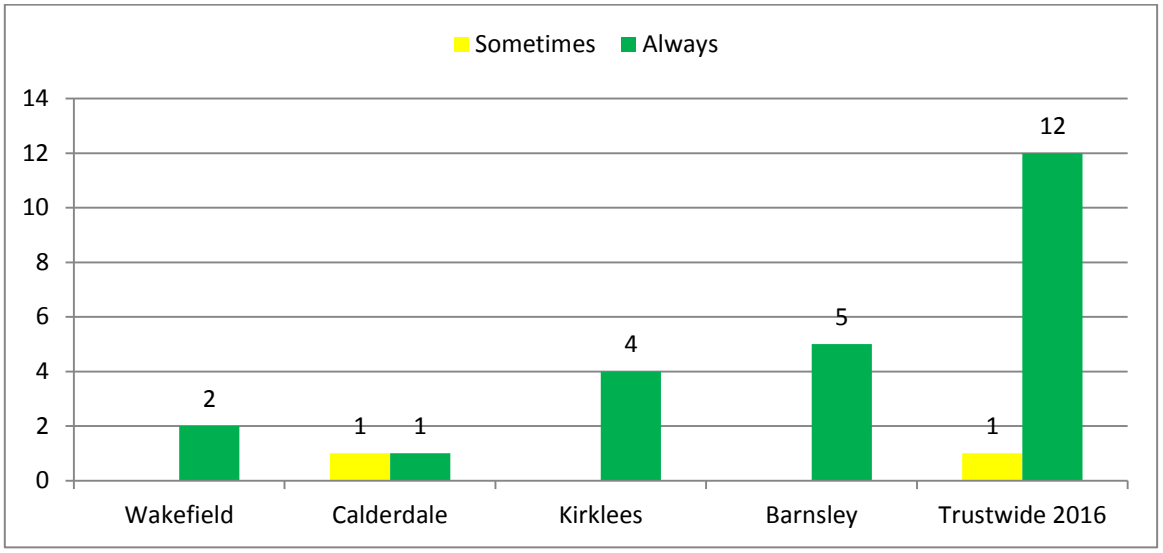
- Enfield Down – *No observation panels – solid doors*
- Lyndhurst – *Only four bedrooms with viewing windows*

The 2 wards, (both rehabilitation and recovery units) responded that the question was not applicable, of the wards where observation windows were installed and appropriate, 13/13 (100%) reported compliance.

2.6 Separate male and female toilets and washing facilities

Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department. Of the 15 responses, 2 were not applicable. The following chart overleaf shows the results Trust wide and by BDU:

Figure 3: Separate male and female toilets (n=13)



The results indicate that separate male/female toilets were 'always' available on 12/13 (92%) of the wards/units for which this standard was judged to be applicable.

Wards that stated not applicable were:

- Horizon Centre – *All bedrooms are ensuite there is a separate accessible bathroom and toilets*
- Newhaven - *No comments*

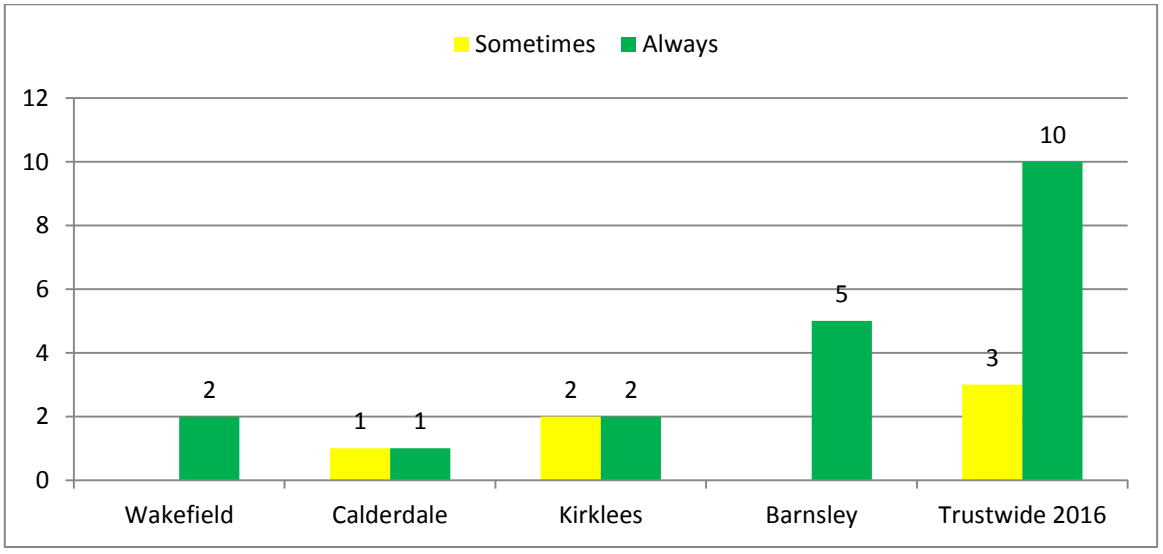
The ward that stated sometimes was:

- Lyndhurst – *only 4 bedrooms with viewing windows*

2.7 Male and female toilets and washing facilities are clearly labelled

Male and female toilets and washing facilities are clearly labelled male or female. Of the 15 responses, 2 were not applicable. The following chart shows the results Trust wide and by BDU:

Figure 4: Facilities clearly labelled (n=13)



The results indicate that separate male/female toilets were 'always' labelled on 10/13 (77%) of the wards/units for which this standard was judged to be applicable.

Wards that stated not applicable were:

- Horizon Centre – *All bedrooms are ensuite and patients have access to their own rooms*
- Newhaven – *No comment given*

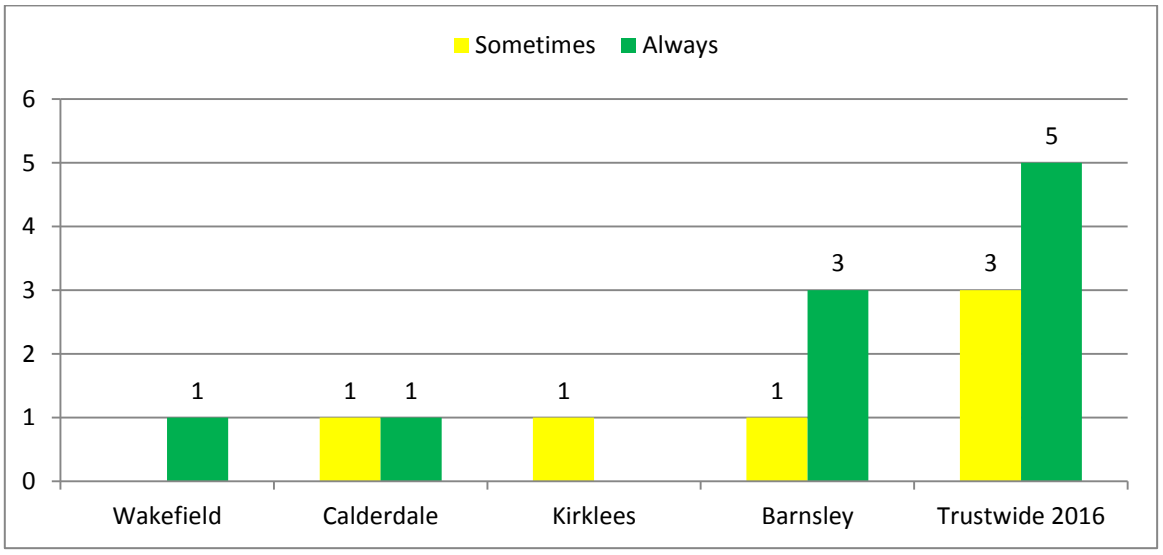
Wards that stated sometimes were:

- Ward 19 Male and Female – *Awaiting new signage*
- Beechdale – *No comment given*

2.8 Internal privacy curtains

Toilets and washing facilities are fitted with internal privacy curtains. Of the 15 responses, 7 were not applicable. The following chart shows the results Trust wide and by BDU:

Figure 5: Internal privacy curtains (n=8)



The results indicate that privacy curtains were 'always' available on 5/8 (63%) of the wards/units.

Wards that stated sometimes were:

- Ward 19 Female – *No comment*
- Ward 5 – *All toilets and washing facilities are for one person use only, the assisted bathroom has a privacy curtain*
- Beechdale – *No comment*

Wards that stated not applicable were:

- Enfield Down – *No comment*
- Poplars – *Single use*
- Ward 18 – *No comment*
- Chantry – *Awaiting privacy screen in one shower room following decant*

- Newhaven – *Ensuite facilities. Two other bathrooms on ward with same locking system as bedrooms*
- SRU – *Patient toilets are within their own rooms*
- Ward 19 Male – *No comment*

2.9 Toilets and bathroom doors are lockable

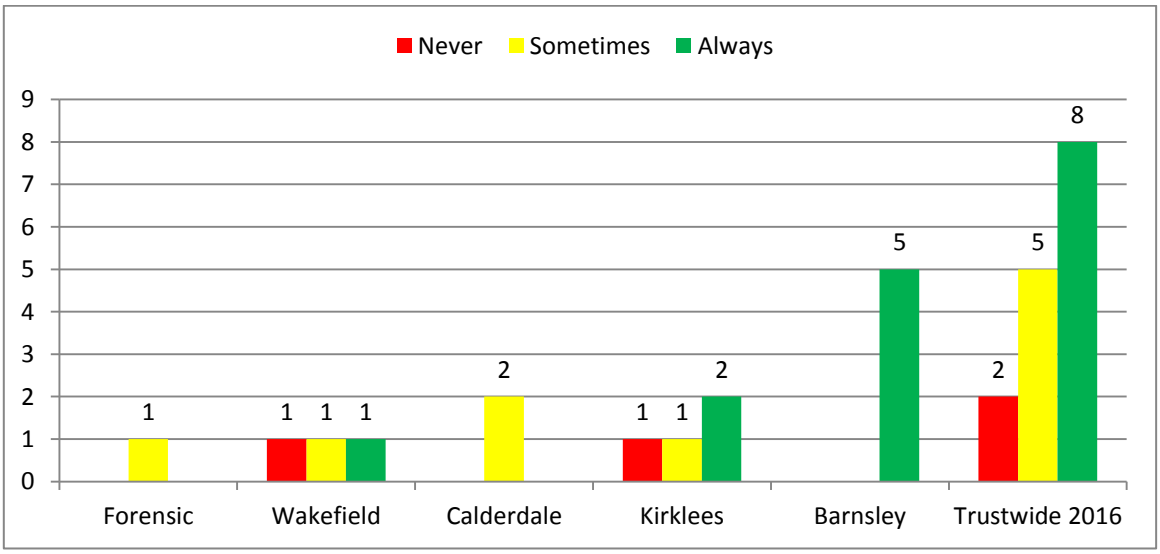
Toilets and bathroom doors are lockable from the inside and are fitted with fail safe entry mechanisms which can only be opened by staff. The majority of wards were 100% compliant, except:

- Never was stated by Newhaven
- Sometimes was stated by Enfield Down– *Bathroom doors have been logged with facilities as requiring replacement as are sometimes difficult to open in an emergency*

2.10 Toilets have nurse call systems to ensure safety

The following chart shows the results Trust wide and by BDU:

Figure 6: Nurse-call systems (n=15)



The results indicate that nurse call systems were available on 8/15 (53%) of the wards/units for which this standard was judged to be applicable.

Wards that stated sometimes were:

- Lyndhurst – *In assisted bathroom*
- Beechdale – *no comment given*
- Ward 18 – *Two assisted bathrooms have nurse call buttons, standard toilets do not*
- Poplars – *New toilet does not yet have one fitted*
- Newhaven – *One bariatric bedroom with this facility*

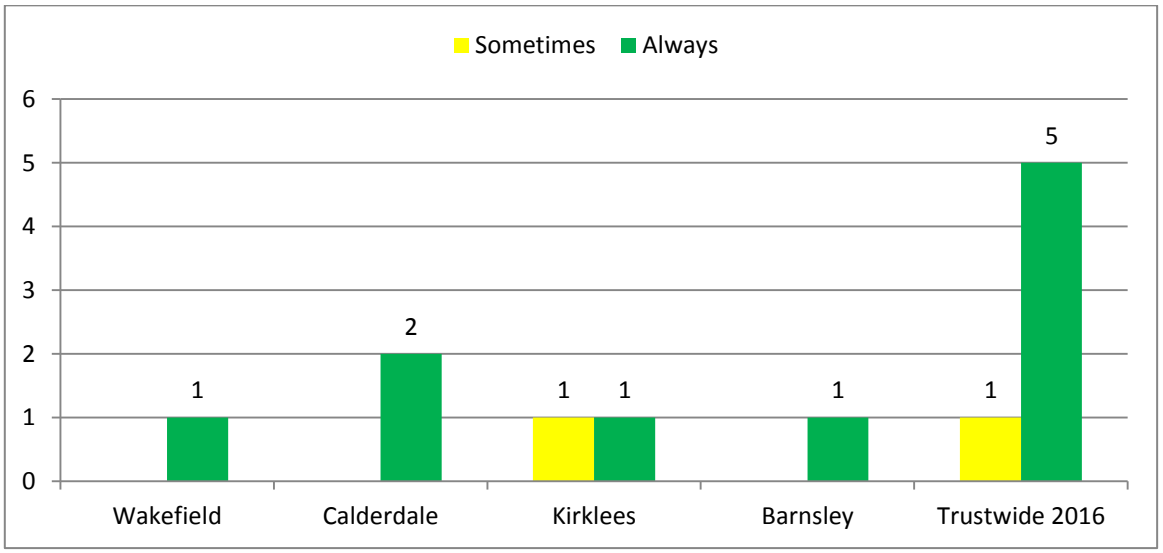
Never was stated by the following wards:

- Enfield Down – *no comment given*
- Chantry – *Following decant to Priory the 4 toilet areas do not have nurse call systems in place*

2.11 Toilets do not have nurse-call systems

Where toilets do not have nurse-call systems the service user is risk assessed and a personal alarm provided when applicable. Of the 15 responses, 9 were not applicable. The following chart shows the results Trust wide and by BDU:

Figure 7: Risk assessed (n=6)



The results indicate that where toilets do not have nurse call systems the service user is risk assessed and a personal alarm provided when applicable on 5/6 (83%) of the wards/units for which this standard was judged to be applicable.

Wards that stated sometimes were:

- Ward 18 – *This may occur but very infrequently and where thoroughly risk assessed*

Not applicable was stated by the following wards:

- Ward 19 Female – *No comment given*
- Ward 19 Male – *No comment given*
- Ward 5 – *All toilets have nurse call*
- Chantry – *Staff escort patients to the toilet area and wait for patients to ensure safety. This will also be care planned*
- Horizon Centre – *No comment given*
- Melton Suite (PICU) – *No comment given*
- SRU – *All toilets have nurse call*
- Newhaven – *No comment given*
- Willow – *All toilets have nurse call*

2.12 Clear information is provided for service users, relatives and carers

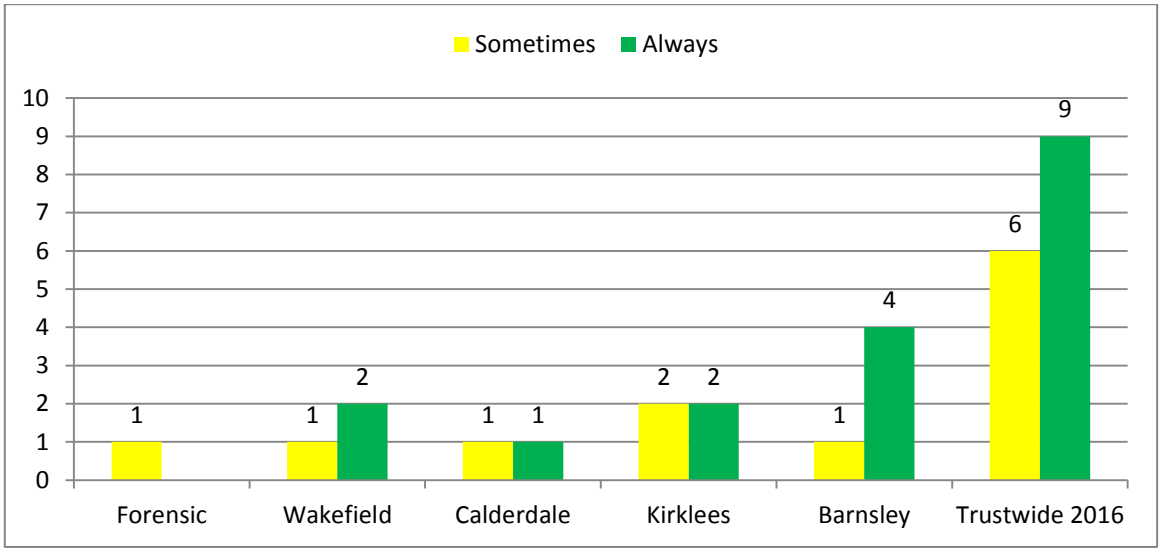
Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained. This must include who to contact if necessary. 14/15 (93%) of the wards/units were compliant with this standard.

Never was stated by Horizon – *we need to address this*

2.13 Preference regarding same sex key worker or named nurse

Service users are asked if they have a preference regarding same sex key worker or named nurse. Only 9/15 (60%) of the wards/units for which the standard was judged to be applicable were 'always' compliant with this standard. The following chart shows the results Trust wide and by BDU:

Figure 8: Same sex key worker (n=9)



6/15 (40%) of the wards stated that they were sometimes compliant with this standard.

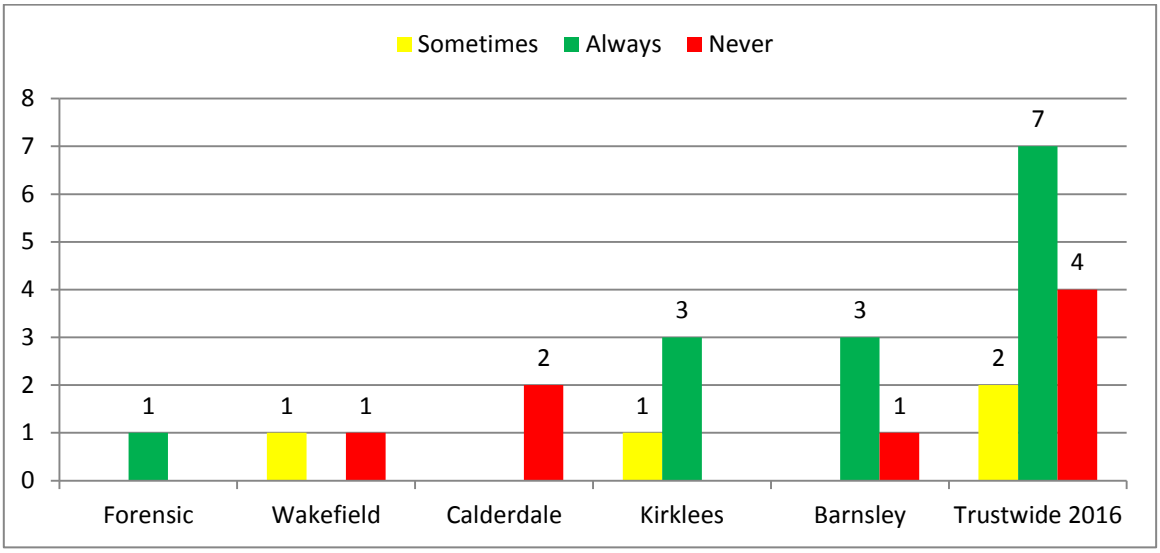
Comments included:

- Chantry – *There are currently 2 qualified staff nurses that are male. We have more female staff than males untrained. Where possible we strive to offer this*
- Ward 5 – *Females are asked this question*

2.14 Access to emergency clothing

Staff have access to emergency clothing if required. Of the 15 responses, 2 were not applicable. The following chart overleaf shows the results Trust wide and by BDU:

Figure 9: Emergency clothing (n=13)



The results indicate that emergency clothing was 'always' provided on 7/13 (54%) of the wards/units for which the standard was judged to be applicable.

Wards that stated sometimes were:

- Chantry – *There is a small stock held on the ward however this is limited. More need to be ordered for the ward*
- Enfield Down – *No comment given*

Never was stated by the following wards:

- Lyndhurst – *Rehab setting, can bring own belongings*
- Beechdale – *No comment given*
- Horizon – *No comment given*
- SRU – *Hospital provided nightwear is available*

Not applicable was stated by the following wards:

- Ward 5 – *This is not a problem all admissions are planned and therefore patients arrive with clothing. If there was a problem we would contact relatives or social services. There is a small stock of nightwear*
- Poplars – *All patients bring their own clothes in with them*

2.15 Physical examinations

Staff carrying out physical examinations are the same gender as the service user or if not is the service user accompanied by a chaperone of that gender. 14/15 (93%) of the wards/units for which the standard was judged to be applicable were compliant with this standard.

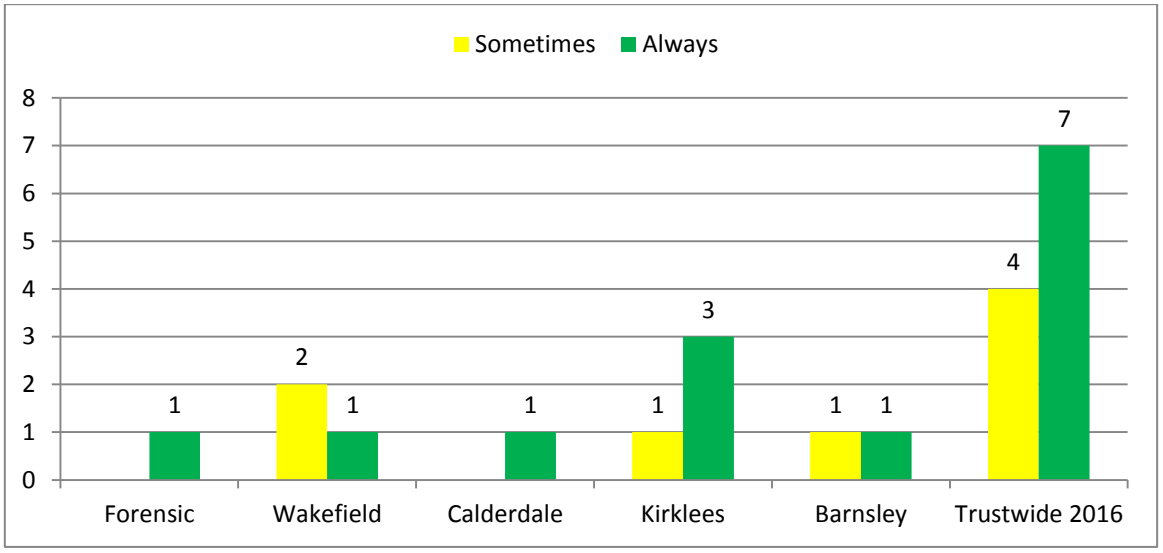
Ward that stated sometimes was:

- Willow – *Where possible same gender staff are appointed for physical observation, this is always the case with female service users but not always available for male service users. Service users are always asked if they give consent to female staff attending them. If they don't give consent male staff from other areas are sorted or the examinations have to wait until male staff are available*

2.16 Staff using restraint

Staff using restraint are the same gender as the service user, or if not, is the service user accompanied by a chaperone of that gender. Of the 15 responses, 4 were not applicable. 7/11 (64%) of the wards/units for which the standard was judged to be applicable were compliant with this standard.

Figure 10: Restraint (n=11)



Sometimes was stated by:

- Ward 19 Male – *On the male ward, we do not always have male staff on duty*
- Chantry – *On occasion the response team has been all female. On occasion male patients have not had a male staff worker present*
- Poplars – *Due to limited male staff, this can be hard, but is always tried*
- Willow – *This is not always attainable dependent on gender mix on shift in an emergency. If this is a planned intervention same gender staff will be sort from other ward areas. Or in an emergency as soon as possible this is an issue for male service users as we are currently staff with a higher ratio of female staff*

Not applicable was stated by the following wards:

- Ward 5 – *Restraint not used*
- NRU – *This is a general medical ward not mental health*
- SRU – *Restraint not used*

2.17 Single sex bedroom (Datix)

In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix). Of the 15 responses, 7 were not applicable. 100% (8) of the wards/units which responded were compliant with this standard.

7/15 (47%) felt this was *'not applicable'* as the unit was single sex or had single bed rooms on separate corridors.
Comments included:

- Ward 5 – *The single sex bedrooms are not in a specific designated area*
- NRU – *We do not have designated male/female bedroom areas, single ensuite bedrooms*
- SRU – *All rooms are ensuite and single sex*
- Horizon – *Ward does not have designated single sex areas due to low number of beds where possible rooms are allocated to comply with single sex accommodation*

2.18 Single sex bedroom (safeguarding)

In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex, appropriate safeguarding measures such as enhanced observation are applied. Of the 15 responses, 6 were not applicable. 100% (9) of the wards/units which responded were compliant with this standard.

Many of the wards 6/15 (40%) felt this was *'not applicable'* as the unit was single sex or had single bed rooms on separate corridors.

Wards who stated not applicable were:

SRU - *All rooms are ensuite single sex*
NRU - *Not designated areas*
Ward 5 - *Single rooms are not in specific sex areas*
Newhaven – *No comment given*
Lyndhurst – *No comment given*
Enfield Down – *No comment given*

2.19 Comments

The following additional comments were made:

Chantry – *To contact capital planning regarding nurse call/pin point in toilet areas following decant*

3. CONCLUSIONS AND RECOMMENDATIONS

3.1 Conclusions

- No EMSA breaches were reported in 2016. All service users admitted to in-patient areas were accommodated in a single sex ward or a single sex bedroom
- 93% of consultations took place in a private room or in a space that facilitates private discussion
- 91% lockable bedroom doors were 'always' available
- Ward 18 in North Kirklees is the only mixed sex acute adult admission unit in the trust. It is split into a male and female side, however all accommodation is single bedrooms. Where a service user needed to be admitted in a clinical emergency to a bed designated for the opposite sex, they were accommodated in a single room and managed with enhanced levels of observation in accordance with the policy.

3.2 Recommendations

- To continue to explore opportunities through the transformation agenda for wards to be designated single sex or to improve the availability of en-suite accommodation in mixed sex units

Appendix 1

Eliminating Mixed Sex Accommodation
Self-assessment checklist for mental health trusts 2016/17

I would be grateful if you could complete the following on behalf of your ward / unit. The audit tool is in-line with standards from the Delivering Same Sex Accommodation DoH Operating Framework.

Q1 Ward

Q2 Service users (including those admitted as emergencies) are accommodated in: (*tick all that apply*)

Pods ☐ Single sex bed bays ☐ Separate corridors ☐ Single rooms ☐
Other ☐

If other please state:

For the following questions the scoring definitions described below should be used as a guide:

0 - Not applicable - The standard is not relevant in this care setting
1 - Never / rarely - The standard is never (or rarely) achieved, and improvement is urgently required
2 - Sometimes - The standard is sometimes achieved but there is room for improvement
3 - Always / usually - The standard is always (or usually) achieved

If you answer not applicable, never / rarely or sometimes in any of the following questions *a comment must be entered.*

CONSULTATIONS

Q3 Do consultations take place in a private room or in a space that facilitates private discussion?

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

BEDROOM DOORS[1]

Q4 Bedroom doors are lockable from the inside with fail-safe entry mechanisms to ensure service user safety?

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q5 Bedroom doors have observation mechanisms to ensure service user safety?

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q6 Bedroom doors are fitted with an observation peephole or panel window which can only be operated by members of staff?

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

TOILET AND WASHING FACILITIES

Q7 Separate male and female toilets and washing facilities (other than assisted facilities) are available within the ward or department

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

[1] ***(Please note that in new builds it is good practice to fit doors which can only be opened externally by staff but also allow service users to control this from the inside for when they are getting undressed etc)***

Q8 Male and female toilets and washing facilities are clearly labelled male or female

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q9 Toilets and washing facilities are fitted with internal privacy curtains

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q10 Toilets and bathroom doors are lockable from the inside and are fitted with fail safe entry mechanisms which can only be opened by staff?

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q11 Toilets have nurse-call systems to ensure safety

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q12 Where toilets do not have nurse-call systems the service user is risk assessed and a personal alarm provided when applicable

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

INFORMATION & CHOICE

Q13 Clear information is provided for service users, relatives and carers on the arrangements made and the standards they should expect to ensure their privacy and dignity is maintained. This must include who to contact if necessary.

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q14 Service users are <u>asked</u> if they have a preference regarding same sex key worker or named nurse

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

DIGNITY

Q15 Staff have access to emergency clothing if required

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q16 Staff carrying out physical examinations are the same gender as the service user, or, if not, the service user is accompanied by a chaperone of the same gender

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q17 Staff using restraint are the same gender as the service user, or, if not, the service user is chaperoned by someone of the same gender

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

SAFEGUARDING

Q18 In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex this incident is reported in accordance with the Trusts reporting procedure (through Datix)

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q19 In instances where a service user has been placed in a single sex bedroom within an area designated for the opposite sex appropriate safeguarding measures such as enhanced observation are applied

0 – N/A ☐ 1 – Never ☐ 2 – Sometimes ☐ 3 – Always ☐

Comments

Q20 Any other comments / evidence

Thank you for taking the time to complete this questionnaire

APPENDIX 2

Recommendations and action plan for Eliminating Mixed Sex Accommodation Trust Audit 2016

Recommendations	Actions	Expected Outcome	Person(s) responsible	Deadline(s)
Transformation projects should work with commissioners to look for opportunities to create new, and improve current single sex environments.	All transformation projects which involve changes to estate should consider if new single sex accommodation could be created or improved.	Proportion of single sex accommodation continues to increase and fewer service users are admitted to mixed sex wards.	Transformation project leads/BDU's	ongoing

Is a re-audit required after this audit? Yes

If 'Yes' please indicate time period until start of re-audit (e.g. 6 months or 1 year)	1 year		
Signed on behalf of Business Unit		*(Please print name below)*	
Date		**Contact number**	

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 7.4

Title:	**Information Governance Position Statement**
Paper prepared by:	Information Governance Manager
Purpose:	Advise the Trust Board on the Trust's position in relation to Information Governance as at March 2017.
Mission/values:	Information Governance (IG) is a key issue to support patient safety. Information Governance Toolkit compliance at level 2 across all 45 requirements is currently needed to remain IG Statement of Compliance (IGSoC) compliant.
Any background papers/ previously considered by:	Monthly IG updates are provided to the Executive Management Team (EMT) and headline information is communicated to Trust Board through the Integrated Performance Report. EMT approved the following policies in February 2017: ➢ Access to Health Records Policy ➢ Health Records Management Policy
Executive summary:	**Outcome of IG toolkit and Internal Audit Review** The Information Governance Toolkit (IGTK) is a Department of Health (DH) Policy delivery vehicle that NHS Digital is commissioned to maintain. It draws together the legal rules and central guidance set out by DH policy and presents them in a single standard as a set of Information Governance requirements. Organisations in scope are required to carry out annual, self-assessments of their compliance against 45 IG requirements. In order to be compliant organisations must achieve at least level 2 on each. Results of the baseline assessment must be submitted by the end of July and an interim assessment is required by the end of October. The Trust was not fully compliant on two requirements at that time: mandatory IG training and SIRO support. KPMG were commissioned to audit ten IGTK requirements in December and subsequently made seven recommendations. Three of these will shortly be agreed as 'implemented' and four will be as agreed as being 'partially implemented'. The partially implemented recommendations concern formal governance structure, membership of the Improving Clinical Information Group (ICIG), ICIG standing agenda items and SIRO support. The first three have been reviewed and were approved by the ICIG on 21/03/2017. In respect of the final recommendation, training for Information Asset Owners (IAO) was delivered on the 22/03/2017, therefore ensuring compliance with the SIRO support requirement. For mandatory IG training the target is for 95% of current employees, excluding those on long term sick or maternity leave, external secondments, etc. to be compliant. The Trust's position at 08/03/2017 was 95.2%. 249 employees were excluded from this statistic given this criteria.

Due to issues surrounding the availability of an electronic IG training solution, NHS Digital advised that employees who completed IG training during the previous financial year could be included in the current year's training compliance statistics: on this basis only 0.8% of Trust staff are currently non-compliant.

Pending final approval by KPMG, the IGTK for 2016/17 will be ready for submission as follows:

Assessment	Level 0	Level 1	Level 2	Level 3	Not Relevant	Total Req'ts	Overall Score	Initial Grade	Current Grade
Version 14 (2016-2017)	0	0	44	0	1	45	66%	Satisfactory	Satisfactory

Director leads

The Director of Finance is the Trust's Senior Information Risk Owner (SIRO) and IG director lead. The Director of Nursing & Quality is the Trust's Caldicott Guardian and the lead director of clinical records. The Director of Corporate Development is the lead director for non-clinical records.

Incidents

Guidance is issued annually by NHS Digital requiring Trusts to report any incidents scored level 2 or above to the Information Commissioners Office (ICO). The scoring criteria takes into account the number of individuals affected, the type of incident and the sensitivity of the information. As such, one letter with sensitive information wrongly addressed may score a level 2, as is the case with some of the incidents detailed below.

Currently seven SIRIs are being investigated: six involved confidential information being disclosed in error, of which five were caused by incorrectly addressed mail and one involved sensitive information being issued to the wrong patient. The other SIRI involved the inappropriate use of a smartcard. As well as leading to a potential fine from the ICO and disciplinary action being taken against the individual, there can be a very real impact on the individuals who have had their personal information incorrectly treated or disclosed. To counter this risk there is a focussed communications plan, implementation of a range of recommendations, and bespoke training where it is felt there will be some benefit.

Data protection audit

Following the undertaking that was signed by the Trust in June 2015, the ICO conducted a consensual audit during w/c 28/11/2016. The final report has been shared with the Trust and the executive summary has been published on the ICO's webpage. The overall conclusion is that there is a reasonable level of assurance that processes and procedures are in place and delivering data protection compliance. Some scope for improvement in existing arrangements was identified that will reduce the risk of non-compliance with data protection legislation. We will be implementing all the recommendations that were made and will continue with our efforts to ensure confidential information remains that way.

Future plans

The EU General Data Protection Regulation (GDPR) will apply in the UK from 25/05/2018. The ICO has already published general guidance around data portability and the role of the data protection officer; draft guidance on consent has been published for consultation. Sector specific guidance is expected later in 2017. Indications are that the areas of most significance for health will be changes to the conditions for processing personal data, a new requirement to verify consent and enhanced protection for children's data.

Feedback from consultations on the National Data Guardian's Review of Data Security, Consent and Opt-Outs ('Caldicott 3') is being analysed by the Department of Health. However there is currently no date for publication of the outcomes. The review includes a recommendation for a new set of data security standards which, if implemented, will significantly impact the completion of the toolkit.

A revised IGTK is expected for 2018/19. A review and consultation were undertaken that determined the IGTK is fit for purpose but changes are required to the support provided during the assessment process and to the requirements to ensure they provide a robust assessment of performance. Information regarding the changes and the impact on Trusts will be provided by NHS Digital during 2017/18.

The focus of the IG team will be to review common patterns across previously and newly recorded incidents to assist the Trust in reducing the total number of incidents.

Key areas of concern remain and there is more work to be done around the number of incidents being recorded by staff. The table below summarises IG incidents logged by BDU/Corporate Service over the past 12 months. The IG team has taken a number of steps to improve compliance with the data protection and confidentiality principles including targeted training, (both mandatory IG training and ad-hoc awareness sessions), performing consensual and unannounced spot checks and providing guidance through the Trust's communication channels.

The IG team will continue to raise awareness and provide training, advice and support across the organisation.

BDU	***Q4 15/16***	***Q1 16/17***	***Q2 16/7***	***Q3 16/7***
Barnsley	***26***	***41***	***36***	***19***
Wakefield	***6***	***10***	***17***	***6***
Calderdale	***7***	***6***	***6***	***2***
Forensic	***4***	***3***	***5***	***6***
Kirklees	***11***	***12***	***10***	***8***
Specialist services	***25***	***26***	***22***	***19***
Corporate	***3***	***7***	***6***	***11***
Total	***82***	***105***	***102***	***71***

Risk appetite

	The Trust risk appetite for IG remains as low with a target score of 1-3. Current risk given the impact is higher than this (4-6). Actions continue as identified above to reduce the likelihood of the risk occurring.
Recommendation:	**Trust Board is asked to NOTE the current position regarding the points noted and APPROVE the submission of the IGTK for 2016/17.**
Private session:	Not applicable

NHS
South West Yorkshire Partnership
NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 7.5

Title:	**NHS Staff Survey Results 2016**
Paper prepared by:	Director of Human Resources, Organisational Development and Estates
Purpose:	The purpose of this paper is to update the Trust Board on the results from the NHS Staff Survey results 2016 for the organisation. The paper also provides an update on initial action.
Mission/values:	The NHS Staff Survey supports the development of a strong healthy culture through staff feedback. Staff feedback is vital in measuring how our Values are embedded in the Trust, and how confident staff feel about raising concerns at work. These are 2 key elements of a safe and compassionate culture. The survey will be used as an important measure of the Trust's commitment to being a values driven organisation and an equal opportunities employer.
Any background papers/ previously considered by:	The results of the survey have been used to help shape the Trust's Workforce Strategy. In addition, the Key Performance Indicators to measure the progress of the Workforce Strategy will use a number of metrics from the NHS Staff Survey.
Executive summary:	The Trust's overall staff engagement score is 3.77, this is average compared to other combined MH, LD and community Trusts, the best score in this group is 3.95. <u>The Trusts top 5 ranking results</u> ➢ % feeling satisfied with the quality of work and patient care they are able to deliver, scale summary score 3.99, national average 3.93, national average MH/LD/Community Trusts 3.89. Best score for combined Trusts 4.07%. ➢ % staff working extra hours 65%, national average 72%, national average MH/LD/Community Trusts 72%. Best score for combined Trusts 65%. ➢ % of staff believing the organisation provides equal opportunities for career progression or promotion, 90%, national average 85%, national average MH/LD/Community Trusts 88%. Best score for combined Trusts 91%. ➢ % of staff reporting errors, near misses or incidents witnessed in the last month, 96%, national average 90%, national average MH/LD/Community Trusts 93%. Best score for combined Trusts 96%. ➢ Organisation and management interest in and action on health and well-being, scale summary score 3.79, national average 3.62, national average MH/LD/Community Trusts 3.74. Best score for combined Trusts 3.88%. <u>The Trusts bottom 5 ranking results</u> ➢ Staff motivation at work, scale summary score 3.85, national average 3.92, national average MH/LD/Community Trusts 3.94. Best score for combined Trusts 4.06%.

	➢ % of staff witnessing potentially harmful errors, near misses or incidents in the last month 27%, national average 29%, national average MH/LD/Community Trusts 24%. Best score for combined Trusts 19%. ➢ % of staff experiencing physical violence from patients, relatives or the public in last 12 months 18%, national average 15%, national average MH/LD/Community Trusts 15%. Best score for combined Trusts 9%. ➢ Staff confidence and security in reporting unsafe clinical practice scale summary score 3.60, national average 3.67, national average MH/LD/Community Trusts 3.71. Best score for combined Trusts 3.89%. ➢ % of staff satisfied with the opportunities for flexible working patterns 56%, national average 52%, national average MH/LD/Community Trusts 58%. Best score for combined Trusts 64%. <u>Where staff experience has improved since 2015</u> ➢ % of staff reporting good communication between senior management and staff, this has increased from 28% to 35%, the national average all trusts 33%,national average MH/LD/Community Trusts 35%. Best score for combined MH/LD, community Trusts 47%. ➢ Fairness and effectiveness of procedures for reporting errors, near misses and incidents, scale summary score increased from 3.65 to 3.75, the national average is 3.72, national average MH/LD/Community Trusts 3.77. Best score for combined Trusts 3.90. <u>Where staff experience has worsened since 2015</u> There were no scores where there has been a statistically significant negative change. The experience of BAME staff in the Trust is positive. Disabled staff have a poorer experience and young staff are more likely to feel discriminated against. **Action Planning** The Trust will review the results through the Well-being at Work Partnership Group. This will build on the Workforce Strategy and the Robertson Cooper work. Results are also being reviewed at a BDU and professional group level. The Members Council receive an annual protection on the survey and key action. This will be linked to the future discussions on the Workforce Strategy. Key areas for action planning will be those areas where the Trust's scores are below the national average. These include: <u>The percentage of staff attending work in last 3 months despite feeling unwell due to pressure to attend</u> The Trust is committed to improving employee well-being and resilience. A key aim is to ensure the prevention of ill health. The Trust's well-being at work partnership group will review these results and agree actions. A key focus will be preventing illness due to work related MSK injury and work related stress. <u>Staff confidence and security to report unsafe clinical practice.</u> The freedom to speak up guardians have been appointed and work is ongoing to ensure their role is clearly understood by all staff and staff are properly supported to raise concerns.

	Reducing levels of physical violence in the workplace The MAV team will review these results and ensure actions are taken to reduce levels of aggression and violence in the workplace. Flexible working opportunities The Trust has guidance on flexible working options and the process of making requests for flexible working. Further promotion will take place to encourage managers and staff to review flexible working opportunities in line with service needs. **Risk Appetite** The NHS Staff Survey is one source of feedback from staff on what we do well as an employer and where we can get better. The Remuneration and Terms of Service Committee will monitor overall workforce risks in line with the Trust's Risk Appetite statement.
Recommendation:	**Trust Board is asked to NOTE the results of the survey and initial action.**
Private session:	Not applicable

South West Yorkshire Partnership NHS Foundation Trust

Trust Board: 28 March 2017

National Staff Survey Update

Introduction

This paper provides the EMT with a summary of the 2016 NHS Staff Survey results. A total of 537 colleagues completed the questionnaire from a sample of 1250, a response rate of 44%. The number of respondents equates to approximately 12% of the Trust's workforce, which means whilst it is an indicator of overall potential development areas, it does not allow for drill down into services.

The results are presented in section 1 detail the Trust score, the national average for all NHS Trusts and the national average for mental health, learning disability and community NHS trusts (combined Trusts). The best score for combined trusts is also detailed.

1. Summary of 2016 results

The Trust's overall staff engagement score is 3.77, this is average compared to other combined MH, LD and community Trusts, the best score in this group is 3.95.

The Trusts top 5 ranking results

- % feeling satisfied with the quality of work and patient care they are able to deliver, scale summary score 3.99, national average 3.93, national average MH/LD/Community Trusts 3.89. Best score for combined Trusts 4.07%.
- % staff working extra hours 65%, national average 72%, national average MH/LD/Community Trusts 72%. Best score for combined Trusts 65%.
- % of staff believing the organisation provides equal opportunities for career progression or promotion, 90%, national average 85%, national average MH/LD/Community Trusts 88%. Best score for combined Trusts 91%.
- % of staff reporting errors, near misses or incidents witnessed in the last month, 96%, national average 90%, national average MH/LD/Community Trusts 93%. Best score for combined Trusts 96%.
- Organisation and management interest in and action on health and well-being, scale summary score 3.79, national average 3.62, national average MH/LD/Community Trusts 3.74. Best score for combined Trusts 3.88%.

The Trusts bottom 5 ranking results

- Staff motivation at work, scale summary score 3.85, national average 3.92, national average MH/LD/Community Trusts 3.94. Best score for combined Trusts 4.06%.

- % of staff witnessing potentially harmful errors, near misses or incidents in the last month 27%, national average 29%, national average MH/LD/Community Trusts 24%. Best score for combined Trusts 19%.

- % of staff experiencing physical violence from patients, relatives or the public in last 12 months 18%, national average 15%, national average MH/LD/Community Trusts 15%. Best score for combined Trusts 9%.

- Staff confidence and security in reporting unsafe clinical practice scale summary score 3.60, national average 3.67, national average MH/LD/Community Trusts 3.71. Best score for combined Trusts 3.89%.

- % of staff satisfied with the opportunities for flexible working patterns 56%, national average 52%, national average MH/LD/Community Trusts 58%. Best score for combined Trusts 64%.

Where staff experience has improved since 2015

- % of staff reporting good communication between senior management and staff, this has increased from 28% to 35%, the national average all trusts 33%,national average MH/LD/Community Trusts 35%. Best score for combined MH/LD, community Trusts 47%.

- Fairness and effectiveness of procedures for reporting errors, near misses and incidents, scale summary score increased from 3.65 to 3.75, the national average is 3.72, national average MH/LD/Community Trusts 3.77. Best score for combined Trusts 3.90.

Where staff experience has worsened since 2015

There were no scores where there has been a statistically significant negative change.

Changes over a 3 year period 2014-2016

Improvements which are statistically significant are the increasing percentage of staff reporting errors, near misses and incidents, the percentage of staff recommending the Trust as a place to work or receive treatment, percentage of staff reporting good communication between senior management and staff and support from immediate managers. There are no key scores that have significantly worsened over this period.

Key data equality and diversity

The NHS Staff Survey data suggests the overall experience of BAME staff (32) working in the Trust is positive, a number of scores are better than average. BAME staff experience higher levels of discrimination at work and the percentage of BAME staff witnessing potentially harmful errors, near misses or incidents in last month is higher than average.

Disabled staff (103) report a lower quality of appraisal and experience discrimination at work to a greater extent than the average for the Trust. 55% of disabled staff report feeling unwell due to work related stress and 74% have attended work in the last 3 months despite feeling unwell because they felt pressure to attend, both scores are above average. Disabled staff are also less likely to recommend the Trust as a place to work or receive treatment. 36% of disabled staff report experiencing harassment, bullying or abuse from patients, relatives or the public which is above average.

There are no significant differences in results by gender.

The percentage of younger staff 16-30 (43) reporting discrimination is 20% which is the highest total in the Trust. 36% of 16-30 staff have experienced harassment, bullying and abuse from patients, relatives or the public in the last 12 months although reporting levels are higher than average. This age group are more likely to recommend the Trust as a place to work or receive treatment.

2. Comparison of SWYPF Trust results with other NHS Trusts

The Trust's overall staff engagement score of 3.77 is higher than the following local Trusts:

- Bradford District Care NHS FT 3.75
- Leeds and York Partnership FT 3.71
- Sheffield Health and Social Care NHS FT 3.74
- Leeds Community Healthcare NHS 3.70
- Mid Yorkshire Hospitals 3.57

The following Trusts have higher staff engagement scores:

- Rotherham, Doncaster, and South Humber NHS FT 3.80
- Calderdale and Huddersfield NHS FT 3.80
- Leeds Teaching Hospitals NHS FT 3.83
- Sheffield Teaching Hospitals NHS FT 3.83
- Harrogate and District NHS FT 3.92

Nationally the following NHS Trusts have high staff engagement scores:

- East London NHS FT 3.95
- Northumbria Healthcare NHS FT 3.96
- Wrightington, Wigan and Leigh NHS FT 3.95
- South Essex Partnership University NHS FT 3.88
- Tees,Esk and Wear Valley NHS FT 3.89

3. Action Planning

The NHS Survey whilst providing a helpful indicator of development areas, does have limited value given the overall response and the delay in receiving the report. The Robertson Cooper Staff wellbeing and Engagement Survey does provide a more comprehensive and timely review. However, the Trust will review the results through the Well-being at Work Partnership Group to ensure current action plans reflect staff feedback. Results are also being reviewed at a BDU and professional group level.

Key areas from staff feedback are part of the part of the Workforce Strategy.

These include:

The percentage of staff attending work in last 3 months despite feeling unwell due to pressure to attend.

The Trust is committed to improving employee well-being and resilience. A key aim is to ensure the prevention of ill health. The Trust's well-being at work partnership group will review these results and agree actions. A key focus will be preventing illness due to work related MSK injury and work related stress is in the Workforce Strategy.

Staff confidence and security to report unsafe clinical practice.

The freedom to speak up guardians have been appointed and work is ongoing to ensure their role is clearly understood by all staff and staff are properly supported to raise concerns.

Reducing levels of physical violence in the workplace

The Management of Aggression and Violence team will review these results and ensure actions are taken to reduce levels of aggression and violence in the workplace. The tackling of harassment and bullying, particularly from Service Uses, Carers and visitors on BME staff is a priority for the Trust.

Flexible working opportunities

The Trust has guidance on flexible working options and the process of making requests for flexible working. Further promotion will take place to encourage managers and staff to review flexible working opportunities in line with service needs.

Next Steps

The NHS Staff Survey provides valuable feedback to support the ongoing development of the Trust.

Ashley Hambling
Human Resources Manager (Wellbeing and Engagement)

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017

Agenda item 8.4 – Receipt of public minutes of partnership boards

Barnsley Health and Wellbeing Board

Date	31 January 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Minutes from the Children and Young People's Trust Executive Group held on 24 November 2016 ➢ Minutes from the Barnsley Community Safety Partnership held on 23 November 2016 ➢ Minutes from the Provider Forum held on 7 December 2016 ➢ Minutes from the Stronger Communities Partnership held on 22 November 2016 ➢ Health and Wellbeing Board Risk Register ➢ Suicide Prevention Action Plan ➢ Future in Mind Transformation Plan ➢ End of Life Care ➢ CCG Commissioning Intentions 2017/18 - 2018/19
Minutes	Papers and draft minutes are available at: http://barnsleymbc.moderngov.co.uk/mgCommitteeDetails.aspx?ID=143

Calderdale Health and Wellbeing Board

Date	16 March 2017
Non-Voting Member	Dr Adrian Berry/Karen Taylor
Items discussed	➢ Policing Issues on the Health and Wellbeing Board ➢ Public Health's Annual Report 2016 ➢ Single Plan for Calderdale ➢ Sustainability and Transformation Plan Update ➢ Delayed Transfers of Care Update ➢ Meeting Timetable – Proposed Dates for 2017/18 Municipal Year ➢ South West Yorkshire Partnership Foundation Trust – Health and Wellbeing Board Representatives
Minutes	Papers and draft minutes are available at: http://www.calderdale.gov.uk/council/councillors/councilmeetings/agendas-detail.jsp?meeting=23343

Kirklees Health and Wellbeing Board

Date	2 March 2017
Invited Observer	Rob Webster/Karen Taylor
Items discussed	➢ CAMHS Transformation Plan update ➢ Kirklees Health & Wellbeing Plan Update ➢ Update on Improvements relating to Children Services ➢ Minutes of CSE & Safeguarding Member Panel
Minutes	Papers and draft minutes are available at: https://democracy.kirklees.gov.uk/mgCommitteeDetails.aspx?ID=159

South Yorkshire and Bassetlaw Sustainability and Transformation Plan Collaborative Partnership Board

Date	13 January 2017
Member	Rob Webster
Items discussed	➢ Summary update to the Collaborative Partnership Board (CPB)/ Transformation funding to support clinical priority areas. ➢ Communications and engagement approach to public consultation. ➢ Health, disability and employment. ➢ Healthy lives. ➢ STP governance Terms of Reference (ToR). ➢ Workforce Terms of Reference. ➢ Social Kinetic 3De proposal.
Minutes	Ratified minutes attached.

Wakefield Health and Wellbeing Board

Date	26 January 2017
Member	Rob Webster/Sean Rayner
Items discussed	➢ Sustainability and Transformation Plan - West Yorkshire and Harrogate STP. ➢ Wakefield Health and Wellbeing Plan - Feedback from Development Session. ➢ Better Care Fund Plan 2017/18 ➢ Mid Yorkshire Hospitals NHS Trust - Update ➢ Public Health Annual Report ➢ Community Pharmacy Offer for Improving the Public's Health ➢ Future in Mind ➢ Connecting Care Executive - Summary and Minutes ➢ GP Forward View Update and Plan ➢ Better Care Fund - Quarterly Assurance ➢ Public Health Commissioning Intentions 2016-2020.
Minutes	Papers and draft minutes are available at: http://www.wakefield.gov.uk/residents/health-care-and-advice/public-health/what-is-public-health/health-wellbeing-board

Paper A

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

13 January 2017, The Birch and Elm Room, Oak House, Rotherham

Decision Summary

Ref	Item	Lead
1	**Minutes of the meetings held 11 November and 16 December 2016**	
02/17	(a) that the minutes of the previous meeting held 11 November 2016 and 16 December 2016 were ratified to be made publicly available subject to amendments recorded	**ALL**
	(b) that a query around the Sustainable Hospital Services Review terms of reference and research raised at the previous meeting would be discussed outside the session	**WILL CLEARY-GRAY, MIKE PINKERTON**
	(c) that discussions by the local authorities were still taking place around a proposal for focused support in each area.	**LOCAL AUTHORITY LEADS**
2	**Summary update to the Collaborative Partnership Board (CPB)/ Transformation funding to support clinical priority areas**	
04/17	(a) that the Mental Health and Learning Disabilities and Cancer transformation funding bids would cross reference one another	**KATHRYN SINGH, JACKIE PEDERSON, LESLEY SMITH**
	(b) that the summary update on next steps, when fully developed, would be shared with all for use when updating organsiations	**WILL CLEARY-GRAY**
	(c) that CPB supported the proposal that work would take place on the workstreams and priorities to ensure clarity on deliverables, enabling the STP to track back what the ask was of the financial gap, working with place and having focus on the SYB outputs	**WILL CLEARY-GRAY**
3	**Communications and engagement approach to public consultation**	
05/17	(a) that an agreed approach on discussions with stakeholders and the public on the STP would be taken forward at place level and be consistent across the patch	**ALL**
	(b) that a draft report on the public consultations for Hyper Acute Stroke Services and Children's Surgery and Anaesthesia would be given to the STP CPB in March 2017	**HELEN STEVENS**
4	**Health, disability and employment**	

06/17	(a) that the STP CPB approved the work in principle and further detail including baseline metrics would be presented to the STP CPB in due course	**GREG FELL (CHRIS SHAW)**
5	**Healthy lives**	
07/17	(a) that the STP CPB committed to aspirations outlined in principle requesting that constituent organisations be consulted and a considered approach be delivered back to the STP CPB for final approval in April/May	**GREG FELL**
6	**STP governance Terms of Reference (ToR)**	
08/17	(a) that the STP CPB supported the ToR presented	**ALL**
7	**Workforce Terms of Reference**	
09/17	(a) that the STP CPB supported the ToR and agreed to contribute to this work where required.	**ALL**
8	**Social Kinetic 3De proposal**	
12/07	(a) that the STP CPB supported the proposal and would work with Social Kinetic 3De on leadership and development at the meeting on 3 February 2017	**ALL**

South Yorkshire and Bassetlaw Sustainability and Transformation Plan

Collaborative Partnership Board

Minutes of the meeting of 13 January 2017, The Boardroom, 722 Prince of Wales Road, Sheffield

Present:

Andrew Cash, South Yorkshire and Bassetlaw STP Lead/Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust (CHAIR)
Adrian Berry, Medical Director, South West Yorkshire Partnership NHS Foundation Trust (Deputy for Rob Webster, Chief Executive)
Dominic Blaydon, Associate Director of Transformation, The Rotherham NHS Foundation Trust (Deputy for Louise Barnett, Chief Executive)
Catherine Burn, Director, Voluntary Action Bassetlaw
Julia Burrows, Director of Public Health, Barnsley Metropolitan Borough Council (Deputy for Diana Terris, Barnsley Metropolitan Borough Council)
Will Cleary-Gray, Director of Sustainability and Transformation, South Yorkshire and Bassetlaw STP
Jeremy Cook, Interim Director of Finance, South Yorkshire and Bassetlaw STP
Mike Curtis, Local Director, Health Education England
Chris Edwards, Accountable Officer, NHS Rotherham Clinical Commissioning Group
Adrian England, Chair, Healthwatch Barnsley
Idris Griffiths, Interim Accountable Officer, NHS Bassetlaw Clinical Commissioning Group
Richard Jenkins, Medical Director, Barnsley Hospital NHS Foundation Trust
Alison Knowles, Locality Director North of England, NHS England
Ainsley Macdonnell, Service Director – North Nottinghamshire and Direct Services, Adult Social Care, Health and Public Protection, Nottinghamshire County Council (Deputy for Anthony May, Chief Executive)
Richard Parker, Interim Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Jackie Pederson, Accountable Officer, NHS Doncaster Clinical Commissioning Group
Matthew Powls, Interim Director of Commissioning, NHS Sheffield Clinical Commissioning Group (Deputy for Maddy Ruff, Accountable Officer)
Mathew Sandford, Associate Director of Planning and Development, Yorkshire Ambulance Service NHS Trust (Deputy for Rod Barnes, Chief Executive)
Steve Shore, Chair, Healthwatch Doncaster
Kathryn Singh, Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Paul Smeeton, Chief Operating Executive, Nottinghamshire Healthcare NHS Foundation Trust (Deputy for Ruth Hawkins, Chief Executive)
Lesley Smith, Accountable Officer, NHS Barnsley Clinical Commissioning Group
John Somers, Chief Executive, Sheffield Children's Hospital NHS Foundation Trust
Richard Stubbs, Acting Chief Executive, The Yorkshire and Humber Academic Health Science Network
Kevan Taylor, Chief Executive, Sheffield Health and Social Care NHS Foundation Trust
Neil Taylor, Chief Executive, Bassetlaw District Council
Jon Tomlinson, Assistant Director of Commissioning, Doncaster Metropolitan Borough Council (Deputy for Jo Miller, Chief Executive)
Mark Tuckett, Assistant Director of Public Service Reform, Sheffield City Council (Deputy for John Mothersole, Chief Executive)

Apologies:
Louise Barnett, Chief Executive, The Rotherham NHS Foundation Trust
Des Breen, Medical Director, Provider Working Together Programme
Frances Cunning, Deputy Director of Health and Wellbeing, Public Health England
Greg Fell, Director of Public Health, Sheffield City Council
Ruth Hawkins, Chief Executive, Nottinghamshire Healthcare NHS Foundation Trust
Richard Henderson, Chief Executive, East Midlands Ambulance Service

Sharon Kemp, Chief Executive, Rotherham Metropolitan Borough Council
Jo Miller, Chief Executive, Doncaster Metropolitan Borough Council
Leaf Mobbs, Director of Planning and Development, Yorkshire Ambulance Service NHS Trust
Paul Moffatt, Chief Executive, Doncaster Children's Services Trust
Tim Moorhead, Clinical Chair, NHS Sheffield Clinical Commissioning Group
Simon Morritt, Chief Executive, Chesterfield Royal Hospital NHS Foundation Trust
John Mothersole, Chief Executive, Sheffield City Council
Mike Pinkerton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Maddy Ruff, Accountable Officer, NHS Sheffield Clinical Commissioning Group
Diane Wake, Chief Executive, Barnsley Hospital NHS Foundation Trust
Rob Webster, Chief Executive, South West Yorkshire Partnership NHS Foundation Trust
Janet Wheatley, Chief Executive, Voluntary Action Rotherham

In Attendance:
Chris Shaw, Director of Health Improvement, Sheffield City Council
Susan Hird, Consultant in Public Health, Sheffield City Council
Lynsey Hamilton, Transformation Board Manager, Health Education England
Helen Stevens, Associate Director of Communications and Engagement, Commissioners Working Together
Janette Watkins, Programme Director, Providers Working Together Programme
Kate Woods, Programme Office Manager, South Yorkshire and Bassetlaw STP

Minute reference	Item	Action
01/17	**Welcome and introductions** The Chair welcomed members.	
02/17	**Minutes of the meetings held 11 November 2016 and 16 December 2016** The minutes of the meetings held 11 November and 16 December were accepted as a true and accurate record subject to the comments below and were ratified by the STP CPB. The minutes will be published. Amendments were recorded as: 11 November 2016 minutes: John Somers to be removed from apologies list and organisation for Neil Priestley to be amended to Sheffield Teaching Hospitals NHS Foundation Trust. The STP CPB noted that all actions arising from 11 November 2016 were complete. Actions outstanding from 16 December 2016 were noted as: **Sustainable Hospital Services Review** **(Item 24/16 refers)** A query about research raised previously would be discussed outside the meeting. **SYB STP resources** **(Item 26/16 refers)** It was confirmed that discussions by the local authorities were still taking place on a proposal for focused support in each area.	**WILL CLEARY-GRAY, MIKE PINKERTON** **LOCAL AUTHORITY LEADS**

03/17	**National update from the STP Lead** The STP CPB were updated on a time-out for the STP leads taking place in January 2017 and it was anticipated that a further national update would be available at this session. LS updated the group on an STP summit, highlighting a case study presented to this group by Simon Stevens. There was also reference at the session to ensuring fragmentation between organisations was proactively resolved. Discussions had taken place on the challenges to come together for the planning of the STP and therefore consideration was required around ensuring there was capacity to deliver the plans. Discussions had taken place around leading at an organisational level as well as leading across the wider footprint to underpin the STP and that engaging Councilors as part of the process was crucial. There had been a focus at the session on ensuring systems were not "stifled by regulation." The group noted that local contracts were signed off, highlighting a shift in behaviours between systems and organisations to achieve this at such an early stage. It was anticipated that the direction of travel for the STP would emerge shortly and would move from plan to implementation. A delivery timetable would be developed collaboratively. An electronic update would be circulated weekly sharing work and best practice within the STP.	
04/17	**Summary update to the Collaborative Partnership Board/ Transformation funding to support clinical priority areas** The STP CPB was updated on work within the Mental Health and Learning Disabilities and Cancer work streams. **Mental Health and Learning Disabilities** The group noted that a Mental Health and Learning Disabilities Steering Group had been established and would review the Case for Change and agree next steps for four priority focus areas. An initial meeting of the Mental Health Provider Alliance between RDaSH and SHSCT would be held in January. It was noted that capacity had been identified as the main risk. An update on the transformation bid was given: **Integrated IAPT** The purpose was outlined: to expand the IAPT workforce to offer psychological therapies to long term conditions pathways and for people with medically unexplained symptoms, evidence for highest savings from Diabetes, Cardiovascular and Respiratory Disease. This supported the five year forward view (FYFV) access target that by 2020/21, at least 25% of people with common mental health conditions could access services each year. The total national funding available was highlighted as £20m in 2017/18. **Urgent and Emergency Mental Health Services**	

	The purpose was outlined: to pump prime and accelerate existing plans to expand acute hospital liaison mental health services so that they operate at the required standard within one year of receiving the funding. This supported the FYFV target that by 2020/21, all acute hospitals would have all-age mental health liaison teams in place, and at least 50% of these would meet the required standard service standard as a minimum. The total national funding available was highlighted as £19m in 2017/18 and 2018/19 and the approach taken was outlined to the group. **Learning Disabilities – Reducing reliance on specialist inpatient care** The purpose was outlined: supporting the implementation of the Transforming Care Partnerships three year plans for reforming services, in line with *Building the Right Support*, October 2015. This had included strengthening support in the community and reviewing specialist inpatient services. The total national funding available was highlighted as £15m in 2017/18 and £15m in 2018/19. **Reduction in children placed away from their home and local community** The purpose was outlined: providing Positive Behavioural Support based services for children to improve support for children and young people that display behaviour that challenges and prevents escalation and the need to be looked after away from home. The total national funding available was highlighted as £1m in 2017/18 and 2018/19. **Cancer** The STP CPB was asked to note that the current process covered 2017/18 and 2018/19 only. Colleagues from the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance member organisations had supported the development of the Delivery Plan and Transformation Fund Bid. A draft Delivery Plan and bid was supported in principle by the Cancer Alliance Board. The Delivery Plan added to the next level of detail onto the work undertaken by the STP Cancer work stream. Includes funding to support the Cancer Alliance in 2017/18 & 2018/19. An update on the transformation bid was given: **Cancer Transformation fund bids** **Early Diagnosis** The purpose of the bid was outlined: the funding would be to support the interventions on early diagnosis in the Cancer Alliance delivery plan. The bid proposed a package of interventions. **Recovery package** The purpose of the bid was outlined: existing funded Living With And Beyond Cancer programme with Macmillan and all localities within our Cancer Alliance footprint and therefore the bid focused on integrating	

	'electronic holistic needs assessments' into existing Trust systems. In response to a query, it was confirmed that the early diagnosis bid would be focused on reducing inequalities and to move the Cancer Alliance agenda forward. It was agreed that the Mental Health and Learning Disabilities and Cancer bids would cross reference one another, acknowledging the work to be done. **Diabetes** The STP CPB noted that the bids were being developed locally. The bids being submitted were structured into four components; education, NICE treatment targets, multi-disciplinary foot care teams, and inpatient specialist nursing services. There were links between places for some elements of the bids. All transformation bids would be submitted on behalf of SYB by the STP PMO by 18 January 2017 (IAPT bid due 25 January 2017). As part of a general update, the STP CPB noted key next steps for the coming months. The group was reminded of the approach taken to develop the STP, and how this had been worked through in terms of the STP process. The themes and priorities of the STP were highlighted, using place plans and the submission of the STP. An outline on establishing the workstreams was delivered. Collaborative programmes, projects and the task and finish groups were outlined, showing where there was a clearly defined project and programme to deliver and where this was under development that would change and evolve. The group was invited to comment. In response to a query around demonstrating place on the diagram, it was confirmed that place colleagues had been asked to overlay workstream information with local work taking place alongside the work of across SYB. Strategic direction and coordination would take place at SYB level for those workstreams for those workstreams that SYB coordinate for whole system delivery. The presentation would be developed further to reflect this. In response to a query around community integration, it was confirmed that the programmes outlined in the presentation to STP CPB were collaborative, connecting with place. Discussions would be required around what was taking place at South Yorkshire and Bassetlaw level and local. Key outputs over the past year were highlighted to the STP CPB, including the STP, Commissioning Intentions, the cases for change, the implementation plan, and place plans. System wide objectives were noted by the STP CPB. An update was given on the financial strategy noting triangulation between the financial plans submitted in December and the STP submitted in October 2016. Changes in assumptions were outlined to	**KATHRYN SINGH, JACKIE PEDERSON, LESLEY SMITH**

	the group which may reflect increased financial risk, noting deterioration in the underlying position, Clinical Commissioning Group (CCG) allocation adjustments to reflect changes in national tariff and identification rules, non-recurrent income not reflected in control totals, that clinical negligence scheme for trusts premium increases may not be cost neutral as assumed in the STP plan, that financial plans between commissioners and providers may not be aligned, and the delivery risks on provider Cost Improvement Programme plans and commissioner Quality, Innovation, Productivity and Prevention plans. It was proposed that work would take place on the workstreams and priorities to ensure clarity on deliverables, enabling the STP to track back what the ask was of the financial gap, working with place and having focus on the SYB outputs. This was supported. Work was also taking place around how the STP would develop as a whole system. Workshops had taken place around how this would happen. There existed already cross-working between collaboratives. A proposal would be taken to both programme boards to set out how to best align the delivery teams to support the STP. The STP CPB noted that the current meeting schedules would be readdressed. Work would take place around this and a proposal given to the group. It was agreed that the narrative presented was helpful and would be used to update organisations across the patch. This would be further developed and circulated. The presentation would also be circulated in its current format for information.	**WILL CLEARY-GRAY** **WILL CLEARY-GRAY** **KATE WOODS**
05/17	**Communications and engagement approach to public consultation** HS updated the STP CPB on work undertaken with communication and engagement colleagues across the partnership. The group had been developing the shape of discussions with the public. An approach and principles had been agreed. The STP CPB noted these: • That this must be an open conversation • That the difficult issues faced should be outlined and ask for views and what is important • That public conversations would be led by Healthwatch and the voluntary sector, with commissioner support • That staff conversations would be led by provider teams, with STP support • That political conversations would be led by STP partners, with STP support • That these discussions would happen at place level. The governance approach for this was outlined; a task and finish group to be established made of representatives from all areas, co-	

	creating the plan and timelines. A report would be delivered to the STP CPB in April 2017. It was agreed that actions at local level must be cohesive and consistent. In response to a query, it was confirmed that discussions and engagement with members would take place in February 2017. An update was given on the HASU and Children's Services consultation. A piece of work had been undertaken at the midpoint of the consultation, and as a result of the outcomes of this review, the deadline had been extended to 14 February. At the end of this process, an independent analysis would take place to show key themes and feedback. The draft report would be given to the STP CPB and Joint Healthy Overview and Scrutiny Committee before being taken to the Joint Committee of Clinical Commissioning Groups.	**HELEN STEVENS**
06/17	**Health, disability and employment** The STP CPB noted the data presented around the numbers of unemployment across the patch and the landscape across the city region and that initiatives were taking place across the city region/city. Money was available across the city region and what was required now was coordination and potentially to collaborate. The STP CPB was invited to comment. It was noted that two elements that would impact on health were employment and cessation of smoking. A request was made to ensure links were made to the workforce workstream, particularly around possibilities with apprentices. It was highlighted that discussions and engagement with employers was crucial to ensure occupational health services were utilised appropriately in organisations. It was noted that access to support must be simplified and links to IAPT for this was important. The STP CPB approved this work in principle. Further detail including baseline metrics would be brought back to the STP CPB.	**GREG FELL (CHRIS SHAW)**
07/17	**Healthy Lives** The STP CPB noted the Healthy Lives workstream related to three elements; scaling up primary care, workforce and healthy lifestyles. A key recommendation for this was employment and smoking. The STP was asked to sign up to a 10% prevalence for smoking in SYB. Detail around work that all could collaborate on was also highlighted. The group was invited to comment. It was highlighted that the 10% prevalence target felt ambitious. The timescale was confirmed as 5 years. In response to a query it was confirmed that the resource	

	requirements for this work had been included in the STP plan. It was commented that there was work that acute providers could do to support this. A discussion took place around smoking and mental health and that the work needed to align with the MH workstream to change the prevalence trend. The STP CPB committed to aspirations outlined in principle requesting that constituent organisations be consulted and a considered approach be delivered back to the STP CPB for final approval in April/May.	**GREG FELL**
08/17	**STP governance terms of reference** The STP CPB was sighted on detail of the establishment of the Governance Group. Two initial pieces of work were agreed at the first meeting; to draft out the terms of reference (ToR) and to produce a summary of the governance as it currently existed and to work with boards and members to consider what future governance could look like. Two gaps were noted in membership for Local Authority and Medical Director representation which would be considered further. A discussion took place, noting that Neil Riley was linked to this work with experience in his previous role of board secretary. The STP CPB supported the ToR.	
09/17	**Workforce terms of reference** The STP CPB were updated on the Local Workforce Action Board which had a programme of work established. A briefing would be developed, giving a comprehensive overview of the workforce landscape. A briefing would then be delivered to the board in 3-4 months time. A workstream lead was required. HEE would fund this. Business intelligence would be provided by HEE but links would be required locally. The STP CPB supported the ToR and agreed to contribute to this piece of work where required.	
10/17	**Independent review of hospital services** The STP CPB were updated on the progress around the Sustainable Hospital Review, noting the draft ToR had been agreed, steering group membership was being established and that the first meeting was taking place 7 February 2017. A project plan was being developed as well as a business case to engage support from NHS England and NHS Improvement. In response to a query, it was noted that an initial task of the steering group would be to define what sustainable services would mean. It was confirmed that the amendments to the TOR in light of discussions at the previous meeting around researched were accepted.	

	An update would be given at the next meeting.	
11/17	**Review of commissioning** The STP CPB were updated on the review of commissioning, noting that an external consultancy would be engaged to work with CCGs and that a fuller scope would be developed. A senior commissioning operations group would be established, the first meeting of which was taking place 13 January. The ambition outlined was for shadow commissioning arrangements to be in place by April 2017, aligning with the pace of the hospital services review.	
12/07	**Social Kinetic 3De proposal** The group was updated on a meeting that had taken place around the leadership work with Social Kinetic and the proposal was that the STP CPB would engage with this group and utilise a future meeting to start this work. The STP CPB supported taking this work forward.	

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017

Agenda item 9 – Assurance from Trust Board Committees

Clinical Governance and Clinical Safety Committee

Date	14 February 2017
Presented by	Julie Fox
Key items to raise at Trust Board	➢ Risk register process for Committees. ➢ Update on Child and Adolescent Mental Health Services (CAMHS). ➢ Update on Safer staffing. ➢ Workload of Committee as identified in Committee self-assessment.

Mental Health Act Committee

Date	14 March 2017
Presented by	Chris Jones
Key items to raise at Trust Board	➢ Legislative changes and impact on Trust. ➢ Mental Health Act Code of Practice and partner engagement for sign off policies. ➢ Mental Health Act/Mental Capacity Act mandatory training. ➢ Mental Health Act Code of Practice feedback showed that Trust values are embedded. ➢ Engagement in audits. ➢ Bed availability.

Remuneration and Terms of Service Committee

Date	21 February 2017 and 28 February 2017
Presented by	Rachel Court
Key items to raise at Trust Board	➢ Sickness absence reporting. ➢ Agency spend. ➢ Ensuring there are effective plans for implementation and transitional arrangements in relation to the Directors Portfolio review. ➢ Financial risk around the possible use of Mutually Agreed Resignation Scheme (MARS) in future CIPs and decommissioning. ➢ Annual report including self-assessment and review of terms of reference. ➢ Risk register process for Committees. ➢ ET business case.

South West Yorkshire Partnership NHS Foundation Trust

Minutes of Clinical Governance and Clinical Safety Committee held on 14 February 2017

Present:	Ian Black	Chair of the Trust
	Alan Davis	Director of HR, OD and Estates
	Charlotte Dyson	Non-Executive Director
	Julie Fox	Deputy Chair of the Trust (Chair)
	Adrian Berry	Medical Director / Deputy Chief Executive
	Tim Breedon	Director of Nursing and Quality
	Dawn Stephenson	Director of Corporate Development
Apologies:	Committee	
	Nil	
	Attendees	
	Carol Harris	District Director – Forensic and Specialist Services
In attendance:	Mike Doyle	Deputy Director Nursing, Clinical Governance and Safety
	Karen Taylor	District Director – Calderdale and Kirklees
	Emma Jones	Integrated Governance Manager (author)
	Sean Rayner	District Director – Barnsley and Wakefield
	Dave Ramsay	Deputy Director of Operations (item 8)

CG/17/01 Welcome, introductions and apologies (agenda item 1)

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

CG/17/02 Minutes of previous meeting held on 8 November 2016 (agenda item 2)

It was RESOLVED to APPROVE the minutes of the meeting held on 8 November 2016.

CG/17/03 Matters Arising (agenda item 3)

The following matters from the meeting held on 8 November 2016 were discussed:

Patient-led assessment of the care environment (PLACE) (agenda item 3.1)

Alan Davis (AGD) reported that notification would be provided by NHS England of when the assessments should take place which was generally in March/April each year. Work has taken place around pre-PLACE to ensure that accommodation and cleaning was to the required standard which was more challenging in smaller community and rehabs as it was difficult to replicate the standards that apply to hospitals. There has been a lot of contact with Ward Managers to clarify what was expected under normal duties and what would fall under housekeeping.

Ian Black (IB) asked if Governors were involved in the assessments and suggested Bob Clayden due to his background. AGD advised that Governors and Directors would be invited to take part with the team which usually consists of a service user, a clinician, and someone from Estates, Infection Prevention and Control, and Housekeeping.

CG/16/51 Update on revised action plan following national audit of schizophrenia (agenda item 3.2)

Dr Adrian Berry (ABe) reported that detailed returns from BDUs had been received on their progress against the action plan and it was encouraging to see that many of activities were now part of main stream or other lines of action. ABe highlighted the following:

- Medication information on the NHS Choices web based patient information system is now routinely utilised.
- Vocational activities were promoted and picked up through Recovery Colleges in Community and Forensic Services.
- Physical health care was part of CQUIN monitoring and there were good results in terms of uptake.
- All clinical rooms are now up to required standards.
- Prescribing practices were now routine and the incorporation of e-prescribing into a future clinical records management system would provide further improvement.
- All areas now have early intervention services in line with national requirements.

CG/17/04 Consideration of items from the organisational risk register relevant to the remit of the CG&CS Committee (agenda item 5)

Dawn Stephenson (DS) reported that over the last six months there had been a refocused view by the Executive Management Team (EMT) of risks and work with the Trust Board around Risk Appetite with a session provided by the External Auditors. Further work would now take place to do a deep dive on the organisational risk register as well as aligning risks to a lead Committees. Over the next quarter some work would take place with the Datix lead to understand the full functionality of the risk module in Datix as it was currently limited in how the risk appetite could be captured and extraction of the risk register into a useable format was currently being done through a manual process.

IB commented that risks 275 and 772 were in relation to commissioner funding being reduced and should the Trusts be focusing on its own future plans. DS commented that EMT had split the overall risk to commissioning into two parts. Risk 275 was in relation to impact on the demand for services where the Local Authority was the provider such as integrated teams due to a reduction in the funding Local Authorities receive. Risk 772 was in relation to the impact on level of financial resources of Local Authorities to commission services from the Trust, where contracts were being commissioned with a reduced envelope which has an impact on our service users. An example of this was the impact to changes to the smoking cessation contract which would be discussed at the Overview and Scrutiny Committee on 15 February 2017. IB asked what action the Trust can take nationally on the impact of the changes to funding. DS commented that it could be discussed further by EMT and could be discussed as part of the Sustainability and Transformation Plans.

Action: Dawn Stephenson

Charlotte Dyson (CD) asked where new risks are discussed. DS commented that new organisational level risks were discussed at EMT meetings and a lead Director and lead Committee would be identified. JF asked how EMT monitors the actions against risks. Karen Taylor (KT) commented that risks are discussed at EMT each week as part of horizon scanning and sharing intelligence as things happen, as well as a monthly focus on the risk register. DS commented that during the monthly review by EMT each risk was assessed to ensure it was still described correctly, the correct actions were place, and that the risk rating was right. JF requested that a mechanism be put in place to allow for EMT to provide assurance to committees that actions were taking place on the risks aligned to the committee.

Action: Dawn Stephenson

Tim Breedon (TB) highlighted that the mitigation of risks was included in items on the CG&CS Committee agenda such as the Child and Adolescent Mental Health Services (CAMHS) update, Transformation update, and Medicines Management.

The Committee discussed the need for there to be further wording included in the Committee Terms of Reference around the process for review of risks. DS commented that there would be a similar format report received through all Committees and the proposed changes to the Terms of Reference would be circulated to the Committee for agreement prior to their submission to Trust Board for approval.

Action: Dawn Stephenson

The Committee noted the report.

CG/17/05 Committee annual report, review of terms of reference and agreement of annual work programme (agenda item 4)

Annual report 2016/17 and self-assessment

The Committee discussed the results of the self-assessment and felt the comments in the free text were useful.

JF commented that one area the self-assessment had identified for further discussion was "*Has the Committee considered the costs that it incurs and are the costs appropriate to the perceived risks and benefits?"* and that she had asked Mark Brooks, Director of Finance if he would be able to do a calculation. CD asked if whether there was a way to measure that the Committee was making a tangible difference to service users. TB commented that it may be possible to look at areas such as patient safety and the use of resources as measures. IB commented that he felt the question was in relation to the Committee agreeing to the spending of funds which this Committee had not done and he was not sure whether that was because the Committee was not aware or whether it was because there was no further areas that were not in line with what had been agreed by management. The Committee discussed whether doing the calculation exercise would provide any assurance or lead to any action. JF commented that she would raise it for discussion at the next Non-Executive Director meeting.

Action: Julie Fox

Work programme 2017/18

The Committee agreed the annual work programme for 2017/18 and requested further consideration of the following:

- Timing of Quality Account.
- Timing of consideration of CQC reports.
- Risk register process and request for exception reports as required.

Action: Julie Fox / Tim Breedon

Terms of reference

The Committee requested that the Terms of Reference be updated to reflect the Risk Register process and Internal Meeting Governance Framework requirements for circulation an agreement prior to their submission to Trust Board.

Action: Dawn Stephenson

CG/17/06 Child and adolescent mental health services – update (agenda item 8)

Dave Ramsay (DR) highlighted the following:

- Future in Mind – there had been a recent non-recurrent investment as part of a waiting list initiative agreed with commissioners and it may see an impact on agency spend to get the right level of capacity into the system.
- CQC guidance – have published guidance around CAMHS waiting times that they intend to measure against the national waiting time standard of 18 weeks. Wait time was currently being measured on a levels agreed with commissioners.
- CQC action plan – it was felt that CAMHS would still be rated as requires improvement due to the wait times.
- Barnsley – the school-based '4Thought' team is now operational and offering consultation for school staff and brief intervention support for children/young people and parents. Recruitment to the Band 5 SPA practitioner posts has been progressed and implementation plans agreed with the CCG.
- Calderdale – the procurement process was terminated with potential to reach a negotiated solution between the CCG and the two existing contracted providers SWYPFT (Tier 3) and Northpoint (Tier 2). To facilitate this process it was agreed to renew SWYPFT's contract for CAMHS delivery - for a 2 year period at existing funding levels. Significant risk remains with respect to the funding of the First Point of Contact
- Kirklees – Successful in partnership with Locala as the lead provided around 0-19 healthy child programme. The contract was awarded for 5 years with an option to extend for a further 5 years. There was still significant challenge around transformation and ASD assessment waiting times. Deep dive review as part of Kirklees Safeguarding, report went to December Safeguarding Board, there is a subgroup to work through the recommendations to understand the details. OFSTED inspection found Kirklees provision to be inadequate, only specific recommendation to CAMHS was work with vulnerable children's team which has since been strengthened to follow the model in place in Calderdale.
- NHS Benchmarking Network 2015/16 data –data quality concerns continue to undermine meaningful like-for-like service comparison. SWYPFT waiting times for a first appointment (initial assessment) were above the national mean at 12 weeks (compared to 9 weeks). The wait for a second appointment (treatment) was over twice that of the national mean - 37 weeks compared to 17 weeks.
- Referrals – Introduction of the SPA function in Kirklees (from 1 April 2016) and Calderdale (from 1 August 2016) continues to underpin a general reduction in referrals in these areas.
- Eating Disorders – compliant with standards measured against the national Access and Waiting Time Standard for Children with an Eating Disorder (NHSE, 2015).

Sean Rayner entered the meeting.

DR highlighted the following in relation to waiting times:

- Calderdale and Kirklees CAMHS – based on a conservative trajectory it was estimated that the total number waiting for treatment should come down to less than 20, with the average wait of less than 10 weeks, by the end of March 2017.
- Barnsley CAMHS – the waiting list was 483 in December 2016 and the current position is 417 with a projection of 280 by the end of March 2017. However the average waiting times was hard to predict.

- ASD – there was still a concern in relation to wait times in Kirklees with approximately 300 on the waiting list with a waiting time of over two years. Commissioners have put in additional resource however it would only meet current demand. There was £150k of funding on a non-recurrent basis as a waiting list initiative for 2017/18 and further work was needed on the trajectories to agree with the commissioner.

TB commented it relation to the benchmarking data that it was not known what the impact was of ASD numbers on CAMHS numbers as no one could be clear whether they were included. CD suggested that it would be useful to have the waiting times separated further to see if the initiatives are having an impact on waiting times.

Action: Dave Ramsay

The Committee noted and thanked staff for the very detailed report.

CG/17/07 Transformation – update (agenda item 6)

TB reported that the transformation update was included as part of the Integrated Performance Report received by Trust Board each month and there was nothing specifically flagged in relation to clinical risks. One area to keep in focus was in relation to rehab and recovery work and whilst it was being managed there were still ongoing discussions on the outcome with commissioners in terms of final model. A second area was around intra team referrals due to the changes in team structure. This is being monitored by BDU governance. It was important that changes are made appropriately on the clinical system and this relies on manual reentry.

CD suggested that it would be good for the Committee to receive some deep dives and asked how it would be known that the benefits had been realised. KT commented that the detail behind the plans sits with the Transformation Board and when benefits have been realised it would be shown in the report. CD asked when there would be a detailed review of the overall transformation plan. DS commented that she would raise it with the EMT.

Action: Dawn Stephenson

The Committee noted the report.

CG/17/08 Quality accounts 2017/18 (agenda item 7)

TB reported that the production of the Quality Account was on track with key performance indicators agreed by the Members' Council. Guidance had been published yesterday which included some new areas, however it looked like they were already being captured. The production of quality priorities would be a longer process due to the amount of changes in the system.

The Committee noted the report.

CG/17/09 Quality Impact Assessment of cost improvement programme (agenda item 9)

TB reported that there were Cost Improvement Programme (CIP) plans in place however not all would be simple to deliver. Mike Doyle (MD) commented that a weekly scan was taking place with finance and there were some discrepancies between the ratings as a Quality Impact Assessment (QIA) had been done on plans for two years, however the current financial detail was for one year. KT commented that there was currently a £2m gap on CIPs with some more difficult to deliver than others which takes time to explore further and effort to get through the system.

The Committee noted the helpful update and requested further updates be received on any substantial changes.

Action: Mike Doyle

CG/17/10 Safer staffing (agenda item 10)

MD reported that the safer staffing agenda remained challenging however a lot of actions and initiatives were in place and in comparison to organisations the Trust was doing well and highlighted the following:

- The fill rates for registered nurses was increasing and at a satisfactory level, however it did come as a cost as the vacancies tended to be filled by agency staff.
- There was funding in place for 23 non-registered staff on the peripatetic bank next year, with further work on whether this could be increased as based on calculations the Trust was using a large whole time equivalent for unregistered agency staff. These staff could be aligned with BDUs and moved if needed to address hot spots.
- When the Care Quality Commission (CQC) inspected previously it was felt they hadn't taken into account the Trusts safer staffing plans, however on the revisit they requested fill rates, recruitment figures, unfilled shifts, exception reports, summit plans, safer staffing minutes and action plans.
- Recruitment data since February 2016 shows that 109 registered staff had been recruited with 65 who had already commenced with the Trust.
- Ward vacancies were steadily increasing last year up to August 2016 and saw a reduction although they have slightly increased again and will continue to be assessed monthly.
- Requirements for working on the bank had been modified and 180 applicants from newspaper advertisement had been received.
- Advanced practitioners is also being looked at which may help reducing agency costs.

IB asked for an update in relation to apprenticeships. AGD commented that it was important to try to keep them in the system once qualified as they were receiving a high level of training and Band 2's were now able to be used as part of redesign our system.

IB asked for an update in relation to university placements. KT commented that there was a reduction of 23% in nursing student applications. AGD commented that the impact of whether that translated into universities not filling their places was not known. TB commented that Huddersfield University had closed its Learning Disability Nursing course which would have an impact on services.

The improved reporting to Board was noted and this is to be enhanced during 17/18.

The Committee noted and thanked staff for the detailed report.

CG/17/11 Care Quality Commission (agenda item 11)

CG/17/11a Care Quality Commission learning, candour and accountability report, December 2016 and implications (agenda item 11.1)

MD reported that the Care Quality Commission (CQC) report was in response to Jeremy Hunt asking to them to look into the way healthcare providers investigate deaths. There was still a lack of clarity nationally about what actions would be required as a result of the report other than the Trust would need to have a system of identifying a threshold of deaths that require investigation. The CQC found that overall families and carers had a poor experience however as a Trust we feel we engage well with the families and ask them to be involved setting the terms of reference for investigations. There were inconsistencies in ways

organisations are advised of deaths as there was no single framework and the quality of reports was variable. The Trust has done a lot of work around mortality and how the Datix incident module could be used. The Improvement Academy also provided training for 24 senior staff on a system of case note review which would be piloted in preparation of the action anticipated from the report which was due to be published in March 2017.

IB asked if there was anything in place around the deaths occurring outside the service and within secondary care. MD commented that the Trust was part of a northern alliance group who has mentioned that they want to implement a similar methodology in primary care.

The Committee noted the report and that the Trust was well positioned to meet the revised requirements.

CG/17/11b Care Quality Commission inspection action plan (agenda item 11.2)
TB reported that 82% "must do" and 92% "should do" actions had been completed and for the areas outstanding most had a completion date end of March 2017. TB highlighted that there were areas of pressure and challenge such as Mental Health Act and Mental Capacity Act training and the embedding of supervision recording.

IB asked if it was anticipated that the training would reach the required target. TB commented that there would be a better indication at the end of February 2017 with actions in place, however there were pressures around whether staff could be released to attend the training in time.

The Committee noted the report.

CG/17/11c Mental Health Act visits – clinical and environmental issues (agenda item 11.3)
KT reported that work was progressing. JF commented that for areas that were past the expected date of completion it would be helpful to know the reason for the delay, mitigations in place, and expected date for completion.

Action: Karen Taylor

The Committee noted the report.

CG/17/12 Incident management (agenda item 12)

CG/17/12a Incident report Q3 2016/17 (agenda item 12.1)
MD reported that some improvements were being made in Serious Incident (SI) reporting with a new report into the clinical risk panel and changes to the incident module in the Datix system which was acknowledged by Care Quality Commission (CQC) as showing real time benefits. The report should show a reduction of SIs by the end of the year, a reduction in reported incidents, and a reduction in the number of apparent suicides.

TB commented that in relation to the recent suicide the investigation process was taking place by an external reviewer, all the necessary checks internally had been completed with any areas for action also completed. The Trust was maintaining positive contact with family throughout the process.

CD requested the definition of Never Events be provided.

Action: Mike Doyle

CD asked if the higher number of SIs around people on leave in Calderdale and Kirklees was showing a trend. MD commented that there was a larger population in that area and no specific issues had been identified.

The Committee noted the report.

CG/17/13 Nursing strategy progress report (agenda item 13)

MD highlighted the following:

- Ward managers network re-established.
- Supervision policy updated and new centralised recording processes in place.
- Nursing metrics to support intelligent use of data being developed for dashboards to support monitoring of clinical quality.
- Proposals for professional appearance policy being developed.
- Volunteer to support reducing restrictive physical interventions being recruited.
- Patient/service user stories published on trust website.
- Wakefield peer support workers on wards.
- Developing new roles such as the Advanced Nurse Practitioner (ANP) Band 7 roles incorporating dementia diagnosis developed for Kirklees, Barnsley & Wakefield.
- Second wave band 4 Nursing Associates bids successful.
- Trust nurses continue to contribute to development of pre and post graduate curricula with local universities.
- A project plan to manage the introduction of revalidation for nurses was developed and supported by staff seconded into the nursing directorate. All registered nurses to date have successfully revalidated or deferred if appropriate.
- Community nurse competency framework developed in Barnsley BDU.

The Nursing Quality Group has reviewed progress and was currently developing the second year action plan towards meeting the aims of the National Strategy. This would support the five year forward view with key actions to demonstrate leadership for change, the value added for patient outcome, and to eliminate clinical variation where appropriate. The Group would learn from the first year of implementation and keep the action plan more focused on a specific key deliverables that align with BDU priorities. BDU's would be asked to identify and work on their own priorities.

CD asked how it would be determined that the strategic objectives had been met. MD commented that some of the general metrics were from performance indicators i.e. nursing supervision and some would be developed around contact time and level and quality and engagement to have a measurable metric for each of the objectives set.

IB suggested that risks should be incorporated into the progress report. TB commented that the nursing directorate risk could be included in the report. MD advised that the practice placement quality team had been doing a lot of work with higher education institutions to try to match up the numbers receiving training with the workforce plan.

Action: Mike Doyle

The Committee noted the report.

CG/17/14 Deteriorating patient report (agenda item 14)

MD reported that the paper had been provided to close the loop on the patient safety alert. A group had been established with ABe as the nominated lead for CPR and physical health training and members of the nursing directorate. The national system had been adopted and would start to move to implementation.

The Committee noted the report.

CG/17/15 Sign up to safety report (agenda item 15)

MD reported that part of Patient Safety Strategy was to look at some specific outcomes and highlighted that it had been difficult to get the correct measures in place, however baselines had been agreed and making progress. One area was in relation to reducing the use of prone restraints, accepting they are appropriate for use in certain circumstances, and the rate of medicines omissions which seems to be under older persons where service users refuse the medication.

JF asked in relation to medicines omissions if information was available around the mental capacity of the service user. ABe commented that it was not an area that information had been captured previously.

The Committee noted the report.

CG/17/16 Update on topical, legal and regulatory risks (agenda item 16)

TB reported that in terms of horizon scanning most updates would come through the assurance section of the agenda. Intelligence was received from weekly clinical risk scans which looks at trends, legal risk scans were received by the Mental Health Act Committee, and any regulatory risks would be received through the Care Quality Commission (CQC) and NHS Improvement briefings. JF commented that the item on the agenda would allow a further prompt for updates to be provided. The Committee supported this approach.

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

CG/17/17a Medicines management (agenda item 17.1)

ABe reported that the paper had been included under item 17.6 and highlighted that insulin administration was a rare clinical risk, however a potentially serious risk that could be caused by different regulatory requirements. This would be discussed by the area prescribing committees to see if there were obvious ways of mitigating the risk and would be discussed at next Drug and Therapeutics Committee. JF asked if it should be raised as a potential risk for inclusion on the risk register.

Action: Adrian Berry

CG/17/17b Health and Safety and Emergency Planning (agenda item 17.2)

AGD reported that the Executive Management Team (EMT) had a discussion on potential fire risks with a healthy level of debate including the management of the Trusts no smoking policy. A paper would come back to the EMT with a recommendation on any further actions to take in relation to the policy.

IB asked in relation to training for staff if trial evacuations were conducted. AGD commented that mandatory training requirements in place, however they do not include trial evacuations due to security concerns.

CG/17/17c Infection Prevention and Control (agenda item 17.3)
TB highlighted that an influenza outbreak at Mount Vernon Hospital had been well managed by the team and on an operational perspective with service continuity maintained.

CG/17/17d Safeguarding children and adults (agenda item 17.4)
TB highlighted that there had been a review of the function of each of the Safeguarding Boards and guidance was due to be received.

CG/17/17e Managing Aggression and Violence (agenda item 17.5)
TB highlighted that new guidance had recently been issued that was being considered.

CG/17/17f Any feedback from other TAGs/groups (agenda item 17.6)

- Whistleblowing

TB reported that the paper had been included under item under 17.2. The Director of Nursing and Quality acts in the designated senior manager under stage 2 of the policy if it becomes a formal matter. Most concerns are likely be resolved by a local discussion under stage 1, informal.

AGD reported that the Audit Committee had agreed for a summary report to be received to provide an overview of the amount and type received. A page on the intranet had been recently re-launched for staff around how they could raise their concerns which included information on Freedom to Speak Up Guardians and Whistleblowing.

IB commented that the process for a Whistleblowing subcommittee should be in place should an issue arise. AGD commented that some management oversight was needed about how the process would work.

Action: Alan Davis

CG/17/17g Internal meeting governance arrangements (agenda item 17.7)
The Committee noted that the Internal Meetings Governance Framework was adopted by the Trust Board on 31 January 2017 and supported the further work required to review the Committee terms of reference to align it to the framework as discussed under item 4.

CG/17/18 Issues and items to bring to the attention of Trust Board (agenda item 18)

Issues were identified as:

- Risk register process for Committees.
- Update on Child and Adolescent Mental Health Services (CAMHS).
- Update on Safer staffing.
- Workload of Committee as identified in Committee self-assessment.

CG/17/19 Date of next meeting (agenda item 19)

The next meeting will be held at 14:00 on Tuesday 11 April 2017 in Room 52, Folly Hall, Huddersfield, HD1 3LT.

Signed …… Date ……

South West Yorkshire Partnership NHS Foundation Trust

Trust Board 28 March 2017
Agenda item 10

Title:	**Use of Trust seal**
Paper prepared by:	Chief Executive
Purpose:	The Trust's Standing Orders, which are part of the Trust's Constitution, require a report to be made to Trust Board on the use of the Trust's seal every quarter. The Trust's Constitution and its Standing Orders are pivotal for the governance of the Trust, providing the framework within which the Trust and its officers conduct its business. Effective and relevant Standing Orders provide a framework that assists the identification and management of risk. This report also enables the Trust to comply with its own Standing Orders.
Mission/values:	The paper ensures that the Trust meets its governance and regulatory requirements.
Any background papers/ previously considered by:	Quarterly reports to Trust Board.
Executive summary:	The Trust's Standing Orders require that the Seal of the Trust is not fixed to any documents unless the sealing has been authorised by a resolution of Trust Board, or a committee thereof, or where Trust Board had delegated its powers. The Trust's Scheme of Delegation implied by Standing Orders delegates such powers to the Chair, Chief Executive and Director of Finance of the Trust. The Chief Executive is required to report all sealing to Trust Board, taken from the Register of Sealing maintained by the Chief Executive. The seal has been used five times since the report to Trust Board in December 2016 in respect of the following: ➢ Transfer of Registered Titles for property Elmfield House, Prescott Street, Halifax from the Trust to Urban Phoenix Limited (transfer in duplicate, change of purchasing company); ➢ Deed of Surrender relating to rooms at Mapplewell Health Centre between the Trust and Doctors; ➢ Contract of Sale of freehold land at No. 15 Margaret Street and Beech House, Wakefield. ➢ Transfer of whole of Registered Titles for No. 15 Margaret Street and Beech House, Wakefield. ➢ Trust Deed to make Spirit in Mind a linked charity of the Trust.
Recommendation:	**Trust Board is asked to NOTE use of the Trust's seal since the last report in December 2016.**
Private session:	Not applicable.

NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Trust Board annual work programme 2017

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	✘	✘	✘	✘	✘	✘	✘	✘
Assurance from Trust Board Committees	✘	✘	✘	✘	✘	✘	✘	✘
Receipt of minutes of partnership boards	✘	✘	✘	✘	✘	✘	✘	✘
Quarterly items								
Customer services quarterly report	✘		✘		✘		✘	
Assurance framework and risk register	✘		✘		✘		✘	
Investment appraisal framework	✘		✘		✘		✘	
Strategic overview of business and associated risks	✘		✘		✘		✘	
Use of Trust Seal		✘		✘		✘		✘
Serious incidents quarterly report		✘		✘		✘		✘
Corporate Trustees for Charitable Funds# (annual accounts presented in July)	✘		✘		✘		✘	
Annual items								
Eliminating mixed sex accommodation (EMSA) declaration		✘						
Information Governance toolkit		✘						
Strategic objectives		✘						
Draft Annual Governance Statement (final approval by Audit Committee)			✘					
Audit Committee annual report			✘					
Planned visits annual report			✘					
Risk assessment of performance targets, CQUINs and Single Oversight Framework and agreement of KPIs for 2017/18			✘					
Annual report, accounts and quality accounts				✘				

Agenda item/issue	Jan	Mar	Apr	June	July	Sept	Oct	Dec
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)								
Policies and strategies								
Constitution (including standing orders), Scheme of Delegation and Standing Financial Instructions *(next due for review in January 2019 or as required)*	✘							
Policy for the development, approval and dissemination of policy and procedural documents (Policy on Policies) *(next due for review in January 2019)*	✘							
Risk Management Strategy *(next due for review in January 2019)*	✘							
Treasury Management Policy *(next due for review in January 2019)*	✘							
Workforce Strategy		✘						
Membership Strategy			✘					
Commercial Strategy				✘				
Quality Improvement Strategy *(next due for review in July 2017)*					✘			
Information Management and Technology Strategy								
Communication, Engagement and Involvement strategy *(next due for review in December 2019)*								
Organisational Development Strategy *(next due for review in December 2019)*								

	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.	